

Nutrition Policy and Programs in Ghana

The limitation of a single sector approach

Adom Baisie Gharthey



June 2010



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Health, Nutrition and Population (HNP) Discussion Paper

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Health, Nutrition and Population (HNP) Discussion Paper

Nutrition Policy and Programs in Ghana: *The limitation of single sector approach*

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Paper prepared as a case for a regional study on the political economy of nutrition in
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Abstract: Although Sub-Saharan Africa has some of the worst nutrition indicators in the world, nutrition remains a low priority on the policy agendas of many African governments. This despite the fact that proven interventions are known and available and that investment in them is considered a cost-effective strategy for poverty reduction.

This case study is one in a series seeking to understand (1) what keeps African governments from committing fully to reducing malnutrition, and (2) what is required for full commitment. It documents how the Ghanaian government has addressed the issue of malnutrition since Independence, examines what political and institutional factors have prevented full commitment, and identifies what conditions have moved the nutrition agenda forward at different points in time.

The primary objective of this study as well as the series as a whole is to help African governments, development partners, and nutrition and health practitioners identify, understand and address the political and institutional obstacles preventing sustainable progress in nutrition.

Keywords: Nutrition security, community mobilization, institutional development, scaling up nutrition, mainstreaming nutrition

Disclaimer: The findings, interpretations and conclusions expressed in the paper are entirely those of the authors, and do not represent the views of the World Bank, its Executive Directors, or the countries they represent.

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FOREWORD

Repositioning nutrition as central to development is one of our priorities in the Health, Nutrition and Population sector in Africa. The region has the highest prevalence rates of malnutrition in the world, and as such it jeopardizes the chances of achieving the MDGs and making the reduction of poverty meaningful and sustainable. Tackling malnutrition is directly related to the achievement of MDG 1 (eliminating hunger), MDG 4 (reducing child mortality) and MDG5 (reducing maternal mortality). In fact, the achievement of many of our goals in human development hinges upon the elimination of malnutrition, as it impacts on health, productivity and educational achievement.

Nutrition interventions have also been singled out as some of the most cost-effective among an array of solutions available to tackle poverty and underdevelopment. The 2008 Copenhagen Consensus of eminent economists concluded that the return of investing in micronutrient programs are first and third, among a lengthy list of ways to meet the world's development challenges, and all five nutrition interventions ranked among the top 10. Thus, making nutrition a priority is not only the right thing to do, but it is also economically sensible.

In the last years, the region has been trying to significantly ramp up efforts to scale up nutrition at country level. In the last year, the HNP sector in Africa has hired two senior nutritionists to strengthen its capacity to assist governments in the adoption of nutrition policies and programs. And it has also put more resources to their disposal to make the goal of supporting the scale up of nutrition programs a reality. However, this remains a challenging task, as nutrition usually suffers from inadequate capacity, lack of commitment and non conducive institutional arrangements. In supporting countries to get out of this situation, we need to work with their specific circumstances and turned them around, without leaving any country behind.

The current fuel and food crises have in fact made more evident that nutrition systems need to be strengthened at country level. Pouring in resources will not solve the problem if we do not support the adoption of sustainable nutrition services and systems. The series of case studies on the political economy of nutrition policies that HNP Africa conducted in the last two years should provide us with important insights on how to better support countries to make nutrition a priority. The Ghana case study is the first in this series to be published, and it constitutes an excellent account of some of the challenges that making nutrition a priority faces in Africa, as well as some of the strategies that could be taken to overcome them. Although the research for this report was completed in 2008, it is hoped that its findings are still helpful to governments, development partners, and nutrition and health practitioners in identifying, understanding and addressing the political and institutional obstacles preventing sustainable progress in nutrition.

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ACRONYMS AND ABBREVIATIONS

ADRA	Adventist Development Relief Agency
AEAs	Agriculture Extension Agents
AIDS	Acquired Immune Deficiency Syndrome
BCC	Behaviour Change Communication
CBNFSP	Community Based Nutrition and Food Security Project
CHAG	Christian Health Association of Ghana
CHPS	Community Based Health Planning Systems
CRS	Catholic Relief Service
CSIR	Council for Scientific and Industrial Research
CSPG	Cross-Sectoral Planning Group
DHS	Demographic Health Survey
DOT	Direct Observation Treatment
DPCUs	District Planning Coordinating Units
ECOWAS	Economic Commission of West African States
EPI	Expanded Programme on Immunisation
FRI	Food Research Institute
GAIN	Global Alliance for Improved Nutrition
GES	Ghana Education Service
GHS	Ghana Health Service
GOG	Government of Ghana
GPRS I	Ghana Poverty Reduction Strategy
GPRS II	Growth and Poverty Reduction Strategy
GPRSP	Ghana Poverty Reduction Strategy Paper
HIRD	High Impact Rapid Delivery
HIV	Human Immunodeficiency Virus
HR	Human Resource
HRDD	Human Resource Development Directorate
ICN	International Conference on Nutrition
IMF	International Monetary Fund
KEEA	Komenda Edina Eguafo Abrem Municipal Assembly
MCH	Maternal and Child Health
IMCI	Integrated Management of Childhood Illnesses
MDA	Ministry, Department and Agency
MDAs	Ministries, Departments and Agencies
MDBS	Multi Donor Budget Support
MDGs	Millennium Development Goals
MMDA	Metropolitan, Municipal and District Assembly
MOESS	Ministry of Education Science and Sports
MOFA	Ministry of Food and Agriculture
MOH	Ministry of Health
MOST	Micronutrient Operational Strategies and Technology
MOWAC	Ministry of Women and Children's Affairs

MTDP	Medium Term Development Plan
NDPC	National Development Planning Commission
NEPAD	New Partnership for Africa's Development
NGOs	Non Governmental Organisations
NIDs	National Immunization Days
PAMSCAD	Programme of Action to Mitigate the Social Cost of Adjustment
PEM	Protein Energy Malnutrition
PHD	Public Health Directorate
PPMED	Policy Planning, Monitoring and Evaluation Directorate
RCC	Regional Coordinating Council
RPCUs	Regional Planning Coordinating Units
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAS	Vitamin A Supplementation
WFP	World Food Programme
WHO	World Health Organisation
WIAD	Women in Agricultural Development
WIADD	Women in Agriculture Development Directorate
WVI	World Vision International
5YPOW	5-Year Programme of Work

EXECUTIVE SUMMARY

Context of the study

This report is part of a larger comparative study of nutrition policies in eight countries in Africa: Benin, Burkina Faso, Ethiopia, the Gambia, Ghana, Madagascar, Senegal, and Tanzania. This larger comparative study was conducted by the World Bank and aims to identify and understand the factors that produce long term government commitment to nutrition policies over time.

This case study evaluates the main actors, institutions (formal/informal), and agencies that were relevant to the nutrition policy making arena in Ghana. Agenda setting, design, adoption, implementation and sustainability are also considered. Objectives were to:

- i. Document the trajectory of nutrition policies in Ghana, identify the moments in which they were incorporated into the government’s agenda, provided with budget and administrative support and implemented through a consistent plan;
- ii. Provide an analysis of the political, institutional and administrative factors, including tactical behaviours and decisions, which led to these outcomes.

Study methodology

A common conceptual framework and set of issues/questions were developed for the eight country comparative study. The Ghana report, therefore, relies largely on the methodology envisaged for the comparative study, namely literature reviews, interviews with key informants and focus groups. In a few cases, telephone interviews were conducted with key informants who could not be reached in person. Information obtained from key informants was triangulated to assure validity and completeness and to facilitate development of a responsive storyline. The “snowball” approach that uses interviewees to provide leads to other relevant informants was also used to capture other key informants not originally targeted by the study process.

The case study focuses largely on key institutional and individual informants at the national level, including representatives of relevant Ministries, Departments and Agencies (MDAs), as well as development partners and NGOs. In addition, owing to the decentralised system of governance in Ghana, two regions, the Central and Upper East Regions, were also covered in the study to provide regional and district perspectives on the issues addressed.

Key findings

The key findings of the study include:

Trajectory of Nutrition Policies

Nutrition policies that have been adopted and implemented in Ghana since Independence can be chronologically arranged into six time periods. Although some of the periods appeared to have a distinct focus, in practice they have overlapped and have been cumulative in nature in relation to the issues addressed and their outcomes, with subsequent periods adding on to focal points from the preceding periods. The six periods are:

- a. *The period immediately after independence (1957–1966)*: This was the period when the idea of nutrition dawned on the government. Main focal points were food demonstration and nutrition education. Understanding of the nature and requirements of nutrition was not adequately clear to the main actors involved in this period.
- b. *Continuation of food demonstration, nutrition education and transition into identifying attitude and behaviour change requirements in nutrition (1966–1974)*: A period in which very low priority was given to nutrition due largely to inadequate understanding of nutrition issues among most professionals. Nutrition was seen mainly as a food intake issue and not related to other factors such as addressing micro-nutrient requirements, exclusive breastfeeding, food supplementation and other associated issues. However, later developments resulting in some level of understanding shifted the focus on food demonstration and nutrition education to include micro-nutrients, food hygiene and effective ways of storage and preservation of food in the home and to advice on ways to address gaps in knowledge, skills and attitudes to respond to behaviour change in nutrition.
- c. *Weaning foods, supplementary food and malnourished children (1974–1987)*: The attitude and behaviour change interventions initiated in the previous period were consolidated during this stage of the trajectory, which focused on community and school-based nutrition education and food demonstration. Weaning foods, which were the focus of nutrition interventions in this era, were introduced to address the nutrition needs of malnourished children.
- d. *Transition into addressing micronutrient requirements (1987 – 1990)*: During this period, the primary focus was on addressing iodine deficiency through salt iodization, in addition to continued promotion of nutrition education, attitude and behaviour change and weaning foods. This followed an International Conference on “Ending Hidden Hunger” that sought to highlight the negative consequences of iodine deficiency.
- e. *Planning and mobilising for action: Addressing micronutrient deficiencies and exclusive breastfeeding (1990 – 2000)*: This period marked a **positive process of change** that led to higher visibility and increased resources for nutrition. In addition to new policies addressing food demonstration, attitude and behaviour change, weaning foods and iodine deficiency, further policies on micronutrients were formulated, government commitment in terms of policy decisions secured and their implementation pursued. **However, government commitment in relation to human and financial resource allocation, putting in place a central coordination mechanism, and effective monitoring and evaluating to ensure sustainability remained absent.** Moreover, strategies for pursuing policies were largely donor driven in terms of funding and mobilisation of key actors. Opportunities were therefore missed in securing government commitment to budget allocations and consistent

implementation of the policies over time in order to institutionalise and sustain reduction of malnutrition.

Involvement of the different ministries and departments in the International Conference on Nutrition (ICN) and follow up activities through a multi-sectoral coordinating committee and thematic working groups engaged wider participation of MDAs in pursuing nutrition policies by formulating a Nutrition Plan of Action in Ghana. The multi-sectoral central committee and thematic working groups also participated in the preparation of a national strategy and policy documents aimed at placing nutrition high on the government policy agenda.

Use of PROFILES models¹ during this period heightened awareness regarding the economic costs of malnutrition and promoted increased allocation of resources for nutrition activities from government, donors and other development partners.

f. Consolidation of strategies for addressing micronutrient deficiencies, exclusive breastfeeding and community-based growth monitoring (2000 – 2008): This era marked **another positive process of change** in the trajectory of nutrition policies in Ghana. Policies to further address micronutrient deficiencies; exclusive breastfeeding, supplementary feeding, and community based growth monitoring were initiated during this period. **However, inadequate government commitment in terms of funding, coordination and sustainability continued to hamper implementation.**

Policy Making: Analysis of Main Stakeholders

Key actors in the nutrition policy making process have tended to be the same actors that play significant roles in nutrition agenda setting, design, adoption, implementation and sustainability. The main actors have been the Ministers of Health and Agriculture, some key staff of the Ghana Health Service (GHS), especially members of ad-hoc committees set up to address specific issues in nutrition, the Nutrition Department and the donor community. Other key actors have been the Children's Department of the Ministry of Women and Children's Affairs (MOWAC), the Women in Agriculture Development Directorate (WIADD) of the Ministry of Food and Agriculture (MOFA), the Ghana Education Service and the Ministry of Local Government, Rural Development and Environment. This second group of stakeholders are active mainly at Municipal and District Assembly levels where they advocate and make financial resources available for nutrition policy interventions through their Medium Term Development Plans.

Stakeholders' have been motivated primarily by the desire to achieve Ghana's development agenda including Vision 2020, GPRS I and II, the MDGs, and other international commitments. In most cases stakeholders have pushed their agendas via various forums on health. These

¹ PROFILES uses interactive computer-based models to project the functional consequences of poor nutrition on important development outcomes such as mortality, morbidity, fertility, school performance, and labor productivity. PROFILES also estimates the costs and benefits of nutrition programs in a given country. (source: <http://www.aedprofiles.org>)

include the Annual Health Summits of the MOH and development partners; radio and television discussions and debates on health issues; organization of annual NIDs, Child Health Promotion Week; and health-oriented events at various churches and festivals..

Parliamentary approval of such agendas, in terms of passage of laws such as LI 1667 on sale of complementary foods and Act 525 on iodized salt, which are critical, has been readily secured. In addition to the critical role of parliament, individual Ministers and others have used their political influence to lobby for placing nutrition issues higher on the government policy agenda. The interests and power of individuals in positions such as the Ministers of Agriculture and Health and the Director General of GHS have catalyzed nutrition policy processes.

Despite some successes in terms of advocacy and legislation, a number of challenges continue to confront Ghanaian nutrition policy formulation and implementation. First, policies are largely pursued at the national level through seminars, conferences and establishment of committees that meet on the issues leading to inadequate translation of the policies into action at the district and community levels where implementation is to be done. In addition, inadequate cross-sectoral coordination and collaboration, mismatch between causes of undernutrition and nutrition actions, unreliability of data to inform outcomes of policy interventions, and inadequate personnel and funding are all constraints. Last though certainly not least, there is no inter-ministerial body to coordinate nutrition activities. Most agencies participate more in the design of policies and implementation of activities through attendance at meetings rather than via funding their implementation. They often do not integrate the policy interventions in their annual plans and budgets. Funding implementation of nutrition policies in Ghana has therefore been largely donor driven with some funds made available through annual budgets of MOH and GHS to cover salaries of personnel, haulage and other overhead costs.

Explaining the Drivers of Nutrition on the Government Agenda

Factors that seem to have put nutrition on the GOG's policy agenda and to allow for its sustainability included the desire of the government to meet MDGs four and five, and human development objectives under government policy frameworks such as Vision 2020 and GPRS I and II. The government's ratification of international conventions and its commitment to other international declarations have also been key motivations. However the absence of a national level coordinating body to provide leadership, coupled with inadequate funding for implementation have led to the failure of government to make nutrition a consistently high priority agenda item.

Further, nutrition policy interventions have been largely donor driven. They have been evidence-based, beginning with development partners being concerned with particular nutrition deficiencies and other related issues and initiating research to establish the extent and nature of the deficiency in question. The research has been followed by pilot interventions based on strategic recommendations from the research. The Government in collaboration with development partners has then scaled up the interventions to other parts of the country. Although the policies have been largely donor driven, in this sense the government has provided policy backing, personnel, facilities and some logistics for their implementation. However, government commitment to providing financial resources has been inadequate in ensuring sustainability.

International conferences, commitment of Government to international conventions and response to international goals have catalysed adoption of the relevant policies. Advocacy and leadership roles played by the Ministers of Agriculture and Health and the Director General of GHS facilitated the design, adoption and implementation of the *Nutrition Plan of Action* and subsequent incorporation of the policy in the Government policy framework, Vision 2020 and GPRS I and II, and a *Concept Paper Imagine Ghana Free of Malnutrition*. These actors were essential to championing adoption and implementation of the policies, ensuring that provisions were made in the annual budgeting processes.

Ad-hoc inter-ministerial committees set up from time to time have also championed formulation and implementation of nutrition policies, primarily via participation in media debates. However, the majority of these committees' activities have framed nutrition as ancillary to other health care interventions (e.g. National Immunization Days (NIDs), malaria control, and polio eradication). In most cases, budgetary allocations for activities of the Nutrition Department have been fused into activities of other Divisions and Departments of the GHS at the national and regional levels.

Additionally, weak coordination of nutrition policy interventions has contributed to inadequate implementation and sustainability of nutrition policies.

The inter-sectoral and multi-faceted nature of nutrition makes it difficult for the Nutrition Department - which is under the aegis of the GHS - to operate effectively. Moreover, other MDAs continue to pursue nutrition policy interventions without recourse to the activities of the Nutrition Department.

