Gender Equality and Social Inclusion in Health Policies on Universal Health Coverage (UHC): A situational analysis of Ghana

1.1 Introduction

Gender equality and social inclusion (GESI) has received global attention in both policies and treaties (Box 1). Gender equality according to the United Nations (UN) refers to equal rights, responsibilities and opportunities for women and men and girls and boys. Social inclusion is the removal of institutional barriers and the enhancement of incentives to increase the access of diverse individual and groups to development opportunities. Social exclusion is the other hand is defined by the Department of Economic and Social Affairs of the United Nations as the involuntary exclusion of individuals and groups from society's political, economic and societal processes, which prevents their full participation in the society in which they live. Gender equality and social inclusion are seen as not only a fundamental aspect of human rights and social justice, but also a precondition to improve the development process by putting social concerns at the forefront of interventions.

Leaving no one behind is the slogan for ensuring that all people have access to health and social protection as we race towards universal health coverage (UHC). Social health protection through UHC is the aspiration that all people will obtain the quality health services they need while not suffering financially as a result of seeking health care. The journey towards UHC requires inclusive social health protection based on health systems that are affordable and able to adapt to socio-demographic and technological changes and, therefore, responding to the evolving needs of the population. In Low and Middle Income Countries (LMICs), it is particularly challenging to ensure effective essential health services as well as financial risk protection to the poorest segments of the population and other groups who are often excluded.

Poverty undermines the basic rights to development and to health. Those living in poverty, with disability, illiterate and unaware of their basic rights are often marginalized.

Gender inequality destroys the physical and mental health of millions of girls and boys and women and men across the globe. Thus there are gender-based differences in life expectancy, healthy life years, health behaviours, mortality and morbidity risks. The magnitude of the problem is such that taking actions to address gender equality and social exclusion is one of the most direct ways to improving health and reducing health inequities and ensuring effective use of health resources. Thus having legislative instruments, declarations, international conventions and policies on health that address gender and social inclusion are powerful ways of motivating and mobilizing governments, civil society and men and women to address Gender Equality and Social Inclusion (GESI).

Box 1: provides summary Global and Regional Treaties and Convention on Gender Equality and Social Inclusion.

Box 1: Global and Regional Treaties and Convention on Gender Equality and Social Inclusion	
Treaty	Year
The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)	1979
UN Declaration on the Elimination of Violence Against Women	1993
The International Conference on Population and Development	1994
Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (the Convention of Belem Do Para)	1994

The Beijing Platform for Action	1995
The Millennium Development Goals	2000
Women, Peace and Security Frame work and Commitments (Resolutions)	2000-2013
Protocol on the Rights of Women in Africa	2003
The Hyogo Frame work for Action	2005
Aid Effectiveness Commitment	2005, 2008
UN Frame work Convention for Climate Change	2010
European Convention on Preventing Violence against Women and Domestic Violence	2011
Pacific Islands Forum Gender Equality Declaration	2012

Although there is large evidence in the literature about the need for mainstreaming gender and how this should be done there is little evidence and a gap in knowledge and practice. In many countries national health policies and programmes have gender woven into the objectives but activities to specifically address gender issues are lacking. This apparent gap in knowledge and practice can be attributed to lack of integrating gender in health programmes and investing more on form rather than the content. The lack of progress is also attributed to lack of linking gender to social transformation and social justice agenda.

The aim of this review is to understand the integration of GESI into health policies in Ghana, the progress made so far and the challenges and gaps that exist in attempts to integrate GESI into health policies.

Review of Literature on Gender Equality and social Inclusion

Gender equality refers to the equal rights, responsibilities and opportunities of women and men and girls and boys. Social exclusion is however defined by Department of Economic and Social Affairs of the United Nations as the involuntary exclusion of individuals and groups from society's political, economic and societal processes, which prevents their full participation in the society in which they live. Gender is not equal to the biological construct because sex refers to the biological differences between men and women but gender refers to the socially constructed characteristics of women and men such as norms, roles, relationships of and between groups of women and men. These socially constructed roles influence women and men 's susceptibility to different health conditions and diseases. They affect good mental and physical health and levels of wellbeing. These roles also affect access and uptake of health services and on the health outcomes they experience throughout lifetime.

GESI is a fundamental human right and social justice required of every nation but it is also a precondition for improving the development process by ensuring that social concerns are at the forefront of interventions and programmes. The right to health is affirmed in the Universal Declaration of Human Rights and is enshrined in the universal rights to health for all people irrespective of economic class, gender, race, ethnicity, disability, age or location. There are clear differences in development of countries that consciously integrate GESI and those that do not.

Gender relations and power constitute the root causes driving the need for gender mainstreaming and it is the most important influential factor of social determinants of health. Gender relations determine peoples' health needs and how they can realize health rights. Health differences between men and women, and medical expenses may or may not trap women and men to the same degree thus requiring conscious efforts to monitor and eliminate these differences when they arise.

Social Inclusion or Exclusion

Not much literature is available on social inclusion but rather the opposite of it social exclusion. Yet in the literature that touch on social inclusion it refers to affirmative actions undertaken to reverse the situation in which individuals or groups are excluded from the society. What are these affirmative actions? Reviewing literature on social exclusion give pointers to these affirmative actions that are and can be undertaken.

Many definitions of social exclusion exist but the term generally describes the state of disadvantage faced by various groups who 'are felt to be removed' from mainstream society, and who cannot fully participate in normal life. Poverty is often associated with exclusion but exclusion goes beyond being just poor and includes participation in social and political decision-making. For example social exclusion goes beyond material poverty to include other forms of disadvantages such as the lack of health care, social care, access to education, proper housing. Other literature point to the fact that the homeless, people with drug problems, people who engage in sex work, those unemployed, migrants and refugee, people with mental problems, rural dwellers, single parent families, women and children are commonly mentioned as those who are excluded or likely to be excluded. In a similar away examining the causes of social exclusion point to a wide range of reasons that also go beyond material poverty such as discrimination in terms of gender, ethnic minority, disability, the aged and so on suggesting that one can be excluded for different reasons and in multitude of ways.

Shaw and colleagues explained further that the term social exclusion can also refer to people "who may be stigmatized and marginalized such TB patients or HIV/AIDS patients because of the disease. In much of the literature, social inclusion is one of the social determinants of health.

Thus the seminal 2008 WHO World Health Report recommended that making primary healthcare universal would ensure that "health systems contribute to health equity, social justice and the end of exclusion"

What are the consequences of social exclusion?

