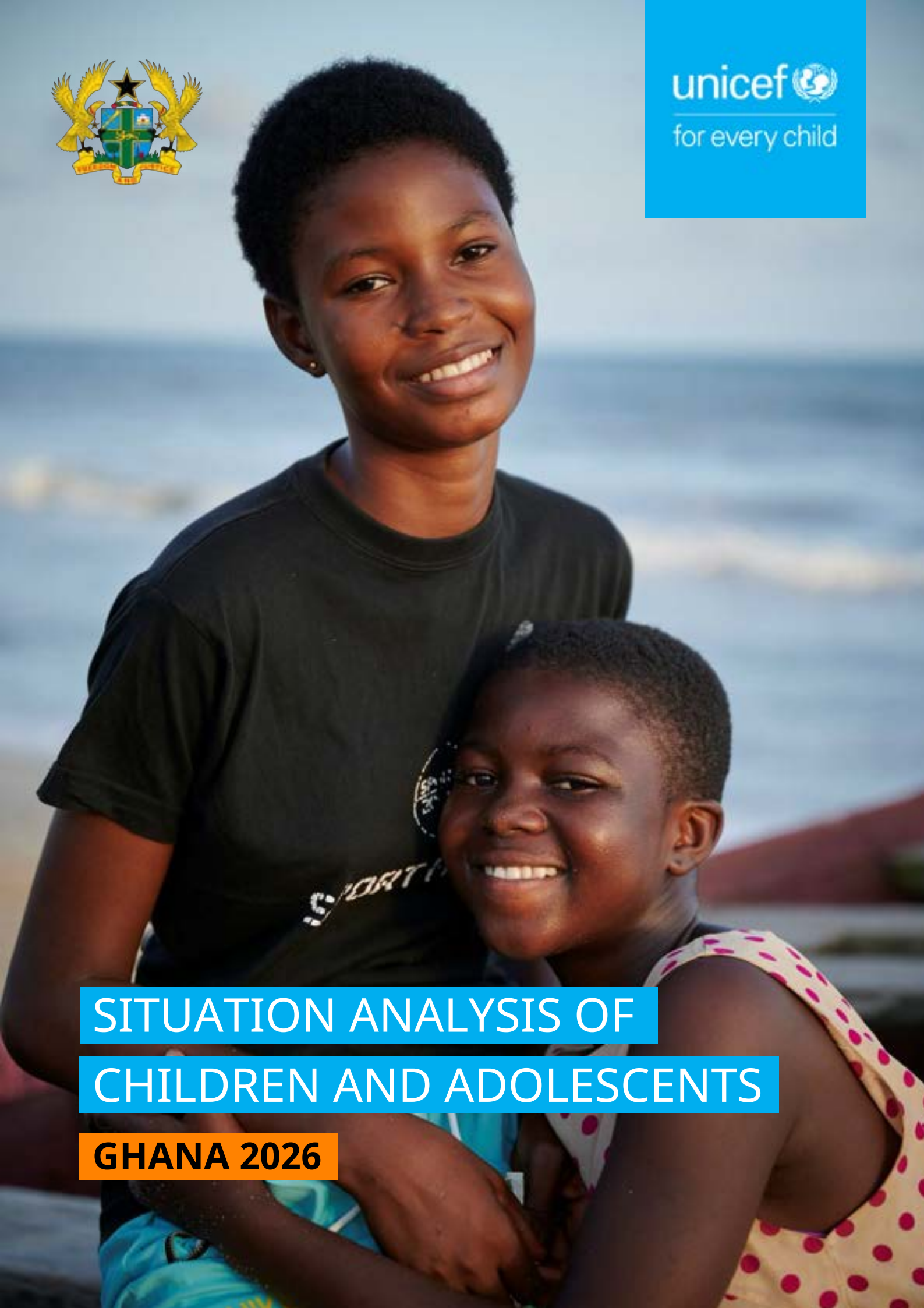

SITUATION ANALYSIS OF CHILDREN AND ADOLESCENTS

GHANA 2026

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Acronyms

ACRWC	African Charter on the Rights and Welfare of the Child
AHIES	Annual Household Income and Expenditure Survey
AHTU	Anti–Human Trafficking Unit
ANC	Antenatal care
ARI	Acute respiratory infections
ART	Antiretroviral therapy
BCG	Bacillus Calmette-Guérin
BDR	Births and deaths registry
BECE	Basic Education Certificate Examination
CHPS	Community-based Health Planning and Services
CRC	Convention on the Rights of the Child
CSA	Cyber Security Authority
CSCC	Coalition for Street Connected Children
CSPS	Centre for Social Policy Studies Research
CSW	Commercial sexual work
DACF	District Assemblies Common Fund
DHIMS	District Health Information Management System
DHS	Demographic and Health Survey
ECE	Early childhood education
EMIS	Education management information system
ESP	Education Strategic Plan
FGD	Focus Group Discussion
GDP	Gross Domestic Product
GET Fund	Ghana Education Trust
GHS	Ghana Health Service
GLSS	Ghana Living Standards Survey
GNHR	Ghana National Household Registry
GSFP	Ghana School Feeding Programme
GSS	Ghana Statistical Service
GTEC	Ghana Tertiary Education Commission
HIV	Human immunodeficiency viruses
IMF WEO	International Monetary Fund World Economic Outlook
ISS	Integrated social services
JHS	Junior high school
JMP	WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene

KII	Key Informant Interview
LI	Legislative instrument
LEAP	Livelihood Empowerment Against Poverty
MDA	Ministries, Departments and Agencies
MLGDRD	Ministry of Local Government, Decentralisation and Rural Development
MMDA	Metropolitan, Municipal and District Assemblies
MMR	Maternal mortality ratio
MICS	Multiple Indicator Cluster Survey
MoE	Ministry of Education
MoGCSP	Ministry of Gender, Children and Social Protection
MoH	Ministry of Health
NaCCA	National Council for Curriculum and Assessment
NDPC	National Development Planning Commission
NEET	Not in Employment, Education, or Training
NER	Net enrolment rate
NHI	National Health Insurance
NHIF	National Health Insurance Fund
NHIL	National Health Insurance Levy
NHIS	National Health Insurance Scheme
NHR	National Household Registry
OECD	Organisation for Economic Cooperation and Development
OHLGS	Office of the Head of Local Government Service
PCV	pneumococcal conjugate vaccine
PIP	Poverty and Inequality Platform
PPP	Purchasing power parity
PMTCT	Prevention of mother-to-child transmission
PTTR	Pupil-to-trained teacher ratio
SDG	Sustainable Development Goals
SHS	Senior high school
SitAN	Situation Analysis
SOP	Standard operating procedures
SWIMS	Social Welfare Information Management System
TVET	Technical and Vocational Education and Training
USD	United States Dollar
WASH	Water, Sanitation and Hygiene
WASSCE	West African Senior School Certificate Examination
WB	World Bank

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Executive summary

Ghana has made important progress in advancing the rights and wellbeing of children and adolescents. Since becoming the first country to ratify the Convention on the Rights of the Child in 1990, the country has expanded access to education and health services, strengthened its legal and policy framework for child protection, and maintained a strong national commitment to children's rights. These gains are visible in high primary school participation, broad use of maternal health services, improvements in newborn survival, expanded social protection architecture, and renewed attention to integrated service delivery.

Yet, the situation of children and adolescents remains marked by deep and persistent inequalities. Ghana's child population is large: around 15.1 million children aged 0-19 live in the country, representing close to 45 per cent of the population. This demographic profile creates both an opportunity and an obligation. If children and adolescents can access quality health, nutrition, learning, protection and social support, Ghana's youthful population can become a major driver of inclusive growth. If current inequalities persist, however, poverty, exclusion and weak human capital formation will continue to constrain national development.

The analysis shows that children experience higher and more multidimensional deprivation than adults. National estimates based on MICS (2017/18) indicate that 97.5 per cent of children experienced at least one deprivation and 73.4 per cent are multidimensionally poor, with the highest rates among children aged 0-4. Deprivation is strongly shaped by household income, place of residence, region, disability status, gender and access to quality services. Children in poorer households, rural areas, northern regions, informal urban settlements, and children with disabilities face the greatest cumulative disadvantages.

The report applies a lifecycle approach, recognising that risks and opportunities change as children move from pregnancy and birth, through early childhood and middle childhood, into adolescence. Across all stages, the same underlying constraints recur: insufficient and uneven public investment, gaps between policy and implementation, weak decentralised capacity, workforce shortages, limited coordination across sectors, and household-level financial barriers. Climate shocks, inflation, urban poverty, displacement, public health emergencies and digital risks add new pressures to families and public systems.

Pregnancy and birth

Pregnancy and birth remain decisive windows for survival, healthy development and intergenerational wellbeing. Ghana has achieved high levels of antenatal care attendance and skilled birth attendance, reflecting long-term investment in maternal and newborn health. Neonatal mortality has declined to approximately 19 deaths per 1,000 live births (DHS, 2022). However, progress has slowed, and newborn deaths remain concentrated in the first week of life, when timely, high-quality care is most critical.

The key challenge is no longer only whether women and newborns reach services, but whether services are timely, continuous, adequately staffed and equipped, and responsive to the needs of different groups. Early initiation of antenatal care and completion of the recommended package of services remain uneven, particularly among adolescents, women from poorer households, and women in underserved rural areas. Gaps in referral systems, emergency obstetric and newborn care, transport, staffing, supplies and service readiness continue to affect outcomes.

Maternal and newborn outcomes are also shaped by broader household and gender dynamics, including women's decision-making power, the affordability of care, transport constraints, nutrition during pregnancy, and the availability of family and community support. Addressing pregnancy and birth outcomes therefore requires both stronger health systems and more gender-responsive prevention, outreach and postnatal support.

The priority is to strengthen the full continuum of maternal, newborn and postnatal care. This includes improving the capacity of primary health care and Community-based Health Planning and Services (CHPS), strengthening referral and emergency transport systems, expanding adolescent-friendly reproductive health services, and ensuring that financial and transport costs do not prevent families from seeking timely care.

Infancy and early childhood

Infancy and early childhood are the stages at which deprivation is most acute and investments are likely to yield the highest returns. Children under five face overlapping risks related to nutrition, preventable illness, inadequate sanitation, unsafe housing, limited early stimulation, and incomplete access to early learning. These risks are mutually reinforcing: poverty affects nutrition, housing and care practices; poor WASH conditions contribute to disease and undernutrition; and limited early learning opportunities undermine readiness for school.

Ghana has achieved important progress in immunisation and child survival, but inequalities remain. Under-five mortality varies substantially by region, ranging from around 20 deaths per 1,000 live births in Greater Accra to 72 per 1,000 in Oti Region (DHS, 2022). Childhood illnesses, malnutrition and poor environmental conditions continue to affect children's growth and development, particularly in rural and low-income settings.

Birth registration has improved but remains incomplete. DHS (2022) data indicates that 74.5 per cent of children under five had their births registered, while only 61.4 per cent had a birth certificate. This gap matters because legal identity is often a gateway to services, protection and social inclusion. Remote communities, poorer households and vulnerable groups remain at higher risk of exclusion.

Children with disabilities are among the most structurally excluded groups. Key informants highlighted barriers in early identification, inclusive education, health access, assistive services and protection. The absence of a Legislative Instrument for the Persons with Disabilities Act continues to limit enforceability and operational

clarity. These constraints increase the risk of institutionalisation, neglect and exclusion from essential services.

Early childhood development requires a more integrated policy and financing response. The analysis shows that Ghana's public spending on children is skewed toward later years, especially older school-age children, while the earliest years receive comparatively little investment despite the high levels of deprivation. A stronger early childhood package should combine maternal and child health, nutrition, responsive caregiving, disability-inclusive services, WASH, early learning and child-sensitive social protection.

Middle childhood

Middle childhood is a critical period for foundational learning, social development and protection. Ghana has made strong progress in expanding access to primary education, and primary school participation is high. However, access has not translated consistently into learning. Many children are not achieving expected literacy and numeracy outcomes, and learning gaps are shaped by poverty, region, school infrastructure, teacher availability, language, disability and household support.

Indirect schooling costs continue to affect children from low-income households, even where formal fees have been reduced or removed. Inadequate infrastructure, overcrowding, weak access to learning materials, and insufficient WASH facilities in some schools affect attendance, dignity and learning conditions. Children with disabilities face additional barriers, including limited screening, insufficient specialist support, inaccessible infrastructure and stigma.

Protection risks also become highly visible during middle childhood. Survey evidence indicates that approximately one in five children aged 5-17 are engaged in child labour (GLSS, 2016/17). Child labour is closely linked to poverty, household shocks and local livelihoods, including agriculture, mining, informal work and domestic labour. Some children combine school with work, while others drop out entirely. Violent discipline, trafficking, exploitation and family separation further undermine children's wellbeing and learning.

Addressing these issues requires a combined education, protection and social protection response. Ghana's policy framework includes action to eliminate child labour and strengthen child and family welfare systems, while the Integrated Social Services approach provides a promising platform for coordinated referrals and case management. However, implementation depends on adequate financing, a stronger social welfare workforce, reliable data systems, and operational capacity at district level.

Adolescence

Adolescence is both a period of opportunity and a period of heightened risk. Ghana's large adolescent population can contribute to future productivity and social development if young people are supported to complete school, gain relevant skills, access health services, remain safe from violence and exploitation, and transition into decent work. At present, many adolescents experience barriers across all these domains.

Secondary education access has expanded, but progression, completion and learning outcomes remain unequal. Girls, poorer adolescents, adolescents in rural areas and those with disabilities face greater barriers to staying in school. Costs, distance, household responsibilities, pregnancy, child marriage, low perceived returns to schooling and limited support for struggling learners all contribute to dropout or irregular attendance.

The transition from school to work is also difficult. Many adolescents and young people face inactivity, informal work or precarious employment. Weak links between education, skills development and labour market opportunities limit the returns to schooling. Expanding relevant technical and vocational education, career guidance, digital skills, apprenticeships and pathways to decent work will be essential if Ghana is to benefit from its demographic transition.

Adolescent girls face specific gendered risks. Adolescent pregnancy, child marriage, sexual violence and unmet need for family planning continue to affect health, education and life chances. DHS (2022) indicates that 15.2 per cent of girls aged 15-19 have ever been pregnant, and 31 per cent of adolescents aged 15-19 have an unmet need for family planning. These outcomes reflect not only service gaps but also social norms, poverty, unequal decision-making power, and limited protection from violence.

Adolescents also face emerging risks linked to urban poverty, substance use, mental health pressures and digital environments. Increased access to communication technology brings opportunities for learning and connection, but also exposes children to online exploitation and abuse. Ghana has established a legal and policy basis for cyber safety, including the Cybersecurity Act and child online protection frameworks, but prevention, reporting, enforcement and survivor support require continued strengthening.

Cross-cutting bottlenecks

Ghana's challenge is not only a lack of policy commitment. In many areas, laws, strategies and institutional frameworks exist, but implementation is constrained by financing, staffing, coordination and accountability. This is particularly clear in child protection, disability inclusion, social protection, WASH and decentralised service delivery.

Public finance for children remains under pressure. Although social sector allocations increased between 2024 and 2025, fiscal constraints, debt servicing and inflation have limited real spending power. Education, health and social protection spending remain below relevant international benchmarks as a share of GDP. Financing is also uneven across the lifecycle, with young children receiving comparatively less support than their level of deprivation would suggest.

Ghana's social protection system has developed significantly, including LEAP, the Ghana School Feeding Programme, NHIS-related exemptions, the Ghana National Household Registry, Integrated Social Services and the Social Protection Act, 2025. However, coverage remains limited and insufficiently child sensitive. LEAP coverage is modest relative to need and disproportionately reaches adults rather than children;

there is no broad child benefit or family allowance, and virtually no cash support targeted to children under five. This leaves families without predictable income support during the period when nutrition, caregiving and early learning investments matter most.

Decentralisation is central to service delivery, but district-level capacity is weak. MMDAs have limited fiscal autonomy, depend heavily on transfers, and often lack sufficient trained personnel, transport and operational budgets. In child protection, only 41 per cent of minimum required government social welfare positions are filled nationally, only four districts meet minimum staffing requirements, and districts have on average around three social welfare staff serving populations above 100,000. These capacity gaps affect prevention, case management, referrals, enforcement and follow-up.

Humanitarian, climate and public health risks are becoming more salient. Cross-border displacement linked to Sahel insecurity, internal conflicts, flooding, drought, cholera and food insecurity are placing pressure on households and services. Children affected by displacement, service disruption or climate shocks face increased risks of school interruption, documentation gaps, psychosocial stress, disease, exploitation and family economic hardship.

Strategic priorities

Accelerating progress for children in Ghana will require prioritising resources and reforms where they can have the greatest impact. The following priorities emerge from the lifecycle analysis:

1. **Ensure equitable access, quality, and continuity of services.**

   Strengthen Ghana's broad-based national programmes so that they reach and retain the children currently least well served, narrowing the gaps in access, quality, and continuity that fall along lines of poverty, geography, gender, and disability. Public investment in children should be protected and prioritised, with allocation guided by where deprivation is greatest, directing resources, staffing, and support toward the districts and communities furthest behind, including poorer, rural, and northern regions, children with disabilities, street-connected children, and children in conflict with the law. Raise education and health spending toward international benchmarks (the UNESCO Incheon target of 4 to 6 per cent of GDP, the WHO target of 5 per cent, and the Abuja target of 15 per cent) and revise the DACF allocation formula to channel more resources to poorer districts.

2. **Strengthen and scale up integrated, child-centred service systems.**

   Move away from fragmented, sector-specific responses toward integrated systems capable of addressing the interconnected risks children face, from malnutrition and learning poverty to violence, child labour, adolescent pregnancy, and climate vulnerability. The ISS approach provides a platform for this shift, and its expansion to all 261 MMDAs in 2026 is an opportunity. Effective implementation will require clearly defined institutional roles, interoperable referral pathways, enhanced district-level coordination, operational budgets and transport, and routine case

management that ensures families can access multiple services in a timely manner. The documented underperformance in northern districts must be addressed as a priority, not deferred.

3. **Strengthen social and behavioural change at scale.**

   Addressing harmful social norms is essential to unlocking demand for services; without tackling these underlying drivers, supply-side investments alone will not deliver results. Evidence-based campaigns on gender equality, positive parenting, and school attendance should be scaled, with traditional, religious, and community leaders actively championing norm change. Community dialogue platforms should be institutionalised within district planning processes and the ISS coordination framework. Life skills, sexual and reproductive health education, and youth engagement platforms should be expanded, with adolescent voices integrated into local governance, ensuring that demand-side barriers are addressed as systematically as supply-side ones.

4. **Foster resilient, evidence-informed systems.**

   Policy, planning, and reporting must be based on timely and credible evidence. This requires stronger administrative and survey data systems, child-focused monitoring, and expanded use of evidence for targeting interventions and tracking inequities, building on the SWIMS platform and the data governance provisions of the Social Protection Act (2025). Special attention is needed to address the paucity of data on children with disabilities, street-connected children, children in conflict with the law, and adolescents. Accountability must be strengthened at both national and subnational levels to ensure that commitments to children's rights are reflected in implementation, resource allocation, and measurable improvements in outcomes.

5. **Integrate climate resilience across sectors.**

   Given the scale of climate-related risk, climate resilience and environmental sustainability should be integrated into sectoral planning, particularly in education, child protection, nutrition, and social protection, ensuring that development strategies account for the long-term impacts of environmental change on children's wellbeing and that social protection systems are increasingly shock-responsive.

Overall, Ghana has a strong foundation on which to build. Its legal and policy commitments, expanding service platforms, and growing attention to integrated delivery create important opportunities. The central task now is to close the implementation gap: to ensure that financing, institutions and frontline systems are strong enough to reach every child, especially those facing the greatest deprivation.

CHAPTER 1.
INTRODUCTION

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1 Introduction

In 1990, Ghana made history as the fir st country in the world to ratify the Convention on the Rights of the Child (CRC). Decades later, this landmark commitment remains at the heart of the nation's development agenda. However, as Ghana's economic, social, and environmental landscapes continue to shift, so too do the risks and opportunities its children face. This Situation Analysis of Children and Adolescents in Ghana (SitAn) offers a timely, evidence-based stock-take on the lived realities of children today. Developed collaboratively by UNICEF and the Government of Ghana, the report assesses the structural barriers and capacity gaps that still prevent many children from surviving, thriving, and reaching their full potential, as well as some of the success stories and their enabling environments.

As the country navigates complex, intersecting challenges and UNICEF Ghana approaches its Mid-Term Review, there is a pressing need for fresh insights to guide national policies, strategic partnerships, and targeted investments. By mapping the current landscape, and anticipating emerging trends through strategic foresight, this report aims to feed national dialogue on child-relevant policies. Ultimately, it seeks to accelerate progress toward fulfilling the promises of the CRC, the African Charter on the Rights and Welfare of the Child (ACRWC), and the 2030 Agenda for Sustainable Development.

Grounded in a human-rights-based approach, this report examines the causes and manifestations of child rights violations and analyses the structural circumstances in which children, adolescents, their families, and communities live. A core objective of this report is to identify the underlying barriers, bottlenecks, and capacity gaps that hinder young people from fully realising their rights.

To achieve this, the analysis applies a strong equity lens, generating evidence on inequalities disaggregated by socio-economic status, age, gender, disability, and location. This ensures the identification of those groups of children who face the greatest deprivations. Special attention is also given to the cross-cutting intersections of gender, disability, climate action, and early childhood development.

The report considers key drivers of change, including demographic growth, economic trends, climate shocks, and digital transformation. By engaging with these trends through a forward-looking lens, the SitAn aims to help the Government of Ghana and its development partners better anticipate emerging risks and inform the design of more adaptable and resilient policies, rather than simply reacting to current challenges.

To provide a comprehensive assessment of children's wellbeing, risks, and access to essential services, this report adopts a lifecycle framework. This approach structures the analysis around age-specific developmental stages, exploring outcomes across health, nutrition, education, Water, Sanitation and Hygiene (WASH), and child protection. For the purposes of this analysis, the lifecycle stages are broadly defined as follows:

- Pregnancy and birth: 0 to 1 month

- Infancy and early childhood: 1 to 60 months
- Middle childhood: 5 to 11 years
- Adolescence: 12 to 19 years

While these definitions provide a structural backbone for the report, human development is fluid, and there is a natural overlap between these stages. Vulnerabilities are rarely confined to a single phase. Although a topic may be explored in-depth within one specific chapter—for example, WASH or violence against children—this does not imply it is irrelevant to other ages. Rather, these issues remain deeply interconnected and impactful across the entire life course.

The report is structured as follows:

- **Chapter 2: Conceptual framework and methodology** details the mixed-methods approach employed for this research, outlining the desk-based review of literature and policies, secondary data analysis of recent national surveys, and qualitative primary data collection.
- **Chapter 3: Country context** establishes the macro-level environment shaping children's lives. It provides a snapshot of demographic and poverty trends, while examining public finance for children, humanitarian contexts, social protection systems, urbanisation, and child rights governance.
- **Chapter 4: Pregnancy and birth** examines the critical window of maternal and newborn health, unpacking trends and bottlenecks related to antenatal care, maternal and neonatal mortality, skilled birth attendance, and breastfeeding initiation.
- **Chapter 5: Infancy and early childhood** explores the foundational years of physical and cognitive development, assessing vulnerabilities related to immunisation, under-five mortality, childhood illnesses, nutrition, early childhood education, and access to safe water and sanitation.
- **Chapter 6: Middle childhood** shifts the focus to the primary school years. It investigates educational access alongside severe protection risks such as violence against children, child labour, child trafficking, and technology-facilitated sexual exploitation.
- **Chapter 7: Adolescence** addresses the complex transition toward adulthood. It highlights secondary education, the school-to-work transition, and adolescent-specific vulnerabilities including child marriage, adolescent pregnancy, reproductive health, and justice for children in conflict with the law.
- **Chapter 8: Conclusion and strategic recommendations** synthesises the main findings from the preceding chapters and sets out practical, prioritised recommendations to accelerate progress toward the realisation of child rights in Ghana.

CHAPTER 2.

CONCEPTUAL FRAMEWORK AND METHODOLOGY

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2 Conceptual framework and methodology

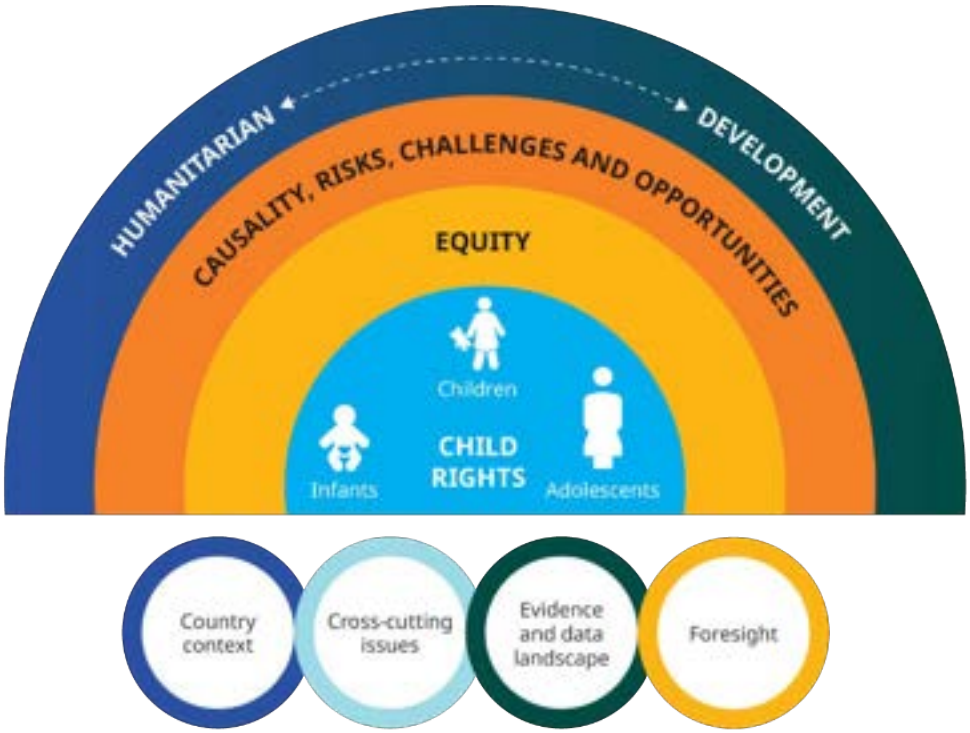
This SitAn employs a mixed-methods approach based on the 2024 UNICEF Guide to Developing a Situation Analysis. The purpose of the SitAn is to provide an evidence-based assessment of children's and adolescents' wellbeing across key domains, identify disparities between population groups, and analyse the underlying factors shaping observed outcomes. The analysis focuses on three interrelated objectives:

- Documenting recent trends and levels of child wellbeing outcomes
- Examining inequalities across key dimensions, including socio-economic status, geography, sex, age, and disability, while applying a gender lens to understand how intersecting vulnerabilities affect different groups of children, particularly adolescent girls and boys.
- Identifying structural bottlenecks across service delivery, household demand, and the broader enabling environment.

2.1 Conceptual framework

The analysis applies a human-rights-based approach grounded in the CRC. As illustrated in Figure 2-1, the conceptual framework examines causality at multiple levels, identifying specific bottlenecks across supply, demand, and the enabling environment that prevent the fulfilment of child rights. The analysis is situated within the broader national context, integrating relevant socio-economic and cultural factors.

Figure 2-1: The conceptual framework for the analysis



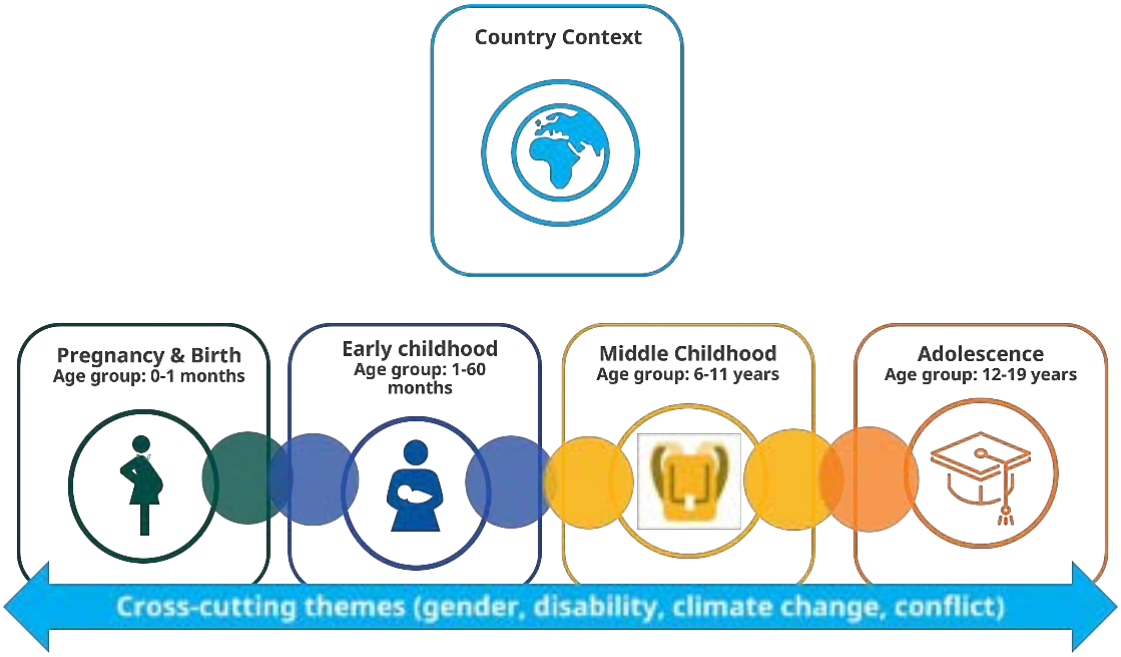
Source: UNICEF (2024 SitAn Guidelines)

The report utilises an equity lens to assess which groups of children experience the most significant deprivations. Data and findings are disaggregated by socio-economic status, geography, gender, and disability. Attention is given to how cross-cutting themes—namely gender, disability, climate change, and conflict affect children and adolescents.

2.2 The lifecycle approach

To reflect how risks, needs, and opportunities evolve over time, the SitAn adopts a lifecycle approach (Figure 2-2), organising analysis around four developmental stages: pregnancy and birth, infancy and early childhood, middle childhood and adolescence.

Figure 2-2: Lifecycle approach



Source: Authors' elaboration

While global frameworks often define childhood stages differently, age boundaries in this SitAn have been adapted to align with Ghana's national education structure and policy context. In particular, middle childhood is defined as ages 5–11 to correspond with primary education, and adolescence as ages 12–19 to capture the full secondary school cycle and transition to adulthood. Table 1 outlines the specific age groups used in this report, and the key thematic areas and topics explored within each stage.

Table 1: Lifecycle stages, definitions, and thematic mapping

Lifecycle stage	Age group (SitAn)	Ghana-specific alignment	Core thematic areas in this SitAn
Pregnancy and birth	0–1 month	Maternal and newborn care continuum	Antenatal care, skilled birth attendance, maternal mortality, neonatal mortality, postnatal care, early breastfeeding
Infancy and early childhood	1–60 months	Pre-primary years	Immunisation, nutrition, under-five mortality, childhood illness, WASH, early childhood education, disability, birth registration

Lifecycle stage	Age group (SitAn)	Ghana-specific alignment	Core thematic areas in this SitAn
Middle childhood	5–11 years	Primary education cycle	Primary schooling, learning outcomes, violence against children, child labour, HIV, disability inclusion
Adolescence	12–19 years	Junior and senior secondary education and transition to work	Secondary education, school-to-work transition, adolescent pregnancy, child marriage, reproductive health, children in conflict with the law, digital access

Source: Authors' elaboration

This mapping offers a structural framework for analysis, but human development is inherently fluid leading to natural overlaps between stages. Vulnerabilities and developmental milestones rarely fit neatly into a single phase. While core themes are highlighted for each stage, issues like violence against children, child labour, and HIV cut across multiple lifecycle stages and are addressed throughout the report where relevant.

Furthermore, to facilitate a clear and structured narrative, certain thematic areas have been situated within specific age-stage chapters where their impact is most critically formative or visible. For example, while household WASH is explored in depth during early childhood due to its severe impact on stunting and under-five mortality, and violence against children is highlighted heavily in middle childhood, this does not imply these issues are irrelevant to other ages. Rather, these structural barriers remain deeply interconnected and critically impactful across the entire life course of a child.

2.3 Data sources and analytical methods

Building on the frameworks outlined above, the SitAn applied mixed methods to triangulate evidence from a variety of sources relying first on in-depth desk-based review of recent and relevant literature and legislation, secondary analysis of recent data, and in-person consultations.

Desk-based review of literature and legislation

A structured desk review was conducted covering academic and grey literature, national legislation, government strategies, sectoral policies, and public expenditure documents. The review supports causal analysis by situating quantitative findings within Ghana's institutional and policy context and drawing on lessons from comparable countries.

Secondary data analysis

The quantitative analysis draws primarily on nationally representative surveys and administrative data, including:

- Ghana Demographic and Health Survey 2022 (GSS & ICF, 2024). Cited in-text as (DHS, 2022).
- 2021 Population and Housing Census (GSS, 2021). Cited in-text as (Census, 2021).

- Ghana Multiple Indicator Cluster Survey 2017/18 (GSS, 2018a). Cited in-text as (MICS, 2017/18).
- Ghana Living Standards Survey, Round 7 (2016/17) (GSS, 2018b). Cited in-text as (GLSS, 2016/17).

Additional datasets are introduced in full at first use in the chapters where they appear. For brevity, all subsequent in-text references throughout the report use the short forms shown above.

Indicators were selected based on relevance to child wellbeing, alignment with SDG frameworks, and availability of recent data. Priority was given to child-level indicators and to disaggregation by region and urban–rural location to identify geographic disparities. Older data were used selectively where more recent information was unavailable.

Secondary quantitative findings are complemented by evidence from government reports, UNICEF studies, and partner evaluations.

Qualitative primary data

To complement the analysis and deepen understanding of system-level bottlenecks and lived experiences, qualitative data were collected through key informant interviews (KIIs) and focus group discussions (FGDs) conducted between November 2025 and February 2026.

The qualitative component aimed to:

- Explore implementation challenges behind current trends in health, nutrition, education, child protection, WASH and social protection outcomes
- Analyse gendered barriers, power dynamics, and intersectional inequalities affecting children and adolescents
- Capture perspectives on service quality, access barriers and equity
- Understand institutional capacity constraints and coordination across sectors
- Incorporate children's and caregivers' experiences into the analysis

KIIs were conducted with national government officials, development partners, civil society organisations, and technical experts across health, social protection, child protection, and education. FGDs were held with caregivers and children in selected locations to capture demand-side perspectives on service access and household decision-making. Discussions for both KIIs and FGDs covered maternal and newborn care, children and adolescent access to basic health care services, education, violence against children, social protection delivery, and child protection systems, partnerships required for effective child rights governance.

Qualitative data were analysed thematically and triangulated with findings from the household survey data, administrative data and literature review. Rather than being

treated as a standalone component, qualitative insights were integrated throughout the report to help explain disparities in service utilisation and outcomes, identify system-level bottlenecks, and contextualise quantitative trends.

Several cross-cutting themes emerged, including gaps between policy and implementation, human and financial resource constraints, uneven service readiness, indirect and cost-related barriers to accessing services, and limited participation of children and caregivers in decision-making processes. These systemic challenges cut across sectors and informed the bottleneck analysis presented in subsequent chapters.

Limitations of the qualitative component include its sampling design and limited geographic coverage for the FGDs with children and caregivers, meaning findings are not statistically representative. However, triangulation with national datasets and consistency across stakeholder groups strengthen confidence in the relevance of the themes identified.

A full list of interviews and focus group discussions, by position and institution, is provided in Annex 1.

2.4 Forward-looking perspective

In addition to assessing current conditions, the SitAn incorporates a forward-looking perspective that identifies key drivers of change shaping children's wellbeing over the coming decade. These include demographic shifts, fiscal pressures, climate risks, technological and digital transformation, and evolving social norms. By examining how these drivers interact, the analysis highlights both emerging risks and opportunities for children and adolescents. This forward-looking lens is intended to inform anticipatory policy dialogue, supporting the design of more adaptive, resilient, and child-responsive systems.

CHAPTER 3.

