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GENDER EQUITABLE CARE POLICIES IN GHANA: A CRITICAL FEMINIST REVIEW

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INTRODUCTION

In many parts of the world, social norms and traditional gender roles assign caregiving responsibilities to women. This establishes and reinforces the expectation that women prioritise family over economic activities. Care work, which includes a wide range of activities such as childcare, care for the sick, care for the elderly, care for persons with disabilities, and household maintenance, is disproportionately shouldered by women. The bulk of this work is also unpaid. Globally, women perform about 76% of unpaid care work (World Economic Forum, 2023), dedicating several hours each day to activities that are essential for the functioning of families and societies. In Ghana, women and girls spend 8-24 hours more per week on unpaid housework and care compared to boys and men (Valiani, 2022). This situation is not unique to Ghana. In Burundi, women work 13 hours per day, with six hours spent on unpaid care work, while men work seven hours per day on productive or market work and do not engage in unpaid care work at all (Plantwise, 2025). In the Asia-Pacific region, women spend an average of four hours and 20 minutes daily on unpaid care and domestic work—almost three times more than men (APEC, 2022). This imbalance between women's and men's burden of care work not only limits women's opportunities to engage in economic activities but also perpetuates gender inequalities in both the household and the broader economy. The burden of unpaid care work on women remains one of the most significant barriers to their economic empowerment.

The disproportionate burden of care work on women has profound implications for their economic empowerment. Women who spend significant time on unpaid caregiving are often unable to participate fully in the labour market, access better-paying jobs, pursue professional development or grow their businesses. According to the International Labour Organization, unpaid care responsibilities keep approximately 708 million women out of the labour force worldwide (ILO, 2024), thereby limiting their ability to accumulate productive assets and to achieve economic independence (Orozco et al., 2022). The ILO estimates that unpaid care and domestic work contribute approximately 9% of global GDP, with women's contribution accounting for around 6.6% (APEC, 2022). Despite this, women's unpaid care work is largely invisible and undervalued in economic terms. The contributions of women's unpaid care work to the economy are neither recognised nor well compensated.

Demand for care is rising, with estimates indicating that 2.3 billion people globally will require active care by 2030, including children and ageing populations (ILO, 2018). Within the status quo, the demand for women's unpaid care work would also increase, further intensifying the burden of care work on women, with dire implications for their economic empowerment. Public policies are essential to address this burden of care work on women, promote women's economic empowerment, and offset a looming care crisis which will result from intensified care deficits.

National policies provide the frameworks necessary to recognise, reduce, and redistribute unpaid care work (Maestre & Thorpe, n.d; UNDP, 2009; UN Women Africa, 2023). Progressive national policies, for instance, can formally acknowledge the economic and social value of unpaid care work, ensuring it is included in national statistics and considered in policy design (UNECE, 2021). This recognition is vital for shifting societal attitudes and legitimising the need for interventions (UN Women, 2024). Policies can also invest in public services and infrastructure, which significantly reduce the time women spend on unpaid care tasks (UN Women Africa, 2024), and implement social protection programmes that support caregivers and reduce the burden on women (OECD, 2019). Additionally, progressive national policies can promote shared responsibility for care work between women and men, as well as between families, the state, and the private sector (OECD, 2019; UNECE, 2021), through arrangements such as parental leave, flexible work schedules, and encouraging men's participation in caregiving.

When such care policies are lacking or exist but are simplistically framed, they can reinforce women's care burden and be injurious to their economic empowerment. Care policies can address the burden of care work and empower women when they are critically framed and progressive. Care policies can be progressive through policy-making contexts that support women's representation, active participation and leadership in policy-making to ensure that their perspectives are included in the design of the policies and programmes (UN Women Africa, 2024). Representation and participation in policy-making matter for equitable processes and outcomes because policies affect people differently depending on their positions in society. The differential effects of policies on men, women and other gender identities have been notable. Thus, policy-making, that is, the activities through which states articulate problems, set agendas, formulate policies, allocate resources, implement actions, and monitor progress (Parsons, 1995), cannot be approached as gender-neutral processes. Normative biases that favour masculinities and patriarchy feature prominently in policy-making. The process and the resultant policies are therefore undergirded by power imbalances, which engender unequitable outcomes. Progressive care policies, therefore, have to be proactively gendered to favour all gender identities through gender-equitable processes.

Unpacking and critically reviewing national policy-making processes and policies on care are essential to understanding who participates in care policy-making, what intentions and actions emerge from such processes into policy documents, and what potential and actual outcomes such policies engender to address the burden of care work on women, with positive effects on their economic empowerment. Using a critical feminist policy analysis lens, we review care policies and policy-making processes in Ghana to critically reflect on their ability or inability to address the burden of care work on women, intentionally or unintentionally, and the implications for women's economic empowerment.

In the remainder of the paper, we first present, in Section Two, our theoretical framework, which centralises feminist critiques of policy-making processes broadly and policies on care. We highlight what recommended actions are proposed for addressing the burden of care work through policy actions. These critiques and recommended actions inform the analytical framework and questions we use in our review of care policies and policy-making in Ghana. Afterwards, in Section Three, we provide a brief historical overview of care policies in Ghana from independence to 1999. In Section Four, we zoom in on analysing key care policies in Ghana from the year 2000 onwards. In Section Five, we critically appraise the policy-making processes of care policies. In Section Six, we synthesise insights from the review and critically reflect on the care policies and policy-making processes for their equitable outcomes for women's economic empowerment. We provide our conclusion in Section Seven.

FEMINIST PERSPECTIVES ON POLICY-MAKING AND CARE POLICIES: TOWARDS A CRITICAL FEMINIST ANALYTICAL FRAMEWORK

The Politics of Policy-Making and Analysis

Policies are key to promoting gender equity and equality, including addressing the burden of care work on women, which impedes their economic empowerment. However, the processes through which policies are made and issues get prioritised can constrain their ability to foster equitable outcomes. Achieving equitable policies requires rethinking dominant assumptions of policy-making as a gender-neutral process, which shrouds the power asymmetries moored in policy-making and, consequently, policy analysis.

For instance, because policy-making is often assumed to be neutral, policies tend to be analysed in terms of whether they have achieved their stated aims and objectives, rather than from a critical perspective that interrogates the normative values, power dynamics, interests and associated intended and unintended implications on gender and gender relations (Tsikata, 2001). As a result, traditional approaches to policy-making and analysis tend to reproduce masculine and patriarchal norms that manifest in the oppression of marginalised groups, including women (Mansfield et al., 2014), rather than address inequalities through intentional action (Kanenberg & Leal, 2019). Who makes policies, how they are made, the values and assumptions that guide the process, and the implications for different categories of men and women are fundamental questions to consider if policies and their outcomes are to be equitable.

Feminist Policy Analysis (FPA) raises two fundamental and mutually inclusive critiques of policy-making: the inadequate representation of women in policy-making, and the general lack of critical inclusion of women's issues, concerns and interests in policy formulation and action (Tsikata, 2001). A third fundamental and closely related critique is what Lombardo et al. (2012) refer to as the genderedness of policy-making; that is, how gender is actually framed and integrated into policies when such efforts are made. For example, gender issues are often simplistically framed in instrumental ways that feed dominant narratives, aligning with gender mainstreaming that has been co-opted into policy-making as symbolic representation rather than transformative practice.

Gender mainstreaming is intended to be a transformative approach that assesses, develops, implements and evaluates policies and policy-making to address the underlying challenges women face (Vyas-doorgapersad, 2015). However, evidence abounds of how gender mainstreaming has been diluted in policy-making through the inclusion of token paragraphs on gender, which are then used to claim gender

sensitivity. FPA critiques such simplistic framings, highlighting the lack of critical reflection on how policies affect women in specific ways, which is generally absent in conventional policy circles (see Carey et al., 2018).

Critiquing conventional policy analysis, FPA centres on asking questions of how policies are made, who is involved, how women's issues are included, whether these issues are backed by concrete actions and resource allocations, and what outcomes are produced for different categories of women and other gendered groups. FPA rests on the tenet that every policy is a women's policy and ought to be viewed through the lens of how women are included or excluded, and the intended and unintended outcomes thereof. Policy-making without diagnostic reflections on gender limits understanding of how existing policies fail to account for gendered implications. Similarly, policy-making without prognostic reflection of gender impedes understanding of how policies can be improved (Lombardo et al., 2012). FPA therefore focuses on unpacking policies to unearth gendered biases erroneously categorised as neutrality (McPhail, 2003). It advocates for the integration of critical gender and women's issues in problem formulation, solution identification, policy framing and design, implementation and evaluation.

Of utmost importance to FPA is the awareness of differences among women and the multiple axes of inequalities, i.e., race, class, gender, disability, etc., that intersect to produce varied outcomes. Analysing policies through an intersectional lens is key to unveiling how multiple identities and the associated matrices of domination affect women (McPhail, 2003). Kanenberg and Leal (2019), in advancing McPhail's FPA, reiterate that an intersectional lens encourages deeper reflection on policy-making processes aimed at promoting enduring gender-equitable outcomes. A genuine response to the call to "leave no one behind" requires an intersectional lens to unpack gender (in)equality in policy-making and its implications for equality. Naming and seeking to transform particular forms of inequality in policy-making in itself is a political process that centres intersectionality (Unterhalter et al., 2020). Intersectionality in FPA thus advances deep thinking that situates policy-making within the complex system of inequalities in which it operates.

In situating FPA in the complex system of inequalities, three dimensions of intersectionality are particularly useful: intra-categorical complexity, inter-categorical complexity, and anti-categorical complexity (see McCall, 2005). As intra-categorical complexity, intersectionality recognises, labels, and tackles the multiple, overlapping and cumulative inequalities faced by women as a particular gendered category. It recognises the centrality of identifying and tackling the intersecting inequalities of sex, class, religion and other socio-economic factors that amplify gender inequality. At the systemic level, intersectionality as inter-categorical complexity allows for deeper reflection on how policy-making, as a political activity, intersects with economic and social inequalities that reinforce inequities within the policy-making process itself. Intersectionality, in its anti-categorical complexities, on the other hand, calls for a

critical reflection of simplistic framings and discourses of gender that find expression in policies and policy-making.

Expanding on anti-categorical complexities, Bacchi's (1999) "What's the problem" paradigm provides a foundation for critiquing hegemonic gender discourses that shape how problems are articulated and solutions sought. For instance, the dominant framing of households as having a male head and breadwinner and a female home-maker and caregiver has been one of the simplistic yet hegemonic gender narratives that influences problem formulation and policy solutions. This hegemony is reinforced by policies and institutions, creating path dependency where interventions on domestic care provision are almost always targeted at women. In policy-making, how gender is framed as a category influences how actors envision ideal policy directions for gender-equitable outcomes (Yates, 2018). Therefore, centring intersectionality in all its complexities in policy analysis renders it transformational in the pursuit of systemic change. FPA broadly, and intersectional FPA in particular, has yet to gain significant momentum in policy analysis.

Critiques of Care Policies

Care policies are a key component of social policy, which, according to Mkandawire (2005, p. 13), encompasses policies deployed to pursue a wide range of goals, including nation-building, equality, human capital formation, and reproduction of society through family and care. In the ethos of all policy being women's policy (McPhail, 2003), care policies are especially conspicuous as the set of policies that ought to be central to this mantra, both in their framing and envisaged outcomes, given women's dominant role in care provision.

Care includes activities done to directly care for someone, as well as the necessary preconditions for caregiving (Razavi, 2020), such as providing supervisory responsibilities for children and other household and community members (Folbre, 2021). Conceptually, therefore, mundane activities such as childminding, meal preparation, and cleaning in the domestic sphere, for both persons who need care and able-bodied persons, are as integral to care as critical care provision for children, the elderly, the sick, or persons with disabilities (PWDs). Care is dominantly described as meeting the needs of someone who cannot meet their own (Kittay, 1999), thereby connoting a dependency relationship. However, there is interdependency between care-giving and care-receiving (Kittay, 1999). This requires centralising the reciprocity involved in care as a universal human need, of which the portion carried out through women's unpaid labour is fundamental.

Care is integral to social reproduction, that is, the processes that make it possible for individuals, families, and society itself to reproduce and continue. To this end, Standing (1999) views care, akin to employment, as a dimension of citizenship for which persons can claim rights. In this instance, the right to care, as much as the

right to employment, is integral to social protection. Framing care as a universal human need that is central to societal and economic development gives it a central place in policy-making. All policy actions directly and indirectly affect care-giving, whether paid or unpaid, in the domestic, public, market or voluntary domains, all of which are disproportionally dominated by women. Policy responses to care are therefore a key concern for fostering gender-equitable outcomes between men and women, as well as among different categories of women as, historically, women from lower social classes have tended to provide care services to women in relatively higher social classes while neglecting their own care needs (Razavi, 2020).

