



REPUBLIC OF GHANA

# HEALTH SECTOR GENDER POLICY



MINISTRY OF HEALTH

April 2009



Republic of Ghana

HEALTH SECTOR

# **GENDER POLICY**

Ministry of Health

April 2009

# GENDER POLICY

© April 2009 Ministry of Health, Ghana

ISBN – 978-9988-1-2170-9

Published By Ministry Of Health

All rights reserved. No portion of this book may be produced, stored in a retrieval system or transmitted in any form or by any means, electronic, mechanical, photocopying, recording or otherwise without the prior written permission of the publisher.

**For further information please contact the**

**Gender Focal Person,**

**Ministry of Health.**

**P.O.Box MB 44, Accra**

**Designed & Printed by Imagine Communications Ltd.**

## ACKNOWLEDGEMENTS

### HEALTH DEVELOPMENT PARTNERS

- |                                  |   |
|----------------------------------|---|
| 1. Mad. Salimata Abdul-Salam     | Chief Director (MoH)                              |
| 2. Dr. Cecilia Bensti            | Private Sector Unit (MoH)                         |
| 3. Dr. Reginald Aryee            | Private Sector Unit (MoH)                         |
| 4. Mr. Yaw Okyere-Nyarko         | Ministry of Finance/IERD                          |
| 5. Ms. Alice Attipoe             | Office of the Head of Civil Service (OHCS)        |
| 6. Ms. Alice Lamptey             | Vision Consult                                    |
| 7. Dr. Nii Ayite Coleman         | Ministry of Health (MoH)                          |
| 8. Dr. Gilbert Buckle            | National Catholic Secretariat                     |
| 9. Ms. Mabel Cudjoe              | Department of Women, MOWAC                        |
| 10. Ms. Gifty Ohene- Konadu      | Ministry of Women and Children's Affairs ( MOWAC) |
| 11. Ms. Philomina Johnson        | National Development Planning Commission (NDPC)   |
| 12. Ms. Esther Yaa Apewokin      | National Population Council                       |
| 13. Mr. Seth Acquah              | HRDD - MoH  |
| 14. Mr. Kwakye Kontor            | PPME - MoH  |
| 15. Ms. Rejoice Nutakor          | FH Unit PH Division - MoH                         |
| 16. Ms. Francesca Pobee-Hayford  | Acting Director Department of Women, MOWAC        |
| 17. Ms. Linda Asamoah            | HRDD - GHS  |
| 18. Mrs. Martha Gyansa-Lutterodt | GNDP - MoH  |
| 19. Ms. Janet Kwansah            | PPME – MoH  |
| 20. Mrs. Theresa Akuoko          | PPME - Ghana Health Service                       |
| 21. Ms Patience Agyare-Kwabi     | Gender Consultant                                 |

### MEMBERS OF THE GENDER COMMITTEE - MoH

- |                              |   |                                     |
|------------------------------|---|-------------------------------------|
| 1. Mr. Abraham Dwuma Odoom   | - | Chairman, MoH                       |
| 2. Lepowura M.N.D. Jawula    | - | Member, MoH                         |
| 3. Mad. Salimatu Abdul-Salam | - | Member, GDO                         |
| 4. Alhaji Mohammed Muniru    | - | Member, PPME/MoH                    |
| 5. Mrs. Theresa Akuoko       | - | Member, PPME/GHS                    |
| 6. Mrs. Marian Tackie        | - | Member, MOWAC                       |
| 7. Dr. Gloria Quansah        | - | Member, GHS, Family Health Division |
| 8. Mrs. Molley Brown Ackah   | - | Member, Attorney General's Dept.    |
| 9. Mr. Ian McFarlane         | - | Member, UNFPA                       |
| 10. Ms. Mercy Konadu         | - | Member, UNFPA                       |

## LIST OF ABBREVIATIONS

AAP	Affirmative Action Programme
BCC	Behaviour Change Communication
CBHDs	Community Based Health Delivery system
CEDAW	U. N. Convention on Elimination of All Forms of Discrimination Against Women
CHIM	Centre for Health Information and Management
CSOs	Civil Society Organisations
DHMT	District Health Management Team
DVL	Domestic Violence Law
ECOSOC	Covenant on Economic, Social & Cultural Rights
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
GPRS	Growth and Poverty Reduction Strategy
GRB	Gender Responsive Budgeting
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
LI	Legislative Instrument
MDAs	Ministries, Departments and Agencies
MDGs	Millennium Development Goals
MoE	Ministry of Education
MoFA	Ministry of Food and Agriculture
MoH	Ministry of Health
MOWAC	Ministry of Women and Children's Affairs
MTCT	Mother to Child Transmission
MTEF	Medium Term Expenditure Framework
NACA	National Advisory Council on AIDS
NACP	National AIDS/STD Control Programme
NCDs	Non-communicable Diseases
NDPC	The National Development Planning Commission
NGOs	Non-Governmental Organizations
NHIS	National Health Insurance Scheme
NTCA	National Technical Committee on AIDS
OHCS	Office of the Head of Civil Service
OPD	Out-patients Department
PHD	Public Health Division
SDHMT	Sub-District Health Management Team
STIs	Sexually Transmitted Infections

# TABLE OF CONTENTS

## PREFACE

CHAPTER 1	INTRODUCTION	1
CHAPTER 2	SITUATION ANALYSIS OF GENDER ISSUES IN THE HEALTH SECTOR	4
2.1	International and National Commitments to Gender Equality	5
2.2	Gender, Health and the GPRS II	6
2.3	Gender and the National Health Policy (2007)	7
2.4	Gender Issues in the Health Sector	8
2..4.1	Access to Health Care	10
2..4.2	Quality of service delivery and care	11
2.4.2.1	Ethics and Human Rights	11
2.4.2.2	Communicable Diseases	12
2.4.2.3	Non-communicable Diseases	13
2.4.2.4	Mental Health and Gender-Based Violence	13
2.4.2.5	Nutritional Disorders	14
2.4.2.6	Sexual and Reproductive Health	15
2.4.3	Gender and Social Transformation	17
2.4.4	Management, Governance and Finance	17
CHAPTER 3	GENDER POLICY FRAMEWORK	19
3.1	Guiding Principles	19
3.2	Rationale	20
3.3	Goal	21
3.4	Broad Objectives	21
3.5	Key Elements	22
CHAPTER 4	GENDER MAINSTREAMING FRAMEWORK FOR THE HEALTH SECTOR	24
4.1	Access to healthcare	25
4.2	Quality of care	26
4.2.1	Ethics and Human Rights	26
4.2.2	Gender Insensitivity in Healthcare Delivery	27
4.2.3	Diseases and Disorders	28

4.2.4	Reproductive Health	31
4.2.5	Gender Based-Violence	32
4.3	Management of the Health System	34
4.3.1	Administrative Structures	34
4.3.2	Management Information Systems	34
4.3.3	Human Resource	36
4.4	Gender Responsive Budgeting In the Health Sector	38
<b>CHAPTER 5 IMPLEMENTATION ARRANGEMENTS</b>		<b>39</b>
5.1	Implementation Strategies	39
5.1.1	Sex disaggregation and Gender Based Analysis	39
5.1.2	Capacity Enhancing, Training and re-orientation of staff	40
5.1.3	Advocacy	41
5.1.4	Information Education and Communication (IEC) / Behaviour Change and Communication (BCC)	41
5.1.5	Partnership and Inter-sectoral Collaboration	42
5.1.6	Reporting system/Mechanisms	45
5.2	Institutional Arrangements	45
5.2.1	Ministry of Health	46
5.2.2	Ghana Health Service	46
5.3	Resource Mobilization and Allocation	48
5.3.1	Financial	48
5.3.2	Human Resource	48
5.4	Gender Responsive Budgeting	48
5.5	Research	49
5.5.1	Operational Research	49
5.6	Monitoring and Evaluation	50

## PREFACE

Enshrined in the 1992 Constitution, the Government of Ghana is mandated to ensure fair treatment of men and women. Ghana has also made commitments towards gender by ratifying a number of international instruments and guidelines to promote gender equality which also has implications on the development and promotion of health for all its citizenry. These include the United Nation's Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Safe Motherhood Conference in Nairobi (1987) the Cairo-Population Conference (1994), and the International Conference on Population and Development (ICPD).