There is evidence that social exclusion processes lead to a continuum in which inclusion/exclusion are characterised by inequalities in access to resources, capabilities of individuals and groups and their rights. This persistent inclusion/exclusion results in health inequities and also affects health directly through how the health system is organized and the policies available to improve social inclusion.

Gender equality often affect active participation of men and women in decision making regarding health, politics and social issues and is one of the affirmative actions that can be undertaken to

address social exclusion. Thus actions such as integrating GESI into policy alleviate this state of exclusion are crucial in addressing the health needs of all, and the health needs of marginalised groups in particular. The 2010 World Health Organization (WHO) report on poverty and social exclusion explicitly indicated that these two factors were the “driving forces of health inequities for millions of people across the 53 Member States of the European Region” and it is also so for the African Region.

Further emphasis on need to take affirmative action on addressing social exclusion is in the goal number three of the sustainable development goals (SDG) in which health and wellbeing across the life course of the individual is emphasized. The SDG in particularly mentions the introduction of universal health coverage to address social exclusion and gender equality.

There are also pointers that the action to improve the health of disadvantaged populations should be grounded in a human rights approach to health and the values and principles of primary health care”. The need to include communities who are poor or facing social exclusion in the design is also paramount.

This is based on the fact that improving the health status of such socially excluded groups may improve the health of the population as a whole. This also overlaps with the argument from some authors that health should be considered a human right and that a rights framework should be used to set appropriate standards and allocate responsibility for the improvement of the health status of certain groups in society

Why relate social exclusion to primary healthcare?

The Alma Alta declaration on primary health care in 1978 of making health care available and accessibility to everybody ushered in the quest for universal health coverage. Since this declaration, Ghana has put in measures to remove geographical and financial barriers to accessing health care. Ghana adopted the community-based Health Planning and Service (CHPS) approach to health care as her primary health strategy to bring health care to the door-step of people, hence removing geographical barrier. The National Health Insurance Scheme (NHIS) was also introduced in 2003 to remove financial barrier to health care. Evidence exist to show that these two interventions on Universal Health Coverage contributed to the achievement Ghana made in the Millennium Development Goals (MDGs) and will be essential in the Sustainable Development Goals (SDGs).

In September 2015, world Leaders of 293 countries assembled in New York to sign on to the 17 Sustainable Development Goals (SDGs), which have 169 targets; the new development milestones to be achieved by the year 2030. Goal 4 of the SDGs is to achieve gender equality, social inclusion and Human Rights for all. This goal recognise that without the equal participation of all people, including individuals at risk of exclusion, society has less of an opportunity to reach its full potential, both in terms of its economy and its level of governance. To achieve gender equality and social inclusion will therefore require countries to address these issues in their policies. This policy analysis intends to provide evidence on the extent to which policies that aim at UHC have incorporated GESI.

The concept of Primary health care is bringing services closer to those in need and it is thus the best approach to begin to document and analyse social exclusion in relation to primary health care services. PHC offers treatment and care in continuum that is supported by a facility-linked home-based care system and a referral system. The principles of primary health care include universal access to care and coverage on the basis of need; commitment to health equity; community participation; and inter sectorial collaboration (WHO, 1978). Extending coverage to basic primary health care services to all Ghanaians has been a primary focus of the Ministry of Health (MOH) since the Alma Ata conference on 'Health for All', in 1977. A major policy statement by the then MOH in 1977 stated that "most disease problems that causes high rates of illnesses and deaths among Ghanaians are preventable and curable if diagnosed promptly by simple basic primary health care procedures " (Health Policies for Ghana, NHPU, 1977). Thus PHC able to address and alleviate the causes of ill health that affect those that are socially excluded. Further to that health workers at the PHC level need to understand that in resolving health problems of those socially excluded, they need to find solutions to the processes that are excluding patients as well as treating the disease and ailment at hand.

Integrating Gender Equality and Social inclusion Framework

The framework outlines how GESI are to be included in health policy to address disparities in health care access and health care status. GESI defines the excluded to be in the poor economically excluded, socially excluded, those who are vulnerable because of location, physically disabled, health status, age, or affected by human-made or natural disasters. Government efforts and policies should seek to reduce these inequities and equalities as well and remove barriers that lead to social disadvantage. In addressing GESI in policies it should consider the various dimensions such as the abilities and barriers faced by the poor, women, the vulnerable and those excluded form accessing and using services. In addition attention should focus on the impact of these policies, on gender, income, location or area of residence, and so on to target those actually in need.

1.2 Dimensions in GESI

The UNDP strategic plan, 2014-2017, outlines three main areas of gender inclusion. These areas include; sustainable development pathways, inclusion and effective governance and resilience building. These areas therefore form the basis for the analysis. Box 2 provides a summary of United Nations three areas of gender inclusion.

Box 2: Three Areas of Gender Inclusion	
Sustainable development pathways	The sustainable development pathways area of work provides an opportunity to address inequalities and reshape policies to empower women and girls in all their diversity, so that they can become catalytic agents of change and equal partners with men in the quest to

	promote growth that is inclusive, just, equitable and sustainable
Inclusive and effective democratic governance	Ensuring women's and men's equal participation in governance processes, and their equal benefits from services, are preconditions for the achievement of inclusive and effective democratic governance.
Resilience-building	Gender equality and women's empowerment are integral to building individual, institutional and societal resilience

1.3 Gender Equality and Social Inclusion in the Ghanaian Context

Despite the fact that Ghana is signatory to UN treaties and conventions, locally the country has legislature which espouse gender equality and social inclusion (GESI). Article 17 (1) and (2) of the 1992 Constitution of Ghana stipulates that all persons are equal before the law. This provision expressly guarantees gender equality and freedom of women and men, girls and boys from discrimination on the basis of social, economic status, race and ethnicity. The enactment of the Domestic Violence Act, 2007 (Act 732) also provided the legal environment to tackle gender inequality and the promotion of the welfare of women and girls.

Recognizing that removing barriers to social inclusion can allow for full equality and inclusion of women in the productive economy, the Government of Ghana has taken steps through the enactment of a new national policy framework to promote GESI. In 2004, the Government developed her first gender and children policy under the Ministry of women and children affairs (MOWAC). In 2013 the Ministry of Gender, Children and Social Protection (MoGCSP) was created to replace MOWAC. In 2015, the Government passed a new Gender Policy, which is the primary policy statement outlining the government's efforts to ensure equality and gender mainstreaming and step toward efforts to achieve SDG 4.

In Ghana, various groups of people are vulnerable to social exclusion and should therefore be given priority in any analysis on GEGI. Box 2 provide a summary of the vulnerable group and reasons they are often excluded.