Despite care being integral to social reproduction, both social reproduction broadly and care in particular, are rarely central components of policy-making, nor do they receive special attention in gender-specific policy design. As a result, although the invisible and often undervalued domain of care, especially women's unpaid care work, is the very fabric that enables social reproduction (Randriamaro, 2013), this is rarely recognised or critically appraised in policy processes.

Feminist scholars have critiqued care policy-making on several grounds. First is the sheer lack of policies that treat care as a crucial component of the economy, deserving public attention. This is particularly prevalent in African countries, where the gendered division of labour and the dominance of women's unpaid care work have relegated care to the domestic domain, rather than recognising it as an economic contributor. Unpaid care work remains invisible in macroeconomic analysis and resultant GDP calculations. Consequently, its contribution to the economy is undervalued, providing little impetus for states to prioritise it in policy-making or to adequately compensate those who perform it.

Closely related to this is the conception of social policies, including care, as appendages to productive pursuits, or worse, as hindrances to them. Yet social policies, including care, are mutually constitutive of productive goals such as human capital formation, underscoring the importance of care policies for productive development (Mkandawire, 2005). However, the welfare state has often been narrowly viewed as "dashing freebies to citizens," rather than as a legitimate expression of the state's responsibility to care for its people. Reframing welfare policies as rights-based and integral to both production and reproduction is essential.

Another critique highlights the lack of critical reflection on the complex interplay between care and other policy domains. For instance, policies aimed at economic transformation, especially those involving cuts to state social provision and welfare, disproportionately affect women, who are the main caregivers in households and communities. This was particularly evident during the Structural Adjustment era, when macro-economic stabilisation goals were pursued with little recourse to their implications for public care provision and the indirect ramifications on the domestic

care burdens on women (Elson, 1991). Such economic goals and policies continue to reinforce and intensify demands on women's unpaid care work.

In some instances, care policies do exist, but they generally lack inter-categorical complexity, that is, they fail to account for the complex interplay among political, social and economic structures that shape the care economy and burden women. For example, the paid care economy is dominated by women who, despite working in the market, do not get adequate compensation due to the devaluation of care work. As a result, those in the formal economy are poorly paid, while those in the informal economy often lack any form of welfare protection (Ehrenreich & Hochschild, 2002).

In other cases, anti-categorical complexity is absent from the framing of care policies. Assumptions of unitary households and normative gender roles that cast women as caregivers continue to dominate policy-making on welfare issues, an approach that was also one of the core policy agendas in the Women in Development (WID) discussions (see Kabeer, 1994). In such contexts, even when care policies are conceived as women's issues, their gendered implications are often overlooked, leading to simplistic solutions with unintended outcomes that worsen the plight of women.

Incorporating anti-categorical complexity into policy analysis enables a critical reflection on how gender inequalities related to care are framed. Meanwhile, inter-categorical complexity helps to unpack the intersections between care, the labour market, and the household. Both are crucial for understanding the intended and unintended outcomes of care policies for women.

Recommended Actions for Progressive Care Policies and Policy-Making

Care is the daily reproduction of life. It is the very foundation upon which life itself exists and, as such, requires progressive policy action. Policy actions aimed at fostering gender-equitable care outcomes should, among other things, focus on recognising care work, reducing its burden, redistributing and socialising care responsibilities, and rewarding care work through adequate compensation.

Progressive national policies that are keen on care should formally acknowledge and recognise the economic and social value of care work, ensuring it is included in national statistics and considered in policy design (UNECE, 2021). In addition, policies should promote investment in public services and infrastructure that significantly reduce the time women spend on unpaid care work (UN Women, 2024) and implement social protection programmes that support caregivers and alleviate the burden on women (OECD, 2019). Such policies should also promote shared responsibility for care work between women and men, as well as between families, the state, and the private sector (OECD, 2019; UNECE, 2021). This can be achieved through

arrangements such as parental leave, flexible work schedules, and the socialisation of care work by encouraging men and entire communities to participate in caregiving.

Summarising the key policy actions for equitable care outcomes, Haq (2025) presents a 5R framework for an equitable care economy. This framework underscores the urgency to:

- **Recognise** the social and economic value of care work (paid or unpaid) and the human right to care.
- **Reduce** the burden of care work on women to *de-feminise* care.
- **Redistribute** care work between households and the state to *de-familiarise* care (making it less dependent on family members).
- **Reward,** remunerate and represent care workers (both formal and informal) through decent work, strong union representation, and full rights to unionise and bargain collectively.
- **Reclaim** the public nature, financing, provision, and regulation of care systems and services.

To achieve 5Rs through progressive care policies, policy-making processes themselves must be progressive. Policy-making contexts that support women's representation and active participation are essential to ensure that their perspectives are included in the design of care policies. This inclusion is critical for engendering equitable outcomes and promoting women's economic empowerment (UN Women, 2024).

Towards a Critical Feminist Policy Analysis Framework for Care

Building on the feminist critique of policy-making and analysis, we examine critiques of care policies and suggest actions to foster equitable care policies. To accomplish this, we utilise a critical feminist policy analysis framework (see Table 1). This framework is grounded in intersectionality and addresses the complexities of intra-categorical, inter-categorical, and anti-categorical factors.

The framework critically reflects on care policies and policy-making in five key areas:

- **Policy Context**

Critically reflects on the broad socio-economic context in which care policies are formulated.

- **Policy Theory, Goals, and Targets**

Appraises how care is framed as a problem, the solutions proposed, and the target groups.

- **Institutional Arrangement for Implementation**

Assesses resource allocation and the concrete mechanisms established to support policy implementation.

- **Policy Outcomes**

Evaluates the effects of care policies on women, using intra-categorical complexity to analyse outcomes for different categories of women.

- **Policy-Making Processes**

Investigates the culture of policy-making, including the presence of policy dialogue or agenda-building, and the constituency of actors involved in the process.

Table 1 presents these dimensions alongside critical questions in this framework that guide our analysis of care policies.

Table 1: *Critical Feminist Policy Analysis Framework for Care*

Dimension	*Critical Questions*
Policy Context	1. What is the broad socio-economic policy context in which this policy is being made? 2. What are some of the issues that have given rise to the concerns driving this policy?
Policy Theory, Goals and Targets	1. What is the policy theory, i.e., what assumptions and values form the basis of this policy? 2. What problems does the policy seek to address? How are they defined from a gender perspective, and what kind of gender issues are targeted? 3. What are the solutions being proposed - who are they targeted at, and who is ignored? 4. Are the solutions adequate (and for whom) given the problem as identified in the policy? 5. Are the solutions gender-aware, i.e., does the policy recognise that both men and women contribute to development and have different needs? If so, which of the following applies:

	a) Gender-neutral b) Gender-specific c) Gender-redistributive or transformative d) Is unpaid care work taken for granted or valued?
Institutional Arrangement for Implementation	1. Who leads the implementation of the policy? 2. What are the arrangements and resources for implementation? Are the resources merely symbolic or substantial?
	3. What proportion of the resources is targeted at promoting gender equity?
Policy Outcomes	1. What are the impacts of the policies on particular social groups and social relations? 2. Are there specific groups of women who are more negatively or positively impacted by these policies – e.g., by class, age, marital status, location (both rural/urban and North/South) or disability?
Policy-Making Processes	1. Who initiated the document, and what processes led to its formulation? 2. Who were the various actors involved, and how influential were they? 3. Were women's groups acknowledged as present and contributing? In what ways did they contribute? To what extent were alternative perspectives suggested by women's groups adopted in the final document? 4. What are the implications of women's presence, or lack thereof, in the policy being discussed?

Note. Author's construct (Tsikata 2001; McPhail, 2003; Kanenburg & Leal, 2019)

Scope of Analysis

As highlighted earlier, care encompasses activities undertaken to directly support individuals who cannot care for themselves, such as children, the elderly, sick persons, and PWDs, as well as the necessary preconditions for caregiving. These include mundane domestic activities such as childminding, meal preparation, and cleaning, which benefit both care recipients and able-bodied persons.

Care, therefore, has a broad scope, and numerous policies, both directly and indirectly, can be analysed for their gender-equitable outcomes. In this analysis,

however, we focus specifically on legislation, policies and strategies (hereafter generically referred to as "policies") that address issues of active or direct care. These include policies related to childcare, elder care, care for PWDs, and care for the sick. We acknowledge that by focusing on active care, this analysis may miss critical insights from policies that intersect with indirect care, such as those governing water and energy provision, both of which are fundamental to reducing the burden of care work.

Care Policies and Policy-Making in Ghana Before the 2000s: An Overview

Ghana, like many countries on the continent, has a relatively young population, which has been widely touted as a key resource integral to the country's economic development as these young people grow into the working population. However, the realisation of this demographic potential is largely contingent on the care provided to them (Valiani, 2022). Without adequate care services, including childminding, provision of nutritious food, quality education, and health care, among others, harnessing the potential of this demographic for national development will remain an illusion.

Beyond children, providing care for the sick, the elderly, and PWDs remains fundamental to Ghana's socio-economic development. With improvements in medicine, for instance, the proportion of the population that is aged is expected to rise, necessitating adequate measures to care for this group. Care must therefore be placed at the centre of national development and recognised as such. This recognition is essential to prompt policy actions aimed at reducing the burden of care work, which, according to Valiani (2022), disproportionately falls on Ghanaian girls and women, who spend 8-24 hours more per week on unpaid housework and care compared to boys and men.

In the immediate post-independence era, the development plans formulated by the National Planning Commission provided policy direction for several critical areas of the country's economic and social development. These plans sought to establish a seemingly holistic development agenda, offering guidance on broad socio-economic development, including care. Policy direction and focus from the First and Consolidated Development Plans (1951-1957), and the Second Development Plan (1959-1963), focused on building social services and amenities, particularly expanding access to education, health, electricity supply and water.

Public sector healthcare provision, in particular, received significant attention through the Free Healthcare for All policy. This initiative not only expanded physical access to health facilities, especially in rural areas, but also sought to abolish private fees in government hospitals and reduce medical costs. Children under 16 years were treated free of charge, while civil and public servants, as well as all workers, were entitled to free treatment at all outpatient clinics (Konotey-Ahulu et al., 1970). By 1965, the government had abolished hospital fees and charges at all government health facilities, allowing free access to healthcare for all.

The first Seven-Year Plan for National Reconstruction and Development (1963/64 to 1969/70), unlike the first two plans, placed the greatest emphasis on modernisation of agriculture and rapid expansion of industrial activity as the foundation for development. Its goal was to ensure that all Ghanaians were free from anxiety about

the necessities of life. Nevertheless, the plan recognised healthcare and the provision of social services, including transport, water and electricity, as critical components of socio-economic development. Budgetary allocations were made to expand both physical and financial access to healthcare further, thereby continuing the free healthcare policy.

Development in post-independence Ghana was anchored in a logic that sought to align the economic and social aspects of development to generate gains in the productive economy. This alignment was considered fundamental to safeguarding the well-being of Ghanaians. For instance, the massive investments in social services and amenities between 1951 and 1963 were intended to serve as a springboard for the productive aspects of agriculture and industrialisation to take off in the post-1963 period.

The focus on education as a social service in the Seven-Year Development Plan was to equip citizens with the necessary skill sets for the productive spheres of the economy. Education was thus linked directly to manpower and employment. Similarly, the emphasis on healthcare provision was fundamentally tied to productive gain, as 'a healthy population was considered much more productive than an unhealthy one' (Seven Year Plan for Reconstruction and Development 1963:176). Thus, although social policies were integral to development, they were often treated as instruments for economic growth rather than ends in themselves.

While social policies, in addition to enhancing the productive potential of the workforce, also concern themselves with reconciling the burden of reproduction, including care, with the other social tasks (Mkandawire, 2011), progressive policies that recognised care workers or actively redistributed care work from the domestic to the public or market spheres were largely absent. The development plans in the immediate post-independence Ghana were not progressive in their approach to care.

Care for the elderly, for instance, was conceived through old-age pensions in a Provident Fund Policy, seemingly imported from the colonial era pensions ordinance. This policy focused heavily on populations engaged in the formal productive spheres of the economy, neglecting the many others in the informal sector. Additionally, policies targeting PWDs, akin to broader social policy-making within this period, aimed at integrating them into the workforce as productive labour. The government thus established a workfare training programme to provide employable skills to PWDs (Grischow, 2011, cited in Anyidoho & Kpessa-Whyte, 2023), rather than making provisions for comprehensive care for them.

