



Government of Ghana



National Nutrition Policy

July 2016, Accra

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Acknowledgements

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Foreword

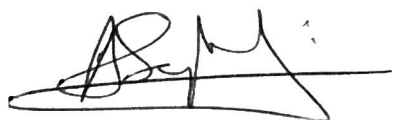
Despite appreciable reductions in malnutrition rates significant numbers of people in Ghana, especially women and children are still affected by micronutrients deficiencies, stunting and the emerging issue of over-nutrition that ultimately undermine their health and development.

Indeed the gains made have not been equitable across all areas of the country and across all categories of women and children, with wide geographical and socio-economic disparities. This is largely because interventions have not been implemented at scale in all parts of the country in a sustainable and coordinated manner across relevant sectors.

Recognizing the need to accelerate actions to fast-track reduction of under-nutrition, prevent further increases in overweight and obesity and promote national health, is the reason the Ministry of Health and partners commissioned the development of the National Nutrition Policy (NNP). A comprehensive and integrated approach for planning and implementation of the policy is required to address the multiple and diverse factors affecting nutrition. The proven interventions listed in the policy have to be implemented at scale and prioritized in the national development agenda, prioritizing the most vulnerable groups of the population.

The National Nutrition Policy has three overarching objectives that focus on scaling up evidence-based nutrition-specific and nutrition-sensitive interventions and ensuring an enabling environment for effective and sustained impact. It provides a framework for coordinated implementation of high-impact nutrition intervention by government and nutrition stakeholders for maximum impact at all levels.

It is time to build on the momentum achieved through the Millennium Development and Sustainable Development Goals and other initiatives, and focus on factors that have contributed to the improvements seen so far, while addressing emerging challenges and bottlenecks in the attainment of optimal nutrition for all Ghanaians. It is our fervent hope that government leadership and support from partners will ensure full implementation of the policy and outlined strategies for combating malnutrition in all its forms and ultimately contribute to improved health and development in Ghana.



HON. ALEXANDER SEGBEFIA
MINISTER FOR HEALTH



Photo credit: GHS/Nutrition

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Abbreviations and Acronyms

AIDS	Acquired Immunodeficiency Syndrome
BMI	Body Mass Index
CHPS	Community-Based Health Planning and Services
GA-Canada	Global Affairs Canada
CLTS	Community-Led Total Sanitation
CSO	Civil Society Organization
CSPG	Cross-Sectoral Planning Group
DPCU	District Planning Coordinating Unit
FAO	Food and Agricultural Organization of the United Nations
GDHS	Ghana Demographic and Health Survey
GDP	Gross Domestic Product
GPRS (I&II)	Ghana/Growth and Poverty Reduction Strategy
GSGDA	Ghana Shared Growth and Development Agenda
HIV	Human Immunodeficiency Virus
MICS	Multiple Indicator Cluster Surveys
M&E	Monitoring and Evaluation
MDA	Ministries, Departments, and Agencies
MDG	Millennium Development Goal
MOH	Ministry of Health
NCD	Non-Communicable Disease
NDPC	National Development Planning Commission
NGO	Non-Governmental Organization
NNP	National Nutrition Policy
RPCU	Regional Planning Coordinating Unit
SHEP	School Health Education Programme
SUN	Scaling Up Nutrition
REACH	Renewed Efforts against Child Hunger
UNICEF	United Nations Children's Fund
WFP	World Food Programme
WHO	World Health Organization

Executive Summary

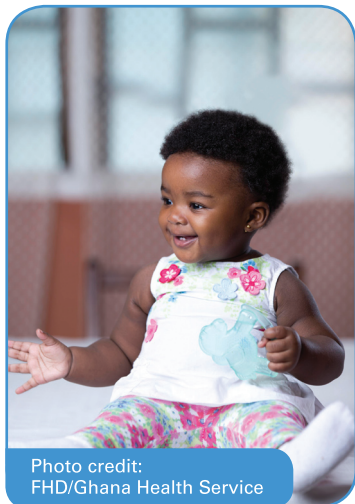


Photo credit:
FHD/Ghana Health Service

Malnutrition is recognized as a major impediment to socioeconomic development at both the individual and national level. When citizens are poorly nourished, their cognitive and physical performance is compromised and productivity is ultimately impaired. Malnutrition is caused by a wide array of factors, which must be identified, prioritized, and addressed. For Ghana to increase the pace of economic development, there must be a strong focus on human development, including investing in the nutrition of its citizens, particularly women and children.

Achievement of desired outcomes in nutrition has been slow for many reasons. First, nutrition has not been prioritized as a key development issue and thus has not received adequate political and financial investments. Second, nutrition and nutrition-related interventions implemented by various sectors have not been adequately prioritized, coordinated,

and integrated. Third, the sheer scope of the problem is enormous: The entire population, especially women and children who are the most vulnerable, suffer from all the major micronutrient deficiencies, and Ghana is seeing an increasing number of cases of overweight and diet-related non-communicable diseases. Moreover, slow progress in addressing poor child feeding practices, food insecurity, and infections have further hindered progress in reducing malnutrition.

The National Nutrition Policy was prepared by representatives of key government sectors and partners with guidance and leadership from the Ministry of Health. It offers a framework for key sectors to align their programmes and policies around specific nutrition objectives and promotes effective coordination and collaboration of all stakeholders.

The goal of the NNP is to ensure optimal nutrition for all people living in Ghana, to promote child survival, and to enhance capacity for economic growth and development. To achieve this goal, the following policy objectives will be pursued:

1. To increase coverage of high-impact nutrition-specific interventions that ensure optimal nutrition of Ghanaians throughout their lifecycle, with special reference to maternal health and child survival
2. To ensure high coverage of nutrition-sensitive interventions to address the underlying causes of malnutrition
3. To reposition nutrition as a priority multi-sectoral development issue in Ghana

The successful implementation of the NNP requires cross-sectoral action involving all key ministries, departments, and agencies (MDA); civil society organizations (CSOs); research institutions and academia; and the private sector. The policy will be monitored and evaluated over a 5-year period based on the national monitoring and evaluation (M&E) framework.

1. Background of the National Nutrition Policy



Photo credit: UNICEF/Ghana

1.1 General Context

The socioeconomic development of every nation is closely linked to the nutrition of its citizens. When children are poorly nourished, especially during the first 1,000 days from conception through their second birthday, their cognitive and physical developments are compromised. They become more prone to illnesses and death, productivity is impaired, and they may not

achieve their full potential³. Malnutrition, therefore, is a major impediment to socioeconomic development. If Ghana is to increase the pace of economic development, there must be a strong focus on investing in the nutrition of Ghanaians, particularly women and children who currently carry the highest burden of malnutrition.

The Government of Ghana has supported the formulation and implementation of important policies and legislation related to nutrition. At the national level, successive National Medium-Term Development Policy Frameworks, including the Growth and Poverty Reduction Strategy (GPRS) I and II and the Ghana Shared Growth and Development Agenda (GSGDA) I and II, have had specific targets for nutrition. Several health policies and regulations, including the Breastfeeding Promotion Regulation (L.I1667), Food and Drugs Law (Public Health Act, 2012 [Act 851]), Vitamin A Policy, Anaemia Strategy, Infant and Young Child Feeding Strategy, and Universal Salt Iodization Policy, have also been put in place. Other sectors' policies, programmes, and strategies that are important for nutrition include the National Water Policy, the National Environmental and Health Sanitation Policy, the Education Strategic Plan 2010–2020, the School Health Education Programme Strategic Framework, the National Community Water and Sanitation Policy, the Food and Agriculture Sector Development Policy II, and the National Gender Policy, among others. (See Annex A for list of relevant policies.)

1.2 Country Profile

In 2010, Ghana's population was estimated at 24.7 million, growing at an annual rate of 2.3 percent. The literacy rate of 15–24-year-olds was approximately 71.3 percent among males and 61.4 percent among females in 2011. The per capita gross domestic product (GDP) was US\$1,652.00 in 2011. The agriculture sector employs about 55.8 percent of the adult labour force. In 2012, services contributed the largest share of GDP at 47.9 percent, with industry and agriculture following at 27.4 percent and 24.6 percent, respectively³.

Recent economic growth has propelled Ghana from low-income status to lower-middle-income status. As a result, Ghana achieved the United Nations Millennium Development Goal 1 of eradicating extreme poverty by 2015. Despite the growing economy and improvements in

¹Ghana Statistical Service. 2011. Multiple Indicator Cluster Surveys 2011.