Box 2: Vulnerable groups who are often socially exclusion	
Group	**Why they are excluded and discriminated**
Women and girl	Most societies being patriarchal; seen as inferior; social norms; economically poor
Youth	Social norms; poverty
People with disability, 4D (Birth defects, disability, deficiency, diseases).	Unemployed; lack of disability friendly institutions
People with mental conditions	Stigma and discrimination
People with HIV and AIDS	Stigma and discrimination, perceive to be sexually promiscuous

Aged	Poverty; unemployed
Poor	Poverty; low and unpaid jobs
Migrants/Nomadic	Stay in Ghana may be illegal; low and unpaid jobs
Most At Risk Population (MARPs)	Sexual orientation is illegal and perceived to be immoral
People living at hard to reach areas	Challenges in access to their places of residence

2.1 Methodology for Policy Analysis

This is in-depth analysis of government laws and policies. Policies on UHC were first identified and retrieved from the various ministries website. Each policy was then reviewed. The review was guided by the following questions:

1. What is the policy objectives?
2. How does the policy objective link to the overall aim of ensuring gender equality and social inclusion?
3. Who are the targets for this policy?
4. What will be the impact of this policy on various vulnerable groups (men, women, girls, boys, elderly, hard to reach groups and people with disability)?
5. What type of gender disaggregated data have been provided to contextualize the policy?
6. Are there specific policy areas that clearly identified the need for gender equality and social inclusion?

3.1 UNIVERSAL HEALTH COVERAGE RELATED POLICIES AND LEGISLATURE

This section discusses the policies on universal health coverage and the extent to which issues about gender and social inclusion have been addressed in these policies. It further discusses the strengths and challenges in these policies and the opportunity for advocacy and education by civil society organisations (CSOs). The policies that were analysed included:

1. The National Community-based Health Planning and Services Policy of 2016
2. The national Health Insurance Act 2003
3. The National Ageing Policy of 2010
4. The National Gender Policy of 2015
5. The National Nutrition Policy 2013-2017
6. The Ghana National Social Protection Policy of 2015
7. The National Health Promotion Policy of 2016

3.1.1 The National Community-based Health Planning and Services Policy

The CHPS policy is designed to bring health care to the door step of people. CHPS is designed to bridge inequity gap in the provision of health care service in attaining universal health coverage (UHC). The goal as stated in the policy is to attain the goal of reaching every community with a basic package of essential health services towards attaining Universal Health Coverage and bridging the access inequity gap by 2030. In this policy, a Community Health Officer (CHO) who is a trained nurse work with community volunteers in CHPS zones to provide promotive,

preventive and some curative health services in their communities from CHPS compounds. The policy defines a CHPs Zone as a demarcated geographical zone which provide health service to 5,000 people or 750 households. Box 3 provides a summary of the guiding principles of this policy.

Box 3: General Principles Guiding the CHPs Policy
The general principles guiding the Ghanaian CHPS policy are • Community participation, empowerment, ownership, gender considerations and volunteerism • Focus on community health needs to determine the package of CHPS services • Task shifting to achieve universal access • Communities as social and human capital for health system development and delivery • Health services delivered using systems approach (es) • The Community Health Officer (CHO) as leader and community mobilizer

The policy made reference to the Ghana Shared Growth and Development Agenda objectives that are relevant to the Ministry of Health as:

- Bridge the equity gaps in access to health care and nutrition services and ensure sustainable financing arrangements that protect the poor
- Improve governance and strengthen efficiency and effectiveness in health service delivery
- Improve access to quality maternal, neonatal, child and adolescent health services
- Prevent and control the spread of communicable and non-communicable diseases and promote healthy lifestyles
- Expand access to and improve the quality of institutional care, including mental health service delivery

The underlying principle and alignment of the policy with the objectives of the Ghana Shared and Development Agenda Objective provides opportunity for access to health care by both men, women, children, youth, and mentally ill. It also bridges the gap in access to health care to people living in deprived areas and hard to reach place in line with the objectives of social inclusion. Box 4 provides a summary of CHPS policy strengths and opportunities, challenges and direction for advocacy.

Box 4: CHPS Policy: : Strengths and Opportunities, Challenges and Direction for Advocacy		
Strengths/Opportunities of the CHPS Policy	**Challenges**	**Proposed Direction for Advocacy by Civil Society**
Community Involvement and ownership: The model relies on communities and other stakeholders to provide financial or in-kind resources for construction and provide oversight for service delivery and welfare of the CHOs	• CHPS has changed focus as government now constructs CHPS compound minimizing community involvement and ownership • Unwillingness of Community Health Volunteers to offer their services for free barrier	• Raising awareness on community participation and ownership of CHPs • Advocate for government to only assist communities to construct the CHPS compound to facilitate ownership

	to effective implementation especially in urban areas. • There is no policy on reward and incentives for these volunteers leading to volunteer fatigue and various programs introducing cash incentives. This has distorted the volunteer system in several communities resulting in some volunteers demanding cash for services.	• Advocate for policy on incentives for community volunteers if CHPS is to be sustainable as a strategy to reach deprived communities with health care
Inadequate dissemination of guidelines: At the implementation level technical health and local government officers referred severally to the confusion in directives received from the centre. Written guidelines were not adequately disseminated, and were difficult to understand and implement.	While local government and district assemblies are willing to take on the challenge of scale up there is still no clarity in roles and responsibilities. It is also unclear whether CHPS should be implemented in urban areas given its origin as a strategy for reaching deprived rural areas.	To ensure social inclusion, implementation of CHPS in deprived urban areas is required.
Poor understanding about CHPS: Communities expect a facility to be able to deliver clinical care when required. Hence, some CHPS receive poor patronage because of poor understanding about the purpose of CHPS	Lack of communication and engagement has led to community members not understanding the distinction between community-based health service and services at a higher level health facility	Awareness creation about CHPS and its purpose. Differentiate CHPS from higher level health facilities
Insurance: NHIS does not cover preventive and promotive services provided by CHPS. Where services are provided and qualify for NHIA reimbursement, the cost is claimed through the Health Centres as part of the	New services are constantly layered onto existing ones with supervisors and communities coming to expect an increasing variety and complexity of clinical services to be delivered at the community level using the	Advocate for the inclusion of promotive and preventive services in NHIS

services provided by the Health Centre.	CHPS strategy which are not covered by NHIS	

3.1.2 National Health Insurance Act 650 of 2003 and Act 852 of 2012

In the early 1990s various health insurance schemes evolved as ways of providing financial protection against high cost of health care arising from the introduction of the user fees. Community based mutual health organizations (MHO) were formed in some districts. The Nkoranza Community Health Insurance Scheme was the first to be established in 1992. By 2001, 57 district MHOs had been established in different parts of the country. The government in 2003 drafted the health insurance act (Act 650) to set up a national health insurance scheme (NHIS) in all the districts as a policy to minimize out of pocket health expenditure at point of service and to ensure equitable access to health care particularly among the poor.