Following the overthrow of the Nkrumah regime, Ghana experienced alternating and short-lived military and civilian governments, ushering in a period of economic decline and political turmoil. Social policies generally received little attention, even as instruments of economic development. A downturn in the economy, political uncertainty and budgetary constraints meant that government expenditure fell short

even for economic policy implementation, which had been the government's primary occupation. Social policies, viewed largely as appendages to economic goals, took the brunt in this period. For instance, hospital user fees were introduced by Ankrah's military regime in 1967, suspended by the Busia civilian regime in 1969 following a public outcry, only to be reintroduced by the same government under the Hospital Fee Act of 1971 (Konotey-Ahulu et al., 1970; Arhinful, 2003). The provident fund, intended to provide income security for the aged, was adversely affected (Dei, 1997), as were workfare training programmes for PWDs. This era, therefore, saw a breakdown of social policies, even for instrumental purposes, including the collapse of free healthcare for all and the workfare programme.

The 1980s marked a clear shift in social policy-making, including care, due to the adoption of a neoliberal policy regime under the Structural Adjustment Programmes (SAPs). This period of high liberalisation was characterised by the retreat of the state from social provisioning, including through the introduction of cost-sharing mechanisms in health and education sectors previously seen as instruments of economic development. In healthcare, user fees and other charges were introduced in public facilities in 1983 (Hutchful, 2002). Users of health facilities were required to pay at the point of access, as a means of recovering at least 15% of recurrent expenditure (Arhinful, 2003).

Anyidoho and Kpessa-Whyte (2023) note that these cost-recovery mechanisms were accompanied by policy instruments that privatised and outsourced public services to private actors. The reintroduction of out-of-pocket payments signalled the end of healthcare provision as a form of social citizenship that had been in place since independence. Adverse effects included malnourished children discontinuing treatment and mothers absconding from hospitals, leaving their babies behind due to the inability to pay. While exemptions were granted to pregnant women, children under five, persons aged 70 and above, and other poor and vulnerable groups (Anyinam, 1989), these exemptions were inconsistently applied and often arbitrarily interpreted (Britwum et al., 2001). Thus, even for instrumental purposes, the social policies which intersected with care did not receive a lot of attention.

Efforts to redistribute care to the public domain through state provisioning retreated. With health risks increasingly individualised and healthcare commodified (Anyidoho & Kpessa-Whyte, 2023), many, especially the poor, resorted to self-medication and home treatment (Wahab, 2008). Women, as primary caregivers in households and communities, bore the greatest brunt of the state's retreat from healthcare provisioning and its relegation to the domestic domain.

The social costs of structural adjustment were dire, prompting the launch of the Programme of Action to Mitigate the Social Cost of Adjustment (PAMSCAD). PAMSCAD aimed to alleviate the consequences of the SAPs on vulnerable populations

through community initiatives, employment generation, and basic needs projects. However, this programme largely failed to mitigate the social cost (Hutchful, 1994).

The 1990s ushered in a relatively watered-down version of neo-liberal logic in the post-Washington Consensus, with renewed focus on some semblance of social inclusion, albeit through market-based logic. The Poverty Reduction Strategy Papers (PRSPs), dominant in this period, sought to reintegrate social provisioning into public policy, making social and economic policy mutually constitutive in poverty alleviation. This reintroduced the central role of the state in social provisioning, but the narrow focus on poverty also relegated care and broader social policy to the domain of social protection for vulnerable populations.

From the 1980s through to the 1990s, therefore, social policies, including care, were effectively replaced by protection mechanisms for the most vulnerable. The logics underpinning PAMSCAD, refashioned in the PRSPs, have persisted and continue to shape how social protection programmes in particular, and care policies broadly, have been framed in the 2000s and beyond.

The 1990s are pivotal to situating care policies within the current conjuncture. Among other developments, the 1992 Constitution of Ghana laid the foundation for the country's socio-economic trajectory and its outlook on care provision. For instance,

- Article 27 accords special care to mothers during and after childbirth, including paid leave for working mothers. It also mandates the provision of facilities for the care of children below school-going age to enable women, who have the traditional care for children, to realise their full potential.
- Article 28 outlines child rights, affirming every child's entitlement to special care, assistance and maintenance necessary for its development from its natural parents, except where those parents have effectively surrendered their rights and responsibilities in respect of the child in accordance with law; parents undertake their natural right and obligation of care, maintenance and upbringing of their children in co-operation with such institutions as Parliament may, by law, prescribe in such manner that in all cases the interest of the children are paramount; the protection and advancement of the family as the unit of society are safeguarded in promotion of the interest of children.
- Article 29 affirms the rights of PWDs to live with their families or foster parents and to participate in social, creative or recreational activities. It also mandates that specialised establishments provide environments and living conditions as close as possible to those of a typical peer.

The directive principles of the state, enshrined in the Constitution, guarantee the right to good healthcare for all and affirm the rights of children, the aged, PWDs and other vulnerable groups to a decent life, including access to social assistance.

The trajectory of care policy implementation – from the immediate post-independence era, through the pitfalls of the 1970s and the neoliberal reforms of the 1980s, to the social protection imperatives of the 1990s - provides a comprehensive overview of what worked and what did not in Ghana's care sector prior to the 2000s. The enactment and promulgation of the 1992 Constitution as a framework for social, economic and political pursuits with clauses on care provision and the emergence of a stable political regime marked by the peaceful transfer of power in the year 2000, set the foundation for what could be the beginning of an era of progressive care policies in Ghana from the 2000s onwards.

Care Policies and Policy-Making in Ghana; 2000s and Beyond

Using the Critical Feminist Policy Analysis Framework (see Table 1), we interrogate selected policies from the post-2000 era in Ghana, critically appraising their policy context, theory, goals and targets, institutional arrangements for implementation, outcomes, and policy-making processes. We pay particular attention to how these policies recognise and reward those who perform care work, provide support to reduce their burden, and/or socialise and redistribute care responsibilities from the domain of the family, especially from women, to the broader societal structures.

We organise and discuss clusters of policies around each of the active care dimensions: childcare, care for the sick, elderly care and care for PWDs.

Childcare Policies

A number of policies have been enacted to address childcare in Ghana. These cut across several sectors, including labour, education, health, social protection, and disability. The selected policies, listed in Table 2, are fundamental to this analysis as they highlight the state's vision of what caring for children entails and how this responsibility is to be carried out.

Table 2: *Selected Policies on Childcare*

S/N	Policy	Implementation period
1	The Children's Act 1998 (ACT 569) and The Children's Amendment Act 2016 (Act 937)	2003 onwards
2	Child and Family Welfare Policy 2015	2015 onwards
3	National Inclusive Education Policy (2015)	2015 onwards
4	Under Five's Child Health Policy 2007	2007 – 2015
5	Child Health Policy and Strategy 2017	2017 – 2025
6	Adolescent Health Service Policy and Strategy 2016	2016 – 2020
7	National Nutrition Policy 2013	2013-2017
8	The School Feeding Policy 2015	2015 onwards
9	Labour Bill, 2024	2024 onwards

Policy Context

Childcare policies are framed around two central imperatives: the right of children to care, and the role of care in nurturing children to develop their potential fully to

become productive citizens. Thus, policies on childcare (Table 2) recognise caring for children not only as a fundamental right, but also a strategic investment in the country's socio-economic development.

Policies on child and infant health, for instance, such as the Under-Fives Child Health Policy and the Child Health Strategy, are designed to reduce infant and child mortality through interventions that ensure that children grow into healthy and productive adults. Related to this, nutrition policies, such as the National Nutrition Policy and the School Feeding Programmes, aim to contribute to the enhancement of cognitive development and productivity. The latter, in particular, is seen as an effective mechanism for addressing child nutrition through the provision of meals to supplement household nutrition in deprived areas.

Education is positioned as a crucial component of childcare. The state is mandated to ensure that all children of school-going age are enrolled in school. This includes learners with disabilities, who constitute a significant proportion of out-of-school children. The National Inclusive Education Policy makes provisions for these learners to access education, not only as a right but also as a pathway to becoming productive members of society.

Policy Theory, Goals and Targets

The values and assumptions underpinning childcare policies take impetus from the framing of the Children's Act (Act 569), which provides the foundation for other childcare policies. The Act asserts that the best interest of the child should be paramount in any matter concerning the child. It states that "no person shall deprive a child access to education, immunisation, adequate diet, clothing, shelter, medical attention or any other thing required for his development." It further mandates that a parent or any other person legally liable to maintain a child or contribute towards the maintenance of the child, is under a duty to supply the essentials of health, life, basic education, and reasonable shelter. This framing positions the family, community and state apparatus as collectively responsible for the child's welfare, including the right to grow up in a caring and peaceful environment. However, this environment is primarily conceptualised as being within the domestic domain, with the fundamental responsibility for care placed in the hands of parents.

An alternative caring environment becomes imperative only when a child living with their parents does not receive the required care or peace. In such cases, the state may issue a care order, transferring parental rights to the Department of Social Welfare, which then provides institutionalised care in a residential home. This care is, however, considered a temporary substitute for family care, and social welfare officers are encouraged to reunite the child with their parents or family or to arrange adoption if it serves the best interest of the child. In other cases, a supervision order

may be issued, allowing the child to remain with their parents, guardian or family under monitored conditions.

Thus, the Children's Act provides for the redistribution of direct care from the domestic sphere only when protection is required. Institutionalised care, in the form of residential homes akin to day-care for children below school-going age, is framed to encompass both governmental and non-governmental providers but is implicitly treated as private-sector driven rather than state-driven. Redistribution from the domestic sphere is therefore directed more towards the market sphere than the public sphere, with the state's role largely limited to regulation and protection.

The Child and Family Welfare Policy (2015) builds on this framework by establishing a child and family welfare system comprising laws and policies, programmes, services, practices and structures designed to promote child well-being. The policy identifies the disintegration of the closely-knit social and family system, which traditionally provided care and protection for children, as a dominant challenge. While riddled with challenges, the policy prioritises informal foster care (where children live with extended family) over formal care. Thus, it anchors childcare and well-being in efforts to strengthen families to care for their children effectively.

Here too, the state's role in redistributing childcare to the public domain is delimited to child protection, clearly taking its impetus from the values and assumptions of the Children's Act. The policy does not envision a proactive state role in universal care provisioning, but rather a reactive role in cases of neglect or abuse.

Despite this pattern of value commitment that locates the primary and direct responsibility for childcare in the domestic sphere, other policies, particularly in health, nutrition and education, highlight the state's role in supporting families to care for children effectively. For example, the Under Five Child Health Policy (2007), Child Health Policy and Strategy (2017), and Adolescent Health Service Policy and Strategy (2016) collectively aim to provide a range of technical interventions across the continuum of care, that is, pregnancy, birth and immediate newborn period, neonatal period, infancy and childhood, and adolescence. While these interventions and associated services are designed to safeguard children's health and well-being, accessing them is the responsibility of parents and guardians, with the state assuming oversight responsibility.

In educating children, the state has several policies in place to ensure that education services are available and accessible to all children, including those with disabilities. The National Inclusive Education Policy (2013) specifically mandates that educational facilities be conducive for learners with disabilities to access and receive

education. However, akin to other support services policies, the primary responsibility for accessing and benefiting from these measures remains with parents.

Another state support service is food provision through the School Feeding Programme. The School Feeding Policy initiated this programme in 2005 to deliver a well-organised, decentralised intervention that provides disadvantaged schoolchildren with nutritionally adequate, locally produced food, mainly in contexts where such provisions are lacking in the household or domestic sphere.

Problem Definition in Childcare Policies. Following the patterns of value commitment and assumptions underlying childcare policies, which locate the primary responsibility of childcare in the domestic sphere, problem definition emanates from how these policies problematise existing challenges in domestic childcare provision and the state's roles in ameliorating childcare either directly or indirectly. Three main areas of problem definition are apparent:

1. Challenges within domestic/household provision of childcare and well-being that require efforts to strengthen family-based care and/or institute effective measures for state oversight responsibilities.
2. Challenges that necessitate state-provided services or amenities to support families in improving childcare.
3. Challenges where domestic provision fails, requiring the state to provide direct care services for children who are not receiving appropriate care in the domestic domain.

The Children's Act and Child and Family Welfare Policy define the problem of childcare across all three areas. In contrast, the Inclusive Education Policy and child health-related policies primarily define the problem from the perspective of state service provision to support families, and secondarily from the standpoint of state oversight and sensitisation of families to ensure these services are accessed and utilised. The School Feeding Policy, on the other hand, defines the problem from the perspective of direct state provision of care, offering nutrition to schoolchildren both as a standalone intervention and a strategy to improve school enrolment, attendance and retention in deprived communities.

These problem definitions are framed in both instrumental and structural senses. However, they lack a critical gender perspective. There is no substantive unpacking of how gender issues are fundamental to, or intersect with, the problem of childcare. For instance, while the Child and Family Welfare Policy identifies the breakdown of closely-knit families as a key factor in worsening child welfare, it fails to consider that care deficits can also arise when caregivers, predominantly women, are overburdened.