²World Development Indicators. 2012.

³Index Mundi. 2013.

some of the social and development indicators, wide disparities exist in wealth distribution⁴. In 2013, the United Nations Development Programme ranked Ghana 135 out of 187 on its Human Development Index, illustrative of the wide range of social indicators that have yet to see the same success as the poverty indicator.

The successful implementation of the NNP requires cross-sectoral action involving all key ministries, departments, and agencies (MDA); civil society organizations (CSOs); research institutions and academia; and the private sector. The policy will be monitored and evaluated over a 5-year period based on the national monitoring and evaluation (M&E) framework.

Ghana's population remains vulnerable to a high burden of infectious diseases and non-communicable diseases (NCDs), translating into high and slowly declining mortality among women and children. The national prevalence of malaria parasitaemia in children aged 6–59 months based on microscopy was 27.5 percent, according to the Holistic Assessment of the Health Sector Programme of Work for 2012. Current life expectancy at birth is approximately 65 years.

1.3 Overview of the Nutrition Situation in Ghana

Ghana's nutrition situation has shown a general trend of improvement, as reflected in several nutrition indicators over the last few decades. This is demonstrated by declining rates of undernutrition among women and children, who constitute the most vulnerable groups. However, the observed improvements have occurred rather slowly and unequally across the population. At the same time, Ghana has seen an increase in overweight and obesity in selected population groups over the past 5–7 years. Thus, wide disparities in nutrition status and coverage of nutrition services are commonly observed based on sex, age, and location. In addition, not all nutrition indicators are showing progress. Ghana has also lost ground on some areas of previous gain, such as exclusive breastfeeding and optimal complementary feeding.

1.3.1 Growth and Development

Poor nutritional status as indicated by early growth faltering remains a major challenge among children in Ghana. At birth, close to 11 percent of children weigh less than 2,500 g⁵. The 2011 Multiple Indicator Cluster Survey (MICS) found that 22.7 percent of children under 5 years were stunted (too short for age), representing a rather slow decline from the 34.0 percent reported in 1988. Ghana is thus among the 36 countries with the highest burden of stunting, globally⁶. In addition to high rates of stunting, the 2011 MICS found that 13.4 percent of children under 5 years are underweight (low weight for their age) and 6 percent are wasted (low weight for their height).

According to the DHS 2014 report, regional variations of stunting rates range from 10.4 percent in Greater Accra to 33.1 percent in the Northern Region. Underweight rates follow a similar pattern, with 8.7 percent of children under 5 years old underweight in Greater Accra compared to 20 percent in the Northern Region. Considering stunting, the richest wealth quintile shows a rate of 8.5 percent compared to the lowest wealth quintile where 24.8 percent of children are stunted. The rates of stunting seen in the richest quintile, where access to health services and food at the household level is not normally a constraint, indicate infant and young child feeding and other caring behaviours are not optimal.

⁴United Nations Development Programme. 2012. 'International: Human Development Indicators.' <http://hdr.undp.org/en/statistics/>.

⁵Ghana Statistical Service. 2011, 2014. Multiple Indicator Cluster Surveys 2011.

⁶Black et al. 2008. 'Maternal and child undernutrition: global and regional exposures and health consequences'. The Lancet Series on Maternal and Child Undernutrition Series 1.

Although some regions have lower rates of stunted, wasted, and underweight children, they top the list in terms of actual numbers of stunted children. Taking into account population size and stunting rates, approximately 40 percent of stunted children in Ghana live in the Ashanti, Central and Northern Regions.

Limited data exist on the nutritional status of school-age children and adolescents. However, among girls 15–19 years of age, 16 percent are chronically undernourished (body mass index [BMI] < 18.5), suggesting that undernutrition persists through school-age and adolescence. In women of reproductive age, 10 percent are undernourished (BMI < 18.5), with higher rates among those in the lowest wealth quintiles and in the three northern regions⁷.

On the other hand, overweight and obesity are also a growing challenge across all age groups. While the 2011 MICS found 3 percent of children under 5 years of age to be overweight, recent surveys have reported overweight prevalence between 10 and 15 percent among urban-dwelling school-age children⁸.

Among women aged 15–49 years, the 2014 DHS found overweight prevalence to be about 40.1 percent. The range is from 12.6 in the lowest wealth quintile to 60.3 percent in the highest wealth quintile. The high prevalence of overweight and obesity is paralleled by increasing incidences of diet-related NCDs, including cardiovascular disease, diabetes mellitus, and some cancers⁹. Health care expenditures related to NCD care can be a major burden for an economy.

1.3.2 Micronutrient Deficiencies

Micronutrient deficiencies, particularly of vitamin A, iodine, and iron, are of major concern and continue to undermine health and development across all age groups. Iron deficiency coupled with the high malaria burden contributes to very high prevalence of anaemia, especially among women and children in Ghana. The 2008 Ghana Demographic and Health Survey (GDHS) reported 59.0 percent of women of reproductive age (15–49 years) to be anaemic, up from the 44.7 percent reported by the 2003 GDHS. Among children under 5 years old, 66 percent suffer from anaemia, according to the 2014 DHS. The anaemia situation is more alarming in the three northern regions, with the Northern Region reporting 82.1 percent, the Upper East and Upper West reporting 73.8 percent.

Iodine deficiency disorders are still of concern as the majority of households (65%) do not use adequately iodized salt in meal preparation¹⁰. Around 40 percent of school-age children are at risk of iodine deficiency, with a higher level in the Northern Region¹¹. More than 70 percent of children under 5 years are at risk of vitamin A deficiency¹².

1.3.3 Causes of Malnutrition in Ghana

According to the United Nations Children's Fund (UNICEF) Conceptual Framework in Figure 1, the immediate causes of chronic malnutrition include poor feeding and care practices, insufficient nutrient intake by pregnant and lactating women and young children, and high rates of infection.

⁷Ghana Statistical Service. 2008. Ghana Health and Demographic Survey.

⁸Department of Nutrition and Food Science. 2012. Report of the Ghana School Nutrition Survey.

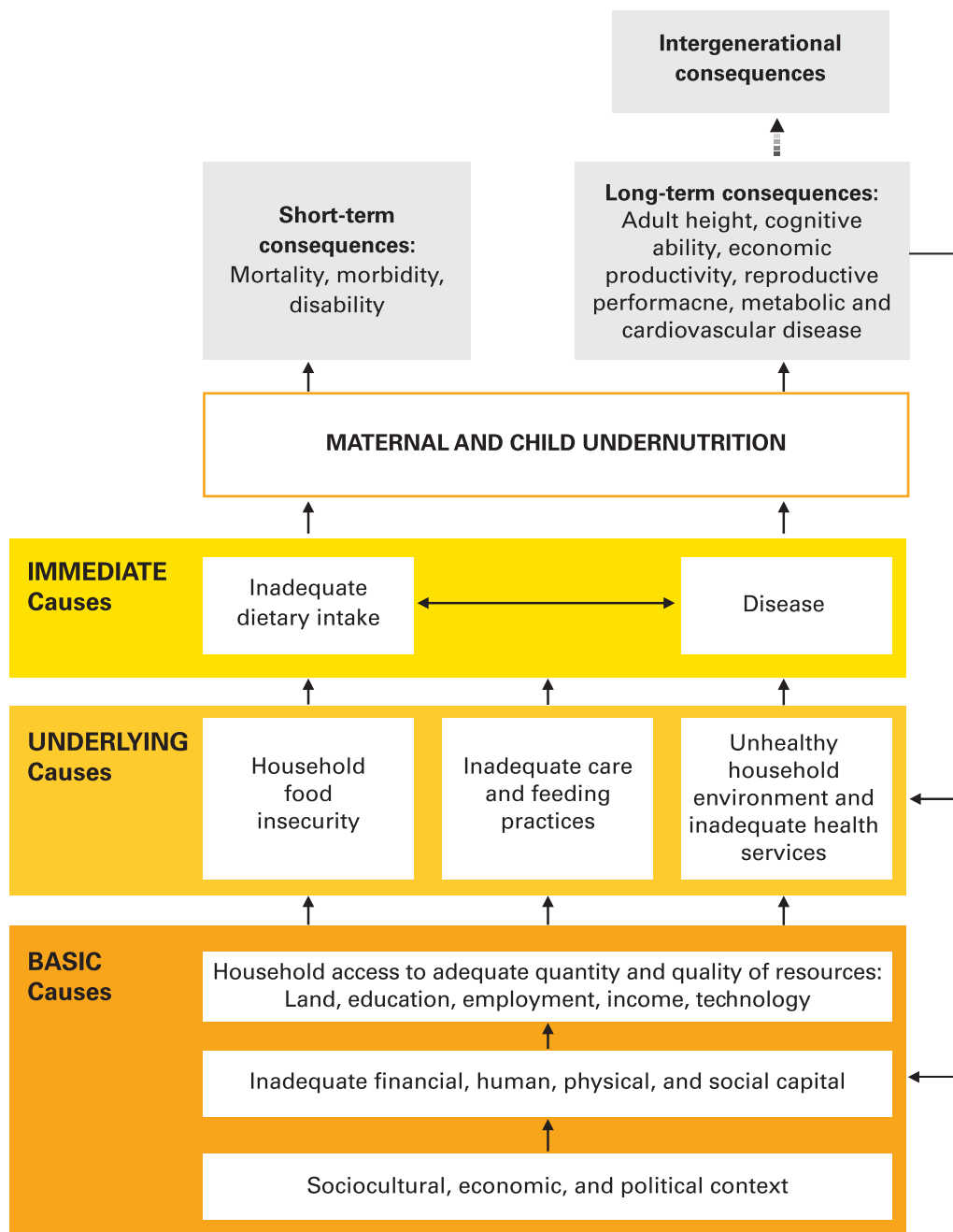
⁹Bosu, W.K. 2013. 'Accelerating the control and prevention of non-communicable diseases in Ghana: The key issues'. Postgraduate Medical Journal of Ghana. Vol. 2 No. 2.