The NHIS is financed by a national health insurance fund. The fund has three main sources: tax revenue of a 2.5% VAT which contributes to about 70% of the fund, 2.5% of contributions of Social Security and National Insurance Trust (SSNIT) contributors who are largely formal sector workers; and which contributes to about 20% of the fund; and income adjusted premiums which ranges from between GH¢7 to GH¢48 for non SSNIT contributors which contributes to about 5% or less to the fund.

The Act was reviewed in 2012 (Act 852) to make some addition and exemptions for category of people. Some of the addition to the old Act (Act 650) were:

- making NHIS universal and national in picture instead of district based mutual health insuarnce schemes as historical was the case;
- introducing premium exemptions schemes for persons with mental disorders
- putting an expenditure cap of 10% on non-core NHIS activities
- including a relevant family planning package and
- instituting a board oversight committee for scheme operations, private health insurance schemes and fund management.

The exemptions policy was introduced for children (People under 18 years as defined by the 1992 constitution), elderly 70 years and above, SSNIT contributors, pensioners, ante-natal, delivery and post-natal services for women and LEAP beneficiaries. In 2012 capitation was introduced for outpatient primary care and piloted in Ashanti. The exemptions on premium payment for this category of staff is an all-inclusive strategy and increase access to poor and vulnerable.

The National Health Insurance Scheme is also available and subscribers with valid membership are eligible for free treatment covering about 95% of common diseases people in the country but active membership remains below 40% of the total population since the NHIS implementation 15 years on. Renewal rate are low among the poor. Therefore opportunities exist for advocacy (Box 5).

Box 5: NHIS: Strengths and Opportunities, Challenges and Direction for Advocacy

Provisions/Strengths/ Opportunities	**Challenges**	**Directions for Advocacy**
Exemption policy: The NHIS provides opportunities for gender equality and social inclusion through: Exemption policy: Persons under 18 years, pensioner, people above 70 years and on LEAP, pregnant women and people with mental condition	Major issues affecting membership management include low active membership especially among the people in community, delay in reimbursement to providers, exclusion of psychotropic drugs from list medicines resulting in frequent shortage, misconceptions that NHIS card holder do not given best treatment in health facilities	• Awareness creation on benefits of the NHIS especially among the people • Education to disabuse the notion that health facilities give differential care to card and non-card holders • Advocate for the inclusion of psychotropic drugs on NHIS list to minimize frequent shortage because hospital management are unwilling to purchase such medication because treatment of mental conditions are free in Ghana
Coverage of condition: The NHIS provide social gender equality and inclusion through the covering of 95% of the common conditions	• The scheme provider insurance cover for most common condition. However, there current data show increasing prevalence of cancers (breast, cervical and prostate) in the country. However, these conditions are currently not included in the list of conditions (Diagnostic-Related Grouping, DRG) for beneficiaries • Treatment for infertility is also not covered in NHIS. However, social norms make women tend to suffer more from couple childlessness	• Advocate for inclusion of cancers and fertility treatment in NHIS

3.1.3 The National Ageing Policy

The ageing policy was first developed in 2003 and revised in July 2010. It has the theme "Ageing with security and dignity". The policy acknowledges that the increasing number of older persons have implications for many sectors including health, social services, housing, transportation and agriculture, etc. as they become overstretched due to heavy demand of these services with advancement in age. The revision of the old policy adopted bottom-up participatory approach that brought together both primary and secondary stakeholders. This strategy ensured inputs from various stakeholders as a social inclusion approach. The goal of the policy is to achieve the social, economic and cultural re-integration of older persons into mainstream society and foster their full participation in national development. The policy gives full recognition to fundamental human rights including the right to independence, active participation in society, benefit from community support and care, self-fulfillment in pursuit of educational and other opportunities and dignity, security and freedom from exploitation. Box 6 provides a summary of the strategies for the implementation of the national ageing policy. These strategies incorporate both gender equality and social inclusion of aged in Ghana.

Box 6: Ageing Policy Strategies

The strategies guiding the implementation of the ageing policy are:

- Upholding the Fundamental Human Rights of Older Persons
- Ensuring Active Participation of Older Persons in Society and Development
- Reducing Poverty among Older Persons
- Improving Health, Nutrition and Well-Being of Older Persons
- Improving Housing and Living Environment of Older Persons
- Strengthening the Family and Community to Provide Support to Older Persons
- Improving Income Security and Enhanced Social Welfare for Older persons
- Providing Adequate Attention to Gender Variations in Ageing
- Strengthening Research, Information Gathering and Processing, and Coordination and Management of Data on Older Persons
- Enhancing Capacity to Formulate, Implement, Monitor and Evaluate Policies on Ageing
- Improving Financing Strategies to Ensure Sustainability of Implementation of Policies and Programmes of Older Persons

The policy acknowledge the fact that the some social and cultural norms discriminate against the elderly especially women. Women go through widowhood rites and in some communities are branded as witches and isolated. HIV and AIDS had further increased the burden on women who have to take care of HIV/ AIDS. The policy also acknowledges that ageing affect women and men differently both physiologically and socially. It indicates that women suffer the brunt of extreme poverty and continue to remain at the top of the list of excluded and vulnerable groups. Women also face barriers concerning the acquisition of assets and lack access to opportunities that engender economic prosperity. All these notwithstanding older women are most often the primary caregivers in household settings. The policy makes reference to reviewing national gender policy to address gender-based disparities to ensure equality. Hence steps should be taken to address these inequality in society.

The policy alluded to the fact that specific interventions will continue to be implemented to reduce disparities in ageing among women and men and mainstream gender into policy formulation and budgeting processes. In addition, effort will be invested in increasing opportunities for women in

decision-making and accelerate the removal of outmoded customs that violate the rights of women and deny women from property whilst perpetuating the feminization of poverty. Based on the strategies, opportunities exist for advocacy for civil society (Box 6).