COUNTRY CONTEXT

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3 Country context

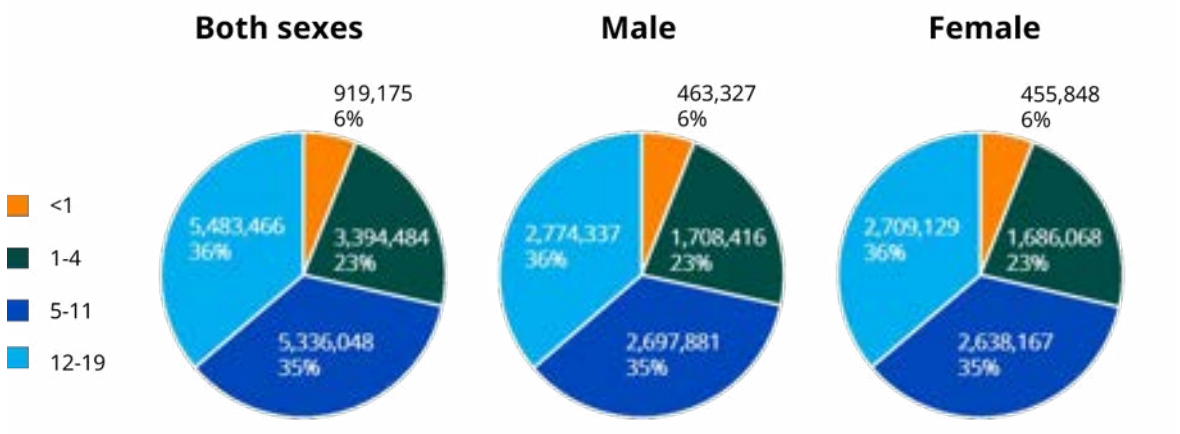
This chapter places the situation of children and adolescents within Ghana's broader demographic, economic, institutional and environmental context. It examines population dynamics, household welfare, public finance, social protection systems, urbanisation, governance of child rights, and exposure to shocks, with the aim of identifying structural factors that shape children's wellbeing and access to services. Together, these elements provide the macro-level foundation for the lifecycle analysis presented in subsequent chapters.

3.1 Demographic dynamics and population change

Ghana's population was estimated at around 33 million in 2025, with children and young people comprising a substantial share of the total population (Ghana Statistical Service, 2024). The country continues to exhibit a predominantly youthful demographic structure. There are approximately 15.1 million children aged 0–19 years in Ghana, of whom around 7.4 million are girls, this represents close to 45 per cent of the total population.

Within this group of children, an estimated 0.9 million children are aged below one year, around 3.4 million are in early childhood (ages 1–4), approximately 5.3 million are in middle childhood (ages 5–11), and around 5.5 million are adolescents (ages 12–19) (Figure 3-1). When those under the age of 25 are included, this share rises to approximately 54 per cent of the total population (Ghana Statistical Service, 2024). Working age adults aged between 25 and 65 form 41 per cent of the total population, and less than 5 per cent are aged 65 years and above.

Figure 3-1: Projected child population in Ghana, 2025



Source: Ghana Statistical Service, Population Projections

This age structure reflects sustained declines in fertility over previous decades; however, the pace of decline has slowed in recent years. For example, the total fertility rate declined only marginally from around 4.0 children per woman in 2008 to 3.9 in 2022 (DHS, 2022). Fertility remains significantly higher in rural areas and among

women with lower levels of education and household income. These disparities are closely linked to gendered factors, including adolescent pregnancy, child marriage, limited access to sexual and reproductive health services, and school dropout among girls, which continue to shape reproductive outcomes and influence Ghana's long-term human capital development.

Historically, Ghana's demographic profile has been characterised by a relatively high child dependency. Although the share of the working-age population now exceeds that of children, the total age dependency ratio remains elevated at an estimated 65 dependents per 100 working-age adults (Ghana Statistical Service, 2024). Although fertility decline has contributed to an increasing share of the working-age population, the relatively high dependency ratio and persistent regional disparities—particularly between urban and rural areas—suggest that Ghana has not yet fully entered a sustained demographic dividend (Odame, Kwame, & Frempong-Ainguah, 2025).

Demographic projections indicate significant structural change over the coming decades. As shown in Figure 3-2, the population pyramid for 2021 displays a broad base, reflecting a large cohort of children. By 2035, projections suggest a relative narrowing of the youngest age groups and a bulge in the working-age population, signalling the potential onset of a demographic window of opportunity. By 2050, the age structure is projected to become more rectangular, with a declining youth share and a gradual increase in older age groups, indicating the early stages of population ageing (Ghana Statistical Service, 2024).

For children and adolescents, these demographic shifts have several implications. The large size of younger cohorts continues to place pressure on education, health, nutrition, and social protection systems, while the ongoing transition of adolescents into working age will increase demand for employment opportunities and income-generating activities. At the same time, persistent regional differences in fertility and population growth are likely to reinforce spatial inequalities in service provision and household welfare (Ghana Statistical Service, 2024).

Although the working-age population is expanding, the continued presence of a relatively high dependency ratio indicates that many households remain responsible for supporting large numbers of children and dependants. In this context, economic vulnerability among families with children remains closely linked to labour market conditions, access to basic services, and the availability of social protection.

Taken together, Ghana's demographic transition is reshaping the scale and distribution of demand for services across the lifecycle, with direct consequences for children's access to quality provision that are explored further in subsequent chapters.

Figure 3-2: Ghana population pyramids 2020, 2035, 2050

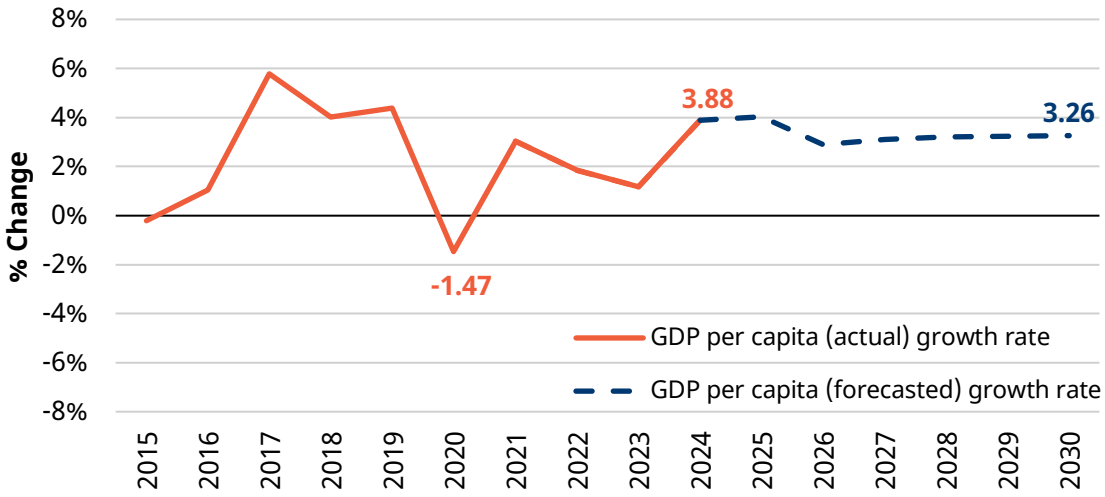
Source: Ghana Statistical Service, Population Projections

3.2 Economy, governance and household welfare

Over the past decade, Ghana has experienced modest growth in Gross Domestic Product (GDP) per capita, rising from approximately GHS 30,032 in 2015 to an estimated GHS 40,889 in 2025 (in 2025 prices), equivalent to an average annual growth rate of around 2.3 per cent (Figure 3-3). This performance exceeds the Sub-Saharan African average (around -0.5 per cent annually) and global growth rates (approximately 1.8 per cent) between 2015 and 2024, according to World Bank estimates.

The projections indicate a continued rise in GDP per capita in constant prices beyond 2025, extending the upward trajectory observed over the past decade. After reaching GHS 40,889 in 2025, the forecast series increases steadily to around GHS 46,841 by 2030 (in 2025 prices), implying an average growth rate of over 3 per cent per year over the projection period. This is slightly faster than the long-run trend in the historical series, suggesting a modest acceleration in per-capita growth relative to recent experience.

Figure 3-3: Ghana's GDP per capita (constant prices) growth rate, 2015-2030



Source: IMF World Economic Outlook October 2025 Database

The COVID-19 pandemic marked a significant turning point, disrupting economic activity and weakening fiscal conditions. Recovery has been further complicated by elevated global inflation, currency depreciation and rising public debt, constraining government capacity to sustain investment in key social sectors (World Bank, 2021). Structural characteristics of the economy including reliance on commodity exports such as gold, cocoa and oil, persistent fiscal deficits, and high debt-servicing costs continue to limit economic resilience and amplify vulnerability to external shocks (World Bank, 2025).

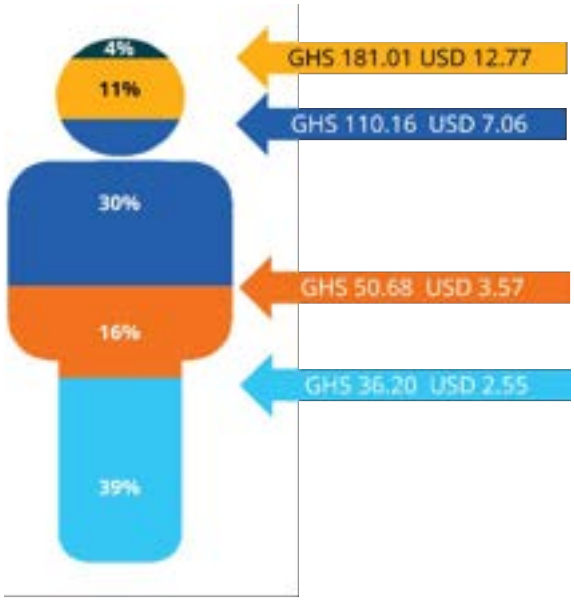
These macroeconomic pressures have translated into declining purchasing power for many households. Inflation increased sharply between 2022 and 2024, driven largely by food prices and exchange rate movements (World Bank, 2025).[1] Although more recently inflation has declined in 2025, suggesting less pressure on the affordability of food, transport, education-related expenses and healthcare for families with children, the cumulative erosion of household purchasing power over the preceding two years continues to affect living standards.

Despite long-term reductions in poverty, a substantial share of the population continues to live on very low incomes. Using World Bank Poverty and Inequality Platform (PIP) data, as shown in Figure 3-4, approximately 39–40 per cent of Ghanaians are estimated to live below the international poverty line of $3.00 PPP per person per day (equivalent to approximately GHS 39.03, adjusted to 2025 prices). National estimates indicate that around 6.6 million people or approximately 26 per cent of the

[1] According to GSS, the year-on-year inflation at the end of 2022, 2023 and 2024 were 54.1, 23.2 and 23.8 per cent (data available at GSS's StatsBank). At the end of 2025, the year-on-year inflation was recorded as 5.4 per cent.

population were living below the national poverty line in 2018, with higher poverty rates concentrated in rural areas and northern regions (GLSS, 2017/18).

Figure 3-4: Level of poverty in Ghana using calculations based on WB PIP data, adjusted to 2025 prices



Notes: International poverty rates are expressed in 2021 $ PPP. Nominal values (in GHS and USD) are expressed in 2025 prices. Source: poverty rates, consumer price index 2021 and 2025, PPP conversion factor for 2021 and inflated to 2025 using projections from IMF WEO Database and GHS to USD exchange rate 2024 from pip.worldbank.org (based on 2021 microdata).

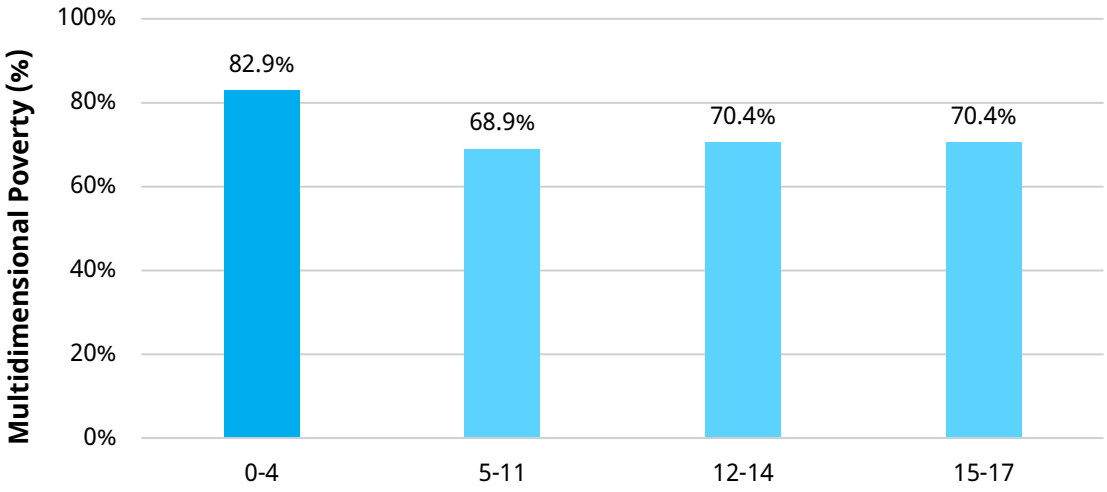
Low household incomes intersect with limited access to quality services to shape children's living conditions. Multidimensional poverty measures indicate that children experience substantially higher deprivation than adults across multiple domains. According to national estimates based on MICS (2017/18), 97.5 per cent of children experience at least one deprivation, and approximately 73.4 per cent are classified as multidimensionally poor (UNICEF & GSS, 2020). As shown in Figure 3-5, multidimensional poverty is highest among children aged 0–4 years (exceeding 80 per cent), while rates for older children and adolescents remain around 70 per cent.

These have largely also been corroborated by the consultations, which have highlighted how economic hardship directly drives child labour, early unions and exploitation, with adolescents increasingly entering relationships or hazardous work as coping strategies. Stakeholders reported rising street-connected children, increased teenage pregnancy, and growing substance use among adolescents, particularly in low-income urban settlements and rural communities affected by environmental degradation and flooding.

As shown in Figure 3-6, income inequality remains pronounced. A clear location divide emerges, urban residents are heavily concentrated in the top 60 per cent, whereas rural residents are more concentrated in the bottom 40 per cent. Education shows the strongest gradient: people with tertiary education are overwhelmingly in the top 60 per cent, those with secondary education are also mostly in the top 60 per cent, primary education is closer to balanced but still tilts towards the top 60 per cent, and

those with no education are predominantly in the bottom 40 per cent. By contrast, gender differences are minimal, with males and females showing almost identical splits close to 60/40.

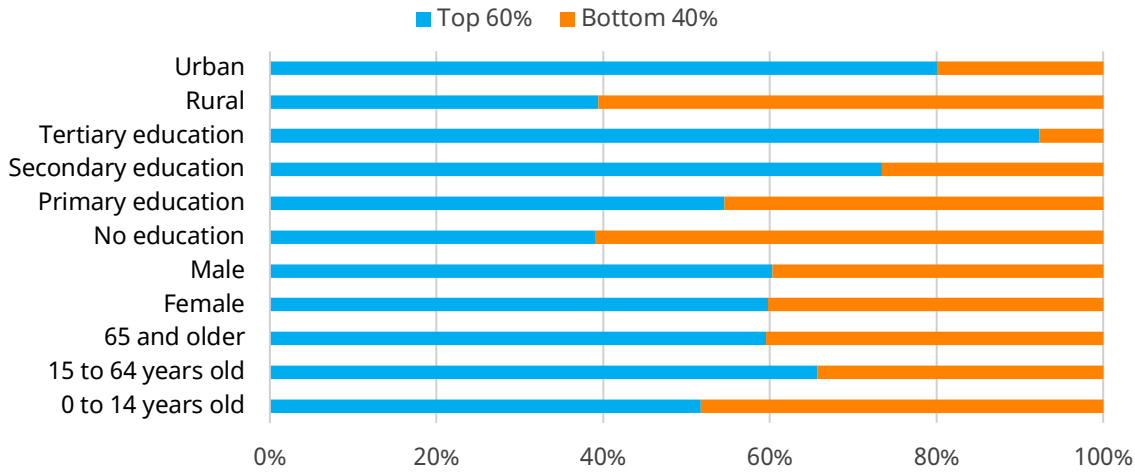
Figure 3-5: Multidimensionally poor children in Ghana by age groups



Source: NDPC, based on MICS (2017/18)

Ghana's economic context is shaped by a relatively stable political environment. Since adopting the 1992 Constitution, the country has consolidated a multi-party democratic system characterised by regular elections and peaceful transfers of power. The most recent transition followed the December 2024 elections and the inauguration of a new administration in January 2025, initiating a new political cycle that may influence policy priorities and budgetary allocations over the medium term (Freedom House, 2025).

Figure 3-6: Inequality in Ghana: Group in the top 60 and bottom 40 per cent

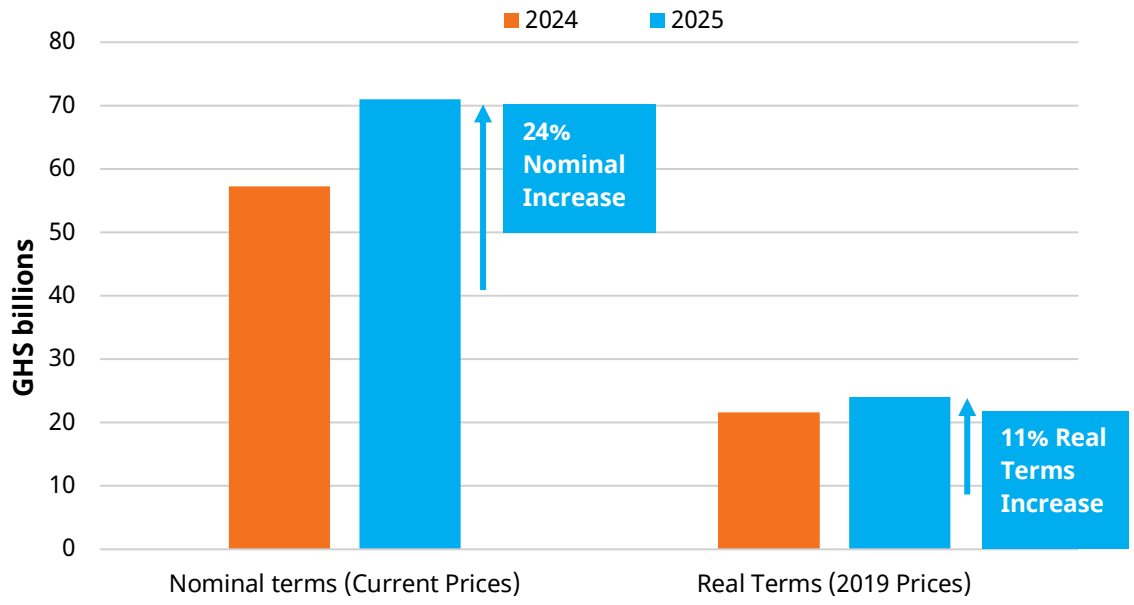


Source: World Bank Poverty and Inequality Platform

3.3 Public finance for children

Recent fiscal constraints have limited Ghana's capacity to expand investment in child-relevant social sectors. High public debt and rising interest payments have reduced discretionary fiscal space, affecting allocations to health, education, water and sanitation, child protection and social protection (UNICEF, 2025c). As illustrated in Figure 3-7, between 2024 and 2025, the combined budgets for the major social sector Ministries and statutory funds increased by 24 per cent, and 11 per cent in real terms if accounting for inflation (UNICEF, 2025c). Allocations to social sectors have also increased when compared as a share of the total budget from 25.3 per cent in 2024 to 26.2 per cent in 2025 (UNICEF, 2025c).

Figure 3-7: Social sector financing in nominal and real terms (2024 – 2025)



Source: MoF 2025 Budget Statement retrieved from UNICEF (2025c). Notes: Social Sectors includes: MoE, MoGCSP, MoH, Ghana Education Trust Fund (GETFund) and National Health Insurance (NHI) Fund.

When examined as a share of total government expenditure, education spending represents approximately 15.6 per cent of the national budget, while health accounts for around 10.2 per cent and social protection around 4.5 per cent (UNICEF, 2025c).[2] Although nominal allocations increased in 2025, inflation-adjusted spending tells a more constrained story.

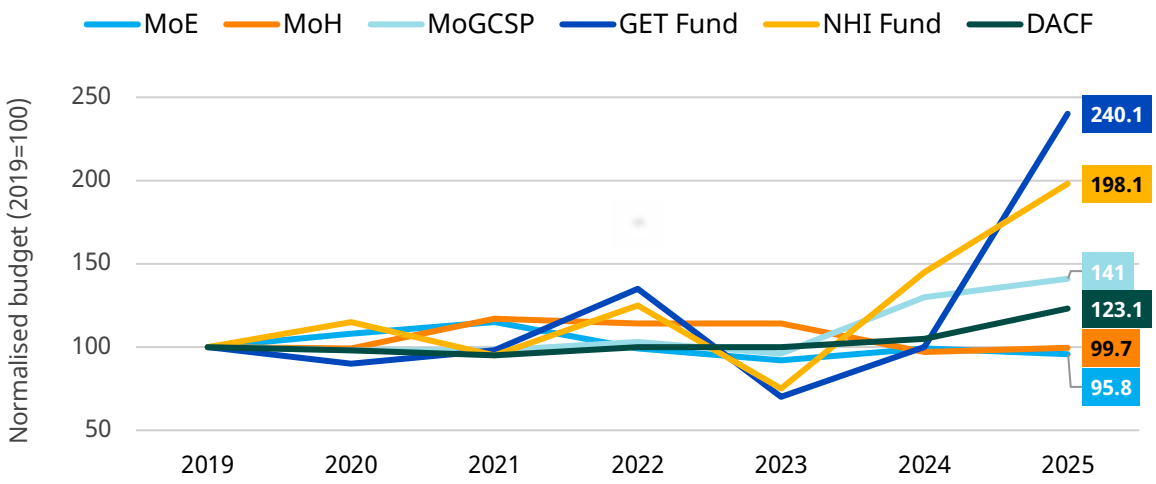
As Figure 3-8 shows, the MoH and the MoGCSP both recorded increases in 2025, with MoGCSP rising by 41 per cent in real terms between 2019 and 2025, largely reflecting

[2] For education, this includes both the Ministry of Education's spending and the Ghana Education Trust Fund (GETFund). For health, it covers spending from the Ministry of Health and the National Health Insurance Scheme. Social protection encompasses the Social Security and National Insurance Trust, the LEAP programme and the School Feeding Programme. To avoid double counting the National Health Insurance Scheme's spending has been included as part of health.

the expanded coverage and higher benefit levels of LEAP. By contrast, real education expenditure is projected to decline, while health spending shows near-zero real growth, limiting scope for expanding coverage or improving service quality under current fiscal conditions. However, between 2024 and 2025, both the NHI Fund and the GET Fund recorded sharp real-term increases. The NHI Fund recorded an increase of roughly 37 per cent while the GET Fund increased even more dramatically, by about 140 per cent, meaning it more than doubled in real terms over the year.

Relative to international benchmarks, Ghana's investment in child-relevant sectors remains low. As a percentage of GDP, the 2025 allocated combined budget for the major social sector's Ministries, Departments and Agencies (MDAs) and statutory funds decreased slightly from 5.5 per cent to 5.1 per cent of GDP (UNICEF, 2025c). The total projected education spending of 3 per cent of GDP is below the UNESCO Incheon benchmark of at least 4–6 per cent of GDP. The projected health expenditure of 2 per cent of GDP also remains below the WHO benchmark of 5 per cent of GDP, or even the Abuja target of allocating 15 per cent of government spending to the sector. Social protection spending, at approximately 0.9 per cent of GDP, also falls below the international averages.

Figure 3-8: Social sector MDAs and Statutory Funds Budgets in real terms (2019-2025)



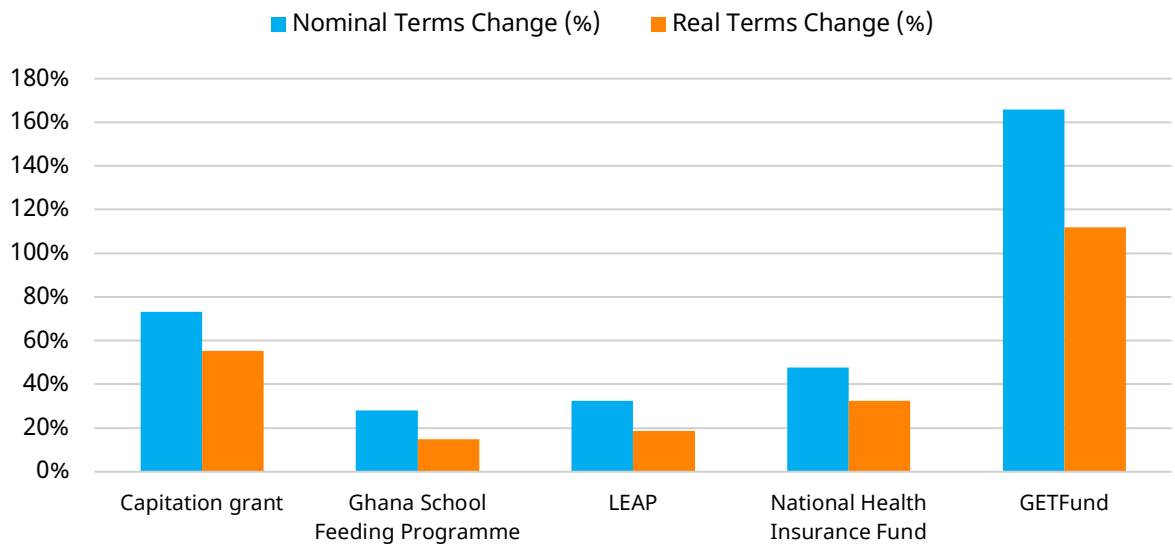
Source: MoF 2025 Budget Statement retrieved from UNICEF (2025c)

On the other hand, key national social sector programmes recorded budget increases between 2024 and 2025 both in nominal and real terms (UNICEF, 2025c). As illustrated in Figure 3-9, across the four programmes, nominal increases were consistently higher than real-term gains, indicating that inflation eroded part of the headline growth. The Capitation grant recorded the largest rise, increasing by 73 per cent in nominal terms and 55 per cent in real terms. The National Health Insurance Fund also grew strongly (48 per cent nominal; 33 per cent real). By contrast, increases were more modest for LEAP (32 per cent nominal; 19 per cent real) and the Ghana School Feeding Programme (28 per cent nominal; 15 per cent real).

An advancement in the health budget is that in March 2025, the Government of Ghana undertook a key health financing reform by uncapping the National Health Insurance Levy (NHIL), a 2.5 per cent consumption levy that constitutes the main source of revenue for the National Health Insurance Scheme (NHIS) (UNICEF, 2025e). Previously, a statutory cap limited the share of NHIL revenue that could be allocated directly to the National Health Insurance Fund (NHIF), with the remainder diverted to the general budget. Removing that cap restores 100 per cent of NHIL revenue to the NHIF, strengthening the predictability and quantum of funding for health services, including maternal, newborn and child health.[3] In addition to the uncapping of the NHIL, in 2025 Ghana launched the Medical Trust Fund, which will complement total health spending, and strengthen the NHIS by addressing the coverage gap for chronic non-communicable diseases including children, ensuring children with chronic non-communicable sicknesses receive the necessary medical treatment and care.

A similar reform was introduced in the education sector through the uncapping of the Ghana Education Trust Fund (GETFund). This restored the Fund's access to the full proceeds of its earmarked 2.5 per cent levy and contributed to an increase in GETFund resources from an estimated GHS 3.9 billion in 2024 to GHS 10.4 billion in 2025. However, the Education Budget Brief notes that the Ministry of Education's allocation declined over the same period, suggesting that the reform may have expanded earmarked financing without yet fully increasing overall fiscal space for education (UNICEF, 2025b).

Figure 3-9: Percentage changes of key social sector programmes budgets from 2024 to 2025 (in nominal and real terms)



Source: MoF 2025 Budget Statement retrieved from UNICEF Summary Budget Brief (2025)

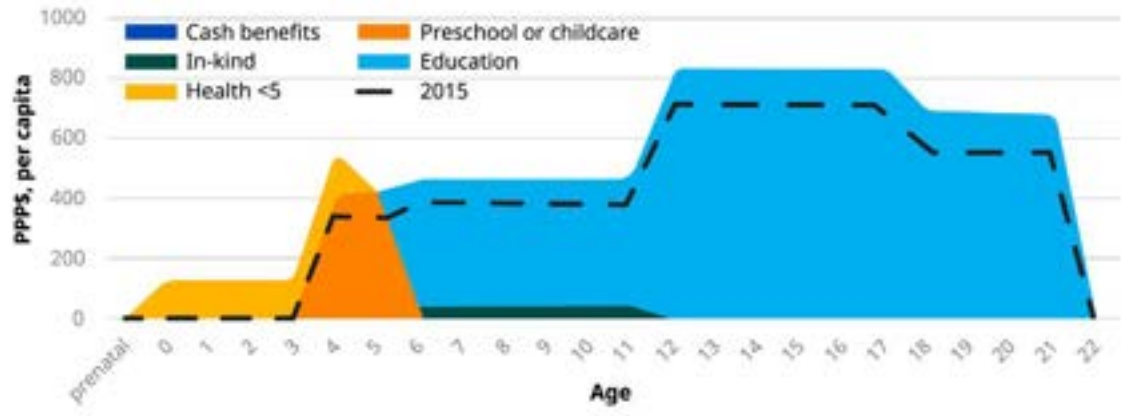
[3] Based on consultation with UNICEF Ghana Health and Nutrition Unit.

Unlike many countries with established child benefits or family allowances, Ghana's social protection benefit system does not include income support for families during the crucial early childhood period and around birth and infancy to support gender-equitable family leave. Similarly, in-kind benefits represent only a small fraction of total spending. This limited social protection coverage risks leaving many vulnerable families without adequate support during key periods of a child's nutritional, health, and developmental needs. In Section 3.6 a more detailed discussion on Ghana's social protection system can be found.

Ghana's overall spending on childhood by age is skewed towards later years of children's life course, compared to best-performing OECD countries. The country's spending by age is heavily weighted towards older children from 11 years or over, those aged 0-3 years are receiving the least investment, despite being disproportionately affected by multidimensional poverty. Education spending accounts for this unequitable spending structure, starting at age three, with minimal investment in under-five health services, cash benefits, or in-kind support, which was the only spending category that saw a reduction between 2015 and 2021. Despite a general increase in spending and the introduction of under-five health spending, the fundamental structure of spending remains largely unchanged, suggesting the lack of a systemic review of spending plans and strategies to make overall improvements in critical early childhood services (Figure 3-10).

Although Ghana's decentralisation reforms have established local government structures, meaningful budget decentralisation remains limited because fiscal authority and resources are still highly centralised. According to the Centre for Social Policy Studies Research (CSPS) at the University of Ghana, Metropolitan, Municipal and District Assemblies (MMDAs) generate relatively little own-source revenue and therefore depend heavily on the District Assemblies Common Fund (DACF) (CSPS, 2019). However, CSPS continues that the DACF allocation formula is not sufficiently pro-poor: it places substantial weight on population-related variables and its "need" component does not systematically channel more resources to poorer districts, which tends to advantage larger, often better-resourced, assemblies (CSPS, 2019)

Figure 3-10: Ghana child spending by age, 2021



Source: UNICEF (forthcoming)

CSPS also highlights implementation weaknesses that further erode the effectiveness of decentralised financing, including delays in fund releases, sizeable deductions at source (reducing the share available for locally prioritised spending), and non-transparent discrepancies between formula-based allocations and actual disbursements. Together, these issues reduce predictability, weaken local planning, and undermine the equalisation function that intergovernmental transfers are meant to serve (CSPS, 2019).

Therefore, while decentralisation is conceptually designed to bring governance and essential services into close proximity with the population, in practice, district assemblies face severe constraints in staffing, financing, and mobility—specifically a lack of functional vehicles for outreach—that hinder the "last-mile delivery" of child protection and social services.[4] These logistical gaps are most prevalent in rural and peri-urban areas, where poor road networks and high costs further marginalize vulnerable children.[5]

3.4 Children in emergency and humanitarian context

Although Ghana is not classified as a large-scale humanitarian crisis setting, children and adolescents are increasingly exposed to overlapping emergency risks that place pressure on essential services and household resilience. Recent UNICEF regional reporting for the Gulf of Guinea coastal countries indicates that approximately 3 million children were in need of humanitarian assistance across Benin, Côte d'Ivoire, Ghana and Togo in 2024, within an estimated 6.1 million people requiring support overall (UNICEF, 2024a).

In Ghana, humanitarian vulnerability is shaped by four interconnected pressures: (i) cross-border displacement linked to insecurity in the Central Sahel, particularly affecting northern border areas; (ii) localised conflict and insecurity, including chieftaincy and land disputes affecting northern regions; (iii) recurrent public health emergencies, including cholera outbreaks; and (iv) climate-related shocks, notably seasonal flooding and drought conditions, which disrupt livelihoods and basic services. UNICEF's 2025 humanitarian planning for West and Central Africa includes Ghana among coastal countries affected by Sahel spillover dynamics, with priorities focused on child protection, continuity of education, health, nutrition and WASH preparedness (WHO, 2026).

Forced displacement represents an important dimension of child vulnerability. UNHCR estimates that Ghana hosted approximately 17,300 registered refugees and asylum-seekers as of December 2024, primarily from neighbouring and regional crisis-affected countries (UNICEF, 2024a). At regional level, insecurity in Burkina Faso and surrounding Sahel areas has contributed to population movements into coastal countries, with an

[4] Based on information gathered from key informant interviews with Department of Children (2025) and Ministry of Local Government, Chieftaincy and Religious Affairs (2025).
[5] Key informant interview with SDG Platform in Ho (2025).

estimated 166,000 displaced persons recorded across these countries by end-2024 (UNICEF, 2024a). Concentrations of displaced populations place additional demands on local systems in hosting areas and are associated with increased risks for children, including documentation gaps, interruptions in schooling, psychosocial stress, protection concerns and barriers to equitable access to health and social services.

In addition to cross-border displacement, internal conflicts also contribute to population movements and service disruptions. For example, the 2025 chieftaincy-related land dispute in the Sawla-Tuna-Kalba district, illustrates the scale of these risks, with reports indicating at least 31 fatalities and displacement of up to 50,000 people, alongside school closures, restrictions on movement, and disruptions to essential services, including increased protection risks such as gender-based violence (UN OCHA, 2025).

Refugee children face additional barriers related to documentation, interrupted education and household poverty. While refugee households are formally integrated into national systems such as NHIS and free senior high school, practical access remains constrained by material costs, language barriers and uneven coverage of the National Household Registry (NHR), limiting inclusion in social protection programmes.

Public health emergencies remain a recurrent risk. Ghana experienced a significant cholera outbreak response cycle in 2024–2025, affecting multiple regions and prompting emergency operations by national authorities and partners (WHO, 2026). Cholera and acute diarrhoea pose heightened risks for children, particularly in settings with constrained access to safe water, sanitation and hygiene. Regional surveillance suggests that Ghana's experience reflects broader West and Central African patterns in which climate variability, population mobility and service gaps increase epidemic vulnerability (WHO, 2026).

Climate-related hazards further compound humanitarian pressures. Seasonal flooding and extreme weather events continue to damage housing, schools and basic infrastructure, increasing the likelihood of temporary displacement and service disruption. In 2024, flooding associated with dam overflows affected communities across central and southern Ghana, while dry spells contributed to food shortages and heightened vulnerability in parts of the north (UNICEF, 2024a). These shocks place additional strain on already stretched systems and highlight the importance of preparedness, early warning mechanisms and resilience-building measures at community level.

3.5 Child's rights governance and institutional capacity

Ghana has established a relatively comprehensive legal and policy framework for the protection of children's rights, anchored in the Constitution, the Children's Act (1998), the Child and Family Welfare Policy (2015), and a range of sectoral strategies. Ghana was also the first country globally to ratify the Convention on the Rights of the Child and has since acceded to most major international and regional child rights

instruments, signalling strong alignment with international normative standards (UNICEF, 2021a). Key elements of the national legal and policy framework include:

- Protection from violence, abuse and exploitation: the Criminal and Other Offences Act, 1960 (Act 29), the Domestic Violence Act, 2007 (Act 732), and the Human Trafficking Act, 2005 (Act 694).
- Family protection and care environment: the Intestate Succession Act, 1985 (PNDCL 111) and the National Plan of Action on Orphans and Vulnerable Children.
- Early childhood and child development: the Early Childhood Care and Development Policy (2004).
- Child labour and hazardous work: the National Plan of Action on Child Labour and the Worst Forms of Child Labour and the Hazardous Child Labour Framework.
- Legal identity and civil registration: the Births and Deaths Registry Act, 2020 (Act 1027).
- Child marriage prevention: the National Strategic Framework for Ending Child Marriage (2017–2026).
- Digital safety and online protection: the Cybersecurity Act, 2020 (Act 1038) and the National Child Online Protection Framework.