Key Lessons

Key lessons include:

- i. Inadequate linkage and coordination arrangements limit implementation and sustainability of nutrition policies;
- ii. Government commitment to international nutrition conventions and declarations have facilitated pursuance of nutrition policies and programs;
- iii. Dominance of donors in initiating and implementing nutrition policies has created some degree of dependence on donors by the government and other policy actors, leading to inadequate commitment in terms of funding implementation of nutrition policies.
- iv. The role of decentralised structures in nutrition policy formulation and implementation is unclear, thus leading to inadequate participation of local government in nutrition policy formulation, implementation and sustainability;

- v. Inadequate prominence given to the role of research and training institutions in nutrition policy formulation and implementation leading to missed opportunities in adopting strategies to optimise outcomes of policy interventions;
- vi. Inadequate civil society participation in the nutrition policy arena leading to the absence of coalitions for nutrition advocacy, thus limiting the scope and scale of opportunities for lobbying nutrition policy formulation, implementation and funding;
- vii. Absence of a coherent national nutrition policy that (1) outlines a framework for pursuing nutrition interventions at the national, regional and district levels, (2) defines institutional roles and responsibilities, (3) stipulates monitoring and evaluation processes, and (4) articulates linkage and coordination arrangements. Absence of a national policy limits the extent to which pressure can be brought to bear on the government to provide resources for implementation in a sustained manner;
- viii. Inadequate dissemination of nutrition information: Data and findings from the GDHS and PROFILES are not systematically disseminated beyond national and regional levels. This leads to inadequate understanding and appreciation of nutrition policy issues and actions at the district and community levels.
- ix. Health sector interventions in Ghana have been largely clinical and curative in nature, limiting the scope and scale of nutrition and other preventive health interventions.

PART I - INTRODUCTION

RATIONALE

The World Bank and its partners have been involved in supporting the implementation of nutrition programmes for several years. Some of these nutrition programmes have become very successful and sustainable large-scale operations. However, in a number of countries the government has shown little interest in supporting long-term, effective nutrition policies. The disparate results of these programmes suggest that technical and sound knowledge about nutrition is not sufficient for achieving good results. Understanding the motivations of politicians, public officials, and other relevant players to initiate, implement and sustain sound policies and programmes that can aid achievement of the desired results is critical. A political economy perspective can contribute to reaching this objective by providing an analysis of the political interests, the institutional landscape and the key actors that influence nutrition policy formulation.

Consequently, the World Bank conducted a comparative study of nutrition policies in eight countries in Africa: Benin, Burkina Faso, Ethiopia, Gambia, Ghana, Madagascar, Senegal, and Tanzania. The study aimed at comparing relatively successful experiences in reaching longstanding commitment by government to nutrition, achieving a certain level of institutionalisation and obtaining good results in the reduction of malnutrition (Madagascar and Senegal) with less successful experiences (Benin and Burkina Faso) in Francophone Africa, three experiences in Anglophone Africa in which commitment was reached and has subsequently declined (Gambia, Ghana, and Tanzania), and an experience in which government commitment to nutrition policies has increased in recent years (Ethiopia).

OBJECTIVE OF STUDY

This study was undertaken to produce a case study of the political economy of nutrition policies in Ghana as an input into the comparative study. It aims to:

- i. Document the trajectory of nutrition policies in Ghana, identifying moments in which they were incorporated into the government's agenda, provided with budget and administrative support and implemented through a consistent plan.
- ii. Provide an analysis of the political, institutional and administrative factors, including tactical behaviours and decisions that led to such outcomes.

In addition, the study evaluates main actors, institutions (formal/informal), and agencies relevant to nutrition policy development in Ghana.

This report documents the outcomes of the study. Chapter two outlines the policy making context and state of nutrition from Independence to 2008, chapter three presents the trajectory of nutrition policies and programs, identifying positive processes of change and

missed opportunities, and chapter four analyzes the strategies and actions of nutrition stakeholders. Chapter five provides lessons learned from the study.

METHODOLOGY

This section provides an overview of the study approach and methodology, the scope, coverage, as well as key informants.

Study Approach and Methodology

This case study relied largely on the methodology developed for the comparative study (namely literature reviews and field research), to investigate the political, institutional and administrative factors that influenced successful or missed opportunities in establishing nutrition as a priority on the GOG's agenda.

Interviews were conducted using the interview guide developed for the comparative study and adapted to the Ghana case study (see Annex 1). Individual interviews and focus group discussions were both used. In a few cases, telephone interviews were conducted with key informants who could not be reached in person. Information obtained from key informants was triangulated to assure validity and completeness and to facilitate development of a responsive storyline.

Field work was initiated on 23 May and completed on 15 June 2008. The different stages of the study: literature review; field research including arrangements and appointments for interviews, interviewing and reporting, as well as feedback and backstop support to and from the lead consultant, were pursued iteratively. The "snowball" approach that uses interviewees to provide leads to other relevant informants was used to identify key informants not originally targeted in initial interviews. This approach enabled validation of issues captured in the storyline. It also ensured timely delivery of the outputs of the study.

Scope, Coverage, and Key Informants

The study focused largely on key institutional and individual informants at the national level. These included representatives of relevant Ministries, Departments and Agencies (MDAs), as well as donors and NGOs.

In addition to national level, owing to the decentralised system of governance in Ghana, two regions, the Central and Upper East Regions, were covered in the study to provide regional and district perspectives on the issues addressed.

The time frame for the study, which was fixed in nature (April – June 2008), was such that a few key informants could not be reached during the study. Efforts made to contact these informants, either physically or by telephone, failed as their whereabouts could not be traced readily. Such informants included retired heads of the Nutrition Department, a retired Director General of the Ghana Health Service (GHS) and former key actors in the nutrition policy arena. The latter were of interest due to the institutional memory they

might have provided to complement information elicited on the trajectory of Ghanaian nutrition policy, and to provide insights on the key factors for success and/ or missed opportunities. Although not everyone in this latter category was reached, involvement of some interviewees in the nutrition policy arena predates the period of Independence. They included the first head and the immediate past head of the Nutrition Department. However, the majority of interviewees had been involved in the nutrition policy arena after Independence. A list of persons interviewed is presented in Annex 2.

PART II – COUNTRY CONTEXT FOR NUTRITION

BRIEF DESCRIPTION OF THE COUNTRY

Ghana is located on the West coast of Africa. It is bordered by Togo on the east, Côte d'Ivoire on the west, Burkina Faso to the north, and the Gulf of Guinea to the south. Ghana was the first Sub-Saharan African British colony to gain independence after the 1957 merger of the Gold Coast and Togoland trust territory. After two decades of coups, Lieutenant Jerry Rawlings took power in 1981, banning political parties until the approval of the 1992 constitution. The most recent election was held in early 2009.



Source: CIA World Factbook

Ghana is divided into ten administrative regions: Ashanti, Brong Ahafo, Central, Eastern, Greater Accra, Northern, Upper East, Upper West, Volta, and Western. The regions are further divided into a total of 138 districts.

With over two decades of rapid economic growth and political stability, Ghana has emerged as a leader in Sub-Saharan Africa. Yet despite Ghana's relative prosperity, poverty remains pervasive, primarily in the country's three northern regions, which now account for approximately 50% of the population living under the poverty line (UNICEF, 2010). Ghana's Human Development Index ranking is 152 out of 182 (UNDP, 2009), and it is included in the list of countries having the highest burden of malnutrition in the world (Black et al., 2008).

STATE OF NUTRITION²

The first demographic health survey conducted in Ghana (GDHS 1988) reported that 30% of Ghanaian children 0-36 months of age were stunted, while 31% were underweight. The numbers dropped slightly according to the 1993 GDHS, which estimated that among children aged 0-36 months, 26% were stunted, 28% were underweight and 12% were wasted. The 1998 GDHS estimated prevalence of stunting, underweight and wasting to be 26%, 25%, and 10% respectively. And by 2003, underweight had dropped to 22% and wasting was down to 7%. However, stunting was shown to have increased from 26% to 29%.

Both the 1998 and 2003 GDHS estimated that rates of stunting were higher in the three northern regions (35-40% in 1998 and 32-49% in 2003) than in the rest of the country. The 2003 survey also found that in general, 34% of children in rural areas and 20% in urban areas had stunted growth. The children most at risk were those between the ages 6 and 26 months.

The 2003 GDHS found that 43% of infants 0-1 month were exclusively breastfed and this percentage dropped rapidly by age 4-6 months. Moreover, only 19% of mothers initiated breastfeeding within an hour of delivery, whilst up to 25% initiated breastfeeding more than 24 hours after birth. Additionally, 32% of mothers offered a variety of pre-lacteal feeds to their infants as early as within the few hours of birth. Some mothers reported discarding colostrum, believing that it was not good for the baby. In a survey in 1989, only 50% of mothers allowed their newborns to consume colostrum (MOH, Nutrition Division, 1989).

The 2003 GDHS estimated that 76% of pre-school children were anaemic (GDHS 2003); this prevalence rate is dramatically higher than the World Health Organisation's (WHO) cut off point of 10%. Anaemia was also found among 65% of pregnant women. And a survey conducted in the 1990's found that about 33% of the 27 districts in the country surveyed had serious iodine deficiency disorders (IDD); 54% had moderate levels of IDD; 13% were considered normal while the remaining districts had moderate to mild conditions. The most severe iodine deficiency was found in the Upper East and Upper West Regions, with 56.5% goitre prevalence (MOH/UG Survey 1994). Vitamin A deficiency is also widespread. A MOH survey conducted in 1997 indicated that Vitamin A affected 72% of the county's under five population and contributed to 1 out of 3 of all child deaths between the ages of 6 and 59 months (MOH, 1997).

A situation analysis in 1990 indicated that 32% of maternal deaths in Ghana were attributable to cardiovascular diseases. In 2005, diabetes prevalence was 13% and hypertension was 30% among Ghanaian adults (GHS 2005). A community based survey conducted in 2003 showed that the prevalence of hypertension in the Greater Accra Region was 26.3% among males and 28.4% among females (Amoah 2003). A second

² The information under this was largely extracted from GHS (2005) *Imagine Ghana Free of Malnutrition, A Concept Paper For Addressing Malnutrition in Ghana as a Development Problem Using Health as an Entry Point*.

survey conducted in 2004 in the Ashanti Region showed prevalence rates of 32.9% among males and 24.1% in females (Cappucio et al 2004). The 2003 GDHS revealed that prevalence of overweight among women aged 15 to 49 years in Ghana was 17% and ranged from 29% in the Greater Accra Region to 5% in the Upper West Region. The national figure for obesity was 8% and ranged from 17% in Greater Accra to 1% in each of the three Northern Regions.

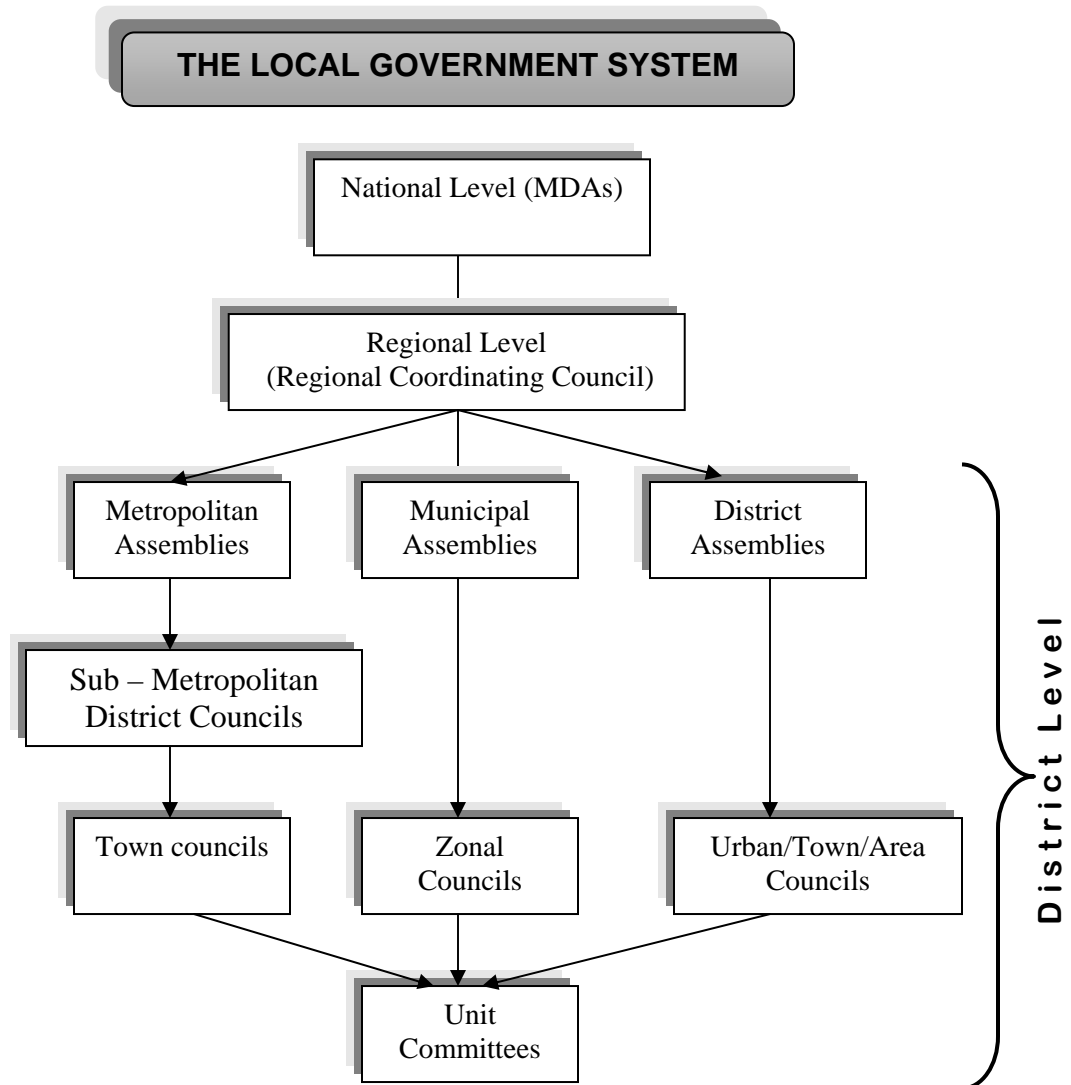
POLICY-MAKING AND BUDGETING RULES

Ghana is a constitutional democracy. It operates a multi-party democratic presidential system of government under which executive power is vested in a President elected every four years serving a maximum of two terms. There is a parliament elected every four years, an independent judiciary, and a vibrant media. Ghana gained its independence from British rule in 1957, and became a sovereign state in the British Commonwealth of Nations in 1960. It has experienced a cumulative period of 30 years of constitutional rule and 21 years of military rule. Ghana adopted a decentralised system of governance in 1988 known as the Local Government System. Under this system, the governance structure has three main levels: national, regional and district (Figure 1).

At the national level, policy direction is provided through line ministries and departments, each headed by a Minister nominated by the President and ratified by Parliament. The regional level structures perform coordination and monitoring roles at the district and regional levels in the implementation of policies through the Decentralised Departments and Agencies in the districts and regions under the direction of the Regional Coordinating Councils (RCCs). Each regional level government includes a Coordinating Council and is headed by a Regional Minister.

District level structures are charged with implementation via the decentralised departments and agencies of the Ministries, Departments and Agencies (MDAs) who work under the direction of the District Coordinating Directors and District Chief Executives. The Chief Executives are nominated by the President and ratified by the Metropolitan, Municipal and District Assemblies (MMDAs), (GOG: Local Government Act 462). Currently, there are 10 administrative regions that are divided into 170 MMDAs to facilitate effective and efficient administration at the local levels.

Figure 1: The Local Government System



Source: GOG: The New Local Government System in Ghana, 1988

Policy Planning and Budgeting Process

Policy, planning and budgeting processes have been decentralised, with each MMDA being responsible for the formulation and approval by the General Assembly of the MMDA, of its three-year Medium Term Development Plan (MTDP). The approved MTDP then forms the basis for annual planning and budgeting by the MMDA for allocation of funds from the Central Government (Ministry of Finance) through the District Assembly Common Fund (DACF).

The DACF is the means by which the Central Government allocates funds to the MMDAs for development activities, and it mainly covers capital investment, recurrent

costs related to the capital investments, monitoring and evaluation, as well as community self-help development initiatives. Capital investments funded include special projects for the vulnerable groups, health, education, agriculture, and water and sanitation infrastructure. Other sources of funds for implementing the MMDA MTDP include Internally Generated Funds (IGF) from revenue generated from fees, levies, taxes (ceded), services provided, and donor funding.

The National Development Planning Commission (NDPC), the government agency responsible for policy planning, monitoring and evaluation, provides guidelines for the MDAs for their annual plans and budgets based on the government policy framework and adapted to the priorities of each MDA. It also provides guidelines for the formulation of MTDPs as well as annual planning and budgeting by the MMDAs based on the policies adopted at the national level and adapted to the priorities of each MMDA. In addition, the NDPC ensures that the plans formulated conform to the guidelines provided, and performs monitoring and evaluation to inform performance in pursuance of national policies and strategies.

The decentralisation process is, however, still being consolidated and has therefore not enabled effective integration of sectoral plans into MMDA plans. Although by the law and within the decentralised administration framework, the decentralised departments and agencies, including education, health and agriculture are expected to integrate their decentralised sector plans into the MMDA plan at the district level for budgeting and funding, this is not happening. This means that policies devised at the national level, as it is case with nutrition, do not necessarily get translated into the budgeting and planning at the district level where actual implementation takes place. Therefore, prioritization of nutrition at the national level will not necessarily translate into the same level of priority at district level.

