

Nutrition Policy in Ghana



What does this brief tell you?

This brief summarizes nutrition-relevant policies in Ghana.

We examine i) nutrition context, policy objectives, indicators, budget, and activities, ii) key beneficiaries, actors and coordination, iii) monitoring, evaluation, and accountability, and iv) whether current policies are aligned with the World Health Assembly (WHA) global targets.

Key messages

Why was this brief developed?

- To strengthen understanding of the current direction of nutrition-relevant policy in Ghana and its implications. It was developed in response to partners' request and priorities.

What are the key findings?

- Nutrition is featured most prominently in nutrition, health, economic, social, and education policies.
- Young children, women of reproductive age and adolescents are the most frequently mentioned groups and targeted beneficiaries.
- Of the six WHA targets and their indicators, policies' content focuses most on U5 stunting and exclusive breastfeeding followed by low birth weight, and least on anemia in women of reproductive age and U5 wasting. The National Nutrition Policy adopts all six WHA target values as its own.
- All policies point to the importance of multisectoral coordination.

What are the policy recommendations?

- Address gaps and incoherence in nutrition-relevant policies, clearly aligning nutrition targets, objectives, activities and indicators.
- Prioritize nutrition across policy areas, including WASH, gender, environment, social protection, education, and economic policy.
- Mainstream nutrition in policies and strategies that are now being drafted to overcome shortcomings identified in current policy documents.
- Build and sustain strong vertical and horizontal coordination mechanisms to tackle mutually reinforcing issues which call for multistakeholder engagement.

The state of nutrition in Ghana

Ghana is on track to achieve the World Health Assembly (WHA) 2025 targets on under five (U5) overweight (1% in 2018ⁱ) and U5 stunting (18% in 2018ⁱ). Despite improvements in low birth weight (down from 16.1% in 2000ⁱⁱ to 14.2% in 2014ⁱⁱⁱ) and anemia in women of reproductive age (WRA) (from 59% in 2008^{iv} to 42% in 2014^v), Ghana is not on track to meet either of these targets. Exclusive breastfeeding during the first 6 months of life has shown no progress since 2014ⁱⁱⁱ (52.3% in 2014ⁱⁱⁱ and 43% 2018ⁱ). Ghana is not on track to achieve the WHA target on U5 wasting (4.7% in 2014ⁱⁱⁱ and 7% in 2018ⁱ). Beyond the WHA targets, U5 anemia (66% in 2014ⁱⁱⁱ) and underweight (13% in 2018ⁱ) remain high. There is a double burden of underweight and overweight/obesity in the adult population: while 6% of WRA are thin (2014ⁱⁱⁱ), 16.6% of women and 4.5% of men are obese (2016)^{vi}.

Current nutrition policy landscape in Ghana

Ghana has a multiparty political system, with 16 regions, 260 local districts, and a national capital^{vii}. National policies are ratified by the Parliament of Ghana. As such, they are implemented across the whole country. Seventeen nutrition-relevant policies currently in use are included in this brief (See **Table 1**). They are in the areas of health (n=13), nutrition (n=2), and economic/social/education policy (n=2).

Table 1: List of nutrition-relevant national policies

NR	Area	Policy Name	Acronym	Start	End
1	Nutrition	National Nutrition Policy 2016	NNP	2016	2021
2		Ghana Integrated Anaemia Control Strategy	IACS	2003	NS
3	Health	National Breastfeeding Policy	NBP	1995	NS
4		Ghana National Newborn and Child Health Advocacy and Communication Strategy and Year One Work Plan	NNCHACS	2015	2019
5		Ghana National Healthcare Quality Strategy	GNHQS	2016	2021
6		Health Sector Gender Policy	HSGP	2009	2014
7		National Community-Based Health Planning Services Policy	CHPS	2016	2021
8		Revised National Health Promotion Policy	NHPP	2016	2020
9		National Food Safety Policy	NFSP	2019	2024
10		National Health Policy: Ensuring Healthy Lives for All	NHP	2020	NS
11		Ghana National Newborn Health Strategy and Action Plan	GNNHSAP	2019	2023
12		National Tuberculosis Health Sector Strategic Plan for Ghana	NTHSSP	2015	2020
13		National Acceleration Plan for Paediatric HIV Services Ghana	NAPPHIVS	2016	2020
14		Reproductive Health Strategic Plan	RHSP	2007	2011
15		Ghana Health Service Quality Assurance Strategic Plan	QASP	2007	2011
16	Economic/Social/ Education	National School Feeding Policy	NSFP	2015	2020
17		Medium-Term National Development Policy Framework: An Agenda for Jobs: Creating Prosperity and Equal Opportunity for All 2018–2021	MTNDPF	2018	2021