Despite this extensive policy architecture, both stakeholders and independent assessments consistently identify implementation gaps as the principal constraint. The challenge is not the absence of legal provisions but limited institutional capacity to operationalise them through sustained financing, coordination, monitoring and accountability. UNICEF's national child protection assessment highlights uneven progress across key protection areas, including birth registration, violence prevention and alternative care, alongside persistent disparities by geography, household wealth and caregiver education, as discussed in subsequent chapters (UNICEF, 2021a).

Implementation gaps are closely linked to chronic under-resourcing and weak decentralised capacity.[6] District social welfare offices report severe funding constraints, staffing shortages and lack of transport, often requiring families to cover operational costs such as fuel for case referrals. These concerns are consistent with wider evidence showing that only 41 per cent of minimum social welfare positions are filled nationally, that only 4 MMDAs meet minimum staffing requirements, and that districts have on average around three social welfare staff serving populations of more than 100,000. Enforcement is further undermined by delays in forensic services and court processes, leading some poor households to abandon cases or accept informal settlements, even in instances of sexual abuse. Coordination mechanisms exist on paper but remain

[6] As made evident across multiple key informant interviews with the Department of Social Welfare (2025), Department of Children (2025) and Ministry of Local Government, Chieftaincy and Religious Affairs (2025).

significantly weaker at district level due to fragmented mandates and limited operational budgets, constraining effective child protection response.

This implementation gap is also reflected in findings from the UN Committee on the Rights of the Child. Ghana's most recent Concluding Observations were issued by the UN Committee on the Rights of the Child in February 2026, and many of the concerns raised align closely with issues highlighted in stakeholder consultations and recent national assessments. The Committee highlighted concerns regarding the absence of a comprehensive policy and strategy on children with dedicated resources for implementation, the need for stronger coordination and cooperation among government institutions at all levels, and persistent weaknesses in child-rights budgeting, including the absence of dedicated budget lines and pressure on spending from debt servicing (United Nations Committee on the Rights of the Child, 2026).

Institutionally, responsibility for child protection is led by the Ministry of Gender, Children and Social Protection, supported by the Department of Children and the Department of Social Welfare at regional and district levels. The 2015 Child and Family Welfare Policy provides a systems-based framework integrating statutory services with community structures, emphasising prevention, early intervention, alternative care, and family strengthening. However, the Policy recognises that the system remains largely reactive, constrained by weak information management, limited human resources, and fragmented coordination, particularly at decentralised levels (MoGCSP, 2015a).

Financing and institutional capacity remain persistent challenges. Ghana does not yet operate a dedicated child-focused budgeting framework, and allocations for child-related services remain insufficient relative to population needs. District Assemblies, which play a central role in implementation, frequently face shortages of trained personnel and constrained fiscal autonomy, weakening service delivery at community level (UNDP, 2023).

A significant legal gap highlighted by stakeholders concerns disability rights. While Ghana enacted the Persons with Disabilities Act in 2006 (Act 715), the absence of a corresponding Legislative Instrument continues to limit enforceability and operational clarity. This gap has particular implications for children with disabilities, affecting access to inclusive education, health services and protection mechanisms, and constraining oversight of service standards. Indeed, stakeholders consistently identified children with disabilities as the most structurally excluded group, noting that the majority of abandoned children in residential care are children with disabilities, compounded by the absence of the Legislative Instrument for the Disability Act.

3.6 Social protection system

Situation

- Ghana has progressively formalised its social protection system through successive policies and legislation, culminating in the Social Protection Act (2025), which provides a stronger legal and institutional framework for delivery, financing and coordination.
- The system is increasingly multi-tiered and diversified, combining social assistance programmes such as LEAP and school feeding with contributory social insurance schemes such as pensions and NHIS, alongside newer efforts to integrate services across sectors through the Integrated Social Services (ISS) model.
- As of mid-2025, LEAP covered 325,000 households, but its beneficiary profile is disproportionately skewed towards adults: 77 per cent of beneficiaries were aged 19 years and above, compared with 23 per cent who were children, with virtually no coverage for children under five.
- Delivery system reforms have been introduced, including the Ghana National Household Registry (GNHR), improvements in LEAP transfer values and payment timeliness, and growing interest in shock-responsive and gender-responsive social protection.

Bottlenecks

- Implementation continues to lag behind policy ambition, with financing constraints, uneven district capacity, and weak operational readiness limiting effective rollout of reforms and integrated service delivery.
- Coverage gaps remain significant, especially for informal workers, vulnerable households excluded from targeting systems, and children, particularly young children, due to the absence of broad child or family cash benefits.
- Administrative systems still face operational weaknesses, including incomplete social registry coverage, delayed payments, barriers in payment access, and weak grievance redress and public awareness mechanisms.

Social protection in Ghana has historically been delivered largely through informal systems, including extended family and community support networks, as well as faith- and welfare-based organisations. Over time, economic change, urbanisation and the gradual weakening of traditional reciprocity mechanisms have increased the demand for more formal and predictable state support, particularly among households facing chronic poverty or repeated exposure to shocks (Abdulai et al., 2021). Within this context, the Government of Ghana has progressively developed a policy architecture aimed at providing a more coherent social protection system, including the National Social Protection Strategy (initially developed in 2007 and later revised in 2012) and later the Ghana National Social Protection Policy (2015) and more recently the Social Protection Act, 2025 (Act 1148) which has been passed to provide a formal legal framework for social protection provisioning in Ghana.

Institutionally, the creation of the MoGCSP in 2013, as a successor to the Ministry of Women and Children's Affairs was intended to strengthen oversight, coordination and strategic leadership of the social protection sector (MoGCSP, 2015b). Administrative reforms have also sought to improve delivery systems, most notably through the establishment and expansion of the Ghana National Household Registry (GNHR), which is intended to support more consistent identification of poor and vulnerable households across programmes (Dias, et al., 2023). There are however concerns around the long-awaited introduction of the revised proxy means test (PMT) within the GNHR which may by design exclude these groups.

The National Social Protection Policy articulates an ambition of an integrated system that combines social assistance, social services, productive inclusion and social insurance, and frames social protection as a mechanism to reduce poverty and vulnerability across the lifecycle (MoGCSP, 2015b). In the short term, the Policy highlights a set of flagship interventions including the Livelihood Empowerment Against Poverty (LEAP), Labour-Intensive Public Works, Ghana School Feeding Programme (GSFP), Education Capitation Grant and health insurance-related exemptions, while positioning longer-term reforms as more preventive and transformative, including expanded social insurance coverage and the gradual realisation of universal schemes such as a universal old-age pension.

The recently enacted Social Protection Act contributes to the government's effort of strengthening and institutionalising social protection in Ghana. The Act provides a clear legal framework for coordinating social protection services, establishing a Social Protection Fund, and ensuring predictable and sustainable assistance for those most in need. It reinforces key national programmes such as the LEAP Programme, the Ghana School Feeding Programme, and other pro-poor interventions. Through these measures, the Act aims to reduce poverty, promote equity, and ensure that vulnerable groups are protected. Furthermore, the MoGCSP has begun a series of consultative meetings to develop a Legislative Instrument (L.I.) for the Social Protection Act. The L.I. will play a key role in translating the provisions of the Act into clear, practical measures that guide effective service delivery. This process will help ensure that the Act becomes a strong mechanism for reducing poverty, protecting vulnerable populations, and promoting equity within Ghana's development agenda

In parallel, Ghana has begun to operationalise an Integrated Social Services (ISS) approach, led by MoGCSP in collaboration with sector ministries and local governments, with UNICEF support. The model seeks to address multidimensional vulnerability by strengthening coordination across social protection, health, education and child protection—improving joint planning, referral mechanisms and case management at national and MMDA level. Early evidence shows uneven implementation across regions, with weaker performance in northern districts and limited execution of child-protection interventions, reflecting persistent constraints in financing and local capacity (see Box 3-1).

Box 3-1: Ghana's Integrated Social Services (ISS) approach

The Integrated Social Services (ISS) approach was launched in 2020 to strengthen coordination between social protection, health, education and child protection systems at both national and sub-national level. The initiative is implemented by the Ministry of Gender, Children and Social Protection (MoGCSP), the Ministry of Local Government, Decentralisation and Rural Development (MLGDRD), the Ministry of Finance (MoF), the Office of the Head of Local Government Service (OHLGS), the Ghana Health Service (GHS), the National Health Insurance Authority (NHIA) and the National Development Planning Commission (NDPC), with a Technical Working Group under the coordination OHLGS and a steering committee under the coordination of the NDPC. The initiative is also supported technically and financially by UNICEF.

ISS aims to address multidimensional poverty and vulnerability by linking households, particularly those benefiting from programmes such as LEAP, to a broader package of services. The approach promotes joint planning, referral mechanisms and case management across sectors, supported by tools such as the Social Welfare Information Management System (SWIMS) and inter-sectoral standard operating procedures for child protection and family welfare. Within its child protection component, ISS supports coordinated prevention, identification, referral and response across multiple protection concerns, including child labour.

Its key objectives are to:

- Support Metropolitan, Municipal and District Assemblies (MMDAs) in implementing child and family welfare and social protection priorities in the National Medium-Term Development Policy Framework.
- Strengthen the coordination, capacity and systems at national and sub-national levels needed to deliver sustainable, integrated services—especially in child protection, social protection and health.
- Enable MMDAs to access financing from various mechanisms, including the District Development Facility, DACF/RFG and internally generated funds, to support social and child protection programmes.

Since its introduction, ISS has expanded from an initial group of districts to more than 210 MMDAs nationwide and is planned to be scaled up to all 261 districts in 2026. Districts are expected to report on a set of 22 child and social welfare indicators through their Annual Progress Reports, covering areas such as birth registration, school participation, child protection responses and access to social services. National reporting shows gradual improvements in indicator reporting among supported districts, although implementation of planned social interventions remains uneven across regions, with lower performance observed in several northern districts.

ISS represents an important institutional step toward integrated, child-sensitive service delivery. However, its effectiveness depends on sustained financing, district-level capacity, clarity of roles across ministries and stronger operational linkages between cash transfers and complementary services.

Source: UNICEF (2025)

Despite this progress, recent assessments continue to highlight a persistent gap between policy ambition and implementation. The most recent system readiness assessment for shock-responsive social protection notes that Ghana's flagship programmes have demonstrated potential to scale during crises, but that rapid expansion is constrained by factors such as incomplete social registry coverage, funding bottlenecks (including delayed access to contingency resources), and operational challenges related to payment systems and grievance handling (Dias, et al., 2023). These constraints are particularly relevant for children, as shocks tend to translate into heightened risks of food insecurity, disrupted schooling, reduced care-seeking, and increased exposure to harmful coping strategies.

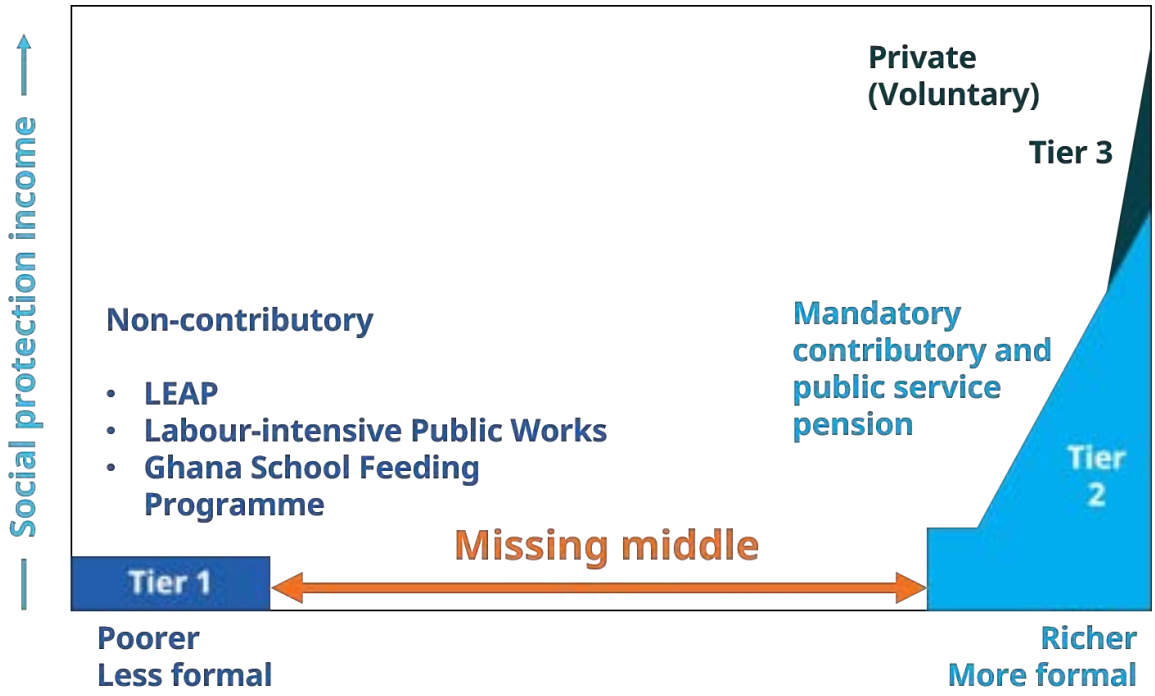
As part of the recommendations from the SRSP readiness assessment and in ensuring that vulnerable populations are protected when disruptions occur, the MoGCSP is developing a national shock responsive social protection strategy that would further enhance the country's social protection system readiness to prepare for, respond to and recover from shocks. The national SRSP Strategy—together with its accompanying Standard Operating Procedures (SOPs) and multi-year implementation plan—forms a comprehensive framework for embedding shock responsiveness within Ghana's social protection system. The Strategy outlines the policy vision, principles and strategic priorities; the SOPs detail the operational and coordination mechanisms required for implementation; and the Implementation Plan translates the strategic direction into concrete, sequenced actions with clear institutional responsibilities, timelines, and resource requirements.

Recent policy reforms further strengthen Ghana's institutional commitment to gender-responsive governance and financing within the social protection ecosystem. The adoption of the Affirmative Action (Gender Equity) Act 2024 and the launch of the National Gender Policy 2025–2034 represent significant milestones in advancing gender equality and embedding gender-responsive budgeting within national development frameworks. The Affirmative Action Act establishes legally binding measures to promote women's participation in decision-making and mandates public institutions to integrate gender considerations into policy planning, budgeting, and accountability mechanisms. Complementing this legislative framework, the National Gender Policy provides a strategic roadmap for addressing structural gender inequalities across sectors, including health, education, economic empowerment, and social protection. Together, these policy shifts strengthen the strategic positioning of the Ministry of Gender, Children and Social Protection as the central coordinating body for gender equality and social protection, reinforcing its mandate to promote gender-responsive budgeting, multisectoral coordination, and more equitable resource allocation for women, children, and vulnerable populations across Ghana's development agenda.

Today, Ghana's overall social protection benefit system can be understood as multi-tiered (Figure 3-11). Non-contributory social assistance programmes, most prominently LEAP, provide a limited protective floor targeted to households classified as extremely poor (Tier 1). Contributory schemes (Tier 2) are more accessible to individuals in formal employment through national social security and pensions, with voluntary private

provision (Tier 3) available to those with sufficient resources. A central limitation of this structure is the large "missing middle": individuals and households in the informal economy with low and volatile incomes who may not qualify for narrowly targeted assistance but are also excluded in practice from contributory insurance mechanisms. This gap is significant in a labour market where informality remains widespread, and it has important implications for children's welfare given the sensitivity of informal household incomes to shocks and seasonal fluctuations.

Figure 3-11: Social Protection benefit system in Ghana



Source: Authors' elaboration

From a child perspective, coverage within Ghana's current social protection system remains uneven. The National Health Insurance Scheme (NHIS) provides the broadest reach, with total coverage rising to 18.5 million people in 2024, equivalent to 53.7 per cent of the population; children under 18 represented the largest membership group, at 6.8 million or 36.7 per cent of all beneficiaries (UNICEF, 2025e). By contrast, cash-based social assistance remains far more limited and insufficiently child-focused. As of mid-2025, LEAP covered 325,000 households, but its beneficiary profile is disproportionately skewed towards adults: 77 per cent of beneficiaries were aged 19 years and above, compared with 23 per cent who were children, with virtually no coverage for children under five.[7]

This limits the programme's contribution to early childhood development and child poverty reduction, despite high levels of multidimensional deprivation among children.

[7] In 2026, The programme is aiming to expand coverage up to 450,000 households by December 2026 through an ongoing reassessment

More broadly, Ghana's social protection system still lacks statutory and categorically targeted cash benefits for families with children, such as child grants or birth grants, which are used in many other countries to provide support during pregnancy, birth and early childhood. As a result, important gaps remain in direct income support for children during the life stages when nutrition, care and developmental investments are most critical.

While LEAP coverage remains limited, particularly for early childhood, there have been some positive developments regarding the adequacy and frequency of transfers. In 2023 and 2024, the LEAP grant per beneficiary household was doubled and indexed to inflation (UNICEF, 2025f). This adjustment aims to lessen the economic impact on vulnerable families and maintain the purchasing power of the LEAP cash grant. Furthermore, in 2025, the grant was increased again based on the LEAP indexation formula, ensuring that its real value remains above 2023 levels. This boost in grant value supports household consumption and investment. Additionally, payment delays decreased from 117 days in 2022 to 28 days in 2025 (UNICEF, 2025f).[8] This reduction alleviates financial stress for families with children, however, it remains significant and irregularity persist. Of the six scheduled payment cycles in 2025, three were delivered on time, undermining households' ability to plan for children's needs. Indeed, the positive impacts from LEAP would have likely been greater if payment delays were not so frequent and prolonged.

Recent system reviews indicate that Ghana has built several delivery system components that could support more adaptive social protection, but that implementation constraints persist. The shock responsiveness assessment highlights that LEAP and the GSFP have been used to respond to shocks and are viewed as programmes with potential for vertical expansion (top-ups) and horizontal expansion (temporary enrolment of new beneficiaries). However, reliance on GNHR data for expansion targeting is constrained by incomplete coverage, which can result in the exclusion of vulnerable groups (Dias, et al., 2023). Payment mechanisms are generally functional, but ID requirements and barriers to digital financial access can exclude particular groups, including refugees, displaced persons, persons with disabilities, and individuals in hard-to-reach areas (Dias, et al., 2023). The same assessment also identifies limitations in grievance and complaints resolution systems, including low awareness and delays in resolving complaints through the Single Window Citizens Engagement Service (Dias, et al., 2023).

Citizen perceptions research further suggests that limited public understanding of social protection, weak rights-based messaging, and the perception of benefits as discretionary "gifts" rather than entitlements can undermine accountability and uptake. Many respondents reported limited knowledge of programme eligibility criteria, financing arrangements and feedback mechanisms, and social protection was rarely framed as a citizenship-based right in public understanding (Abdulai et al., 2021). These

[8] Of the six scheduled payment cycles in 2025, three were delayed, undermining households' ability to plan for children's needs (UNICEF, 2025f).

findings showcase the importance of predictable financing, transparent eligibility rules, and accessible grievance mechanisms, particularly for households with children.

Recent policy efforts have also sought to strengthen gender and age responsiveness within the social protection system. MoGCSP's Roadmap for strengthening the gender responsiveness of social protection programmes identifies persistent gendered vulnerabilities—including unpaid care burdens, exposure to gender-based violence, teenage pregnancy and child marriage, and economic shocks—and notes limited progress in systematic gender mainstreaming in programme design and implementation. The roadmap proposes adjustments and coordination measures across flagship programmes including LEAP, GSFP, National Health Insurance Scheme (NHIS), Labour-Intensive Public Works and productive inclusion interventions (Ministry of Gender, Children and Social Protection, 2023). For children and adolescents, these reforms are relevant both directly (through programme targeting and service linkages) and indirectly (through impacts on caregivers' income security, safety and time use).

3.7 Urbanisation and urban deprivation

Ghana's settlement pattern reflects rapid urbanisation alongside persistent deficits in housing quality and access to basic services. According to the 2021 Population and Housing Census and the 2025 thematic report on slums and informal settlements, only 9.9 per cent of Ghana's 17,989 localities meet the enhanced "Urban-2" classification defined not only by population size but also by access to electricity, potable water, health and education facilities. Yet, these areas accommodate the majority of households nationwide (GSS, 2025). Urban-2 localities account for just 5 per cent of Ghana's total land area, highlighting the spatial concentration of population growth.

Urbanisation has accelerated markedly over recent decades. Ghana's urban population increased from 23.1 per cent in 1960 to 56.7 per cent in 2021 and is projected to reach approximately 60.7 per cent by 2030, indicating continued demographic pressure on urban systems over the medium term (GSS, 2025). This trajectory aligns with the demographic dynamics outlined in Section 3.1, suggesting that future population growth, driven largely by young cohorts will be increasingly urban in character.

Despite this urban expansion, living conditions remain highly unequal. Nationally, 46.1 per cent of urban households (around 2.2 million) exhibit at least one slum characteristic, including inadequate water or sanitation, overcrowding, or non-durable housing. In population terms, approximately 4.82 million people or 30.8 per cent of Ghana's urban population live in slum conditions, a proportion higher than the global average (24.7 per cent), though lower than the Sub-Saharan Africa average (53.9 per cent) (GSS, 2025).[9] Slum prevalence varies substantially by region, with the highest

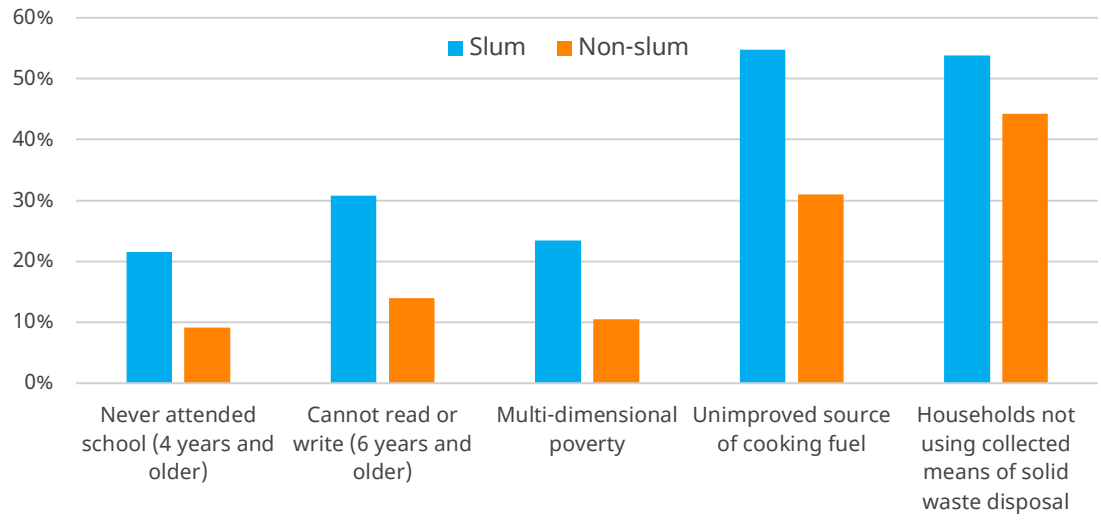
[9] Assuming constant proportion across all ages of the urban population, this represents around 222 thousand children 0-18 years.

concentrations observed in the Northern, Savannah, Oti and parts of Greater Accra and Ashanti Regions.

Urbanisation also has important implications for children. Based on the 2021 Population and Housing Census, children aged 0–18 number approximately 7.21 million in urban areas compared to 6.38 million in rural areas, meaning that urban areas now host a larger absolute population of children. However, children constitute a smaller share of the total urban population (41 per cent) than in rural areas (48 per cent), reflecting differing age structures across settlement types (Census, 2021). This pattern indicates that while rural areas remain relatively younger, urban centres already accommodate the largest number of children nationwide, with direct implications for the scale of demand for education, health, protection and basic services in towns and cities.

According to GSS there are stark disparities between slum and non-slum urban areas, as depicted by Figure 3-12. Multidimensional poverty is more than twice as prevalent in slum communities, and educational, health and sanitation outcomes are consistently worse in slums. Further, mortality rates are higher: there are 41.6 deaths (per 10,000 persons) in slum areas as opposed to 30.7 in non-slum areas. These patterns highlight that urban residence does not automatically translate into improved wellbeing, particularly for children growing up in informal settlements (GSS, 2025a). In fact, stakeholders cautioned that urban poverty is often more severe than rural deprivation in informal settlements, where children lack access to government schools, safe water and protection services, highlighting that geographic averages sometimes mask deep intra-urban inequality.[10]

Figure 3-12: Key indicators of well-being in slum and non-slum urban areas



Source: Ghana Statistical Services (2025). Notes: Y-axis represents percentage (%) but varies by indicator. Never attended school = % population; Cannot read or write = % population; Multi-dimensional poverty = % population; Unimproved cooking fuel = % households; No sanitation means = % households. Blue = slum, Orange = non-slum.

[10] As supported by consultations with the Department of Social Welfare, Department of Sociology (University of Ghana) and UNDP.

3.8 Forward-looking risks and opportunities

The trends described in this chapter point to a future in which increasing numbers of children and adolescents will grow up under conditions shaped by rapid urbanisation, persistent poverty, climate volatility and constrained public investment. These structural forces are likely to interact over time, meaning that early disadvantages may accumulate unless systems respond at scale.

Population projections indicate continued growth through the next decade, with urban areas absorbing a rising share of this increase. Given that a substantial proportion of urban residents already live in slum conditions, the absolute number of children living in deprived urban environments is likely to rise unless housing supply, infrastructure and basic services expand in line with demographic change.

Economic vulnerability also remains widespread. High levels of income poverty and multidimensional deprivation will likely persist given current levels, while fiscal constraints may continue to limit expansion of child-relevant services and social protection. Climate-related shocks, particularly flooding and environmental degradation, are expected to intensify, reinforcing risks for households in climate-sensitive and low-income settings.

These forward-looking pressures are not uniform. Their effects are likely to vary across geography, gender, disability status and household income. As discussed in Box 3-2, children perceive many of the same structural concerns, including environmental degradation, unequal education quality and limited opportunities, while also emphasising aspirations related to digital inclusion and accountable governance.

Box 3-2: Children's perspectives on Ghana's future

In 2025, UNICEF Ghana facilitated foresight workshops with children in selected regions using a Three Horizons approach. Participants highlighted environmental degradation, unequal education quality, digital exclusion and weak enforcement of protections as present challenges. Looking towards 2035, they emphasised equitable access to education, safe water and sanitation, environmental protection, digital inclusion and transparent governance.

Although qualitative and not nationally representative, these perspectives reinforce the structural risks identified in this chapter and underline the importance of incorporating children's voices into forward planning.

Rather than acting independently, demographic, economic and environmental dynamics are likely to shape children's experiences in cumulative ways. The following chapters therefore examine how these risks and opportunities manifest across different stages of childhood and adolescence, and where strategic entry points exist to strengthen outcomes over time.

CHAPTER 4.

PREGNANCY AND BIRTH

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4 Pregnancy and birth

Pregnancy and birth represent a critical entry point into the lifecycle, shaping both immediate survival outcomes and longer-term development trajectories. This chapter examines maternal and newborn health in Ghana, focusing on access to essential services along the continuum of care, patterns of utilisation, and key outcomes including maternal and neonatal mortality. It applies an equity lens to identify disparities by geography, socio-economic status, and other characteristics, and explores system-level bottlenecks affecting service delivery, care practices, and enabling environments.

A Continuum of care during pregnancy and delivery

Access to quality maternal health services during pregnancy and delivery is a central determinant of both maternal and newborn outcomes. This section examines utilisation of antenatal care and skilled birth attendance as key entry points to the continuum of care, highlighting patterns of coverage, inequalities across population groups, and constraints affecting service availability and uptake.

4.1 Antenatal care and delivery

Situation

- Antenatal care (ANC) coverage is high, with around 98 per cent of women attending at least one visit and 89 per cent completing four or more contacts (DHS, 2022).
- The share of women achieving eight or more ANC visits increased from 25 per cent in 2008 to 39 per cent in 2022 (DHS, 2022).
- Improvements are observed in both urban and rural areas, though inequalities by age, wealth and geography persist.

Bottlenecks

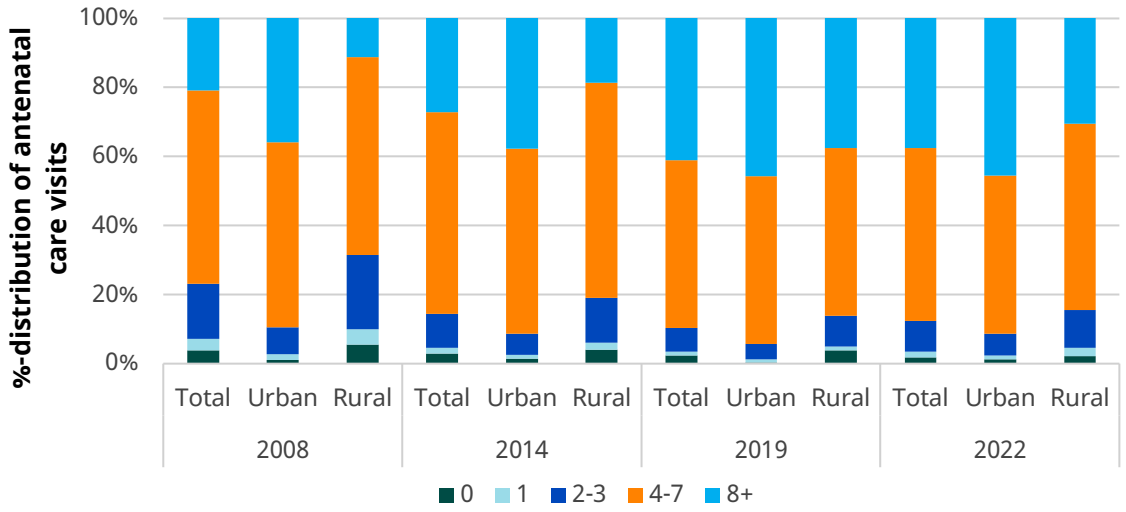
- Early initiation of ANC remains uneven, particularly among adolescents and women in poorer or remote households.
- Many women do not receive the full package of recommended interventions during pregnancy, indicating gaps in quality and continuity of care.
- Disparities in service readiness, staffing and referral linkages continue to affect outcomes.

Pregnancy represents a critical period in the lifecycle, during which the health of both mother and child is shaped by access to timely, continuous and quality care (UNICEF, 2024b). Antenatal services provide an opportunity to identify and manage risks, support maternal wellbeing and prepare families for safe delivery and early newborn care (UNICEF, 2019). The adequacy and quality of care received during pregnancy

therefore have important implications for survival, healthy birth outcomes and the transition into the postnatal period (WHO, 2016).

Ghana has recorded steady improvements in antenatal care utilisation over time. As shown in Figure 4-1, the proportion of women completing four or more ANC visits has increased consistently across successive DHS rounds up to 2019, with a notable rise in the share completing eight or more visits since 2019. Between 2019 and 2022, the share of pregnant women with 8 or more ANC visits has apparently plateaued around 40 per cent, likely due to COVID. Yet, this trend since 2008 reflects expanded service availability and outreach, including through the Community-based Health Planning and Services (CHPS) system (see Box 4-1), alongside financial protection for maternal care under the National Health Insurance Scheme.

Figure 4-1: Distribution of antenatal care visits among women, by year and area of residence



Source: DHS (2008, 2014 and 2022) and MIS-DHS (2019)

While utilisation has improved, increased contact with services has not consistently translated into better maternal and newborn outcomes. Evidence from recent analyses indicates that many women initiate ANC late in pregnancy or miss key components of recommended care (Abanaga, Ziblim, & Boah, 2025). In northern Ghana, fewer than one in four women received high-quality ANC, defined by early initiation, adequate visit frequency and receipt of core services, and higher-quality care was significantly associated with reduced risk of low birth weight and preterm delivery (Ghana Statistical Service, 2022). This highlights the central importance of care content and timing, not only visit counts. Stakeholders interviewed for this SitAn similarly highlighted that the content and quality of care received during ANC visits varies considerably, particularly in underserved settings.

Box 4-1: Community-based Health Planning and Services (CHPS) in Ghana

CHPS is Ghana's national strategy for delivering primary healthcare at the community level. Introduced in 1999, the programme places community health officers and volunteers within local communities to provide preventive services, health education, referrals and basic maternal and child health care. By bringing services closer to households, particularly in rural areas, CHPS aims to reduce geographic barriers to accessing care and strengthen contact with services such as antenatal care. Despite its expansion, implementation challenges remain in some areas, including staffing, logistics, and uneven service coverage (Adusei et al., 2024).

Patterns of utilisation also vary across population groups. Adolescents, women from poorer households and those living in remote areas are less likely to complete recommended visits or receive comprehensive care. For example, women aged 20–24 in Ahafo Region had significantly higher odds of completing recommended ANC contacts compared with adolescents aged 15–19, pointing to additional barriers faced by younger mothers, including stigma, reduced autonomy and weaker continuity across services (Tabiri, 2024).

These patterns suggest that remaining challenges relate less to increasing the number of contacts and more to ensuring early initiation and consistent delivery of the full recommended package of care. Qualitative consultations emphasised variability in service readiness and continuity of care across facilities and districts, including constraints related to staffing, referral linkages and the availability of essential supplies. These constraints may help explain why increased utilisation has not consistently translated into improved outcomes.

4.2 Skilled birth attendance

Situation

- The proportion of births attended by a skilled provider has increased substantially over the past three decades, rising from around 43 per cent in the 1990s to around 88 per cent national coverage by 2022 (DHS, 1993; DHS, 1998; DHS, 2022).
- Gains have occurred in both urban and rural areas, with a narrowing but persistent urban–rural gap: As of 2022, 95.3 per cent of births in urban areas are attended by a skilled provider, compared to 81 per cent in rural areas (DHS, 2022).
- Large disparities by household wealth remain, with consistently lower coverage among women from poorer households: while almost all births among the highest quintile are attended by a skilled provider (98 per cent), coverage is much lower among the lowest quintile (73 per cent) (DHS, 2022).

Bottlenecks

- Access to skilled attendance remains uneven across geography and socio-economic groups.
- Variations in facility readiness, staffing and referral capacity affect the quality of care received at delivery.
- Adolescents and women in poorer or remote households continue to face additional barriers related to distance, indirect costs and decision-making autonomy.

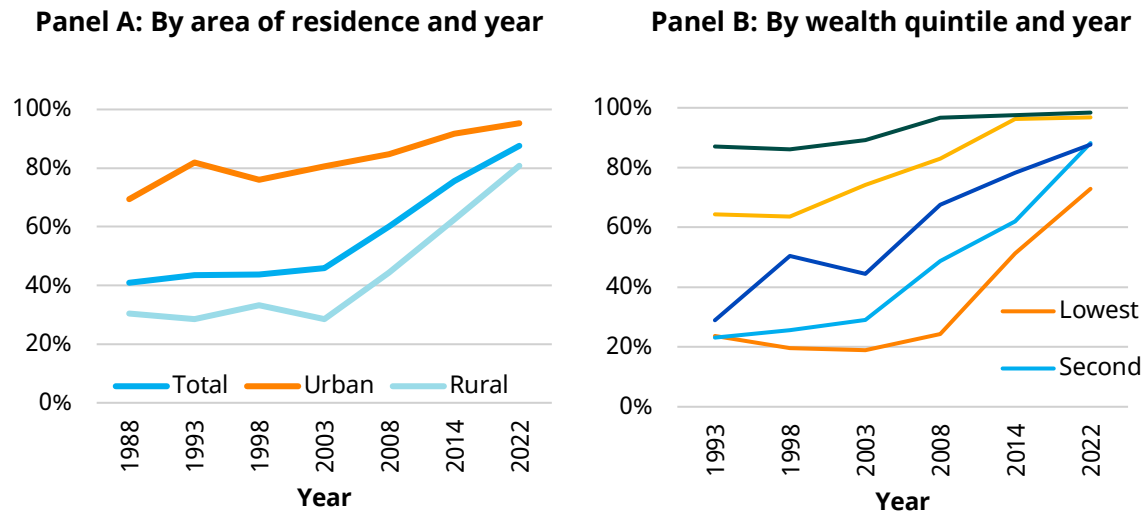
Childbirth represents the point in the lifecycle when risks to both mother and newborn are highest (UNICEF, 2024b). Skilled attendance at birth is widely recognised as one of the most critical interventions for preventing maternal and neonatal deaths, enabling early identification and management of complications, timely referral and initiation of immediate newborn care.