Relevant laws have been passed and systems and structures put in place to facilitate full administrative and fiscal decentralisation, but fiscal decentralisation is yet to be realised. Funds for implementing activities of the decentralised agencies are largely budgeted for and disbursement done at the national level to the decentralised departments and agencies. Consequently, the Ministry of Health in which the Nutrition Department is housed largely controls budgeting and disbursement to the districts, even if the districts in theory control planning and budgeting at this level. Thus, even though the centralized levels of government have difficulty incorporating sectoral plans into district level plans, they still control the budget and disbursement and presumably have the capacity to influence decisions of what programs are adopted in the end. .

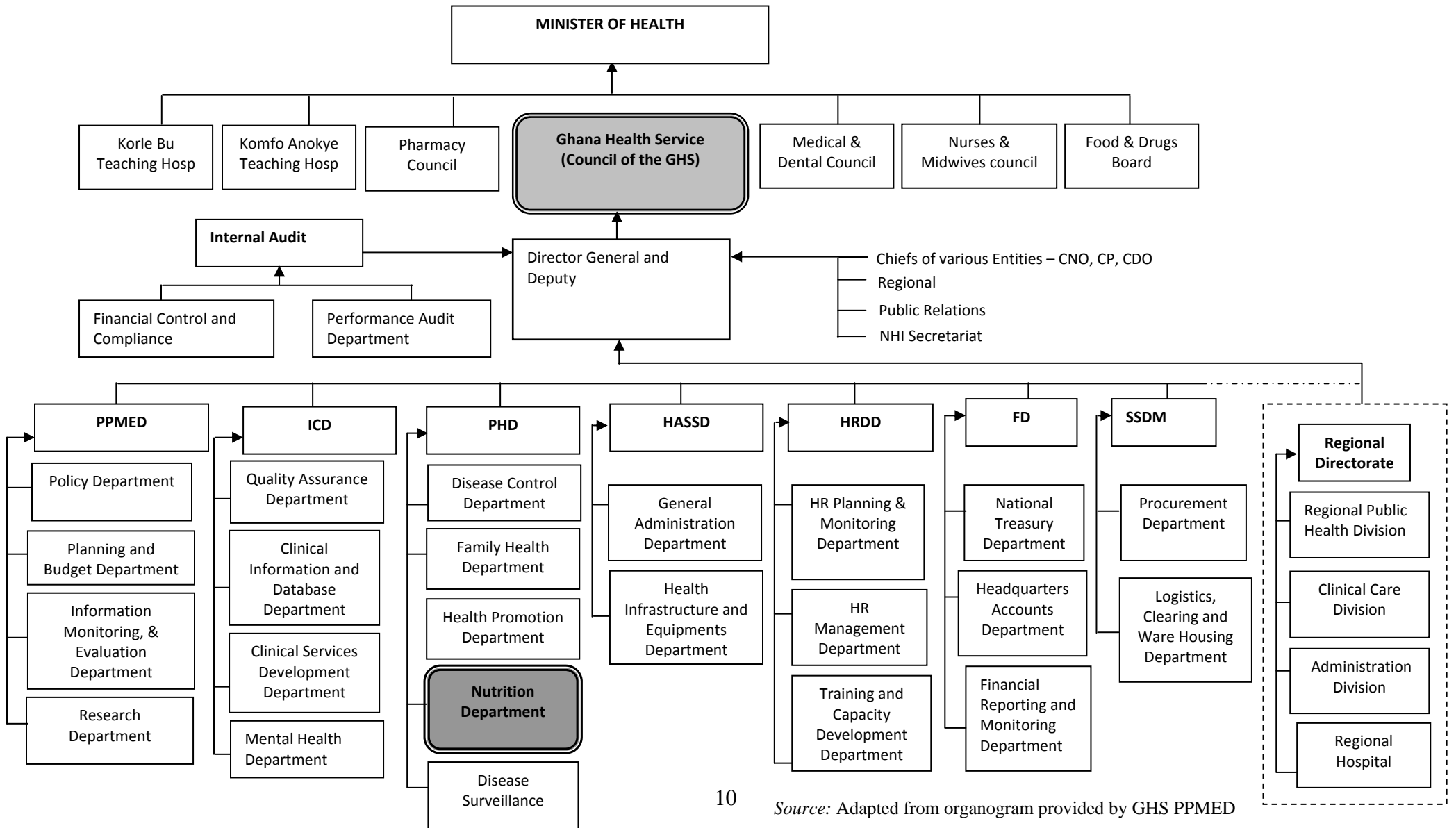
Figure 2 outlines the organisational structure of the MOH, which has seven main agencies: the Ghana Health Service (GHS), Korlebu Teaching Hospital, Komfo Anokye Teaching Hospital, Medical and Dental Council, Nurses and Midwife Council, Pharmacy Council and the Food and Drugs Board.

Other key sectors directly involved in addressing nutrition issues include the:

- **Women in Agriculture Development Directorate (WIADD)** of the Ministry of Food and Agriculture (MOFA) responsible for promoting food utilisation aspects of MOFA through education, sensitisation, awareness creation and advocacy;
- **Ghana Education Service (GES)** of the Ministry of Education Science and Sports responsible for school feeding and health education programmes among others;
- **Children’s Department** of the Ministry of Women and Children’s Affairs (MOWAC) responsible for child right promotion, child protection, and early childhood care and development (child health including nutrition through: education, sensitisation, awareness creation and advocacy; child welfare; registration; etc);
- **Department for Community Development** of the Ministry of Local Government, Rural Development and Environment (MLGRDE) charged with the promotion of rural development issues, including the welfare and development of vulnerable groups in the rural and urban areas with focus on women and children; and
- **Department of Social Welfare** of the Ministry of Manpower Development, Youth and Employment charged with promotion of the welfare of children, the youth and other vulnerable groups.

The policy, planning and budgeting systems and processes outlined above limit the extent to which MMDAs may exercise discretion in initiating nutrition policies and ensuring commitment to their implementation and sustainability, as they depend on the central level in terms of policy direction and financing. At the same time, the central levels do not have the authority or the capacity to monitor effective implementation of these policies, and therefore cannot ensure that national policies are actually implemented at the district level. In the end, MMDs usually implement programs for which funds are available from the central level, regardless of their own needs or priorities, but the central level cannot monitor effectively its implementation.

Figure 2: Ministry of Health - Organisational Structure



In formulating policies, including nutrition and other pro-poor policies, the government is guided by international conventions, commitments to international goals such as the Millennium Development Goals (MDGs) and the country's priorities in responding to its own development agenda. The policies adopted are used as a basis for formulating strategies that constitute the policy framework for the government's development agenda. The previous policy framework, Vision 2020 and Ghana Poverty Reduction Strategy (GPRS I), 2003-2005, were directed primarily towards attainment of the antipoverty objectives of the United Nation's MDGs. The current framework, the Growth and Poverty Reduction Strategy (GPRS II), 2006 – 2009, continues to pursue the MDGs while also aiming to accelerate economic growth, enabling Ghana to achieve middle-income status within a measurable planning period (GOG/NDPC 2005). The policy, planning and budgeting processes of the MMDAs and the MDAs are guided by these policy frameworks. However, planning and budgeting at the district level does not always take these recommendations into account. Consequently, these international commitments do not easily translate into policy implementation at the district level.

For the MOH, which is the main ministry expected by the state to address issues of malnutrition, and for which a specific department has been earmarked (Nutrition Department), budgetary provisions and expenditure for nutrition activities have mostly been linked to other health related issues, such as immunisation, deworming exercises and malaria control. This made it difficult to track budget and expenditure patterns in addressing issues of nutrition during the study.

It was impossible to compare budget and expenditure allocations in order to establish the extent of government commitment to responding to nutrition policies at the various levels of the decentralised governance system. At the national, regional and district levels of the GHS and other related MDAs such as agriculture and education, the budget and expenditure returns were always aggregated and captured under such broad issues as Expanded Programme of Immunisation (EPI), HIV/AIDS and malaria control. These issues are the priority focus and core of the services delivered by the MOH, which are largely clinical in nature, (as explained in detail in subsequent paragraphs and sections).

ROLE OF THE STATE IN NUTRITION

As noted earlier, the state plays a predominant role in responding to health related issues such as immunisation, malaria control and epidemics. It also plays a prominent role in addressing educational needs, responding to famine by providing support to farmers to increase production of certain crops and managing disaster. Unfortunately, the attention given to issues of nutrition has not been comparable. Although the government is seen as being largely responsible for initiating actions to address nutrition issues by putting in place appropriate policies, the view held by over 80% of the interviewees indicated that the government had not been proactive in putting in place policies and resources to combat malnutrition. The generally held view of the interviewees was that nutrition policies had largely been donor driven.

As noted by Heaver (2005), and Benson (2008) and confirmed by the majority of the interviewees, a number of factors account for the weak commitment by government and policy elites to nutrition. These include poor understanding of the prevalence, causes, welfare and economic costs of malnutrition; low political demand for action against malnutrition; as well as the multi-sectoral nature of nutrition and subsequent absence of immediate responsibility and location for action to improve nutrition.

Interviewees noted that owing to the hidden nature of nutrition deficiencies, which do not often manifest themselves physically and/ or result in death directly, the government and policy elites have since Independence responded to nutrition deficiencies only when they reach alarming proportions as a result of such factors as drought, famine, floods, ethnic conflicts, and/ or when the international community initiated actions to heighten awareness through international conferences, research and adoption of international conventions (Box 1).

Box 1: Perceptions of Malnutrition

Malnutrition is seen as an individual's problem rather than a state concern. It only becomes a concern when there are disasters such as floods, epidemics, droughts and food shortage, and children begin to die. The beneficiary families, especially the illiterate community do not see malnutrition as a problem. It is only when it comes to the point of death that the family tries to find solutions to it. Such families prefer to spend resources on funerals, expensive social activities such as festivals, marriage and christening ceremonies. The mothers experience the difficulties children go through when malnourished and therefore pay some attention to the child. In some rural communities malnutrition is linked to superstition. The child is perceived to be bewitched by an enemy when anaemic or has "korshiokor" (local name for malnutrition). The family therefore consults the "witch doctor" instead of seeking medical attention. – **Perspectives of interviewees at the national level**

At the community and assembly levels, the issue of nutrition is not addressed. The focus is on food security and not nutrition. People are not conscious of nutrition; they are concerned with eating to fill their stomachs. What they eat and what it brings is not looked at. The health, agriculture and education sectors also fail to stress on nutrition. They only focus on food intake. Nutrition is generally not a concern at the family, community, district, regional and national levels. People are not well educated about nutrition. – **Perspectives of interviewees at the district level**

Nutrition is not the focus of politicians. Awareness of politicians about nutrition is very low. Some talk about the School Feeding Programme, but they look at it more in terms of food intake and helping to improve school enrolment, attendance and retention. Awareness is also very low among beneficiaries. What is in vogue now is the elite who are concerned about what they eat, exercises, etc because of the increase in the number of people who are dying and or are suffering from non communicable diseases. - **Regional stakeholder perspective**

Most beneficiaries are not conscious of malnutrition. They know about it but because of poverty they turn a blind eye to nutrition. **Perspective of an interviewee at the district level**

The problem is that we are not giving attention to nutrition. There is a programme for malaria, tuberculosis, safe motherhood, etc, but no budgetary allocation for nutrition specifically. Most politicians pay lip service to the issue of nutrition **Perspective of a District Health Directorate,**

The issue of nutrition/malnutrition has been on the quiet. It has not been a specific agenda on the table for discussion and therefore it is important that it is given a voice in the policy making process. Nutrition/malnutrition is not considered an issue in most communities, especially in the remote communities because they have been used to it. Ignorance coupled with poverty has made them blind to nutrition. – **Perspectives of the Parliamentary Select Committee on Health**

In most cases nutrition deficiency interventions had been initiated by development partners such as the United States Agency for International Development (USAID), United Nations Children's Fund (UNICEF), World Food Programme (WFP), World Vision, Adventist Development Relief Agency (ADRA) and the World Bank through research and funding of actions in response to outcomes of research on Vitamin A, iodine and iron deficiencies, as well as exclusive breastfeeding, before the government takes them up. Funding of nutrition related interventions by the government has therefore been largely donor driven. The trajectory on nutrition policies (Part III) provides further insights on this.

Current discourse (since 2004) of the policy elites however points to some degree of focus and attention being paid to nutrition. The current minister of health is championing “regenerative health” as a way of responding to the high incidence of non-communicable diseases such as diabetes, high blood pressure, hypertension and other heart related diseases.³ According to over 60% of interviewees, however, such discourse seems to be promoted at the expense of undernutrition among children, pregnant and lactating mothers as they tend to dominate the discourse on nutrition at the institutional level and through the media on radio, television and in the newspapers. Strategies to address undernutrition have not been consolidated adequately, and therefore the prominence given to over-nutrition without a corresponding focus on undernutrition may make the latter an underdog in terms of policy priorities.

Much as some policy elites in Ghana may see reducing undernutrition as critical for sustained development, there is inadequate awareness and understanding about undernutrition amongst them. According to over 80% of the interviewees, most policy elites have very low understanding and appreciation about issues of nutrition. They are more concerned about food intake and not the content of the food. They acknowledged that high levels of poverty among much of the population and the increasing cost of living focus policy elites' attention on “what people can get to eat and not the nutritional value of what they eat.” Consequently, increasing agricultural production through improved technologies, improving access to credit to enhance income earning capacities of households, employment creation, increasing access to education and combating diseases such as malaria, polio, measles, HIV and AIDS tend to resonate with them. These are tangibles that the electorate can hold the government accountable for, and which politicians focus on during their political campaigns. Conversely, all the interviewees acknowledged that nutrition has never featured in the political campaigns of any of the political parties. Rather, the focus has been on the aforementioned.

Generally, the severely malnourished, who are usually emaciated or have severe oedema which can be seen by the naked eye, have been viewed as requiring attention by the policy elites and government in terms of support for addressing their nutritional needs. However, the focus has tended to be largely on disaster zones, very deprived and socio-economically vulnerable areas: areas frequently afflicted by famine, drought, floods and endemic poverty. These areas tend to be mostly in the three northern regions of Ghana:

³ The Regenerative Health approach focuses on healthy lifestyles including good eating habits, exercises, and regular medical checks to address issues of over-nutrition and non communicable diseases.

the Northern, Upper East and Upper West Regions where poverty and other social, economic and health indicators are usually far below the national average as indicated by the incidence of poverty in Table 1.

Table 1: Poverty Incidence by Region

Region	Poverty		Extreme Poverty	
	1998/99	2005/06	1998/99	2005/06
Western	27.3	18.4	13.6	7.9
Central	48.4	19.9	31.5	9.7
Greater Accra	15.2	11.8	2.4	6.2
Volta	37.7	31.4	20.4	15.2
Eastern	43.7	15.1	30.4	6.6
Ashanti	27.7	20.3	16.4	11.2
Brong Ahafo	35.8	29.5	18.8	14.9
Northern	69.2	52.3	57.4	38.7
Upper East	88.2	70.4	79.6	60.1
Upper West	83.9	87.9	68.3	79.0
All	39.5	28.5	26.8	18.2

Source: Ghana Statistical Service, Patterns and Trends in Poverty in Ghana, 1991-2006, April 2007, Tables A1.5 and A1.6 in GOG/NDPC, Implementation of the Growth and Poverty Reduction Strategy (2006-2009), 2006 Annual Progress Report, Table 2.4, March 2007, Accra.

Malnutrition rates in these three regions and other such areas are very high and therefore become visible and attract the attention of policy elites and government. Due to their high visibility, government and development partner interventions have focused largely on these vulnerable areas in the country. This explains the high intensity of nutrition related interventions by Catholic Relief Services (CRS), World Vision, WFP, ADRA and lately the World Bank in the three Northern Regions.

PART III – TRAJECTORY OF NUTRITION POLICIES

Nutrition policies that have been adopted and implemented in Ghana since Independence fall broadly into six periods:

- Food demonstration and nutrition education (1957 – 1966);
- Continuation of food demonstration and transition into identifying attitude and behaviour change (1966 – 1974);
- Weaning and supplementary foods/ Treating the malnourished (1974 – 1987);
- Addressing micronutrient requirements (1987 – 1990);
- Planning and mobilising for action: Addressing micronutrient deficiencies and exclusive breastfeeding (1990 – 2000); and
- Consolidation of strategies for addressing micronutrient deficiencies, exclusive breastfeeding and community-based growth monitoring (2000 – 2008).

Although each period has had its own distinct focus, they have also overlapped and have been cumulative in nature, as indicated in Figure 3. However, as new policies and programmes are brought on board, the intensity of policy issues and interventions pursued in the preceding period are reduced, with more emphasis placed on those policy issues and interventions introduced within the current period. These shifts in emphasis at each stage of the trajectory, largely influenced by the development partners, required that the MOH, GHS, Nutrition Department and other related agencies recalibrate to focus on the issues at the time in order to secure funding for pursuing intended actions.