NS (Not Specified)

Methods

All nutrition-relevant national policies, strategies, and action plans currently in use or in the advanced drafting stage as of September 2020 were included in this brief. Inclusion criteria were the presence of a nutrition objective, a budget for nutrition, and/or a nutrition indicator. Policies were not included in our analysis when i) we did not have access to the policy documents; ii) they were released or updated after expert consultation (September 2020).

We obtained potentially relevant documents from a systematic search that included pre-identified websites (e.g., relevant national government ministries, United Nations agencies and nongovernmental organizations), a Google search, a reference search, and country expert consultation. Targeted consultations with regional and in-country experts were used to access documents not available online and for validation. We screened identified documents (see Annex 1) against our eligibility criteria. Seventeen documents met our inclusion criteria. Coding, data extraction, and content analysis for these documents were carried out with Excel.



What is the focus of policies' presentations of the nutrition context and what problems are highlighted?

Sixteen out of the seventeen policies included provide some nutrition context. This context is most comprehensive in health, nutrition, and economic/social/education policies. Across policy areas, the nutrition context is predominantly focused on the country level. However, all sixteen of these policies also present the global context, with six policies reporting information on regional/international trends and conventions, the Millennium and Sustainable Development Goals, the International Conference on Nutrition (ICN) in 1992, and Ghana's adherence to the SUN Movement. Policies from the nutrition ($n=1$), health ($n=7$), and economic/social/education ($n=1$) areas recognize wide rural/urban, state, and/or economic disparities in Ghana's nutrition context. None of the policies present sex-disaggregated nutrition data.

Across policy areas, the focus is on under- and overnutrition. Nine policies in the areas of nutrition, health, and economic/social/education present the context on micronutrient deficiencies, namely, vitamin A, iodine, and iron deficiencies. Nine, from the same three policy areas, present information on noncommunicable diseases (NCDs), including diet related NCDs such as diabetes and high blood pressure and their risk factors. Overweight/obesity are featured as NCDs in three policies across the nutrition and health policy areas. The role of nutrition in contributing to certain types of NCDs is

emphasized in several of the policies. Nutrition, health, and economic/social/education policies present a more holistic picture of nutrition problems. The majority of policies, mainly from the nutrition, health, and economic/social/education policy areas, outline causes ($n=15$) and/or consequences ($n=15$) of nutrition problems. Causes include poor diets and infant and young child feeding practices, social/cultural norms, inadequate health/nutrition services, and limited physical and financial access to healthcare. Consequences include increased malnutrition, increased mortality and morbidity, reduced economic, social, and cognitive development, and poor educational attainment.

Table 2 highlights policies that include information on the WHA targets' indicators in the nutrition context. Low birth weight, exclusive breastfeeding, U5 stunting, and anemia among WRA are most frequently included. U5 overweight is mentioned in only one policy's nutrition context (NNP); only three policies mention U5 wasting (NNP, HSGP, and MTNDPF). Apart from U5 stunting and U5 wasting, WHA indicators mentioned are almost exclusively confined to nutrition and health policies. The NNP, the most recent national nutrition policy, includes all WHA indicators in its nutrition context, unlike earlier health and nutrition policies.

Is the nutrition context evidence-based?

The nutrition context is most consistently evidence-based (i.e., cites scientific references) in nutrition, health, and economic/social policies. Across all policy areas, citations are predominantly reported for statistics rather than textual information. Data sources for evidence in the policies' nutrition context include the Ghana Demographic and Health Survey (GDHS),

Multiple Indicator Cluster Survey (MICS), Ghana Cost of Hunger Study conducted by the African Union Commission, and data from UNICEF and the Ministry of Food and Agriculture. Cited evidence mainly relates to the prevalence of nutrition problems, nutrition disparities, causes and consequences of nutrition problems, rather than to solutions.