Ghana has achieved major gains in expanding access to skilled delivery. As shown in Figure 4-2 (Panel A), the proportion of births attended by a skilled provider increased steadily from the late 1980s to 2022. Progress has occurred in both urban and rural areas, with rural coverage rising particularly sharply since the early 2000s. Although urban women remain more likely to deliver with skilled assistance, the gap between urban and rural areas has narrowed to approximately 15 percentage points, reflecting expanded outreach and facility-based delivery services nationwide.

Despite these improvements, substantial socio-economic inequalities persist. Figure 4-2 (Panel B) shows that coverage remains strongly patterned by household wealth. While nearly all births among women from the richest households are attended by skilled personnel, coverage among the poorest households, although improving, remains markedly lower. Adolescents also tend to have lower utilisation of skilled delivery services, reflecting intersecting challenges including unintended pregnancy, stigma, reduced decision-making power and weaker linkage between antenatal care and delivery services (UNICEF, 2024c). These disparities point to barriers that extend beyond coverage, including indirect costs and uneven service readiness, alongside social barriers affecting adolescents' access to respectful and timely care.[11]

[11] As supported by multiple key informant interviews with Ghana Health Service, UNICEF Ghana Health and Nutrition Unit, and both the Departments of Social Welfare and Children of the MoGCSP.

Figure 4-2: Births attended by a skilled provider, by area of residence and household wealth



Source: DHS (1988, 1993, 1998, 2003, 2008, 2014 and 2022)

At the same time, utilisation alone does not guarantee safe outcomes. These indicators capture whether deliveries are attended by skilled providers, but do not reflect whether facilities are consistently equipped, adequately staffed or prepared to manage obstetric and newborn complications. Variations in service readiness, referral systems and provider workload mean that differences in quality may continue to influence survival even as coverage expands (Abredu et al., 2024). As coverage expands, further progress will depend on strengthening facility readiness and effective referral, particularly in underserved settings.[12]

B Survival outcomes

Maternal and neonatal mortality provide critical indicators of health system performance and broader social conditions affecting women and newborns. This section reviews levels and trends in maternal and neonatal mortality, situating observed outcomes within service readiness, continuity of care, and underlying household and community factors.

4.3 Maternal mortality

Situation

- The maternal mortality ratio (MMR) was estimated at 301 deaths per 100,000 live births in 2021 (GSS, 2024a).
- The decline over the past decade has been modest and uneven.

[12] As supported by consultations with Ghana Health Service and UNICEF Ghana Health and Nutrition Unit.

- Rural mortality has increased from 364 to 374 deaths per 100,000 live births, whereas urban areas experienced the opposite trend, where it declined from 271 to 233, widening geographic disparities (GSS, 2024a).

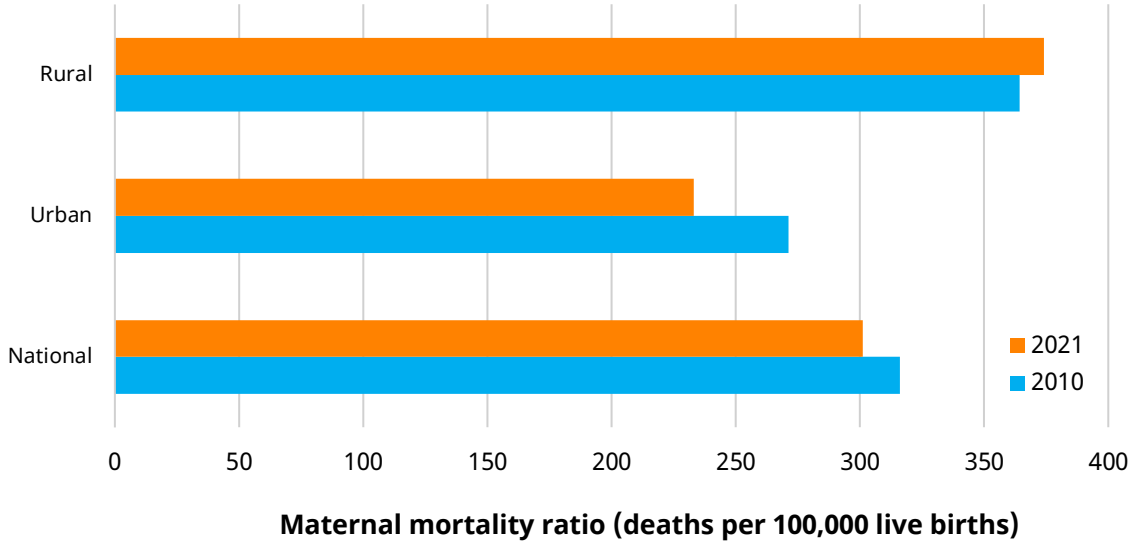
Bottlenecks

- Delays in recognising and managing obstetric complications persist, particularly in rural settings.
- Referral systems, emergency obstetric capacity and facility readiness remain uneven.
- Socio-economic and geographic inequalities continue to shape survival risks.

Maternal mortality remains a critical indicator of women's health and of the functioning of the health system during pregnancy, childbirth and the immediate post-partum period. Despite expansion of maternal health services over recent decades, preventable deaths continue to occur, particularly among women facing geographic and socio-economic disadvantage.

Ghana has recorded a gradual but slow decline in maternal mortality. As shown in Figure 4-3, the maternal mortality ratio decreased from 316 deaths per 100,000 live births in 2010 to 301 in 2021. While this reflects progress, the pace of reduction remains modest relative to national targets and the Sustainable Development Goal commitment to reduce maternal mortality to below 70 per 100,000 live births by 2030.

Figure 4-3: Maternal mortality ratio (per 100,000 live births), by area of residence and year



Source: GSS (2024a)

Importantly, progress has not been evenly distributed. Urban areas experienced a reduction in maternal mortality, declining from 271 to 233 deaths per 100,000 live births over the same period (GSS, 2024a). In contrast, rural mortality increased from 364 to 374, widening the rural–urban gap (GSS, 2024a). This divergence suggests

persistent disparities in timely access to quality obstetric care, emergency response capacity and referral systems.

These patterns suggest that maternal mortality in Ghana is increasingly shaped by differences in system readiness rather than service contact alone. Qualitative consultations highlighted persistent constraints in emergency readiness and referral, including delays in reaching appropriate care and variability in facility capacity to manage obstetric complications. Where these capacities are limited, especially in rural settings, delays in receiving appropriate care continue to result in preventable deaths.

Accelerating reductions in maternal mortality will therefore require targeted investments in emergency obstetric services, referral efficiency and workforce distribution, ensuring that improvements in coverage translate into effective response when complications arise.

4.4 Neonatal mortality

Situation

- Neonatal mortality was estimated at 19 deaths per 1,000 live births in 2022 (DHS, 2022).
- While this represents substantial progress over three decades, reductions have been slower and less consistent than for postneonatal mortality.
- Newborn deaths now account for an increasing share of under-five mortality.

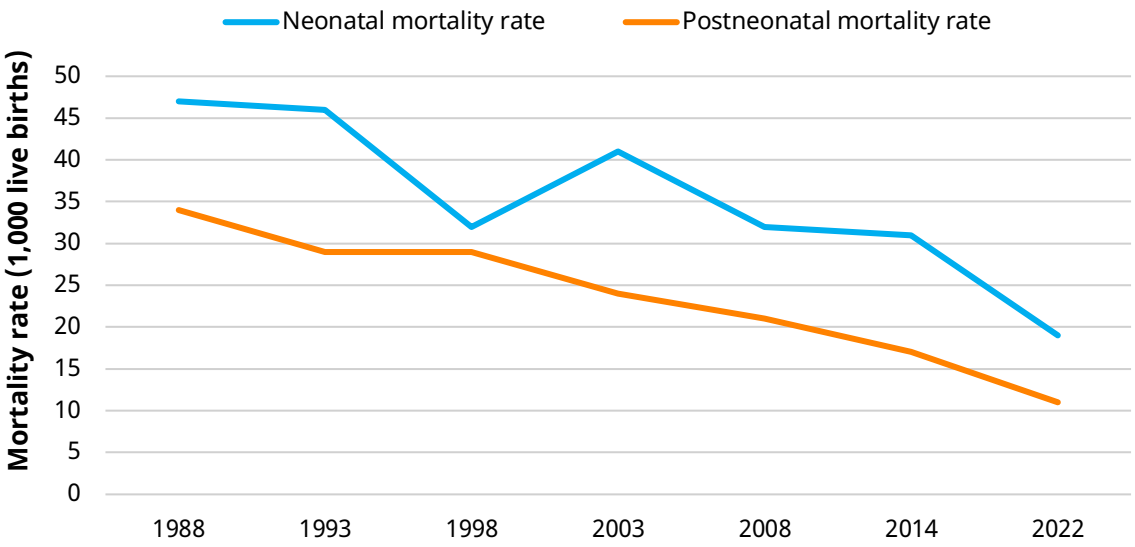
Bottlenecks

- Most deaths occur within the first days of life, placing high demands on quality of care at delivery and immediately after birth.
- Complications related to prematurity, birth asphyxia and infection remain leading causes.
- Gaps in facility readiness, referral systems and early postnatal care continue to limit rapid response.

The neonatal period, defined as the first 28 days of life, represents the most vulnerable stage of childhood and a critical determinant of overall survival (UNICEF, 2025b). Outcomes during this window are closely linked to maternal health, quality of intrapartum care and access to timely postnatal services (UNICEF, 2024c). Effective antenatal risk detection, skilled delivery, immediate newborn care and early identification of complications are therefore central to preventing neonatal deaths (UNICEF, 2024c).

Ghana has achieved substantial reductions in neonatal mortality over the past three decades. As shown in Figure 4-4, rates declined from approximately 47 deaths per 1,000 live births in the late 1980s to around 19 in 2022, representing a reduction of more than 50 per cent. However, progress has been uneven. After early declines in the 1990s, neonatal mortality increased in the early 2000s before resuming a gradual downward trend. In contrast, post neonatal mortality declined more steadily over the same period.

Figure 4-4: Neonatal and post neonatal mortality rates, by year



Source: DHS (1988, 1993, 1998, 2003, 2008, 2014 and 2022)

The slower and more variable reduction in neonatal deaths highlights persistent challenges in care at and around birth. As overall child mortality declines, deaths are increasingly concentrated in the first week of life, when survival depends heavily on the quality and timeliness of clinical response. Immediate causes include complications of prematurity, birth asphyxia, thermal stress and infection, conditions that require skilled attendance, functional referral pathways and adequately equipped facilities (Abanaga, Ziblim, & Boah, 2025).

Socio-economic inequalities further shape neonatal survival. Evidence indicates lower mortality among newborns from wealthier households compared with poorer families, reflecting differences in access to timely care and facility quality (Ghana Statistical Service, 2022). For example, neonates in households in the middle wealth quintiles experienced substantially lower mortality risk than those in the poorest households in parts of central Ghana.

Further reductions in neonatal mortality will depend on strengthening readiness to provide timely and effective care around delivery and in the first days of life, including early identification and referral of newborn complications, particularly in underserved areas.[13] As neonatal deaths increasingly drive under-five mortality, addressing these system-level constraints will be essential to sustaining gains in child survival.

[13] Based on consultations, including the Ghana Health Service (GHS), the UNICEF Health and Nutrition Unit, and the National Development Planning Commission (NDPC).

C Early caregiving practices

Early postnatal care and infant feeding practices play an important role in supporting newborn survival and healthy development. This section examines postnatal service utilisation and early initiation of breastfeeding, considering how caregiver behaviours, cultural norms, and health system factors interact to shape early life outcomes.

4.5 Postnatal care

Situation

- A large majority – around 87 per cent - of mothers and newborns receive a postnatal check within the first two days of birth (DHS, 2022).
- Coverage is high in both urban and rural areas, with only small proportions reporting no postnatal contact.
- Care is often provided jointly to mother and newborn.

Bottlenecks

- Fewer than half of women receive the full package of recommended postnatal interventions within 48 hours.
- Completeness of care is strongly associated with facility delivery, insurance coverage and prior antenatal engagement.
- Gaps in continuity across pregnancy, delivery and postnatal services persist, particularly in rural areas.

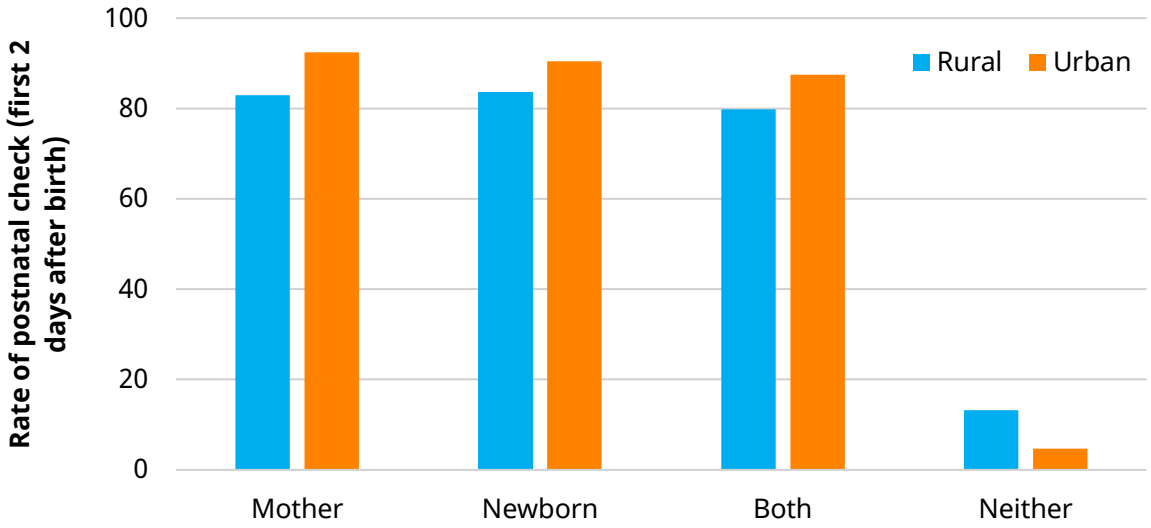
The period immediately following birth is one of heightened vulnerability for both mother and newborn (UNICEF, 2021b). Timely postnatal care provides an opportunity to detect complications, support early breastfeeding, promote essential newborn practices and ensure referral where risks are identified (UNICEF, 2021b). Effective postnatal services therefore form a critical bridge between delivery and longer-term child survival and development.

Coverage of early postnatal contact in Ghana is high. As shown in Figure 4-5, most mothers and newborns receive a postnatal check within two days of birth in both urban and rural areas, with urban coverage consistently slightly higher. Similar patterns are observed when examining care for mothers alone, newborns alone or both together, indicating that follow-up is frequently delivered as integrated care for the mother-baby pair.

However, these indicators capture whether contact occurred, not whether women and newborns received the full set of recommended interventions. Recent analysis of DHS (2022) data indicates that only around 46 per cent of women received complete postnatal care within the first 48 hours, meaning that more than half missed at least one essential component (Yabila, Amenu, Gmayinaam, & Geyevu, 2024). Completeness is higher among women who delivered in health facilities, are covered by national health insurance and attended the recommended number of antenatal visits,

highlighting the importance of continuity across the maternal care pathway (Yabila, Amenu, Gmayinaam, & Geyevu, 2024).

Figure 4-5: Postnatal checks within two days of birth for mothers and newborns, by area of residence



Source: DHS (2022)

4.6 Breastfeeding

Situation

- Early initiation of breastfeeding has improved substantially, with nearly six in ten newborns breastfed within the first hour of life in 2022.
- Exclusive breastfeeding among infants under six months increased markedly from very low levels in the 1990s but has plateaued at just over half in recent years.
- Continued breastfeeding at one year remains high, while continuation to two years has declined.

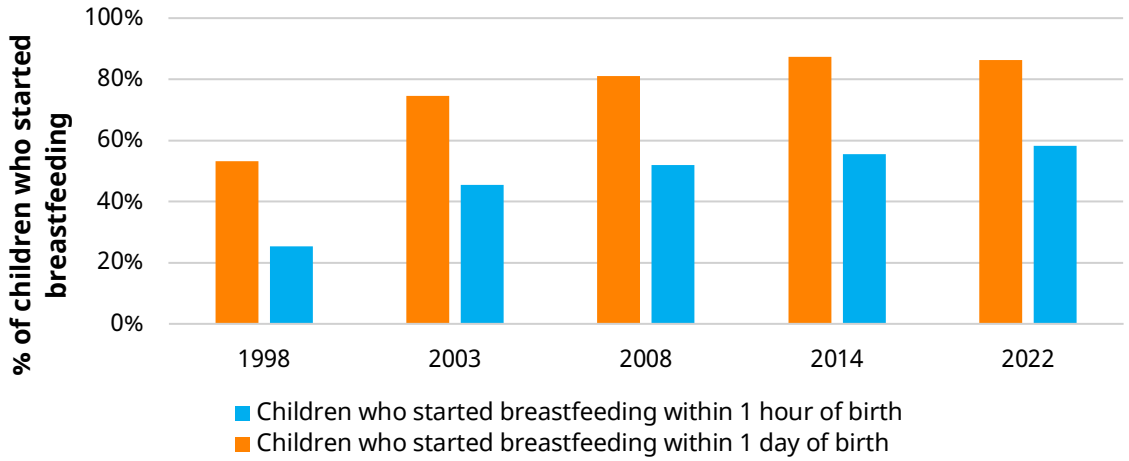
Bottlenecks

- Sustaining exclusive breastfeeding for six months remains challenging, particularly in urban areas.
- Short maternity leave, informal employment, perceived insufficient milk and early introduction of substitutes reduce continuation.
- Limited postnatal follow-up and community-based support weaken adherence once routine contact with health services declines.

Breastfeeding is a foundational determinant of child survival, nutrition and development (UNICEF, 2009). Feeding practices in the hours and months following birth shape immunity, growth and cognitive outcomes, and influence vulnerability to infection and malnutrition in early childhood (UNICEF, 2009; UNICEF, 2025a).

Ghana has achieved clear gains in the early initiation of breastfeeding. As shown in Figure 4-6, while initiation within one day of birth has remained consistently high for decades, the proportion of newborns breastfed within the first hour increased sharply from around 25 per cent in 1998 to nearly 60 per cent in 2022, aligning more closely with UNICEF and WHO recommendations. This improvement reflects expanded facility delivery and greater integration of breastfeeding counselling into antenatal and immediate postnatal care.

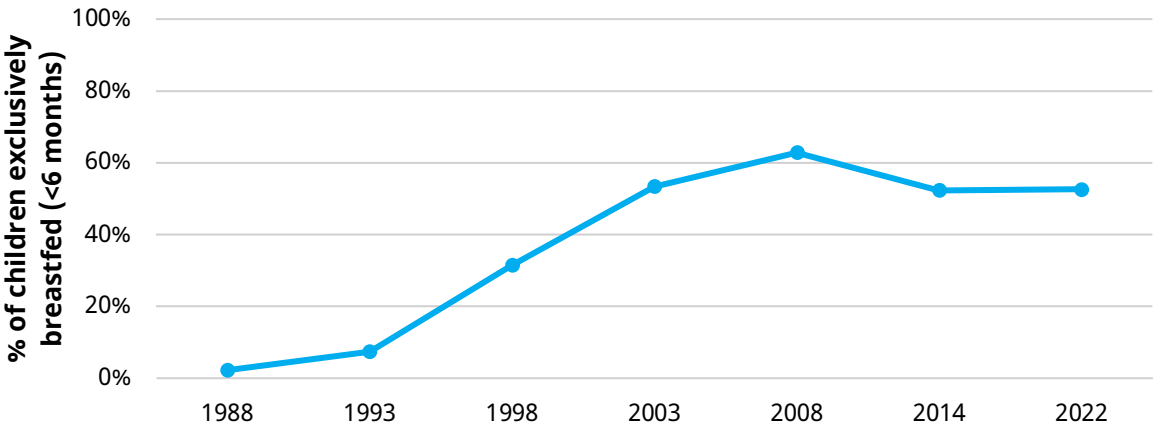
Figure 4-6: Early initiation of breastfeeding, by selected years



Source: DHS (1998, 2003, 2008, 2014 and 2022)

Despite progress in initiation, sustaining optimal feeding practices remains more difficult. Exclusive breastfeeding among infants under six months rose steadily from the late 1980s and peaked at over 60 per cent around 2008 but has since plateaued in the low 50 per cent range (Figure 4-7). Rates remain lower in urban areas than rural settings and continue to fall short of the World Health Assembly target of 70 per cent. Facility delivery, adequate antenatal care and breastfeeding counselling are associated with higher exclusivity, while urban residence, short maternity leave, perceived insufficient milk and early introduction of complementary foods are linked to lower adherence.

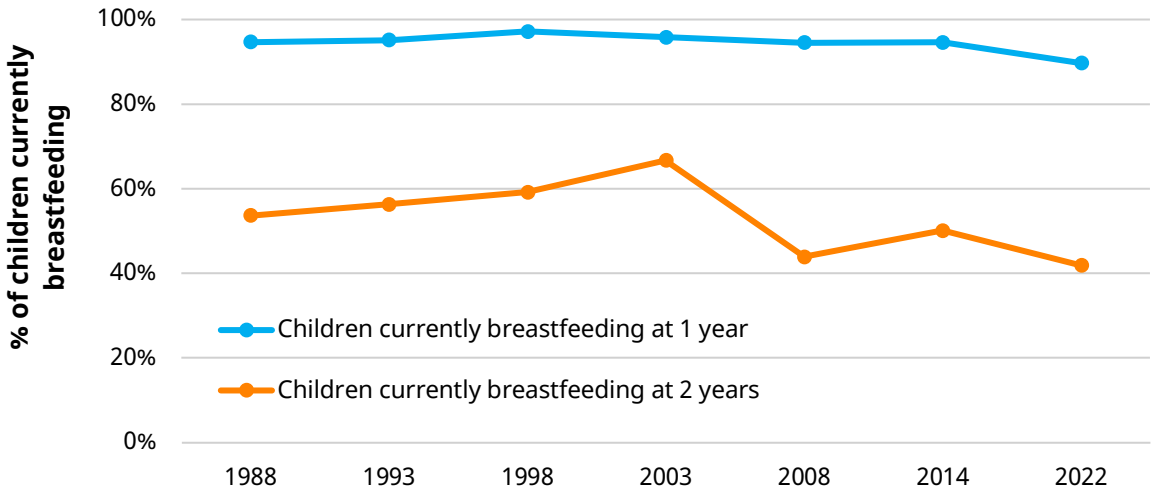
Figure 4-7: Exclusive breastfeeding among infants under six months, by selected years



Source: DHS (1988, 1993, 1998, 2003, 2008, 2014 and 2022)

Continuation of breastfeeding at one year has remained consistently high, close to or above 90 per cent across survey rounds. However, continuation to two years has declined markedly since the early 2000s, falling from around 70 per cent to approximately 45 per cent in 2022 (Figure 4-8). This trend suggests increasing pressures on caregivers as children grow older, alongside limited enabling conditions for sustained breastfeeding.

Figure 4-8: Continued breastfeeding at one and two years, by selected years



Source: DHS (1988, 1993, 1998, 2003, 2008, 2014 and 2022)

Taken together, these patterns indicate that Ghana has been successful in improving early initiation but faces persistent challenges in maintaining exclusive and continued breastfeeding over time. Barriers extend beyond awareness to include maternal workload, informal employment conditions and limited access to ongoing counselling and community support once routine postnatal contact declines. Because breastfeeding practices influence risks of infection, malnutrition and delayed development, these gaps have implications that extend well beyond infancy, particularly for children already affected by poverty and limited-service access.

D Forward-looking considerations

The evidence presented in this chapter highlights both important gains and persistent vulnerabilities during pregnancy, childbirth and the immediate postnatal period. While coverage of antenatal care, skilled birth attendance and early postnatal contact has expanded substantially, outcomes remain strongly shaped by inequalities in service quality, continuity and emergency readiness. These patterns suggest that survival and wellbeing at birth increasingly depend not only on access to services, but on the capacity of health systems to deliver timely, complete and high-quality care when risks arise.

Looking ahead, Ghana's continued population growth and urbanisation are likely to increase demand for maternal and newborn services, particularly in under-resourced urban settlements and rural areas. At the same time, fiscal constraints and workforce

pressures may limit the pace at which quality improvements can be scaled. Without targeted investments in emergency obstetric and newborn care, referral systems and postnatal follow-up, disparities in maternal and neonatal outcomes are likely to persist, even as overall service coverage remains high.

Early life conditions established during pregnancy and around birth have lasting implications for nutrition, immunity and development. Gaps in quality antenatal care, delivery readiness, breastfeeding support and postnatal services risk placing some children on disadvantaged trajectories from the outset. These early vulnerabilities are likely to interact with household poverty and environmental shocks, shaping outcomes well beyond the neonatal period.

The following chapter examines how these early foundations influence health, nutrition and development during infancy, with particular attention to how risks emerging around birth translate into vulnerabilities in the first years of life.

CHAPTER 5.

INFANCY AND EARLY CHILDHOOD

UNICEF/UNI680064/Noorani

5 Infancy and early childhood

Infancy and early childhood constitute a foundational period for physical growth, cognitive development, and the acquisition of essential capabilities. Deprivations experienced during this stage across health, nutrition, care, and living conditions can have lasting consequences over the life course (UNICEF, n.d.-a). This chapter examines key early childhood outcomes in Ghana, focusing on survival, development, and the enabling environment, and identifies inequalities and systemic bottlenecks shaping children's wellbeing.

A Early survival and health foundations

The first years of life are characterised by heightened vulnerability to illness and mortality, with outcomes shaped by access to preventive and curative health services. This section examines key early survival indicators, including prevention of mother-to-child transmission, immunisation, childhood illnesses, and under-five mortality, highlighting disparities and health system bottlenecks influencing child survival.

5.1 Prevention of mother to child transmission

Situation

- National estimates suggest that approximately 98 per cent of pregnant women living with HIV in Ghana receive antiretroviral therapy to prevent vertical transmission, reflecting the expansion of facility-based PMTCT services (UNAIDS, 2025).
- There are pronounced regional disparities in HIV testing during antenatal care, with coverage exceeding 85 per cent in several southern regions but falling to 32.8 per cent in Savannah and below 55 per cent in parts of the northern belt (Amo-Adjei et al., 2025).
- Engagement with PMTCT services varies across regions and socio-economic groups, with women in rural and poorer communities facing higher risks of discontinuity in follow-up, mirroring broader inequities in maternal and child health access.

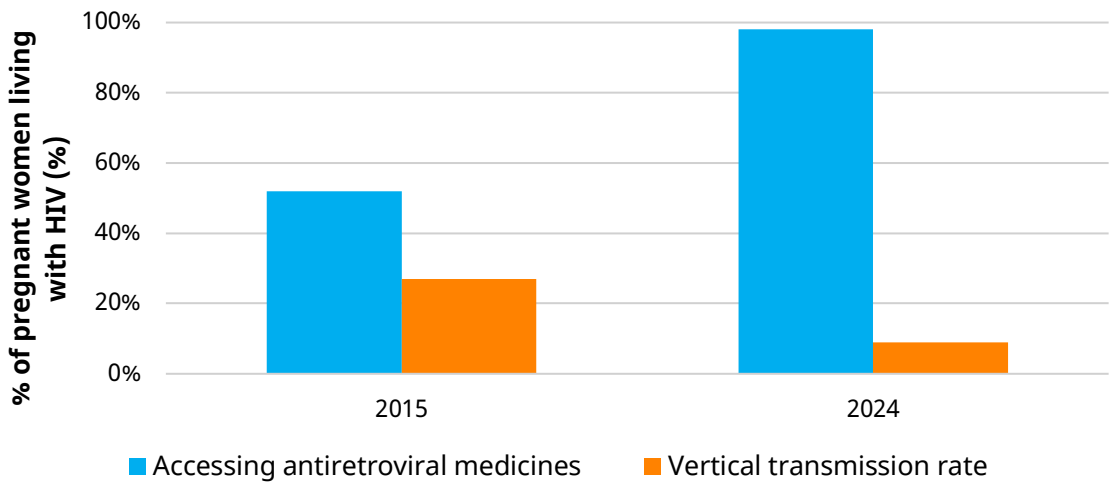
Bottlenecks

- Continuity of care across antenatal, delivery and postnatal services remains weak, with limited tracking of mother–infant pairs contributing to loss to follow-up and missed early infant diagnosis.
- Health facilities in some districts face staffing shortages and limited operational resources, reducing capacity for consistent counselling, outreach and infant follow-up services.

- Routine health information systems do not provide comprehensive, real-time data on retention and infant outcomes along the PMTCT cascade, constraining subnational planning and timely programme adjustments.

Prevention of mother-to-child transmission (PMTCT) of HIV is a core intervention for reducing paediatric HIV infections and improving early childhood survival (WHO, n.d.). In Ghana, national estimates indicate high reported coverage of antiretroviral therapy among pregnant women living with HIV. According to UNAIDS modelled country estimates, coverage rose from approximately 51 per cent in 2015 to an estimated 98 per cent in 2024 (Figure 5-1). Over the same period, the estimated vertical transmission rate declined from around 26 per cent to 9 per cent.

Figure 5-1: Antiretroviral therapy coverage for prevention of mother-to-child transmission and transmission rates among pregnant women living with HIV, Ghana (modelled estimates)



Source: UNAIDS country data. Notes: UNAIDS Spectrum modelling is based on national programme and surveillance data and should be interpreted as modelled estimates with associated uncertainty ranges rather than direct administrative counts.

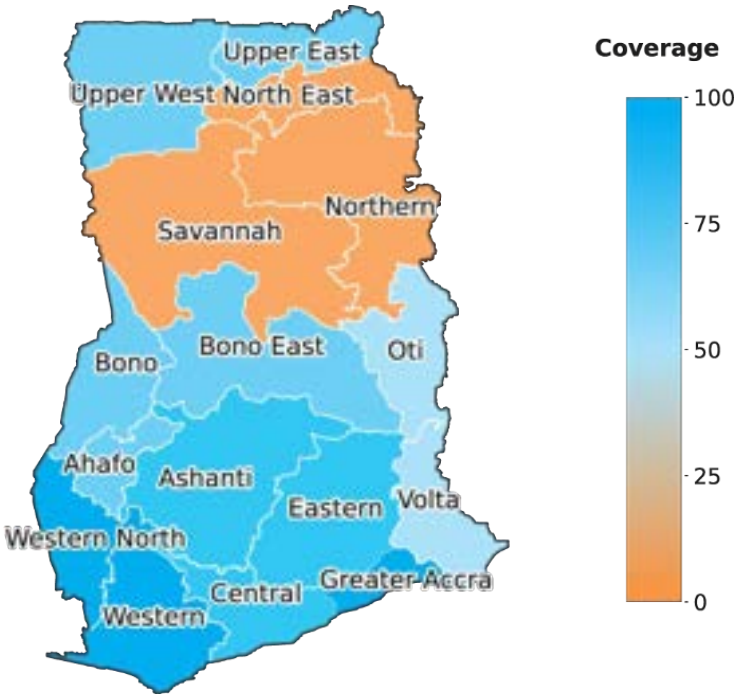
Despite this reported progress, available indicators focus largely on treatment initiation and do not capture completion of the full PMTCT cascade, including retention through pregnancy and breastfeeding, early infant diagnosis, and confirmation of infant HIV status (UNAIDS, 2025). As a result, national coverage figures may overstate effective protection against vertical transmission.

Evidence also points to persistent inequities in PMTCT outcomes. While HIV testing and treatment uptake during pregnancy have improved over time, women in rural and economically disadvantaged communities remain more likely to experience interruptions in care, reflecting structural barriers to accessing health services (Amo-Adjei et al., 2025). Indeed, recent secondary analysis of the 2022 Demographic and Health Survey highlights pronounced regional disparities in HIV testing during antenatal care, with coverage exceeding 85 per cent in several southern regions but

falling to 32.8 per cent in Savannah and below 55 per cent in parts of the northern belt (Figure 5-2).

Qualitative consultations identified several system-level bottlenecks likely affecting PMTCT delivery.[14] Weak referral and follow-up mechanisms between antenatal care, delivery and postnatal services increase the likelihood that mothers and infants disengage before early infant diagnosis. Facility-level staffing shortages and limited operational resources further constrain consistent counselling and outreach, particularly in underserved districts. Informants also highlighted significant limitations in routine data systems, noting the absence of reliable, real-time information on retention and infant outcomes along the PMTCT cascade, which restricts targeted programme responses.

Figure 5-2: Inequalities in HIV testing uptake among pregnant women during antenatal care in Ghana by region



Source: Amo-Adjei et al., 2025

5.2 Immunisation

Situation

- Ghana has achieved substantial long-term gains in routine childhood immunisation, with full vaccination coverage among children aged 12–23 months increasing significantly since the late 1990s.

[14] Based on consultations with Ghana Health Service and UNICEF Ghana Health and Nutrition Unit.

- In 2022, approximately 75 per cent of children aged 12–23 months were fully vaccinated with all basic antigens, while a higher proportion had received at least one vaccine dose, indicating strong initial service contact but incomplete schedule completion.
- Coverage varies across regions and socio-economic groups, with lower full vaccination rates observed among children in poorer households, rural areas, and several northern regions.

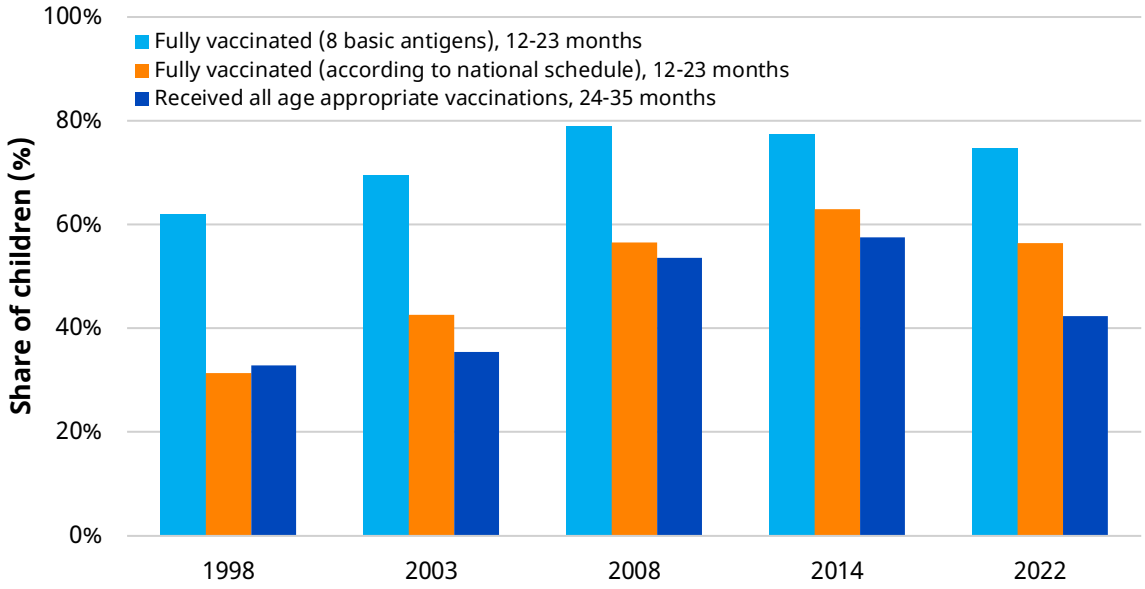
Bottlenecks

- Dropout between early and later vaccine doses limits completion of the full immunisation schedule.
- Structural access barriers, including distance to facilities and uneven outreach services, constrain equitable service delivery.
- Recent health system disruptions may have affected continuity of routine immunisation services, particularly follow-up doses.

Ghana has made sustained progress in routine childhood immunisation over the past three decades. As shown Figure 5-3, the proportion of children aged 12–23 months who are fully vaccinated with all eight basic antigens increased steadily from the late 1990s, rising from just over 60 per cent in 1998 to close to 80 per cent by 2008, and remaining high in 2014. In 2022, full vaccination coverage declined modestly to approximately 74.6 per cent. Although coverage remains relatively strong by regional standards, this reduction suggests emerging challenges in maintaining continuity of services, particularly for follow-up doses.