¹⁰Ghana Statistical Service. 2011. Multiple Indicator Cluster Surveys 2011.

¹¹Ghana Health Service, Ministry of Health. 2010. Food Fortification Baseline Survey.

¹²Ministry of Health. 2007. Food Fortification Baseline Survey.

Figure 1. UNICEF Conceptual Framework of the Determinants of Undernutrition



Source: UNICEF. 2013 'Improving Child Nutrition: The Achievable Imperative for Global Progress'.

Figure 1 highlights the following important considerations:

- Malnutrition has a wide array of potential causes at different levels (immediate, underlying, and basic) that are all linked and must be addressed holistically.
- Specific causes of malnutrition are context-specific and therefore efforts to address them must be tailored to each setting.
- Because the causes of malnutrition are linked, they can best be tackled when multiple sectors work together in a well-coordinated manner.
- The mere supply of food, nutrients, or health services is not enough to solve the problem of malnutrition; the basic and underlying causes within the broader sociocultural, economic, and political contexts must also be dealt with.

The following sections highlight the major causes that contribute to the high and persistent rates of malnutrition in Ghana.

1.3.3.1 Disease Burden and Health Care

The nutrition situation is complicated by the synergistic relationship between nutrition status and disease, particularly infectious disease. Maternal and perinatal diseases or complications constitute a little more than half of the disease burden in Ghana¹³. Endemic falciparum malaria remains the main disease reported at health facilities across all life stages. The national prevalence of malaria parasitaemia in children aged 6–59 months based on microscopy was 27.5 percent, with the highest prevalences in the Upper West Region (51.2%) and the Northern Region (48.3%).

Diarrhoea, pneumonia, and intestinal worm infestations contribute significantly to child morbidity¹⁴. In addition, conditions related to pregnancy and delivery complicated by high rates of anaemia also contribute to elevated risk of malnutrition and death among infants and young children and women.

Overall, there is poor financial and physical access to services delivered through the health system. Access to health care services is most limited in the three northern regions. There is one doctor for every 28,000 persons in the Upper Western Region, compared to one doctor for every 3,500 persons in Greater Accra. Fifty percent of all Ghana's doctors are in the Greater Accra Region and another 20 percent are in the Ashanti Region¹⁵. While Community-Based Health Planning and Services (CHPS) provide additional access to services at the community level, only 64 percent of the CHPS were functional at the end of 2012. Furthermore, the national health insurance scheme has limited coverage (35% in 2012) and does not reimburse therapeutic feeding costs, which are critical and life saving for severely malnourished children. Strategic direction on health care in Ghana is indicated in the National Health Policy.

¹³World Health Organization. 2011. 'NCD Country Profiles, 2011: Ghana'. http://www.who.int/nmh/countries/gha_en.pdf.

¹⁴World Health Organization. 2010. 'Ghana: Health profile'. <http://www.who.int/gho/countries/gha.pdf>.

¹⁵Ministry of Health. 2012. Holistic Assessment of the Health Sector Programme of Work.

1.3.3.2 Dietary Practices

Major challenges persist regarding breastfeeding and complementary feeding practices in Ghana. The 2011 MICS reported 45.9 percent of infants benefitting from early breastfeeding initiation, showing a decline from 52.3 percent reported in the 2006 MICS. Furthermore, there is no difference in early initiation rates between those assisted by skilled birth attendants and those assisted by traditional birth attendants. Comparing the DHS 2008 and the MICS 2011 surveys, show a decline in the rate of exclusive breastfeeding during the first 6 months of life, down from 62.8 percent in 2008¹⁶ to 46 percent in 2011. The same surveys also found the median duration of exclusive breastfeeding to have declined between 2008 and 2011, whereas the rate of bottle feeding in babies below 6 months of age increased from 11 percent in 2008 to 18 percent in 2011¹⁷. These estimates suggest that the gains made in the number of mothers practicing exclusive breastfeeding between 2003 and 2008 may have been lost over time.

Even more problematic are the persistently high rates of sub-optimal complementary feeding practices throughout all regions in Ghana. According to the World Health Organization (WHO) and UNICEF, at 6 months of age, children need to be fed nutrient-dense food at regular intervals throughout the day to meet their nutritional requirements. This requires that breastfed children have two or more meals of solid, semi-solid, or soft nutrient-dense foods if they are 6–8 months old and three or more meals of nutrient-dense food if they are 9–23 months old. For children aged 6–23 months and older who are not breastfed, four or more nutrient-dense meals of solid, semi-solid, or soft foods or milk feeds are needed. In 2011, the MICS reported only 31.0 percent of children 6–23 months of age were adequately fed with respect to the recommendations on variety of foods and frequency of feeding. This is a significant decline from 41.1 percent reported in the 2008 GDHS. Furthermore, in 2008, only 30 percent of infants aged 6–8 months received iron-rich food compared to 90 percent of those aged over 2 years.

Regional variations in the 2011 MICS show that only 15.3 percent of children in the Western Region benefit from optimal feeding practices, compared to 40.7 percent in the Brong-Ahafo Region.

Child overweight has also been cited as a growing problem in Ghana and follows a global trend of increasing overweight in children as well as adults, especially women. The 2011 MICS reported that 4 percent of children under 5 are overweight. Changing lifestyles and diets are at the root of these trends. As Ghana moves from a low-income to a middle-income country, there is a risk of society moving more and more toward an obesogenic culture of low levels of physical activity and high consumption of dietary fat, carbohydrates, and sweets.

¹⁶GDHS. 2008.

¹⁷Ghana Statistical Service. 2011. Multiple Indicator Cluster Surveys 2011.

1.3.3.3 Food Insecurity

The nutrition situation in Ghana is significantly influenced by challenges in food availability, access, and utilization at both the national and household levels. Over the last 20 years, Ghana has achieved sustained improvement in food availability as indicated by the Food and Agricultural Organization of the United Nations (FAO) Food Balance Sheet for Ghana and the FAO's undernourishment indicator for Ghana, which has declined from 40 percent of the population in the early 1990s to less than 5 percent in 2012¹⁸. Nevertheless, there are deficits in available staple food, such as rice, maize, sorghum, and millet, as well as meat and fish¹⁹. At the household level, food access is challenged mainly by inadequate incomes. The majority of households in Ghana spend between 50 and 60 percent of their incomes on food²⁰. An estimated 14 percent of the Ghanaian population are either food insecure or at risk of food insecurity²¹. Also, wide disparities exist in household food insecurity, with households in the three northern regions and those in farming communities being the most vulnerable²².