What is included in the relevant policies to address the highlighted problems?

As shown in **Table 2**, most policies across nutrition, health, and economic/social/education policy areas include nutrition in their general and/or specific **objectives**. These objectives contain nutrition-specific content (e.g., to increase coverage of high-impact nutrition-specific interventions that ensure optimal nutrition of Ghanaians throughout their lifecycles, with special reference to maternal health and child survival) and to a lesser degree, nutrition-sensitive content (e.g., to ensure high coverage of nutrition-sensitive interventions to address the underlying causes of malnutrition). Almost all included **nutrition indicators** are outcome indicators (e.g., U5 stunting), although policies in the areas of health (n=5) and economic/social/education (n=1) also include output indicators (e.g., number of babies being exclusively breastfed at discharge from health facility). In terms of nutrition problems, indicators focus on U5 stunting, low birth weight, exclusive breastfeeding, and to a lesser extent, micronutrient deficiencies, with few indicators on diet related NCDs including overweight/obesity. No policies include any disaggregated nutrition indicators. The least prominent WHA indicators in policies are anemia in WRA, low birth weight, U5 wasting, and U5 overweight. The NBP is notable for specifying exactly how the exclusive breastfeeding indicator will be measured. **Planned nutrition activities** are detailed in fourteen of the policies, across all policy areas. NNP, IACS (nutrition), NBP, NNCHACS (health), and

MTNDPF (economic/social/education) present the most comprehensive range of nutrition activities. Only seven policies have sufficiently detailed budget information, and only three of these have a **budget for nutrition**. Content on **scaling up** focuses on mechanisms for piloting and implementing the policy (e.g., guiding principles, advocacy, tools such as implementation frameworks and protocols, scaling up high-impact interventions, resource mobilization, capacity building and research). Nutrition features specifically in information on scaling up for ten health policies, two nutrition policies, and one economic/social/education policy. A few policies mention risks or challenges to scaling up, namely, uncertain or limited financial resources and political uncertainty.

How do policies' targets align with the WHA 2025 Global Targets?

Table 2 shows nine policies with nutrition indicators that coincide with WHA indicators. Six of these policies, from the health (n=5) and economic/social/education (n=1) areas, include targets for at least one of these indicators. All set different years as their target date (QASP: 2011; NNCHAS: 2019; NTHSSP: 2020; MTNDPF: 2021, and GNNHS: 2023). While Ghana's WHA target dates vary across policies, if they were met, they would generally put Ghana on track to achieve or even surpass four of these targets—low birth weight, U5 stunting, U5 overweight, and anemia in WRA—by 2025. There are, however, eight policies with targets that, even if met, would not necessarily put Ghana on track to achieve the WHA targets by 2025: NBP, IACS, GNNHSAP, RHSP, MTNDPF, HSGP, GNHQ, NNCHACS.

Is there coherence within policies?

Policies with nutrition objectives would be expected to include both planned nutrition activities and nutrition indicators, while policies without nutrition objectives would be expected to include neither. Yet there are several instances (see Table 2) where this is not the case. Generally, this is not due to a lack of coherence within policies but because a) policies' objectives are broad and do not explicitly link to nutrition (while their indicators or planned activities are specific enough to make this link explicit), or b) indicators and/or planned activities are to be addressed in a separate document (which is noted in the main policy document). There are, however, some cases of incoherence within different parts of the same policy. Problems presented in the nutrition context are not always reflected in policies' nutrition indicators: for example, the NHPP highlights anemia in WRA, stunting, and exclusive breastfeeding in its nutrition context but does not refer to these WHA targets in its nutrition indicators. In other instances, nutrition targets feature within nutrition indicators but not in the context section; for example, the IACS features anemia in WRA, low birth weight, and exclusive breastfeeding in its nutrition indicators, but in its nutrition context it highlights only anemia in WRA and low birth weight. Similarly, the HSGP covers the whole population, is health-relevant, includes both nutrition objectives and indicators, but sets no targets for indicators. Finally, several policies fail to clearly define concepts (e.g., chronic and/or acute malnutrition), or age ranges for prevalence indicators.