Significantly, Ghana has ratified the Beijing Platform of Action, which urges all governments and other development actors to actively promote a visible policy of mainstreaming gender perspectives in all policies and programmes. As evidence of its commitment to the international treaties and conventions, the Government of Ghana has initiated an Affirmative Action Programme (AAP) as well as established a Ministry of Women and Children's Affairs (MOWAC). The ministry has developed a National Gender and Children's Policy Framework. The Policy has set a national agenda to mainstream gender concerns in the development process in order to improve the social, legal/civic, political, economic and cultural conditions of the people of Ghana, particularly women and children, which is an integral part of the national development policy. This policy framework guides the development of all sector policies and programmes aimed at evolving a society that is informed and conscious of the rights of children and gender development issues.

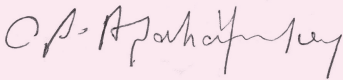
This Alma Atta Declaration of Health for all in 1977, placed emphasis on 'a state of complete physical, social and mental well-being of people and not merely the absence of disease'. The Ministry of Health, taking a cue from the level of government's commitment to gender issues has since 1999 began an initiative to look at the health sector through a 'gender lens'. This health sector Gender Policy document therefore



seeks to recognize the ways in which gender relations, roles, responsibilities, access and control of resources impact on women and men's health.

This policy document is the outcome of a broad-based consensus building process, which drew on the expertise of a wide range of stakeholders and resource persons from all sectors including Ministries, Departments and Agencies (MDAs), the Private Sector, Civil Society Organizations including Non-Governmental Organizations (NGOs). Health development partners have also contributed immensely towards the realisation of this policy document.

It is the Ministry's hope that users of this document will find it useful in mainstreaming gender in the planning and implementation of health sector programmes and that sector gender analysis shall be undertaken to support the prioritization of critical gender related and specific health issues for redress.



Dr. George Sipah Yankey  
Minister of Health

## CHAPTER 1 INTRODUCTION

Whilst health needs of both men and women are crucial, gender issues are real and permeate every facet of health promotion and delivery. It is a complex consideration in health choices and needs to be understood and mainstreamed to ensure that the health needs of both men and women are met as well as the roles and responsibilities of men and women working with the health system are equitably considered. Gender equality is important for the achievement of sustainable management and development of the health sector because it ensures that both men and women are in a position to contribute effectively to health delivery and to demand for equitable health services, by recognising gender as one of the factors influencing roles, responsibilities, status and influence in society.

Society prescribes to women and men different roles and responsibilities within different social contexts. There are also differences in the opportunities and resources available to women and men, and in their ability to make decisions and exercise their human rights, including those related to protecting health and seeking care in case of ill health. Gender roles and unequal gender relations interact with other social and economic variables, resulting in different and sometimes inequitable patterns of exposure to health risk, and in differential access to and utilization of health information, care and services.

Although the health sector in Ghana has over the past decades made considerable progress in improving the health status of Ghanaians, it has become evident that these improvements have not been shared by all people living in Ghana. Ghanaians continue to suffer the burden of infectious diseases, poor reproductive health, malnutrition and non-communicable diseases, which affect their quality of life and life expectancy. This situation has been attributed to the fact that little

consideration is given to socio-economic, cultural and other factors that impact on the health of individuals (women and men) in the determination of ill health.

In Ghana the promotion of gender equality is mandated by the constitution as well as national frameworks and instruments for gender mainstreaming. The 1992 National Constitution: - Chapter Five makes provision for the equitable engagement of both women and men, and embodies the need to focus on redressing existing imbalances including health accessibility, quality care and also in decision-making. Section 2.8 of Ghana's National Population Policy (revised, 1994) states: "in view of the woman's central role in production and reproduction, her importance both as an agent and beneficiary of socio-economic development and change cannot be overemphasised". In addition, section 5.6 of the Population Policy argues that "women play an important role in the socio-economic development of the country". The Decentralisation policy seeks to bring participation in decision making and development closer to communities, and provides a window of opportunity for addressing specific economic and socio-cultural imbalances at the district level through specific support for both men and women equitably, to facilitate human development.

In 2001 a fully-fledged Ministry of Women and Children's Affairs (MOWAC) was established. It was given same responsibilities and focus on facilitating the creation of an enabling environment for gender equity and women's empowerment. Similarly, the efforts of MOWAC are to be complemented by the activities of sector ministries and several NGOs, including those of women and civil society in partnership with multi-lateral and bi-lateral development agencies. The ministry's previous policy documents providing a framework for planning at the various levels of the health delivery system were noted to be gender neutral or gender blind. They failed to recognize that in view of their different roles, responsibilities, access and control over resources, men and women have different health needs, priorities, challenges and opportunities, which impact on their health.

The Ministry has a Gender Committee chaired by the Sector Minister and Gender Desk Officers in the various Ministries, Departments and Agencies (MDA's) with draft guidelines for the operation of these officers developed. These officers are expected to make inputs into policy formulation in their various MDA's by way of promoting gender mainstreaming.

The Domestic Violence Act 2007, (Act 732) was passed by Parliament on 21st February, 2007 and enacted as law on 3rd May, 2007 with Presidential assent. The Domestic Violence Act provides the long awaited legal environment to empower various actors and professionals to deal more effectively with the problem of domestic violence. The diverse experiences of victims of domestic violence require that systems develop individualized responses to meet victim needs while conforming to best practice. The effects/consequences of domestic violence on the victims and society at large are far too serious to be left unchecked. Domestic violence denies victims and survivors their fundamental rights and undermines human development goals. The health consequences on abused women and the negative psychological and emotional impact on children compromise their well being and undermine development.

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

## CHAPTER 2

# SITUATIONAL ANALYSIS OF GENDER ISSUES IN THE HEALTH SECTOR

Men and women are different in terms of their healthcare needs and their disease epidemiology. They also have different roles to play in their response to health promotion and the reduction of barriers to accessing health services. The concept of gender differentiates the sociologically attributed aspects of individuals' identities from the physiological characteristics of men and women. It refers to the attributes and opportunities associated with being male and female and the socio-cultural relationships between women and men which reflect the social, cultural, economic, and political roles ascribed to women and men because of their sex difference.

The 2000 census indicated a Ghanaian population of 18.9 million, with an annual growth rate of 2.7 per cent. The total fertility rate declined from 6.4 children per woman in 1988 to 4.4 in 2003. The ratio of males to females is 97.9:100 in 2000 indicating that there are more females than males. In response to the growing concerns of gender neutrality, the Ministry of Health in 1999 undertook a situational analysis of gender issues within the sector and a document "Promoting Gender Equity in Health, A Framework for Action" was produced. This document highlighted some of the gender issues in the health sector and also proposed a framework for action to address them. The study indicated that the current health care delivery interventions have failed to appreciate that gender is relevant to health. The different roles and responsibilities of women and men, inequities in access to resources, information and power are reflected in their health seeking behaviour, their vulnerability to illnesses and quality of care provided them.

## 2.1 INTERNATIONAL AND NATIONAL COMMITMENTS TO GENDER EQUALITY

The negative effects of discrimination against women became an international concern during the UN Decade on Women (1975-1985). Since then gender equality promotion and gender mainstreaming has become an area of increasing concern as reflected in the recommendations and statements from all the international UN conferences during the 1990s. Ghana has consistently confirmed its commitment to gender by ratifying and supporting international commitments to gender equality promotion.

Ghana's sectoral policies and strategies to address gender discrimination and promote women's rights derive from its own constitution and the international conventions and declarations on gender which provide the legal framework upon which gender equality issues are addressed. These include: the Universal Declaration of Human Rights, the Convention on the Elimination of all Forms of Discrimination against women (CEDAW), the Covenant on Economic Social and Cultural Rights (ECOSOC), the UN Declaration on the Elimination of all Forms of Violence against Women (CEDAW) ratified in 1986, the Vienna Declaration on Human Rights of 1993, the Beijing Declaration and Platform for Action of 1995, the International Conference on Population and Development (ICPD) declaration of 1994, the African Charter on Human and People's Rights and the Protocol on the Rights of Women in Africa.