Care is not inelastic. Women who shoulder the burden of care work cannot stretch their capacity indefinitely without compromising care adequacy and quality.

Thus, even in unbroken families, childcare may deteriorate due to care overload, especially when care work is not de-feminised and redistributed to include other household and community members through socialisation. Yet, such critical framing of the problem from a gender perspective is missing.

Moreover, childcare policies often adopt an assumed gender-neutral framing, using terms like "parent" or "guardian". This, shrouds the reality of who actually performs care work, leading to a lack of recognition of women's disproportionate care burden. In cases of neonatal and infant care, where the mother's biological role is central, the term "mother" is used instead of parent, and this is often with the instrumental aim of ensuring that the mother, with the support of her male partner, presents the neonate or infant to welfare clinics. Thus, regardless of whether the gender-neutral term "parent" or the gender-specific one "mother" is used, the problem definitions in the childcare policies generally lack critical gender perspectives.

An exception is the Adolescent Health Services Policy and Strategy, which defines the problem from a gender perspective by highlighting the distinct health risks faced by adolescent boys and girls, and the need for gender-specific interventions.

Proposed Solutions and Institutional Arrangements. Following the problem definitions outlined in the country's childcare policies, three main categories of solutions emerge. First, the state institutes measures to sensitise parents and communities on children's rights, which encompass care, and empowering parents to play their role as primary caregivers. The state is positioned as an oversight body that ensures that parents and communities uphold their caregiving responsibilities. This is the main solution proposed in the Child and Family Welfare Policy. Second, policies targeting child health and education focus on addressing inefficiencies in service delivery, including financial and institutional bottlenecks. These policies propose technical interventions to improve access and quality, such as inclusive education infrastructure and health service packages. Third, some policies propose direct care interventions, such as the School Feeding Programme, which provides nutritionally adequate meals to disadvantaged children, and the provision of temporary alternative care homes for children in need of protection.

While these solutions are largely adequate in their instrumental dimensions, in terms of technical arrangements, they seem inadequate in tackling structural challenges, particularly those relating to gender. For instance, the Child and Family Welfare Policy recognises poverty as a fundamental cause of child neglect and abuse but relies on existing social protection programmes such as the Livelihood Empowerment Against Poverty (LEAP) programme, National Health Insurance Scheme (NHIS), free maternal healthcare, and school feeding, to address it. These programmes have shown limited effectiveness in reducing poverty, and the policy does not propose new or transformative approaches.

At the core, therefore, child protection tends to override a more holistic view of child welfare, which is strongly connected to family welfare, including the well-being of women. The Inclusive Education Policy, while proposing technical solutions to make schools more accessible, does not include targeted efforts to support mothers of children with disabilities beyond general community sensitisation. Structural vulnerabilities of households are acknowledged, but responses are limited to existing social protection mechanisms.

Not only are these solutions inadequate in addressing structural challenges, but they are also gender-blind or gender-reinforcing. Most policies assume gender neutrality or offer cursory gender awareness, which inadvertently reinforces the burden of care work on women. For instance, the Infant and Child Health Policies highlight the role of mothers in maintaining child health and seek to strengthen this role. While well-intentioned, measures like requiring mothers to visit periodic child welfare clinics can unintentionally increase their burden of care work.

Institutional Arrangements and Resources for Implementation

Childcare policies in Ghana are spearheaded by ministries aligned with their thematic focus. The Ministry of Health leads policies on infant and child health; the Ministry of Gender, Children and Social Protection leads the Child and Family Welfare Policy; and the Ministry of Education leads the Inclusive Education Policy.

Policy measures and actions, however, typically involve multi-sectoral steering or technical committees, coordinated by the lead ministry and comprising relevant ministries, departments, and agencies (MDAs). In the case of the School Feeding Policy, an independent agency, that is, the National School Feeding Agency, in line with the Public Service arrangements of Ghana, backed by the requisite legislation with a governing Board, a multi-sectoral technical advisory committee and a Secretariat, was proposed to lead the implementation of the policy. Until the passage of the relevant legislation to create the Agency, the programme is delivered from a School Feeding Secretariat, which works under the supervision of the Minister for Gender, Children and Social Protection. The clout that the Ministry or Agency leading the implementation of the specific policy has vis-à-vis other state institutions and especially the donor community is key to effective mobilisation of financial and human resources for implementation.

All the childcare policies propose a combination of three main resource arrangements for implementation. First, resources mobilised from the Government of Ghana budgetary allocations; second, resources mobilised from the donor community, civil society organisations (CSOs), non-governmental organisations (NGOs) and the private sector; and third, leveraging on available community capacities and structures as a crucial resource. In all these policies, the Government of Ghana is earmarked as the principal funder. Budgetary allocations are expected to be made

for the implementation of these policies, drawing on funding from sources including the consolidated fund. The policies place a responsibility on the Ministry of Finance and Economic Planning (MOFEP) to make such budget allocations and release them promptly for policy implementation. Additionally, the policies enjoin the implementing MDAs to allocate human and financial resources from their budgets towards policy measures and actions.

While core funding for these policies comes primarily from government budgetary allocations, they also rely heavily on resources from development partners[1], CSOs, the private sector and in-kind community support. For example, child healthcare policies are anchored in the provisions of the National Health Insurance Scheme, yet financial resources from donors are crucial for financing health packages and interventions. Therefore, these child healthcare policies emphasise the need for innovative approaches to attract more donor funds and manage them effectively to improve healthcare outcomes for children.

On the other hand, the Child and Family Welfare Policy places significant emphasis on utilising existing community resources and capacities. It aims to ensure that government-funded services complement rather than replace existing community structures for providing childcare. However, many childcare policies are largely gender-blind or only cursorily aware of gender issues, resulting in the absence of gender-specific solutions. Consequently, no resources are allocated to promote gender equity.

Policy Outcomes

The outcome of childcare policies on children's well-being has been positive. Neonatal, under-five and child mortality rates in Ghana have been consistently declining while child nutrition, education and protection are improving (UNICEF, n.d). One notable outcome is the attention and care it has generated for pregnant women within the ambit of the continuum of healthcare that begins during pregnancy. This has led to the inclusion of free maternal healthcare under the National Health Insurance Scheme.

Census data indicate that the maternal mortality ratio has consistently declined from 378 per 100,000 live births in 2007, to 316 in 2010, 310 in 2017 and 301 in 2021 (GSS, 2024). While these policies have had some positive effects on the health of children and mothers, they have not directly reduced the burden of care work on women. If anything, it has rather increased women's care burden as the interventions along the continuum of care from pregnancy, to neonate, to infancy, to childhood and to adolescence place enormous demand on women's time and effort to care for the health of children.

1. The appendix presents an overview of development partners key in policy formulation and implementation.

Childcare starts from pregnancy and, importantly, caring for neonates and infants. How the labour laws recognise this period and make allowance for women to combine care work with productive work, while redistributing between men and women, and between the domestic and public spheres, is crucial. Ghana's draft Labour Bill, 2024, is expected to provide a framework for labour and work-related matters. Although the Bill focuses on the productive domain of the economy, it has implications for the care economy through provisions on maternity, paternity and family care leave, which determine how much time is available for care work and the distribution between men and women.

The Labour Bill makes provisions for 12 weeks of maternity leave; however, a range of workers, including the self-employed, domestic workers, those employed by family members without contracts, agricultural workers, casual labourers, and artisans, are not covered by the provision that recognises maternity leave as fundamental to social reproduction (Valiani, 2022). The majority of women in Ghana work in the informal sector, and the Bill does not make provisions for them to engage in the crucial reproductive role of caring for neonates or infants while having a secure income.

Paternity leave, one of the key ways of redistributing care (Razavi, 2020), is introduced in the Bill for men within three months of their wife or surrogate giving birth, or who have adopted a child under one year. The leave is limited to a minimum of five days, granted only once every 24 months, with no defined upper limit. This provision is inadequate, especially in cases where a man's partner has more than one child within two years. Moreover, the disparity between maternity and paternity leave reinforces the assumption that childcare is primarily a woman's responsibility, with men offering limited and inconsistent support.

Many families supplement care work with paid domestic workers, often from the informal sector. These workers, predominantly women, are not adequately recognised in the Bill. The legal protection of informal care workers is an important indicator of the social value accorded to their work (Valiani, 2022), yet the Bill does not provide sufficient safeguards for these women who perform care work in domestic settings.

One of the greatest burdens of care work for women is caring for children with disabilities and special needs. Many of these women struggle to engage in economic activities due to the extensive time required for caregiving (Den Besten et al., 2016; Amo-Adjei et al., 2023). As part of de-institutionalisation efforts in Ghana, the government has shifted from institutionalised care of children with disabilities and special needs to family and community-based care. As a result, the state envisions its active role mainly in the provision of support services for carers, especially in health and education. However, these services remain woefully inadequate (Den Besten et al., 2016; Amo-Adjei et al., 2023).

The Inclusive Education Policy (2015), if well implemented, should provide support facilities where children with disabilities or special needs can be cared for during the day, allowing mothers time to rest or work. Recent studies highlighting the lack of education facilities for these children as a major problem for their carers (Den Besten et al., 2016; Amo-Adjei et al., 2023) are indicative that the Inclusive Education Policy has not lived up to its intended purpose.

Generally, childcare policies are designed to improve the quality of care for children, but they place the primary responsibility on families and communities—particularly women. The expectation to deliver high-quality care falls disproportionately on female caregivers in homes and communities. These policies make limited attempts to redistribute care to the public domain and only marginal efforts within the community, often restricted to sensitisation campaigns. As a result, childcare policies risk compounding the burden of care work on women with significant implications for their ability to participate in economic activities and achieve empowerment.

Healthcare Policies

Another set of care-related policies in Ghana focuses on providing care for sick persons and preventing sickness to ensure the health and well-being of the population. A number of these policies from the post-2000 era are of interest (Table 3).

Table 3: *Selected Policies on Caring for the Sick*

S/N	Policy	Implementation period
1	National Health Insurance Policy Framework: Revised, 2004	2004 onwards
2	National Health Insurance Act, 2012	2012 onwards
3	National Health Policy, 2007	2007-2022
4	National Health Policy: Revised Edition, 2022	2022 onwards
5	National Nutrition Policy, 2013	2013 onwards
6	National Health Sector Gender Policy, 2009	2009 onwards

Policy Context

Healthcare policies are framed around the value and assumption that the social and economic development of every nation is closely linked to the health of its people. The mantra is that a healthy population is one that can productively reproduce itself and contribute meaningfully to economic development. Health is therefore seen as a major contributor to economic development, a prominent narrative from independence to the current era.

The main goal of the National Health Policy 2007, for instance, positioned health as a strategic driver of Ghana's ambition to become a middle-income country by 2015, explicitly linking health outcomes to wealth creation. Similarly, the National Nutrition Policy 2013 considers good nutrition as essential for a productive population, since malnutrition contributes to low intelligence, reduced productivity, increased risk of illness, and, ultimately, higher poverty rates, slow economic growth, and poor human development.

The policies assume that improvements in health and nutritional status lead to:

- Reduced spending on preventable diseases
- Enhanced productivity
- Economic development
- Wealth creation

Thus, while health is recognised as an end in itself, these policies, including the National Health Insurance Policy Framework, which seeks to remove financial barriers to accessing healthcare for the population, are strongly anchored within a socio-economic policy context where social policy goals are aligned towards economic development.

Policy Theory, Goals and Targets

The underlying value of Ghana's healthcare policies is that state provision of healthcare services and measures to improve access and utilisation are fundamental to developing the essential human capital for development. These policies adopt a holistic view of health, considering physical, social, economic, and spiritual dimensions that contribute to the total well-being of individuals, their families and communities.

As a result, there is a shift from curative approaches to health promotion and disease prevention, including addressing the broader determinants of health. The policies derive their impetus from the Directive Principles of State Policy in Article 34 (2) of the 1992 Constitution, which, among other things, require the state to ensure the realisation of the right to good healthcare for people living in Ghana, irrespective of colour, race, geographical location, religion or political affiliation, as well as the prevailing development agenda. For instance, the National Health Policy (2007) derives inspiration from the development agenda of transforming Ghana into a middle-income country, while the Revised National Health Policy (2022) derives inspiration from the National Medium-Term Policy Development Framework developed by the National Development Planning Commission (NDPC), as well as the Coordinated Programme of Economic and Social Development Policies (2017-2024).

Problem definition. Healthcare policies define problems from three main perspectives:

1. Prevailing and projected health challenges, including demographic shifts and lifestyle-related diseases.
2. Institutional and technical inefficiencies in delivering holistic healthcare, including health promotion.
3. Financial barriers that prevent access to healthcare, particularly out-of-pocket payments.