Table 2: Inclusion of nutrition and WHA indicators in policies' context, objectives, indicators, activities, and budget; Key scaling-up mechanisms

NR	Area	Acronym	Nutrition context on WHA indicators ¹	Nutrition objective	Nutrition indicators	Nutrition indicators on WHA indicators ²	Planned nutrition activities	Budget for nutrition ³	Key scaling-up mechanisms
1	Nutrition	NNP		✓	✓		✓	NA	Advocacy strategies; scale-up of nutrition-specific and nutrition-sensitive interventions with strong evidence, coordination, donor/UN support—UNICEF, WHO protocol, and feasible delivery mechanism; capacity building; resource mobilization; tools (e.g., protocols)
2		IACS		✓	✓		✓	NA	Resource mobilization, information, education and communication (IEC), behavior change communication (BCC), advocacy, research, capacity building
3	Health	NBP		✓	✓		✓	NA	Capacity building of health staff; curriculum and training of pre-service staff; health education of mothers; advocacy and communication, research, and monitoring and evaluation; promotion of exclusive breastfeeding
4		NNCHACS		✗	✓		✓	✓	Partnership, leadership, and coordination; advocacy, communication, BCC, and media campaigns; institutional and sectoral collaboration; community engagement; partnership building
5		GNHQS		✗	✓		✗	NA	Adaptation and scale-up of effective interventions based on evidence; scale-up of implementation policy; tools and resources; capacity building; research; leadership and governance; resource mobilization
6		HSGP		✗	✓		✗	NA	Advocacy; information, education and communication (IEC)/ behavior change communication (BCC); research
7		CHPS	✗	✗	✗	✗	✓	NA	Scale-up of CHPS infrastructure in less-deprived areas; resource mobilization; communication
8		NHPP		✓	✓	✗	✗	NA	BCC (health communication, development and dissemination of health messages and educational materials, health promotion); capacity building (skills improvement)
9		NFSP	✗	✓	✓	✗	✓	NA	Research; communication; policy dissemination and advocacy strategy; resource mobilization
10		NHP	✗	✓	✓	✗	✓	NA	Coordination, collaboration, and harmonization; determination of policy targets; preparation of multisectoral/sectoral policy implementation plans and budgets; resource mobilization; research; capacity building Community ownership and participation; health and nutrition promotion; BCC; monitoring and evaluation
11		GNNHSAP		✓	✓		✓	NA	Scale-up of interventions including nutrition components; tools including job aids, manual; promotion and support of exclusive breastfeeding and continued breastfeeding; adherence to WHO International Code of Marketing of Breast-Milk Substitutes; exploration of accreditation processes; prioritization of record-keeping on maternal and neonatal information
12		NTHSSP	✗	✗	✓	✗	✓	✓	Resource mobilization; capacity strengthening; multisectoral coordination; superior screening and algorithm and diagnostic tools; WHO evidence-based protocol for prioritization and planning
13		NAPPHIVS	✗	✗	✓	✗	✓	NA	Capacity building; coordination; resource mobilization; evidence-based planning; service delivery and promotion of innovative models; advocacy; expansion of technical working group and services

¹ U5 stunting is indicated for policies with nutrition context on chronic malnutrition. U5 wasting is indicated for policies with nutrition context on acute malnutrition.

² U5 stunting is indicated for policies with nutrition indicators on chronic malnutrition. U5 wasting is indicated for policies with nutrition indicators on acute malnutrition.

³ Not applicable (NA) indicates policies that do not have sufficiently detailed budget information to assess whether nutrition is included, while ± is used for policies that provide sufficient budget information but with no mention of nutrition.

NR	Area	Acronym	Nutrition context on WHA indicators ¹	Nutrition objective	Nutrition indicators	Nutrition indicators on WHA indicators ²	Planned nutrition activities	Budget for nutrition ³	Key scaling-up mechanisms
14	Economic/ Social	RHSP	  	✓	✓	  	✓	✓	Integration and coordination of management information systems; research; monitoring and evaluation; capacity building; scale-up of neonatal facilities with special care in districts
15		QASP	✗	✓	✓	✗	✓	NA	Capacity building; monitoring and supervision; resource mobilization; coordination and collaboration; record-keeping/documentation
16		NSFP	✗	✓	✓	✗	✓	NA	Scale-up of School Feeding Programme; social accountability, communication, and information-dissemination, vertically and horizontally throughout the programme; resource mobilization; transparency and accountability
17		NMTDPF	 	✓	✓	 	✓	NA	Resource mobilization; research and development; scale-up of nutrition-specific and nutrition-sensitive interventions; dissemination and communication of M&E

 U5 STUNTING
  WRA ANAEMIA
  LOW BIRTH WEIGHT
  U5 OVERWEIGHT
  EXCLUSIVE BREASTFEEDING
  U5 WASTING



Who are the key people and organizations targeted by and responsible for these policies?