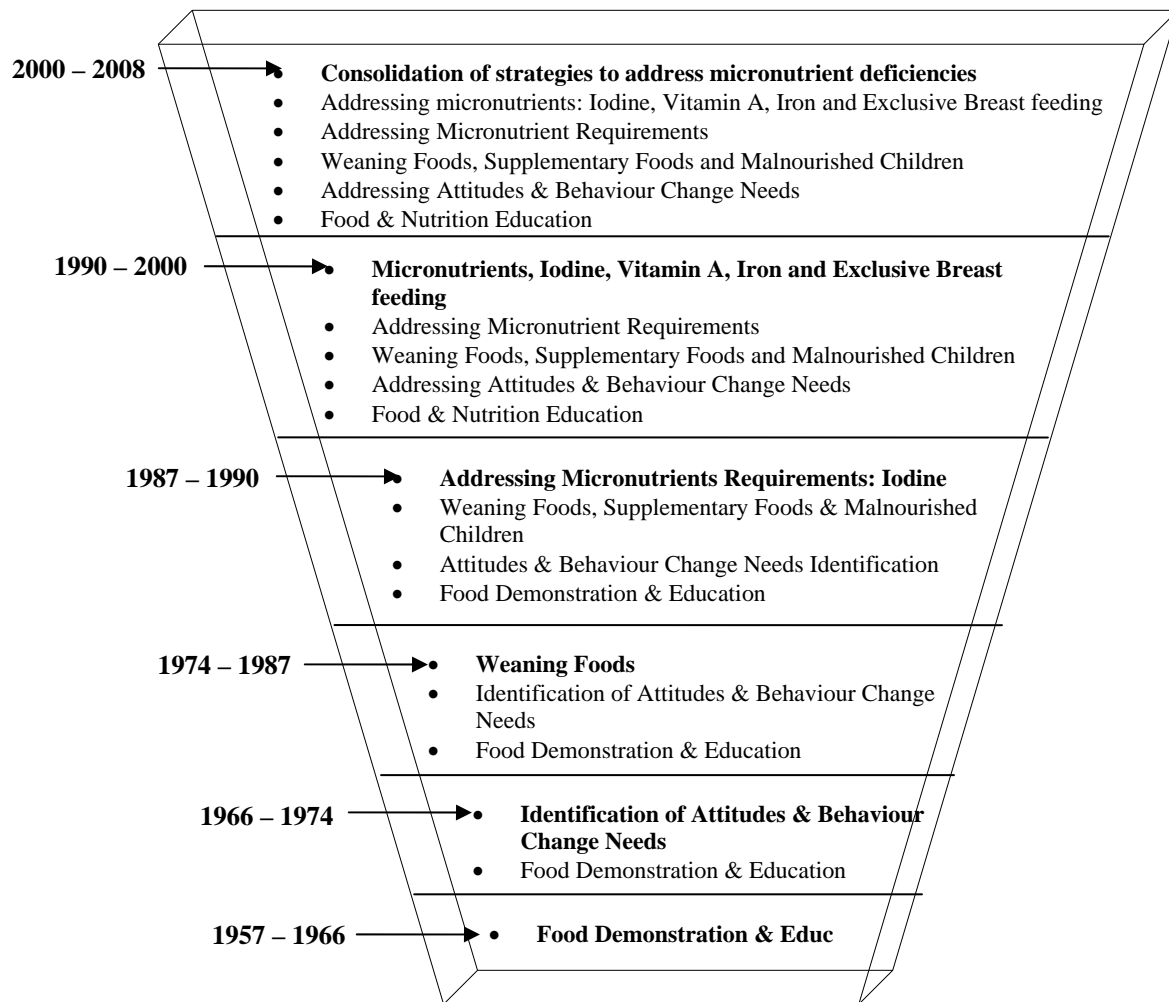
FOOD DEMONSTRATION ERA (1957 – 1966)

The first health policy in Ghana was formulated during the transitional period between colonial rule and Independence (1951 – 1957) as part of the Accelerated Development Policy formulated under the leadership of Dr. Kwame Nkrumah who was the leader of Government Business. After independence, Dr. Nkrumah, who also became the first President of the Republic of Ghana, set up the National Food and Nutrition Board in 1961.

Dr. Cicely-Williams, a Medical Officer in charge of the Princess Marie Louis Hospital in Accra had observed high levels of “Korshiokor” (local version of malnutrition) among children attending the hospital, prompting a National Nutrition Survey to be conducted to establish the causes of malnutrition among children. The survey findings revealed that inadequate attention to feeding the older child when the mother had a new baby resulted in malnutrition of the older children. A National Food and Nutrition Board was therefore established under the Office of the President to undertake nutrition education and food demonstration in communities and schools, as well as monitoring visits to canteens and local restaurants to ensure that food was prepared under hygienic and acceptable conditions⁴.

⁴ Perspectives shared by interviewees

Figure 3: Trajectory of Nutrition Policies in Ghana



Source: Author's own construct

The National Food and Nutrition Board was staffed with people, most of them with little or no knowledge about nutrition, and many of them relatives of politicians and/ or political activists. The Board was therefore seen more as an appendage of the government and was dissolved after the change in government through a military coup d' etat in 1966.

INTRODUCING ATTITUDE AND BEHAVIOUR CHANGE (1966 – 1974)

The activities, programmes and staff of the National Food and Nutrition Board were absorbed into the Ministry of Health in 1967 as the Nutrition Division⁵. Although some of the original staff were dismissed or left on their own accord out of fear of intimidation,

⁵ The Nutrition Division subsequently became the Nutrition Unit until recently (2007) when it became a department under the Public Health Division (See Figure 2).

the majority remained. The Nutrition Division continued to perform the same functions as were performed under the Board. Unfortunately, other units and agencies within the Ministries, Departments and Agencies (MDAs), including the Ministry of Health, performed similar functions and therefore saw the Nutrition Division as competing with them for activities and resources. These MDAs were also involved in food demonstration, promotion of hygiene, and food storage and preservation education. The competing departments and agencies who had been with the MOH longer than the Nutrition Division and who were more favoured by the leadership of the ministry therefore ensured that the new division did not have as much power in decision-making and resource allocation as they had. Consequently the division had little or no access to resources to undertake its activities.

During this period, very low priority was given to nutrition due largely to inadequate understanding of nutrition issues among most professionals. Nutrition was seen mainly as a food intake issue and not related to other factors such as addressing specific micro-nutrient deficiencies, or proper care and hygiene. Consequently, budgetary allocations to support nutrition activities were done after all other divisions in the MOH had been attended to.

At the same time, in 1966, the Department of Nutrition and Food Science was established at the University of Ghana, Legon. It started with only six students receiving training in food science and nutrition. These graduates were absorbed into other Divisions of the MOH as well as the Nutrition Division. The Nutrition Division therefore ended up with only a few qualified graduates from the university.

However, the few graduates that were introduced into the nutrition department and other related divisions of the MOH, and who were exposed to the technical content of nutrition began gradually to influence the nutrition policy agenda and its implementation. This led eventually to greater concern for attitude and behaviour change in relation to addressing nutritional deficiencies. The nutrition staff at field level, referred to as nutrition extension workers, started to focus their education activities on demonstrating ways to retain vitamins and other nutrients during cooking, as well as addressing hygiene, storage and preservation requirements. These extension workers began to focus on what was desirable in the home and the community and to address gaps in knowledge, skills and attitudes regarding nutrition.

WEANING AND SUPPLEMENTARY FOOD/TREATING THE MALNOURISHED (1974 – 1987)

The attitude and behaviour change interventions initiated during the previous era were consolidated during this period. They constituted key aspects of nutrition education and food demonstration at the household, community and school levels. At the same time weaning foods, which were the primary focus of nutrition interventions in this era, were introduced to address the nutrition needs of malnourished children.

In 1974, a national Food Conference was organized in Ghana under the leadership of Professor Sai, who was responsible for malnourished children in the MOH as part of the World Food Conference in 1974. This conference started a new thinking about nutrition, focusing on attitude and behaviour change, including food hygiene, appropriate modes of food preparation, utilisation and storage to retain the micronutrients. The 1974 World Summit organised in Italy and the Alma Matta Indocinti Declaration, on “Health for All by the Year 2000” declaration changed the focus of nutrition and reinforced the need for attitude and behaviour change. As a result, the MOH began focusing more on preventive measures for addressing nutritional deficiencies and establishing rehabilitation centres.

Ghanaian nutrition policy from 1979 to 1987 focused on preparation of weaning food for malnourished children. Much of the motivation for this focus was derived from UNICEF survey findings in the 1980s indicating that many children 6-9 months were not receiving appropriate complementary foods in addition to breast milk, thus putting them at risk of malnutrition. In response to these findings, a campaign was initiated to introduce weaning foods (typically a mixture of maize and legumes). Implementation was done by UNICEF in collaboration with the Department of Community Development of the Ministry of Local Government and Rural Development.

As part of the Programme of Action to Mitigate the Social Cost of Adjustment (PAMSCAD), a supplementary feeding programme was also put in place during this period. It involved the distribution of wheat, oil and non-fat powdered milk to children. This was the first time supplementary feeding was funded directly by government. Other supplementary feeding programmes were supported by the Catholic Relief Service (CRS) and USAID countrywide during this period.

Nutrition rehabilitation centres were also established in the three northern regions where the majority of the severely malnourished children were found, in order to provide them with food supplements and treatment.

Another important event took place in the mid 1970s. The Kintampo Rural Health Training School was established as an intensive three-year training programme for technical staff. Graduates received a certificate in nutrition and disease control. Establishment of the school was initiated by the head of the Nutrition Division, Professor Addy. The programme was targeted at staff of the MOH’s Nutrition Division, who were mainly post-secondary students, as part of upgrading the skills of the Division’s personnel.

This programme is still extant and currently offers two possible orientations: i) nutrition and disease control or ii) health information and medical assistance; each leading to the award of Diploma in Rural Health. Ironically, even though the training is supposed to increase the supply of trained nutritionists, interviews at the district, regional and national levels revealed that most of the graduates of the nutrition and disease control course preferred and prefer to work with the disease control division of the MOH. The reason for this is that the division of disease control has a larger government budget and other donor resources at its disposal.

ADDRESSING MICRONUTRIENT REQUIREMENTS (1987 – 1990)

From 1987 to 1990, the focus of nutrition was on addressing micronutrient requirements, primarily iodine deficiency through salt iodization. This followed an International Conference on “Ending Hidden Hunger” that sought to highlight the negative effects of iodine deficiency.

A survey commissioned by the International Research Development Centre, a Canadian group, and co-funded by CIDA, was conducted to assess the extent of iodine deficiency in Ghana. It was done in collaboration with the Nutrition Division and the University of Ghana’s Department of Nutrition and Food Science. The survey covered 30 districts in the three northern regions, and revealed that a third of the study population had iodine deficiency. These results led to the recognition of iodine deficiency as a public health challenge by the MOH and the adoption of strategies to address it. UNICEF and the WHO collaborated with the Nutrition Department to put in place a two-year programme to address iodine deficiency.⁶

The programme included distribution of iodine capsules to the most severely affected populations, as well as a salt iodization campaign. CIDA contributed about US\$2m based on a proposal developed by UNICEF for fund mobilisation. Currently, other MDAs including the Ghana Standards Board, Food and Drugs Board, GES, Ministry of Trade and Industries and President’s Special Initiative as well as Environmental Health Officers have been engaged to support the programme through monitoring salt production and sales.

Although the policy on iodized salt is now in place, implementation remains problematic, due primarily to a lack of effective regulation. As noted by interviewees at the MOH, GHS and Nutrition Department:

Countries such as Burkina Faso have strict laws and are able to enforce them by strictly checking inflows of salt into their countries, and sale of salt on their markets to ensure that they contain the right proportions of iodine. In Ghana however, there is laxity in the implementation of the policy due largely to weaknesses in the overall policy monitoring mechanisms in the country. As with all other government policies relating to distribution and sale of commodities, there are no checks on the market to enforce sale of iodized salt, and since the poor find the price of non-iodized salt cheaper compared to the iodized salt, they go in for the non-iodized salt. Moreover, border checks by the relevant authorities such as the Customs, Excise and Preventive Services on salt imported into Ghana are weak, leading to influx of non-iodized salt on the market.

⁶ Outcomes of interviews with staff of GHS, Nutrition Department and UNICEF

The MOH is currently collaborating with relevant MDAs and food vendors to produce foods fortified with iodized salt, in the hopes of reaching a greater portion of the population.

PLANNING AND MOBILISING FOR ACTION/EXCLUSIVE BREASTFEEDING (1990 – 2000)

The period 1990-2000 marked a **positive process of change** in the trajectory of nutrition policies in Ghana. In addition to the policy actions of previous periods, further policies on micronutrients were formulated, other important policy decisions were made and their implementation pursued.

However government commitment in relation to human and financial resource allocation, developing a central coordination mechanism, and monitoring and evaluation to ensure sustainability was missing. In addition, strategies for pursuing the policies remained largely donor driven in terms of funding and mobilisation of key actors. Opportunities were therefore missed in securing government commitment to budgetary allocation and consistent implementation of policies over time in order to institutionalise and sustain reduction of malnutrition. Comments made by most interviewees illustrate the inadequate government commitment to nutrition policy implementation and sustainability (Box 2).

Box 2: Government Commitment to Improving Nutrition

Government has so far paid lip service to the implementation of nutrition policies. What it has succeeded in doing is to put the policy in place, but not to back it with resources to see to their implementation and sustainability. – **Perspectives of interviewees**

Implementation of nutrition policies has largely been donor driven, with the donors funding research and pilot implementation of the policies. In some cases such as the case of addressing iodine deficiency and food supplementation, UNICEF, USAID, CIDA and other development partners were able to upscale support to cover the entire country, but government support in sustaining this by funding key interventions over time has been limited in scope. Most of the donors are getting fatigued and are beginning to focus on other issues, but one rarely sees concrete plans by the government to finance implementation of such policy in a sustainable manner at the central and local government levels- **Perspectives of interviewees at the national level.**

Despite this lack of political commitment, a number of international conferences organised during this period did heighten awareness of the government, policy elites and other actors in the nutrition policy arena about key nutrition issues and their impact on economic growth. These included the World Summit for Children (1990), the International Conference on Nutrition (ICN) in 1992, the International Conference on Population and Development (1994), the World Summit for Social Development (1995), and the World Food Summit (1996).⁷

⁷ GHS 2005

The ICN was perhaps particularly influential in its ability to galvanize multi-sectoral collaboration, and in its designation of the Nutrition Department as lead agency. The Minister of Agriculture was assigned responsibility for preparation and participation of Ghana in the ICN conference by the Food and Agriculture Organisation (FAO) and the World Health Organisation (WHO) who organised the conference. The Minister of Agriculture assigned a lead role to the Nutrition Department in the mobilisation of key sector agencies and departments in the preparation of position papers on the status of nutrition in Ghana and in the organisation of other activities geared towards successful participation in the conference.

The Nutrition Department gained importance for chairing the meetings and processes leading to the conference. The Minister ensured that Ghana's delegates selected for the conferences were multi-sectoral in nature, as it had become apparent that nutrition was a multi-sectoral issue. Ghana's delegates at the ICN therefore included an economic and development planner, as well as representatives of other sectors and a media representative from the state owned newspaper, the Daily Graphic, who reported on deliberations of the conference to heighten awareness among the general public.

During the ICN, a multi-sectoral central committee and thematic working groups were constituted to operate during and after the ICN. This committee was responsible for the overall planning and implementation of policy actions leading to and emanating from the conference. The thematic working groups were sub-groups composed of members of the multi-sectoral central committee with additional technical personnel drawn from relevant departments and agencies such as education, health, agriculture and research. Each group was tasked with addressing specific themes and issues identified during the conference.

Involvement of the different ministries and departments in the ICN and follow up activities through the multi-sectoral central committee and thematic working groups marked a **positive process of change** in nutrition policy formulation and implementation. It engaged wider MDAs participation and commitment of the Ministers to nutrition.

Following the ICN, a *National Plan of Action on Food and Nutrition (1995-2000)* was developed by the multi-sectoral central committee. The Minister of Agriculture tasked the committee, chaired by the Deputy Minister of Health, to formulate the plan in response to key issues identified by the conference and to operationalize government commitment to outcomes of the conference. The overall goal of the plan was to contribute to the national goal of sustainably improving quality of life for all Ghanaians via improved nutritional status. The goal was to be achieved through the following strategic objectives:

- Improved household food security;
- Adequate intake of food, micronutrients and other nutrients by individuals;
- Strengthened prevention measures against nutrition related diseases;
- Increased adoption of breastfeeding and appropriate weaning practices; and
- Improved national capacity to deliver food and nutrition education and services including capacity building and coordination of food and nutrition related issues.