Ghana's policy commitments to gender equality promotion with implications on health are also enshrined in the National Plan of Action on Girls Education (1995); the Ghana Poverty Reduction Strategy 1 (2002); Growth and Poverty Reduction Strategy II (2005); National Gender and Children's Policy (2004); The National Plan of Action for Women; the National Gender and Children's Strategy (2004); The Early Childhood Care and Development Policy (2004); the Three Year Strategic Implementation Plan of the Ministry of Women and Children (2005-2008) and the Domestic Violence Law, 2007. Critical to this

policy is the national response in addressing HIV/AIDS which includes the establishment of National Advisory Council on AIDS (NACA) in 1985 and National Technical Committee on AIDS (NTCA); the National AIDS/STD Control Programme (NACP) in 1987 and the establishment of the Ghana AIDS Commission in September 2000.

Ghana has also signed on to a series of key international development targets with direct and specific implications on gender and health provision.

### **The Millennium Development Goals (MDGs)**

These include 8 goals, 18 targets and over 40 indicators. The MDGs are to be achieved between 1990 and 2015. The global approach to health and development is increasingly influenced by these MDGs:

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

## **2.2 GENDER, HEALTH AND THE GPRS II**

The Growth and Poverty Reduction Strategy (GPRS II: 2006 – 2009) focus on health has been outlined to relate to improved access to health care, malaria control and prevention of HIV/AIDS. The GPRS II envisages that to accelerate access to quality health services, the health sector will continue to deepen efforts and focus on the three broad policy objectives: (i) bridge equity gap in access to quality health and nutrition services; (ii) ensure sustainable financing arrangements that protect the poor; (iii) enhance efficiency in service delivery. These focus indeed have direct implications on gender since a key factor that

influences these objectives is individual needs, roles and responsibilities. Gender mainstreaming and women's empowerment is identified as cross cutting issues and strategies in the GPRS II which calls upon all stakeholders to ensure that its plans and programmes address gender inequality.

Critically all the priority areas identified for health have gender implications. These include Malaria and HIV/AIDS. The susceptibility of pregnant women and children to malaria for instance makes it important to see gender considerations as imperative. The vulnerability of women and girls to HIV/AIDS infections demands some effort at addressing gender and HIV/AIDS issues. Population management is another priority area outlined within the GPRS II with specific strategies which include the promotion, access to and utilization of family planning services; educating the youth on sexual relationships and also, fertility regulation. Issues relating to adolescent health, marriage and child bearing are to be specifically addressed through the promotion of sexual health, delayed marriage and child bearing; promote compulsory education for children especially the girl-child up to secondary school level.

### **2.3 GENDER AND THE NATIONAL HEALTH POLICY (2007)**

Currently, the National Health Policy of 2006, themed "Creating Wealth through Health" captures the central role of health in national development for it is only a healthy nation that can be productive (MOH, 2007). The health sector policy has been designed within the context of Ghana's vision of achieving middle income status by 2015.

According to the document, the strategic direction of improving human capital makes health central to Ghana's development efforts: only a healthy population can bring about improved productivity and subsequent increase in GDP, and by doing so ensure economic growth. Hence the old adage "a healthy population is a wealthy population". The mission of the Ministry of Health as stated in the policy document



is to contribute to socio-economic development and wealth creation by promoting health and vitality, ensuring access to quality health, population and nutrition services for all people living in Ghana and promoting the development of a local health industry. This mission puts the concept of health beyond the confines of curative care to other socio-economic determinants of health.

The policy document provides a new direction in the development of health in this country, and will serve as the basis for the development of our health sector priorities and planning and therefore has direct implications on gender mainstreaming in the health sector. The policy views health in its broadest sense as a multi-sectoral programme focusing on the physical, social, economic, and spiritual dimensions which can bring total health to individuals, their families and communities. There is therefore a paradigm shift from curative action to health promotion and the prevention of ill-health. The policy argues that a healthy population can only be achieved if there are improvements in environmental hygiene and sanitation; proper housing and town planning; provision of safe water; provision of safe food and nutrition; encouragement of regular physical exercise; improvements in personal hygiene; immunization of mothers and children; prevention of injuries in our work places and prevention of road accidents. Implicit in all these are the different roles that men and women play to support the achievement of a healthy population in the Ghanaian society where culture and tradition determine roles and opportunities for women.

## **2.4 GENDER ISSUES IN THE HEALTH SECTOR**

The majority of conditions leading to out-patient attendance at clinics in Ghana are malaria, diarrhoea, upper respiratory tract infection, skin disease, accidents, hypertension, eye infection, pregnancy-related conditions, helminthiasis and osteoarthritis. Over 90% of these diseases and conditions could easily be prevented if appropriate environmental and lifestyle measures were to be taken. The

programmes and projects of the Ministry of Health to date, however, have focused on curative care, leading to failures of the Ministry to make a significant impact in the development of promotive and preventive health to the benefit of its people. It is within this context that this new health policy is being proposed. Among key gender issues identified in the health sector are as follows:

- Access to health care for men and women
- Gender and Life Expectancy
- Communicable and non-communicable diseases
- Sexual and reproductive health
- Gender and HIV/AIDS
- Sexual and gender based violence
- Gender and Mental Health
- Implications of traditional and cultural gender issues on health
- Gender and Nutritional Health
- Emerging Trends and Issues with Gender and Health Implications

Relevant to the above is the gender sensitivity of the health service delivery. The Ministry of health conducted a Community Consultative Study in three regions namely Brong Ahafo region, Upper East region and Volta region in 2003 which established the perspectives of partners at the community and district levels on pertinent issues. The study findings reinforced that in seeking medical care, socially ascribed gender roles are reinforced in terms of decisions, consent, resource ownership and control. Access to reproductive health for men was also found to be generally poor and has contributed significantly to the inability of most men to encourage their female partners to access the service whilst access to health services in rural communities, especially for women was poor. This is mainly due to the long distances of communities to the nearest health facility and the operating hours. Certain cultural and religious practices also sometimes delayed or prevented both men and women, (especially women) from seeking health care. The study revealed that some modes of disseminating

health messages are preferred and regarded as more effective than others. It is noteworthy that the study also revealed some degree of gender-based violence including rape, wife beating and child abuse still exist. These forms of violence have serious effects on the emotional and psychological well being of the women and children. The issue of privacy during consultations and same sex health staff was preferred by most men and women. Certain diseases such as TB, HIV/AIDS, maternal mortality and other protracted illnesses were perceived as due to witchcraft and other spiritual forces. This results in delay in seeking medical attention which in turn results in complications and sometimes avoidable deaths.

#### **2.4.1 Access to Health Care**

Evidence shows that only about one-third of the total population of the country has access to orthodox health care facilities, which are mostly urban-based. The health seeking behaviour of women is generally believed to be low with the exception of women in the reproductive age group. However, empirical evidence also reveals that although there are higher levels of utilization of health facilities by women because of their care giving roles, travelling to health facilities is an added burden to their already heavy domestic schedules. Women's higher levels of poverty, lower literacy levels and ignorance as compared to men affect them adversely. In addition, negative socio-cultural practices such as food taboos, non-involvement in decision-making regarding their health and that of their families also tends to compound this situation. The above factors cause women to delay in seeking health care and in turn results in high maternal mortality. Working hours of most health facilities do not favour most clients especially women, since they have to do household chores and other economic activities.

Anecdotal evidence has also revealed that, most service providers are females and this serves as a deterrent to most men in accessing health care, particularly reproductive health services.

## 2.4.2 Quality of service delivery and care

Quality of care has been a major issue in the health sector and was identified as one of the major themes of the first Medium Term Health Strategy (1997-2001). Recent studies have confirmed the lack of gender sensitivity on the part of healthcare providers, many of whom have been described as authoritative, insensitive and discourteous. Respect for clients/patients is usually more skewed towards men than women. The negative staff attitudes of some service providers, which are due to inadequate and poor conditions of service has been found to adversely affect the quality of care. The lack of awareness on the part of clients of the difficult circumstances under which health care providers have to work also results in their negative and uncompromising attitudes to health staff. Current service delivery infrastructure in most health facilities does not facilitate client privacy and this affects all clients, especially women.

Health Information, Education and Communication (IEC) materials for preventive and promotive health activities are often gender unfriendly and insensitive to already disadvantaged clients, majority of whom are women and non-literate. Sometimes the messages reinforce gender stereotype.

### 2.4.2.1 Ethics and Human Rights

Health care providers are often not alert to their professional ethical responsibility enjoining them to accord full respect at all times and in all circumstances to persons they attend to irrespective of sex, sexual orientation, religion, educational level, socio-economic position among others.