Box 6: Ageing Policy: Strengths/opportunities, challenges and proposed direction for advocacy		
Strengths/Opportunities of the Ageing Policy	**Challenges**	**Proposed Direction for Advocacy by Civil Society**
• Policy identified ageing and gender as a challenge in Ghana • Listed Persons with disability act of 2006 as legal framework for policy implementation • The framework makes recommendation for the establishment of a National Council on Ageing • Government to establish "active ageing fund"	• Lack of gender-based disaggregated national data on older persons • No reference to people with disability • National Council on Ageing yet to be established and hence hindering implementation of policy	• Raise awareness for a national gender-based disaggregated data. Gender-based and rural-urban disparities exist in life expectancy • Advocate for inclusion of people with disability in national ageing policy • Advocate for the establishment of the ageing council and resourced to coordinate the implementation of the policy • Opportunity for CSO to push for establishment of fund especially for people in informal sector • Advocate for decentralized system for paying pensioners using mobile money. Evidence exist of high penetration of mobile service or rural banks
• Provides opportunity for older people to plan towards retirement • Provide opportunity for participation in society and recreational activities **Age-based discrimination**: Age-based discrimination is pervasive and prevents older people from accessing basic rights such as adequate health care and legal protection.	• No data on the retirement planning among both public and private sectors workers • Elderly friendly infrastructure and recreational facilities • Older people are abused by family and community members. They are accused of being the cause of everything that	• Advocate for research on financial, psychological, and social planning as well as quality of life for benchmark data • Advocate for elderly-friendly structure and recreational facilities in communities • Advocate special attention to elderly in health facilities. The Eban

Aged are also discriminated with some branded as witches	evades the understanding of family members and women in particular are often falsely accused of witchcraft and violently assaulted and tortured in some cases.	elderly welfare card yet to be operational in rural areas • Educate communities on existing legal aid services • Advocate for the closure of witches camp ad re-integration of them to society.
Definition of Older person: Government will accordingly adopt sixty years (60 years) as the definition of older person in Ghana	• The definition restrict government social interventions programme to this definition	• Need to advocate an expansion to the definition to include functional ability of person. People with chronic illness who become incapable of working to earn a living should be included as a caveat
Access to specialized health care: the aged are faced with several health problems and waiver has been provide to them to improve access to health care. However, the training of health personnel gives little attention to older people and very few specialist services exist.	Currently, there are no special incentives to attract medical and health students to offer courses in geriatrics and gerontology. The negative attitudes of some health workers to older people sometimes due to lack of exposure to older persons' health and other needs. This affected the quality of services provided to older persons.	• Advocate for inclusion of course in geriatrics in training of health care. Advocate for government sponsoring health workers (Nurses, Doctors) to undertake specialized course in geriatrics and gerontology

3.1.4 The National Gender Policy

The national policy of 2015 has the theme "Mainstreaming Gender Equality and Women's Empowerment into Ghana's Development Efforts". The goal of this policy is to mainstream gender equality concerns into the national development processes by improving the social, legal, civic, political, economic and socio-cultural conditions of the people of Ghana particularly women, girls, children, the vulnerable and people with special needs; persons with disability and the marginalized. The guiding principles summarized in box 7.

Box 7: Guiding Principle to Gender Policy
• **Human Rights:** Women's rights are human rights • **Diversity:** Women are not a homogenous group – there is diversity (e.g. there are women with disability with unique concerns)

• **Sustainable Development:** Gender equality is not only women's issue, it is a sustainable development issue • **Mutual Co-existence:** Women and men will co-exist and build positive gender relations. • **Accountability:** Government is committed to promoting accountability through women's leadership, women's voices, women's visibility and effective participation in decision-making, politics towards good governance peace and security • **Economic Sense:** Gender equality makes smart economic sense • **Political Will:** There is enough "political will" from government and all players at all levels, in the economy particularly officials from the Executive, Legislature, Judiciary, Civil Society, the Media, Private Sector, Youth and Faith Based Organizations (FBOs) to mainstream gender • **Resource Availability:** The Ministry of Gender, Children and Social Protection is well resourced and positioned with the capabilities to mainstream gender equality and women's empowerment into all aspects of good and accountable governance practices

The guiding principles provided impetus for advocacy for civil society organisation (Box 8)

Box 8: Gender Policy Strengths/Opportunities, Challenges and direction for advocacy		
Strengths/Opportunities of the Gender Policy	**Challenges**	**Proposed Direction for Advocacy by Civil Society**
• **Legal Framework:** An Affirmative Action Policy of 1998 provides for a 40% quota of women's representation on all government and Public Boards, Commissions, Councils, Committees and official bodies, including Cabinet and the Council of State. • **Access to Justice:** The Judiciary has established two Gender-based and Sexual Offences Courts to expedite the adjudication of cases of violence and abuse. There is also the Legal Aid Scheme which facilitates access to justice for persons who	• Implementation had been a challenge nationally and worse at the district assembly levels • The Legal aid services only available at regional capitals with few lawyers • Only 23 lawyers currently engaged in legal aid in Ghana.	• Advocate for the full implementation of the affirmation action requirement of 40% quota for women • Raise awareness about existence of gender-based courts and advocate for the expansion of legal aid service to districts. Government must employ more lawyers in this department

are unable to afford justice		
• **Harmful socio-cultural Practice:** Policy to take action on widowhood rites, female genital mutilation and close down witches camps	These practices still exist	• Community sensitization on the harmful practices • Advocate for the criminalization of practices
Literacy rates: The overall literacy rate for females stands at 61.2% in 2010 due to regional disparities. Female adult literacy in the Northern and the Upper West Regions stands at 30.4% and 39.9% respectively, while the percentage increased to 85.3% in Greater Accra	Regional disparities exist with the three regions located in the northern part of Ghana worse off.	• Advocate for more females to be sent to use • Education against socio-cultural barriers to female education, forced marriages, sexual violence, and cultural servitude
Employment: majority (About 85%) of Ghanaian active female population are considered to be engaged in vulnerable employment, meaning unpaid family work or own account work	These are informal jobs and have inadequate regulatory framework and higher risk	• Advocate for legislation to regulate such work. Employees should paid social security for such workers (e.g. house helps) • Advocate for the establishment of a directorate for informal sector at Ministry of employment and labour
Disability: Limited attention to issues and aspirations of both men women with disability	Existing interventions for both men and women have not adequately and specifically addressed the concerns of Women with Disability (WWD).	• Advocacy for the inclusion specific intervention to meet the need of people with disability
Media Advocacy and stereotyping: Limited support of the media for gender activism and stereotype women in advertisement	The media also continues to portray women in stereotyped and sexualised roles in adverts.	• Gender activists and the media need to work together as a constituency through partnerships on projects • Advocate legislation to regulate the various forms of advertisement

3.1.5 The Ghana National Social Protection Policy

The national Social Protection Policy of 2015 defines social protection as "*a range of actions carried out by the state and other parties in response to vulnerability and poverty, which seek to guarantee relief for those sections of the population who for any reason are not able to provide for themselves*". The policy derives its power from provisions in the 1992 constitution which grants access of all people resident in Ghana to all public facilities and services; respect for fundamental human rights and freedoms; and the prohibition of discrimination and prejudice on grounds of place of origin, birth circumstances, ethnic origin, gender, religion, creed and other beliefs. The policy aims to deliver a well-coordinated, inter-sectoral social protection system enabling people to live in dignity through income support, livelihoods empowerment and improved access to systems of basic services. The policy identified areas that need to be addressed in the policy (Box 8).