Cost estimates for the plan's implementation were done and coordination and monitoring arrangements at the national, regional and district levels outlined. At the national level, coordination of policies was to be the responsibility of the NDPC Cross-Sectoral Planning Group (CSPG) that had been established by law to perform this function. The Regional Planning Coordinating Units (RPCUs) of the Regional Coordinating Councils were to play the role of the CSPG at the regional level, whilst District Planning Coordinating Units (DPCUs) of the MMDAs were to be responsible for coordination of the policy implementation at the district level. Monitoring indicators were set for all the objectives and the CSPG was to collect monitoring information and review them against national targets. At the regional level the RPCUs were to collect data from the districts as basis for evaluation, whilst at the district level the DPCUs were to do the monitoring based on district targets.

The plan was launched by the government who indicated the importance it attached to the plan in enabling Ghana to improve its nutritional status and quality of life of all Ghanaians. The launch was broadcast nationwide on television and radio stations and this gave it a high profile in terms of the government's recognition of the importance of the plan in facilitating implementation of strategies to address issues of nutrition. It also heightened awareness about nutrition among the policy elites who participated in the launching and who attended follow up seminars and workshops to explore ways to implement the plan effectively.

Development partners looked at the Action Plan and its relationship with the international agenda and provided support and direction in its implementation. However, owing to the centre-stage played by donors in pursuing nutrition interventions, the government got used to relying on the donors to fund related activities. Government commitment to implementation in terms of making financial resources available and coordinating its implementation thus remained inadequate. As had been with other nutrition interventions, implementations of key actions were largely donor driven with donors such as UNICEF, WFP and USAID supporting the Nutrition Department and other relevant agencies such as WIADD, the Department of Community Development and GES with financial and other resources to implement specific aspects of the plan that related to their mandates.

Although the cost of implementing the Nutrition Action Plan was estimated, it was not used for making funding available from Government of Ghana (GOG) sources directly. In addition interviewees indicated that the plan did not form the basis for the design and implementation of their organisational nutrition interventions as they were more interested in pursuing their individual institutional mandates. They followed their own agenda with no direct linkage to the Action Plan or the interventions of the Nutrition Department.

A key attribute of the plan was that it succeeded in providing a framework for putting together specific multi-sectoral committees to deliberate on strategies to address specific food security and nutrient deficiency issues. It served as a base for sourcing funding for the Nutrition Department from donor agencies such as UNICEF, USAID and WFP under their five year rolling plans. It also served as the base for the Nutrition Department's

annual planning and budgeting activities. In most cases activities of the Nutrition Department were selected and structured into the prevailing budget cycle of the government and development partners.

The multi-sectoral central committee and thematic groups also participated in the preparation of a national strategy and policy documents aimed at placing nutrition high on the government policy agenda. Such documents included the:

- Programme of Action to Mitigate the Social Cost of Adjustment (PAMSCAD) formulated by the government in collaboration with the International Monetary Fund (IMF) to address the negative impact of the Structural Adjustment Programme in the 1980's;
- Child Health Policy and Strategies formulated by the MOH and aimed at ensuring that the health and growth needs of children were adequately identified and addressed;
- Vision 2020 which was the GOG development policy framework before the advent of Poverty Reduction Strategy Papers;
- Ghana Poverty Reduction Strategy Papers;
- Medium Term Health Strategy (1997-2001) which comprised a comprehensive integrated Five-Year Programme of Work for the health sector outlining various aspect of child nutrition, infant and young child feeding and the prevention and control of growth and nutrition disorders; and
- Medium term and annual work plans of such agencies as the USAID, UNICEF, WHO and WFP, formulated to provide a base for annual work plans and budgets on health and nutrition interventions.

Also significant was the development of PROFILES during this period, funded by USAID and using data from the 1993 GHDS 1993. From 1996 to 1999, a consultant was engaged by UNICEF and PROFILE training was conducted for the Nutrition Department and related agencies. A comprehensive nutrition PROFILE for Ghana was developed during this period and used for presentations to policy makers by the MOH, GHS, the Director General of the GHS and the Nutrition Department. PROFILES data were also used to highlight the socio-economic impact of malnutrition at key meetings of government institutions and other public forums. Trends in stunting, wasting and underweight were presented in terms of their effects on social welfare and economic growth. These presentations heightened awareness about the impact of malnutrition on child growth and development, morbidity and mortality. Table 2 indicates the undernutrition trends from 1988 to 2003.

According to most interviewees the impact that PROFILES had on government, politicians and other policy elites has faded as a result of inadequate dissemination at national, regional and district levels.

Table 2: Undernutrition Rates Among Children Under 5 Years (1988-2003)

Year	Undernutrition rates		
	% Stunting	% Wasting	% Underweight
1988	30	8	30
1993	26	12	27
1998	26	9	25
2003	29	7	22

Source: Africa Nutrition Chart Books (2005), Ghana 2003: Nutrition of Young Children and Mothers in Ghana. Findings from the 2003 Demographic Health Survey (Page 63)

At the same time, worldwide concern for vitamin A deficiency led to the 1992 VAST study by the Navrongo Research Centre in the Kassena Nankana District (Upper East Region). The study revealed high levels of vitamin A deficiency among children, pregnant women and lactating mothers. After the survey, a vitamin A framework was developed by the Multi-Sectoral Central Committee. It had four components. The first focused on food supplementation, the second on conducting a survey in the south to establish whether vitamin A deficiency was a problem there as well, the third on using vitamin A for the management of measles and the fourth on food based approaches to increasing vitamin A intake. The Vitamin A supplementation project was supported by the GOG, Rotary International, UNICEF and USAID. Additional surveys and studies conducted during this period also focused on Vitamin a deficiency: A MOH survey conducted in 1997 indicated that Vitamin A affected 72% of the county's under five population and contributed to 1 out of 3 of all child deaths between the ages of 6 and 59 months. A Vitamin A Supplementation (VAS) trial done in 1993 also revealed that Vitamin A deficiency accounted for close to 12% of all clinic attendance of pre-school children and 38% of all hospital admissions. The 1997 MOH survey also revealed that lactating mothers were reported to have low breast milk retinol levels (GHS 2005:21).

The outcomes of these studies in terms of their effects on child malnutrition, morbidity and mortality were acknowledged by the MOH, leading government and donors to support addressing the problem. A policy on Vitamin A supplementation was adopted in 1996 to administer Vitamin A to children 6-59 months old biannually, once linked to Polio Immunisation and the other as a standalone supplementation campaign. The stand alone supplementation achieved very close to 100% coverage from 1996-2000 with the achievement level being sustained thereafter until 2005 when the level fell to 80%. Government support was secured in terms of leadership provided by the Minister of Health. Media publicity through radio and TV news, billboard advertisements in English and other local languages, as well as publications in the newspapers on topical issues relating to nutrition provided opportunities for operatives in the health sector to share perspectives on the supplementation campaign's administration. The campaign heightened awareness among mothers, health workers and other policy elites. Vitamin A supplementation is on-going.

Efforts to address anaemia started after a survey conducted in 1996 by UNICEF revealed high prevalence of iron deficiency among children and pregnant women. For preschool children the prevalence was 84%, school age children 71% and pregnant women 69%.

The USAID funded Micronutrient Operational Strategies and Technology (MOST) project was initiated to support anaemia control through UNICEF. MOST targeted children, pregnant women and lactating mothers. School age children received iron supplementation and de-worming treatments. Currently, the iron supplementation, which was introduced in conjunction to administration of new malaria drugs, has stopped for school-aged children due to public misconceptions regarding negative side effects of malaria drugs. However, awareness and sensitisation regarding de-worming is ongoing. Moreover, pre-school children continue to be given iron supplements.⁸ Iron supplementation appears to have resulted in a small reduction in prevalence. Per the 2003 GDHS, anaemia rates are 65% and 76% for pregnant women and preschool children, respectively. Iron has also been included in Ghana's current fortification programme.

A policy on exclusive breastfeeding was adopted after the ICN in 1992. This was preceded by a baseline survey conducted in 1988 by UNICEF, which revealed low levels of breastfeeding. A follow up study conducted by the Kintampo Health Research Unit in 1997 in collaboration with UNICEF and the Academy for Education Development (AED) indicated that early initiation of breastfeeding saved up to 4% and exclusive breastfeeding up to 16% of child mortality (GHS 2005).

The exclusive breastfeeding policy involves feeding children 0-6 months exclusively on breast milk and continuation of breastfeeding in conjunction with appropriate complementary foods between 6 and 24 months. Mothers are supported to breastfeed immediately after delivery and are encouraged through counselling sessions at growth monitoring centres regarding appropriate feeding practices. These growth monitoring centres are found in clinics, hospitals and communities all over the country as part of the Community Based Health Planning System (CHPS) put in place during this period to provide integrated health services at the doorsteps of rural communities.

At these centres children between the ages of 0-2 years are monitored on a monthly basis by weight and immunization. As mentioned above, mothers and caregivers are also counselled on appropriate care giving practices, including exclusive breastfeeding, supplementary feeding, hygiene and nutrition. Currently exclusive breastfeeding rates stand at 53%.⁹ The breastfeeding policy received wide media coverage through radio and TV announcements, discussions and advertisements. Currently, sensitization, education and awareness creation programmes are organized during annual National Immunisation Days (NIDs) and the annual Child Health Promotion Week at growth monitoring centres, clinics, hospitals and churches. Promotion of exclusive breastfeeding has also been successful due to the high level of funding from USAID, UNICEF, and other development partners. It also received support from community health nurses and the other health workers who counsel pregnant and lactating women as part of pre and post natal services.

Policy interventions during this period heightened awareness of nutrition among policy elites leading to nutrition courses being established at the University of Cape Coast and

⁸ Outcomes of interviews with GHS and Nutrition Department

⁹ GOG (2003) Demographic Health Survey

University of Development Studies. Linkages were also established between the Women in Agriculture Development Directorate (WIADD) of the MOFA, the Nutrition and Food Science Department of the University of Ghana, the Crop and Food Research Institutes of the Council for Scientific and Industrial Research (CSIR) and the GES to conduct research on effective ways of addressing micronutrient deficiencies. The following subsections describe the nutrition activities of each of these agencies.

Other government agencies involved in nutrition activities and training

Women in Agriculture Development Directorate

As part of the Directorate's nutrition activities, the WIADD of MOFA was involved in the development of "weanimix" food supplement and in teaching women how to prepare it across the country. WIADD extension workers collaborated with Community Health Nurses at district and community level to promote use of weanimix as a food supplement to mothers. Promotion occurred at growth monitoring centres and during home visits.

WIADD also participated in the formulation of the *National Plan of Action on Food and Nutrition* and the follow up concept paper *Imagine Ghana Free of Malnutrition*. It also collaborated with the Crop Research Institute (CRI) and Food Research Institute (FRI) in development of "Obaatampa" maize, a protein rich maize variety.

WIADD is currently promoting food safety in production, processing, preparation and consumption. According to informant interviews, WIADD's linkages with other collaborating institutions are currently weak due to the absence of a central coordination mechanism for nutrition. Budgetary allocations and disbursements for WIADD nutrition activities have been inadequate. However it has received funding from UNICEF to produce documents on small-scale food fortification for use by Agriculture Extension Agents (AEAs).

Department of Community Nutrition, University of Development Studies

The University of Development Studies has a Department of Community Nutrition in the Faculty of Agriculture. It was established in 1996 as part of University efforts to address the high levels of malnutrition persisting in the northern regions. The Department of Community Nutrition started with 30 students and currently turns out 100 students per year on average. It runs a BSc course in community nutrition with modules on clinical nutrition and agriculture extension. According to the University, the MOH finds it difficult to place the graduates from the programme in the health system. They intimated that the set up of the MOH does not promote positions for nutrition graduates. Therefore most nutritionists in the MOH work in the offices and not in the field. In most cases it is the NGOs, private hospitals and operatives in the industrial sector that employ them. Consequently, most graduates from the Community Nutrition Department are unable to secure jobs after graduation.

In 1998, a Food and Nutrition Security Unit was established in the Faculty of Agriculture as an inter-departmental service unit to support delivery of the “Nutrition for Health and Development” module run by the faculty. This module is a one month training programme for middle level civil servants from different ministries and departments. Students are from the health, agriculture and environmental science sectors. The main issues addressed include research in adolescent nutrition, and food and nutrition security in the northern regions. The Unit works with UNICEF, WFP and other development partners. The Netherlands Embassy and the Nutrition Department were instrumental in setting up the Unit. It is mainly an outreach programme. It does not get funding from the University but develops its own proposals to solicit funding for implementing its activities. It championed Behaviour Change Communication (BCC) for promoting the orange fresh sweet potato rich in vitamin A in 2004. About 25 people are trained every year. This has led to the formation of a Food and Nutrition Security Network made up of past students of the Unit. The network aims at using former students to review and refine the modules run by the Unit. It was mainstreamed into the training activities of the Unit and was used as a tool for establishing continuous relevance of the training activities of the Unit. The network has been dormant for the past three years and linkage and corroboration with the Nutrition Department is weak due to inadequate commitment of the executive members and lack of sponsorship for its activities.

Crop Research Institute and Food Research Institute

The CRI and FRI involved in the development of the high protein maize, “Obaatanpa”. This variety was developed in response to research that indicated low levels of protein intake. It aimed at addressing human protein needs as well as to improve animal protein levels. Maize is a major staple food in Africa, and Ghana in particular, and therefore developing Obaatanpa helps in addressing malnutrition. In addition, the FRI has been involved in the following:

- A small scale salt iodization project funded by UNICEF;
- A study on Household Food Availability and Food Consumption Behaviour in Ghana, started in 1998 and completed in 2000;
- Studies to assess the impact of peanut consumption on energy, appetite and cardiovascular defects (2002-2004) funded by USAID;
- Assessment of the nutritional and health status of children in Gomoa, Ejisu and Bawku East (2002-2004) under the World Bank funded Root and Tuber Improvement Project;
- Research on the potential of banana and plantain to contribute to improved human nutrition conducted in 2006;
- Support to WFP fortification activities in the Upper West Region.

Unfortunately, collaboration between the two research institutions (CRI and FRI) and the other MDAs has not been strong. There is no standing arrangement with the Nutrition Department, GHS, MOH and MOFA. Collaboration has been on a case by case basis and ad-hoc in nature. It is based on specific issues and once they are addressed no follow up is done to monitor, evaluate and capture lessons to inform collaboration. In addition, it is

the perception of most of the interviewees that Ghana lacks a well defined research agenda for nutrition. As mentioned above, most research activities are fragmented and donor-driven, having been initiated on an ad-hoc basis with no sustained funding and coordination to achieve synergy.

Department of Vocational and Technical Education, University of Cape Coast

The Department of Vocational and Technical Education within the Faculty of Education, University of Cape Coast offers modules on food and nutrition, nutrition and health, food micro biology, storage and preservation of food, and experimental study of food. However, the department has no linkage with the nutrition department of the MOH or MOFA in the design of its modules to ensure that key issues of concern in the nutrition policy arena are integrated into the course modules. The programme is organised on a purely academic basis.

Ghana Education Service

The GES includes nutrition in its curriculum at the Basic and Junior High School levels. It focuses on healthy eating under the School Health Programme (SHEP) and covers hygiene, safe and healthy lifestyles. In addition, it is the implementing agency for the Ghana School Feeding Programme. The School Feeding Programme was piloted by the government in 10 schools, one per district of the ten regions of Ghana from September to December 2005. The programme was rolled out in 2006 and as of 2008 was benefiting all deprived schools in each district in Ghana. The GES is also collaborating with the WFP, the Catholic Relief Service and World Vision in providing supplementary feeding interventions in the three Northern Regions.

CONSOLIDATING STRATEGIES FOR MICRONUTRIENTS, BREASTFEEDING, AND COMMUNITY BASED GROWTH MONITORING (2001 – 2008)

This era marks **another positive process of change** in the trajectory of nutrition policies in Ghana. Policy interventions pursued in the preceding era have been continued during this period. Additionally, a number of policies have been initiated to sustain and increase gains made previously in reduction of micronutrient deficiencies, exclusive breastfeeding, supplementary feeding, and community based growth monitoring. However, government commitment to implementation continues to be inadequate in terms of funding, coordination and sustainability. This is well acknowledged by the former Director General of GHS in his foreword to the *Imagine Ghana Free of Malnutrition* Concept Paper. He states:

It is gratifying to note the frantic efforts being made to address the nutritional problems in the country at the household and community levels by government, our development partners and nongovernmental organisations. However, the lack of synergy and conscious efforts to coordinate all these efforts is clearly one of the major constraints towards

adequately addressing the nutritional challenges in the country and indeed meeting the MDGs and effective integrated approach to these causes (GHS 2005:6).

That said, some level of political commitment has been secured in terms of policy backing. Key elements of the GPRS include targets for reducing malnutrition, food insecurity and other nutrition-related barriers to good health. Legislative instruments such as LI 1667 on marketing of Breast Milk Substitutes and Act 525 on Salt Iodization are promoting good nutritional practices. A national school feeding programme is being pursued by the GOG in collaboration with development partners and NGOs. And “Youth in Agriculture” initiatives are increasing involvement of young people in crucial food production activities (GHS 2005: 15).