In most Ghanaian cultures decisions on where and when to seek health care is primarily the preserve of men. This notwithstanding clients, (in particular women) often do not have enough information to empower them decide on treatment options.

Anecdotal evidence shows that health care providers are not alert to the socio-cultural causes of ill health in the disadvantaged and vulnerable groups especially women, adolescent girls and thus do not accord these groups the expected degree of attention.

#### **2.4.2.2 Communicable Diseases**

Biological differences and the socio-cultural environment of men and women have bearing on their presentation and the expression of diseases. Malaria, Tuberculosis (TB) and HIV/AIDS and all other communicable diseases are critical diseases, which have exemplary gender dimensions. Therefore in coming out with disease control interventions, the socio-cultural conditions, roles and relationships between men and women should be analyzed.

Malaria in Ghana is the single most important cause of mortality especially among children under five years and pregnant women. The disease is responsible for a substantial number of miscarriages and low birth weight babies among pregnant women. Among this group, malaria accounts for 13.8% of Out-patient Department (OPD) attendance, 10.6% of admissions and 9.4% of deaths. Around 800,000 children under the age of five die from malaria in Africa every year, making this disease one of the major causes of infant and juvenile mortality. In Ghana it stands out as an important cause of morbidity and contributes significantly to anaemia among pregnant women, miscarriages, as well as maternal and infant deaths. The effect of TB on men and women is stigma and social rejection. However it is more pronounced among women because of gender stereotyping. In most situations where women have been diagnosed they are not able to afford the cost of transportation for continuous treatment, hence the associated high rate of default among women. There are also significant socio-cultural and socio-economic barriers men and women face when seeking TB care and treatment.

HIV/AIDS is one of the serious public health challenges in Ghana today with huge gender implications. The current national prevalence

rate is estimated to be 2.7%) as compared to 3.1% in 2003. The pandemic is taking its toll more on women than men with serious gender dimensions to the disease as a result of women's anatomical, socio-cultural and economic vulnerability to the disease. With regards to men the case has to be made about masculinities and risky sexual behaviour which are condoned culturally and socially in Ghana. As of 2003 it was estimated that for every man infected with HIV/AIDS two women are infected. Mother to child transmission (MTCT) is the second major means of transmissions, accounting for 15% of new transmission. It was estimated that the prevalence rate among pregnant women was 3.1% in 2006. HIV prevalence among women is also high though that among pregnant women declined from 3.2% to 2.6%, exceeding the target for 2007, and the number of HIV-positive individuals receiving ART doubled from around 6,000 to over 13,000 between 2006 and 2007.

#### **2.4.2.3 Non-communicable Diseases**

Non-communicable diseases, particularly the cancers (breast, cervical, prostate and lung) are a growing problem in Ghana. Recent statistics show an increase of 7.5% in the incidence of all cancers and 12.5% of female cancers. Majority of cases in women are not detected early due to lack of awareness and access to diagnostic facilities. Cancer of the cervix and breast respectively are the leading cancers among women. Information from the Cancer Registry from KBTH indicates that women account for 75% of the cancers seen in the hospital. Also 75% of the cancers seen in women are cancers of the reproductive system. Cancer of the cervix and breast respectively are the leading cancers among women. They account for 49% and 42% respectively of the cancers of the reproductive system.

#### **2.4.2.4 Mental Health and Gender Based Violence**

Available health service information indicates that psychiatric illnesses affecting both men and women are on the increase and that the causative factors are different for the sexes. Whereas in men this

increase is predominately due to pathological reasons, that in women is closely related to marital and other social factors. Depression, the most prevalent psychiatric condition is higher among women than in men. The difference in causative factors is often not considered in the management of mental illnesses affecting the sexes, which affects the quality of care rendered by the health sector. There is a general lack of awareness of the gender dimensions of the different causes of mental illness among women and men by the general public.

It is also known that other forms of gender-related violence, (Rape, Child Sexual Abuse, Sexual Harassment, Female Genital Cutting (FGC), Sexual and Domestic Violence), which also have psychosocial implications are seemingly condoned by society and not adequately addressed by the health sector. There is inadequate collaboration and cooperation between the health delivery system, social support networks and law enforcement agencies in dealing with victims of gender-based violence. In May 2007, the Domestic Violence Act, 2007 (Act 732) was enacted by the President and Parliament of Ghana to provide protection from Domestic Violence particularly for women and children and for connected purposes. With the passage of the Domestic Violence Law and the implementation plan being developed by the MOWAC, opportunities for effective and efficient collaboration and cooperation between various relevant stakeholders, including the health sector, now exists.

#### **2.4.2.5 Nutritional Disorders**

While there is little information on the nutritional status of men in Ghana, malnutrition is known to be fairly widely prevalent among women and children, and has been identified as a major contributory factor to high maternal morbidity and mortality. Malnutrition including under nutrition in children of poor families, micro-nutrient deficiency in children and pregnant women and over-nutrition in adults is known to be an underlying factor in high levels of morbidity and mortality in Ghana. Anaemia forms 1.7% distribution of outpatient attendance among the ten leading causes of morbidity in Ghana. The nutritional

status of Ghana is captured as 17 percent underweight, 22.4 percent stunting prevalence and 5.4 percent wasting prevalence. There is also an increase in the number of women (and men) with overweight (obese) problems. Micro-nutrient deficiency is high in Ghana.

The 2003 DHS found that more than three-quarters of Ghanaian children 6 – 59 months old have some level of anaemia, including 23% of children who are mildly anaemic, 47% who are moderately anaemic and 6% who are severely anaemic. In the case of women aged 15 – 49, the prevalent rates are lower with 45% anaemic, 35% mildly anaemic, 9% moderately anaemic and less than one percent severely anaemic. In case of adults, data from the Ghana Health service (GHS) for 2005 on In-Patient Morbidity from January to December, reveals that anaemia was second to malaria as the most reported case. Men (7716 forming 52%) reported more cases than women (7261 forming 48%) at the in-patient department nationally. On the surface, the fact is clear that men were more anaemic than women and the need for programmes and projects to address this issue has not been that much highlighted in documents reviewed. Also culturally there exist food taboos among some ethnic groups which could prohibit the intake of some vital nutrients with nutritional implications.

#### **2.4.2.6 Sexual and Reproductive Health**

In Ghana sexual and reproductive health relates critically to the role of men and women in exposing themselves and others to healthy or poor sexual behaviours; family planning particularly access to and acceptability of contraception; women's risk to abortion; high maternal deaths and general knowledge about reproductive health options and opportunities. The 1985 reform of the criminal code included a law permitting abortion if a pregnancy is the result of rape, incest or "defilement of a female idiot"; if the pregnancy threatens the woman's physical or mental health; or if there is substantial risk that the child would suffer from a serious deformity. However, existence of this law does not guarantee women's access to abortion services. To begin with, safe abortion was not integrated into the national reproductive health policy until 2003.



In Ghana like elsewhere different standards are applied to men's and women's sexual behaviour, women often have little say in their sexual lives and are left vulnerable to unwanted pregnancies and sexually transmitted infections (STIs), including HIV/AIDS. After improving between 2005 and 2006, institutional Maternal Mortality Rate (MMR) worsened between 2006 and 2007 from 197/100,000 to 244/100,000. There is therefore an urgent need to step up efforts to address these worsening indicators which indeed is a gender issue that affects mostly women. The following factors contribute to the high rate of maternal mortality:

- Insufficient knowledge among health staff and community members, especially adolescents on risk factors and danger signs during pregnancy, labour, delivery and the postnatal period expose pregnant women to the risk of death.
- Inadequate basic emergency obstetric and gynaecological healthcare packages within reach of women and adolescents of childbearing age; for instance, health centres which can provide sustainable services including blood transfusions, theatre services for minor obstetrics and gynaecological emergency operations, ambulance services, et cetera with appropriately trained staff.
- Lack of comprehensive abortion care rather than post abortive care. This issue however needs a legal backing from the Attorney General to develop the Legislative Instrument (L I) before it can properly be rolled out in the country.
- Inadequate supervision at all health centres, both government, private and NGOs, inadequate number of health workers trained in life saving skills as well as poor communication and transportation system also compounds the problems.

- Socio-cultural values/stereotypes, negative attitudes of healthcare providers or lack of customer oriented service by healthcare providers interfere with the right of women and adolescent males and females to family planning and safe abortion services.