In addition to trends in full vaccination with basic antigens, DHS data also show lower coverage when assessed against Ghana's expanded national immunisation schedule. Among children aged 12–23 months, approximately 56.4 per cent were fully vaccinated according to the national schedule in 2022, compared with around 63 per cent in 2014. Coverage of age-appropriate vaccination among children aged 24–35 months was 42.4 per cent, indicating further attrition as children progress through later doses. These differences reflect the increasing complexity of the immunisation schedule and highlight challenges in maintaining caregiver engagement and service continuity beyond early infancy.

Figure 5-3: Share of children fully vaccinated



Source: DHS (1988, 2003, 2008, 2014 and 2022). Notes: A child is considered fully vaccinated according to the national immunisation schedule if, by age 2, they have received BCG; OPV birth dose; hepatitis B birth dose; three doses of OPV and one dose of IPV; three doses of DPT-HepB-Hib; three doses of pneumococcal conjugate vaccine (PCV); two doses of rotavirus vaccine (RV); one dose of measles–rubella (MR); and yellow fever vaccine. By age 3, the child should also have received a second dose of MR and one dose of meningitis A vaccine. The eight basic antigens are BCG, three doses of DPT-HepB-Hib, three doses of polio vaccine (excluding the birth dose), and one dose of measles–rubella vaccine.

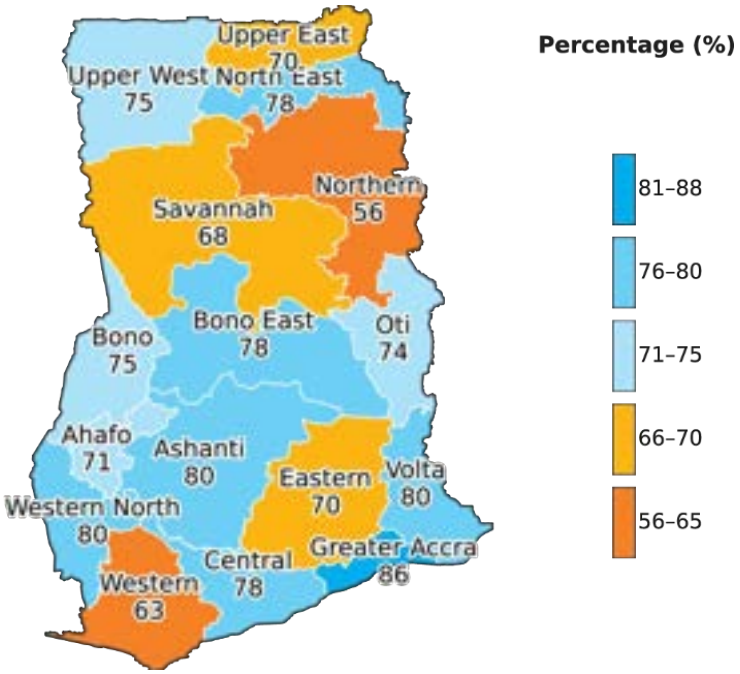
DHS (2022) indicates that over 90 per cent of children have received at least one vaccination. Specifically, 95 per cent of children aged 12–23 months received BCG, 97 per cent received the first dose of DPT-HepB-Hib and pneumococcal vaccine, and 96 per cent received the first dose of rotavirus vaccine. However, only 18 per cent received the hepatitis B birth dose, which substantially reduces completion of the full national immunisation schedule. Additional attrition is also observed for vaccines requiring multiple doses, pointing to challenges in sustaining caregiver engagement over time and ensuring timely delivery of later doses, rather than in initial access to services.

The slight decline observed in 2022 coincides with the period of the COVID-19 pandemic, during which routine health services in many settings experienced disruptions due to mobility restrictions, workforce pressures, and shifts in health system priorities. Although causal attribution cannot be established using DHS data alone, the timing suggests that pandemic-related shocks may have contributed to interruptions in routine immunisation delivery and caregiver follow-up, particularly in already underserved areas.

Disaggregation of DHS (2022) data reveals pronounced inequalities in immunisation outcomes. Full vaccination coverage is higher among children from wealthier households and those living in urban areas, while children in poorer households and rural communities remain less likely to complete the vaccination schedule. Regional variation is also substantial, with several northern regions recording significantly lower coverage compared with southern regions, reinforcing broader spatial inequalities in access to health services and infrastructure (Figure 5-4). As discussed previously,

qualitative consultations highlighted structural and household-level barriers affecting access to health services, including distance to facilities, transport costs, caregiver time constraints, and limited awareness, which are likely contributing to missed or delayed doses, especially in rural communities.

Figure 5-4: Full vaccination (8 basic antigens) coverage among children aged 12–23 months, by region



Source: DHS (2022)

5.3 Childhood illnesses

Situation

- Common childhood illnesses, including fever, diarrhoea and acute respiratory infections (ARI), remain important contributors to morbidity during early childhood, with prevalence highest among children aged 6–35 months, peaking between 12 and 35 months, reaching nearly 19 per cent (DHS, 2022).
- Care-seeking for fever and diarrhoea is relatively high across age groups, indicating widespread caregiver engagement with health services.
- Long-term trends show substantial declines in diarrhoeal disease and ARI prevalence, alongside narrowing wealth disparities, reflecting improvements in preventive care and access to treatment.

Bottlenecks

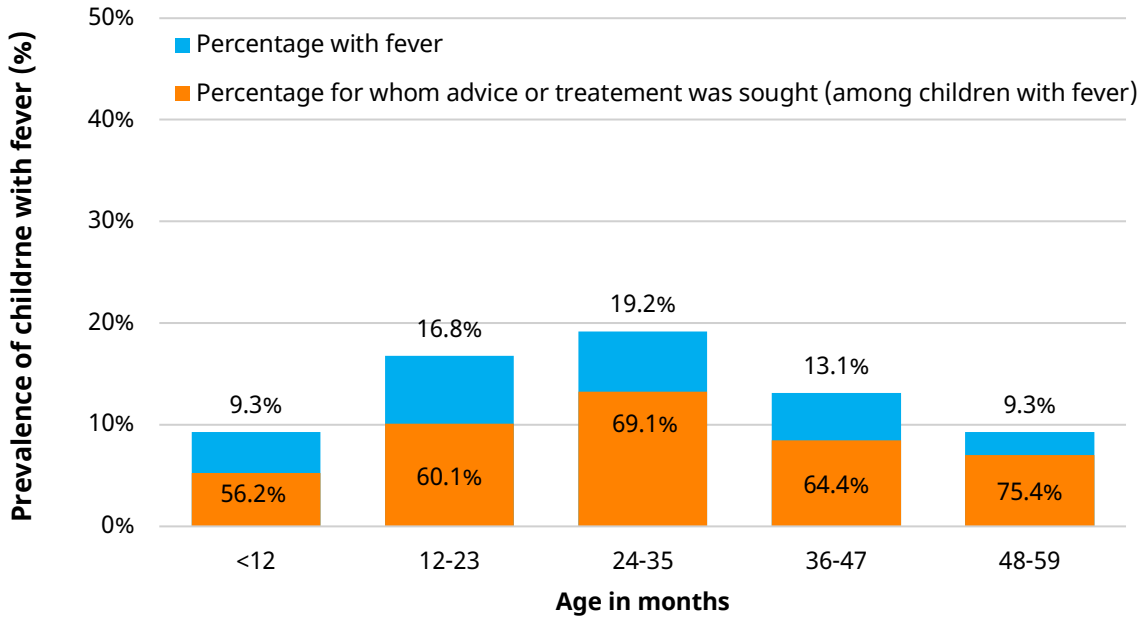
- Illness prevalence remains concentrated in the period of complementary feeding and increased mobility, when children are more exposed to environmental risks and have still-developing immunity.

- Care-seeking appears lower among the youngest infants, suggesting potential gaps in early recognition or access to services for children under six months.
- Persistent socio-economic and regional differences in illness exposure and treatment-seeking indicate that children in poorer and underserved communities remain at elevated risk of delayed or inadequate care.

Common childhood illnesses such as fever, diarrhoea and acute respiratory infections remain major contributors to morbidity during infancy and early childhood. This stage is characterised by heightened biological vulnerability as children transition from exclusive breastfeeding to complementary feeding and increased environmental exposure (WHO, 2023). Effective prevention, timely care-seeking and quality treatment are therefore critical determinants of survival and healthy development.

In Ghana, fever prevalence varies by age and peaks between 12 and 35 months, reaching nearly 19 per cent, compared to around 9–10 per cent among infants under 12 months (Figure 5-5). This pattern reflects increased exposure to infections as children become more mobile and interact more frequently with their surroundings. Care-seeking for fever is relatively high across age groups, ranging from approximately 56 to 75 per cent, suggesting that most caregivers seek advice or treatment when symptoms arise. However, the gap between fever prevalence and care-seeking among the youngest infants indicates that children under six months may not be taken for treatment as consistently, pointing to possible challenges in recognising severity or prioritising care for very young infants.

Figure 5-5: Prevalence of fever and care-seeking behaviour among children under five, by age group

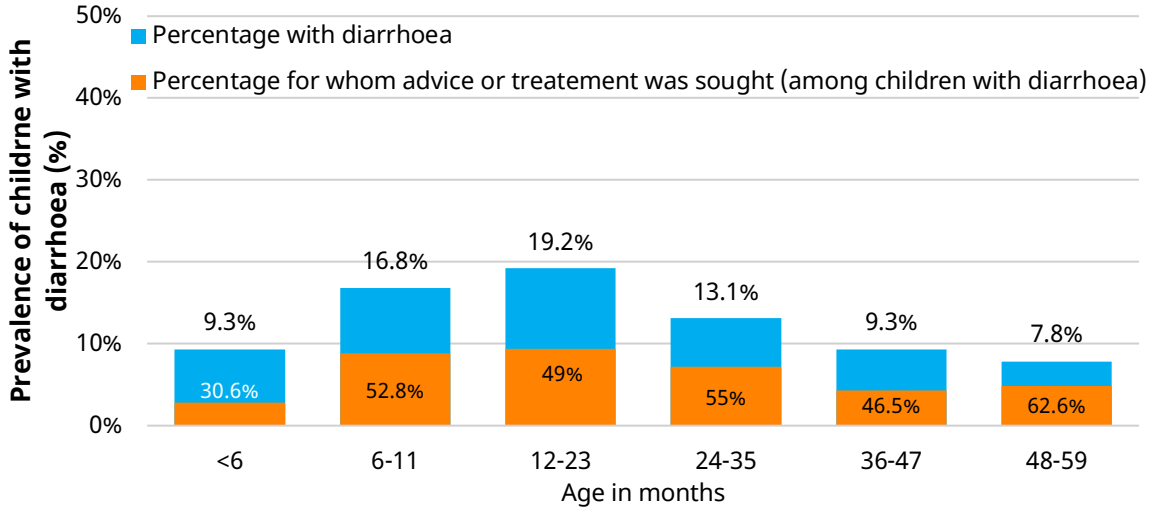


Source: DHS (2022)

A similar age pattern is observed for diarrhoea (Figure 5-6). Prevalence rises from about 9 per cent among infants under six months to nearly 19 per cent among children aged 12–23 months, before declining in older age groups. This concentration among children aged 6–23 months has been consistent over time, even as overall diarrhoeal prevalence declined substantially in Ghana—from approximately 26 per cent in 1988 to 13 per cent in 2022. The peak in the second year of life aligns with the transition to complementary feeding and increased exposure to contaminated food and water, at a stage when immunity is still developing.

The long-term downward trend in diarrhoeal disease likely reflects improvements in water, sanitation and hygiene, expanded vaccination coverage including rotavirus, and better infant feeding practices. As with fever, care-seeking levels for diarrhoea exceed prevalence across age groups, demonstrating generally strong treatment-seeking behaviour. Nevertheless, treatment-seeking remains comparatively lower among infants under six months, again suggesting potential gaps in early recognition or access for the youngest children.

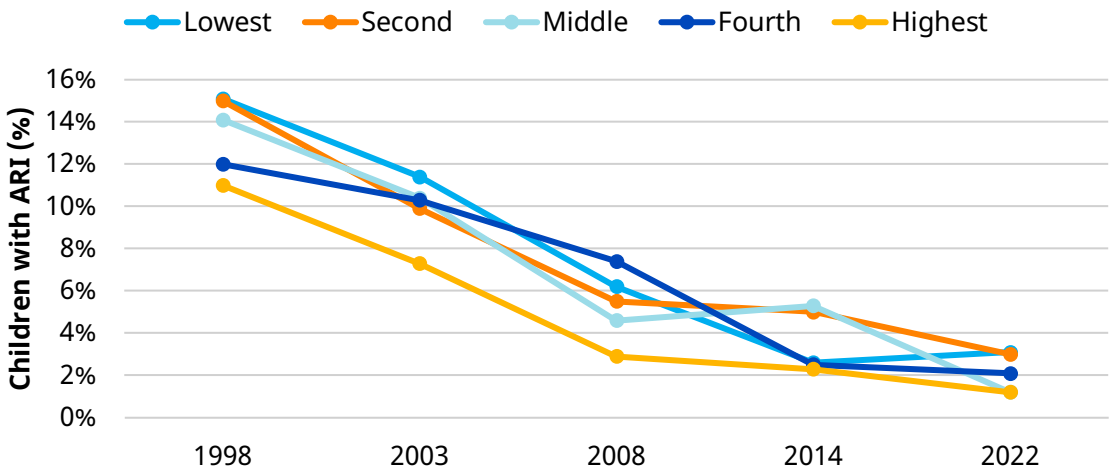
Figure 5-6: Prevalence of diarrhoea and care-seeking behaviour among children under five, by age group



Source: DHS (2022)

Trends in acute respiratory infection also show substantial improvement. Between 1998 and 2022, ARI prevalence declined markedly across all wealth quintiles, with rates falling to below 5 per cent by 2022 and wealth-based disparities narrowing over time (Figure 5-7). These trends likely reflect expanded access to primary healthcare, increased insurance coverage, and improvements in household living conditions. However, persistent differences in care-seeking by wealth and region indicate that children in poorer households remain at elevated risk of delayed or inadequate management.

Figure 5-7: Trends in ARI prevalence among children under five, by wealth quintile



Source: DHS (1998, 2003, 2008, 2014 and 2022)

Although tuberculosis accounts for a relatively small share of childhood illness compared to fever, diarrhoea and ARI, it remains an important concern due to diagnostic challenges and the risk of severe outcomes among young children. As indicated in the previous section, BCG coverage is around 95 per cent among children 12-23 months which provides protection against severe forms of childhood tuberculosis. However, BCG does not prevent infection, and under-detection of paediatric tuberculosis remains common, particularly in settings characterised by overcrowded housing and household exposure. Delayed diagnosis may therefore contribute to ongoing transmission within families and communities. Strengthening integration between child health services and TB screening, especially in high-risk and underserved areas, remains important for early identification and timely treatment.

The age and wealth patterns observed suggest that exposure and vulnerability are shaped by both environmental and service-related factors. Higher illness prevalence among children aged 6–35 months coincides with increased mobility, complementary feeding and greater contact with contaminated water, food and surfaces. Children in poorer households remain more exposed to unsafe sanitation, overcrowded housing and limited preventive measures, while barriers related to distance, cost and facility readiness may delay timely and effective treatment.

While care-seeking levels are generally high, the DHS indicators capture contact rather than the timeliness, appropriateness or quality of care received. If early recognition and quality management are inconsistent—particularly for infants and children in poorer households—recurrent illness may undermine nutritional status, cognitive development and resilience as children transition into later childhood.

5.4 Under-five mortality

Situation

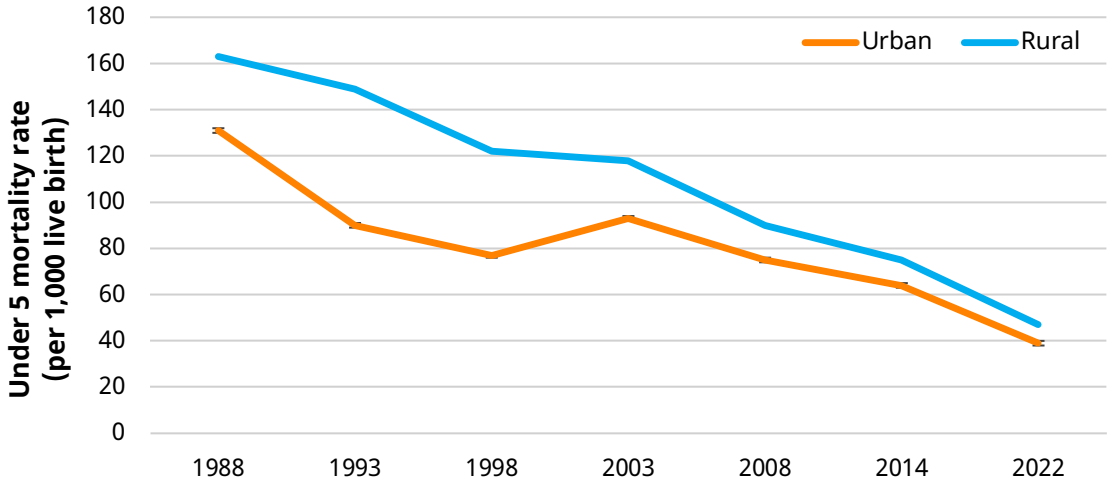
- Under-five mortality in Ghana has declined substantially over the past three decades, falling to below 50 deaths per 1,000 live births in both rural and urban areas, and the historical gap between them narrowing (DHS, 2022).
- Despite this progress, preventable deaths remain concentrated among children from poorer households and those living in rural and underserved areas.
- Neonatal conditions and infectious diseases continue to account for a large share of under-five deaths, highlighting the importance of integrated maternal, newborn and child health services.

Bottlenecks

- Inequities in access to skilled personnel, referral systems and timely emergency care continue to place children in rural and underserved areas at higher risk.
- Survival outcomes remain strongly associated with maternal education, household wealth, place of delivery and birth order, reflecting persistent socio-economic gradients in child mortality.
- Preventable conditions persist including birth complications, neonatal infections, pneumonia, malaria and malnutrition, pointing to gaps in nutrition, water and sanitation, and continuity of care across the lifecycle.

Under-five mortality remains a critical indicator of the realisation of children's right to survival and development in Ghana. As shown in Figure 5-8, mortality rates have declined markedly since the late 1980s in both rural and urban areas. In 1988, under-five mortality exceeded 150 deaths per 1,000 live births in rural areas and was substantially higher than in urban settings. By 2022, mortality had fallen to below 50 deaths per 1,000 live births in both areas, with the rural–urban gap narrowing considerably.

Figure 5-8: Under 5 mortality rate per 1,000 live births, by area of residence and survey year



Source: DHS (1988, 1993, 1998, 2003, 2008, 2014 and 2022)

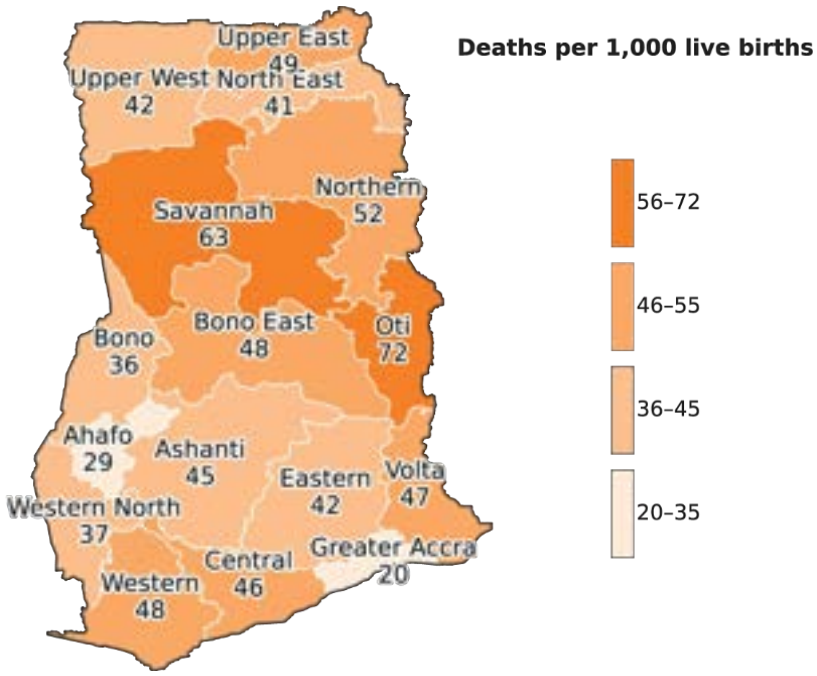
The convergence between rural and urban mortality trends reflects broad-based improvements in access to maternal, newborn and child health services, including expanded immunisation, malaria prevention and treatment, improved management of childhood illness, and increased utilisation of skilled birth attendance. These gains are consistent with Ghana's progress towards Sustainable Development Goal 3.2, which aims to end preventable deaths of newborns and children under five.

However, subnational disparities remain pronounced. As shown in Figure 5-9, under-five mortality varies considerably by region, with the highest rates observed in Savannah (63 deaths per 1,000 live births), Oti (72), Northern (52) and North East (41), compared with substantially lower rates in Greater Accra (20) and Ahafo (29). This geographic pattern underscores persistent inequities between northern and southern regions and highlights the concentration of child mortality in areas with weaker service coverage and higher levels of socio-economic deprivation.

Despite this progress, preventable child deaths remain closely linked to persistent inequalities in access to essential health services. Children in rural and underserved communities continue to face higher mortality risks due to shortages of skilled health personnel, weaker referral systems, and geographic barriers that limit access to timely maternal and newborn care. Child mortality in Ghana remains concentrated in areas where access to skilled birth attendants, postnatal care and neonatal services is limited, particularly in rural and underserved regions (Opoku et al., 2025). Child survival outcomes are also strongly influenced by maternal education, household wealth, place of delivery and birth order, with disparities in these factors contributing to persistent rural–urban differences in mortality risks (Sarkodie, 2021).

Underlying causes of under-five mortality remain largely preventable. Birth asphyxia, neonatal infections, low birth weight, malnutrition, and infectious diseases such as pneumonia and malaria continue to account for a substantial share of child deaths (Opoku et al., 2025). Malnourished children face significantly higher mortality risks, and diarrhoeal disease remains a major predictor of child death, highlighting ongoing gaps in nutrition, water and sanitation, and continuity of care following illness (Tette et al., 2016). These risks are closely intertwined with poverty, inequitable access to services, and broader social determinants of health, reinforcing cycles of vulnerability among the most disadvantaged children.

Figure 5-9: Under-five mortality by region (deaths per 1,000 live births, ten-year period preceding survey)



Source: DHS (2022)

B Legal identity and care environment

Legal identity and stable care arrangements are essential for children's access to services and protection. This section examines birth registration and the situation of orphans and children living in alternative forms of care, focusing on vulnerabilities, institutional capacity, and implications for early childhood wellbeing.

5.5 Birth registration

Situation

- In 2022, 74.5 per cent of children under five had their births registered with civil authorities, although only 61.4 per cent possessed a birth certificate, indicating gaps between registration and certification (DHS, 2022).
- Registration coverage is substantially lower among infants under one year (61.1 per cent) compared with children aged 1–4 years (77.7 per cent), suggesting that many births are registered after infancy rather than within the first year of life (DHS, 2022).
- Administrative data from the Births and Deaths Registry indicate that 73.4 per cent of expected births were registered nationally in 2025, with substantial regional variation ranging from below 60 per cent in some regions to above 90 per cent in others.

Bottlenecks

- Delays in birth registration remain common, reducing the timeliness and functional value of registration during early childhood.
- Behavioural incentives for early registration remain limited, as birth certificates are not consistently required for access to core services. Further, there are financial barriers to registration after the age of 1 year, which disincentivises registration.
- Administrative and infrastructural constraints, including uneven district capacity and legal provisions allowing late registration, affect completeness and timeliness across regions.

Birth registration provides legal proof of identity and age and is fundamental to safeguarding children's rights. In Ghana, the legal framework for civil registration is set out in the Births and Deaths Registry Act, 2020 (Act 1027), which provides the basis for registration and certification of births and deaths. Birth registration facilitates access to education, health services, social protection, child protection and legal safeguards, while supporting national planning through reliable population statistics.

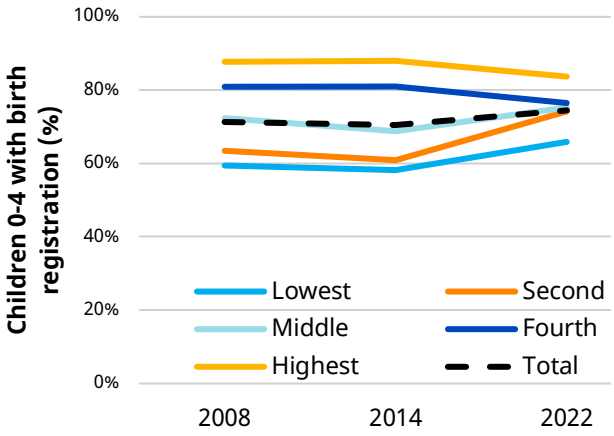
According to DHS (2022), 74.5 per cent of children under five had their births registered with civil authorities. Of these, 61.4 per cent had a birth certificate, while 13.1 per cent were registered but did not possess a certificate. The gap between registration and certification suggests that administrative registration does not always translate into immediate documentation.

Age disaggregation reveals important patterns in timeliness. Among children under one year, only 61.1 per cent had their births registered, compared with 77.7 per cent among children aged 1–4 years. This difference indicates that a significant share of births are registered after infancy. While eventual registration contributes to overall coverage, delayed registration may limit children's access to services at an early stage and reduce the effectiveness of civil registration and vital statistics systems in generating timely data.

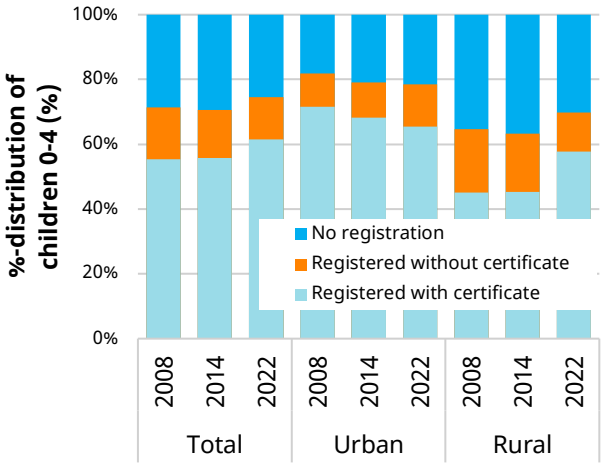
Wealth and residence disparities persist, although they have narrowed over time. According to DHS in 2022, 77.5 per cent of urban children were registered compared with 71.7 per cent of rural children (Figure 5-10). Registration increased with household wealth, from 65.8 per cent in the lowest quintile to 83.7 per cent in the highest quintile. Compared with 2014, gains were particularly notable among children in the lowest and second wealth quintiles, reflecting improved outreach and expanded service access. Regional variation is also evident in DHS data. Registration ranged from 60.5 per cent in Oti and 65.1 per cent in Savannah to 85.6 per cent in Western and 83.4 per cent in Upper East. Although disparities remain, patterns are less stark than in earlier survey rounds.

Figure 5-10: Birth registration among children under five, by wealth quintile and area of residence, 2008–2022.

Panel A: Trends in registration by household wealth quintile



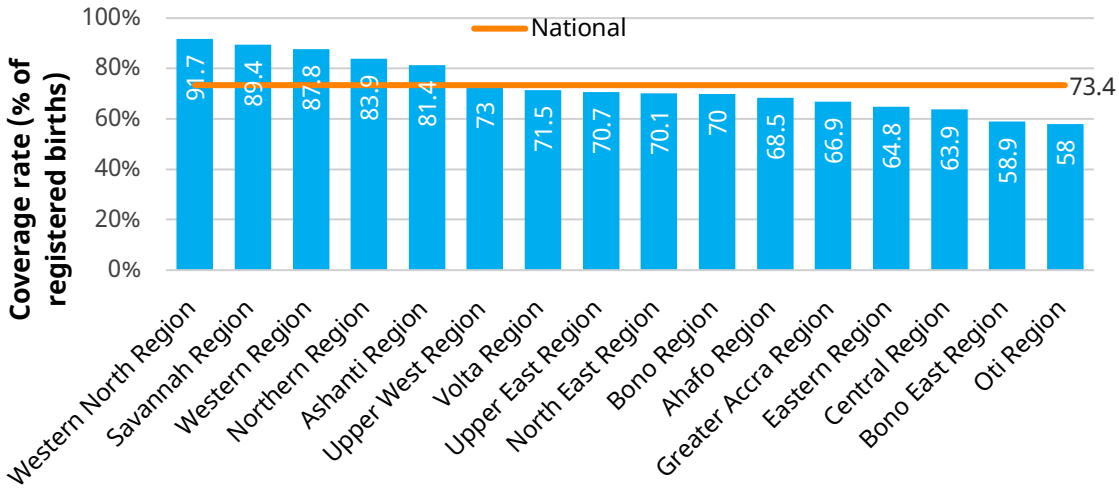
Panel B: Distribution of children by registration status in urban and rural areas and by year



Source: DHS (2008, 2014 and 2022)

Administrative data from the Births and Deaths Registry (BDR) provide a complementary system-level perspective. In 2025, 588,972 births were registered out of 801,935 expected births nationally, corresponding to 73.4 per cent coverage. However, regional disparities remain substantial. Coverage exceeded 90 per cent in Western North and was high in Savannah, Western, Northern and Ashanti. In contrast, coverage remained below the national average in 10 regions.

Figure 5-11: Birth registration coverage rates by region in 2025



Source: Administrative data from the Births and Deaths Registry (January-December 2025)

Although there are discrepancies in some regions, national DHS and BDR figures appear broadly similar in magnitude despite measuring different aspects of registration.[15] DHS captures the cumulative proportion of living children under five whose births have ever been registered, regardless of when registration occurred. BDR data reflect the proportion of expected births registered within a given calendar year. The lower DHS registration rate among infants under one year is consistent with delayed registration, whereby births occurring in one year may be registered in subsequent years. Administrative coverage may also be influenced by revisions to projected expected births and differences in reporting completeness.

Key informant interviews with the BDR, conducted as part of this SitAn, highlight several targeted interventions that have driven this progress:

- Establishment of well-staffed Registry offices or service points in all 261 districts that are able to issue birth certificates, reducing travel and increasing accessibility.
- Collaboration with the Ghana Health Service to reach all mothers, including those who deliver outside health facilities through door-to-door outreach during health promotion weeks, and mobile registration in markets and along roadsides, often using vans that issue certificates instantly.
- Leveraging child-weighing and vaccination centres as effective registration points for children born outside facilities.
- Introduction of the Community Population Register in 2023, piloted in selected regions, using trained community volunteers to maintain local birth records and support comprehensive community-level coverage.

Despite these advancements, persistent institutional, legal, and behavioural barriers continue to limit progress. Parents often have little incentive to register children promptly, as birth certificates are not consistently required for essential services beyond passport or visa applications. Consequently, many delay registration until a specific need arises—sometimes years later. However, while registration is free for infants 0-1, registration fees apply thereafter, which further hinders registration, particularly among the poorest families.

Infrastructural challenges also remain significant. Many Registry offices operate in inadequate facilities, underscoring the need for substantial investment to ensure that all offices are properly resourced and conducive to effective service delivery.

[15] For instance, Savannah has a coverage rate of 89.4 per cent according to the BDR 2025, whereas the DHS 2022 reports a coverage of 65.1 per cent.

5.6 Orphans and children living in alternative forms of care

Situation

- In 2022, 8 per cent of children under 18 were reported to have lost one or both parents, and 16 per cent were not living with a biological parent (DHS, 2022).
- Only 51 per cent of children under 18 live with both biological parents, indicating that a substantial proportion of children experience some form of family separation (DHS, 2022).
- As of 2021, 139 residential homes were housing approximately 3,530 children, with significant concerns identified regarding registration, licensing and quality of care (GDSW & UNICEF, 2021).

Bottlenecks

- Limited national-level data on children outside parental care constrains monitoring of living arrangements, placement quality and long-term outcomes.
- A significant proportion of residential homes operate without full registration or valid licensing, affecting oversight and safeguarding mechanisms.
- High exposure to violent disciplinary practices and poor nutritional outcomes among children in residential care highlight ongoing protection and care quality challenges.

An orphan is defined as any child under the age of 18 who has lost one or both parents. According to DHS (2022), 8 per cent of children in Ghana are orphans. In addition, 16 per cent of children do not live with a biological parent. Only 51 per cent of children under 18 live with both biological parents, indicating that nearly half of children experience some form of parental absence or alternative living arrangement. However, the DHS does not provide detailed information on the specific living arrangements of these children, limiting understanding of the nature and quality of alternative care.

The 1992 Constitution of Ghana and the Children's Act place primary responsibility for childcare and protection on biological parents, and extend obligations to adoptive and foster caregivers. Where children are deprived of a family environment, the Department of Social Welfare under the Ministry of Gender, Children and Social Protection is mandated to provide alternative care arrangements, including adoption, foster care and residential placement.

Historically, residential care has been the predominant formal alternative care option when families are unable or unwilling to provide care. For many years, comprehensive data on residential homes and their residents were lacking, despite recommendations from the UN Committee on the Rights of the Child (UN CRC, 2015). This gap was partially addressed through the first comprehensive national survey of residential homes, conducted jointly by the Department of Social Welfare and UNICEF (GDSW & UNICEF, 2021).

The survey identified 139 residential homes housing 3,530 children and adolescents, of whom 57 per cent were boys and 43 per cent girls. More recent data from the Department of Social Welfare suggest that these numbers have declined slightly, with around 109 residential homes housing 3,125 children. The findings raised significant concerns regarding regulatory compliance: nearly one in four homes were either unregistered or non-compliant with registration requirements, and only about one-third possessed a valid licence. Weak regulatory oversight has implications for safeguarding, periodic review of placements, monitoring of care quality, and mechanisms for reporting and addressing abuse.

The survey also revealed protection and wellbeing concerns within residential care. More than half of children were exposed to violent disciplinary methods, 40 per cent of children under five living in residential homes were moderately or severely stunted, and one in five adolescents reported involvement in a physical fight within the home. These findings suggest that residential care environments may not consistently meet standards for safety, nutrition and psychosocial wellbeing.

At the same time, residential homes have contributed positively in some areas, including provision of basic needs such as drinking water, sanitation and access to education. The majority of children exiting residential care in the 12 months preceding the survey were reunified with parents or extended family members, aligning with constitutional and policy commitments to prioritise family-based care.

Policy reforms have sought to strengthen family-based alternatives. The establishment of a Central Adoption Authority regulating local and inter-country adoptions, the 2016 amendment of the Children's Act, and the passage of Foster Care Regulations represent important steps towards deinstitutionalisation and promotion of family-based care. More than 500 foster parents have been trained and approximately 200 children have been placed in foster care (Department of Social Welfare & UNICEF, 2021). However, the continued absence of reliable, comprehensive national monitoring data makes it difficult to assess the scale, quality and long-term outcomes of these alternative care arrangements.

C Developmental risks and vulnerabilities

Developmental outcomes in early childhood are shaped by intersecting risks related to disability and nutrition, with long-term implications for learning, health, and social participation. This section explores early childhood disability and nutritional status, examining inequalities and structural factors influencing children's growth and developmental trajectories.

5.7 Children living with disabilities

Situation

- Children with disabilities in Ghana face persistent barriers to accessing education, health care, protection and social services, with particularly acute vulnerabilities among those in rural areas and lower wealth quintiles.
- Limited national-level data on the prevalence, living conditions and outcomes of children with disabilities constrains evidence-based planning and monitoring.
- Children with disabilities, especially those with intellectual and psychosocial disabilities, are among the most vulnerable to stigma, abuse and exclusion.

Bottlenecks

- Persistent socio-cultural stigma and limited awareness of different forms of disability contribute to discrimination, neglect and social exclusion.
- Lack of reliable, nationally representative data, monitoring and research on the prevalence and living conditions of children with disabilities prevents comprehensive assessments of their risks and vulnerabilities to guide policy, enforcement and protective responses.
- Inadequate disability-friendly infrastructure, trained personnel and specialised services limit access to inclusive education and health care.
- Implementation gaps and resource constraints hinder effective delivery of inclusive education and social protection policies.