An ECOWAS Nutrition Forum was organised in September 2001 in Ghana. It was the eighth in the series of such forum. The Minister of Health and the Director General of the GHS were deeply involved, leading to integration of strategies to address nutrition policy interventions under the New Partnership for Africa’s Development (NEPAD) agenda in 2004.

During this period, the Director General of GHS, Professor Akosa, facilitated the formulation of strategies and a concept paper, *Imagine Ghana Free of Malnutrition*, for addressing malnutrition in Ghana as a development problem, using health as an entry point. The concept paper aims at exploring the role of the health sector and specifically the GHS at rallying together all relevant MDAs, the development partners, NGOs and the private sector to address the unacceptably high levels of malnutrition in the Ghanaian population (GHS 2005: 6). It is a follow up to the *National Plan of Action on Food and Nutrition (1995-2000)* aimed at guiding implementation of nutrition interventions by the MOH, Nutrition Department, other related MDAs and development partners.

However, the minister was changed and the Director General went on retirement, leading to inadequate implementation of the concept paper. All interviewees acknowledged that although the document provides a framework for guiding policy actions on nutrition, not much had been done to implement the plan. The strategies remain largely on paper and responsibility for pursuing implementation of key actions remains unclear. Owing to its inter-sectoral nature it has become difficult for the Nutrition Department to secure the necessary financial backing and administrative authority to mobilise other divisions and departments in the GHS and related sectors for action. As was noted by one of the interviewees “[The] Nutrition Department alone cannot solve malnutrition problems. The issues involved are multi-sectoral and should therefore be integrated into the activities and programmes of other sectors such as agriculture, education, research and governance in order to address them effectively.”

Strategies are however being adopted to implement those policies which fall under the purview of the Nutrition Department and the GHS. Currently, all clinics include services for growth monitoring, counselling mothers on exclusive breastfeeding and complementary feeding, immunisation and administration of vitamin A.

Regarding the latter, the GHS has adopted a policy to administer vitamin A routinely during growth monitoring of children. Since 1997, the majority of vitamin A capsules used in supplementation have been provided by CIDA through UNICEF. Rotary International has also supported provision of vitamin A. Vitamin A is now included in the essential drug list (i.e. drugs that government considers essential and are provided as a matter of urgency). Vitamin A is also administered for the treatment of measles. The MOH has therefore made budgetary provision for its procurement and administration as part of the NHIS and care of the aged and children.¹⁰

However, most children do not go for routine monitoring after two years, and therefore its administration for children 2-5 years has been difficult. Coverage for this age group has reduced from close to 100% at inception in 1996 to 80% in 2006 to about 60% in 2007.

Maintaining routine monitoring after two years is difficult for a number of reasons. First and foremost, caregivers find visiting the clinic time consuming and at odds with income-generating activities. Second, most caregivers are of the view that the critical period to attend growth monitoring sessions is 0-2 years, when growth needs to be monitored closely and infants and toddlers are immunised. Once children are past this age, many caregivers see no reason for continuous attendance at growth monitoring sessions. By age two, many children are taken clinics for specific health problems only. According to interviewees at the Nutrition Department and the GHS, funding vitamin A supplementation as a standalone intervention for children 2-5 years had been expensive and therefore since 2005 it had been administered only during celebration of the Child Health Promotion Week organised annually to promote the growth and health needs of children.

To facilitate malaria control, pregnant women are given prophylaxes using the Direct Observation Treatment (DOT) approach. Since malaria control is a key intervention on the GHS', the GOG's and development partners' agendas, all the micronutrients have been integrated into malaria treatment. The programme is backed by a communication strategy, using information dissemination materials that have been developed specifically to heighten awareness about it. Community Change Agents (dressmakers, hairdressers, etc) have been identified and trained to disseminate information on issues related to anaemia, iodine and vitamin A deficiencies.

Rehabilitation of moderate to severe Protein Energy Malnutrition (PEM) in children's wards takes place in hospitals/health centres as well as 45 Nutrition Rehabilitation Centres nationwide (GHS 2005). Management of nutrition rehabilitation centres was left largely in the hands of the regions until the last five years when the GHS at the national level started providing oversight in their administration. A manager has been appointed at the national level to manage the rehabilitation centres and coordinate their activities. Guidelines have also been introduced to guide their operations.

¹⁰ Outcomes of interviews with MOH, GHS and Nutrition Department

In the early stages of the establishment of rehabilitation centres in the 1980s, government funded activities of the centres in collaboration with development partners such as CRS, ADRA and World Vision. However, currently there are no earmarked budgets for the rehabilitation centres. All the four MMDAs visited during the study expressed disquiet about the absence of designated funds for the operations of rehabilitation centres. The Cape Coast Metropolitan Health Directorate indicated that it received on average GH¢100 and the Bongo District GH¢250 per month for addressing requirements of the centres that house four and 10 children respectively on residential basis, in addition to others that come from within and around the districts on referral for treatment. The KEEA district health directorate supports its newly established rehabilitation centre (since August 2007) with its own resources, whilst the Bolgatanga rehabilitation centre gets nothing for its operations. The CRS, World Vision and ADRA are supporting most of the facilities across the country with dried milk, wheat, soya and oil. The study revealed that in some rehabilitation centres across the country, mothers are sometimes made to contribute to buying vegetables, charcoal and other inputs to support provision of meals.

During this period, the 2003 GDHS was conducted and revealed stagnation in indicators on stunting, wasting and underweight. The stagnation in the indicators led to a revolution on how nutrition interventions were being provided. The development partners, through the Multi-Donor Budget Support Group (MDBS), the main mechanism for coordinating donor support in Ghana, and the health sector group of the MDBS in particular, were apprehensive of the impact of their support to the health sector. They expressed disquiet about the stagnation in undernutrition rates among children under five (Table 2) and other related health indicators such as child mortality rates (Table 3) at key meetings such as the MDBS review meetings, Annual Health Summits and other key strategic forums, prompting the government and the MOH in particular to adopt strategies to respond to the situation.¹¹

Table 3: Trends in Early Childhood Mortality Rates (Infant and under-five mortality, Ghana 1983-2003)

Survey Year	Approximate Calendar Period	Infant Mortality	Under-five Mortality
1988	1983-1987	77	155
1993	1989-1993	66	119
1998	1994-1988	57	108
2003	1999-2003	64	111

Source: Ghana Statistical Service (GSS) Noguchi Memorial Institute for Medical Research (NMIMR), and ORC Macro. 2004. Ghana Demographic and Health Survey 2003. Calverton, Maryland: GSS, NMIMR, and ORC Macro. Page 128

A micronutrient group made up of representatives from the Nutrition Department, GHS, and other related sectors was therefore established by and located in the MOH to identify factors accounting for the stagnation. The Global Strategy for Infant and Young Child

¹¹ Outcomes of interviews with development partners and the MDBS Health Sector Group

Feeding also became a concern of the group. The stagnation in the indicators was traced to sub-optimal breastfeeding, sub-normal quantity and quality of food, low levels of food safety, lack of potable water and good sanitation, and repeated infection

Based on identification of good feeding and care practices as essential inputs for improved nutrition, the focus was turned to FADUR (**F**requency of Feeding, **A**mount fed to the child, **D**ensity in terms of micronutrient content, **U**tutilisation in terms of how the body utilises the food eaten, and **R**esponsive Feeding in relation to feeding actively and supervising the child during feeding). This formed the basis for revisiting the policy on Essential Nutrition Action which started around 2000 under the USAID funded LINKAGES project that focused on seven aspects of nutrition namely: Breastfeeding, Complementary feeding, Feeding the sick child, Women's nutrition, Control of Vitamin A deficiency, Control of iron deficiency and Control of iodine deficiency. All the elements of Essential Nutrition Action are incorporated in the 5 Year Programme of Work (2007-2011) of the MOH under Strategic Objective 2 that seeks to scale up high impact health, reproduction and nutrition interventions and services targeting the poor, disadvantaged and vulnerable throughout the country (MOH 2008:12)

The MOH also adopted the High-Impact Rapid-Delivery (HIRD) approach in 2006, aimed at responding to MDGs 4 and 5. The HIRD approach aims to attain universal (at least 90%) coverage for those interventions which have been proven to reduce maternal and child mortality. The initiative became necessary following the realisation that at the current pace of maternal and child mortality reduction Ghana will not achieve MDG 4 (reducing the 1990 under-five mortality rate of 132 per 1000 live births to 42 per 1000 live births) and MDG 5 (reducing maternal mortality from 214 per 100,000 live births to 54 per 100,000 live births) by 2015. It noted that there was an urgent need to do things differently in order to move coverage levels of key interventions higher. Ten simple steps are outlined in the HIRD to guide regions and districts to state their vision for Maternal and Child Health (MCH), assess the situation regarding the availability and utilisation of key MCH interventions that will lead to the realization of the vision, identify bottlenecks hampering the achievement of universal coverage, and formulate strategies and develop plans for overcoming those bottlenecks.¹²

The Essential Nutrition Action and community based growth promotion strategies are being used to facilitate achievement of the objectives of HIRD at the district and regional levels and are perceived to be effective in addressing the health needs of children, pregnant women and lactating mothers at those levels by the district and regional health directorates.¹³ The focus is on BCC for nutrition. Apart from community based growth promotion efforts, which occur only in certain pockets of the country, a more comprehensive, nationwide mother-to-mother support group system is being promoted. This system involves mothers trained to give peer support using counselling cards and to do promote breastfeeding as well as malaria detection and treatment, sanitation and hygiene.

¹² MOH (2006) Partnership for achieving MDG 4 and 5 using the High-Impact Rapid-Delivery approach: Implementation Guidelines for Regions and Districts

¹³ Outcomes of interviews with district and regional level stakeholders

During this period, the MOH has formulated a Five Year Programme of Work (5YPOW), 2007-2011, under which nutrition is being addressed. The Plan uses the Imagine Ghana Free of Malnutrition concept paper, which while still not being pursued actively, provides ideas regarding delivery platforms for addressing malnutrition. The 5YPOW has four main strategic objectives:

- i. To promote individual lifestyle and behaviour models for improving health and vitality;
- ii. To scale up high impact health, reproductive and nutrition interventions and services, targeting the poor, disadvantaged and vulnerable groups;
- iii. To strengthen health system capacity to expand, manage and sustain high coverage of services; and
- iv. To improve governance and sustainable financing

Nutrition is captured in the first two strategic objectives. Under (i), the strategy prioritises development and piloting of regenerative health and nutrition programme, safe food and water, and prevention of non communicable diseases. Under (ii), the priority is to scale up HIRD to all regions, targeting malaria and expanding Integrated Management of Childhood Illnesses (IMCI), as well as reducing malnutrition using supplementary feeding and the Essential Nutrition Actions as key interventions.

A large number of organisations have responsibilities in the 5YPOW and this poses significant coordination challenges (MOH 2008: 36). The organisations include MOH headquarters, the GHS and Teaching Hospitals Service, regulatory bodies, budget centres, the National Health Insurance Council, and for-profit health providers. Other actors include development partners and related government sectors (NDPC, Cabinet Secretariat, Ministry of Public Sector Reform, Public Service Commission, Office of the Head of Civil Service, Ministry of Trade and Industry, MOESS, MLGRDE, MOWAC, the National Population Council and the Ghana AIDS Commission).

An agreed annual programme of work will guide implementation of the 5YPOW. Agreement will be formalised in service agreements, contracts and commissions between, at the first level, the Minister and Chief Executives of GHS, Teaching Hospitals Service, NHIS, other MOH agencies and the Christian Health Association of Ghana (CHAG). Budgets will be allocated on the basis of the agreements. The Policy Planning, Monitoring and Evaluation Directorate (PPMED), MOH, will be responsible for undertaking performance assessment at the first level and making recommendations to the Minister. It will do this based on the information generated by the health information system, continuous oversight and tracking of implementation by the MOH in collaboration with other MOH agencies and other MDAs to ensure that impacts, activities, targets and other required actions proceed according to plan. The information for the M&E system will help the MOH and other relevant stakeholders to identify potential risks, and take timely actions and decisions on programmes and interventions.

In addition to pursuing further implementation of policies on micronutrients, exclusive breastfeeding and complementary feeding, a number of interventions have been pursued by the development partners in collaboration with the Nutrition Department, the GHS and the Health Directorates of the MMDAs. Among the interventions are the World Bank funded Community Based Nutrition and Food Security Project (CBNFSP); UNICEF and ADRA funded Community Growth Promotion; and the recently initiated programme of the World Bank: Nutrition and Malaria Control for Child Survival Project. Also pursued are the School Feeding Programme of the WFP and the Government of Ghana, Supplementary Feeding by the CRS, ADRA and World Vision in various parts of the country. In addition, other supplementary feeding interventions are being provided by the USAID, the WFP and UNICEF. These interventions are discussed in the sub-sections below.

World Bank funded Community Based Nutrition and Food Security Project (2002-2005)

The World Bank supported initiation of the CBNFSP in 2002. The project aimed at testing appropriate models and implementation mechanisms for providing assistance to communities and District Assemblies (DAs) in four districts, one each in the Central, Upper East, Volta and Western Regions, to enable them to identify and take action against local causes of malnutrition, and to improve food security for target communities in the four districts. The project was estimated at US\$2,020,900. It used growth promotion as the entry point into the communities. Guidelines, protocols and aids for community growth monitoring were developed and volunteers were selected by the communities and trained by the Nutrition Department as Community Growth Promoters to undertake growth monitoring activities in the communities.

Logistics requirements were identified and procured and growth monitoring was conducted monthly for children 0-2 years and quarterly for children 2-5 years, beginning in January 2003. A total of 7,081 children 0-2 years and 3,747 children 2-5 years as well as 4,547 women of reproductive age had been reached in the four districts as of December 2005. At that point, the percentage of children 0-24 months attending monthly growth monitoring sessions ranged from 68 – almost 100%. Exclusive breast feeding had increased from baseline rates as low as 22.4% to as high as 82.3%. And the percentage of children with low weight for age had reduced from the worst baseline rate of 23.8% to a mean rate of 12.5% (Ghartey Associates 2005). Caregivers, community members and the health personnel all expressed high levels of appreciation regarding the benefits of the growth monitoring sessions (Box 3).¹⁴

Health staff reported increased environmental hygiene practices by caregivers and households during home visits, which together with better nutrition and reduction in the occurrence of childhood diseases led to appreciable weight gain among most children. All children that participated in the growth monitoring sessions were fully immunized at the prescribed ages.

¹⁴ Quotation taken directly from Ghartey Associates (December 2005) Community Based Nutrition and Food Security Programme (CBNFSP) Process Monitoring Organisation Comprehensive Terminal Report, Accra, December 2005, Pages 16-19

During the study a conscious effort was made to visit two of the rural beneficiary districts to enable comparison between their nutrition policy formulation and implementation processes and those of the district capitals of the two regions. It was noted that in the two rural districts interventions provided under the project had heightened awareness about nutrition in the participating districts, leading to the District Assemblies collaborating with the District Health Management Teams to sustain the interventions by integrating nutrition in their three year Medium Term Development Plans (MTDPs), 2006-2009. Out of these MTDPs, annual plans are formulated to secure funding from the MMDAs to implement the stipulated nutrition interventions. A visit to a few of the communities that benefited from the interventions also indicated that the beneficiary communities were still practicing the community growth monitoring of children.

It was noted that apart from Bolgatanga Municipal Assembly in the Upper East region (which had integrated nutrition in its MTDP under the human development component), the Cape Metropolitan Assembly had failed to address nutrition in its plan. All the interviewees at the regional and district levels indicated that although provision had been made under the plans to address nutrition issues, inadequate financial resources had led to inadequate implementation of the nutrition interventions. In all cases funding of nutrition activities by the MMDAs had been limited to support provided in the organisation of NIDs, which include vitamin A administration. In addition, the MMDAs of the two districts in the Upper East Region had been financing haulage of food supplements supplied by CRS and WFP.

Box 3: Benefits of Growth Monitoring

The project has made valuable contributions to improve the health of children in the communities. We are particularly happy with the free growth monitoring services in the community. Parents can now save money, time and energy to give health care to the children. We used to walk long distances to access growth monitoring and immunization services, but now the services are at our doorsteps and we have no excuse for not taking advantage of it. There is the joy of having our own promoters who understand our language, culture and circumstances to provide such services. We are also proud to see our own community members do such professional work. Our women and children get maximum attention when they attend the growth monitoring sessions. – **Perspectives shared by community members during community meetings and durbars.**

Mothers' understanding is improving and attendance at weighing sessions is encouraging. Mothers no longer walk 5 km to Ahamasu for weighing. Parents, especially mothers, save time, money and energy to give weighing services to the children. Children are now growing well. – **Perspectives shared by Yaadzo Community Growth Promoters and Community Implementation Committees in the Kadjebi District during Process Monitoring Organisation (PMO) Quarterly Monitoring Visits**

Mothers now understand the essence of exclusive breastfeeding. Children no longer cry in the night as they are well fed. We are also saving a lot because we do not have to buy the powdered milk for children during the first six months. They are very expensive and most of us do not have the means to buy them. – **Perspectives shared by caregivers during PMO monitoring visits.**

The health and weight of the children have improved. Mothers do not have to waste time and

money to send the children to the hospital or buy drugs. The children sleep well and play a lot. The children therefore do not disturb them and they are able to attend to their household and other economic activities. - **Perspectives shared by Growth Promoters and Health Staff**

USAID Supplementary Feeding Programme

USAID has been supporting the MOH and UNICEF in implementing the supplementary feeding policy/programme from 1974 to date countrywide. It is also helping the Nutrition Department to address severe malnutrition cases through provision of ready-to-use therapeutic foods in collaboration with UNICEF; this initiative is referred to as the Plumpy'Nut Project: children with severe malnutrition are given Plumpy'Nut, which is a ready-to-use therapeutic food high in both macro and micronutrients. Children with complications are also given Plumpy'Nut in addition to treatment. About 60 health professionals and technicians have been trained in the administration of Plumpy'Nut. The project is being piloted in the Upper West Region by UNICEF via CRS and is also targeted at northern districts that were affected by the floods in 2007. USAID has also initiated a Plumpy'Nut project in March 2008, in the Southern Greater Accra Region at Asiedu Keteke and in Agona Swedru in the Agona District in the Central Region.