### **2.4.3 Gender and Social Transformation**

There has been reported progress in poverty reduction in the country since 1990. The proportion of Ghanaians in extreme poverty has declined from 37 per cent to 27 per cent. The Ghanaian society is also transforming from a rural community towards rapid urbanizations. This invariably goes with important changes in gender roles of women and men. Growing phenomenon of female headed households (unexpectedly these seem to be not the poorest) with implications for child care at the household levels (HH) and access to health care (mothers are working, opening hours of health facilities usually only in day-time) and probably many more core-households versus extended family arrangements. These impacts on health and health care.

### **2.4.4 Management, Governance and Finance**

The management of the current health delivery system is gender neutral, and therefore, there are no structures and mechanisms to address gender concerns.

There is a general gender imbalance at all levels of management positions (district, regional and national) in the health sector. Competent and qualified women who could occupy higher positions are found mainly in the lower and middle levels. Subtle forms of discrimination exist which keeps them out of these positions. Reverse forms of subtle discriminatory practices and attitudes have also not encouraged men to enter into the nursing and midwifery professions.

Most Ministry of Health (MoH) staff, especially women, do not know

the conditions of service and career opportunities that exist. The prevailing arbitrary career progression opportunities often leave the women behind. In many instances, staff postings are not mindful of women and men's relationships and social roles. Essential facilities in most work places do not take cognisance of the peculiar needs of women (e.g. baby changing, feeding rooms and nurseries etc).

There is inadequate analysis of sex disaggregated data and use due to lack of gender oriented pre-service and in-service training for health workers. This constitutes a major constraint to gender considerations in decision-making and ultimately gender mainstreaming in the health sector.

All these issues have contributed to inequalities and inequities in the health outcomes of women and men. Hence the need for a policy document that articulates the various dimensions of gender and health to ensure that gender issues are mainstreamed into policies and programmes of the health sector.

## CHAPTER 3

# GENDER POLICY FRAMEWORK

### 3.1 GUIDING PRINCIPLES

This policy document is premised on the overarching objectives that the promotion of gender equality in the Ghanaian health sector is crucial and critical based on these important principles:

- The health sector provides services for people with different gender needs and socio-economic status
- Access to healthcare is an equal right and inherent human dignity for men and women
- Gender equality promotion in health will support elimination of all discrimination based on gender and sex and the infringement of one's human right
- Gender equality is vital to the achievement of the Millennium Development Goals (MDGs);
- Lifelong accessibility to healthcare is crucial to poverty reduction for men and women
- Women and men have different biological and social differences which affect health needs and roles
- Gender mainstreaming and sensitivity in health service delivery will support effective and efficient programming
- Partnership with stakeholders in health

### 3.2 RATIONALE

The promotion of gender equality in the health sector is crucial because in Ghana gender differences and needs affect socio-economic status including health. Gender equality is also a goal in its own right since discrimination based on gender and sex is an infringement on one's human right. Ghana has committed itself to gender equality and women's promotion and this is enshrined in its constitution Article 17(2) and 26 (1 and 2). Gender equality promotion is also a goal in the achievement of the Millennium Development Goals (MDGs) and paramount to all. Gender neutrality of the health delivery system contributes to the inequalities and inequities in the health outcomes of men and women (Promoting Gender Equity in Health, 1999). This situation has also contributed to the unequal opportunities for women and men in the health service thereby establishing the need for a policy document that articulates the various dimensions of gender and health to ensure that gender issues are mainstreamed into policies and programmes of the health sector.

This document takes inspiration from two main policies. The National Gender and Children's Policy which is the guiding policy in gender equality and mainstreaming. The objective of the Gender and Children's Policy is:

*'To mainstream gender concerns in the national development process in order to improve the social, legal/civic, political, economic and cultural conditions of the people of Ghana, particularly women and children'*

The recently developed National Health Policy is also another source of inspiration for this gender policy. The stated goal of the Health Sector as found in the National Health Policy is:

*'To ensure a healthy and productive population that reproduces itself safely'*

A critical look at the summary of the Ghana Health Profile shows a skewedness towards poor health for women. This is as a result of the

feminization of poverty. Poverty and poor health are correlated with the majority of women. The profile among others show that

- Maternal, infant and child mortality are frighteningly high
- Diseases show a geographic distribution that reinforces the north-south socio-economic divide
- The poor and rural dwellers have worse health status than the rich and urban dwellers, though urban health is worsening
- Age-specific death rates are higher among the poor than among the rich.

It is in an effort to address these concerns and to ensure that both men and women access and participate in health care delivery equitably that the Health Sector Gender Policy has been developed.

### **3.3 GOAL**

This policy is to contribute to better health for both women and men, through health research, policies and programmes which give due attention to gender considerations and promote equity and equality between women and men. The policy shall help to position the MoH to use strategies that will help to analyze and prioritize gender issues in planning, implementation, monitoring and evaluation of policies, programmes, projects and research in order to achieve the broad objectives outlined below:

### **3.4 BROAD OBJECTIVES**

To achieve the goal of the gender policy, the Ministry of Health will pursue the following policy objectives:

- To reduce gender barriers in access to health care namely financial, geographical and socio-cultural by ensuring that both women, men and children live long healthy and productive lives with reduced risk of injury and death.
- To promote professional ethics and human rights among health workers in the delivery of health care.
- To improve quality of care by fully integrating gender dimensions of health into service delivery at all levels.
- To address gender inequalities in health service delivery, outcomes and management including narrowing the gender gap in the management structure.
- To ensure that Gender HIV/ AIDS and sexual/ gender based violence issues are equitably addressed in the Health Sector.
- To promote gender equality in health financing and governance by increasing coverage, effectiveness and efficiency of programmes and intervention.
- To address gender gaps in health care delivery at the household level.

### 3.5 KEY ELEMENTS

To achieve the goals and objectives the MoH will:

- Design gender sensitive policies and programmes that will ensure equal opportunities
- Ensure benefits for women and men in MoH and in the wider Ghanaian society in order to improve the overall

performance of MoH activities and service delivery.

- Create an enabling work environment for women and men.
- Build the capacity of MoH to create a gender sensitive environment.
- Build the capacity of MoH to mainstream gender at all levels of health promotion and service delivery.
- Build the capacity of MoH to ensure gender responsive budgeting.
- Ensure equity of participation in the development of community-based service delivery and health management systems that incorporate the needs and interests of women and men
- Build strong collaboration with traditional leaders, district authorities and church leaders to enhance and enforce their role in health delivery
- Develop Monitoring and Evaluation Mechanisms



## CHAPTER 4

# GENDER MAINSTREAMING FRAMEWORK FOR THE HEALTH SECTOR

Gender mainstreaming is a globally accepted strategy or approach for promoting gender equality. Any gender policy developed provides a platform for effectively mainstreaming gender. Mainstreaming is not an end in itself but a means to achieve the goal of gender equality. It involves ensuring that gender perspectives and attention to the goal of gender equality are central to all activities: policy development, research, and advocacy/dialogue. Its approaches include legislation, resource allocation and planning, implementation and monitoring of programmes and projects. Gender mainstreaming, therefore, is the systematic integration of the respective situations, priorities and needs of women and men in all policies and with a view to promoting and ensuring equality between women and men.

Mainstreaming includes gender in planning and programming and also the development of gender-specific activities. Affirmative Action is also sometimes emphasized whenever women or men are in a particularly disadvantageous position. Gender-specific interventions, which are necessary temporary measures designed to combat the direct and indirect consequences of past discrimination, can target women exclusively, both women and men, or only men to enable them to participate in and benefit equally from the development effort. Clear political will and allocation of adequate resources for mainstreaming are important for translating programmes into reality.

Within the health sector gender mainstreaming needs to be considered in relation to access to health care, quality of care, management of the health system.

## 4.1 ACCESS TO HEALTHCARE

*Empirical evidence reveals that although there are higher levels of utilization of health facilities by women, travel to health facilities is an added burden to their already heavy domestic schedules.*

*Evidence has also revealed that most men do not access reproductive health services because most of the service providers are females.*

### Policy Objective

- To reduce gender barriers in access to health care namely financial, geographical and socio-cultural by ensuring that both men, women and children will live long healthy and productive lives with reduced risk of injury and death.