Box 8: Issues identified in the policy to address
• Inequality in access to social protection by the marginalized, vulnerable and the poor • Inequalities in the burden of extreme poverty, education, skilled training gaps and excess maternal mortality • Unequal access to social, economic power and justice including lack of respect for and inadequate protection and promotion of human rights of women and girls • Inequalities between women and men in sharing of power and decision making at all levels and in dealing with all kinds of conflicts, in securities and threats on women and girls • Inequality in macro-economic issues including trade, industry structures and productive resources • Stereotyping and persistent discrimination against women and girls that manifest in negative gender relations, and value for gender roles and responsibilities with severe implication for maternal health and mortality

The policy therefore makes five commitments to address these issue. These commitments include; Women's Empowerment and Livelihood; Women's Rights and Access to Justice; Women's Leadership and Accountable Governance; Economic Opportunities for Women and Gender Roles and Relations. The policy recognises that issues of disability and gender will be mainstreamed throughout it implementation. It further identifies three vulnerability groups to be given specially attention in the implementation of the policy:

- The **chronically poor**: such as the severely disabled; terminally ill; rural unemployed; urban unemployed; and subsistence smallholders;
- The **economically at risk**: including food crop farmers, persons on the street, refugees and internally displaced persons, orphans, informal sector workers, widows, older persons and migrants; and
- The **socially vulnerable**: comprising people with HIV and AIDS (PLWHA), tuberculosis sufferers, victims of domestic violence, homeless persons, people living on the street, internally displaced persons and female headed households, amongst others.

The policy recognise the need for social protection issues for marginalized and vulnerable groups such as the homeless and the displaced and other sub groups such as Kayayei, and persons with disability. The inclusion of these people constitutes social inclusion aspect of GESI.

Generally, the policy has identified the need for gender equality and social inclusion, however opportunities still exist for advocacy. Box 10 provides a summary of the strengths of the policy, challenges and opportunity for advocacy

Box 10: Strengths/Opportunities, Challenges and Proposed Direction for Advocacy on Social Protection Policy		
Strengths/Opportunities of the Social Protection Policy	**Challenges**	**Proposed Direction for Advocacy by Civil Society**
Gender disparity in vulnerability: The policy recognised vulnerability especially during older age vary across gender and existence of rural-urban gradient	The policy identified various vulnerable groups for special attention. The main challenges is the lack of regulatory frameworks to regulate the social protection for people who work in informal section, majority of whom are females.	• Gap exist for policy advocacy for social protection schemes for informal sector employees
Job opportunities: The policy advocate for equal job opportunities for both males and females.	Some of the challenges in area is lack of job opportunities in rural areas which has led to increase migration of the youth to urban areas. This migration has increased inequality and led to an ageing and generally less dynamic population in rural areas. The migration has also increased unemployment in urban areas and exploitation of the youth who are engaged in menial jobs for survival.	• Opportunities exist for education about non-existent jobs in urban area
Mainstreaming disability and gender: Disability considerations shall be mainstreamed in all social protection efforts. Attention is paid to the extent of provision for disabled children, adults of working	Opportunities for participation of the disabled in productive inclusion interventions exists and provision are made in the Persons with Disability Act (Act 715). However, implementation of the	Major advocacy campaign to ensure compliance with the provisions of the Persons with Disability Act.

age and older persons in social assistance interventions	provisions of this Act is a challenge	

3.1.6 The Health Sector Gender Policy

This health sector gender policy was developed in 2009. The policy recognises that 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 recognizing gender as one of the factors influencing roles, responsibilities, status and influence in society.

The policy was developed to support MoH and its partners and agencies to adopt requisite strategies to analyze and prioritize gender issues in planning, implementation, monitoring and evaluation of policies, programmes, projects and research. The policy objectives include:

- 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.

The guiding principles of the policy recognises the need for gender equality and social inclusion (Box 11)

Box 11: Guiding Principles of Health Sector Gender Policy
• 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

These objectives have elements of GESI and are therefore relevant in achieving the objectives of GESI as envisioned in local and international treaties and conventions. Box 12 provide a summary of the strengths, challenges and opportunities for advocacy.

Box 12: Strengths, Challenges and Opportunity for Advocacy		
Strengths	**Challenges**	**Opportunities for Advocacy**
• The policy acknowledge disparities in vulnerability between males and females • All the objectives of the policy address one form of GESI and therefore very relevant	• The Policy was formulated within the context of a previous national gender policy which has been succeed by a 2016 National Policy • Tools and instruments for gender analysis and planning must be updated to reflect the changing demographics and institutional structures/responsibilities in health care delivery • Healthcare providers 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 • Inadequate gender sensitive training, coupled with poor conditions of service has resulted in the discourteous attitudes of some service providers • Infertility is a growing problem in the country for men and women and its sociocultural implications for women	• Advocacy on the requirements of the policy • Advocate a review of the policy in line with national policy and SDGs • Advocate for the inclusion of adolescent friendly health care in training of health workers • Advocate for gender sensitive training for health workers and trainees • Education and awareness about causes of infertility. Advocate for inclusion of fertility services in NHIS benefits • Promote BCC for the general public on the stigmatization of infertile couples

	are more pronounced yet receives less attention in health advocacy	

3.1.7 Private Health Sector Development Policy (2013)
This policy draws on and applies the principles of the National Public-Private-Partnerships Policy to the health sector. It acknowledges that the private sector owns about 55% of health facilities and services in Ghana. The policy recognizes the importance pluralistic health sector to improve access and quality of care for all people and prioritizes the collaboration of non-state actors in sustainable health delivery.

The policy recognizes the private sector as including a range of non-governmental actors –self-financing, for profit, not-for-profit, formal and informal, mission and faith actors in the entire health care delivery system; hospitals, clinics, pharmaceuticals, training, research and health financing.

The aims of the policy are:

- improving the investment climate for private health sector growth
- supporting the transformation of the private health businesses to meet industry expectation
- building capacities of private healthcare providers; and
- increasing opportunities for the poor to access private healthcare services.