The National Health Policies (2007 and 2022) highlight the challenge of emerging health issues resulting from changing demographics and lifestyles, environmental health, and improved access to health, population and nutrition services. The National Nutrition Policy targets malnutrition and its consequences for productivity and development, while the National Health Insurance Policy Framework and Act address the cost barriers that limit access to healthcare for large segments of the population.

While the policies in their framing acknowledge the complexity of health and of its intersection with socio-economic status, they do not define healthcare challenges from a critical gender perspective, except for a few references in the National Nutrition Policy to the diverse nutritional needs of men, women, boys and girls. References to equity issues are generally framed around geographical location, rural-urban disparities and wealth status.

The National Health Sector Gender Policy (2009) highlights the lack of critical gender perspectives in health sector policies and seeks to address this issue. The policy emphasises the need for a deep understanding of the diverse health needs of men and women, as well as their differentiated roles in healthcare provision, to ensure equitable access and outcomes. It aims to reduce gender-based barriers to healthcare, including geographic, financial and socio-cultural constraints, and also to address gender gaps in healthcare delivery at the household level. However, when viewed through the lens of anti-categorical intersectional complexities, the policy misses out on problematising the socio-cultural challenges critically, including how women's burden of care work itself is a major contributory factor to their ill health (Folbre, 2021). Thus, even though the policy's central focus is gender, the framing of gender is more simplistic and instrumental than transformational.

Proposed Solutions. As a logical consequence of how the problems are defined, the proposed solutions are largely technical and aimed at combating or preventing prevailing and projected health challenges. These solutions include:

- Ensuring quality standards for effective preventive and curative services.
- Ensuring effective institutional arrangements, including financing mechanisms for healthcare service delivery.
- Sensitisation of individual and community structure and choices to promote the effectiveness of the technical interventions.

Examples include:

- The National Health Policies (2007 and 2022) propose managing complex disease burdens through technical interventions, supported by community education on healthy lifestyles.
- The Nutrition Policy promotes maternal, infant and child nutrition through technical interventions and community sensitisation on good nutrition practices.
- The Health Insurance Policy Framework introduces health insurance schemes to reduce cost barriers, with public education on scheme modalities and benefits.

The Health Sector Gender Policy proposes gender-specific services and gender-sensitive delivery models. It adopts a gender mainstreaming approach, aiming to systematically integrate the distinct priorities and needs of women and men in all health policies and interventions. The goal is to promote and ensure equality in access, quality of care, and management of healthcare services.

Adequacy and Gender Responsiveness. Given how the problems are defined in the policies, the proposed solutions seem adequate. They focus on healthcare quality, delivery, and accessibility while also promoting a healthy lifestyle among the population. In the case of the Health Insurance Policy Framework, the adequacy of the solutions is highly contingent on the minimum benefits package guaranteed to all members of the scheme. This minimum package is intended to provide adequate protection against disease and injury, while promoting and maintaining good health.

The healthcare policies are generally gender-aware, even when the problems and proposed solutions are not framed from a critical gender perspective. They tend to address practical gender needs (e.g. maternal health, breastfeeding support) and accommodate existing gender norms rather than challenge or transform them.

For instance:

- The National Nutrition Policy includes actions to support working mothers in breastfeeding, in line with ILO Convention No. 183 and relevant state legislation, but does not propose redistributing the burden of breastfeeding or childcare.
- The National Health Policy (2022) promotes healthy eating and nutrition, which intersects with women's reproductive roles, but fails to consider how this may increase women's unpaid care work.
- In the case of the Health Sector Gender Policy, the solutions are gender-specific with a few attempts towards gender transformation. It advocates for:
- Behaviour Change Communication (BCC) to empower women to participate in health-related decision-making at household and community levels.

- Professional ethics and human rights training for health workers to promote gender fairness and respect in service delivery.

These interventions have the potential to challenge underlying gender norms and foster institutional change. However, the overall approach remains incremental, with limited structural transformation of the gendered dynamics of care and health.

Institutional Arrangements for Implementation

The Ministry of Health and its agencies spearhead the implementation of these healthcare policies. However, the holistic approach adopted in these policies necessitates the involvement of multiple ministries, departments and agencies (MDAs). Thus, akin to childcare policies, inter-ministerial and multi-sectoral coordination committees, chaired or led by the Ministry of Health, serve as the main institutional arrangement for implementation. These committees operate across national, regional, and district levels, mobilising the structures of various MDAs to deliver on policy actions. In the case of the NHIS, the Act establishes an independent Authority mandated to implement the scheme and manage its operations.

Resource Mobilisation. The policies envision resources for their implementation to come from:

1. Government budget allocations to MDAs involved in implementing policy actions.
2. Budgetary commitments and personnel deployment by MDAs.
3. Funds from development partners, CSOs and NGOs.

These healthcare policies emphasise the use of the Common Management Arrangements as a framework for coordinating donor participation in the health sector. However, they also problematise donor dependency. The National Nutrition Policy, for instance, laments that donor agencies have dominated the initiation and implementation of nutrition activities, resulting in inadequate domestic commitment to funding these interventions.

The Policy calls for a shift towards mainstreaming nutrition funding within government budgets. This concern has become even more urgent with the freeze of USAID funding in 2025, which has exacerbated challenges in the Ghana health sector (Akoto, 2025). The policies underscore the critical need for sustainable national financing, yet also acknowledge that inadequate government funding remains a persistent institutional challenge.

NHIS Funding Mechanisms. Given that the success of the NHIS in addressing cost barriers is directly proportional to the financial resources available, the Policy Framework and Act make provisions for direct sources of funding for the Health Insurance Fund. These include:

- National Health Insurance Levy: 2.5% charge on goods, services and imports.
- Social Security Contributions: 2.5% of each person's contribution to the National Social Security Scheme.
- Parliamentary Appropriations.
- Returns from investments made by the Health Insurance Authority.
- Grants, donations, gifts and any other voluntary contributions made to the Fund.
- Fees charged by the Authority in the performance of its functions.
- Member contributions to the Scheme.
- Funds accruing under Section 198 of the Insurance Act, 2006 (Act 724).

These diversified funding streams are designed to ensure the financial sustainability of the NHIS and guarantee a minimum healthcare benefits package for all citizens.

Equity and Gender Considerations. Equity is a core principle in Ghana's healthcare policies, but it is largely defined in terms of geographical location and wealth status, rather than from a gender perspective. While policies such as the NHIS seek to ensure equity, they do not earmark resources specifically for the promotion of gender equality.

The Health Sector Gender Policy, whose primary aim is to promote gender equity, indicates that its implementation shall be financed through existing channels within the Ministry of Health, as well as other innovative approaches. It calls for gender mainstreaming activities to be planned and budgeted for under the Government of Ghana's planning and budgeting process, i.e., the Medium-Term Expenditure Framework (MTEF).

Policy Outcomes

Ghana's healthcare policies have yielded some positive outcomes. For instance, life expectancy at birth has improved by 7.02 years, from 59.1 years in 2000 to 66.1 years in 2021, slightly higher than the African average of 63.6 years. The WHO[2] predicted that by 2025, an additional 9.5 million Ghanaians will enjoy better health and well-being, an additional 3.4 million will access essential healthcare without financial hardships, and 3.9 million more will be protected from health emergencies, compared to 2018 figures. Some policies have had particularly positive effects on women's health outcomes. The Health Insurance Policy and Act, with its free maternal health component, has significantly improved access to healthcare for pregnant women. Maternal mortality rates have declined from 378 per 100,000 live births in 2007, to 316 in 2010, 310 in 2017 and 301 in 2021 (GSS, 2024). The fee

2. Health data overview for Ghana

exemptions under the NHIS have removed financial barriers to healthcare-seeking, especially those in underprivileged locations (Atakorah et al., 2021).

Despite these gains, healthcare policies generally place the primary responsibility for health on individuals and communities, with the family unit seen as central to healthcare provision. Consequently, the policies emphasise sensitisation of the population to participate in health-promoting behaviours.

For example:

- The National Health Policy (2007) links population health to improvements in environmental hygiene, sanitation, safe water, food and nutrition, personal hygiene, and immunisation.
- The National Health Policy (2022) encourages the strengthening of traditional family systems that provide care and support for the elderly.

Implicit in all these directives are expectations placed on women's reproductive roles, particularly in such areas as safe water, safe food and nutrition, environmental hygiene, child immunisation, and elderly care. Without deliberate effort to socialise and redistribute these responsibilities, such policy actions risk intensifying women's care burden.

While the primary aim of the policies is to strengthen access to healthcare services within the public domain, there are limited efforts to redistribute care work. One notable example is the National Nutrition Policy, which proposes:

- Investing in understanding the social context of care
- Developing strategies sensitive to socio-cultural norms
- Scaling up activities that involve men in childcare and nutritional interventions

This approach signals an intent to socialise and redistribute care work, particularly around child nutrition, by encouraging male participation.

Elderly/Aged Care Policies

Caring for the aged is an increasingly important component of Ghana's care landscape, especially as life expectancy rises due to advances in medicine. A few policies are particularly relevant to this domain and are summarised in Table 4.

Policy Context

Ageing has become a growing concern in Ghana, with the percentage of older persons steadily increasing. The National Ageing Policy (2007) was developed in response to the absence of a comprehensive, coherent and well-articulated framework to address ageing-related issues. Like other social policies, it is framed within a socio-economic

development context, emphasising the need to transform and improve the lives of older persons and enable them, as far as practicable, to participate fully in national development.

As the aged population grows, the policy seeks to pre-empt and address the implications for service provision, including the reality that many older persons may no longer contribute directly to the economy. The National Pensions Act (2008) and its amendment (2014) are similarly anchored in this development logic, aiming to develop a robust framework to secure old-age income for workers in the country.

Table 4: *Selected Policies on Caring for the Aged.*

S/N	Policy	Implementation period
1	National Ageing Policy, 2010	2010 onwards
2	National Pensions Act 2008 (Act 766) and National Pension Amendment Act 2014 (Act 883)	2008 onwards
3	National Health Insurance Policy Framework and Act (sections on exemptions for the aged)	2004 onwards

Policy Theory, Goals and Targets

The overarching goal of the National Ageing Policy is to achieve the overall social, economic and cultural reintegration of older persons into mainstream society. It envisions ageing with **security and dignity**, supported by social protection and long-term care. This includes the right to independence, active participation in society, community support, and freedom from exploitation, principles aligned with the 1992 Constitution of the Republic of Ghana.

The Pensions Act establishes a three-tier pension scheme to ensure retirement income security for workers in both the public and the private sectors. It sets standards for the administration and payment of retirement benefits. The NHIS Policy Framework complements this by providing **free healthcare for the aged**, a key component of ageing with dignity.

Problem Definitions and Gender Dimensions. These policies address several challenges related to ageing:

- Old-age poverty, especially among women, due to lifelong gender discrimination.
- Health vulnerabilities in old age, with women disproportionately affected by disability and disease.

- Cultural norms around widowhood and witchcraft, which exacerbate the marginalisation of older women.
- Care responsibilities placed on older women, such as caring for orphaned grandchildren, even when they themselves require care.

While the Ageing Policy explicitly integrates gender dimensions into its problem definition and proposes gender-responsive solutions, the Pensions Act and NHIS Policy are largely gender-blind, failing to account for the structural inequalities that shape ageing experiences—particularly for women.

Proposed Solutions and Gaps. The policies propose solutions to secure the rights and freedoms of older persons. These include:

- Income-generating and voluntary work opportunities.
- Lifelong learning and community participation.
- Elimination of violence and discrimination.
- Access to preventive and rehabilitative healthcare.
- Social protection and support services.

While the National Ageing Policy is gender-aware in its framing, the Pensions Act and Health Insurance Policy do not incorporate gender-specific provisions. This limits their effectiveness in addressing structural vulnerabilities faced by older women. In spite of problems of eldercare in the Ageing Policy and solutions identified incorporating a gender lens, the proposed solutions to eldercare in the policies are inadequate in several respects:

- Opportunities for economic participation in old age are limited, especially for those who lacked access during their working years.
- The Ageing Policy calls for government agencies to integrate retirement preparation and post-retirement well-being into their programmes, but this primarily benefits formal sector workers.
- The Pensions Act includes provisions for personal pension schemes for informal sector workers, but these are underdeveloped and poorly operationalised, offering little security.
- The LEAP programme is cited as a social protection measure, but its benefits are woefully inadequate for securing old-age income.
- Access to healthcare through the NHIS is limited, with many essential services for the aged—such as assistive devices—not covered.

Institutional Arrangements for Implementation

At the time of its formulation, the National Ageing Policy (2010) was under the purview of the Department of Social Welfare (DSW), then housed within the Ministry of Employment and Social Welfare. Today, the DSW operates under the Ministry of Gender, Children and Social Protection (MoGCSP), which leads the implementation, monitoring and evaluation of the policy.