### Policy Measures

- Improve access to health care in underserved areas.
- Advocate for the intensification of poverty reduction programmes that target women.
- Collaborate with the relevant Ministries, Departments and Agencies to promote the education of the girl child and economic empowerment of women.
- Empower women through Behaviour Change Communication (BCC) to be part of decision making on their health at family and community levels.
- Intensify Advocacy and BCC on the gender dimensions of health for all.

## 4.2 QUALITY OF CARE

### 4.2.1 Ethics and Human Rights

*Although most frontline health care providers are women, evidence suggests that men are most often given better reception and priority attention over women. Most often patients particularly women are not informed and involved in decisions affecting the management of their health.*

*Healthcare providers often do not pay attention to the fact that adolescent boys and girls are vulnerable, have special needs that must be addressed and rights that must be respected.*

#### Policy Objective

- To promote professional ethics and human rights among health workers in the delivery of healthcare.

#### Policy Measures

- Ensure respect for all clients irrespective of their sex, sexual orientation, race, age, religion, educational level, language, and social standing including persons with disability in line with the existing guidelines and Patients' Charter.
- Institute reward and sanctions systems for health staff in the application of professional ethics and human rights.
- Develop and review guidelines on the management of sexual abuse.

## 4.2.2 Gender Insensitivity in Healthcare Delivery

*Inadequate gender sensitive training, coupled with poor conditions of service has resulted in the discourteous attitudes of some service providers. Also the uncompromising attitudes of some clients have been found to adversely affect the quality of care.*

*The health care delivery system is not responsive to the peculiar health needs of women and men. The design of health infrastructure does not facilitate client privacy especially for women. In the process women and men's specific concerns are often overlooked in the provision of health care.*

*BCC materials are often unfriendly to disadvantaged clients, majority of whom are women who are non-literate.*

### Policy Objectives

- To improve quality of care by fully integrating gender dimensions of health into service delivery at all levels by eliminating gender biases in the health delivery system.
- To develop and put in place mechanisms that will ensure that the peculiar gender needs of clients are met in the delivery of health services.

### Policy Measures

- Build capacity of service providers to render gender sensitive services in a more efficient and effective manner by integrating consumer-oriented gender principles into the curricula of training institutions at pre-service and in-service levels.
- Re-orient healthcare providers with skills to deal with the peculiar gender needs of clients.

- Upgrade the existing health facilities to be more gender sensitive and incorporate gender concerns in the design of new facilities.
- Develop BCC materials that will re-orient the negative perceptions and uncompromising attitudes of clients (men and women) towards health workers.

### 4.2.3 Diseases and Disorders

*The human life course approach is not adequately used in the analysis of most diseases (communicable and non-communicable). Health care providers often do not relate social circumstances to individuals presenting with disease conditions or illness.*

**Communicable diseases:** *Malaria, TB and HIV/AIDS and all other communicable diseases are critical diseases, which have exemplary gender dimensions that should be analysed and addressed.*

**Non-communicable diseases:** *Particularly the cancers (breast, cervical, prostate and lung) are a growing problem in Ghana. Majority of cases in both women and men are not detected early due to lack of awareness, education and access to diagnostic facilities. However for women it is more pronounced because the majority, are uneducated and cannot access health information for early detection.*

**Psychosocial Disorders:** *There is a general lack of awareness of the gender dimensions of the different causes of mental illness among women and men by the general public. The gender related causative factors of psychosocial disorders are also often not considered in the management of mental illnesses.*

**Nutritional Disorders:** *Higher prevalence of malnutrition among girls and women resulting from socio-cultural beliefs/practices, upbringing and poverty leading to their poor dietary habits.*

## Policy Objectives

- To improve and establish data collection and analysis mechanisms that will facilitate the inclusion of the gender dimensions (i.e. social circumstances and lifecourse approaches to health) of all diseases.
- To increase awareness of non-communicable diseases such as cancers among women to enhance early detection, reporting and effective management.
- To increase awareness of the gender dimensions of the causes of mental illnesses among the general public.
- To introduce gender analysis into the management of mental illnesses in the health sector; and
- To reduce the incidence and prevalence of malnutrition among women and men.

## Policy Measures

- Sensitize and train health care providers on the need to use socio-cultural data in the management of clients.
- Improve counseling referral services in collaboration with other agencies.
- Advocate for the training of more counselors and establishment of counseling facilities outside the health sector.

## Non-communicable Diseases (NCDs)

- Integrate IE&C into health education programmes for NCDs.

- Collaborate with the relevant agencies to advocate for the improvement of existing facilities for the management of NCDs.

### **Psycho-social Disorders:**

- Create awareness on the gender dimensions of the causes of mental illness.
- Collaborate with relevant organizations to advocate for the elimination of socio-cultural practices that perpetuate preventable causes of mental illnesses e.g. Gender-based Violence like domestic violence, FGM and sexual harassment.

### **Nutritional Disorders**

- Collaborate with relevant stakeholders to sensitize communities, families, and individuals on the need for good nutrition for women and girls.
- Work in partnership with traditional leaders (Queen-mothers, chiefs, religious leaders, opinion leaders, etc) to review negative traditional beliefs and practices that negatively impact on women and girls' nutritional status.
- Advocate for improved food fortification and security (production, storage and distribution)

#### 4.2.4 Reproductive health

*The high level of maternal mortality indicates unmet health needs of women of childbearing age, particularly those in the adolescent age group. This is attributed to insufficient knowledge of risk factors sometimes among health workers and community members. Inadequate basic emergency obstetric and gynaecological healthcare packages and socio-cultural values/stereotypes, negative attitudes and lack of customer-oriented service have contributed to this phenomenon.*

*Infertility is a growing problem in the country for men and women and its socio-cultural implications for women are more pronounced.*

#### Policy Objectives

- To contribute to the reduction in Maternal Mortality Rate(MMR) from 214 to 160 per 100,000 live births; and
- To minimize the stigmatization associated with infertility, particularly among women.

#### Policy Measures

- Continue refresher training of all health staff in the early detection and management of complications of pregnancy and childbirth.
- Select health centres in the various districts and equip them with appropriate staff, supplies and equipment to deliver basic obstetric care.
- Strengthen supervision of reproductive healthcare including maternal audit reports and implement lessons learnt at all levels i.e.community/institutional levels.



- Intensify advocacy and BCC, health education on the shift from MCH to RH and encourage men and adolescents to actively patronize RH services.
- Make the management of infertility available to both men and women and give information on alternative methods.
- Promote BCC for the general public on the stigmatization of infertile couples.
- Advocate for cultural changes in the practice of early marriages for adolescent girls.
- Intensify advocacy for men's support for women's empowerment in reproductive health decision making.

#### 4.2.5 Gender Based-Violence

*Gender-related violence, (Rape, Child Sexual Abuse, Sexual harassment and Domestic Violence, FGM,), which have psychosocial implications are seemingly condoned by society. The health care delivery system does not deal adequately with the sufferers of gender-based violence when they report at health facilities. There is inadequate collaboration and cooperation between the health delivery system, social support networks and law enforcement agencies in dealing with victims of gender-based violence.*

*In May 2007, the Domestic Violence Act, 2007 (Act 732) was enacted by the President and Parliament of Ghana to provide protection from Domestic Violence particularly for women and children and for connected purposes. With the passage of the Domestic Violence Law and the implementation plan being developed by the MOWAC, opportunities for effective and efficient collaboration and cooperation between various relevant stakeholders have become more available.*

*The MoH and the Gender and the Domestic Violence Law (DVL). An action plan drawn for the implementation of the DVL has clearly outlined the role of the health sector.*

## Policy Objectives

- To minimize the incidence of Gender-Based Violence
- To establish protocols for better case management of Gender-Based Violence
- To implement the health sector component of the National plan of action of the Domestic Violence Law

## Policy Measures

- Develop and disseminate BCC materials on the harmful effects of all aspects of Gender-Based Violence.
- Collaborate with key stakeholders to create awareness among the general public, about the health implications of Gender-Based Violence
- Advocate for the enforcement of gender-related laws including the law against FGC and Trokosi Practice
- Develop protocols for the case management of victims of Gender-Based Violence and ensure collaboration between the health delivery system, MDAs, social support systems and law enforcement agencies to effectively curb domestic violence.
- Build the capacity of healthcare providers to recognize and effectively manage patients who suffer from Gender-Based Violence.