Children with disabilities continue to face significant challenges in the realisation of their rights. Key informant interviews conducted for this SitAn consistently identified children with disabilities as among the groups most affected by child rights violations in Ghana.[16] Vulnerability appears particularly pronounced among children and adolescents living in rural areas and those in the lowest wealth quintiles. Children with intellectual and psychosocial disabilities were reported to be especially exposed to abuse, violence, stigma and social exclusion, particularly in traditional communities.

Reliable, nationally representative data on the prevalence and living conditions of children with disabilities remain limited. Although recent disability reporting has improved for the population overall, the available census data do not provide a robust prevalence estimate for children specifically, and the disability statistics cover the population aged 5 years and older. Available 2021 census data indicate that the prevalence of difficulty in performing activities rises from 2.8 per cent among children aged 5–9 and 10–14 to 4.0 per cent among adolescents aged 15–19. The sex pattern also shifts with age: prevalence is slightly higher among boys at ages 5–9 (2.9 per cent versus 2.6 per cent for girls), but higher among girls by ages 15–19 (4.6 per cent versus

[16] This was confirmed through multiple consultations including the Ghana Federation of Disability Associations, the Departments of Social Welfare and Children of MoGCSP, the SDG Platform in Ho and UNICEF' Ghana Planning Monitoring and Evaluation Unit.

3.5 per cent for boys) (GSS, 2024b). This data gap constrains the ability to assess service coverage, identify disparities and monitor progress across sectors. Available qualitative and administrative evidence suggests that persistent poverty, limited understanding of the spectrum of disabilities, and entrenched socio-cultural beliefs continue to undermine the protection and inclusion of children with disabilities. This underscores the need to strengthen data collection, monitoring and research to better assess the situation, risks and vulnerabilities of children with disabilities and to guide policy, enforcement and protective responses.

While this chapter is anchored in early childhood, some of the available evidence on disability and school participation relates to older children as well, reflecting both data limitations and the fact that disability-related barriers persist across the life course. Census data show that 14.8 per cent of children aged 5–17 years with difficulty in performing activities had never attended school, compared with 8.2 per cent of children without difficulty (GSS, 2024b). More recent policy analysis also suggests that learners with disabilities constitute only around 0.2–0.4 per cent of total pre-tertiary enrolment, indicating very low participation overall, while only 8 per cent of regular basic schools had ramps (UNDP, 2025). Many early childhood education settings, KG classrooms and basic schools lack accessible infrastructure, specialised learning materials and trained personnel to support children with disabilities.

Although Ghana adopted an Inclusive Education Policy in 2015, implementation challenges remain significant. Broader disability analysis in Ghana points to continuing implementation gaps in inclusive education, including weak enforcement, limited teacher preparation, and inadequate provision of support services (Fordjour, 2022). Many public schools lack accessible infrastructure, specialised learning materials and trained personnel to support learners with disabilities. While Ghana's combined sixth and seventh State Party Report to the UN Committee on the Rights of the Child outlines provisions to support children with severe disabilities, the adequacy, consistency and regional coverage of these interventions remain unclear.

Access to health services presents additional challenges. Many health facilities lack disability-friendly infrastructure, assistive communication services such as sign-language interpretation, and staff trained in disability-inclusive care. Reports from key informants also indicate that stigmatising attitudes among some health professionals may discourage families from seeking timely and appropriate care. Broader disability evidence in Ghana also points to the absence of inclusive disability assessment systems and weak links between assessment and service provision, which can delay identification and support for children with disabilities (Fordjour, 2022).

In the area of social protection, the Government provides support to persons with disabilities, including children, through the District Assembly Common Fund for Persons with Disabilities (Disability Fund). These funds are used to support educational assistance, mobility aids, start-up capital and other essential equipment. However, coverage and adequacy remain uneven across districts, and implementation challenges affect predictability and impact. Key informants also highlighted weak enforcement of

disability-related policies and the absence of a fully operational Legislative Instrument for the Disability Act, which continue to limit implementation in practice.

Previous disability analyses in Ghana have found that negative attitudes toward disability are deeply rooted in socio-cultural beliefs. In extreme cases, such beliefs have contributed to the confinement of persons with disabilities, particularly those with psychosocial disabilities, in prayer camps, where they may be exposed to harmful practices. Such findings underscore the intersection between disability, protection risks and harmful social norms (Fordjour, 2022).

5.8 Nutrition

Situation

- Ghana has achieved substantial long-term reductions in child undernutrition; however, progress slowed considerably between 2014 and 2022.
- Stunting declined only marginally from 19 per cent in 2014 to 17 per cent in 2022, indicating a plateau in improvement.
- Malnutrition remains concentrated among rural children, poorer households and northern regions, where prevalence remains substantially above the national average.

Bottlenecks

- Structural inequalities in food security, livelihoods, sanitation and access to health and early childhood services continue to concentrate malnutrition risk in specific regions and populations.
- Persistent child food poverty, affecting an estimated 2.4 million children under five, limits access to diverse and nutritious diets (UNICEF, 2025h).
- Progress increasingly depends not on broad service expansion, but on targeted interventions in high-burden districts and among the most vulnerable households.

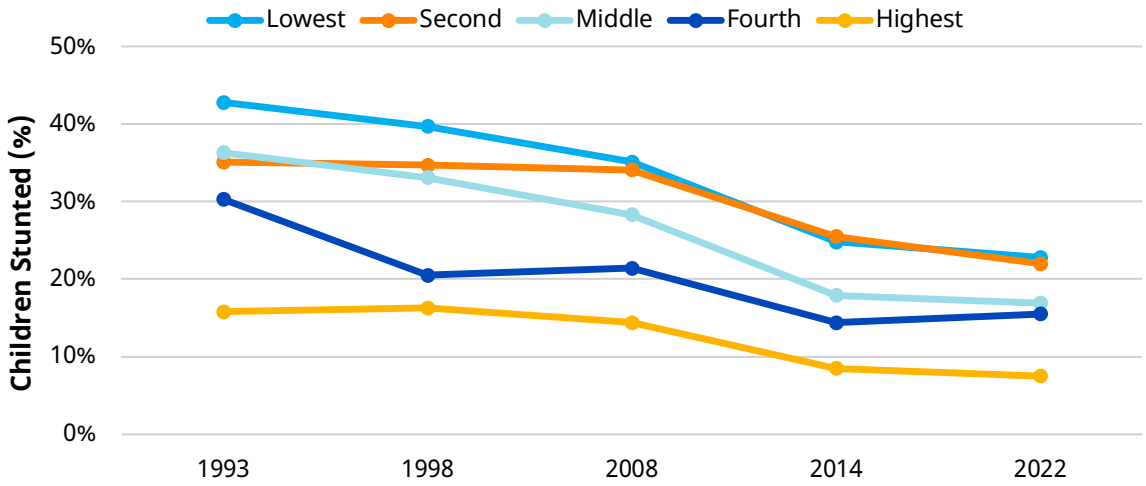
Adequate, safe and age-appropriate nutrition is fundamental to children's survival, growth and cognitive development (UNICEF, n.d.-b). Feeding practices during pregnancy and the first two years of life are particularly critical, shaping lifelong health and development outcomes. Nearly half of all deaths among children under five globally are associated with undernutrition (UNICEF, n.d.-b), underscoring its central role in child survival.

Ghana has made substantial progress in reducing child undernutrition over the past three decades. Stunting declined from 33 per cent in 1993 to 17 per cent in 2022, while wasting fell from 14 per cent to 6 per cent and underweight from 23 per cent to 12 per cent (DHS, 2022). These long-term improvements reflect gains in health services, immunisation, water and sanitation, maternal education and overall socioeconomic development.

However, progress has slowed markedly in recent years. Between 2008 and 2014, stunting fell sharply, but between 2014 and 2022 the decline was modest, from 19 per cent to 17 per cent (Figure 5-13). Similarly, reductions in wasting and underweight during this period were limited. This suggests that earlier broad-based improvements may have reached their limits, and that remaining malnutrition is increasingly concentrated among harder-to-reach populations.

Wealth-based disparities have narrowed over time. In 1993, stunting prevalence among children in the lowest wealth quintile exceeded 40 per cent, compared with approximately 15 per cent among the richest. By 2022, the gap had reduced substantially, with stunting affecting around 22 per cent of children in the lowest quintile and 7 per cent in the highest. While inequality has declined, the poorest households continue to bear a disproportionate burden.

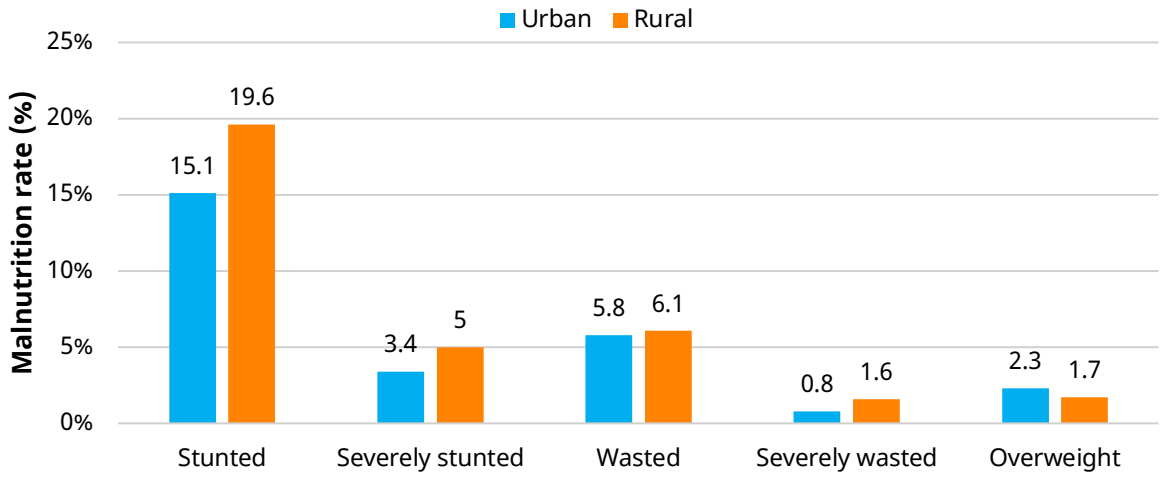
Figure 5-12: Trends in stunting by wealth quintile, 1993–2022



Source: DHS (2022)

As shown in Figure 5-13, rural–urban disparities persist. In 2022, stunting affected approximately one in five rural children (19.6 per cent) compared with around 15.1 per cent of urban children. Severe stunting and wasting show similar patterns, though differences in acute malnutrition are less pronounced. These disparities reflect continued inequalities in food security, dietary diversity, sanitation, maternal nutrition and access to health services.

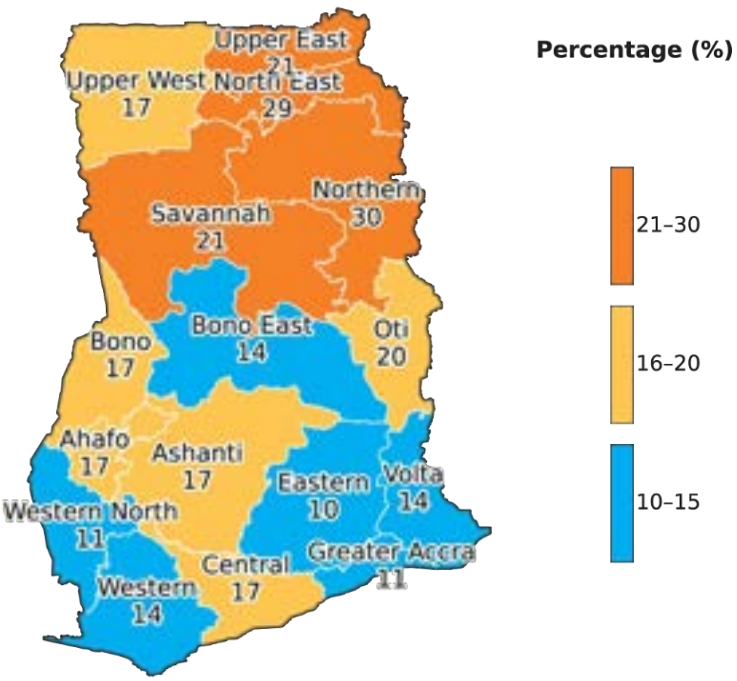
Figure 5-13: Nutritional status of children under five, by place of residence



Source: DHS (2022)

Regional disparities are particularly pronounced (Figure 5-14). Northern (30 per cent) and North East (29 per cent) regions record the highest levels of stunting, followed by Upper East and Savannah (21 per cent each). In contrast, Eastern (10 per cent), Greater Accra (11 per cent) and Western North (14 per cent) report substantially lower rates. This geographic concentration underscores the structural drivers of malnutrition in northern Ghana, including livelihood vulnerability, climate exposure, poverty and service access constraints.

Figure 5-14: Stunting prevalence among children under 5 by region



Source: DHS (2022)

Despite national progress, UNICEF estimates that approximately 2.4 million children under five in Ghana experience child food poverty, meaning they do not have access to a minimally diverse and nutritious diet (UNICEF, 2025h). This highlights that improvements in anthropometric indicators do not fully capture dietary adequacy or vulnerability to future growth faltering.

Overall, Ghana's nutrition profile reflects a transition from widespread undernutrition to increasingly concentrated vulnerability. Future gains are likely to depend less on broad national improvements and more on targeted, region-specific and household-level interventions addressing food security, maternal nutrition, sanitation and early childhood care in high-burden areas.

D Enabling environment for healthy development

Beyond individual health and nutrition, children's development is influenced by their physical and social environments. This section examines access to water, sanitation and hygiene, housing conditions, and early childhood education, highlighting how living environments and early learning opportunities shape wellbeing and school readiness.

5.9 Water, Sanitation and Hygiene

Access to safe water, sanitation and hygiene (WASH) is fundamental to children's survival, growth and development (UNICEF, n.d.-c). Unsafe WASH conditions increase exposure to diarrhoeal disease, intestinal infections and environmental contamination, contributing to undernutrition, impaired cognitive development and preventable mortality. In Ghana, progress in expanding access has been substantial, yet important service quality gaps and inequities persist. This section focuses on WASH in households and health facilities, in the next chapter WASH in schools will be presented.

WASH in households

Situation

- While a majority of households use improved water sources, only around half of the population has access to safely managed drinking water services, and rural residents are substantially more likely to rely on unimproved or surface water sources (WHO & UNICEF, 2025)
- Sanitation remains the most critical gap: open defecation persists at significant levels, particularly in rural areas, and only a minority of the population uses safely managed sanitation services.
- This is a particular concern for young children: only 16 per cent of children under age two living with their mother had their last stool disposed of appropriately (DHS, 2022).
- Hygiene services are incomplete: fewer than half of households have a basic handwashing facility with soap and water, increasing exposure to infection risks, particularly for young children (WHO & UNICEF, 2025)

Bottlenecks

- Persistent open defecation and weak faecal sludge management undermine sanitation safety, even where facilities exist.
- Rural water systems face sustainability constraints, including operation and maintenance challenges, limited financing and weak monitoring systems.
- Water contamination risks, including E. coli presence in some drinking water samples, reflect environmental pollution and sanitation gaps.
- Rapid urbanisation and informal settlement growth strain sanitation infrastructure and regulatory oversight.
- Behavioural and affordability barriers affect hygiene practices and menstrual hygiene management, particularly among low-income households and adolescent girls.

Under SDG 6.1, safely managed drinking water refers to water from an improved source that is located on premises, available when needed and free from contamination. According to the latest JMP modelled estimates for Ghana, approximately 43 per cent of the population use safely managed drinking water services, and around 90 per cent have at least basic drinking water service (WHO & UNICEF, 2025). In 2022, according to DHS, 84 per cent of the population had access to at least basic drinking water service. However, a significant proportion of the population remains below this standard. Around 4 per cent rely on unimproved sources, and approximately 3 per cent rely on surface water. Vulnerabilities in this regard are more pronounced in the rural areas: nearly one in six rural residents rely on unimproved or surface water, compared to a very small proportion in urban areas (Figure 5-15). Among those who only have access to unimproved drinking water, only 5 per cent use appropriate treatment methods.

Evidence from recent operational research indicates that microbiological contamination of drinking water sources remains a significant public health risk in Ghana. In an analysis of nearly 1,900 water samples from 12 regions, Escherichia coli, a standard indicator of faecal contamination, was frequently detected in untreated surface water and well water samples, illustrating that many household water sources remain contaminated by faecal bacteria despite being used for drinking purposes. Furthermore, many of the E. coli isolates displayed resistance to commonly used antibiotics, underscoring both contamination and antimicrobial resistance concerns in water supplies (Quansah et al., 2025). Contamination risks are closely associated with high open defecation rates and environmental degradation, including pollution linked to informal mining activities in some regions.[17] These dynamics pose a clear threat to progress towards universal safely managed drinking water.

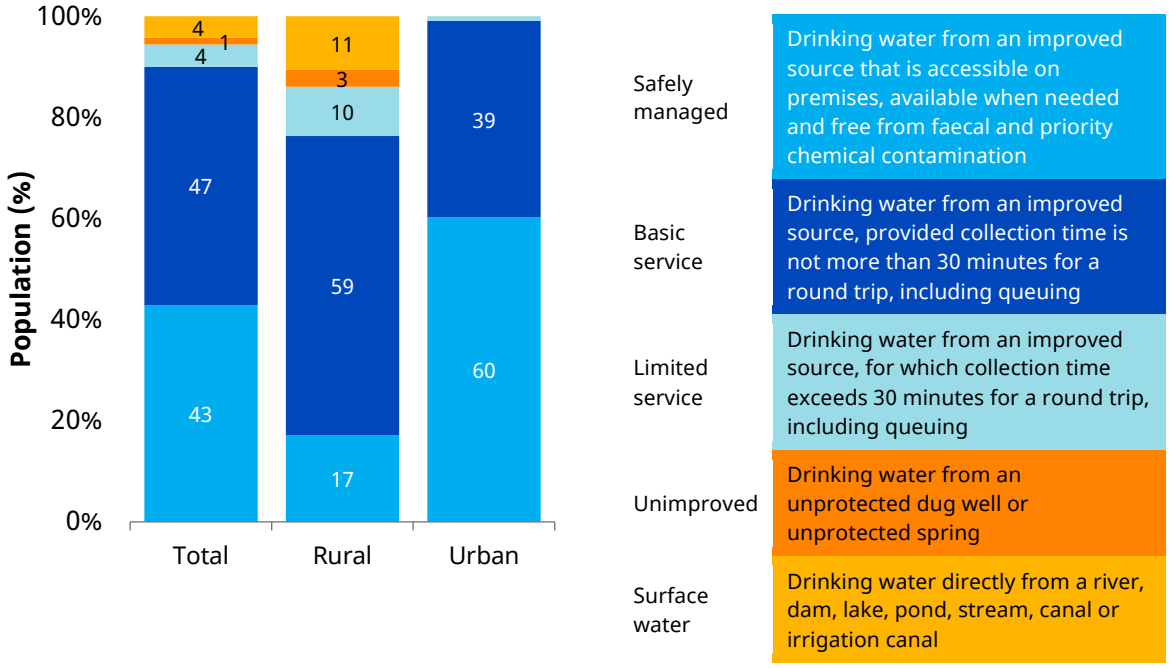
These concerns are consistent with findings from the MICS (2017/18), which included direct water-quality testing at both source and household level. The survey found that

[17] Based on consultations with UNICEF Ghana WASH Unit.

48.3 per cent of household members whose source water was tested had E. coli contamination in source water, while 76.1 per cent had E. coli contamination in household drinking water, indicating that water safety challenges persist even where households use improved sources and may worsen between collection and point of use during transport, handling and storage. Correspondingly, only 18.7 per cent of household members met the criteria for safely managed drinking water services in 2017/18 (GSS, 2018).

Although the majority of the population are living in households with at least basic drinking water services, 60 per cent of the population live in households without drinking water on the premises (DHS, 2022). In every one in five homes without drinking water, a child under 15 is responsible for collecting drinking water, possibly limiting their education and exposing them to safety risks. Furthermore, girls (12 per cent) are more likely to be responsible for collecting water than boys (7 per cent).

Figure 5-15: Drinking water service ladder



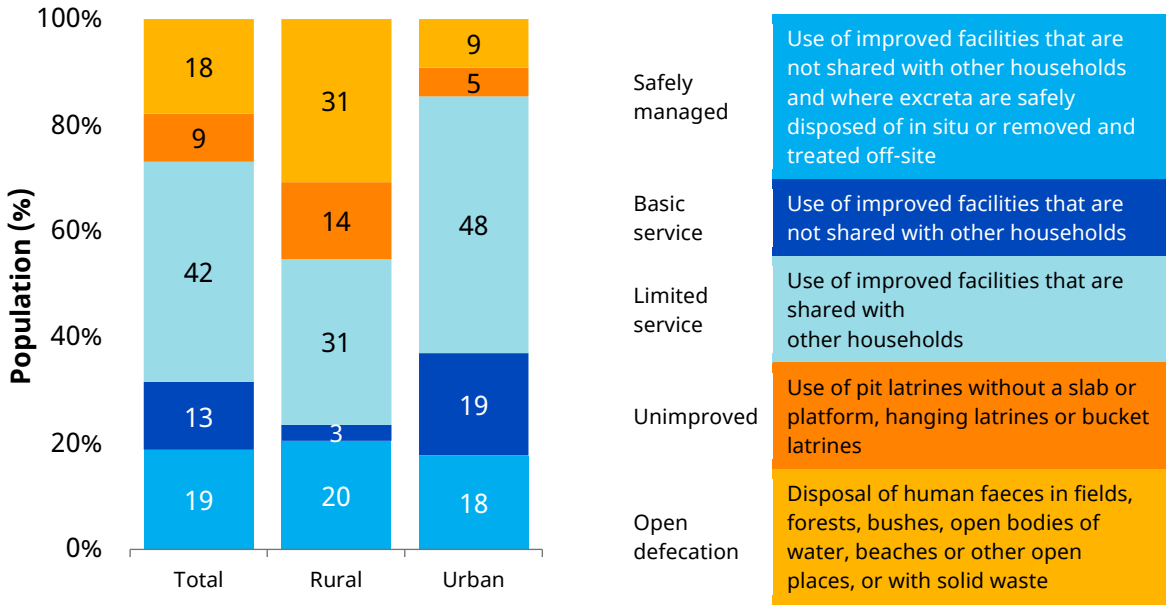
Source: WHO & UNICEF (2025). Notes: these estimates are modelled for 2024

Sanitation presents the most significant structural WASH challenge for children in Ghana. Under SDG 6.2, safely managed sanitation requires the use of improved facilities that are not shared with other households and where excreta are safely disposed of or treated. The latest JMP estimates indicate that only approximately 19 per cent of the population use safely managed sanitation services (Figure 5-16). The JMP estimates that about one in three people in Ghana today have access to at least basic sanitation service, while in 2022 according to the DHS it was 24 per cent of the population (or one in four). Open defecation remains at approximately 18 per cent nationally, rising to over 30 per cent in rural areas.

In addition, a substantial proportion of households rely on limited (shared) sanitation services. Sewer connectivity remains minimal, meaning that most sanitation depends on on-site systems such as pit latrines and septic tanks.[18] However, faecal sludge management systems are uneven and insufficiently regulated. As emphasised in consultations, the absence of a fully operational and financed faecal sludge management chain covering safe containment, emptying, transport and treatment limits the safety of sanitation services even where facilities are present. This contributes to environmental contamination and ongoing exposure risks for children.

DHS (2022) data provides important insight into the management of excreta beyond the type of sanitation facility used. Among households with septic tanks, 69 per cent report that their tanks have never been emptied, and 20 per cent report that excreta are removed by a service provider to an unknown location. For on-site sanitation more broadly, 45 per cent of household members safely dispose of excreta in situ and 12 per cent remove excreta for off-site treatment. However, 12 per cent of the population continues to use unimproved sanitation facilities and 25 per cent practise open defecation. Overall, 58 per cent of household members manage their excreta appropriately.

Figure 5-16: Sanitation service ladder



Source: WHO & UNICEF (2025). Notes: these estimates are modelled for 2024

In addition, the disposal of young children's stools remains a significant concern. According to DHS (2022), only 16 per cent of children under age two living with their mother had their last stool disposed of appropriately. While 15 per cent were put or rinsed into a toilet or latrine, 65 per cent were thrown into the garbage, 8 per cent were put or rinsed into a drain or ditch, and 3 per cent were left in the open. These practices

[18] Supported by consultations with UNICEF Ghana WASH Unit, the National Development Planning Commission and the Ghana Statistical Service.

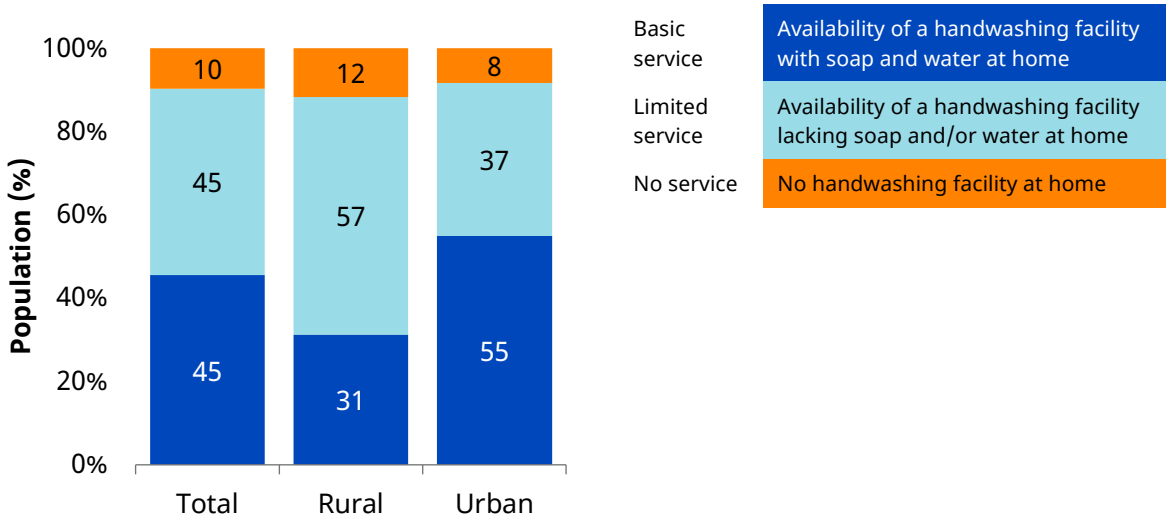
increase the risk of environmental contamination within household compounds and contribute to children's exposure to faecal pathogens, particularly during early childhood when vulnerability to infection is highest.

Sanitation is critical to Ghana's development and to children's safety, health and growth (UNICEF, n.d.-c). However, Ghana currently lacks a clear, coherent strategy and implementation plan for achieving basic sanitation, particularly in urban areas. In rural communities, progress continues to be constrained by weak planning and limited coordination across existing programmes, which reduces coverage, efficiency and sustained behaviour change (UNICEF, n.d.-c).

Basic hygiene services, defined as a handwashing facility with soap and water available at home, are present in approximately 44 per cent of households (Figure 5-17). Around 43 per cent have limited services, lacking either soap or water at the handwashing point, and approximately 13 per cent have no facility at all. Limited access to basic hygiene increases infection transmission risks, particularly for children under five. Persistent behavioural norms and affordability constraints influence handwashing practices, even where infrastructure exists.

It is also important to reiterate that the current rapid and unplanned urbanisation is reshaping WASH risks in Ghana. A significant share of urban households live in informal settlements, where infrastructure expansion has not kept pace with population growth. While urban residents are less likely to rely on surface water, sanitation challenges are intensified by high density, shared facilities and weak excreta management systems.

Figure 5-17: Hygiene service ladder



Source: WHO & UNICEF (2025). Notes: these estimates are modelled for 2024

WASH in health facilities

Situation

- While most health care facilities in Ghana have at least some form of water access, only two-thirds meet the JMP definition of basic water service, with significant disparities between hospitals and primary-level facilities.
- Sanitation remains critically weak, especially in rural areas, where only 2 per cent of facilities meet basic sanitation standards and 16 per cent lacking sanitation services entirely.
- Hygiene and waste management services are inconsistent, particularly in non-hospital facilities, posing risks to infection prevention and maternal and newborn care.

Bottlenecks

- Weak sanitation and faecal waste management systems undermine the safety of care environments and compromise infection prevention and control.
- Primary health facilities are significantly less equipped than hospitals, reflecting infrastructure and financing gaps.
- Data limitations and fragmented responsibility across sectors constrain systematic monitoring and asset management.

Health care facilities are critical environments for safeguarding early child survival. Under SDG monitoring frameworks, basic WASH services in health care facilities require reliable water access, improved sanitation, hand hygiene facilities at points of care and toilets, safe waste management, and environmental cleaning systems (WHO & UNICEF, 2025).

The latest JMP estimates for Ghana, which draw mostly on nationally reported data from the District Health Information Management System (DHIMS), provide the most comprehensive overview of WASH service levels in health care facilities. According to the data, 67 per cent of facilities had basic water service in 2023. However, coverage differs markedly by facility type: 85 per cent of hospitals met basic water standards compared with only 47 per cent of non-hospital facilities. One-third of facilities operate with only limited water service, indicating intermittent supply or lack of water at critical points of care (WHO & UNICEF, 2025).

Sanitation presents a more severe challenge. As of 2021, only 2 per cent of facilities met the criteria for basic sanitation service, while 82 per cent were classified as having limited service and 16 per cent had no service. This indicates systemic weaknesses in safe excreta containment, disposal, and infrastructure adequacy within health care settings.

Hygiene services show moderate progress. In 2023, 57 per cent of facilities met the criteria for basic hygiene service, though performance again varies: 92 per cent of hospitals had basic hygiene compared with 50 per cent of non-hospital facilities. Limited hygiene service — recorded in 40 per cent of facilities — reflects the absence of functional handwashing facilities with soap and water at critical care points.

Waste management and environmental cleaning remain constrained. Only 31 per cent of facilities met basic waste management standards in 2023, while 20 per cent had no service. For environmental cleaning, 41 per cent of facilities met basic standards in 2021, leaving the majority operating below recommended conditions for safe clinical environments.

These gaps have direct implications for child and maternal health. Inadequate sanitation and hygiene increase the risk of health care–associated infections, including neonatal sepsis and postnatal complications. Weak waste management and environmental cleaning compromise infection prevention and control, particularly in primary-level facilities that serve rural and low-income populations. Strengthening WASH infrastructure, clarifying sectoral responsibilities for operation and maintenance, and embedding WASH financing within health system planning remain essential to ensure that facilities are not only accessible, but safe.

5.10 Housing and living conditions

Situation

- Housing conditions in Ghana reflect mixed progress: while 85 per cent of households have electricity and most use durable flooring materials, overcrowding remains common, with more than half of households having only one sleeping room.
- Reliance on solid fuels for cooking remains widespread, with 77 per cent of the population primarily using charcoal or wood, exposing children to household air pollution — particularly in rural areas where 93 per cent rely on solid fuels.
- Structural inequalities persist across residence and region. Rural households and northern regions are disproportionately concentrated in the lowest wealth quintiles, and nearly one quarter of all children aged 0–4 live in the poorest quintile, concentrating environmental and material deprivation among the youngest population.

Bottlenecks

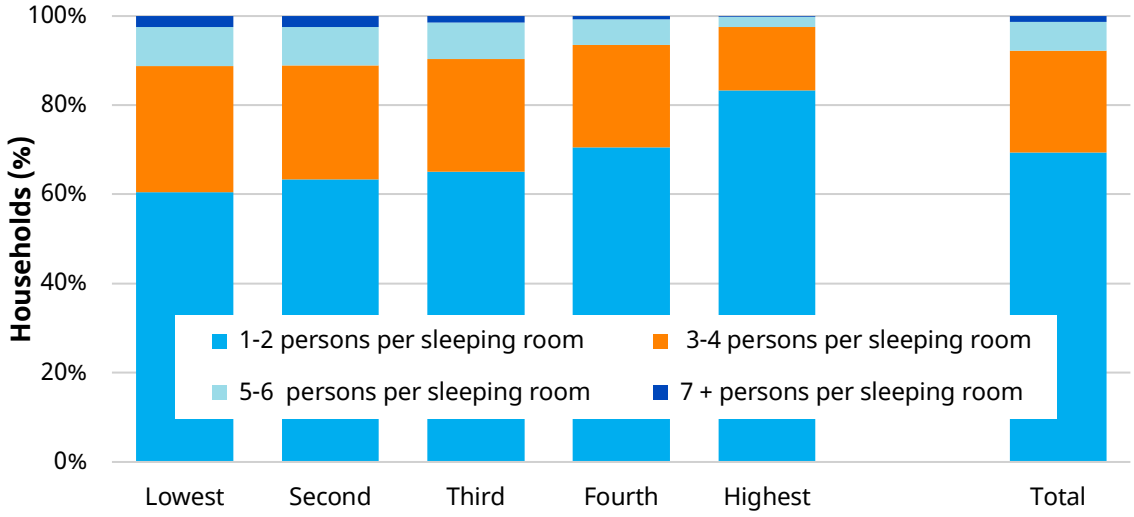
- High dependence on solid fuels and indoor cooking environments continue to expose children to harmful household air pollution, increasing risks of respiratory illness and adverse developmental outcomes.
- Overcrowding and limited living space heighten exposure to infectious disease and reduce safe and supportive environments for learning and early childhood development.
- Persistent rural–urban and regional wealth disparities constrain improvements in housing quality, access to clean energy, and accumulation of household assets, reinforcing cumulative disadvantage across multiple dimensions of child wellbeing.

Housing conditions shape children's daily exposure to environmental risks, safety, stimulation and wellbeing. Information from the DHS (2022) provides insight into

household infrastructure, energy use, crowding and asset ownership, all of which influence child health and development.

Overall, 85 per cent of households in Ghana have access to electricity. The most common flooring materials are cement (61 per cent of households) and ceramic tiles (17 per cent), indicating broad access to relatively durable construction materials. However, overcrowding remains common: 55 per cent of households have only one room used for sleeping, 27 per cent have two rooms, and only 19 per cent have three or more rooms. The average number of persons per room is 2, but varying from 2.2 in the lowest wealth quintile to 1.9 in the highest quintile. However, in the lowest quintile, close to 40 per cent of households have 3 or more persons per sleeping room, and over 10 per cent of homes in the lowest quintile have 5 or more persons per sleeping room (Figure 5-18). Limited sleeping space increases the risk of transmission of respiratory and infectious diseases, particularly among young children. Overcrowding may also affect children's cognitive development and educational outcomes by reducing quiet study space and increasing household stress (WHO, 2018; Solari and Mare, 2012).

Figure 5-18: Housing overcrowding



Source: DHS (2022)

Exposure to tobacco smoke remains present in some homes: in 6 per cent of households someone smokes inside daily, and in 5 per cent weekly (DHS, 2022). For infants and young children, exposure to second-hand smoke increases the risk of respiratory infections and other adverse health outcomes.

Energy use patterns present one of the most significant child health risks linked to housing. While 99 per cent of households use clean fuels or technologies for lighting which is primarily electricity (84 per cent), clean cooking fuel adoption remains limited. Only 23 per cent of households use clean fuels and technologies for cooking, mainly LPG or natural gas stoves. Seventy-seven per cent of the household population primarily relies on solid fuels for cooking, including charcoal and wood. Reliance on

solid fuels for cooking is particularly concentrated in rural areas, where 93 per cent of the rural population primarily use solid fuels for cooking (GSS et al., 2022).

Cooking location also influences exposure. Thirty-one per cent of households cook inside the home, 21 per cent in a separate building, and 43 per cent outdoors (DHS, 2022). In settings where cooking takes place indoors without adequate ventilation, children are exposed to high levels of household air pollution.

Household air pollution from solid fuel use is associated with increased risks of pneumonia, chronic respiratory conditions and adverse birth outcomes. Young children, who spend significant time near caregivers during cooking, are particularly vulnerable. The persistence of solid fuel use therefore remains a major structural risk factor for child survival and healthy development.