Which target groups are the focus of nutrition context?

The groups that feature most often in policies' nutrition context are children and women of reproductive age. The majority of policies, across policy areas, also target adolescents and adults. Adults are mentioned in several nutrition, health, and economic/social policies, with NNP, GNHQs, and NHP specifically focusing on the elderly. Five policies specifically mention men (NNP, GNHQs, HSGP, CHPS, and NAPPHIVS), and six mention adolescents (NNP, IACS, NHP, NAPPHIVS, RSHP, and MTNDPF).

Who are the beneficiaries?

As shown in **Table 3**, primary beneficiaries of policies vary by area. Overall, the most frequent primary beneficiaries are children (including infants and U5), women (especially mothers and WRA), and the general Ghanaian population. Other primary beneficiaries include adolescents, men, disadvantaged/rural populations, traditional leaders, farmers, healthcare workers, and medical risk groups. While not generally among primary beneficiaries, six policies—across the nutrition and health policy areas—include youth/adolescents as beneficiaries. The elderly are mentioned as beneficiaries in two policies, and men/fathers are mentioned in four.

Who are the actors?

For policies that explicitly mention at least one actor involved in policy development (n=17), national government was the most often mentioned (n=17), followed by local government (n=16), communities (n=16), the private sector (n=14), and civil society/NGOs/technical and financial partners (n=15). As shown in Table 3, health and nutrition policies tend to have many types of actors involved in many roles, while the national government has the most extensive role beyond policy development, including management/coordination, financing, implementation, and monitoring and evaluation. The Ministry of Health is the lead state actor for health and nutrition policies. Many other bodies and ministries are involved, however, including the Ghana Health Service, Ministry of Women and Children's Affairs, National Development Planning Commission, Ghana Statistical Service, Ministry of Manpower Development and Social Welfare, Office of the Head of Civil Service (OHCS), Ministry of Education, Ministry of Food and Agriculture, Ministry of Justice, Ministry of Interior and Ministry of Local Government. For example, the NNP recognizes the nutrition role of ministries across various sectors and identifies nutrition objectives, indicators and activities that these actors could lead or contribute to. Communities are featured as actors mainly in health policies, with one mention each in nutrition and economic/social/education policies. National and local governments are noted to be lead implementers and to engage in monitoring and evaluation. Civil society, NGOs, and technical and financial partners feature as funding agents.

Is there multisectoral coordination mentioned in the policy?

The importance of multisectoral coordination is highlighted across all policies and policy areas. Coordination mechanisms include a harmonized and coordinated health system, integrated across different sectors (e.g., multisectoral working groups, joint planning or technical committees of the relevant municipal and district assemblies) for quality planning, quality control, and quality improvement. All the health policies point to the Ministry of Health as a key body for ensuring coordination between actors. Five policies highlight challenges associated with multisectoral coordination. These include the need to make nutrition a trigger issue across sectors, the lack of a budget for nutrition, multiple policy frameworks and priorities, the high number of actors involved, lack of synergy, and weak involvement of certain actors. Nevertheless, most policies across the health, nutrition, and economic/social/education areas, highlight some successes in addressing these challenges to improve multisectoral coordination.