Although Plumpy'Nut is being piloted in a few districts in the Central, Greater Accra, Northern, Upper East and Upper West Regions, the ultimate intention of USAID is to (1) support the GOG in rolling out distribution to the remaining parts of the country and (2) ensure transfer of knowledge and build local capacity for domestic production of an RUTF product similar to Plumpy'Nut. Two firms have been screened and their capacities and competencies for local production certified. Contractual arrangements are nearing completion to enable the firms to start production. However additional financial support is needed to complement the USAID efforts. USAID is therefore in discussions with other donors to support the venture.¹⁵

Catholic Relief Service

CRS runs a national safety net programme under which food aid is supplied at rehabilitation centres, schools, orphanages, and to people living with HIV/AIDS. The programme covers 142 districts throughout the 10 regions in Ghana. It provides food aid to all 36 districts in the three northern regions, covering over 1,000 schools. Most of the foods provided are fortified with micronutrients as well as soya (to increase protein content). The focus is on the three northern regions. As mentioned above, these areas have the worst health and welfare indicators (level of malnutrition, illiteracy, drought, famine, accessibility to health services, and access to education in terms of enrolment, attendance and retention).

In the south, CRS is currently focusing on provision of safety nets implemented through the Catholic Dioceses in Ho, Keta-Akatsi in the Volta Region, Takoradi in the Western Region, and Obuasi in the Ashanti Region. CRS also supported UNICEF in piloting Plumpy'Nut in the Upper West Region.

¹⁵ Outcomes of interviews with USAID, UNICEF and WFP

World Food Programme

WFP is providing fortified blended food. It is collaborating with the Micronutrient Initiative of Canada and supports training of women in the use of iodized food. It is supporting growth monitoring of children and lactating mothers using the life cycle approach of looking at the child's development from pregnancy through to breastfeeding, weaning, and up to the age of five. WFP is also supporting the government in implementing the school feeding programme in the three northern regions. WFP does not collaborate actively with Ghanaian NGOs. However it is collaborating with the private sector, mainly UNILIVER Ghana in conducting studies to inform nutrition interventions.

World Bank Funded Nutrition and Malaria Control for Child Survival Project

The World Bank is supporting the implementation of a Nutrition and Malaria Control for Child Survival Project. The project became effective in September 2007 and is expected to close in March 2012. This project is a follow up to the CBNFSP and aims at improving utilisation of community-based health and nutrition services for pregnant women and children under the age of two in 62 districts in five regions: Northern, Upper East, Upper West, Volta and Central Regions, including one area (district or sub-metropolitan) each in the Western Region, Accra and Kumasi.

This project aims to cover 300,000 children under two and 65,000 pregnant women by the end of its fourth year. The total cost is estimated at US\$25 million, with US\$15 million earmarked for nutrition interventions and US\$10 for malaria control. It has three main components: i) institutional capacity strengthening of the GHS and MOH towards the establishment of a coherent national programme, ii) expansion of community-based health and nutrition service delivery via scaled up community-based health and nutrition services for children under two and pregnant women based on a community-level package of Essential Nutrition Actions; and iii) malaria prevention through provision of long lasting insecticide treated nets. Implementation has been initiated in 19 districts in the three northern regions to enable them cope with the impacts of the floods that were experienced in 2007.

World Vision Supplementary Feeding Programme

World Vision piloted a micronutrient programme titled "Enhanced Programme in the Kwahu South District in the Ashanti Region" from 2005 to 2006. The programme's main foci were prevention of micronutrient deficiency and reducing mortality of children under five. It was funded by World Vision Canada and CIDA. The programme has now been integrated into other World Vision programmes in Sekyere East, Adwira and Asante Akim in the Ashanti Region and Atebubu and Sene in the Brong Ahafo Region. Current objectives are improving access to health services, malaria control and addressing micronutrient deficiencies, including enhancing household access to micronutrient rich food. The programme is currently in phase 2 and has rolled out to two additional districts, Mfantiman district in the Central Region and Nkwanta District in the Volta Region.

Adventist Development Relief Agency

ADRA has established 36 MCH centres in the 10 regions of Ghana. It distributes food rations to undernourished children in very remote parts of the country, as well as in two urban areas, one in Kumasi and the other in Korle Bu. ADRA's education interventions use Health and Nutrition Trainers (HATS) to educate the public on water and sanitation and to do cooking demonstrations in collaboration with the GES. HATS include School Health Education Programme teachers and GES coordinators. Cooking demonstration using soya bean is a key part of the programme. About 600 motivators were trained between 1997 and 2001 under HATS. From 2002-2007, 1,500 were trained and the programme worked with about 400 teachers and 300,000 beneficiaries.

ADRA is collaborating with the USAID-funded Ghana Sustainable Change Project under the Academy for Educational Development rolling out a campaign for breastfeeding and complementary food. The campaign will cover 49 districts in the Central and Volta Regions. It uses a health communication framework covering malaria, family planning, HIV/AIDS and breastfeeding. The campaign started in August 2007 and will end in July 2008. ADRA is also involved in school feeding programmes in two communities, one in Dagme East in the Greater Accra Region and the other in North Tong District in the Volta Region.

Multi Donor Budget Support Group (main mechanism for coordination among donors)

The Health Sector Group of the Multi Donor Budget Support (MDBS) mechanism meets monthly and is led by the MOH. The group comprises representatives from the EU, USAID, JICA, DANIDA, Netherlands, World Bank and the UN. Other participants include the MOH directorate responsible for policy making, implementation, monitoring and evaluation; the GHS (as service provider); international and local NGOs; universities and research institutions; and relevant sector departments and agencies. Health summits are organised two times every year, in April and November, and the outcomes of meetings of the Health Sector Group are fed into the deliberations of the Summit. The April summit reviews implementation of health interventions in the sector, with the November summit discussing strategies and interventions to address challenges in the sector. Overall, three types of meetings are organised in which the Health Sector Group participates to provide inputs into determining the support needed from the MDBS in implementing health sector interventions. They are (1) monthly meetings, (2) business meetings organised four times per year with two business discussions based on annual programme of work, and (3) biannual health summits.

Although NGOs play a significant role in implementing nutrition interventions, no mapping has been done on NGO actors in nutrition, especially in the three northern regions where most of them are operating. There is a lack of harmonization of interventions among NGOs. Most NGOs in the three northern regions, including CRS, World Vision and ADRA, will end their projects by close of 2008, but there is no mechanism in place to ensure sustainability of their interventions.

The Nutrition Department, which is expected to be the lead agency in pursuing nutrition interventions with the MDBS, has inadequate staff and funding and these contribute to its inability to follow up on nutrition policy interventions initiated by the development partners. At the national level the department has only six staff, with each region having one Nutrition officer at the regional level. These are graduates, mostly Master's Degree holders. The graduates in the Nutrition Department countrywide are about 22 in number. At the district level each district health directorate is expected to have a nutrition officer, but some districts do not have the staff in place. On average, there are 8 field officers per region. Most nutrition staff posted to districts appear to prefer working for the Disease Control Unit, which has funds earmarked for its activities. This accounts for the absence of nutrition officers seen in some districts. In the absence of designated nutrition officers, community health nurses may serve as informal technical officers and provide integrated services at the community level.

POSITIVE PROCESSES OF CHANGE AND MISSED OPPORTUNITIES

As indicated in the preceding sections, there had been positive processes of change and/or missed opportunities throughout much of the trajectory of nutrition policies in Ghana. These were moments of inflexion in which the policy went from “low priority” to a “high priority” and/vice-versa. However, to avoid repetition, only two key periods from different periods of the trajectory are reviewed below: 1990–2000 and 2001–2008.

The period 1990-2000 focused on *planning and mobilising for action: Addressing micronutrient deficiencies and exclusive breastfeeding*. It marked a **positive process of change** in the sense that, in addition to the policy actions introduced on food demonstration, attitude and behaviour change, weaning foods and iodine deficiency, further policies on micronutrients were formulated, government commitment in terms of policy decisions secured and implementation pursued.

However government commitment in relation to human and financial resource allocation, putting in place a central coordination mechanism, and monitoring and evaluating the outcomes effectively to ensure sustainability was missing. In addition, strategies for pursuing the policies were largely donor driven in terms of funding and mobilisation of key actors for action. **Opportunities were therefore missed in securing government commitment to budgetary allocation and consistent implementation of the policies overtime** in order to institutionalise and sustain reduction of malnutrition.

A number of international conferences organised during this period heightened awareness of the government, policy elites and other actors in the nutrition policy arena about key nutrition issues and their impact on the capacity of the population to contribute effectively and efficiently to Ghana's socio-economic development.

Involvement of the different ministries and departments in the ICN and follow up activities through the multi-sectoral central committee and thematic working groups marked a positive process of change in nutrition policy formulation and implementation

as it engaged wider MDA participation in and commitment to pursuing nutrition policies (i.e. formulation of a Nutrition Plan of Action on Food and Nutrition).

The multi-sectoral central committee and thematic groups created during the ICN also participated in the preparation of national strategy and policy documents aimed at placing nutrition high on the government policy agenda. The development partners looked at the Action Plan and its relationship to the international agenda and provided support and direction in its implementation. The plan succeeded in providing a framework for putting together specific multi-sectoral committees to deliberate on strategies to address specific food security and nutrient deficiency issues. It served as a basis for sourcing funding by the Nutrition Department from donor agencies such as UNICEF, USAID and WFP under their five year rolling plans. It also served as the basis for the Nutrition Department's annual planning and budgeting activities. In most cases activities of the Nutrition Department were selected and structured into the prevailing budget cycle of the government and development partners. However, government commitment to the plan's implementation in terms of financing and coordination was inadequate. Although the Nutrition Action Plan was costed, it was not used for making funding available from GOG sources directly. In addition the plan did not form the basis for the design and implementation of MDAs' organizational nutrition interventions as they were more interested in pursuing their individual institutional mandates. MDAs continued to pursue their own agendas with no direct linkage to the Action Plan or the interventions of the Nutrition Department.

Also significant was the use of PROFILES data during this period. PROFILES helped in putting nutrition high on the agenda of the MOH and development partners. Trends in stunting, wasting and underweight were presented in terms of economic costs. PROFILES data also heightened awareness about the impact of malnutrition on child growth and development, morbidity and mortality.

From 2001-2008, *consolidation of strategies for micronutrients, exclusive breastfeeding and community-based growth monitoring* was pursued. This era marks **another positive process of change** in the trajectory of nutrition policies in Ghana. Policy interventions pursued in the preceding era have been continued and a number of policies have been initiated to consolidate gains made. However, **implementation continues to be hamstrung by inadequate government commitment in terms of funding, coordination and sustainability.**

That said, some level of political commitment has been secured in terms of policy backing. Key elements of the GPRS include targets for combating malnutrition, food security and other nutrition-related barriers to good health. As previously discussed, legislative instruments such as LI 1667 on marketing of Breast Milk Substitutes and Act 525 on Salt Iodization are promoting good nutritional practices. A national school feeding programme is being pursued by the GOG in collaboration with development partners and NGOs. And the government-led "Youth in Agriculture Initiative" is helping to improve the involvement of young people in crucial food production activities, thus contributing to the crusade of improving the nutrition of the nation (GHS 2005: 15).

However, these achievements have neither attracted coordinated actions nor sustained funding from the government. Most importantly, none of these efforts have changed nutrition indicators, as noted earlier, these have stagnated.

PART IV - POLICY MAKING IN NUTRITION: *ANALYZING THE MAIN STAKEHOLDERS*

Key actors in Ghana's nutrition policy making process have tended to be largely the same actors that play significant roles in agenda setting, design, adoption, implementation and sustainability. These are the Ministers of Health and Agriculture, key staff of the GHS, especially members of the ad-hoc committees set up to address specific issues in nutrition as they crop up, the Nutrition Department and development partners, especially UNICEF, USAID, WFP, ADRA, World Vision, World Bank and WHO.

Other stakeholders include the Children's Department of MOWAC, WIADD of MOFA, GES and the MLGRDE, mainly at the MMDA Levels where they advocate and make financial resources available for nutrition policy interventions through their MTDPs. These agencies contribute cash and in-kind support including transport, fuel, and personnel.

Stakeholders' have been motivated primarily by the desire to achieve Ghana's development agenda including Vision 2020, GPRS I and II, the MDGs, and other international commitments. In most cases stakeholders have pushed their agendas via various forums on health. These include the Annual Health Summits of the MOH and development partners; radio and television discussions and debates on health issues; organization of annual NIDs, Child Health Promotion Week; and health-oriented events at various churches and festivals.

Parliamentary approval of such agendas, in terms of passage of laws such as LI 1667 on sale of complementary foods and Act 525 on iodized salt, which are critical, has been readily secured.

However, in addition to the role of parliament, stakeholders have used their political affiliations and influence with the government to lobby for nutrition issues. This was done by MOWAC, the MOH and the former Director General of the GHS in regards to exclusive breastfeeding, marketing of complementary feeding products, and iodized salt, respectively.

Unfortunately, nutrition policies are largely pursued at the national level through seminars, conferences and establishment of ad-hoc committees that meet on the issues without translating them into action at district and community levels. Some interviewees were therefore of the view that Ghana had not put in place a real policy on nutrition – one that is based on extensive review of the state of nutrition, strategies formulated and implementation backed by action plans, human and financial resources, effective collaboration, coordination, monitoring and evaluation, as well as follow up arrangements for sustainability of the policy interventions. Box 4 highlights some of these views.

Box 4: Views on Ghana's nutrition policy

The problem has always been the absence of a real government policy on nutrition. One finds it difficult to pin point the nutrition policy. There are problems of up-scaling pilot programmes done in pockets of the country. Implementation of most nutrition policies have been on pilot basis. This is largely due to lack of commitment at the central and local government levels. Unless we look at implementation of policies from the central to the local government levels we cannot achieve stated objectives. But there is inadequate understanding of nutrition both at the central and local government levels. Education has been ongoing on the cost of malnutrition, but DCEs are unaware of the cost of malnutrition. Unless we do a lot of advocacy at the local level, it will be difficult to implement nutrition programmes and policies at the local levels. - **Views of an interviewee at the District level.**

The policies in place are mere intentions. They do not set out to indicate the extent to which monitoring and evaluation activities have informed their formulation and to inform further action. Any policy that is implemented in Accra is no policy. Most districts do not know about the nutrition policies. Most of the things are done to satisfy donors in Accra and not what comes out of it in terms of impact on the ground. The clinical component of health is so dominant that it overshadows nutrition policies implementation and sustainability. - **Views of an interviewee**

Although not necessarily key stakeholders *per se*, Ghana's nursing training institutions make nutrition a key module in the courses they offer, and nurses are key actors in the implementation of nutrition policies at community level. Currently there are about nine community health schools in Ghana that train community health nurses. Since 2001, Community Based Health Planning and Services (CHPS) have been established in each district to ensure that health services, including counselling on nutrition, immunisation of children, and growth monitoring are at the door steps of the community members. The community health nurses staff these CHPS.

The media has also been supportive in creating awareness about nutrition issues through opportunities created for discussion. These events take place on private and public television and radio stations, mainly the FM stations, which have networks and branches in each region of the country.

Perhaps the biggest missing link in Ghana's chain of stakeholders is an inter-ministerial body that exists to coordinate activities of nutrition policy actors. Nutrition is so multi-sectoral that policy implementation becomes ineffective if the responsibility for initiating action is left to only one sector. However, although there is no coordinating committee, there are committees that address specific issues on nutrition. These include multi-sectoral committees set up to deal with iron and iodine deficiencies, vitamin A supplementation and exclusive breastfeeding. In addition, groups such as the Consumer Association of Ghana exist to deliberate on issues relating to food quality and safety. The study revealed that there has not been any mapping of such groups and no mechanism has been put in place to ensure that their energies are mobilized to achieve synergy.

