

# Strengthening health and nutrition services in early childhood development centers in Ghana (2024–2026)



## Background

Over the course of two years, from January 2024 to March 2026, PATH and Ghana Health Service (GHS), with support from the [Bainum Family Foundation](#), worked to identify and address gaps in the health and nutrition services that children attending early childhood development (ECD) centers receive. Using the [Nurturing Care Framework for Early Childhood Development](#) (UNICEF and WHO, 2018) as a guide, the project aimed to ensure “good health”, “adequate nutrition”, and “opportunities for early learning” were integrated and prioritized for children under five years of age in kindergarten classrooms across Ghana.

While health and nutrition services for children are mandated in several national health, social welfare, and education guidelines in Ghana, discussions with stakeholders at the outset of the project as well as baseline data collection from project schools revealed several gaps. These included a lack of data tools and school health indicators, a lack of specific provisions for children under five, and barriers to proper implementation of school health and nutrition services such as limited budget, lack of training for teachers, and inadequate accountability measures. The government’s cross-sectoral Nutrition-Friendly Schools Initiative launched in 2020 with ambitious intentions and excellent resources. However, PATH discovered that few teachers were exposed to the Initiative and adherence to a four-star diet required by the Initiative was not evident in many school menus, even when school feeding programs were provided by the government.

To co-create and pilot test solutions that address gaps in both policy and practice, PATH and GHS selected two municipal areas in the Greater Accra Region—Adentan and Ayawaso East—and 24 project schools (17 public and 7 low-cost private schools) with ECD centers, serving approximately 1,300 children under age five.



*Nurturing Care Framework for ECD poster used during teacher training. Photo: PATH.*



*Teachers working on a small group activity during training. Photo: PATH.*

## Key approaches

Three approaches were used to ensure that the project produced sustainable and relevant results. First, all activities built upon existing governmental guidelines and tools. These included the 2005 GHS guidelines for school health services, 2019 national guidelines for nutrition-friendly schools, 2019 kindergarten curriculum, 2021 Maternal and Child Health Record Book, and others. Teacher training materials and project implementation tools were designed based on these materials.

Second, the project was co-created and implemented jointly with national and district stakeholders. Child and environmental health, nutrition, social action, and education officers came together in July 2024 to jointly reflect upon insights generated from a landscape analysis and agree upon key areas the project should focus on. These national and district stakeholders were later trained as trainers and have played an integral part in every training and mentoring activity conducted for the project schools.

Third, the project evolved in response to needs, requests, and observations from the pilot schools, adapting approaches and tools based on experiential learning and feedback. For example, when mentoring visits to the project schools revealed that children were not mastering information about the value of different types of healthy food midway through the project, PATH developed a learning guide with play-based activities to reinforce this content from kindergarten curriculum. Pictorial food cards, required to conduct several of the activities, were printed for the teachers and distributed during a supplementary training where the teachers practiced the various activities in the guide.



Food game cards produced by teachers. Photo: PATH.

The first year of the project was spent building relationships and co-designing the project. Through the implementation period, from January 2025 through March 2026, PATH, GHS, Ghana Education Service (GES), and district leadership came together to facilitate training on three different occasions, to reinforce and build upon teachers' skills. At each training session, new resource materials were distributed and explained so that they could be used effectively and consistently across the project schools.

To further assist teachers and administrators in making changes in instruction and community engagement, PATH, GHS, GES, and district stakeholders visited the schools while children were present for mentoring on four different occasions. These visits were opportunities for the schools to showcase the progress they had made and solicit help with persistent challenges.

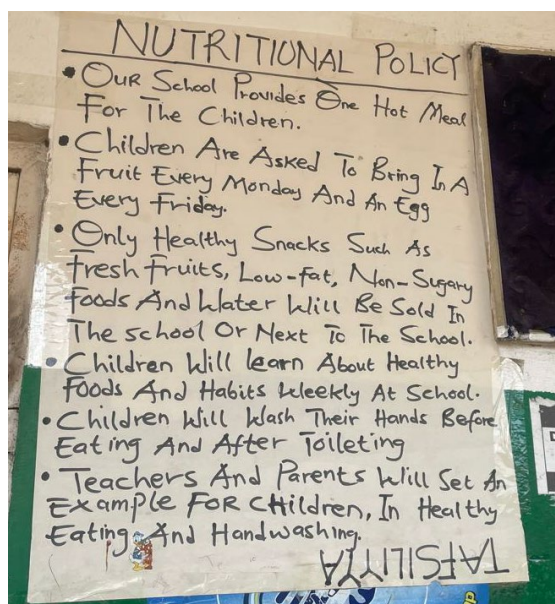
Project activities and achievements centered around three pivotal intervention areas: 1) implementing school health and nutrition policies; 2) monitoring children's health and maintaining proper records; and 3) strengthening children's knowledge of health and nutrition content.