Table 3: Summary of beneficiaries, actors, and multisectoral coordination mechanisms

NR	Area	Acronym	Primary beneficiaries	Other key beneficiaries	Actors' roles*					Primary actors	Multisectoral coordination mechanisms
					National government	Local government	Communities	Private sector	Civil society NGOs technical and financial partners		
1	Nutrition	NNP	U5; children over 5; adolescents; WRA; elderly; adult men and women	✗	1,2,3,4	1,2,3	✗	✗	✗	National government; local government	✓
2		IACS	U5; children over 5; school-aged children; adolescents; WRA	✗	1,2,3	1,2,3	1,3	1,3	1,3,4	National government; local government	✓
3	Health	NBP	U5; children over 5; WRA	✗	1,2,3	1,2,3	1	✗	✗	National government; local government	✓
4		NNCHACS	Newborns; children; WRA; parents of newborns; mothers of U5	Community, traditional, and religious leaders; organized groups; families of pregnant women; focal/frontline healthcare providers	1,2,3,4	1,2,3	1	2,4	4	National government; local government	✓
5		GNHQS	U5; WRA; elderly; adult men and women	Health workers	1,2,3,4	1,2,3	1,2	1	1,4	National government; local government	✓
6		HSGP	Men; women; children; adolescent boys and girls	✗	1,2,3	1,2,3	1	1	1	National government; local government	✓
7		CHPS	U5; WRA; adults	Adolescents; men	4	1,2,3,4	1,2,3	4	4	Local government	✓
8		NHPP	All Ghanaians: women, men, adolescents, children, infants	Health promotion staff Health Promotion staff at all levels and in different sectors	1,2,3,4	1	1	1,4	1,4	National government; local government	✓
9		NFSP	Children; adults; women; general population		1,2,3,4	1	1	2,4	2,4	National government	✓
10		NHP	Children (5–14); adolescents (15–19); WRA; U5; elderly; newborns; adults	Health workers	1,2,3	1,2,3	1	1	1,4	National government; local government	✓
11		GNNHSAP	Newborns	✗	1,2,3,4	1,2,3	✗	✗	✗	National government; local government	✓

* Roles: 1 = Implementation; 2 = Monitoring and evaluation; 3 = Management/coordination; 4 = Financing

NR	Area	Acronym	Primary beneficiaries	Other key beneficiaries	Actors' roles*					Primary actors	Multisectoral coordination mechanisms
					National government	Local government	Communities	Private sector	Civil society NGOs technical and financial partners		
12		NTHSSP	Community subpopulations with risk factors for TB (e.g., household and community contacts); medical risk groups (e.g., diabetics, pregnant women, PLHIV); children; prisoners; miners	General population; all persons in hospital and healthcare settings; all persons in residential institutions (e.g., prisons); workers in certain workplaces (e.g., mines and other locations where workers are exposed to silica)	1,2,3,4	1,2,3	1,2,3	1,2,3	1,2,3,4	National government; local government; community; private sector; civil society	✓
13		NAPPHIVS	Children (0–9 years); adolescents; WRA	Parents (fathers/men)	1,2,3,4	1,2,3	1	4	3	National government; local government	✓
14		RHSP	Newborns; infants; U5; WRA (plus adolescents for general reproductive health policy, not nutrition)	✗	1,2,3,4	1,2,3,4	3	1	2	National government; local government	✓
15		QASP	Health staff; U5; WRA	Health service clients/patients; health service providers—public (not-for-profit) and private (for-profit)	1,2,3	1,2,3	1,3	1,3	✗	National government; local government	✓
16		NSFP	School-aged children	Adolescents	1,2,3,4	1,2,3,4	1,2	1	1,2	National government; local government	✓
17	Economic/ social/ education	MTNDPF	U5; WRA	Adolescents; adults	1,2,3,4	1,2,3	✗	1	1	National government; local government	✓

* Roles: 1 = Implementation; 2 = Monitoring and evaluation; 3 = Management/coordination; 4 = Financing



What are the monitoring, evaluation, and accountability mechanisms?

All policies mention **monitoring and evaluation (M&E)**, with most containing a dedicated M&E section or framework. Some policies, such as NNP, NBP, and MTNDPF contain very detailed M&E information. M&E activities include standardized M&E implementation plans at the national, regional, district, and sectoral levels, data collection on set indicators and targets, and the establishment of databases and information systems. Additional activities include monitoring of key flagship initiatives as well as results-based delivery approaches, regular reporting and reviews, and formative and final evaluations to ensure timely implementation of government priorities.