## 4.3 MANAGEMENT OF THE HEALTH SYSTEM

### 4.3.1 Administrative Structures

*The management of the current health delivery system is gender neutral, and therefore there are no structures and mechanisms to address gender concerns.*

#### Policy Objective

- To establish mechanisms and structures that will address gender inequalities in health service delivery, outcomes and management including narrowing the gender gap in the management structure .

#### Policy Measures

The health sector shall:

- Appoint and build the capacity of gender focal points at all administrative levels to effectively facilitate gender mainstreaming in the health sector.
- Pursue a gender mainstreaming policy in pre-service/in-service training programmes including sensitization programmes for managers.
- Provide budgetary allocations for gender mainstreaming activities.

### 4.3.2 Management Information Systems

*There is inadequate sex disaggregated data, gender analysis and use as a result of inadequate gender oriented pre-service and in-service training for health workers. This constitutes a major constraint to gender analysis in decision making in the health sector.*

## Policy Objective

- To increase availability and improve accessibility to sex disaggregated data for in-depth gender analysis in decision-making, implementation, monitoring and evaluation at all levels in the health sector.

## Policy Measures

The health sector shall:

- Review and redesign data collection tools/instruments where appropriate.
- Build capacities of all categories of health staff at pre/in-service training levels in gender analysis of data.
- Develop and monitor gender sensitive indicators for service delivery and management
- Develop the capacity of the Centre for Health Information and Management (CHIM) to collect, analyze and disseminate gender disaggregated data.
- Produce and disseminate annual gender audit report on gender mainstreaming activities in the health sector

### 4.3.3 Human Resource

*There is a general gender imbalance at all levels of management positions (District, Regional and National) in the health sector. Competent and qualified women who could occupy higher positions are found mainly in the lower and middle levels. Subtle forms of discrimination exist in the system, which keeps them out of these positions.*

*Reverse forms of subtle discriminatory practices and attitudes have also not encouraged men to enter into the nursing and midwifery professions.*

*Most MoH staff especially women do not know the conditions of service and career opportunities that exist. The prevailing arbitrary career progression opportunities often leave the women behind. In many instances, staff postings are not mindful of women and men's relationships and social roles.*

*Essential infrastructure facilities in most work places do not take cognizance of the peculiar needs of women (baby changing, feeding rooms, nurseries etc).*

### Policy Objectives

- To tackle the gender concerns in the development and deployment of the human resources in the health sector.
- To bridge the gender imbalance at the top and middle level management positions in the health sector.
- To ensure that career progression opportunities address the gender needs of health staff, especially women.
- To ensure that the design of new health structures take cognizance of the peculiar needs of women (i.e. baby changing and feeding rooms) and existing structures are upgraded similarly and support other organizations to do likewise.

## Policy Measures

The health sector shall:

- Discourage gender discrimination and support equal opportunities for both women and men.
- Put in place gender responsive conditions of service, career progression opportunities and deployment schedules for health staff, especially women.
- Pursue the Affirmative Action policy of 40% quota of women in top management positions in the health sector.
- Pursue the Affirmative Action policy of 40% quota of men into the nursing and midwifery training schools.
- Provide gender sensitive orientation to the leadership of the nursing regulatory bodies and professional associations (NMC, GRMA, GRNA) and training institutions and the general public at large to change their attitudes towards enrolment of men into nursing and midwifery professions.
- Incorporate gender sensitive education in the curriculum of all health, training facilities (medical school, nursing and all allied medical institutions).
- Advocate for and facilitate the establishment of essential infrastructure within workplaces to cater for the needs of working parents.

## 4.4 GENDER RESPONSIVE BUDGETING IN THE HEALTH SECTOR

*Gender Responsive Budgeting (GRB) aims to mainstream the gender dimension into all stages of the budget cycle. The approach involves analysis of the differential impacts of public expenditure as well as revenue policy on women and girls, and men and boys, respectively. In addition to the impact analysis, gender-responsive budgeting makes proposals for a reprioritization of expenditures and revenues which takes into account the different needs and priorities of women and men, girls and boys.*

### Policy Objectives

- To break down and analyze health sector budgets in order to see how it responds to the differentiated needs of women, men, girls and boys.
- To measure the impact of health sector budgets on women, men, girls and boys.
- To prioritize health sector programmes and interventions to address gender needs and bridge the inequality gaps.

### Policy Measures

The health sector shall:

- Conduct sector gender audits and analysis to reveal needs and gaps.
- Enhance capacity to mainstream gender and undertake gender responsive budgeting.
- Develop budget systems that capture information on gender and incorporate GRB in sector budget plans.

## CHAPTER 5

# IMPLEMENTATION ARRANGEMENTS

The following section details out the implementation arrangements required to successfully operationalise the gender policy in the health sector. It covers the following

- Implementation Strategies
- Institutional Framework
- Resource Mobilization and Allocation
- Research
- Monitoring and Evaluation
- Reports and Documentation

### 5.1 IMPLEMENTATION STRATEGIES

The effective implementation of the policy objectives outlined in this document will require the following key strategies:

- Sex disaggregation of data and gender-based analysis
- Capacity Enhancement, Training and re-orientation of health staff
- Advocacy
- BCC
- Partnership and Inter sectoral Collaboration

A detailed Gender Mainstreaming Strategy document has been developed for the health sector.



### 5.1.1 Sex disaggregation and Gender-Based Analysis

Sex disaggregation of data and gender based analysis is critical to mainstreaming gender in the health sector, since such analysis would account for the various diseases and disabilities that affect either women or men because of their sex, and also identify the group that is affected the most, among other things.

### 5.1.2 Capacity Enhancing, Training and re-orientation of staff

Training will involve short courses, seminars and workshops and will focus on the following key areas:

- Key gender concepts, terminologies and issues
- Gender analysis tools in planning and programming
- Application of the gender analysis in prioritising health interventions, decision making and service delivery interventions
- Gender auditing
- Gender budgeting

Training will target the following stakeholders:

- All categories of health staff, both public and private sector
- Identifiable MDAs
- Identifiable Civil Society groups (NGOs, CBOs, etc)
- Community level health facilitators

### 5.1.3 Advocacy

Advocacy is required in the following areas:

- Gender implications of health and diseases
- Gender, water and sanitation as health determinants
- Gender and HIV/AIDS issues
- Nutrition and Gender
- Economic Empowerment of Women
- Intensification of Poverty Reduction Programmes targeted at Women
- Sexual and Gender-Based Violence – Rape, Child Sexual Abuse, Sexual Harassment and FGC
- Women and Food Security

Advocacy will target the following stakeholders among others: MOWAC, NDPC, MOF, MOLG, Traditional Authorities, Policy makers, Executives, Legislatures, MMDSW, MOJ, MOI, MOFA, MOESS.

### 5.1.4 Information, Education and Communication (IEC)/ Behaviour Change and Communication (BCC)

A great deal of effort is required to change the perceptions of various stakeholders including the general public about gender stereotypes which lead to disparities in health outcomes for women and men, hence the need for intensified BCC.

BCC is particularly needed in the following areas:

- Gender dimensions of health - causes of diseases/illnesses e.g. Mental illnesses.
- Sexual and Gender-Based Violence.
- Women and decision making on their health and that of their families.
- Change clients' poor perceptions of health workers.
- Causes of cancer and means of prevention.
- Promote male involvement and adolescent participation in RH programmes.
- Stigmatization of infertile couples particularly women.
- Gender and HIV/AIDS.

### **5.1.5 Partnership and Inter-sectoral Collaboration**

Partnership and inter-sectoral collaboration is key to the successful achievement of the policy objectives outlined in this document. The key pilot ministries for Gender Responsive Budgeting (GRB) will be focal points for collaboration however regular interaction with identifiable partners and stakeholders will be required to spell out mutual rules of engagement. Major partners and collaborators will include:

#### **Ministry of Women and Children's Affairs (MOWAC)**

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

- Women's participation and empowerment.
- Women's access to credit and productive resources.
- Promotion of Women's Health and Rights.

### **Ministry of Education (MoE)**

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.

### **Ministry of Food and Agriculture (MoFA)**

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

### **Ministry of Justice and Ministry of Interior**

The Ministry of Health shall collaborate with MOJ, MOI and other enforcement agencies (CHRAJ, Police etc) to curb Gender-Related Violence. Specifically, MoH shall work with DOVVSU to ensure the rights of women and juveniles are protected.