### School health and nutrition policies

Ghana's 2019 national guidelines for nutrition-friendly schools mandate that all schools develop their own written health and nutrition policy to orient teachers and parents in raising healthy children.

While only 2 schools had such policies at the start of the project, 20 schools had developed and implemented their policies by 2026. In addition to promoting handwashing and physical activities, most policies instituted regular fruit and egg (or protein) days, reinforced the four-star diet, and discouraged consumption of sugary drinks and snacks.

The policies, written in simple language and exhibited prominently on school walls, spurred several actions. Schools educated parents about the policies during school meetings, at daily drop-off and pick-up times, and through regular WhatsApp messages. Parents were asked to uphold the policies by packing healthier foods from home and following the fruit and egg day guidelines.



Sample school health and nutrition policy. Photo: PATH.

Food vendors and caterers were also sensitized to the policy and what it meant for the food sold or prepared at school. The table below summarizes key improvements observed in health practices because of the introduction of school health and nutrition policies when comparing baseline data collected in November 2024 and endline data collected in February 2026.

Table 1. Changes in health and nutritional behaviors.

Health routines	Baseline	Endline
<b>Regular hygiene checks</b>	8 schools	23 schools
<b>Handwashing stations for kindergarten</b>	30 stations	40 stations
<b>Fruit and protein days instituted</b>	0 schools	23 schools
<b>Vendors sell eggs</b>	4 schools	9 schools
<b>Vendors sell fruits</b>	6 schools	11 schools
<b>Vendors sell sugary drinks and food</b>	11 schools	10 schools
<b>School caterers use plant-based proteins</b>	9 schools	12 schools
<b>School caterers use animal-based proteins</b>	5 schools	8 schools
<b>Children bring biscuits</b>	64%	8%
<b>Children bring sweet drinks</b>	27%	8%
<b>Children bring protein</b>	3%	63%

As can be seen in Table 1, the most significant changes occurred in the types of foods children brought from home: a decrease in sweet beverages and snacks and an increase in protein-rich foods such as beans, eggs, fish, or chicken. Many schools also successfully influenced food vendors to sell fruits and eggs. The fact that fruit and protein days were established at all schools may have encouraged the vendors to sell such products.

Unfortunately, the schools were much less successful in getting vendors to stop selling sweet drinks and sugary snacks. This is particularly true for vendors operating *outside* the school premises, suggesting the need for municipal action.

Finally, even though the school feeding program is centrally controlled, sensitization of food caterers resulted in some improvements in school meals in both private and public schools. More schools began using protein-rich foods such as beans, fish powder, and fish in their weekly menus.

### School health records and checks

2005 GHS guidelines for school health services mandate annual comprehensive school health visits at specific stages, including the first year of kindergarten. School health visits should include a physical exam,

verification of the child's home-based health record for vaccinations and other completed services, and identification of health or developmental concerns that warrant referral for specialized services. To support these actions, PATH convened GHS, GES, and other relevant stakeholders to update the protocol for school health visits to make them more appropriate for children under age five as well as developed and piloted an individual child school health record book where important health information can be recorded and referenced at school. Nurses from nearby health facilities who are responsible for conducting school health visits participated in project trainings and were requested to prioritize physical exams during school health visits.



Child received physical exam with information recorded in the child school health record. Photo: PATH.

The table below summarizes key improvements in health data records and school health visits as a result of the project.

Table 2. Changes in school health records and visits.

Health visit routines	Baseline	Endline
<b>Have individual child school health record books</b>	1 school	23 schools
<b>Have child vaccination/health data filled</b>	0 schools	7 schools
<b>Staff have knowledge of developmental milestones section of child health records</b>	18% directors 7% teachers	48% directors 63% teachers
<b>Had annual health visit with physical exam conducted</b>	1 school	21 schools
<b>Made referrals for children after physical exams done</b>	0 schools	8 schools

The findings show that the teachers' knowledge of the Maternal and Child Health Record Book improved during the project. This is important because teachers

need to understand the book to complete the child school health record and ensure that missed services are made up for during school health visits.

All project schools were provided with ample copies of the child school health record forms for all kindergarten students. However, mentoring visits revealed that teachers still require support in filling out the records correctly, particularly in fully transferring the relevant information from the Maternal and Child Health Record Book to the school health records.

By the endline, nearly all pilot schools had received an annual health visit from a nearby health facility that included physical examinations. Considering that previously most school health visits focused on health education, vaccination, and provision of vitamin supplements, this is a great achievement. However, PATH came to understand that health facilities face logistical and financial challenges in ensuring school health visits and physical examinations are conducted as intended. Currently there is no budget allocated for school health visits, and this requires action at the national and municipal levels.

In a parallel effort at national level, the project has supported the revision of school health program indicators and the national school health register template. This data will facilitate more comprehensive tracking of the health status of children in schools, enhance visibility of child health concerns, and provide an accurate basis for planning.