The 2012 Comprehensive Food Security and Vulnerability Analysis collected data from the three northern regions of Ghana and found that the poorer households, those with smaller farms, female-headed households, and households with an uneducated head, are more often found to be food insecure than other households. Close to 88 percent of households in northern Ghana rely on crop cultivation as their chief livelihood activity. Crop failure and seasonal difficulties in accessing enough food during the lean season are common among the most food insecure.

When households are food insecure or vulnerable to food insecurity, they often resort to unsustainable coping strategies, such as selling productive assets, borrowing, and reducing meal frequency and size. These strategies can have a direct impact on the nutritional status of family members. Often, socio-cultural practices related to intra-household food distribution adversely affect the quantity and quality of children and women's diets. In addition, poor knowledge regarding nutrient-rich food selection limits dietary quality in many households²³. Other vulnerabilities, such as HIV or tuberculosis infection, limit capacity to earn income and access food resources.

1.3.3.4 Food Safety

According to the national food safety situational analysis report, food safety challenges occur across the food chain from production and harvesting, through processing, handling, packaging, distribution, and utilization²⁴. The food safety problem in Ghana is recognized, and efforts to develop the linkages between health and nutrition and food safety need to be reinforced. In addition to inadequate institutional capacity that limits enforcement of existing food safety regulations and standards, there is a need for awareness raising, education, and training on food safety to enhance nutrition outcomes. A food safety policy is being developed to address these challenges.

¹⁸FAO. 2012. 'The State of Food Insecurity in the World'. <http://www.fao.org/docrep/016/i3027e/i3027e00.htm>.

¹⁹Ministry of Food and Agriculture. 2011. Medium-Term Agriculture Sector Investment Plan.

²⁰Ghana Statistical Service. 2010. Ghana Living Standards Survey 5.

²¹World Food Programme (WFP). 2009. Comprehensive Food Security and Vulnerability Analysis.

²²WFP. 2012. Comprehensive Food Security and Vulnerability Analysis.

²³Colecraft et al. 2006. 'Constraints on the Use of Animal Source Foods for Young Children in Ghana: A Participatory Rapid Appraisal Approach'. Ecology of Food and Nutrition. Vol. 45, pp. 351–377.

²⁴Ministry of Health. Food Safety in Ghana – A Situational Analysis.

1.3.3.5 Water, Sanitation, and Hygiene

The sub-optimal water and sanitation situation in Ghana is a key underlying determinant of health and nutritional status. While the water supply in Ghana has improved significantly since 1990, the hygiene and sanitation indicators have stagnated over the same period²⁵. In 2008, the GDHS estimated that 77 percent of households have access to an improved water source²⁶. However, only 23 percent of households had drinking water on the premises. In rural households, only 6 percent had drinking water accessible in their homes.

The 2011 MICS found that 61 percent of households nationwide had access to improved sanitation toilet facilities; in rural communities, only 45 percent of households had access. Open defecation was observed among 18 percent of the population and is close to 30 percent in rural communities. However in the Northern, Upper East and Upper West Regions, the prevalence of open defecation was observed to be 72 percent, 88 percent and 71 percent respectively.

Limited evidence exists on the rate of hand washing with soap; however, the 2011 MICS found that only 24 percent of households surveyed had a specific place for hand washing. Of these, 50 percent had water and soap available. Hand washing with soap is a very effective way of reducing infections and may be linked to improved nutrition outcomes in children²⁷.

1.3.3.6 Caring Practices and Socio-Cultural Factors

Appropriate care practices are recognized as an underlying determinant of nutritional status. Limited evidence on caring practices and how they are influenced by beliefs, taboos, and poor knowledge hinders the development of targeted educational programmes. Some of the most common beliefs and practices that are generally known to influence child nutrition in Ghana include denying infants the benefit of colostrum, sometimes promoting different feeding practices for boys and girls, introducing water at an earlier age than recommended, and preventing the consumption by young children of nutrient-rich plant and animal source foods. Among adults in Ghana, beliefs and practices around consumption of certain food items deny pregnant women adequate nourishment needed to sustain optimal weight gain and good nutrition. Modification of some of the beliefs and practices through schooling, behaviour change communication, and social marketing principles has been found to be effective. For example, increased consumption of iodized salt observed in GDHS and MICS from 2003 to 2005 is widely believed to have resulted from an intense universal salt iodization communication campaign during this period. A major challenge with existing behaviour change communication efforts is to mobilize funding to sustain momentum beyond the end of the projects that initiate the intervention.

1.4 Existing Nutrition Strategies

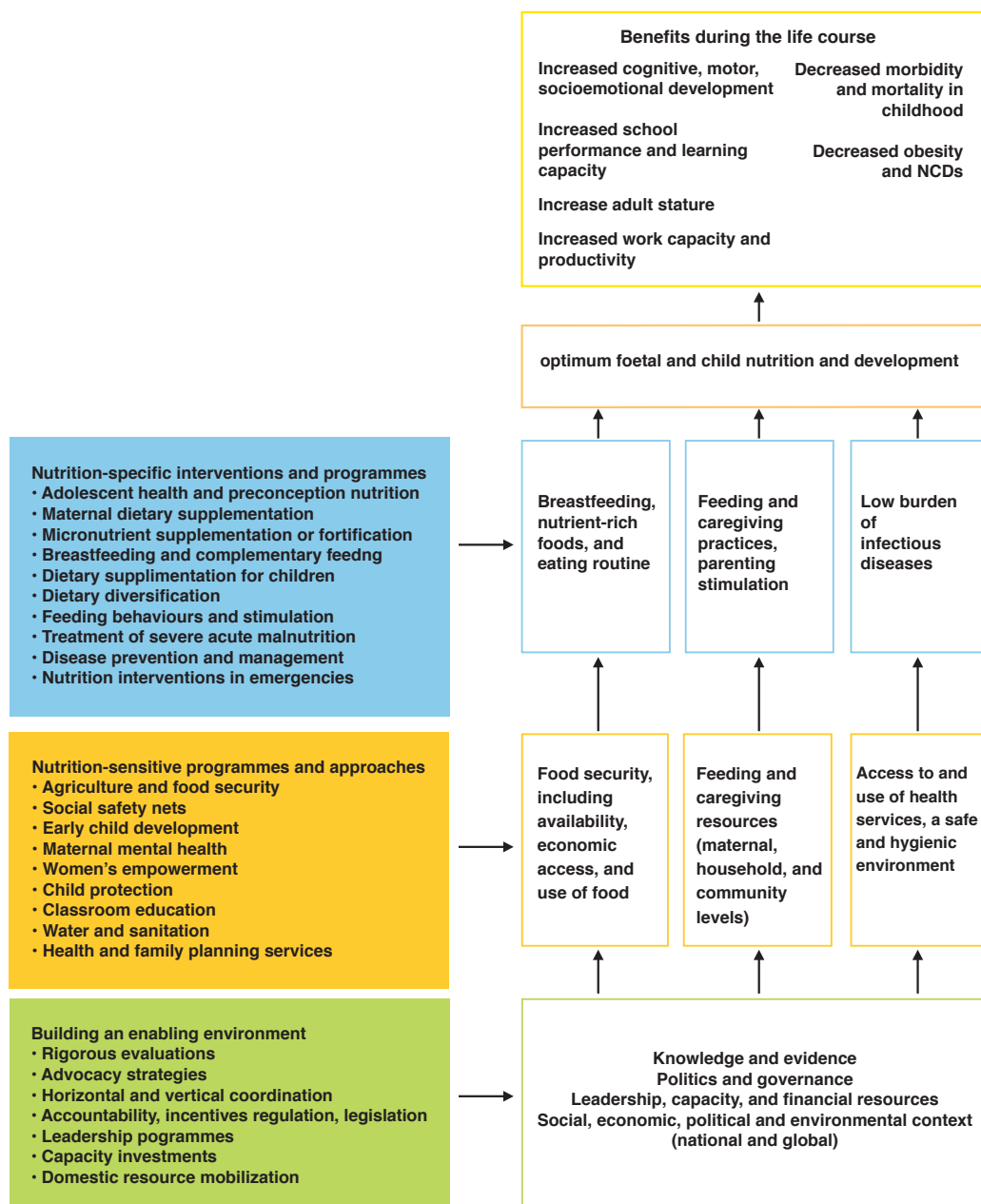
Ghana's response to the previously mentioned nutrition challenges is partly consistent with the conceptual framework on actions to achieve optimum foetal and child nutrition and development as shown in Figure 2. This framework highlights the necessity of implementing both nutrition-specific and nutrition-sensitive strategies.