### **Ministry of Local Government**

The ministry will collaborate with the local government structures, to be precise the District Assemblies, Unit Committees, Traditional Authorities, Opinion Leaders, Local Communities to promote the cause of women and hence the health of women and their families.

### **Office of the Head of Civil Service (OHCS)**

The OHCS, which has overall responsibility for Gender Focal Persons in all the MDAs shall ensure that all gender mainstreaming activities in the Civil Service are integrated.

### **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.

### **Ministry of Manpower Development and Social Welfare**

The Ministry of Manpower Development and Social Welfare is the agency responsible for identifying and meeting the needs of vulnerable groups in the society and protecting their rights. MoH shall work in collaboration with MMDSW to coordinate and monitor efforts aimed at reducing gender related social vulnerability.

### **The National Development Planning Commission (NDPC)**

The Commission is responsible for coordinating the national planning process including the Ghana Poverty Reduction Strategy (GPRS). It shall ensure that gender and health is integrated into the GPRS.

### **Civil Society Organisations**

The health sector will seek partnership with all the relevant civil society organizations that have a stake in health service delivery on issues stated in the policy. Some of these organizations have oversight responsibility over their members that ensure the protection of clients and adherence to professional ethics. Other CBOs who work in other areas and provide women and children with social support networks shall be identified for the Ministry of Health to work out joint modalities for addressing gender concerns.

### **Private Sector**

The Ministry of Health is the public agency with oversight responsibility for the health sector. Therefore it 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 document.

### **Reporting system / Mechanism**

A good reporting and documentation system would invariably help to document good practices and lessons learnt for replication by others. It is an important strategy which requires some level of consistency and prioritization. All reports must be disseminated and recommendations pursued for sustainable achievements in the implementation of this policy in particular and gender mainstreaming in general.

## **5.2 INSTITUTIONAL ARRANGEMENTS**

The existing structures within the Ministry of Health and its Agencies shall be responsible for the implementation of all aspects of the Gender Policy. The gender mainstreaming process will require that the various Directorates, Units and Budget Management Centres (BMCs) of MoH and Agencies use the Gender Policy as a guide in the preparation of their Strategic Plan/Programme of Work/Management System. This strategy will be reflected in the Government of Ghana's Strategic Planning Framework, which is the Medium Term Expenditure framework (MTEF) and Ghana Poverty Reduction Strategy (GPRS).

The implementation of the Gender policy shall take place at the following levels of the health sector:

### **5.2.1 Ministry of Health**

### **5.2.2 National Level**

Policy formulation, co-ordination, advocacy and overall monitoring of policy implementation shall be done by all the National Directorates as well as all the executing/implementation agencies under the ministry and it shall be co-coordinated by the National Gender Focal Point Office.

The above office shall be responsible for the development of a Gender Strategic Programme/Gender Plan of Action/Management System that will spell out the specific roles of the various executing/implementation agencies under the ministry with regards to the implementation of this document.

### **Tertiary and Psychiatric Hospitals**

These hospitals will be responsible for ensuring sound referral clinical practice that takes into consideration the peculiar needs of men and women.

### **Regulatory/Statutory Bodies**

These regulatory bodies e.g. Nurses and Midwives Council, Medical and Dental Council, Private Hospitals and Maternity Homes Board et cetera 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 and women are minimized.

## **5.2.2 Ghana Health Service (GHS)**

This service is the largest executing/implementing agency operating mostly at Regional, District and Sub-district levels

### **National level**

All directorates under the Headquarters of the GHS particularly the Public Health Division (PHD) and Institutional Care Division shall interpret the policy and provide guidelines to the lower levels.

### **Regional level**

The Regional Directorate shall be responsible for the Gender Focal Person who shall coordinate, monitor and evaluate the implementation of the gender policy at the regional, district and sub-district levels.

### **Regional Hospitals**

The Regional hospitals shall be responsible for ensuring sound clinical and public health practice that takes into consideration the peculiar needs of women and men.

### **District level**

The District Health Management Team (DHMT) shall be responsible for the District Gender Focal Person who shall coordinate, monitor and evaluate the implementation of the Gender Policy at the district and sub-district levels.

### **District Hospitals**

The District hospitals shall be responsible for ensuring sound clinical practice that takes into consideration the peculiar needs of women and men.

### **Sub-district level**

The Sub-District Health Management Team (SDHMT) shall be responsible for the Sub-District Gender Focal Person who shall coordinate, monitor and evaluate the implementation of the Gender Policy at the sub-district levels in outreach programmes and in the Community-Based Health Delivery (CBHDs) system.

### **Health Centres**

Health centres will be responsible for ensuring sound clinical practice that takes into consideration the peculiar needs of women and men at the lowest level of institutional care.



## **5.3 RESOURCE MOBILIZATION AND ALLOCATION**

### **5.3.1 Financial**

Financial resources for the implementation of this policy shall be sourced through the existing channels used in the Ministry of Health for resource mobilization as well as other innovative approaches. Gender mainstreaming activities shall be planned and budgeted for under the Government of Ghana's planning and budgeting process i.e. the Medium Term Expenditure Framework (MTEF).

### **5.3.2 Human Resource**

The existing capacity of the human resource of the health sector shall be equipped with the requisite gender sensitivity skills to enable gender to be mainstreamed in all aspects of its work.

## **5.4 GENDER RESPONSIVE BUDGETING**

The MoH is one of the pilot institutions to ensure Gender Budgeting in Ghana. Gender Responsive Budgeting (GRB) aims to mainstream the gender dimension into all stages of the budget cycle. The approach involves analysis of the differential impacts of public expenditure as well as revenue policy on women and girls, and men and boys, respectively. In addition to the impact analysis, gender-responsive budgeting in the sector shall ensure the reprioritization of expenditures and revenues taking into account the different needs and priorities of women and men, girls and boys. GRB distinguishes three stages of a long-term process which can achieve:

- gender-sensitive budget analysis
- formulation of gender-sensitive budgets
- gender-sensitive allocation of resources

## 5.5 RESEARCH

Data on gender and health is very limited at the present time, as can be seen from the analysis of the issues on which this policy document is based. A lot of the evidence used for analysis so far has been anecdotal rather than empirical. Research is required in many areas to establish for example, how socio-cultural circumstances impact on individuals, particularly women. Research is also needed in relation to gender and access to health care, quality of care and the management of the health system. Research into some of the areas identified during the analysis of gender issues in the health sector, where only anecdotal evidence was available will be carried out.

It is important to liaise with MOWAC, GSS and sector stakeholders including the UN System in the generation of gender and sex disaggregated data. A lot of work on sex disaggregated data is currently underway.

### 5.5.1 Operational Research

Gender mainstreaming process will require consistent tracking of progress to ensure that the process is on course. Operational research on gender mainstreaming in the health sector will therefore be undertaken by the Health Research Unit on continuous basis to inform the management of the health sector for the appropriate response.

## 5.6 MONITORING AND EVALUATION

This policy document shall be monitored on yearly basis as part of the Medium Term Health Strategy using the standard guidelines for the annual review process of the MoH. The Plan of Action to be developed out of this policy document will clearly state how each of the strategies are to be achieved and what indicators and timeframes are to be met.

This policy document shall be reviewed at the end of the medium term if necessary.

This comprehensive Health Sector Gender Policy, which has been developed for Ghana covers a wide range of issues that will contribute to redressing the inequalities and inequities in health outcomes of women and men in the country. Its successful implementation will depend on the fulfillment of a number of assumptions and the commitment to its principles by all role players and stakeholders.

## BIBLIOGRAPHY

1. The Health Sector 5Year Programme of Work, 2007-2011
2. 2000 Population Census
3. Growth and Poverty Reduction Strategy II,
4. National Health Policy
5. MoH Report, 2003
6. HIV Sentinel Survey, 2005 report
7. National Monitoring and Evaluation Plan for HIV/AIDS in Ghana, 2006 – 2010, GAC
8. Korle Bu Teaching Hospital, Cancers of the Reproductive System, 2003
9. Domestic Violence Act, 2007 (Act 732)
10. National Health Policy September 2007, Epidemiological Trends
11. MoH / GHS Figures, 2005
12. Multiple Indicator Cluster Survey, 2006
13. Ghana Statistical Service, 2004
14. PATH/Outlook 1998; UNFPA 2000