Accountability mechanisms are also mentioned in fifteen policies. They include use of an M&E framework based on the national M&E system, which requires that all subnational levels develop M&E plans and reports for transparency. Other social accountability measures include review of supervisory reports and feedback at all levels, as well as the strengthening of systems and structures for transparency and public accountability. Additional measures for transparency include tightening the sanctions regime in public accountability mechanisms, promoting public interest in performance-monitoring reports of public institutions, expanding opportunities and structures for public/community ownership of information, participatory budgeting, revenue and expenditure tracking at all levels, and feedback mechanisms in public service delivery. Other accountability mechanisms cited include accelerating the enactment of the Broadcasting Law, further

strengthening partnerships with the media to enhance cohesion on national issues and, finally, encouraging participation of communities and civil society organizations in holding the government to account.

Gaps and recommendations

This policy note is intended to inform national decisions makers, policymakers and a wider audience including implementing partners across all relevant nutrition sectors. Its analysis can help to better understand gaps and incoherence within existing policies. Furthermore, the recommendations emanating from this analysis can inform revisions of existing or the development of new nutrition-relevant policies to improve impact on nutrition in their country.

Recommendation 1: Address gaps and incoherence in nutrition-relevant policy.

The analysis above highlights a number of gaps and incoherencies in current nutrition-relevant policy in Ghana. Future policies or revisions thereof could:

- Ensure that nutrition context, objectives, indicators, and /or planned activities align, in terms of nutrition problems and targeting of populations (e.g., nutrition objectives target several different groups but nutrition indicators only measure progress for some of these groups). This would allow to achieve a better coherence within policies, introduce well-aligned impact pathways, from broad objectives to specific indicator measures, and enable identification of gaps and challenges, leading to more effective targeting.
- Better define nutrition concepts and indicators to allow for common understanding across actors and policy areas, as well as coherence in measurement of indicators. Ideally, indicators are also

disaggregated by gender, geographic area and between urban and rural settings to capture the disparities identified in a policy's context analysis and to ensure effective progress tracking. Only few policies highlight nutrition disparities across regions, gender, urban/rural and socioeconomic status; even if some policies targeting vulnerable populations focus on specific beneficiary groups, disaggregated nutrition indicators and targets are not clearly defined.

- Invest more in inclusion of marginalized population groups. The policies we assessed provided limited nutrition context information on the elderly and men. These groups feature among targeted beneficiaries in only three and six policies, respectively. Adolescent's feature in only one policy's nutrition context and are named as targeted beneficiaries in nine policies. The policies can gain a lot by considering these groups, as they play an important role in child growth and development and its integration in nutrition-relevant policies is essential for policies addressing children's nutrition.
- Invest in fighting malnutrition in all its forms in Ghana by capitalizing on shared drivers, entry points and delivery platforms. In order to curb current trends in malnutrition, namely the coexistence of multiple forms, a holistic lifecycle approach is essential to address causes and consequences of malnutrition and disease burden in Ghana.
- Ensure a clear budget provision for nutrition across nutrition-relevant policies and sectors. Most of the policies we assessed lacked clearly defined nutrition budgets, although budgetary information may be provided in some form in additional documents. Overcoming this limitation is crucial for the attainment of Ghana's long-term goal of meeting the WHA targets.