The policy reviews relevant legislation including the 2011 Health Institutions and Facilities Act, which provides for licensing and regulation through the Health Facilities Regulatory Agency. The policy also refers to the Mental Health Act 830 of 2011 which establishes the Mental Health Authority to champion the provisions of the Act. The Act is supposed to rally the inclusion of people with mental disorders.

The policy acknowledged that about 15-20% of population live in remote, hard to reach and marginalized communities who are often eluded in immunization and other preventive health care. Civil Society Organisation (CSO) are often better placed to reach such marginalized groups. Therefore there is the need for the Ministry of Health to engage CSO to deliver such services. The policy also provide opportunities for advocacy (Box 12).

Box 12: Strengths, Challenges and Direction for Advocacy for Private Health Sector Development Policy		
Strengths/Opportunities	**Challenges**	**Directions for Advocacy**
• This policy provides the framework to guide private sector participation in health care especially to deprived and hard to reach areas (Health services provided by Christian Health Association of Ghana, CHAG)	• Challenges in paying public service wages • No structured partnership and support system between government and	• Advocate for gender considerations in employing staff • Advocate for private health sector employment policy • Advocate for formal partnership and

• Provides job opportunity for both medical ad paramedical staff • Support of health research identified for needs assessment, monitoring and evaluation • The policy is also relevant in detailing how the links between key policies and legislation work together	self-financing private sector	agreement between government and self-financing private sector to make them more accessible to everybody

3.1.8 The National Nutrition Policy 2013-2017

The National Nutrition Policy (NNP) provides an overarching policy framework covering all key dimensions of adequate nutrition, and addresses the synergy that links nutrition outcomes with determinants such as food insecurity, food safety, health services and caring practices as well as cross-cutting issues like capacity development. The long-term goal of the policy is to ensure optimal nutrition and health of all persons living in Ghana in order to enhance capacity for sustainable economic growth and development. The policy supports four strategic objectives, namely:

1. To promote optimal nutrition as an essential component of health and development among all people living in Ghana
2. To increase access to and create demand for quality and timely interventions, for effective control of priority nutrition problems in Ghana
3. To promote food security, food quality, and food safety at the individual, household, community, and national levels
4. To create an enabling environment for the effective co-ordination, integration, and implementation of nutrition programmes in Ghana

The policy acknowledges increase vulnerability to malnutrition among children resident in some regions in Ghana. The three northern regions (Upper East, Upper West, and Northern) as well as the Central Region have the highest rates of stunting and wasting; these rates are linked closely to food insecurity situation in these areas.

Micronutrient deficiencies, particularly of vitamin A, iodine, and iron, are also major a concern and continue to undermine the health of women and children. It further acknowledges that social norms prevent women and children from eating certain food which may lead to anaemia. The policy sees the need to collaborate and partner with agencies that have mandates to implement programmes that seek to establish social safety nets, empower vulnerable groups, and implement economic and livelihood programmes to increase women's economic autonomy. Provisions are therefore made for GESI.

This policy adopts a framework viewing nutritional issues across full lifestyles and generations, taking cognizance of the physiological needs in terms of different population groups at specific stages of life. The nutrition and health needs of individuals through these six stages of the human life cycle are recognised as: (i) pregnancy, (ii) delivery and new-born child, (iii) early and late childhood, (iv) adolescence, (v) adulthood, and (vi) the elderly.

Guiding principle 4 of this policy specifically recognises the need for gender equality. The policy states that gender equality and equity will be enhanced in all nutrition initiatives to ensure improved nutritional status of women, men, girls, and boys. Efforts shall be devoted to improving women's social status relative to that of men in all aspects of nutrition. Box 13 provides a summary of strengths, challenges and direction for advocacy for the nutrition policy.

Box 13: Strengths, Challenges and Direction for Advocacy for the Nutrition Policy		
Strengths/Opportunities	**Challenges**	**Directions for Advocacy**
• It makes a strong argument for a synergistic relationship between nutrition and susceptibility to infectious diseases across various groups and gender • Promotes high coverage of nutrition-sensitive interventions and positioning of nutrition as a high-priority multi-sectoral developmental issue with attention to gender-related factors	• Poor yield as a result of reliance of rainfall which has become erratic • Children and women s • Ghana does not have a robust and responsive surveillance system that can effectively inform the managers of food safety	• Advocate for the enforcement of regulations and laws that protect local food industry • Advocate for activities that involve men in child care and nutritional interventions • Advocate for creating enabling environment in schools and workplaces that will promote healthy eating • Educate stakeholders about the importance of investing in nutrition and the investment priorities

3.1.9 The National Health Promotion Policy

Health promotion is a core and one of the most cost-effective strategies to improving health and quality of life, reducing health inequities and poverty and ensuring the achievement of national and international health goals. The National Health Promotion Policy was developed to provide a sustained health promotion service that will improve the health and wellbeing in line with the health sector goal of ensuring a healthy and productive population capable of reproducing itself safely.

The guiding principles of the policy are:

- Emphasis on Community participation
- Access using the settings approach
- Inter-sectoral Collaboration
- Resource mobilization and Efficient Use
- Evidence-based planning and interventions
- Social Justice and Equity

The policy states that health promotion interventions shall target all groups regardless of gender, ethnicity, literacy, race, or residence. This is essential for effective health promotion outcomes. Emphasis will be placed on advocating for public policies and interventions that promote social justice and address social. Hence, gender and social inclusion have been considered in this policy.

Strengths/Opportunities of the HP Policy	**Challenges**	**Proposed Direction for Advocacy by Civil Society**
Vulnerable groups: The policy acknowledges vulnerability of males and to specific condition and makes provision for targeted health promotion activities	• Although policy recognises males and females as vulnerable to some health conditions, it fails to recognised how to reach out to people with disability, nomadic, people living in hard to reach areas • Low awareness levels, lack of access to care, support and treatment services are some of the key challenges confronting diagnosis and treatment of the 4Ds among children. •	• Advocacy for inclusion of strategies to reach people with disability (4D: Birth defects, disability, deficiency, diseases). Using the Early Childhood Development (ECD) approach; Nomadic; people living in hard to reach • Education and community sensitization on disabilities (4Ds)
Early identification of Disabilities:	• No systems in place to detect birth defects and some disability	• Advocate for the early identification and management of health conditions for early detection, free treatment, and management through mobile health teams should be a priority given the challenges in this area in Ghana