Even prior to this restructuring, the then Ministry of Women and Children Affairs was expected to collaborate with the Ministry of Employment to ensure that the Ageing Policy was gender-responsive. However, given the multi-faceted, multi-dimensional and multi-sectoral nature of ageing issues, the policy proposed the establishment of a coordinating body to oversee institutional commitments required and facilitate effective implementation.

Accordingly, a National Council on Ageing (NCA) was to be established, chaired by the Minister of Employment and Social Welfare. Its proposed membership includes:

- Department of Social Welfare
- Ghana Government Pensioners Association
- Informal sector pensioners' representatives
- National Population Council
- Ministry of Health
- Ministry of Water Resources, Works and Housing
- National Development Planning Commission (NDPC)
- Ministry of Finance and Economic Planning (MOFEP)
- Ghana Statistical Service (GSS)
- Ministry of Local Government and Rural Development (MLGRD)
- MoGCSP
- Ministry of Education
- National Youth Council
- Ghana Employers Association (GEA)
- Association of Ghana Industries (AGI)
- Organised Labour
- Academia
- Media
- HelpAge Ghana and other relevant NGOs
- Ministry of Information

The establishment and operationalisation of this Council is critical for the implementation of the policy.

Resource Mobilisation

Resource Mobilisation. To support long-term implementation, the policy proposes the establishment of an Active Ageing Fund (AAF). This fund is to be financed through:

- Seed money and grants from central government
- Contributions from District Assemblies
- Donations from the private sector, philanthropic institutions, individuals, NGOs, and development partners

A fund mobilisation strategy is to be developed to encourage generous contributions, particularly from NGOs and development partners. The Ministry of Finance is tasked with ensuring that the national budget process includes sufficient allocations for older persons, especially in areas such as:

- Cash transfers
- Training of caregivers
- Educational and skills acquisition programmes for older persons
- Geriatric and gerontology training for healthcare workers
- Payments to community health workers

The Budget Statement and Economic Policy of the Government of Ghana is expected to outline clear objectives for improving the living conditions of older persons. As a gender-responsive policy, the Ageing Policy is to be implemented through a gender mainstreaming approach, implying that resource use should also be gender-responsive.

Policy Outcomes

Since the passage of the National Ageing Policy in 2010, the policy has yet to be funded and implemented (Ashirifi et al., 2021). Both the National Council on Ageing and the Ageing Fund are yet to be established. Consequently, the envisioned support for elderly care in Ghana has not materialised.

When implemented, the policy could potentially reduce women's care burden through specific actions aimed at providing support services for elderly care. However, it may also inadvertently increase women's burden of care. The policy acknowledges the cultural importance of families, intergenerational interdependence, solidarity and reciprocity in caring for the elderly. Yet, without adequate efforts to socialise elder care and train other segments of the population, beyond women, the burden of care within the solidarity economy will disproportionately fall on women.

The policy recognises the burden of care work on women and demonstrates efforts to socialise care for the aged and to redistribute this in the domain of the public. It states: "the vital role of women as caregivers for older persons, especially with respect to HIV/AIDS and other chronic diseases that affect older persons" (National Ageing Policy 2010, p. 38). It further asserts: "it is imperative that governments and policy makers take adequate steps to provide for the phenomena [care for the aged] in a more formalized and systematic manner" (p. 5), signalling a redistribution of care to the formal public domain. While the policy affirms that "older persons are entitled to reasonable care and assistance of family and state" (p. 11), it also acknowledges that changes in family structure mean that the aged can no longer rely on family for care, thereby necessitating social protection schemes that redistribute care into the public domain.

The above notwithstanding, the policy maintains that the family will remain the primary source of support for older persons. It proposes that social welfare and social protection structures should increase focus, attention, and resources for the family. The government will ensure that traditional values and norms inform national and district-level policies concerning family values and elder care. Immense effort will be invested in upholding traditional family structures to enable them to provide the necessary support.

This emphasis on strengthening family support has implications for women's unpaid care work within households and communities. The policy's framing of society and family as key actors in elder care assumes a gender-neutral role within families and societies. In practice, this role may squarely fall on women. Although the policy acknowledges the challenges faced by older women in caring for children as a gendered aspect of ageing, it does not approach the promotion of community and family care from a gender-sensitive perspective, overlooking the reality that the women in these contexts bear the brunt of care responsibilities.

Caring for Persons with Disabilities

Caring for persons with disabilities is mainly enshrined in the Persons with Disability Act, 2006 (Act 715). This Act provides for the rights and welfare of persons with disabilities (PWDs) and establishes the National Council on Persons with Disabilities to oversee related matters. Specific interventions and provisions are also embedded in other policies, including the National Ageing Policy (for elderly persons), the Inclusive Education Policy (for children), and the Social Protection Policy (discussed later in this report).

Policy Context

The Persons with Disability Act aims to ensure that PWDs can live to their full potential through appropriate measures that guarantee access to family life, education, employment, healthcare, access to housing and transportation, and protection from discrimination. In line with broader socio-economic policy frameworks, the Act seeks to enable PWDs to access resources and capabilities that facilitate full participation in society and the economy.

Policy Theory, Goals and Targets

The fundamental value underlying the policy and its provisions is that, with the right services and interventions, PWDs can realise their full potential and contribute meaningfully to society and the economy. The Act affirms that PWD shall not be

denied the right to participate in social, political, economic, creative or recreational activities, as also enshrined in Article 29 of the 1992 Constitution.

The goal of the Act is to ensure that PWDs can access publicly provided support services directly, and indirectly through state regulation of other services to ensure disability-friendly provision. Direct public services, especially in education and health, are central to the Act, alongside the regulation and supervision of transportation, infrastructure, and employment services to prevent discrimination against PWDs.

Although the Act itself does not explicitly define the issue of caring for PWD from a gender perspective, other policies such as the National Ageing Policy and the Inclusive Education Policy recognise gender as a determinant of vulnerability. These policies frame both the problem and the solutions through a gender lens, offering support services tailored to the specific needs of men/boys and women/girls with disabilities.

This notwithstanding, the Act aligns with the broader narrative of care primarily in the domestic sphere. It states that a PWD shall not be deprived of the right to live with their family and to receive care. This emphasis on family as the primary provider of care risks reinforcing the unpaid care burden born by women.

Institutional Arrangements for Implementation

The policy measures are sector-specific, with implementation responsibilities distributed across ministries, including education, employment, health, housing and transportation. The DSW is tasked with coordinating these efforts in close collaboration with the National Council for Persons with Disabilities, as established by the Act.

The Council is mandated to oversee the development of policies and programmes to ensure full participation of PWDs in society. Funding for the Council is to be sourced from parliamentary allocations, donations, grants and gifts, and other financial resources approved by the Minister responsible for Finance, with parliamentary approval.

While disability-induced vulnerability can be exacerbated by gender-based vulnerability, there is a notable absence of programmes and interventions that earmark resources specifically to promote gender equity within disability-focused initiatives.

Policy Outcomes

The extent to which the Persons with Disability Act (2006, Act 715) fulfils its objectives can be assessed by examining how its provisions are reflected in policy documents across other sectors. The Act outlines effective measures to prevent

discrimination against PWDs and makes arrangements for special measures to cater to their explicit needs. However, implementation has not matched these intentions.

For example, the Act states that "the Ministry of Health in formulating health policies shall provide for free general and specialist medical care, rehabilitative operation treatment and appropriate assistive devices for persons with total disability". Despite this, assistive devices are largely excluded from coverage under the NHIS as established by the National Health Insurance Policy Framework and Act.

In the Social Protection Policy (2015), disability considerations are expected to be mainstreamed across all social protection efforts. The policy asserts "that attention shall be paid to the extent of provision for disabled children, adults of working age and older persons in social assistance interventions. Opportunities for participation of the disabled in productive inclusion interventions will be carefully created in consultation with their representative associations and in line with the Persons with Disability Act (Act 715). A major advocacy initiative will involve an ongoing campaign to ensure compliance with the Act's provisions". However, these commitments have not been effectively implemented in social protection interventions and instruments.

The Act further stipulates that a parent, guardian or custodian of a school-aged child with disability must enrol the child in school. Failure to do so constitutes an offence punishable by a fine upon summary conviction. Nonetheless, the education system remains deficient in providing equal access for children with disabilities. The Inclusive Education Policy has made limited progress in guaranteeing educational access for children with disabilities (Den Besten et al., 2016; Amo-Adjei et al., 2023).

Although there are efforts to socialise disability care and redistribute aspects of it into the public domain, care for PWDs remains heavily focused within the domestic sphere. As with other care-related policies, the Disability Act affirms that a PWD shall not be deprived of the right to live with their family or to participate in social, political, economic, creative, or recreational activities. The Act identifies the family as the primary provider of care. Given the inefficiencies in implementing the Act's provisions, the responsibility of caring for PWDs continues to fall disproportionately on women as unpaid caregivers, with minimal public sector support to alleviate this burden.

Social Protection Policies

In response to the social cost of SAPs in the 1980s and 1990s, the Government of Ghana introduced PAMSCAD. The logic underpinning PAMSCAD was later reconfigured in the PRSPs of the 1990s, shaping the government's approach to protecting vulnerable citizens, including through care provision. Ghana's social protection policies have thus become a central component of the country's care framework, as

outlined in the National Social Protection Strategy (2007) and the National Social Protection Policy (2015).

Policy Context

Ghana's social protection apparatus is framed by the recognition that, despite a rich tradition of community-based social protection efforts, persistent inequality remains unaddressed. More targeted approaches are needed to significantly improve incomes, promote equitable development and expand access to social services for the extremely poor and vulnerable.

The social protection policy framework, therefore, envisions creating an all-inclusive society through the protection of persons living in situations of extreme poverty, vulnerability and exclusion. The National Social Protection Strategy (2007) focused on investing in the extreme poor to realise their fundamental rights and develop their potential to contribute to national development, using a social protection floor framework. The 2015 Strategy broadened this focus, aiming to deliver a well-coordinated, inter-sectoral social protection system that enables people to live in dignity through income support, livelihoods empowerment, and improved access to basic services.

While the 2015 Strategy broadened the scope of social protection to include systems of basic services, it defined 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". This definition implies a targeted approach, focusing on vulnerable groups rather than adopting a universal framework for improving access to basic services across all sections of the population. Consequently, the policy's emphasis on social assistance, financial access to social services, productive inclusion, social employment and social insurance remains centred on the poor and vulnerable.

Policy Theory, Goals and Targets

Aligned with the broader socio-economic policy context evident in the other care-related policies, the fundamental goal of Ghana's social protection policies is to productively integrate vulnerable populations into the national economy. These policies challenge the misconception that social protection constitutes wasteful handouts to undeserving poor individuals. Instead, they demonstrate that social protection contributes meaningfully to development and economic growth.

For example, the National Social Protection Strategy (2007) highlights the high opportunity costs of failing to reposition vulnerable and excluded groups, noting

that "vulnerable and excluded segments of the population potentially reverse the gains of overall developmental efforts because of their tendency to take away rather than contribute to national economic activity" (p. 9). Accordingly, the policies aim to prevent livelihood decline rather than focus solely on offering social assistance to the extreme poor. The 2007 Strategy prioritised interventions to reduce extreme poverty and mitigate the effects of shocks on the well-being of the most vulnerable. The 2015 Policy sought to consolidate these gains through effective institutional and fiscal arrangements that prevent livelihood decline.

These policies are grounded in constitutional provisions. Article 17 (4)(a) of the 1992 Constitution mandates the implementation of policies and programmes to redress social, economic and educational imbalances. Similarly, the Directive Principles of State Policy guarantee the protection and promotion of all basic human rights and freedoms, including the rights of PWDs, the aged, children and other vulnerable groups (Article 37(2)(b)). Social Protection is thus recognised as a right of every citizen, with legal instruments such as the Children's Act, Labour Act, Pensions Act, Persons with Disability Act providing a framework for enforceable entitlements.

In operationalising these goals, the 2007 Strategy introduced interventions under the LEAP programme, with Social Grants Programmes including:

- Social grants for subsistence farmers and fisherfolk
- Social grants for extremely poor individuals aged 65 and above
- Caregivers' grants for orphans and vulnerable children (OVCs), particularly children affected by AIDS (CABAs) and children with severe disabilities
- Caregivers' grants for incapacitated or extremely poor persons living with HIV/AIDS (PLWHAs)
- Social grants for pregnant women and lactating mothers with HIV/AIDS

Additional strategic interventions included energy and utility subsidies, child rights protection, survival and development, labour-intensive public works (LIPW), skills training, pensions, and contributory social insurance schemes.