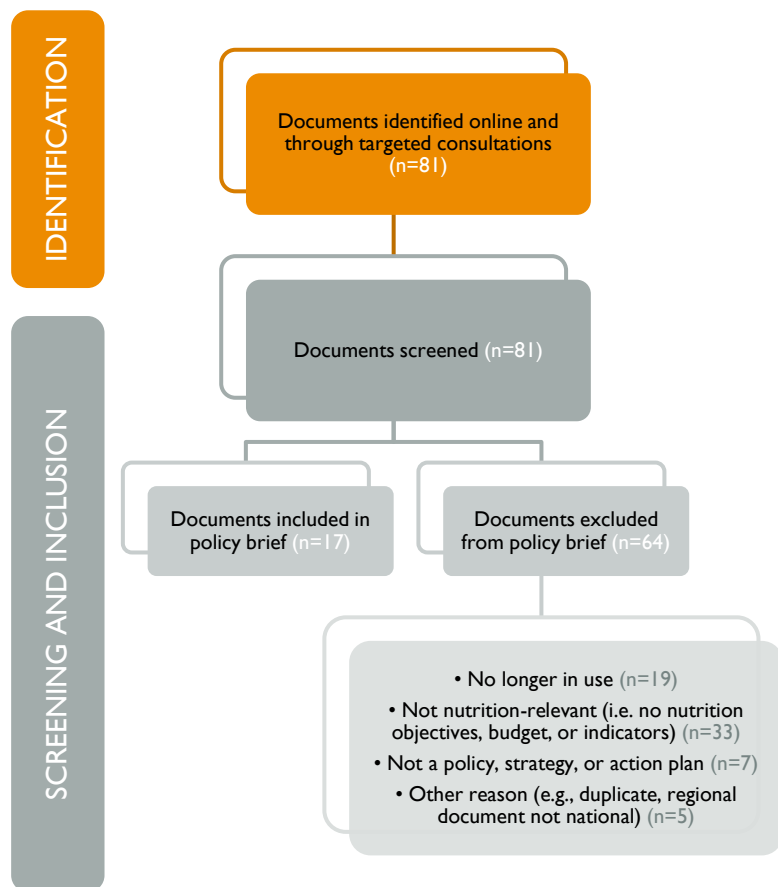
Recommendation 2: Continue to invest in strong multisectoral coordination. Strengthening multisectoral coordination and actions across sectors, ministries, and departments will be essential for achieving the WHA targets in Ghana. Multisectoral and multi-actor coordination is the basic guiding principle of governance for all nutrition policies included in this note. Despite the presence and the importance of multisectoral coordination highlighted by the reviewed policies, significant challenges for its functionality were mentioned. The NNP, dedicated to nutrition, mentions all the WHA targets and recognizes that, with sufficient investment and prioritization of specific actions, multisectoral coordination could be further strengthened. These include institutional and human capacity strengthening for nutrition-related services at all levels of the health system—national, regional, district and subdistrict. Leadership can be strengthened by clearly defining the roles of all actors at a higher hierarchical level with an authority over all contributing sectors. The application of strong vertical and horizontal coordination mechanisms would provide further opportunity for the country to achieve the WHA targets.

Recommendation 3: Mainstream nutrition into future documents across diverse policy areas. Only some policies adequately cover nutrition by including nutrition-relevant objectives and planned nutrition activities. The remaining policies could improve the integration of nutrition into their nutrition context, objectives, indicators, and budgets. Great gain would be achieved if each of the policies would include the key nutrition targets. To begin mainstreaming nutrition into future policies and operational documents into diverse policy areas, such as agriculture, economy, education, environment, gender, and social protection, policymakers could

refer to nutrition objectives, indicators, and relevant activities listed in the NNP. Clearly defined objectives, activities, indicators, and targets together with strong multistakeholder engagement would be essential in improving the nutrition policy landscape and ensure that nutrition is integrated within other sectors.

Recommendation 4: Recognize nutrition as a cross-cutting area in ongoing policy drafts/revisions. Several policies are currently being formulated or revised, including nutrition and health policies (Anemia Control Strategy, the National Child Health Standards and Strategy, the Non-communicable Disease Policy and Strategy and the Health Sector Medium Development Plan), and agricultural policies (the FASDEP and the Agriculture Gender Policy). This presents an opportunity for these policies to better integrate nutrition and align their activities and indicators with the objectives and target groups in the policies. By integrating the above recommendations any new or revised policy could strengthen nutrition-relevant policies in the country and advance nutrition at national level.

Annex: Flow diagram of documents included in the policy brief



Endnotes

- ⁱ Multiple Indicator Cluster Survey, 2018.
ⁱⁱ UNICEF global database on Infant and Young Child Feeding, UNICEF/WHO/World Bank Group: Joint child malnutrition estimates, UNICEF/WHO Low birthweight estimates, NCD Risk Factor Collaboration, WHO Global Health Observatory.
ⁱⁱⁱ Development Initiatives, 2019. Global Nutrition Report 2019: Nourishing the SDGs. Bristol, UK: Development Initiatives, [Ghana: Country] country profile.
^{iv} Ghana Demographic and Health Survey, 2008.
^v Ghana Demographic and Health Survey, 2014.
^{vi} World Data Atlas (2016) <https://knoema.com/atlas/Ghana/Female-obesity-prevalence>.
^{vii} Ghana Districts: A repository of all Local Assemblies in Ghana <http://www.ghanadistricts.com/Home/LinkData/8239>, accessed on 10/13/2020.

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