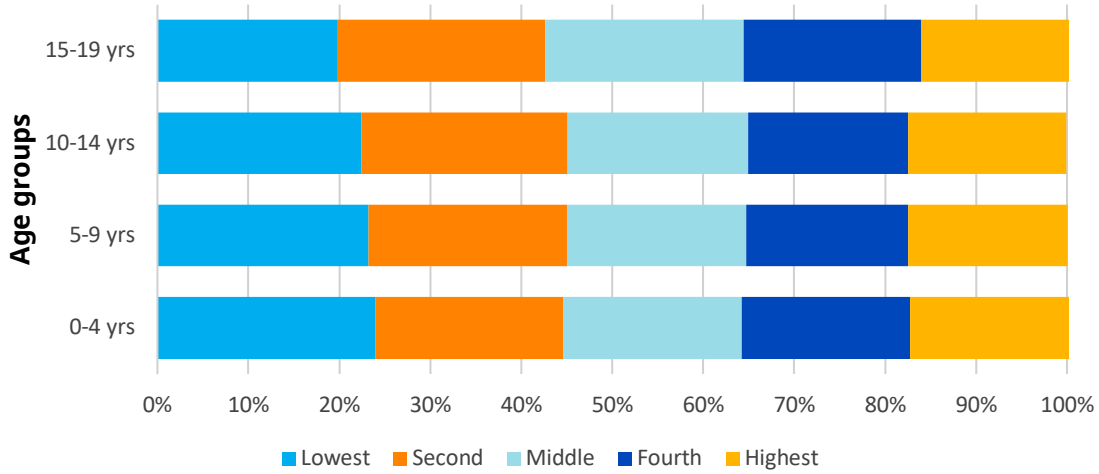
Ownership of durable goods provides additional insight into living standards. Ninety-four per cent of households own a mobile phone, 66 per cent own a television, and 42 per cent own a refrigerator (DHS, 2022). Asset ownership differs substantially by residence: 56 per cent of urban households own a refrigerator compared with 22 per cent of rural households.

Wealth disparities are stark. Eighty-six per cent of urban residents fall within the top three wealth quintiles, compared with only 32 per cent of rural residents. Regionally, nearly half (49 per cent) of the population in Greater Accra falls within the highest wealth quintile, compared with just 1 per cent in North East, 2 per cent in Savannah, and 3 per cent in Oti. In contrast, more than half of the population in North East (64 per cent), Upper East (57 per cent), Savannah (55 per cent), and Upper West (52 per cent) fall within the lowest wealth quintile (DHS, 2022).

These structural inequalities shape children’s exposure to environmental risk, nutritional deprivation, and limited service access. Children in lower-wealth households are more likely to experience overcrowding, reliance on solid fuels, limited access to clean water and sanitation, and lower access to durable assets that support learning and wellbeing.

Children are disproportionately concentrated in lower wealth quintiles. Nearly one quarter of all children aged 0–4 live in the poorest quintile, compared with fewer than one in five in the richest quintile. Similar patterns are observed for older children, indicating that child-related service needs are structurally concentrated among lower-income households (Figure 5-19).

Figure 5-19: Distribution of child population by wealth quintile and age



Source: DHS (2022)

Housing conditions in Ghana reflect both progress and persistent structural vulnerability. Access to electricity and improved flooring is widespread, but overcrowding, solid fuel reliance, and wealth disparities continue to shape unequal child outcomes. Children living in rural and low-income households face cumulative environmental risks: indoor air pollution, limited living space, weaker infrastructure, and fewer material resources. These factors intersect with other deprivations including WASH, nutrition and access to health services reinforcing patterns of multidimensional poverty.

5.11 Early childhood education and organised learning

Situation

- Participation in organised learning at age 5 is high nationally (88 per cent adjusted net attendance ratio), but 12 per cent of children attend neither early childhood education (ECE) nor primary school (World Bank, 2026).
- Wealth-based and geographic inequalities are pronounced: 32 per cent of children in the poorest quintile attend neither ECE nor primary school, compared with fewer than 3 per cent in the richest quintile. In rural areas, only 18 per cent of children aged 5 attend neither ECE nor primary school, compared with 4 per cent in urban areas (World Bank, 2026).
- The net attendance ratio to organised learning has wide regional disparities, with organised learning participation at age 5 as low as 60 per cent in Savannah and below 75 per cent in Northern, North East and Oti regions (GSS et al., 2022).

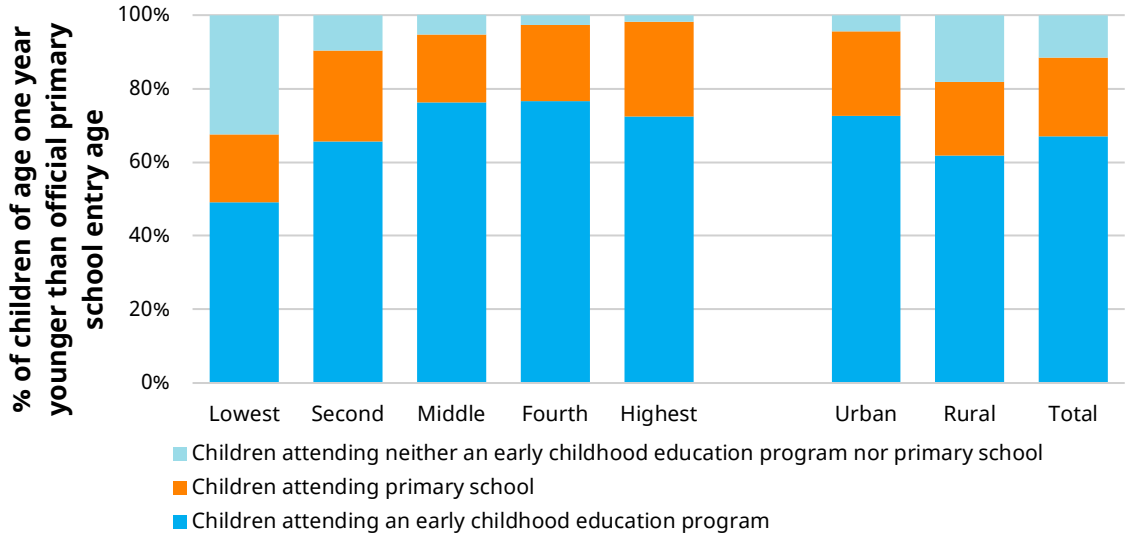
Bottlenecks

- Household poverty remains the strongest determinant of early exclusion, limiting access to ECE and increasing the risk of delayed school entry.

- Uneven geographic distribution of early childhood facilities constrains participation in rural and northern regions.
- Structural weaknesses in the progression and retention of children from early childhood education programmes contribute to sustained exclusion in primary school.
- Compounded disadvantage at the start of the education cycle risks reinforcing long-term inequality in learning outcomes.

Early childhood education provides the foundation for literacy, numeracy and socio-emotional development, facilitating a smoother transition into primary education (UNESCO, 2022).[19] According to the DHS (2022), 67 per cent of children aged 5 attend an early childhood education programme and 21 per cent are already enrolled in primary school, resulting in an adjusted net attendance ratio of 88 per cent (DHS, 2022). However, 12 per cent of children at this critical transition age remain outside organised learning (Figure 5-20).

Figure 5-20: Organised learning participation at age 5 by place of residence and wealth quintile



Source: DHS (2022)

Wealth-based inequality is the dominant pattern. Only 49 per cent of children in the poorest quintile attend ECE, compared with over 70 per cent in middle- and higher-income quintiles (Figure 5-20). Nearly one third of children in the poorest quintile attend neither ECE nor primary school, indicating early and compounded exclusion.

Urban–rural disparities reinforce this inequality (Figure 5-20). While participation in organised learning reaches 96 per cent in urban areas, it falls to 82 per cent in rural areas. Regional variation is particularly stark. Participation exceeds 95 per cent in

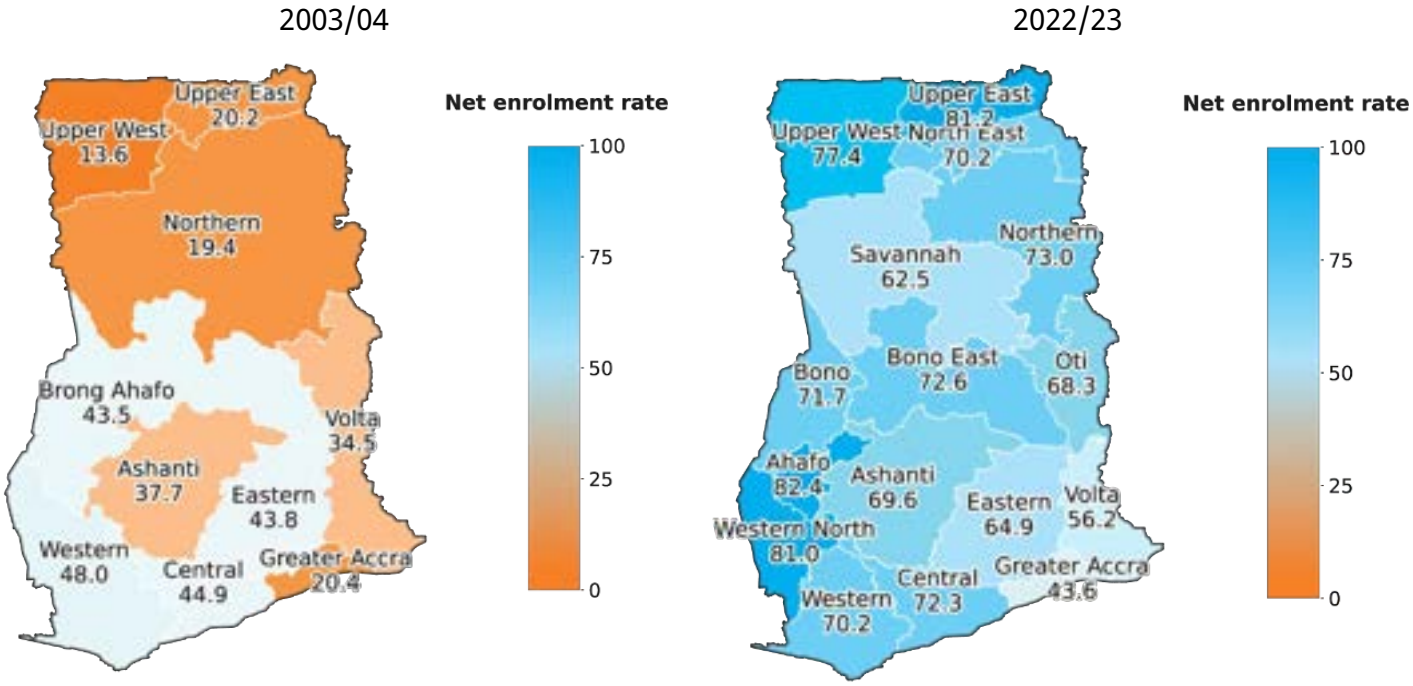
[19] In Ghana, early childhood education comprises two years of pre-primary kindergarten for children aged 4 and 5 years, while primary school begins at age 6 years.

Greater Accra and Ashanti, but drops sharply in Savannah, Northern and North East regions. In Savannah, 40 per cent of children aged 5 are not enrolled in any organised learning programme.

Analysis of the administrative education management information system (EMIS) data by GSS, indicates that there has been a longer-term expansion in kindergarten provision. Gross enrolment at the kindergarten level has more than doubled over the past two decades, rising from 51 per cent in 2003/04 to 122 per cent in 2022/23 (GSS, 2025b). Over the same period, the net enrolment rate (NER) increased from 34 per cent to 66 per cent, indicating substantial gains in age-appropriate participation. The most pronounced improvements occurred in northern regions. For example, Upper West recorded the largest increase in NER, rising from 13.6 per cent in 2003/04 to 77.4 per cent in 2022/23 (Figure 5-21). Similar upward trends are observed across Upper East, Northern and North East regions, suggesting progress in reducing geographic disparities over time.

However, expansion has not fully met national planning targets. In 2020, both gross and net enrolment rates for kindergarten remained below the Education Strategic Plan (ESP) targets, with the net enrolment rate falling short by 18.6 percentage points. These gaps indicate that, despite rapid expansion, universal and equitable access to early childhood education remains incomplete.

Figure 5-21: Net enrolment rate (NER) at kindergarten level by region, 2003/04 and 2022/23



Source: GSS (2025b)

Quality indicators available in GSS (2025b) show parallel improvements. The pupil-to-trained-teacher ratio (PTTR) at kindergarten level declined sharply between 2010/11 and 2020/21, from over 90 pupils per trained teacher to approximately 35 nationally. Regional improvements were particularly striking in Western (228 to 39) and Upper

East (194 to 40), reflecting substantial investments in teacher deployment and training. At primary level, PTTR improved from around 55 to 31 over the same period.

While these data reflect participation, they do not provide sufficient insight into the accessibility and distribution of different types of early childhood services. The administrative data seem to only capture enrolment within formal kindergarten structures, they do not fully reflect participation in different types of organised learning, nor do they provide detailed insight into accessibility, service type or quality at household level. And, the DHS does not distinguish clearly between nursery, kindergarten or childcare arrangements, nor does it measure distance to services or affordability. The absence of nationally representative data on service type and quality constitutes a significant evidence gap for early childhood planning.

Importantly, participation does not guarantee learning. National Standardised Test (NST) results for early primary grades show that a substantial proportion of pupils do not achieve minimum proficiency levels in literacy and numeracy.[20] This indicates that foundational learning deficits emerge early in the schooling cycle and are likely linked to both inequalities in school readiness and variation in early-grade instructional quality. Foundational skills gaps are closely linked to household-level determinants, including caregiving practices, parental stress and knowledge of early childhood development. These parenting-related constraints are summarised in Box 5-1 and represent a critical enabling factor for improved early learning outcomes. Improving foundational learning requires investment not only in schools, but also in caregiver support. Strengthening parenting capacity, including early stimulation, positive discipline, shared caregiving and stress management, is essential to translating school participation into improved learning outcomes.

Box 5-1: Parenting needs and caregiver capacity

Structural constraints on caregivers directly affect children's early development and readiness to learn. A national Parenting Needs Assessment highlights the following patterns:

- Violent discipline remains widespread nationally, with high levels of psychological and physical punishment reported in household surveys.
- Economic stress and time poverty significantly constrain responsive caregiving, particularly among low-income households.
- Knowledge gaps in early childhood development are substantial. Studies in Ghana find that fewer than one in five mothers in some regions demonstrate adequate knowledge of developmental milestones.
- Fathers remain under-engaged in day-to-day caregiving, despite retaining primary decision-making authority in many households.

[20] The NST for the second year of kindergarten, reflecting early ECE grades is being prepared for 2026.

- Adolescent parents, single mothers and caregivers of children with disabilities face compounded barriers including stigma, financial strain and limited access to support services.

Qualitative findings show that while parents strongly value education and want their children to succeed, structured early stimulation, home-based learning activities and dialogue-based discipline are not yet widespread practices. Adolescents consistently express a desire for more respectful and communicative parenting approaches.

Sources: UNICEF (2025g)

The first five years of life represent a period of heightened vulnerability but also exceptional opportunity. In Ghana, persistent inequalities in nutrition, WASH access, early stimulation, and household economic security compound risks during this period. When combined with emerging pressures such as urban overcrowding, environmental degradation, and fiscal constraints on service delivery, these factors threaten to widen developmental gaps if not addressed through integrated early childhood strategies.

E Forward-looking considerations

Over the next decade, Ghana's large cohorts of young children will move through the early childhood stage at scale. The central question is not only whether children survive, but whether they accumulate the foundational cognitive, nutritional and socio-emotional assets required for later learning and productivity.

Evidence presented in this chapter suggests that early risks are cumulative. Inadequate nutrition, unsafe water and sanitation, incomplete birth registration, limited stimulation and exposure to institutional care interact to widen developmental gaps before children reach primary school. Without integrated early childhood interventions, inequalities established in the first five years are likely to persist and compound over the lifecycle.

Urbanisation and environmental degradation pose particular risks for young children, especially in informal settlements and mining-affected communities where water contamination and overcrowding increase exposure to disease and malnutrition. At the same time, digital systems and community-based service platforms offer opportunities to strengthen birth registration, child tracking, early case management and parent education, provided access gaps are addressed.

Ultimately, Ghana's ability to translate demographic growth into inclusive economic progress will depend heavily on investments in early childhood development. The window for shaping cognitive development, resilience and school readiness is narrow. Delayed action risks entrenching inequality and constraining long-term human capital formation.

CHAPTER 6.

MIDDLE CHILDHOOD

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6 Middle childhood

Middle childhood, spanning roughly ages 5 to 11, represents a critical consolidation phase in the lifecycle. During these years, children transition into formal schooling, develop foundational literacy and numeracy skills, and expand their social and cognitive capacities. It is a period when early childhood investments are tested and either reinforced or undermined by the quality of primary education, the safety of learning environments, and the stability of family and community conditions.

In Ghana, primary school enrolment has expanded significantly over the past decades. However, ensuring that enrolment translates into meaningful learning and sustained progression remains an ongoing challenge. At the same time, children in this age group may face increasing exposure to protection risks, including violence, labour exploitation and trafficking, particularly where household poverty, migration or weak local service systems intersect.

The evidence presented in this chapter examines whether children in Ghana are able to consolidate foundational skills within safe and supportive environments, or whether structural vulnerabilities during middle childhood are widening inequalities that may persist into adolescence and adulthood.

A Educational access and learning foundations

Primary education forms the backbone of Ghana's basic education system and is legally guaranteed under the Free Compulsory Universal Basic Education framework. Between the ages of 6 and 11, children are expected to consolidate foundational literacy and numeracy skills while developing the cognitive and social competencies required for later learning. The extent to which children access, remain in, and benefit from primary schooling during these years is therefore central to Ghana's long-term human capital development.

Although primary school enrolment has expanded substantially, disparities in attendance and completion persist across regions, wealth groups and communities. Beyond participation, learning outcomes remain uneven, raising concerns about whether children are acquiring foundational skills at the expected pace. School infrastructure and the broader learning environment, including access to safe water, sanitation and hygiene facilities, further shape children's ability to attend regularly and learn effectively.

This section examines access, learning and school environment conditions during the primary years, with attention to structural inequalities that may affect children's trajectories as they approach adolescence.

6.1 Primary school education

Situation

- Primary gross enrolment has remained above 100 per cent for much of the past two decades, reflecting near-universal participation but persistent age distortion.
- Net enrolment increased by approximately 20 percentage points between 2001/02 and 2022/23, yet remains below full universal coverage.
- A significant proportion of pupils are outside the official age range for primary school, indicating delayed entry and grade repetition.
- Gender parity at primary level has largely been achieved nationally.
- Regional and wealth-based disparities in enrolment and progression persist.

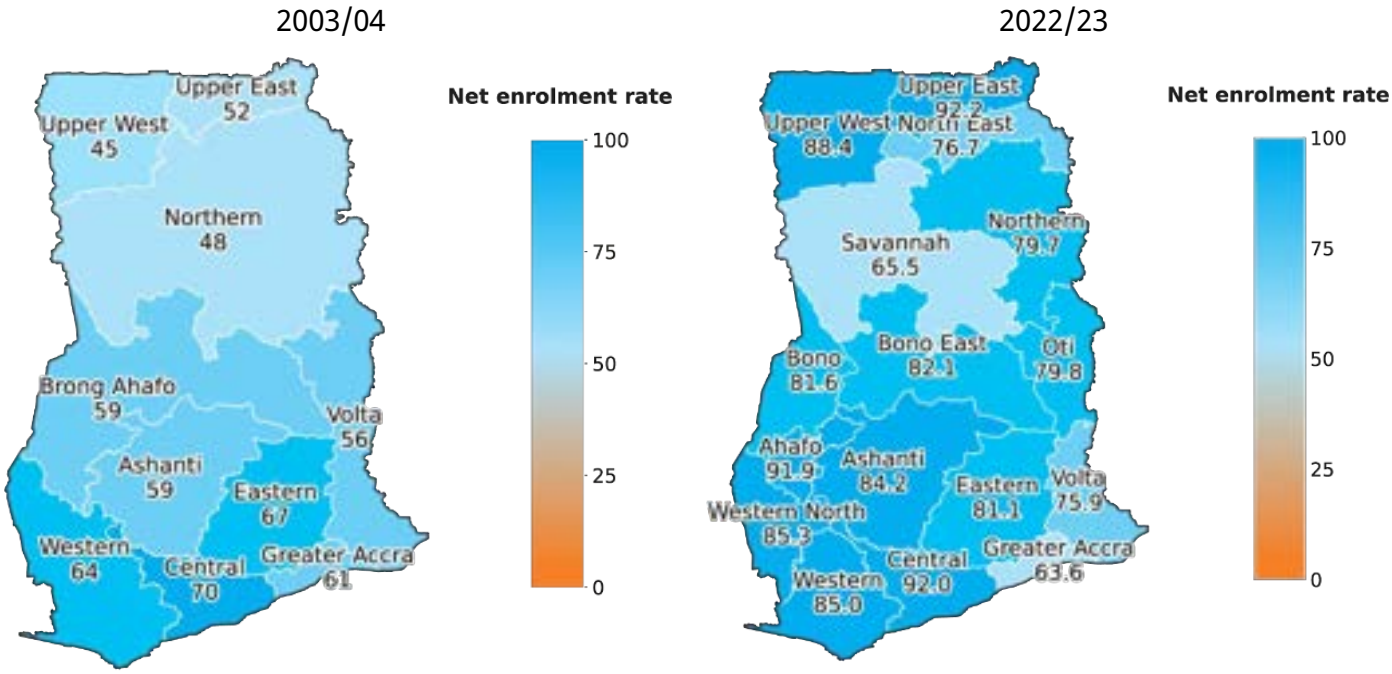
Bottlenecks

- Poverty-related exclusion remains a primary driver of non-attendance and weak progression, alongside distance, indirect costs, and opportunity costs of schooling in poorer households.
- Over-age enrolment and grade repetition continue to undermine efficiency and completion, with implications for learning and transition to JHS.
- Regional disparities reflect uneven availability of teachers, infrastructure, and enabling conditions (including WASH), particularly in historically underserved regions.

Administrative data from the Education Management Information System show sustained expansion in access over the past two decades (GSS, 2025b). Primary gross enrolment increased by approximately 20 percentage points between 2001/02 and 2022/23 and has consistently exceeded 100 per cent. While this reflects strong participation, it also points to age distortion within the system. Net enrolment has similarly improved, though it remains below universal levels (Figure 6-1). This gap between gross and net enrolment indicates that a considerable share of pupils are outside the official age range for primary school, including children who enter school either earlier or later than expected.

Gender disparities have narrowed significantly. The Gender Parity Index at primary level has remained close to 1.00 in recent years (GSS, 2025b), suggesting near parity between boys and girls at national level. However, regional differences persist. Enrolment and progression remain weaker in several northern regions, where poverty rates are higher and school infrastructure is more limited.

Figure 6-1: Primary net enrolment ratio by region



Source: GSS (2025b)

Household survey evidence from the DHS (2022) confirms that wealth-based inequalities continue to shape participation. Children from the poorest households are more likely to experience delayed school entry and irregular attendance compared to children from wealthier households. Rural residence compounds these vulnerabilities.

Out-of-school patterns underline where exclusion is concentrated. The 2023 Education Sector Analysis estimates that nationally the proportion of primary school-age children not attending school is below 7 per cent, but this disguises steep wealth gradients. At primary level around 1 per cent of children from the wealthiest quintile are out of school compared with about 16 per cent from the poorest quintile (DHS, 2022). In absolute terms, the government estimates that around 623,500 primary school-age children are out of school (UNICEF, n.d.-d). These disparities imply that improvements in average coverage will not automatically translate into universal participation without strategies to address household poverty, geographic access constraints, and barriers faced by marginalised groups.

Ghana has also developed alternative pathways for out-of-school children through Complementary Basic Education (CBE), an accelerated programme for children aged 8–14 who are not in school. The most recent programme cycle enrolled around 10,500 children, and available programme evidence suggests that over 70 per cent transitioned into formal schooling (MOFEP, 2025; UNICEF, 2024). However, coverage remains limited relative to the number of out-of-school children, and nationally comparable evidence on sustained transition and learning outcomes remains scarce.

Despite tuition-free education, indirect costs remain a constraint for poorer households. Uniforms, learning materials, transport and examination-related expenses continue to influence attendance patterns. Economic shocks and seasonal income instability further affect school participation, particularly in rural communities.

Teacher distribution and classroom conditions also present challenges. While national pupil–teacher ratios have improved over time, some schools, particularly in high-enrolment or deprived districts, experience overcrowded classrooms. Classes can reach 60 to 80 pupils, leading to teacher fatigue and reduced individual attention.[21] Although this challenge was highlighted particularly at early grades, similar pressures are observed in lower primary classrooms.

Parental engagement is another constraint. The concept of free and compulsory education implies shared responsibility between the State and households. While access is guaranteed, parents retain the obligation to ensure attendance and support learning. However, enforcement of compulsory education remains weak, and misconceptions about the scope of "free education" reduce active parental participation.[22]

Infrastructure disparities further compound inequities. While substantial investments have been made in expanding school facilities, some primary schools, particularly in deprived districts, continue to operate in overcrowded or substandard environments. These disparities contribute to uneven learning conditions and reinforce geographic inequalities.

6.2 Learning outcomes and foundational skills

Situation

- Learning outcomes remain a major concern despite improvements in access. Over 60 per cent of children do not achieve basic literacy and numeracy by the end of primary school (UNICEF, 2025d).
- Ghana's gap between years of schooling and learning-adjusted years remains substantial: it is reported that while there are 11.6 years of schooling, there are only 5.7 effective learning years. (World Bank, 2026)
- Learning deficits appear early and persist, indicating challenges in both school readiness and the quality of instruction through primary years.

Bottlenecks

- Weaknesses in foundational learning reflect teacher deployment and effectiveness, limited learning materials, classroom overcrowding in some contexts, and uneven implementation of remediation/support programmes.
- Inequalities in learning are reinforced by poverty, language of instruction transitions, and differential access to supportive learning environments at home.

[21] Based on consultations with Ghana Education Service.
[22] Based on consultations with Ghana Education Service.

- Internal efficiency constraints (late entry/repetition) reduce learning time and weaken mastery.

Improvements in enrolment are not automatically translating into strong learning outcomes. Multiple sources point to persistent foundational learning deficits, suggesting that many children complete early primary without acquiring minimum proficiency in literacy and numeracy, with implications for retention, transition to JHS, and longer-term human capital accumulation.

Over 60 per cent of children fail to achieve basic literacy and numeracy by the end of primary school (UNICEF, 2025d), consistent with wider global estimates of learning poverty (UNICEF et al, 2022). A large gap between schooling and learning persists. Although Ghana averages 11.6 years of schooling, children experience only 5.7 learning-adjusted years, highlighting the scale of inefficiency in translating schooling into mastery (World Bank, 2026). These gaps are likely to be larger among poorer children and in regions facing service constraints, compounding early inequalities in school readiness and household support.

These patterns suggest that increased enrolment has not translated automatically into improved learning quality. Although more children are entering school, many struggle to acquire core competencies in reading comprehension and basic mathematics. Early-grade literacy gaps are particularly concerning, as they shape progression through subsequent grades and influence the likelihood of transition to junior high school.

According to National Council for Curriculum and Assessment (NaCCA, 2023), the Results from the 2022 National Standardised Test show that only 38.7 per cent of Primary 2 learners achieved mastery in early reading, compared with 62.1 per cent in numeracy, pointing to particularly weak foundational literacy. The same assessment found that while 76.4 per cent of learners could read with fluency, 70.3 per cent scored zero on reading comprehension, suggesting that many children can decode text without adequately understanding it. Children who had attended kindergarten also performed better than those who had not, reinforcing the importance of school readiness for later learning (NaCCA, 2023).

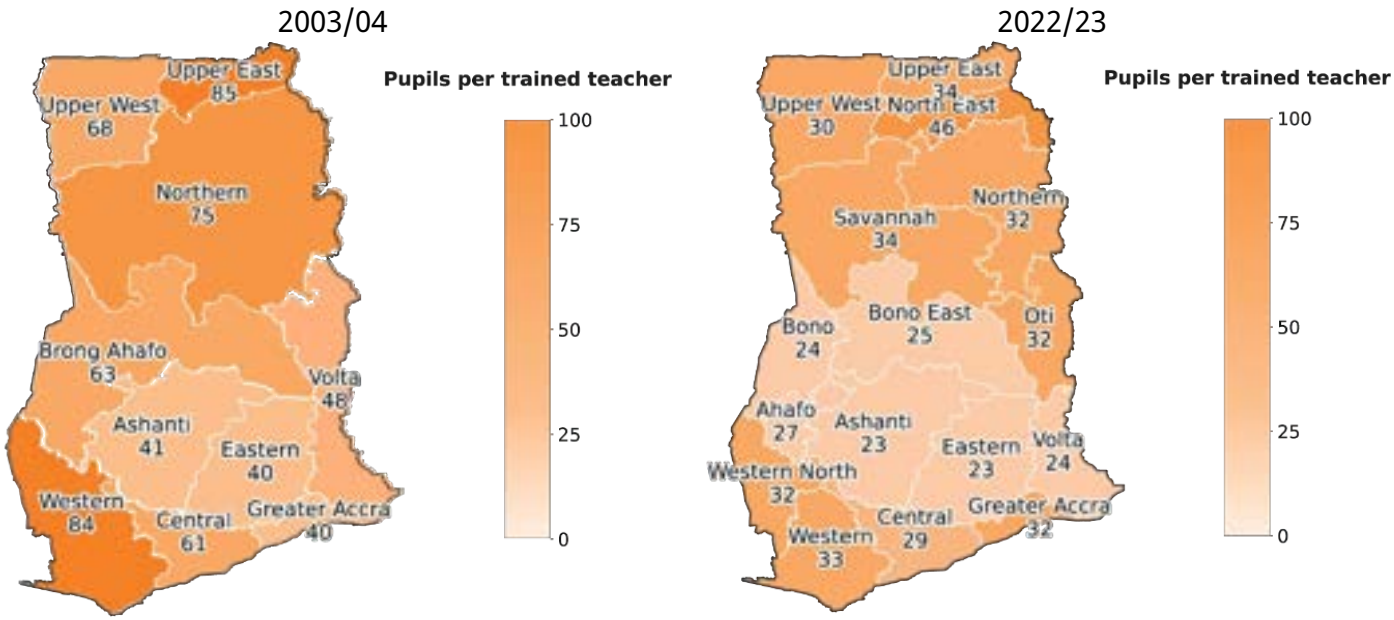
These early deficits remain visible in later primary grades. In the 2024 NST, Primary 4 learners achieved an average score of 60.9 per cent in English and 57.5 per cent in mathematics, while Primary 6 learners scored 61.6 per cent in English and 57.0 per cent in mathematics, indicating somewhat stronger performance in English than in mathematics at both grade levels (NaCCA, 2025). However, a large share of learners still did not reach basic proficiency. At Primary 4, 34.9 per cent of learners were at below basic level in English and 38.4 per cent in mathematics; at Primary 6, the corresponding shares were 32.1 per cent and 38.1 per cent respectively (NaCCA, 2025). These findings suggest that many children progress through primary school without securely mastering core competencies, especially in mathematics.

Regional patterns are also more mixed than the typical north–south divide observed across other outcomes. In the 2022 P2 NST, Greater Accra recorded the highest

regional mean score in English (54.5 per cent), while Volta recorded the highest in mathematics (73.9 per cent); North East recorded the lowest mean scores in both English (24.8 per cent) and mathematics (43.3 per cent) (NaCCA, 2023). In the 2024 NST, regional performance remained uneven but shifted across grades and subjects. At Primary 4, Western North recorded the highest mean score in English (74.0 per cent) and Bono the highest in mathematics (66.7 per cent), while Upper East had the lowest mean score in English (50.2 per cent) and Upper West the lowest in mathematics (48.4 per cent) (NaCCA, 2025). At Primary 6, Oti recorded the highest mean score in English (62.27 per cent) and Western North the highest in mathematics (59.07 per cent), while Bono East had the lowest mean score in English (60.58 per cent) and Volta the lowest in mathematics (53.65 per cent) (NaCCA, 2025). This suggests that learning inequalities are substantial, but not necessarily consistently aligned with a single regional pattern.[23]

System-level constraints continue to affect instructional quality. Large class sizes, particularly in high-enrolment areas, reduce opportunities for differentiated teaching. Although pupil–teacher ratios have improved nationally over the past decade (Figure 6-2), uneven deployment remains a concern. While nationally the primary pupil-to-trained-teacher ratio fell from about 55 in 2010/11 to around 31 in 2020/21, the ratio still remains significant in Savannah (34), Upper East (34) and in North East (46). This indicates, that in some deprived districts, teachers face overcrowded classrooms, limiting the effectiveness of foundational instruction.

Figure 6-2: Trends in PTTR (primary) and regional variation



Source: GSS (2025b)

[23] Regional differences in NST results should be interpreted with caution. The 2024 NST covered about 16,534 public basic schools and was designed to assess all Primary 4 and Primary 6 learners in public schools across Ghana. It therefore does not capture children who are out of school or those enrolled in private schools, and regional differences may partly reflect variation in enrolment, attendance and school composition, rather than differences in instructional quality alone

System-level and pedagogical constraints continue to affect foundational learning. The challenge is not only overcrowded classrooms, but also the simple lack of teachers in some deprived areas, where a small number of staff may be required to cover several grades, reducing the time and attention available for effective instruction. Evidence from Ghana's Education Sector Analysis also points to variability in teacher preparedness, classroom management and effective use of instructional time (Ministry of Education, 2023). This is consistent with findings from the Time to Teach study, which show that excessive workload is an important driver of classroom absence and reduced instruction time, and that teachers in rural areas and lower grades often face heavier workloads because of ineffective recruitment and inequitable teacher allocation (Játiva et al, 2022). These constraints may be compounded further by language-of-instruction challenges in the early grades. Although Ghana's curriculum emphasises a mother tongue-based bilingual approach, teacher deployment does not always align with the dominant language of the school community.

Household-level factors compound these challenges. Poverty, limited caregiver literacy and constrained home learning environments affect school readiness and reinforcement of classroom learning.[24] Even when school attendance is regular, limited exposure to books and structured learning activities at home weakens skill consolidation.[25]

The evidence therefore suggests that Ghana's primary education system is now at a pivotal stage. Access has expanded significantly, but foundational learning remains uneven. Without intensified focus on early-grade instruction, teacher support and targeted interventions for disadvantaged pupils, gains in enrolment risk being undermined by weak learning outcomes. Strengthening foundational skills is critical not only for primary completion, but also for successful transition to secondary education and later skills development.

6.3 WASH in schools

Situation

- WASH conditions in schools remain a significant constraint on participation, safety and learning—particularly for girls and younger children.
- JMP estimates suggest that in 2024, at primary level: basic drinking water coverage is 77.6 per cent (with 19.4 per cent "no service" at national level across school settings); basic sanitation is 62.2 per cent; and basic hygiene is 51.6 per cent, while no hygiene service remains substantial (WHO & UNICEF, 2025).
- These gaps matter for diarrhoeal disease risk, school attendance, dignity and safety, and menstrual health management.

[24] Data from the 2022 DHS show that adult literacy remains uneven between women, who are often the main caregivers, and men. Nationally, only around 67 per cent of women aged 15–49 are classified as literate, compared with 82 per cent of men aged 15–59. Literacy is also substantially lower in several poorer regions and among lower-wealth households.
[25] Based on consultations with experts from the Department of Sociology, University of Ghana.