²⁵Ministry of Water Resources, Works and Housing. 2009. 'Water and Sanitation Sector Performance Report'.

²⁶Ghana Statistical Service. 2008. Demographic and Health Survey 2008.

²⁷Dangour AD et al. 2008. 'Interventions to improve water quality and supply, sanitation and hygiene practices, and their effects on the nutritional status of children'. Cochrane Database Syst Rev 2013 Aug 1;8: CD009382. doi: 10.1002/14651858.CD009382.pub2

Figure 2. Conceptual Framework on Actions to Achieve Optimum Foetal and Child Nutrition and Development



Source: Black et al. 2013. 'Maternal and child undernutrition and overweight in low-income and middle-income countries'. The Lancet Maternal and Child Nutrition Series 1. p. 2.

Ghana is implementing a number of the high-impact nutrition-specific strategies proposed by the Lancet Series on Maternal and Child Nutrition in 2008²⁸. These nutrition specific strategies currently in place in Ghana include policies and programmes related to feeding and care practices, management of severe malnutrition, micronutrient supplementation and improving care practices. In addition, growth monitoring and promotion, provision of insecticide-treated bed nets, and deworming are being implemented, although these interventions are not adequately scaled up throughout the country.

Nutrition-sensitive strategies being implemented in Ghana include both health and non-health interventions. Nutrition-sensitive strategies are being implemented in multiple sectors to address key determinants of nutrition including improved hygiene, water supply, and sanitation; poverty reduction through microfinance; sustaining livelihoods of ultra-poor households using cash transfers; family planning; disease prevention and treatment; and free health insurance of indigents. In addition, bio-fortified foods, such as Quality Protein Maize; orange-fleshed sweet potatoes; and dietary diversification are being implemented in the agricultural sector to improve dietary quality.

In the education sector, the government is providing hot meals to children in primary schools as part of efforts to improve school enrolment, retention, and completion. In addition, the school system provides health and nutrition education as part of the national school curriculum and also as part of the school health programme.

1.5 Key Gaps in the Area of Nutrition

Despite the implementation of the variety of strategies mentioned, the burden of malnutrition remains unacceptably high. Some of the gaps that need to be addressed include:

- Poor coordination and harmonization of the nutrition-specific and nutrition-sensitive strategies across the relevant government ministries, departments, and agencies (MDA) and also among non-governmental organizations (NGOs)
- Limited integration of nutrition in all relevant sectors (health, food and agriculture, education, water and sanitation, social protection, etc.)
- Inadequate understanding of the links between the various determinants of malnutrition, which limits the design and implementation of appropriate strategies
- Inadequate funding for nutrition programmes²⁹
- Inadequate human capacity and governance for managing and delivering nutrition services on a large scale throughout the country
- Poor access to services, including health care, potable water, sanitation, social protection, and agricultural extension
- High rates of extreme poverty and illiteracy, particularly in northern Ghana
- Inadequate monitoring and technical support from the central government to regions and districts in the area of nutrition
- Lack of clarity in roles and responsibilities in the area of nutrition at all levels of the health system
- Over-centralization in the health sector, leading to non-integration of health issues into development planning at the local level
- Inadequate information on nutritional status of school-aged children and the elderly

²⁸Bhutta, Z.A. et al. 2008. 'What works? Interventions for maternal and child undernutrition and survival'. The Lancet. Vol. 371, Issue 9610.

²⁹Brantuo et al. 2009. 'Landscape Analysis of Readiness to Accelerate the Reduction of Maternal and Child Undernutrition in Ghana.' SCN News. No. 37, pp. 31–37.

2. Purpose of the National Nutrition Policy

The National Nutrition Policy (NNP) is an overarching multi-sectoral framework for achieving optimal nutrition and reducing malnutrition among people living in Ghana. The policy represents both a commitment from and a guide for the Government of Ghana and stakeholders in regard to plans and actions to ensure adequate nutrition and well-being in Ghana.

The NNP is designed to:

- Provide a framework for relevant ministries to align their policies and programmes to contribute to a reduction in undernutrition
- Guide the process of prioritizing nutrition challenges for action
- Provide a basis for selecting and implementing priority strategies for prevention and control of malnutrition
- Facilitate mobilization of resources for nutrition programming across all relevant sectors and institutions
- Prioritize nutrition and generate interest and demand for adequate food and nutrition security among policymakers and Ghanaians.



Photo credit: GHS/Ghana
IYCF Support Group at Kumbiehi, Wa Municipal

2.1 Rationale of the National Nutrition Policy

The NNP has been developed to bridge the policy gap for nutrition, following the expiration in 2011 of the 'Imagine Ghana Free of Malnutrition' concept document. In the long term, the policy seeks to coordinate and harmonize existing resources, capacity, and programmes across all relevant sectors, both public and private, to improve the nutritional status of Ghana's citizens.

2.2 Scope of the National Nutrition Policy

In recognition of the multifaceted determinants of malnutrition and the need for cross-sectoral action, the policy has a broad scope. The health sector is recognized as an important leader in the implementation of nutrition-specific interventions. In addition, the important contribution of other key sectors, such as agriculture, education, gender and social protection, local government, and water and sanitation, as well as civil society and the private sector, is considered essential to implementing nutrition-sensitive interventions that address the underlying causes of malnutrition. The policy will thus be implemented across all relevant sectors and integrated into the plans and activities of all relevant MDA. Civil society and other non-governmental agencies whose activities span nutrition will be encouraged to utilize the policy as a guide for all nutrition-related activities.

The policy recognizes and addresses nutritional vulnerabilities that occur across the human lifecycle. Of particular importance is the recognition that adverse exposures occurring during early life have implications for nutrition and health outcomes later in life and even into the next generation. The NNP also gives special attention to vulnerable subgroups of the population, such as women of reproductive age, young children, people living with HIV, and those receiving care in institutions.

2.3 National Nutrition Policy Guiding Principles

The successful implementation of the NNP will be based on the following guiding principles.

- Adequate nutrition is a universal human right: All people living in Ghana must have a right to access safe and nutritious diets. This right shall be observed in accordance with the fundamental basic right of all persons to be free from malnutrition and related disorders.
- Effective inter-sectoral partnership and coordination: Nutrition issues are multidisciplinary in nature, and therefore will be best addressed through well-coordinated multi-sectoral approaches.
- Nutrition is a priority human development issue: The health of Ghanaians and the economic development of Ghana are closely linked to ensuring adequate nutrition for Ghanaians.
- Gender considerations and the needs of all vulnerable groups are given special attention: Eliminating gender and other inequalities will help address some of the underlying causes of vulnerability to malnutrition and accelerate nutrition improvement for all.
- Decentralization of resources and interventions: Effective implementation of nutrition activities through a decentralized governance system will yield greater beneficial outcomes for communities.
- Community empowerment and participation: Partnering with and empowering communities in the delivery of nutritional knowledge, skills, and resources is likely to yield better outcomes and engender community acceptance and ownership.
- Evidenced-based and effective interventions will be implemented at scale: Scientifically tested and proven strategies and best practices are more likely to be successful.

3. Policy Goal, Objectives, and Measures

3.1 Policy Goal

The goal of the NNP is to ensure optimal nutrition of all people living in Ghana throughout their lifecycle.

3.2 Policy Objectives

The NNP has three objectives:

1. To increase coverage of high-impact nutrition-specific interventions that ensure optimal nutrition of Ghanaians throughout their lifecycle, with special reference to maternal health and child survival
2. To ensure high coverage of nutrition-sensitive interventions to address the underlying causes of malnutrition
3. To reposition nutrition as a priority multi-sectoral development issue in Ghana.

3.3 Policy Measures

3.3.1 Policy Objective 1: To increase coverage of high-impact nutrition-specific interventions that ensure optimal nutrition of Ghanaians throughout the lifecycle with specific reference to maternal health and child survival

Policy Measures for Objective 1

1. Nutrition of Women in Child-Bearing Age and the New-Born

- Promote nutrition of adolescent girls and women of child-bearing age through food-based and micronutrient interventions.
- Monitor and support compliance to iron and folic acid supplementation to maintain optimal nutrition during pregnancy and lactation.
- Promote integration of nutrition interventions within existing facility- and community-based maternal, new-born, and child health services.
- Advocate for institutionalization of the 6-month maternity leave.