Building on these gains, the 2015 Policy aimed to reduce poverty through income support and sustained service delivery. It emphasised scaling-up social assistance, improving the implementation of social insurance schemes, enhancing access to health and education services and promoting employment creation, labour market participation, and productive inclusion. The policy also sought to strengthen instruments such as LEAP, LIPW, NHIL exemptions, the School Feeding Programme, and the Capitation Grant, while establishing a Ghana National Household Register (GNHR) as the primary targeting mechanism.

The policies acknowledge the gendered dimensions of poverty. Women are identified as bearing the brunt of extreme poverty and as being disproportionately

excluded from economic opportunities. Barriers to asset acquisition and limited access to growth-enhancing opportunities compound these inequalities. Moreover, women's dominant role as primary caregivers, particularly for PWDs and OVCs, means that poverty and exclusion often have intergenerational effects. The policies affirm that women caregivers should be prioritised for LEAP cash grants.

In the initial phase of implementation, the emphasis is on improving access to the core components of the social protection basket: LEAP, LIPW, NHIS exemptions, the Capitation Grant, and the School Feeding Programme. The social protection floor includes:

- Access to basic essential healthcare for all
- Minimum income security to meet children's basic needs
- Minimum income security for working-age individuals
- Minimum income security for older persons

Across all these domains, gender and disability considerations are to be mainstreamed. Policy implementation is expected to link income and support services to broader developmental and complementary measures, including social housing; water and sanitation; access to sustainable energy; labour market strategies; and public and private measures to build assets and capabilities. Although labelled as complementary, these measures are integral and hold significant potential for advancing gender equity within Ghana's social protection framework.

Institutional Arrangements for Implementation

Ghana's social protection policies assign primary responsibility to the government for ensuring adequate financing from public sources. The policies envisage that social protection will be funded through allocations in the national budget. The Ministry of Finance is tasked with planning and overseeing the financing of social protection within the government budget. It is expected to lead efforts to identify the requisite "fiscal space" through mechanisms such as tax reform, improved revenue collection, and strategic prioritisation.

Proposed fundraising mechanisms for the Social Investment Fund, the National Lottery, the MTEF, and the District Assemblies Common Fund (DACF). These sources, being well-established and permanent, are expected to provide continuous funding for programme implementation of the programme. Additionally, development partners are encouraged to align their financial support with the priorities outlined in the social protection policies.

Despite these arrangements, securing sufficient funding remains a persistent challenge. The Department of Social Welfare Five Year Strategic Plan (2019-2023), which embodies the government's effort at socialising care for the most vulnerable sections of the population, identifies inadequate government funding and delayed

disbursement of available resources as two of the three major economic threats to the department's ability to fulfil its mandate.

Policy Outcomes

Ghana's social protection framework is built on four foundational principles:

1. Supporting target groups to meet their basic human needs to sustain livelihoods.
2. Protecting them from shocks that could push them back into poverty.
3. Enabling access to opportunities and social programmes that enhance their quality of life.
4. Empowering them to participate in social policy development, institutional processes, and democratic governance.

The National Social Protection Strategy (NSPS, 2007) sought to realise these goals through the LEAP Social Grants Scheme. LEAP was designed to provide reliable and cost-effective cash transfers to support basic needs, acting as a "springboard" to assist beneficiaries to "leap" out of their socio-economic status by improving their livelihoods and assisting them to access government services that buffer against risks and shocks.

The effectiveness of Ghana's social protection system is therefore judged by the performance of its primary instruments and the extent to which these services sustain livelihoods. While LEAP has been credited with improving access to education and health (FAO, 2014), its reach remains limited due to poor targeting and funding challenges (de-Graft Aikins et al., 2016). The LIPW programme has had minimal impact on income security for the unemployed and underemployed.

The reach of NHIS exemptions, intended to provide free healthcare for children, pregnant women, the aged, and indigent persons, is also low. For instance, while indigents are significantly more likely to enrol in NHIS, they also part of the core group that drop out easily (Nsiah-Boateng et al., 2019). While the Capitation Grant is mainstreamed and subsidises fees for all children in public schools, the School Feeding Programme, which aims to provide nutritious hot meals to vulnerable children, shows mixed results in terms of reach and impact.

A review of these instruments - LEAP, LIPW, NHIS, School Feeding Programme, and Capitation Grant - suggests that the current approach to social protection requires reform to enhance effectiveness.

Gendered Care and the Logic of Protection. The overt focus on targeting extremely vulnerable groups reflects a broader policy orientation that views social protection as a response to unmet care needs within the household. This framing positions the domestic sphere as the primary site of care, with the state intervening

only in cases of extreme vulnerability. Consequently, care for children, the sick, the aged, and PWDs is treated as a household responsibility. Social protection policies acknowledge the role of caregivers – predominantly women – and include provisions for supporting their care work. However, this recognition reinforces women's role as unpaid caregivers, rather than challenging the gendered distribution of care.

The policies propose the expansion of social protection to integrate and streamline interventions in education and health, such as free healthcare for pregnant women, free deworming programmes, and TB and malaria awareness, prevention and cure. They also advocate for mainstreaming social services, including social housing, water, energy, and sanitation, to target the extreme poor. These services are essential to reducing the burden of care work and improving access to support services for caregivers. Yet, despite acknowledging their importance, these services have received little attention in implementation.

Social protection has become a key mechanism for care provision in Ghana, but it remains rooted in the protection logic (Anyidoho & Kpessa-Whyte, 2023). As Esquivel (2011, 17 cited in Valiani 2022) notes, the logic of social protection is consistent with traditional economic notions of welfare, focusing on minimum levels of consumption. This notion, in many instances, does not account for unpaid care labour in the home, addressing only paid care through disability grants or support for orphaned and vulnerable children.

Unpaid care, essential for the well-being of these people, is not adequately addressed. Ghana's social protection policies thus rely on women's unpaid care work to subsidise what comprehensive protection should entail, thereby rendering the system less equitable for women.

An Appraisal of the Care Policy Formulation Process in Ghana

Policy-making processes are critical to ensuring that care policies are gender equitable. As highlighted by UN Women Africa (2024), one of the key pathways to fostering progressive care policies is the active participation of women in policy-making processes. This section appraises the formulation processes of the reviewed care policies, situating them within the broader culture of policy-making in Ghana.

All the policies reviewed were initiated by the Government of Ghana through the respective ministries responsible for the relevant policy areas. An appraisal of their formulation reveals a convergence of national concerns and global policy directions influencing their initiation. Each policy acknowledges the fundamental challenges of caring for the specific population segments: children, the sick, the aged, PWDs, and other vulnerable and excluded groups. The policies reference national legislative and policy provisions, particularly the 1992 Constitution and the Directive Principles of

State Policy, which mandate the government to ensure adequate care and protection for all its citizens as a fundamental human right. In some cases, evaluative studies and assessments of care challenges are cited as catalysts for policy formulation.

In addition to national imperatives, global and regional frameworks, conventions, and protocols to which Ghana is a signatory have significantly influenced policy initiation. For instance, the Social Protection Policy (2015) highlights Ghana's commitment to comprehensive social protection programmes as outlined in the African Union Social Policy Framework (2003), the Livingstone Declaration (2006), the Ouagadougou Declaration and Plan of Action (2004, 2008), and the AU Heads of State Common Agenda for Action Post-2015. It also references Ghana's effort to meet the Decent Work Indicator (DWI) in the then Millennium Development Goal (MDG) 1 and other relevant aspects of MDGs (2, 4, 5, 6, and 7), as well as its endorsement of the Sustainable Development Goals (SDGs), which underscore the need for coordinated action and coherent social protection strategies.

Healthcare policies also draw impetus from international frameworks such as the International Health Regulations (IHR 2005); the African Union (AU) Vision 2063: "The Africa We Want", the ECOWAS Vision 2020; and the African Health Strategy (2016-2030). They also align with the Global Action Plan for Healthy Lives and Well-being and the Global Strategy for Women's, Children's and Adolescents' Health (2015-2030), both of which are linked to the SDGs.

The National Ageing Policy derives its impetus from Ghana's commitment e Second World Assembly on Ageing and Madrid International Plan of Action on Ageing (MIPAA). It also references conventions that seek to protect the rights of older persons, including the African Union Policy Framework and Plan of Action on Ageing (2002), UN Plan of Action on Ageing (1982), UN Principles for Older Persons (1991), and UN Proclamation on Ageing (1992). These international protocols, alongside national concerns, have provided impetus for care policy-making in Ghana.

Actors in the Policy Formulation Process

The formulation of care policies involves a diverse range of actors:

- State actors: Civil and public servants, typically leading the process through relevant ministries.
- Academia: Providing technical expertise and evidence-based inputs.
- Donor community/development partners: Such as USAID, UKAID, JICA, UNICEF, WHO, FAO, WFP, UNFPA, the EU, the World Bank, and the Palladium Group. These actors contribute both technical expertise and financial support to policy formulation (see appendix).

- Civil society organisations (CSOs): Including HelpAge Ghana, Ghana Blind Union, Federation of Disability Organisations, and the Ghana Coalition of NGOs in Health and Education.

While state actors are usually at the forefront of policy formulation, with technical support from academia, CSOs and the donor community are key non-state contributors. According to de Graft Aikins et al., (2016), nuancing insights from Oduro et al., (2014) CSOs often have high incentives to engage in social policy-making but limited power to influence strategic decision, unless intentionally included, as in the cases of Help Age Ghana and the Ghana Federation of Disability Organisations during the formulation of the Ageing Policy and Disability Act, respectively.

In contrast, the donor community tend to wield both high power and high incentive in shaping social policies. For instance, UNICEF and DFID played instrumental roles in the development of the NSPS (2007), which served as a precursor to the Social Protection Policy (2015). The international donor community's support for the MDGs and SDGs, coupled with Ghana's reliance on donor funding for social policy development, positions these actors as influential contributors to the framing of ideas and policy goals.

Participation in Care Policy Formulation

The reviewed policies highlight the participation of NGOs and CSOs in the policy formulation process. However, in many cases, the names of the specific CSOs or NGOs are not listed. Where such lists are provided, none explicitly mention women's groups as participants in the formulation process.

While it remains unclear exactly which CSOs participated in the formulation of many of the care policies, care policy-making in Ghana, like broader policy-making, is typically top-down. It is led by technocrats who draft policy documents with technical assistance from academia and the donor community. CSOs, including women's groups where present, are generally consulted to review draft documents, but their inputs rarely result in substantive changes to the final policy document. In many policies, the MoGCSP is cited as the body responsible for providing gender insights into problem identification, solution formulation, and gender-equitable implementation.

A notable exception is the formulation of the National Ageing Policy, which followed the United Nations Guidelines for Review and Appraisal of MIPAA. This process adopted a genuinely bottom-up participatory approach. Workshops were held at national and regional levels, bringing together older persons and their representative groups and associations; public sector policymakers; private sector stakeholders; social partners (including employers and organised labour); CSOs (including NGOs and community-based organisations); representatives of academic and research institutions; and development partners, Although women's groups were not explicitly

mentioned, this inclusive approach enabled the problem of ageing to be defined from a gender perspective, resulting in gender-responsive solutions.

Despite the uncertainty about the presence or absence of women's groups in the formulation of care policies, the dominant assumptions embedded in these policies appear to take unpaid care work for granted. This may reflect the limited participation of women's groups in shaping policy goals. Although the polices commit to improving the quality of care, drawing international conventions and protocols to which Ghana is a signatory, they rely heavily on household and community-based provision of care without:

1. Adequate provisions to recognise and reward those who perform care work.
2. Effective measures to strengthen access to care services and reduce the burden of care work
3. Concrete strategies to redistribute care work from the domestic sphere to the public domain, and from women to men, as well as to socialise it within the community and state.

Had women's groups been actively involved and made strategic contributions to the policy formulation, it is likely that women's unpaid care would not have been overlooked. Nor would additional expectations have been laid on women to deliver high-quality care for children, the sick, the aged, and PWDs without corresponding support.

Reflections on Gender-Equitable Care Policies and Policy-Making in Ghana

Centring the burden of care work, particularly women's unpaid care work within the care economy, is critical to understanding barriers to women's economic empowerment. Policy directions and actions that recognise the care work women perform, reduce this burden through the provision of care services, and redistribute care responsibilities across the community, state, or the market are essential for fostering gender-equitable care policies.

Ghana's care policies are heavily anchored in national and internal expectations that prescribe a high-quality of care. Commitments to quality are not misplaced, as such standards are imperative for social reproduction. Fundamentally, however, care provision is not inelastic. Higher quality of care requires greater time commitments, making quality demands directly proportional to hours of care work. Without adequate efforts to redistribute responsibilities or provide support services that reduce the time requirements, women, who are the primary providers t of care, bear the disproportionate burden.