### Strengthening children’s learning

Initial project design did not prioritize creation of teaching and learning materials and training on teaching methodology for health and nutrition content. However, early mentoring visits revealed that children were not mastering key health and nutrition content. Few children could name healthy versus unhealthy foods or explain which foods helped them to be smarter, stronger, or healthier. Additionally, only some children could explain why they washed their hands. The teachers consistently requested additional teaching and learning materials.

As a result, PATH developed two children’s storybooks as well as a guide with play-based learning activities to reinforce key health and nutrition information. The guide was based on Ghana’s 2019 kindergarten curriculum and provides step-by-step instructions for teachers to follow. The storybooks and the guide were reviewed and approved by GHS and GES prior to printing.

Several activities in the guide make use of food picture cards. Children sort the food cards into food groups: “foods that make us smart” (plant and animal proteins), “foods that make us strong” (carbohydrates such as tubers and grains), “foods that protect us from getting sick” (fruits and vegetables), and “unhealthy foods” (sugary drinks, sweets, and ultra-processed foods).

Teachers reported that the children enjoy sorting the food cards.

*“The children pay attention when playing the card game. They ask questions and argue among themselves to place cards in the right box.”*

Teachers also reflected that the storybooks are interactive and engaging. They specifically reported that children like the pictures.

*“The children are able to play along with the story [of foods with superpowers] with actions.”*

*“The children responded well, [talking about] the foods they brought to school.”*

Endline results suggest that these play- and story-based learning activities may have improved both children’s knowledge (Table 3) and practices (Table 1).

Table 3. Children’s knowledge of nutrition.

Indicator	Baseline	Endline
<b>Proportion of children that could name main food groups</b>	32% named at least one food and its group correctly	55% gave an example of a “smart food”
	No child named a “smart food”	70% named a “food that protects from sickness”
		70% named a “food that makes us strong”

### Additional effects

By endline, many teachers shared that learning about nutrition during the project prompted them to change their own health practices.

*“Personally, I eat healthier now. No more fizzy drinks. My children eat fruit every day.”*

Additionally, leadership at several schools reported that the impact of the project was felt beyond the



Storybooks on nutrition developed by the project. Photo: PATH.

kindergarten classes. Primary and secondary classes also changed certain behaviors to uphold the health and nutrition policy, such as reducing consumption of sugary drinks, creating garbage clean-up teams, and using some of the project materials such as the storybooks and child school health record books.

Finally, several schools reported that parental attitudes towards the school improved as a result of the school's emphasis on improving health and nutrition.

*“Improving nutrition education and practices is making the children better and increases parents' confidence in the school.”*

Capturing parents' perspectives directly may help inform future project activities, including potential health information campaigns.



*Play materials used to teach nutrition. Photo: PATH.*

## Persistent challenges

Despite all the positive changes observed, several health and nutrition issues remained unresolved throughout the project. Some of these were related to school sanitation. Specifically, ten schools had no access to their own toilet for children in kindergarten classes—of these, three schools had no toilet provisions of any kind. This challenge was not possible to address through the scope of the project and requires attention from district authorities and development partners.

Additionally, most schools struggle with unreliable and irregular garbage disposal service and have to come up with alternative means getting rid of their trash.

Furthermore, influencing the food and drinks that vendors near the schools sell continues to be a challenge. District or national action to restrict sales of unhealthy food and drinks near schools may be required.

Next, ensuring that all public and private schools receive comprehensive school health visits requires budget allocation as well as monitoring of school health data collected during these visits.

Finally, collaboration between district health, nutrition, social welfare, and education officers requires facilitated interaction. It was observed that there is little regular contact across sectors. While district officers collaborated to conduct mentoring visits, there is a need for regular, well-structured intersectoral meetings at the district level to ensure collaboration is routine and comprehensive to improve school health programming.

## Next steps

Both pilot districts shared that they are satisfied with what the project has achieved and are already planning to expand the approach to benefit other schools in their respective districts. In fact, the districts have already provided books, activity guides, and other resource materials to a few non-pilot schools. They even invited a couple teachers from non-pilot schools to the most recent refresher training that was held as part of the project. Similarly, GHS has expressed willingness to ensure that the revised school health register is rolled out as soon as possible. GHS also desires that the individual child school health record is introduced in more districts and regions. Finally, the Nutrition-Friendly Schools Initiative has expressed interest in using the storybooks and the activity guide as resource materials to supplement their Initiative.

PATH has handed over all the materials co-created throughout this project to Ghana's government agencies and will also make them available to civil society and government stakeholders in other countries to use and learn from by posting them on PATH's [ECD Knowledge Hub](#).

In addition to supporting uptake and scaling of the successful approaches piloted, PATH will continue advocating for actions to strengthen cross-sectoral planning and collaboration at the district level, budget allocation and utilization for comprehensive annual school health visits to all schools, provision of reliable sanitation services at schools, and regulation to restrict the sale of sugary drinks and snacks near schools.