2. Optimal Nutrition during Infancy and Childhood

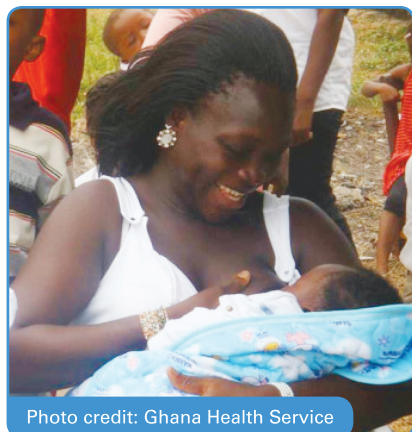


Photo credit: Ghana Health Service

- Promote behaviour change and ensure equitable access to optimal feeding and hygiene practices among infants and young children.
- Promote, protect, and support exclusive breastfeeding, and create an enabling environment that will include enforcement of the law on marketing of breast milk substitutes and supportive measures on maternity leave.
- Promote supportive measures on implementing the approved maternity leave.
- Enhance intake of micronutrients by infants and young children through consumption of diversified diets, food fortification, home fortification, and micronutrient supplementation.

- Facilitate a supportive family, workplace, and social environment that enables caregivers to provide optimal feeding of their infants and young children.
- Promote and create access to appropriate, nutritionally adequate complementary foods for children 6–24 months.

3. Nutrition of School-Age Children and Adolescents

- Promote nutrition for optimal growth and development of all school-age children and adolescents.
- Raise knowledge and skills of adolescence in nutrition.
- Ensure optimal nutritional composition of all school meals that fall under government-sponsored school feeding programmes.

4. Nutrition in the General Population

- Facilitate the prevention and control of micronutrient deficiencies through micronutrient supplementation, appropriate salt iodization methods, food fortification, and various food-based and disease control approaches.
- Promote optimal nutrition and healthy lifestyle among all age groups, especially the aged.
- Promote equity in all actions to ensure that women and men are equally empowered to take the necessary steps to improve nutrition.

5. Prevent and Manage Obesity and Diet-Related Non-Communicable Diseases

- Support the development of guidelines and enhance capacity to provide dietary and lifestyle counselling services.
- Support efforts to prevent NCDs through behaviour change communication on consumption of healthy foods and promote healthy lifestyles and physical activity.
- Support efforts to prevent overweight and obesity in all age groups, especially children.
- Promote interventions on the prevention and management of diet-related NCDs.

6. Prevent and Manage Acute Malnutrition



Photo credit:
Ghana Health Service

- Prevent the occurrence of severe acute malnutrition among children under 5 years through delivery of quality health and nutrition services.
- Enhance the capacity to manage moderate and severe acute malnutrition within all facilities and communities.
- Ensure that treatment of severe acute malnutrition is acceptable and accessible to the beneficiary.

7. Nutrition in Emergency Situations

- Ensure targeting of nutrition and its related services to underserved communities and vulnerable groups in humanitarian situations.

3.3.2 Policy Objective 2: To ensure high coverage of nutrition-sensitive interventions to address the underlying causes of malnutrition

Policy Measures for Objective 2

1. Health, Water, Hygiene, and Sanitation Services

- Ensure that nutrition is integrated into the prevention and management of infectious diseases.
- Promote interventions on awareness of infectious disease prevention strategies at the household level.
- Promote interventions on hand washing with soap at all times, especially the five critical times.
- Scale up Community-Led Total Sanitation (CLTS) initiatives.
- Ensure equitable access to safe water.
- Enhance capacity to address malnutrition in the context of chronic illness, such as HIV/AIDS and tuberculosis.
- Facilitate equitable access and utilization of family planning services.
- Promote the WHO recommended five keys to safer foods.
- Promote early initiation and exclusive breastfeeding for women in both formal and informal employment.

2. Agriculture and Food Security

- Facilitate access to adequate, diverse, safe, and affordable food in an equitable manner.
- Ensure that nutrition is enhanced across all stages of the food system (production through consumption).
- Promote the production and utilization of locally grown and raised, indigenous, and nutrient-rich food.
- Scale up national and local systems for food processing, preservation, and storage in a manner that reduces the loss of nutritional value in products and increases the supply of nutritious foods.
- Enhance the use of sustainable modern agricultural technologies to increase production of nutrient-rich foods.
- Encourage public-private partnerships for promoting food and nutrition security.
- Ensure that the food system is safe across the value chain.
- Promote interventions and technologies that reduce women's workloads and increase income generation.
- Promote agricultural research and development that will result in improved nutritional content and value of plants and animals.

3. Social Protection and Safety Nets

- Expand coverage of social protection measures, including conditional cash transfers to target nutritionally vulnerable groups, including women and children, and strengthen the quality of service provision.
- Include education activities in social protection interventions to increase household awareness of health and nutrition care giving and health seeking behaviours.
- Integrate nutrition into social protection activities.

4. Education

- Encourage the completion of senior secondary school education as a minimum for all young people, especially girls.
- Facilitate the integration of nutrition into school curricula.
- Promote girls' education.
- Ensure proper hygiene and sanitation practices in all schools.
- Ensure that school meals follow optimal dietary requirements for targeted age groups.

3.3.3 Policy Objective 3: To Reposition Nutrition as a Priority Multi-Sectoral Development Issue in Ghana

Policy Measures for Objective 3

1. Advocacy and Communication

- Ensure sustained nutrition advocacy at national and sub-national levels.
- Develop and implement communication strategies to inform and influence individual and community decisions that affect nutrition outcomes.
- Make nutrition under-budget a trigger issue.

2. Nutrition as a Priority

- Ensure that nutrition is given high priority by political leadership.
- Incorporate nutrition into national, sectoral, and local plans, including nutrition specific and nutrition sensitive monitoring and evaluation (M&E) frameworks.
- Elevate the status of nutrition within the health service structure.
- Ensure adequate funding for implementing the NNP and nutrition interventions.
- Ensure that all MDA have budget lines for nutrition.
- Make nutrition a trigger status for MDA.

3. Integration and Coordination

- Establish and maintain a mechanism for regular consultation among stakeholders for planning and implementing nutrition interventions at all levels.
- Strengthen coordination mechanisms at local levels in line with the national-level nutrition architecture and governance to ensure effective implementation of nutrition interventions.
- Encourage public-private partnerships in addressing malnutrition and promoting optimal nutrition.

4. Institutional Strengthening

- Increase the capacity of relevant sectors at the national and sub-national levels to implement nutrition-specific and sensitive interventions.
- Enhance nutrition in pre-service and continuous education for all nutrition service providers.
- Strengthen and sustain capacity for delivering behaviour change communication to promote optimal nutrition.

5. Research

- Strengthen the institutional, technical, and infrastructure capacity of relevant institutions to conduct nutrition-related research.
- Establish and strengthen research coordination mechanisms at the national and sub-national levels.
- Conduct need-based research to inform policy, programme design, and implementation.
- Strengthen research partnerships for addressing malnutrition issues.
- Establish knowledge sharing platforms to inform policy, programmes, and strategies with relevant research.
- Strengthen evidence base on nutrition-related policies, programmes, and strategies.
- Promote agricultural research and development that will result in improved nutritional content and value of plants and animals.

6. Monitoring and Evaluation

- Prioritize and support research and utilize the evidence to address national nutrition issues throughout the policy cycle
- Harmonize indicators to monitor and evaluate nutrition progress across sectors.
- Establish nutrition M&E frameworks and mechanisms at national and sub-national levels.
- Establish and operate a comprehensive Nutrition Surveillance System capable of providing the evidence needed for implementing the NNP.
- Strengthen regular monitoring and periodic evaluation of nutrition programmes.
- Earmark specific funds for M&E and protect them.