PART V - CONCLUSIONS

Analysis of Ghana's nutrition trajectory indicates that the country has achieved largely successful nutrition-related actions and improved nutrition education since its Independence in 1957. Further, the government has been steadily progressing towards greater nutrition commitment through efforts to consolidate nutrition policies in the new millennium and continue implementing nutrition programs. These positive processes of change are results of deeper understanding of nutrition, greater collaboration between local and national governments, and financial and technical support from development partners.

However, challenges affecting policy formulation and implementation still remain. Nutrition is multisectoral in nature and requires collaboration among a variety of actors; however, Ghana lacks an inter-ministerial coordinating body to establish a national vision and objective toward malnutrition reduction. Further, though government has succeeded in developing national policies and pursued nutrition actions, development partners, who do not always coordinate their efforts, largely supply funding. Despite support, funding and resources can be inadequate. Government needs to make a greater commitment to national budgetary support for nutrition.

Critical actions and catalysts that led to increased nutrition commitment, as well as challenges that still exist, are important conclusions from this paper and serve as lessons learned for both Ghana and other countries facing similar political and nutrition contexts:

- i. **Inadequate linkage and coordination arrangements** limit implementation and sustainability of nutrition policies. This has led to difficulties in mobilising actors for action, achieving synergy, and optimising outcomes of policy interventions. There is inadequate coordination and collaboration among donors and development partners, as well as MDAs in pursuing nutrition policy interventions. Most MDAs and donors undertake their policy interventions without collaborating with the Nutrition Department. No evidence of comprehensive mapping exists in regards to the role NGOs play in nutrition interventions, including for the three northern regions where most NGOs are concentrated. There is lack of harmonisation of interventions among key actors in nutrition. In order to synchronise and harmonise interventions, there is a need to strengthen linkage and coordination arrangements among donors, development partners and MDAs. An inter-ministerial coordinating body that wields power and authority across sectors and could mobilise MDAs, donors, development partners and civil society for action needs to be put in place. A mapping of all donor, development partner, NGO and civil society activities needs to be done to provide avenues for initiating coordination and collaboration. To ensure effectiveness, the roles and

- responsibilities of actors in the nutrition policy arena need to be defined and monitoring mechanism put in place to ensure effective role performance.
- ii. **Government commitment to international conventions and declarations** at international conferences has catalysed nutrition policy formulation and implementation. Policy interventions should therefore aim at building on these motivational factors to elicit government commitment to budgetary allocations and fund disbursements to ensure that interventions are implemented and sustained over time.
 - iii. **Donors and development partners have been key partners in nutrition policy formulation and implementation in Ghana.** However, the seeming dominance of donors in initiating and implementing nutrition policies has created over-dependence on donors by the government and other policy actors leading to inadequate GOG commitment to funding implementation of nutrition policies. Donor support should therefore aim at putting in place measures to motivate government to make budgetary allocations available for implementing nutrition policies. The MDBS dialogue processes appear to be key avenues for securing government commitment to policy formulation, implementation and sustainability. The dialogue processes should therefore make nutrition a key issue of concern.
 - iv. **The role of decentralised structures in nutrition policy formulation and implementation is unclear.** Nutrition policy formulation, implementation and funding appear to be addressed from the top down. In addition, current policy, planning and budgeting systems and processes limit the extent to which MMDAs may exercise discretion in initiating nutrition policies and ensuring commitment to their implementation and sustainability. Since Ghana employs a decentralised system of governance, it is imperative that nutrition policy formulation and implementation is seen in that perspective. Local government structures must be empowered to lead their own policy formulation processes in order to ensure success through sustained ownership and commitment to the implementation and funding of nutrition policies.
 - v. **The role of research and training institutions in nutrition policy formulation and implementation has not been given much prominence.** It is important to recognise the key role that these institutions play in nutrition policy formulation and implementation and clearly defined roles carved out for them in implementation, monitoring and evaluation of nutrition policy interventions.
 - vi. **Civil society participation in the nutrition policy arena was not prominent.** There is no coalition for nutrition policy formulation. This limits the scope and scale of opportunities for lobbying for nutrition at all levels of government.
 - vii. **There is no coherent national policy on nutrition.** The absence of a coherent national policy that outlines the overall framework for pursuing nutrition

interventions at the national, regional and district levels, and defines institutional roles and responsibilities, monitoring and evaluation, as well as linkage and coordination arrangements, limits the extent to which pressure could be put to bear on the government to provide resources for implementation of policy interventions in a sustained manner.

- viii. **Inadequate dissemination of nutrition information:** Data from GDHS and PROFILES have played significant roles in informing narratives in nutrition policy design, adoption and implementation. However dissemination of such information is highly centralised at the national level leading to inadequate understanding and appreciation of nutrition policy issues and actions at the district and community levels. Ways to ensure wider dissemination of nutrition policy information, especially at the local levels need to be explored. A responsive Information, Education and Communication Strategy therefore needs to be adopted and implemented.

- ix. **Health sector interventions in Ghana have been largely clinical and curative in nature, limiting the scope and scale of nutrition and other preventive health interventions.** Owing to the clinical nature of health sector interventions in Ghana, nutrition has not been given adequate attention in terms of policy formulation, implementation and sustainability. Nutrition has always been linked to other priority health interventions and relegated to the background. It is important to heighten awareness of policy actors about this and empower the nutrition department to ensure that it is able to champion the course of nutrition policy formulation, implementation and sustainability. Nutrition is inter-sectoral, however the Nutrition Department is without power and authority to mobilise other MDAs for action. For the Department to be effective there is a pressing need to ensure that it is empowered administratively and financially.

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ANNEX 1: DIALOGUE PARTNERS AND DIALOGUE ISSUES

DIALOGUE PARTNERS	DIALOGUE ISSUES
Ministries Departments and Agencies	
Ministry of Health: <ul style="list-style-type: none"> • PPMED, Ministry of Health • PPMED, Ghana Health Service (GHS) • PPMED, Ministry of Health • Directorate of Public Health • Directorate of Family Health • Reproductive and Child Health Unit • Nutrition Department (Head of Department and Staff) • Regional Directorate GHS, Central Region • Regional Nutrition Officer, Central Region • Director, Ghana Health Services, Cape Coast Metropolitan Assembly • Director of Health Services, KEEA Municipal Assembly • Regional Directorate GHS, Upper East • Regional Nutrition Officer • Director of Health Services, Bongo Dist • Director of Health Services, Bolgatanga 	Perspectives on: <ul style="list-style-type: none"> • Trajectories of nutrition policies in Ghana – historical timeline of focus of nutrition policies, trends and outcomes; • The policy making process for nutrition (actors, interests and power, main institutions, main agencies, actions and strategies, outcomes, etc): • Factors associated with policy change and their effects at each stage of the policy making process: agenda setting, design, adoption, implementation and sustainability – role of narratives, agents for policy change, donors, competing interests, strategies, timing/context, beneficiaries, etc • Ways to ensure effectiveness of nutrition policies – ownership, commitment, sustainability, etc
Ministry of Agriculture <ul style="list-style-type: none"> • Women in Agricultural Development Directorate (WIADD) 	Perspectives on: <ul style="list-style-type: none"> • Individual roles in nutrition policy formulation and implementation processes. • The policy making process for nutrition policies (actors, interest and power, main institutions, main agencies, actions and strategies, outcomes, etc): • Factors associated with policy change and their effects at each stage of the policy making process: agenda setting, design, adoption, implementation and sustainability – role of narratives, agents for policy change, donors, competing interests, strategies, timing/context, beneficiaries, etc • Ways to ensure effectiveness of nutrition policies – ownership, commitment, sustainability, etc • For the research and educational institutions further information will be elicited on factors that influencing their choice of modules in the curricula and their role in heightening awareness about nutrition at the individual, institutional and various levels of the decentralised governance system.
Ministry of Education <ul style="list-style-type: none"> • PPMED • School Health Programme • School Feeding Programme/Logistics Unit 	
Ministry of Local Government Rural Development and Environment <ul style="list-style-type: none"> • Department of Community Development • School Feeding Programme • Health and Sanitation Department 	
Ministry of Finance <ul style="list-style-type: none"> • Budget Division • World Bank Desk 	
National Development Planning Commission	
Educational/research institutions <ul style="list-style-type: none"> • University of Ghana • University of Development Studies • University of Cape Coast • Food Research Institute (FRI) • Council for Scientific and Industrial Research (CSIR) 	

Regional/District Level	
Regional Coordinating Councils: Central and Upper East Regions	<p>Perspectives on:</p> <ul style="list-style-type: none"> • The place of nutrition in their decentralised administration, planning, budgeting and policy formulation and implementation processes • Actors and interest in nutrition policy formulation and implementation • Expected future roles of governments at the various levels (district, regional, national)
Metropolitan, Municipal and District Assemblies (MMDAs): Cape Coast, Komenda-Edina-Eguafo-Abrem (KEEA), Bolgatanga and Bongo	Same as above
Donors and Other Development Partners	
<ul style="list-style-type: none"> • World Bank • UNICEF • USAID • WFP • WHO • DANIDA • DFID • ADRA (NGO) • Catholic Relief Service (NGO) • World Vision (NGO) • Multi-Donor Budget Support Group (Sector lead) 	<p>Perspectives on:</p> <ul style="list-style-type: none"> • Individual roles in influencing nutrition policy formulation and implementation • The policy making process for nutrition (actors, interests and power, main institutions, main agencies, actions and strategies, outcomes, etc): • Factors associated with policy change and their effects at each stage of the policy making process: agenda setting, design, adoption, implementation and sustainability – role of narratives, agents for policy change, donors, competing interests, strategies, timing/context, beneficiaries, etc • Channels for influencing government and the specific impact in the content of the government's agenda. • Ways to ensure effectiveness of nutrition policies – ownership, commitment, sustainability, etc

Key informants (Individuals)	
<ul style="list-style-type: none"> • Mrs Rosanna Agble, Former Head, Nutrition Unit. • Dr. N. A. DeHeer, Former Head, Nutrition Unit • Professor Saa Dittoh, University of Development Studies 	<p>Perspectives on:</p> <ul style="list-style-type: none"> • Trajectories of nutrition policy formulation and implementation processes and their responsiveness to nutrition needs and sustainability • Actors, interests and power • Factors associated with policy change and their effects at each stage of the policy making process: agenda setting, design, adoption, implementation and sustainability – role of narratives, agents for policy change, donors, competing interests, strategies, timing/context, beneficiaries, etc

ANNEX 2: LIST OF PERSONS INTERVIEWED

Dr. Evelyn Awittor World Bank, Accra	Mrs. Ernestina Agyepong Nutrition Project Officer, UNICEF, Accra
Mr. Jacob Armah Head, Nutrition Department Ghana Health Service, Accra	Mrs Wilhelmina Okwabi Principal Nutrition Officer & Coordinator, Infant Young Child Feeding Programme, Nutrition Department, Ghana Health Service
Mrs Hannah Adjei Coordinator, Nutrition and Malaria Control for Child Survival Project, Nutrition Department, Ghana Health Service, Accra	Mrs Esi Amofo Responsible for Vitamin A Nutrition Department, Ghana Health Service, Accra
Mrs Kate Quarshie Anaemia Control, Nutrition Department, Ghana Health Service, Accra	Ms Janet Kwansah PPMED, Ministry of Health, Accra
Mr. Seneya PPMED, Ministry of Health, Accra	Mrs Gladys Tetteh-Yeboah National Coordinator, HIV/AIDS World Vision Ghana, Accra
Hon Godfred Okyere Vice Chairman, Parliamentary Select Committee on Health, Accra	Ms Victoria Daaku ADRA Accra
Hon James K. Avedzi Member, Parliamentary Select Committee on Health, Accra	Mr. Michael Amoateng Assistant Clerk, Parliamentary Select Committee on Health, Accra
Dr. Gloria Quansah Director, Family Health Ghana Health Service, Accra	Mrs Veronica Tsekpo Director, Women in Agriculture Development Directorate, Ministry of Food and Agriculture
Mrs Rosanna Agle Consultant and Former Head, Nutrition Unit Ghana Health Service, Accra	Mrs Jackson Supplies and Logistics Coordinator, Partnership with WFP and In-Charge of Institutional Feeding Ghana Education Service
Ms Sabi Lawson-Marriott Head of Programme/Deputy Country Director World Food Programme, Accra	Mr. Ben B. Cronze Director, Logistics and Supply Ghana Education Service
Professor Saa Dittoh Coordinator, Food and Nutrition Security Unit University of Development Studies, Tamale	Dr Joseph Cobbina CSIR, Accra

Mrs Faustina Essandoh National Coordinator of Women's Work & Assistant Director, Department of Community Development, Accra	Mr. Jerry Odoitei Deputy Director National Development Planning Commission, Accra
Ms Yvonne Acatsi Deputy Programme Manager, Health, DFID, Accra	Dr. Paa Nii Johnson Deputy Director, Department of Food Processing and Engineering, Food Research Institute, Accra
Dr. George Amofa Deputy Director General, Ghana Health Service, Accra	Nana Ayim Director, M&E, School Feeding Programme, Office of the President, Accra
Dr. Joseph Amankwaa Director, Public Health, Ghana Health Service, Accra	Ms Helen Dzikunu Senior Programme Advisor, Health Sector Advisory Office, DANIDA, Accra
Jan Borg Senior Policy Advisor, Health Sector Advisory Office, DANIDA, Accra	Andreas Bjerrum JPO, Health Sector Advisory Office, DANIDA, Accra
Mrs Ruth Addison Senior Programme Officer, Head of Programmes Unit and National Coordinator, Early Childhood Development, Ministry of Women and Children's Affairs, Accra	Mrs Cynthia Bosomtwi Sam Director, School Health Education Division, Ghana Education Service, Accra
Mrs. Juliana Pwamang Health Programme Specialist, USAID, Accra	Mr. Ben Asomani Dep. Director, RCC, Central Region, Cape Coast
Mrs. Felicia Ansah-Amprofi Metropolitan Director of Agric, Cape Coast	Mr. Peter Oben Metropolitan Agriculture Officer, Cape Coast
Dr. Joseph Nuertey Metropolitan District Director of Health Service, Cape Coast	Mrs Joyce Bondzie-Asmah Metropolitan Nutrition Officer, Cape Coast
Dr Aaron Offei Regional Director of Health Service, GHS, Cape Coast	Mr. Samuel Sossi Regional Nutrition Officer, GHS, Cape Coast
Mr. Justice Amoah Senior Planning Officer Cape Coast Metropolitan Assembly	Dr. Yaw Ofori Yeboah Director of Health Services, Komenda-Edina- Eguafo-Abirem Municipal Assembly, Elmina
Mrs Leticia Ziem Municipal Nutrition Officer, Komenda- Edina-Eguafo-Abirem Municipal Assembly, Elmina	Mr. Ben Eghan Mensah Deputy Coordinating Director, Komenda-Edina- Eguafo-Abirem Municipal Assembly, Elmina

Mr. Dwamena Godfred, Crops Officer, KEEA Municipal Assembly, Elmina	Mr. Felix Newton Agriculture Extension Agent, KEEA Municipal Assembly, Elmina
Mrs Augustine Araba Amissah Lecturer, Department of Vocational and Technical Education, Faculty of Education, University of Cape Coast, Cape Coast	Dr Nicholas A. de Heer Consultant in Public Health Medicine and First Head of Nutrition Department
Dr. Marius W. de Jong First Secretary, Health & Gender & Health Sector Lead, Multi-Donor Budget Support Group, Accra	Mr. Michael Ayesu Head, World Bank Unit, Ministry of Finance & Economic Planning, Accra
Mr. James Kroduah Principal Economics Officer, World Bank Unit, Ministry of Finance & Economic Planning, Accra	Ms Rofina Asuru District Director of Health Services Bongo
Ms Cecilia Azabu District Public Health Nurse, Bongo	Ms Eva Afoblikane Assistant Nutrition Officer, Bongo
Mr. Eric Baah District Budget Officer Bongo District Assembly	Mr. Damma Mumuni District Planning Officer Bongo District Assembly
Mr. MOHammed Issahaku Deputy District Coordinating Director Bongo District Assembly	Alhaji Musbagu Ahmed District Director of Agriculture Bongo District Agriculture Development Unit
Ms Grace Anafo WIADD Bongo District Agriculture Development Unit	Ms Juliana Agyeyomah Talata Municipal Planning Officer Bolga Municipal Assembly
Mr. Sadito Issaka Chief Economic Planning Officer Upper East Regional Coordinating Council	Mr. Dery G. Lucio Deputy Director (Administration) Ghana Health Service, Upper East Region Bolgatanga
Mr. Benjamin Aggrey Regional Nutrition Officer Ghana Health Service, Upper East Region Bolgatanga	Chief E. A. Atia Regional Accountant Ghana Health Service, Upper East Region Bolgatanga
Madam Juliana Adiale Public Health Nurse Bolgatanga Municipal Health Directorate Bolgatanga	Mr. Anthony Kusseh Disease Control Officer Bolgatanga Municipal Health Directorate Bolgatanga

<p>Mr. Solomon Boamah Health Information Officer Bolgatanga Municipal Health Directorate Bolgatanga</p>	<p>Mrs Clara Weobong Programme Manage, Health Catholic Relief Services, Tamale</p>
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HEALTH, NUTRITION,
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