3.2 Associated Legislature on Gender and Social Inclusion (GESI) in the Health Sector

The organization, management and operations of the health sector in Ghana are governed by parliamentary legislations. These laws govern the operations of certain aspects of health delivery. Some of the laws that currently govern the operations of the health sector which can foster GESI include:

1. The Ghana Health Services and Teaching Hospitals Act 525, 1996 revised into the new General Health Service Bill covering the General Health Service, the Teaching Hospital Authority, the National Ambulance Service and the National Blood Service. This Act set to clarify the roles of the institutions and to help increase their efficiency. Provides opportunity for advocacy for social inclusion in situating in the siting of health care facilities especially in deprived and hard to reach communities.
2. The National Health Insurance Scheme under the National Health Insurance Act (2003, Act 650) revised as Act 852 in 2012, was also enacted to bridge the equity gap in access to healthcare; decrease financial barriers to healthcare. Renewal rates is low among poor[1]. Advocate for exemption for the poor and people living in deprived areas
3. The Local Government Service Act 656 and the National Decentralization Policy and Action Plan which will see a gradual and systematic transfer of responsibility from centralised to decentralized administrations. Advocate for gender consideration in appointment at Metropolitan, Municipal and District.
4. The National Environmental Sanitation Policy (2010) was adopted with priorities to increase access to adequate sanitation facilities; adapt to and mitigate the impact of climate change and promote sustainable environmental practices. Climatic changes increases poverty among rural areas who rely on rain fed agriculture.
5. The Health Coordinating Council Act, 2010 was promulgated to ensure effective integration of health sector agencies. The Act provides council for all health delivery agencies, regulatory bodies, and research and training institutions. The governance structure of Health Professions Regulatory Bodies Bill was based on this Act. This Act provides an opportunity for gender equality in appointment of boards and governing body. Advocate for the inclusion of people with disability during appointments.
6. The Health Professions Regulatory Bodies Act (2010) provide for governance structures that regulate health professional bodies - Medical and Dental Council; Nursing and Midwifery Council; the Pharmacy Council and the Allied Health Professionals Council. Provision of adequate mix of health professional is important for the delivery of preventive and curative health care. The Act was therefore promulgated to regulate the training of health professionals in the performance of their duties, and also to ensure adequate health professional are produced to cater for the health needs of the population. Advocate for policy to ensure fair distribution of trained health workers. Rural-urban disparities exist making some rural areas without appropriate health cadres. Hence they are socially excluded.
7. The Medical Training and Research Act (2010) was established as the Centre for Plant Medicine Research for the promotion of scientific research, knowledge and development in the field of plant medicine. The Act led to the establishment of the Ghana College of Physicians and Surgeons as a national postgraduate medical college for training specialists

[1] Akazili J, Welaga P, Bawah A, et al. Is Ghana ' s pro-poor health insurance scheme really for the poor? Evidence from Northern Ghana. *BMC Health Serv Res*. 2014;14(637).

in medicine, surgery and other disciplines, and the Ghana College of Nurses and Midwives to promote specialist education in nursing and midwifery. Advocate for gender consideration in admission to health care training consideration. Affirmative action required for some programme to bridge gender inequality.

8. The Traditional and Alternative Medicine Act (2010) provides for the promotion and regulation of the practice of traditional medicine and alternative medicine. It established a council that regulates traditional and alternative medicine practice and practitioners. To provide direction in the implementation of traditional medical practitioners in Ghana, a traditional health directorate has been established to provide leadership in the incorporation of traditional medicine into the health care delivery in Ghana. The council therefore regulates the traditional medical practitioners in Ghana. Advocacy for operationalization of this law. Health facilities currently do have place in the hospital for their practice.
9. The Health Institutions and Facilities Act 829 (2010) provides for licensing and regulation of facilities. It sets up the Health Facilities Regulatory Agency to oversee the operations of public and private health institutions and monitor the quality of service rendered by them. The Health Institutions and Facilities Act 829, 2010 covers the Centre for Scientific Research into Plant Medicine; Ghana College of Physicians and Surgeons; the Pharmacy College and the Ghana College of Nurses and Midwives. Using this law, an advocacy for promoting inclusion of gender-based topic geriatric care will be relevant.
10. The Mental Health Act 830, 2011 sets up a separate Mental Health Service leadership and governance structures to improve upon mental health service delivery. The provisions of this Act are yet to be implemented and this provides an opportunity for advocacy for social inclusion and gender-related factors in vulnerability. Women are generally more vulnerable to depression which has poverty, domestic violence and abuse as precipitating factors
11. The Public Health Act of 2012 (Act 851) was enacted to consolidate laws relating to prevention of disease, health promotion and to safeguard, maintain and protect the health of humans and other related matters. Key areas in this Act include certification of vaccines, standards for drugs, prohibition of diseases advertisement, WHO regulations and the regulation of tobacco use as catalogued in the World Health Organization WHO Framework Convention on Tobacco Control. The provision of this Act provides an opportunity to advocacy on women being used on adverts as sexual objectives. It also provides an opportunity for advocacy reaching hard to each population for immunization**.**
12. Persons with Disability Act, 2006 (Act 715) provides the requirement of the rights of persons with disability for rehabilitation and access to job opportunities. Advocacy for the implementation of the provisions of this Act would be necessary.

3.3 Conclusion to Review of Policies and Legislation

The review of national policies and legislations suggests that there are considerable provisions on gender equality and social inclusion. However, implementation of the provisions have been a challenge that provides opportunity for advocacy by civil society organisation. There are sufficient legislation for the enforcement of the provision. Hence, aligning these laws with requirements of the policy can form a firm ground for advocacy.

3.4 Prospects and Way Forward for Gender Equality and Social Inclusion in Policies on Universal Health Coverage

3.4.1 Prospects

Ghana has several policies addressing UHC and issues about the gender and social inclusion have been factored into those policies. Progress have also been made in implementing the provisions of those policies. As measures are put in place to achieve SDGs, it would be important to identify bottle-neck to implementing gender related issues in the policies as well as promote social inclusion.

The increasing life expectancy in Ghana has resulted in a demographic transition with many aged people in community. This has therefore means that if the aged are included in social interventions, they will be able to contribute to national development. This group of people will have acquired a wealth of experience, which could harness for national development.

3.4.1 Way Forward

Fundamental to achieving the SDGs is the recognition of the interdependence between economic growth, poverty, gender, social inclusion and health. This therefore calls for integrated multi-sectoral approach, which should emphasize an agenda of gender equality and social inclusion in all policies. Otherwise Ghana stands the risk of lamenting on another unfinished business as was the case for MDGs and a carry forward into any development goals that may come after 2030. These creates an opportunity for advocacy by CSOs.