4. Coordination and Institutional Arrangements for Implementation of the National Nutrition Policy

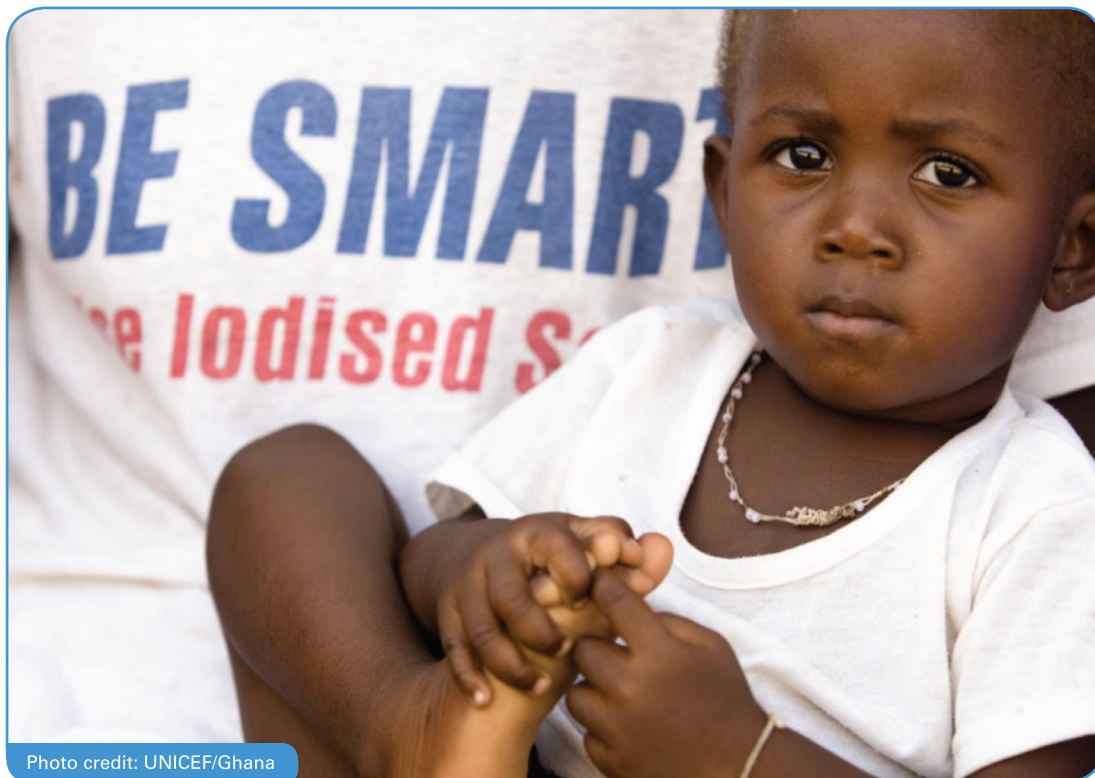


Photo credit: UNICEF/Ghana

The policy will be implemented by various ministries and agencies. A strategy document will be drawn up in line with the policy, identifying responsibility for each activity with a predetermined timeline for implementation and a means of verification. All activities in the strategy document will be coordinated at the national and sub-national levels as indicated in the M&E framework.

4.1 Coordination at the National Level

An effective institutional arrangement is necessary to ensure results-oriented implementation of the NNP. Nutrition policies and programmes require coordination across various MDAs, government and institutions, adequate funding and comprehensive scope and coverage. The NNP provides the framework to establish, strengthen, and support structures that ensure effective coordination of nutrition planning and programming at both the national and sub-national levels and across all relevant sectors. It also ensures sector-specific capacity building at all levels for effective implementation of nutrition programmes and tracking of coordination of funding mechanism. The government shall support nutrition activities at all levels of society through its MDA.

4.1.1 Ministry of Health

The Ministry of Health will strengthen human and institutional development capacity for nutrition and related services at all levels of the health system. The ministry will provide technical support to other MDA for the implementation of nutrition-specific and nutrition-sensitive interventions of this policy. It will provide oversight and guidance on norms and procedures for the prevention of malnutrition.

This ministry will be required to enhance the visibility of nutrition in the health sector by transforming the Nutrition Department of the Ghana Health Service into a directorate. The Ministry of Health will mainstream nutrition into all its departments and agencies, facilities, relevant policies, plans, programmes, and projects. Nutrition indicators will be clearly identified and integrated into health M&E systems.

4.2 Coordination at the Sub-National Level

At the regional and district levels, coordination will take place through the existing decentralized structures of government and technical committees of the relevant MDA.

4.2.1 Regional-Level Coordination

- Existing Regional Planning Coordinating Units (RPCUs) will be responsible for coordinating all nutrition programmes and activities at the regional level.
- The RPCUs will constitute and coordinate a technical team that includes relevant departments, CSOs, the private sector, and other relevant institutions at the regional level. The technical team will be responsible for planning, implementing, and monitoring all nutrition-related programmes and activities.
- A regional nutrition focal person will be appointed from the RPCUs to coordinate nutrition-related activities across sectors.

4.2.2 District-Level Coordination

- The District Planning Coordinating Units (DPCUs) will be responsible for coordinating all nutrition programmes and activities at the district level.
- The DPCUs will constitute and coordinate a technical team that includes all relevant departments, CSOs, the private sector, and other relevant institutions to plan, implement, and monitor all nutrition-related programmes and activities.
- A district nutrition focal person will be appointed by the DPCUs to coordinate nutrition-related activities across sectors.

5. Research, Communication, Monitoring, and Evaluation



Photo credit: UNICEF Ghana

5.1 Research

Evidence of best practices has to be generated through a comprehensive research programme to allow for the identification of appropriate solutions to Ghana's nutrition problems in collaboration with policymakers and other appropriate authorities. Research programmes will be designed in collaboration with research findings that will be disseminated in an appropriate format and timely manner to inform decisions on policies, programmes, and strategies. Research will focus on local-level investigation to guide the design of programmes that address the unique conditions at the decentralized level.

5.2 Communication

Communication around nutrition will be essential to solving malnutrition in Ghana. The elimination of nutrition problems will require working at all levels of society to increase awareness about malnutrition and its consequences, increase knowledge about corrective actions, and develop an understanding of the importance of multi-sector approaches in reducing it.

Cultural beliefs and human behaviour are major factors influencing nutritional status. Nutrition-related behaviours are based on the foods and products available to individuals and are greatly influenced by deeply ingrained traditions, household dynamics, and social norms and beliefs. Hygiene, sanitation, health care, and other care behaviours also influence nutrition outcomes and are rooted in traditions and cultural practices.

A communication and advocacy strategy will be developed to address these underlying behaviours, to develop the knowledge needed by all individuals to make good decisions on consumption and child feeding practices, and to increase awareness and commitment to solving nutrition problems in Ghana.

5.3 Monitoring and Evaluation

Effective and efficient implementation of the NNP depends on accurately tracking progress and performance, evaluating impact, and ensuring accountability at all operational levels.

An M&E framework for the NNP will be based on the national M&E system, which requires that all sub-national levels develop M&E plans and reports for accountability.

Because the NNP will involve input from multiple sectors, a comprehensive M&E system will be developed. This system will utilize existing mechanisms for collecting routine programme and service data obtained from the Policy, Planning, Monitoring and Evaluation Directorates, the RPCUs, and the DPCUs, which are the statutory institutions with direct responsibilities for policy planning and M&E at the sector, regional, and district level, respectively. All relevant sectors, including, but not limited to, health, agriculture, water and sanitation, education, gender, children and social protection, and trade and industries, will report on the relevant nutrition indicators for their sectors.

Administrative data systems need to be developed and complemented with data from nationwide surveys, such as the GDHS; MICS; the Ghana living standards surveys; the Food Security Monitoring System, which detects changes and trends in food security and vulnerability; nutrition surveillance surveys; and the national Comprehensive Food Security and Vulnerability Survey. This data will then be used to identify malnutrition burden and distribution to guide investment plans. It will also enhance the evaluation of existing interventions and contribute to improved nutrition planning and programming.

Key nutrition indicators will be included in the National Monitoring and Evaluation Plan and reported on in Annual Progress Reports on the National Medium Term Development Policy Framework (GSGDA II 2014–2016) by the NDPC. An Annual Progress Report on nutrition will be published.

The M&E of the NNP will also be linked to other strategic frameworks of relevance to nutrition, such as systems for tracking the Sustainable Development Goals and progress reports of the SUN Movement.