The dominant value commitments underpinning policy framings emphasise households and community structures as primary care providers. While these narratives are not inherently erroneous, they lack critical appraisal of intra-family, intra-household and intra-community dynamics. Specifically, they fail to integrate how the burden of care provision falls disproportionately on women and which categories of women bear the greatest brunt. Consequently, associated solutions are framed simplistically, often reinforcing household and community roles in care provision without addressing gendered inequities. As an unintended consequence, such framings exacerbate women's care burden. One potential cause of this simplistic framing is limited consultation with stakeholders, particularly women's groups and women's rights organisations, during policy-making processes. Policies are not gender-neutral. The erroneous conception of policy-making as gender-neutral is a fundamental challenge to enacting gender-equitable policies. Such framings often draw upon hegemonic narratives and norms that are oppressive to women, thereby worsening their plight.

In instances where household breakdown or community-dependent care systems are problematised, policy framings acknowledge the need for alternatives. Policy goals in these cases align with redistribution or socialisation of care, enacted through public-sector provisioning to ensure fundamental access to care. However, resource commitments to such public provisioning remain low. This underinvestment poses a significant challenge to redistributing the burden of care work from the domestic to the public domain.

Women's unpaid care work subjects them to enormous physical and mental stress (Folbre, 2021). Addressing care is therefore fundamental to women's empowerment, as reflected in SDG 5. Goal 5.4 under SDG 5 seeks to achieve gender equality and empower all women and girls by recognising and respecting unpaid care and domestic work through public services, infrastructure, and social protection policies, while promoting shared responsibility within households and families as nationally appropriate. Women's dominance in unpaid care work should engender critical reflection on the choices available to women, the resources provided to lessen their burden, and the extent to which responsibilities are shared (Folbre, 2021). Public policy is key in addressing some of these issues.

There is consensus on the need to politically address care through public policies. However, approaches remain contingent on how the challenge of care is framed and the strategies deemed appropriate (Lewis, 2006). Care sits at the intersection of family, market, and state provision, encompassing both paid and unpaid services delivered through formal and informal channels (Lewis, 2006). This complexity requires public policy to adopt holistic approaches. Holistically tackling care necessitates sectoral policies that centre rather than treating it as tangential. How countries address care holistically has direct implications for gender equality.

Policy Actions for Gender-Equitable Care Systems

Policy actions that nurture a system in which care is not relegated to the domain of women - but is instead shared equitably between men and women across the institutions of state, market and household -are essential to holistically addressing the care challenge (Razavi, 2020). Gender-equitable policies should aim to rebalance care responsibilities between men and women, and among these institutions, as a prerequisite for women's economic empowerment (Durano, 2012).

Given that women dominate as providers of unpaid or underpaid care work (Çağatay, 2003), addressing care requires a fundamental rethinking of policies that have historically reduced state involvement in social provisioning. Efforts to integrate women into economic activities yield only marginal gains if not accompanied by investments in alternative care services. Women do not necessarily cease performing care work when they enter the labour market; thus, without redistributive mechanisms, their total workload increases. In this context, direct provision of care by the state, market, and not-for-profit sectors offers viable pathways to redistribute or socialise care.

State Provision and Financing of Care

State financing and state-led provisioning of care services remain integral to public policy in many countries, albeit through varying approaches. These typically fall into two mutually inclusive categories:

1. Direct provision of care services.
2. Indirect provision through investment in social infrastructure (e.g., water, sanitation, transport), which reduces the time and labour burden of care work on women (Bezanson & Luxton, 2006).

Collectivising the cost of care work (Duffy et al., 2013) is a key strategy for socialising care, ensuring that those who perform care work are adequately compensated and that the quality of care is not compromised. However, the growing trend of privatising public services, often justified by perceived inefficiencies, has diminished the state's indirect care service provision.

Healthcare as a Site of Redistribution

Healthcare remains one of the few domains where public provision is still visible. However, rising user fees have increasingly positioned the state as a profit-oriented actor (Razavi, 2020). In this vacuum, the market, both formal and informal, has assumed a central role in care provision, despite its limitations.

Healthcare has seen significant efforts to socialise and redistribute care through public provision. This sector is heavily reliant on women, particularly nurses and

other frontline health workers. In African health systems, the predominance of women in public healthcare underscores the importance of decent wages and working conditions as both a measure of valuing care and a mechanism for redistributing it. As Valiani (2022, p. 20) notes, "Living wages and adequate training for all healthcare workers is an expression of collective value and respect for care work. Comprehensive public healthcare services and programs would redistribute care for the sick from unpaid labour in households and communities to paid workers."

The Market and the Feminisation of Care Work

The care sector is increasingly recognised as a source of employment (Lewis, 2006), making it an integral component of the market. However, care provision within the market (formal and informal) remains feminised and mirrors the characteristics of women's unpaid care work. Women, often perceived as docile labour, are overrepresented in low-wage care roles (Razavi, 2020), with ramifications on the quality of care.

In many middle and low-income countries, market-based care provision is still informalised, with women employed as domestic workers performing a wide range of care tasks in private homes. To ensure that market-based care provision delivers empowering outcomes for women while maintaining quality standards, it must be accompanied by policies that promote decent work. Adequately rewarding care providers in both the formal and informal market settings is essential for achieving progressive and equitable care outcomes.

Reconciling Recognition and Redistribution in Gender-Equitable Care Policy

Efforts to increase the remuneration of paid care workers, without corresponding plans for public absorption of these costs, risk shifting the burden onto, particularly middle-class women who rely on care services while themselves earning inadequate salaries (Nakano Glenn, 1992). At the same time, recognising care work as formal employment, often taken up by vulnerable women, has not been matched by shifts in their unpaid care responsibilities within the household. These market-based care providers continue to perform unpaid care work at home and are often unable to afford paid care for their own families. Thus, care provision within the market can exacerbate inequality, reinforcing the case for socialising care through state provisioning as a pathway to equitable outcomes.

Public policies can either recognise and reward care workers or aim to redistribute care responsibilities (Valiani, 2022). These goals are sometimes perceived as contradictory; how can policies both validate women's unpaid care work and simultaneously seek to liberate women from it? However, these objectives are not

mutually exclusive. Policy frameworks can both pursue recognition and redistribution in complementary ways. For instance, policies can acknowledge and compensate the diverse forms of care work performed by women, while also promoting shared responsibility and redistribution across

Despite this potential, recognition, redistribution, and socialisation of care have received limited attention in Ghana's care policy landscape, and even less in terms of concrete implementation.

The Importance of Problem Definition

As previously highlighted, how a policy defines the problem of care is critical to its ability to generate equitable outcomes. Gender-neutral terminology – such as "parent" – can obscure the reality that caregiving is disproportionately undertaken by mothers. This linguistic neutrality often leads to policy actions that fail to address the gendered nature of care, thereby reinforcing women's burden.

The capacity of public policy to foster gender-equitable care systems depends on:

- How the problem of care is defined.
- How solutions are framed.
- What resources are allocated.

CONCLUSION

In Ghana, the well-being of families, children, persons who are ill, PWDs, and the aged has shaped policy directions that, both consciously and unconsciously, implicate women's unpaid care work. A key concern is how the state frames family as the primary provider of care, resulting in policy actions that place the responsibility of caregiving on women, who are positioned as caregivers, rather than on men, who are typically framed as breadwinners.

Policies concerning child protection, including those addressing well-being, nutrition and education, have direct implications for women's unpaid care burden. Additionally, rising life expectancy and the increasing prevalence of chronic health conditions have created a looming health crisis, further intensifying the demand for unpaid care work, predominantly performed by women.

To foster an equitable care economy and advance women's economic empowerment, it is essential to:

- Recognise the value of unpaid care work
- Redistribute care responsibilities across the public, community, and market domains
- Provide support services to reduce the burden of care
- Adequately reward care work in both formal and informal market settings

As Haq (2025) points out in the 5R framework, care is the daily reproduction of life; the very foundation upon which life itself exists. Progressive care policies should therefore urgently:

- Recognise the social and economic value of care work.
- Reduce the burden of care on women.
- Redistribute care between households and the state.
- Reward care workers through decent work.
- Reclaim the public nature, financing, provision, and regulation of care systems and services.

A major setback in Ghana's policy landscape is the lack of recognition of care as a public good. This has influenced both the design and funding of care-related interventions. Funding for social policies – including care - is a persistent challenge across the Global South, and Ghana is no exception. The neoliberal turn in Africa from the 1980s onwards led to a significant decline in government expenditure on social sectors, marking a departure from the immediate post-independence era when such investments were considered central to holistic national development.

Care policy financing in Ghana has been heavily reliant on donor support, with few exceptions like the NHIS, which is primarily funded through domestic resource mobilisation, even though it faces its own financial constraints. A critical appraisal

of financing mechanisms for care policies and interventions is therefore imperative. Without sustainable and equitable financing, care policies cannot effectively reduce women's unpaid care burden or meaningfully contribute to their economic empowerment.

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Appendix

List of Policies Reviewed

S/N	Policy and implementation period	Focus of the policy	Development partners providing technical and or financial assistance
1	Seven-Year Development Plan for National Reconstruction and Development (1963-1970)	Chapter on health espouses programmes and actions to provide health care for the population, including maternal and child welfare and rural health.	
2	The Children's Act 1998 (ACT 569), As Amended by Labour Act 2003 (ACT 651). 2003 onwards	Act to reform and consolidate the law relating to children (rights, maintenance, adoption, labour and apprenticeship, etc.).	
3	Child and Family Welfare Policy 2015. 2015 onwards	Policy framework on a well-structured child and family welfare system that promotes the well-being of children, prevents abuse and protects children from harm.	UNICEF
14	National Inclusive Education Policy (2015). 2015 onwards	The policy aims to recast the delivery and management of education services to respond to the diverse needs of all learners.	UNICEF
5	Under Five's Child Health Policy 2007. 2007-2015	Policy framework for promoting the survival, growth and development of all children in the country.	UNICEF, WHO, UNFPA, USAID,
6	Child Health Policy and Strategy 2017. 2017-2025	Policy framework for promoting the survival, growth and development of children in the country. Builds on the Under-Five Policy.	UNICEF, WHO, UNFPA, USAID,

7	Adolescent Health Service Policy and Strategy 2016. 2016 - 2020	Policy framework to enhance the health status and quality of life of adolescents in Ghana.	WHO, UNICEF, UKAID, UNFPA, Palladium Group
8	National Health Policy 2007. 2007 – 2019	Policy framework for health, focusing on the physical, social, and psychological aspects of health care provision.	
9	National Health Policy; Revised Edition (2020). 2020 onwards	It expounds the vision and strategy for a resilient health-care delivery system, including the promotion of a healthy lifestyle and a healthy physical environment.	DFID, UNICEF, JICA
10	National Health Insurance Policy Framework; Revised 2004. 2004 onwards	Framework for financing minimum healthcare benefits for persons who would otherwise not be able to afford out-of-pocket payment for healthcare.	
11	National Health Insurance Act: 2012 (Act 852). 2012 onwards	This Act replaced Act 2003 (Act 650), which has been repealed. This is an Act of Parliament establishing the NHIA and the scheme.	
12	National Health Sector Gender Policy 2009. 2010 onwards.	Policy framework for contributing to better health for both men and women through programmes that give due consideration to gender to promote equity.	
13	National Nutrition Policy 2013. 2013 - 2017	Policy to address nutrition-related challenges, including malnutrition among children and women, as well as over nutrition. Aim to promote optimal nutrition of the population.	USAID, UNICEF, WHO, FAO, WFP

14	National Social Protection Strategy, 2007. 2007 – 2015.	A comprehensive strategy for social protection, including LEAP as one of the programmes.	UNICEF, DFID
15	The National Social Protection Policy 2016. 2016 - 2031	Policy framework outlining institutional provision of care and social protection through programmes such as LEAP, LIPW, Capitation Grant, School Feeding, and NHIS.	UNICEF, EU, World Bank
16	The School Feeding Policy 2015. 2015 onwards	Policy initiating intervention to feed schoolchildren and to improve enrolment and retention of children in school.	
17	Strategic Plan for the Department of Social Welfare 2019. 2019 - 2023	Expounds implementation priorities and modalities of achieving an operative welfare system.	USAID, UNICEF
18	National Ageing Policy 2010. 2010 onwards.	Policy framework for the aged to live with security and dignity. Revised version of a draft ageing policy prepared in 2002 that was never implemented.	UNFPA
19	National Pensions Act 2008 (Act 766) Amendment Act 2014 (Act 883). 2008 onwards	An Act of Parliament to provide for pension reform in the country. Pension is a key component of social welfare that provides retirement income security for the aged.	
20	Persons with Disability Act 2006 (Act 715). 2006 onwards	Act of Parliament enumerating rights, care and protection for persons with disability.	
22	Labour Bill 2024		