Glossary

Term	Definition
Acute hunger	Short-term lack of food causing rapid weight loss. Often caused when shocks such as drought or war affect vulnerable populations.
Chronic hunger	Constant or recurrent lack of adequate quantity and/or quality of food consumed over an extended period of time.
Hidden hunger	A lack of essential micronutrients in diets.
Nutrition-specific interventions	Interventions that have a direct impact on nutrition outcome, such as supplementation, fortification, bio-fortification, behaviour change, and therapeutic feeding.
Nutrition-sensitive strategies	Multi-sectoral strategies that empower households (especially women) for nutritional security, improve year-round access to nutritious diets, and contribute to improved nutritional status of those most at risk (women, young children, disabled people, and those who are chronically ill); improve sanitation, hygiene, access to water, education, poverty reduction, etc.
Food diversification	Maximization of the number of different foods or food groups consumed by an individual, especially above and beyond starchy grains and cereals, considered to be staple foods typically found in the diet. The more diverse the diet, the greater the likelihood of consuming both macro and micronutrients in the diet.
Food security	A condition in which all people, at all times, have physical, social, and economic access to sufficient, safe, and nutritious food that meets their dietary needs and food preferences for an active and healthy life.
Hunger	Hunger is often used to refer in general terms to Millennium Development Goal 1 (MDG 1) and food insecurity. Hunger is the body's way of signaling that it is running short of energy. Hunger can lead to malnutrition.
Iron deficiency anaemia	A condition in which the blood lacks adequate healthy red blood cells that carry oxygen to the body's tissues. Without iron, the body can't produce enough haemoglobin, found in red blood cells, to carry oxygen. It has negative effects on work capacity and motor and mental development. In new-borns and pregnant women it might cause low birth weight and preterm deliveries.
Malnutrition	An abnormal physiological condition caused by inadequate, excessive, or imbalanced absorption of macronutrients (carbohydrates, protein, fats), water, and micronutrients (vitamins and minerals).
Millennium Development Goal 1 (MDG 1)	Eradicate extreme poverty and hunger, which has two associated indicators: 1) prevalence of underweight among children under 5 years of age,

	which measures undernutrition at an individual level; and 2) proportion of the population below a minimum level of dietary energy consumption, that measures hunger and food security, and it is measured only at a national level (not an individual level). Source: SUN Progress Report. 2011.
Millennium Development Goal 4 (MDG 4)	Reduce child mortality rates by two-thirds, which has three associated indicators: 1) under-5 mortality rate, 2) infant (under 1) mortality rate, and 3) proportion of 1-year-old children immunized against measles.
Multi-stakeholder approaches	Multi-stakeholder approaches are implemented by working together, drawing on their comparative advantages, catalysing effective country-led actions, and harmonizing collective support for national efforts to reduce hunger and undernutrition. Stakeholders come from national authorities; donor agencies; the United Nations system, including the World Bank; civil society and NGOs; the private sector; and research institutions.
Nutritional security	Achieved when secure access to an appropriately nutritious diet is coupled with a sanitary environment and adequate health services and care to ensure a healthy and active life for all household members.
Sustainable Development Goals (SDGs)	Adopted in 2015 with 17 goals and 169 targets to be achieved by 2030. SDG2 (End Hunger, Achieve Food Security, Improved Nutrition and Sustainable Agriculture). Target malnutrition. The under-listed SDGs are also major contributors to optimal nutrition. SDG1: End poverty in all its forms SDG3: Ensure Healthy Lives SDG4: Ensure quality education and learning SDG5: Achieve Gender Equality and Empowerment SDG6: Ensure Sustainable Water and Sanitation SDG12: Ensure Sustainable consumption SDG17: Revitalize Global Partnerships
Severe acute malnutrition	A very low weight for height (below -3z scores of the median WHO growth standards), visible severe wasting, mid-upper arm circumference of less than 11.5 cm in children 6–60 months old or the presence of nutritional oedema.
Stunting (chronic malnutrition)	Reflects shortness-for-age, calculated by comparing the height-for-age of a child with a reference population of well-nourished and healthy children.
Underweight	Measured by comparing the weight-for-age of a child with a reference population of well-nourished and healthy children.
Wasting	Reflects a recent and severe process that has led to substantial weight loss, usually associated with starvation and/or disease. Wasting is calculated by comparing weight-for-height of a child with a reference population of well-nourished and healthy children. Often used to assess the severity of emergencies because it is strongly related to mortality.

Annex A. Overview of Nutrition Policies, Strategies, and Major Programmes in Ghana

Policies, strategies, and programmes in Ghana	Nutrition thematic areas addressed																Policy components specified														
	Undernutrition				Overweight		Micronutrients																								
	Underweight	Stunting	Wasting	Therapeutic feeding	Maternal	LBW	Preventive	Treatment	Vitamin A	Iron	Iodine	Fortification	Micronutrient sup	Early initiation	Exclusive breastfeeding	Complementary food	Responsive feeding	Production	Supplementation	School feeding cash transfer	MCH	Vaccination	Deworming	Bednet	Water and Sanitation	Targets	Coverage	Timeframe	Budget	M&E	Action Plan
National Policies																															
GPRS II (2006–2009) (NDPC 2005)	x	x			x									X		x	x			x	x	x	x	x				X			
GSGDA I and II																															
Ministry of Health																															
National Health Policy: Creating health through wealth (Ministry of Health [MOH])	x															x															
Breastfeeding Promotion Regulation (L.1667)															x																X
Food and Drug Law (Public Health Act 2012, Act 851)										x	x		x	x														x			
Food and Drug Law and Amendments: Universal Salt Iodisation Policy (MOH 1995)											x	x																x			x
Integration of nutrition actions into HIV, IMCI, maternal health, HRD policies and protocols	x	x			x	x			x	x	x	x	x	x	x	x	x														
National Plan of Action for Promotion of Breastfeeding, Ghana (MOH 10995c)					x								x	x	x	x												x			x

Policies, strategies, and programmes in Ghana	Nutrition thematic areas addressed																				Policy components specified										
	Undernutrition				Overweight		Micronutrients																								
	Stunting	Wasting	Therapeutic feeding	Maternal	LBW	Preventive	Treatment	Vitamin A	Iron	Iodine	Fortification	Micronutrient sup	Early initiation	Exclusive breastfeeding	Complementary food	Responsive feeding	Production	Supplementation	School feeding cash transfer	MCH	Vaccination	Deworming	Bednet	Water and Sanitation	Targets	Coverage	Timeframe	Budget	M&E	Action Plan	
Reproductive Health Strategic Plan 2007–2011 (GHS 2007)					x			x				x	x	x							x	x	x		x	x	x	x	x		
Regenerative Health Policy Paper (MOH 2007c)						x								x																	
National Breastfeeding Policy (MOH 1995)													x	x	x																
Imagine Ghana Free of Malnutrition (GHS 2005)	x	x		x	x	x		x	x	x	x	x	x	x	x	x	x		x				x	x	x	x	x	x	x	x	
Anaemia Strategy (GHS 2003)								x			x	x								x	x	x	x	x							
Child Health Policy (Final Draft, GHS/MOH 2008)	x	x	x	x	x		x	x	x	x	x	x	x	x	x	x				x	x	x	x	x	x	x	x		x	x	
Infant and Young Child Feeding Strategy for Ghana (GHS 2007)	x	x		x	x		x	x	x	x		x	x	x	x	x	x			x	x	x	x	x	x						
National Reproductive Health Service Policy and Standards (GHS 2003)				x			x				x			x																	
Essential Nutrition Actions Programme	x	x		x	x		x	x	x	x	x	x	x	x	x	x				x	x	x	x								
Universal Salt Iodisation Strategy																															
Community-based milling/fortification and salt rebagging programme							x	x	x	x	x																				

	Nutrition thematic areas addressed																								Policy components specified																	
	Undernutrition												Overweight		Micronutrients																											
Underweight	Stunting	Wasting	Therapeutic feeding	Maternal	LBW	Preventive	Treatment	Vitamin A	Iron	Iodine	Fortification	Micronutrient sup	Early initiation	Exclusive breastfeeding	Complementary food	Responsive feeding	Production	Supplementation	School feeding cash transfer	MCH	Vaccination	Deworming	Bednet	Water and Sanitation	Targets	Coverage	Timeframe	Budget	M&E	Action Plan												
Policies, strategies, and programmes in Ghana																																										
Promotion of Breastfeeding, Ghana (MOH 1995c)																																										
Interim National Guidelines for Community-Based Management of Severe Acute Malnutrition in Ghana, 2010																																										
Nutrition Facts for Ghanaian Families (2nd Edition), 2009																																										
Nutrition Assessment, Counselling, and Support (NACS) for People Living with HIV/AIDS and/or TB, 2010																																										
Food Safety Policy																																										
Community-Based Growth Promotion Programme																																										
Ministry of Food and Agriculture																																										
Food and Agriculture Sector Development Policy (FASDEPC II) (MOFA 2007)																																										
High-Impact Rapid Development approach																																										



National Nutrition Policy

July 2016, Accra