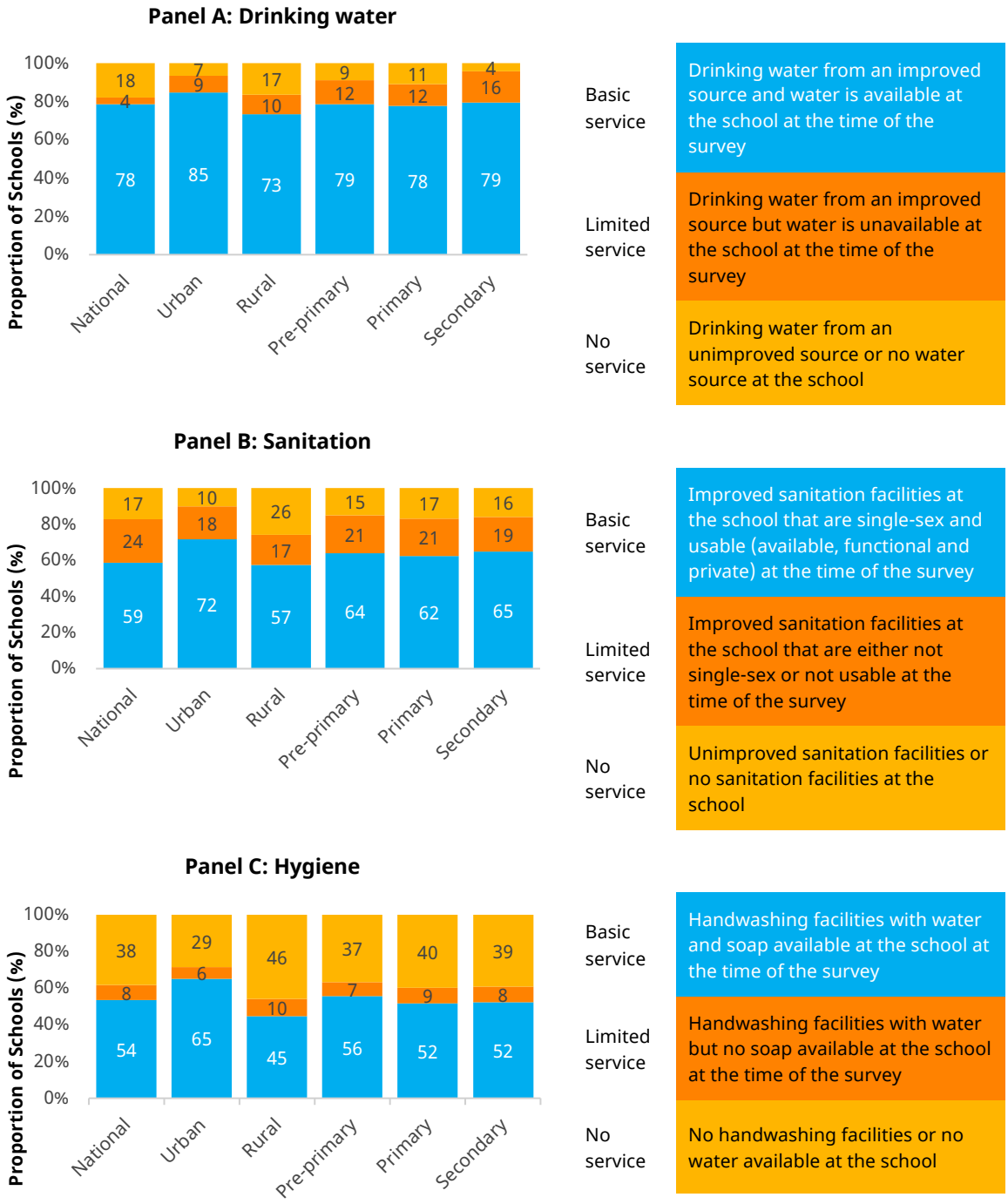
Bottlenecks

- Infrastructure deficits are compounded by operation and maintenance constraints, unreliable water supply, limited budget for consumables (soap), and weak accountability for functionality.
- Inequities are likely to be sharper in deprived districts and in overcrowded urban settings, where service delivery systems face higher stress and maintenance challenges.
- Where WASH is weak, it interacts with learning outcomes through absenteeism, reduced instructional time, and concentration difficulties, and may affect adolescent girls disproportionately.

The school environment, including WASH, shapes both educational participation and learning. Safe, functional WASH services reduce illness-related absenteeism, improve children's ability to concentrate, and support dignity and safety, particularly for girls and for children managing menstruation or disability-related needs. Conversely, inadequate WASH can undermine attendance, reinforce gendered barriers to participation, and increase exposure to health risks.

JMP estimates point to uneven provision of basic services. In 2022, basic drinking water at primary level is estimated at 77.6 per cent, while basic sanitation is 62.2 per cent and basic hygiene is 51.6 per cent (Figure 6-3). Hygiene is the most constrained domain: where soap and water are not available at handwashing facilities, schools cannot reliably support infection prevention or dignified menstrual health management. The persistence of "no service" categories indicates that a significant share of learners still attend schools without minimum WASH standards, which is likely to disproportionately affect poorer and rural communities.

Figure 6-3: WASH in Schools service ladders



Source: JMP (2024)

These conditions should be interpreted alongside broader resource pressures in the sector. Real spending constraints and limited fiscal space can restrict the ability of schools and local authorities to maintain infrastructure and ensure ongoing availability of consumables (UNICEF, 2025d). Improving WASH in schools therefore requires not only capital investment but stronger systems for operation and maintenance, including clear responsibilities, budgets for recurrent inputs, and monitoring of functionality.

B Protection risks and exploitation

Although middle childhood is commonly associated with schooling and skill development, it is also a period during which protection risks may intensify. As children grow older, they may assume increasing economic and domestic responsibilities within households, and in some contexts may become exposed to violent punishments, labour exploitation and child trafficking. These experiences can disrupt schooling, undermine wellbeing and have lasting developmental consequences.

Protection concerns in Ghana are closely linked to broader structural factors, including poverty, migration, urbanisation and environmental vulnerability. For some children, economic pressures may draw them into work that interferes with schooling. For others, exposure to severe punishments at home, in school or in the community may affect attendance, learning and psychosocial development.

This section explores the scale and drivers of key protection risks affecting children aged 5–11, and considers how these risks intersect with education and inequality, shaping children's life chances as they approach adolescence.

6.4 Child discipline and violent punishment

Situation

- Violent discipline is widespread among children aged 1–14 years.
- More than nine in ten children (94.0 per cent) have experienced some form of violent discipline in the past month (MICS 2017/18).
- Psychological aggression affects nearly nine in ten children (88.6 per cent) (MICS 2017/18).
- Physical punishment affects approximately three quarters of children (76 per cent), with severe physical punishment affecting a smaller but significant proportion (16.6 per cent) (MICS 2017/18).
- Older children (5–14 years) are more likely to experience severe physical punishment than younger children.
- Only a very small proportion of children experience exclusively non-violent forms of discipline (3.3 per cent) (MICS 2017/18).

Bottlenecks

- Social norms continue to legitimise physical punishment as an acceptable form of child-rearing. 58.6 per cent of mothers and caretakers currently believe that a child should be physically punished.
- Limited caregiver knowledge of positive discipline alternatives constrains behaviour change.
- Economic stress and overcrowded living conditions increase risk of harsh disciplinary practices. However, violent discipline is witnessed across all quintiles.
- Weak reporting, prevention and parenting support systems limit early intervention.

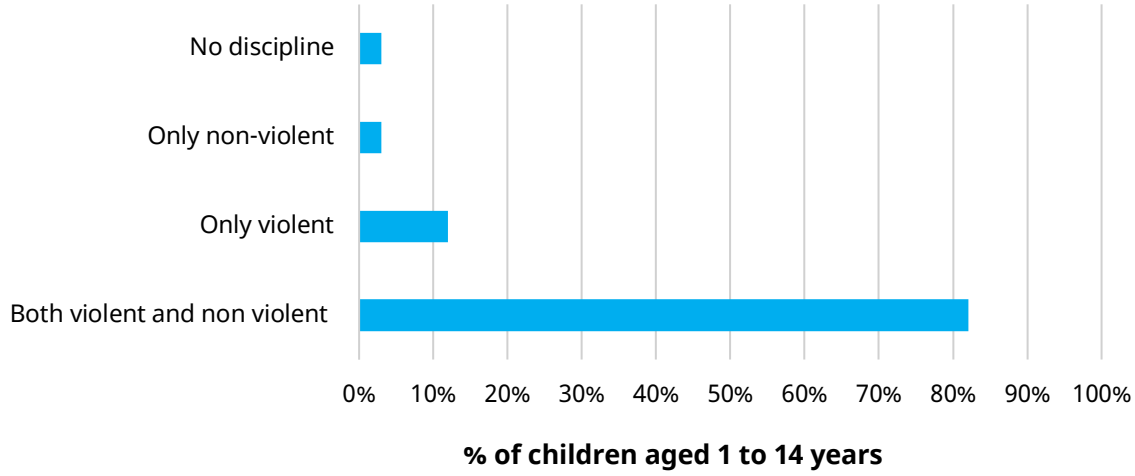
- Legal prohibitions on corporal punishment are not consistently enforced or internalised at household level as well as communities and institutions.

MICS (2017/18) provides data on disciplinary practices affecting children aged 1–14 years. The findings indicate that violent discipline remains pervasive in Ghanaian households. Overall, approximately 94 per cent of children aged 1–14 years experienced at least one form of violent discipline in the month preceding the survey. Psychological aggression—including shouting, insulting or threatening— affected close to 90 per cent of children (88.6 per cent). Physical punishment affected roughly three quarters of children (76 per cent), while severe physical punishment—such as hitting on the head, face or ears, or beating repeatedly—affected a smaller but concerning share (16.6 per cent).

Age patterns show that exposure increases with age. Severe physical punishment affects around 7 per cent of children aged 1–2 years, rising to approximately 15 per cent among children aged 3–4 years and nearly 19 per cent among children aged 5–14 years. This suggests that as children grow older, disciplinary practices may become harsher.

The distribution of discipline types further illustrates the normative nature of violence. The vast majority of children experience both violent and non-violent forms of discipline, while only a small minority experience exclusively non-violent methods (Figure 6-4). Very few children are raised without any form of disciplinary action in the reference period (3.3 per cent). These patterns reflect deeply embedded social norms that consider physical punishment an acceptable — and sometimes necessary — component of child-rearing. Qualitative evidence suggests that many caregivers associate strict discipline with responsible parenting and moral development. However, extensive global evidence demonstrates that violent discipline is associated with adverse developmental outcomes, including increased aggression, anxiety, reduced school performance and heightened risk of later victimisation or perpetration of violence.

Figure 6-4: Distribution of children 1-14 years by discipline types



Source: MICS (2017/18)

Violent discipline intersects with other structural stressors. Household poverty, parental stress, overcrowding and limited access to parenting support programmes can exacerbate reliance on harsh disciplinary practices. Caregivers facing economic insecurity may have reduced capacity for responsive and patient caregiving, particularly in urban informal settlements and deprived rural areas.

Although Ghana has a comprehensive legal and policy framework prohibiting violent discipline — including the Children's Act and obligations under the CRC and ACRWC — enforcement and social-norm transformation remain uneven. Prevention efforts require sustained investment in parenting and caregiving support, social norm change, integration of positive discipline messaging into multiple communication channels and platforms and strengthened integrated social service delivery and multi-sectoral referral systems.

6.5 Child labour

Situation

- In 2020, over 2 million children aged 5–17 years were engaged in child labour across Ghana, particularly in crop farming, forestry, fishing and mining (Dowuona-Hammond, Atuguba, & Tuokuu, 2021)
- Approximately 770,000 children work in cocoa-growing areas.
- An estimated 7,000 to 100,000 children are engaged in gold mining and quarrying, including illegal small-scale mining.
- Nearly four in five working children are concentrated in agriculture, reflecting the dominance of rural livelihoods.
- Many children are exposed to hazardous conditions, particularly in mining and certain forms of agricultural work.
- While GLSS 8 is ongoing and it will reflect child labour data, there is currently no recent nationally representative child labour survey, limiting the ability to assess current trends.

Bottlenecks

- Persistent household poverty drives reliance on children’s labour for income and subsistence.
- Informal rural labour markets limit visibility and enforcement of labour standards.
- Limited social protection coverage and livelihood alternatives constrain household coping options.
- Weak labour inspection capacity reduces deterrence of hazardous child labour practices.
- Educational access gaps and low returns to schooling in some rural areas reinforce early workforce entry.

Ghana continues to face a significant child labour challenge, despite the existence of a national policy framework that includes the National Plan of Action on Child Labour and the Worst Forms of Child Labour and the Hazardous Child Labour Framework. More than 2 million children aged 5–17 years are engaged in economic activities classified as child labour according to national survey estimates from the Ghana Living Standards Survey (GLSS). These figures underscore the intersection between poverty, rural livelihoods and limited economic diversification.

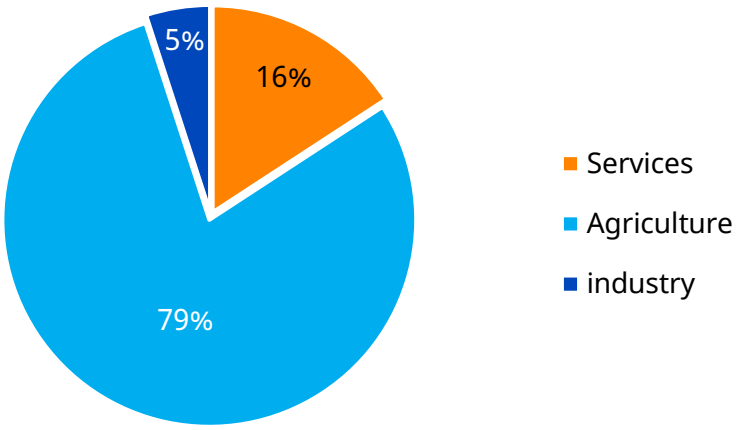
Agriculture dominates child labour in Ghana. Approximately 79 per cent of working children are engaged in agricultural activities, primarily crop farming (Figure 6-5). Cocoa production alone accounts for an estimated 770,000 children involved in labour-intensive activities such as land clearing, harvesting, carrying heavy loads and handling agrochemicals. The concentration in cocoa-growing regions highlights the structural dependence of smallholder farming systems on unpaid family labour.

Although smaller in absolute numbers, mining presents particularly acute risks. Estimates suggest that between 7,000 and 100,000 children are engaged in gold mining and quarrying, including informal and illegal small-scale mining operations. These children face exposure to hazardous chemicals such as mercury, dangerous underground conditions and high risks of injury.

The sectoral distribution illustrates the rural nature of the problem. With nearly four in five working children concentrated in agriculture, child labour is embedded in household production systems rather than formal employment structures. This informality limits oversight and enforcement, rendering much of the labour invisible to regulatory systems.

Importantly, there is no recent nationally representative child-labour survey in Ghana. The most widely cited estimates derive from the latest available round of the GLSS (2016/17), and while sector-specific assessments exist (particularly in cocoa), comprehensive and up-to-date national data are lacking. This evidence gap constrains the ability to assess current trends, evaluate progress and design well-targeted interventions. Given the scale of recent economic shocks, updated data are essential to understanding whether child-labour risks have intensified — and to identifying where to concentrate response.

Figure 6-5: Working children by sector



Source: GLSS (2016/17)

The persistence of child labour reflects structural economic pressures. Many households depend on children's labour as a coping strategy in contexts of low agricultural productivity, seasonal income instability and insufficient social protection coverage. Where schooling is perceived as low quality or weakly linked to future employment opportunities, the opportunity cost of education increases.

6.6 Child trafficking and exploitation

Situation

- Internal trafficking of children into the fishing industry, particularly around Volta Lake, remains a major child protection concern.
- Ghana continues to function as a source, transit and destination country for trafficking involving both children and adolescents.
- Boys are predominantly trafficked for forced labour, particularly in fishing and mining, while girls are disproportionately affected by sexual exploitation and domestic servitude.
- Emerging forms of exploitation include the confinement of adolescent boys for cyber fraud activities.
- Reliable and comprehensive data remain limited, constraining accurate assessment of trends.

Bottlenecks

- Persistent poverty and limited livelihood opportunities in rural communities drive vulnerability to trafficking.
- Low levels of education and limited awareness of trafficking risks increase susceptibility.
- Insufficient shelters and reintegration services constrain victim protection.

- Limited investigations, prosecutions and convictions in particular in rural areas where judicial resources and access to the justice system remain limited.
- Limited funding and logistical capacity hinder enforcement and victim support.
- Weak data systems reduce the ability to monitor trends and target interventions effectively.

Internal trafficking of children from their home communities into Ghana's fishing industry remains one of the most serious threats to child rights and protection in the country, despite the existence of the Human Trafficking Act, 2005 (Act 694), which provides the legal framework for prevention, protection and prosecution. In particular, boys from coastal and rural communities are trafficked to areas such as Yeji to work on Volta Lake, where they are often engaged in hazardous fishing activities. Traffickers frequently target boys who can swim, increasing the vulnerability of children from fishing communities.

Ghana also continues to serve as a source, transit and destination country for human trafficking involving both children and adolescents. Although a ban on labour export for domestic servitude to Gulf States has been in place since 2017, anecdotal evidence suggests that some children and young women continue to be trafficked abroad for domestic servitude. Conversely, children and adolescents are trafficked into Ghana and exploited in sex trafficking, particularly in mining communities. Emerging evidence also indicates that adolescent boys are trafficked and confined to work full-time as cyber fraud operators. Despite these concerns, comprehensive and up-to-date data on trafficking flows remain scarce.

Data from the Anti–Human Trafficking Unit (AHTU) of the Ghana Police Service indicate that children and adolescents constitute a substantial proportion of identified victims. Between 2018 and 2022, children represented the majority of rescued victims in both labour and sex trafficking cases. In 2018, 231 of 285 rescued victims were children, most in labour trafficking, with more boys (175) than girls (56). In 2022, 161 of 291 rescued victims were children. More recent statistics suggest an increase in adult victims; however, the number of trafficked children remains high. In 2024, 95 cases involved 250 victims, including 95 children. In 2025, 89 cases involved 601 victims, including 160 children. While adults now represent a larger share of identified victims, the continued high number of trafficked children underscores the persistence and severity of the problem.

Poverty, low levels of formal education and limited awareness of trafficking risks remain major drivers of both internal and international trafficking. Children from rural and economically marginalised communities are particularly vulnerable. Adolescents are generally at greater risk than younger children, as traffickers perceive them as more "useful" for labour and sexual exploitation.

Child trafficking and exploitation deprive children and adolescents of their fundamental rights, including the right to education, family life, health and protection

from harm. Many victims are exposed to hazardous working conditions, physical and psychological abuse, and sexual exploitation.

Efforts to combat trafficking, including implementation of the Human Trafficking Act, 2005 (Act 694), include nationwide sensitisation campaigns, capacity-building initiatives for security agencies and strengthened coordination led by the Ministry of Gender, Children and Social Protection and the Ministry of the Interior. Partnerships among national agencies including the Ghana Immigration Service, the Economic and Organised Crime Office and the Department of Social Welfare have supported rescue, rehabilitation and reintegration efforts. However, inadequate funding, limited logistical capacity and judicial resources concentrated in urban areas leaving rural citizens with limited access to the justice system continue to hinder effective response.[26] Key challenges include insufficient shelters for rescued victims and the high costs associated with medical treatment, psychosocial support and reintegration services.

C Forward looking considerations

Over the coming decade, the wellbeing of children in middle childhood will be shaped not only by current policy commitments, but by demographic pressures, fiscal constraints, climate variability and rapid technological change. Ghana's existing frameworks including the Education Strategic Plan (2018–2030), the Child and Family Welfare Policy, the Ghana Accelerated Action Plan Against Child Labour and the National Plan of Action for the Elimination of Human Trafficking provide a strong foundation. However, implementation will need to become more adaptive and anticipatory to sustain progress.

Continued population growth, particularly in northern and peri-urban districts, will increase demand for classrooms, teachers and learning materials. Without forward planning based on demographic projections, expansion in enrolment risks placing further strain on infrastructure and teacher deployment, potentially widening inequalities in learning outcomes. Strengthening foundational literacy and numeracy, improving equitable teacher distribution, and integrating population forecasts into district education planning will be critical to safeguarding education quality.

At the same time, fiscal pressures and macroeconomic volatility may constrain public expenditure on social services. In contexts of household economic stress, children will likely remain vulnerable to entering labour markets prematurely, particularly in rural areas where agriculture, fishing, cocoa production and informal mining are predominant. Ensuring social protection financing and strengthening coordination between labour inspection, social welfare and district authorities will be essential to prevent reversals in progress toward eliminating the worst forms of child labour.

[26] In particular, insufficient and irregular budget allocations to key response mechanisms, including the Human Trafficking Fund, continue to limit the availability of comprehensive support for affected children (UNICEF, 2025).

Anticipatory budgeting and shock-responsive social protection mechanisms will become increasingly important.

Climate change adds another layer of risk, as increased drought, flooding and environmental degradation are likely to affect agricultural livelihoods, potentially increasing seasonal migration, school absenteeism and children's exposure to hazardous work. Integrating climate adaptation into district-level education and child protection planning, particularly in climate-sensitive regions will help reduce disruption to schooling and mitigate child protection risks linked to livelihood instability.

Strengthening interoperability across administrative data systems in the education, labour, social welfare and child protection sectors will enable Ghana to better identify emerging vulnerabilities and respond more proactively. This will require continued improvements in data quality, referral tracking and case management, as well as stronger digitisation in sectors where information systems remain weak, including parts of the police system. As demographic and environmental pressures intensify, forward-looking governance that combines policy coherence with timely monitoring will be central to sustaining gains in middle childhood.

CHAPTER 7.

ADOLESCENCE

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7 Adolescence

Adolescence (12–19 years) represents a critical transition from childhood dependency to increasing autonomy. It is a period of rapid physical, cognitive and social development, but also heightened exposure to structural and social risks that can shape life trajectories. As adolescents move through this stage, the opportunities and constraints they encounter in education, health, family life, social relations and the labour market have lasting implications for their wellbeing and future prospects.

In Ghana, adolescence is shaped by both opportunity and inequality. While many adolescents are building skills, continuing in education and preparing for adulthood, others face overlapping disadvantages linked to poverty, gender norms, disability, place of residence and limited access to responsive services and opportunities. This chapter examines adolescents' education and skills development, health and reproductive outcomes, protection risks, and pathways to adulthood, applying an equity lens throughout. As Box 7-1 highlights, adolescent empowerment and agency are important cross-cutting factors that influence outcomes across all these domains.

Box 7-1 Adolescent empowerment and agency

Adolescent empowerment is a cross-cutting determinant of wellbeing across education, health, protection and the transition to adulthood. Adolescents who can build skills, exercise agency, participate meaningfully in decisions that affect their lives, and access supportive services are more likely to remain in school, protect their health, delay early marriage and childbearing, and move into safer and more productive livelihoods. Strengthening adolescent empowerment is therefore central not only to the fulfilment of rights, but also to Ghana's broader human capital development and inclusive growth.

However, many adolescents in Ghana continue to face structural barriers that limit these opportunities. Poverty, unequal gender norms, limited access to quality secondary and post-basic opportunities, weak pathways to skills development and employment, and inadequate access to adolescent-responsive services all constrain adolescents' choices and prospects. These barriers are often more severe for girls, adolescents with disabilities, adolescent mothers, those out of school, and those living in rural and deprived areas.

Although Ghana has expanded programmes related to life skills, youth participation and skills development, access remains uneven. In practice, adolescent empowerment depends not only on service access, but also on whether adolescents are able to participate in decisions within households, schools, communities and institutions, and to exercise voice and agency over their education, health and livelihoods.

A Adolescent Education, skills and transition to work

Adolescence is a critical period for consolidating learning, acquiring specialised skills and preparing for economic participation. Secondary education plays a central role in determining future employment prospects, earnings potential and social mobility. At the same time, it is during this stage that dropout risks increase and inequalities in progression become more visible, particularly among adolescents from poorer households and rural areas.

This section examines patterns of access to and progression through secondary education, as well as the transition from school to work. It considers how structural factors, including household poverty, gender norms, regional disparities and labour market conditions, shape adolescents' trajectories. Given Ghana's youthful population and ambitions to harness a demographic dividend, strengthening the alignment between education systems and labour market opportunities is central to reducing vulnerability and promoting inclusive development.

7.1 Secondary education access and participation

Situation:

- Junior High School (JHS) net enrolment reached 47 per cent in 2022/23, but less than half of adolescents are within the official age bracket.
- Gross enrolment at Senior High School (SHS) increased from 25 per cent in 2005/06 to 72 per cent in 2022/23.
- Net enrolment at SHS rose from 16 per cent to 31 per cent over the same period.
- Gender parity has largely been achieved at JHS and SHS levels, with girls now slightly outnumbering boys at SHS.
- Expansion of TVET, apprenticeship programmes and skills initiatives such as Free TVET and the Ghana TVET Voucher Project are strengthening alternative pathways. However, gender disparities persist as female learners accounted for just 25-28 per cent of total enrolment across the last three academic years (CTVET, 2023)

Bottlenecks:

- Progression into and through secondary education remains a major structural challenge, reflected in the sharp drop in age-appropriate enrolment between JHS and SHS and the high share of over-age learners.
- Persistent regional disparities, especially in northern regions, limit progression.
- Rapid enrolment expansion has strained infrastructure and teacher deployment.
- Weak foundational learning at JHS undermines successful progression and completion.
- Gender-related barriers continue to affect girls' retention and progression into secondary education. Early pregnancy and child marriage remain important

risks, and broader evidence also points to household labour and menstruation-related absenteeism as factors that can interrupt girls' participation, especially after basic education.

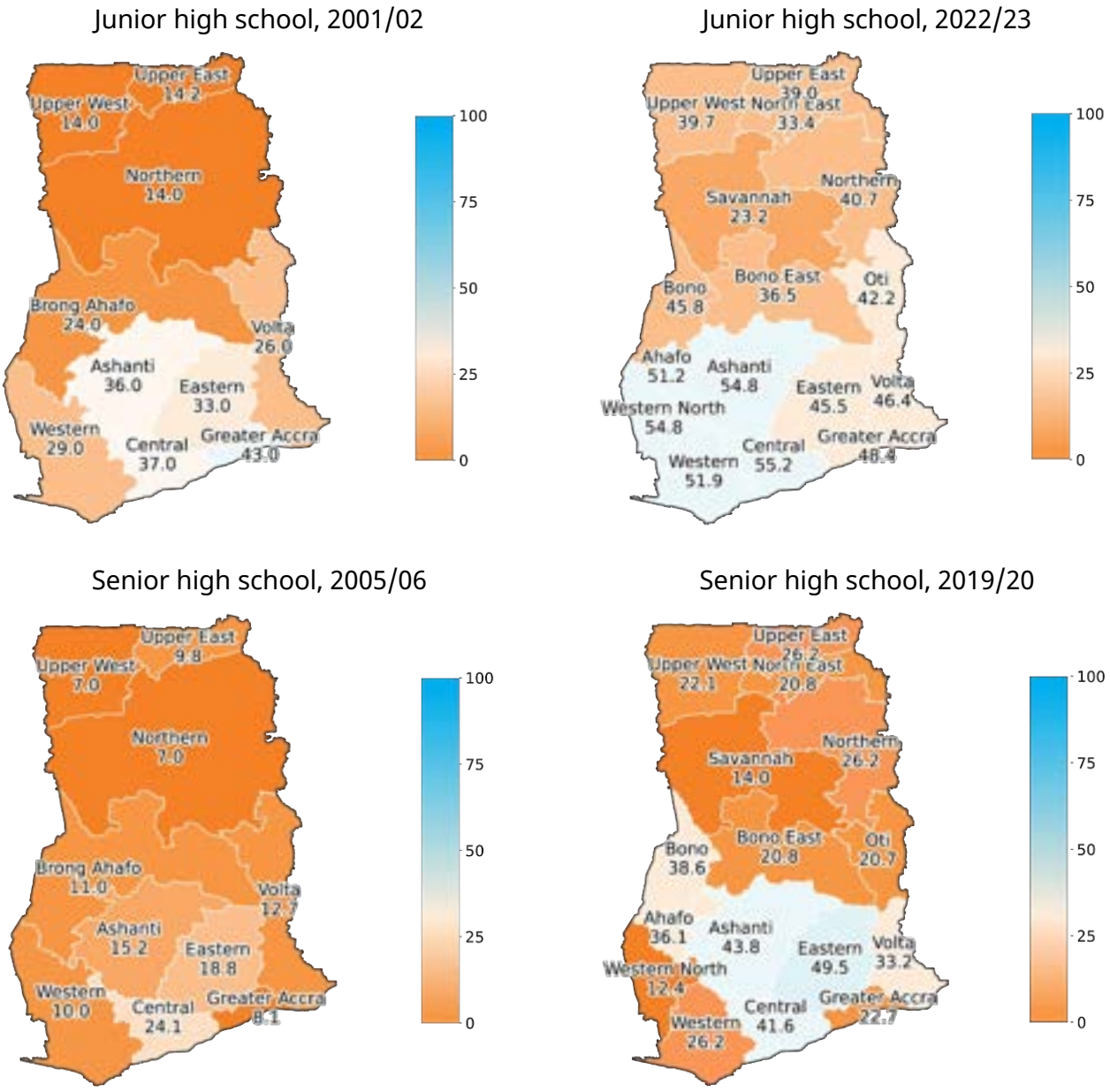
Secondary education in Ghana has expanded substantially over the past two decades. According to the Ghana Statistical Service (GSS, 2025b), gross enrolment at SHS increased from 25 per cent in 2005/06 to 72 per cent in 2022/23, while net enrolment increased from 16 per cent to 31 per cent over the same period. This expansion reflects major policy reforms, including the Free Senior High School policy introduced in 2017, which significantly reduced financial barriers to participation.

Regional disparities remain pronounced. Although SHS net enrolment more than doubled across all regions between 2005/06 and 2019/20, rates remain lowest in Western North and Savannah regions, while Eastern and Greater Accra perform comparatively better (Figure 7-1). The north–south divide persists, particularly at JHS level, where regions such as Savannah and North East remain far from achieving Education Strategic Plan (ESP) targets.

Gender parity has improved considerably. By 2022/23, girls slightly outnumbered boys at SHS level, with a gender parity index above 1.0, while parity has been achieved at primary level and largely sustained at JHS (GSS, 2025b). Recent analysis by the World Bank similarly notes that Ghana has made strong progress in closing gender gaps in basic education access. However, parity in enrolment does not mean that girls and boys experience school in the same way: girls' participation is more likely to be interrupted by pregnancy, marriage, unpaid domestic work and menstruation-related barriers, while re-entry after interruption remains uneven (UNICEF, 2021; Ministry of Education, 2023).

Menstrual health and hygiene management also affects adolescent girls' participation in education. The adolescent situation analysis for Ghana found that 91.5 per cent of girls aged 15–19 reported using appropriate menstrual hygiene materials and having a private place to wash and change at home, yet 22.0 per cent reported not participating in social activities, school or work during their last menstruation. This was especially pronounced in Ashanti and Brong Ahafo, suggesting that menstruation-related barriers remain relevant for attendance and participation during adolescence (UNICEF, 2021c).

Figure 7-1: Net enrolment ratio in Junior and Senior High School, by region



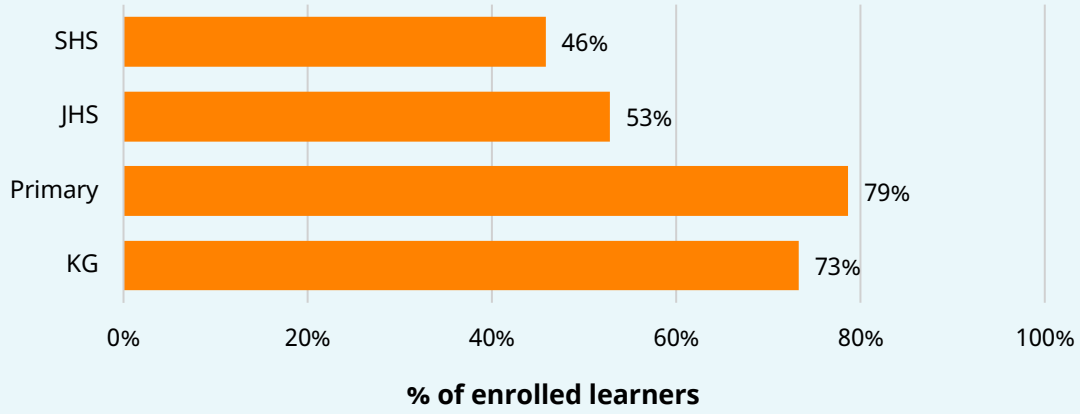
Source: GSS (2025b)

However, progression challenges begin earlier in the system. At JHS level, gross enrolment reached 98 per cent in 2022/23, yet net enrolment stood at only 47 per cent, indicating that a substantial proportion of learners are outside the official age range (GSS, 2025b). Over-age enrolment remains particularly high at JHS and SHS levels, reflecting late entry, repetition and dropout–re-entry cycles (see Box 7-2). These patterns suggest inefficiencies in progression through the basic education cycle.

Box 7-2: Where does age-appropriate participation fall most sharply?

Using 2022/23 administrative data, the share of enrolled learners within the official age range can be approximated by dividing net enrolment by gross enrolment. This suggests that about 73.3 per cent of children enrolled in KG, 78.6 per cent in primary, 52.8 per cent in JHS and only 45.8 per cent in SHS are within the expected age range (GSS, 2025b). In other words, age-appropriate participation drops sharply from lower secondary onward, even where overall enrolment remains relatively high. This reinforces that progression becomes more constrained at JHS and especially SHS level.

Figure 7-2: Share of enrolled learners within the official age range, by education level, Ghana



Source: Based on GER and NER estimates from GSS (2025b). Notes: GER and NER are from 2022/23 (latest available). However, for SHS, the latest NER is from 2020/21.

Rapid expansion has placed considerable pressure on the system. Pupil–teacher ratios at primary and JHS levels have fluctuated, and although pupil-to-trained-teacher ratios (PTTR) improved significantly between 2010/11 and 2020/21, some northern regions remain above ESP targets (GSS, 2025b). Infrastructure constraints, overcrowding and limited boarding capacity continue to affect learning conditions, particularly in rural districts.

Beyond general secondary education, formal Technical and Vocational Education and Training (TVET) has expanded as an important post-basic pathway for adolescents to acquire practical skills and transition into productive work after completing formal schooling. Ghana has been improving its TVET system with the aim of expanding participation, aligning training with labour market needs, and improving pathways to employment (CTVET, 2023). The enrolment in pre-tertiary TVET institutions has increased from 32,407 learners in 2020/21 to 50,049 in 2022/23. Both male and female participation have grown over this period. However, gender disparities remain as female learners accounted for approximately 25-28 per cent of total enrolment across the last three academic years. Scholarship distribution data also indicate disparity, with 69 per cent of scholarship recipients being male and 31 per cent female (CTVET, 2023).

7.2 Learning outcomes and skills

Situation

- BECE core subject pass rates improved from approximately 60 per cent in 2003 to around 75 per cent between 2015 and 2021 (GSS, 2025b).
- WASSCE pass rates have worsened over time and remain uneven across regions and subjects: less than half of the students received a passing grade in mathematics, while just over half received passing grades in English and social studies in the 2025 WASSCE (West African Examination Council, 2025).
- Boys outperform girls in Mathematics and Science at BECE level, while girls perform better in English.
- Significant regional disparities persist, particularly between northern and southern regions.

Bottlenecks

- Learning gains have plateaued in recent years.
- Persistent regional inequalities in BECE and WASSCE performance.
- Mathematics and Science performance gaps remain pronounced.
- Weak foundational competencies at JHS level affect SHS readiness.
- Teacher deployment and trained teacher shortages affect quality in disadvantaged regions.

As with primary education, access expansion has not been matched uniformly by improvements in learning outcomes. Basic Education Certificate Examination (BECE) pass rates in core subjects (English, Mathematics, Science and Social Studies) improved from around 60 per cent in 2003 to an average of approximately 75 per cent between 2015 and 2021 (GSS, 2025b).27 BECE performance is widely used as an indicator of foundational learning outcomes at the end of basic education. However, this improvement has plateaued in recent years, suggesting limits to gains from access expansion alone.

Subject-level disparities persist across gender. Boys continue to record higher pass rates than girls in Mathematics, Science and Social Studies, while girls outperform boys in English (GSS, 2025b). Although the gender gap has narrowed in some subjects, differences remain, particularly in STEM-related performance: while girls have higher pass rates in English, boys have a higher pass rate by 2-3 percentage points in Mathematics and Science (GSS, 2025b). This gap increases to around 6 percentage points in some regions (GSS, 2025b).

[27] The BECE is a national examination taken at the end of Junior High School (Grade 9). It assesses students in core subjects including English, Mathematics, Science and Social Studies, and determines eligibility and placement into Senior High School (SHS) and Technical/Vocational institutions.

The pass rates also present significant regional disparities. In 2019/20, several northern regions recorded BECE English pass rates below 60 per cent, while southern regions achieved rates above 70 per cent (GSS, 2025b). Mathematics performance declined in Upper West and Upper East over the same period, even as other regions improved. These geographic gaps reflect disparities in teacher distribution, infrastructure and broader socio-economic conditions.

At SHS level, West African Senior School Certificate Examination (WASSCE) results are often used as a proxy for readiness for tertiary education and formal sector employment. The 2025 WASSCE results show poor performance across the core subjects of English, science, mathematics and social studies: less than half of the students who sat for the examination received a passing grade in mathematics, while just over half received passing grades in English and social studies.28 Furthermore, there is a declining trend observed in school performance, with students recording consistently lower scores since 2023.29 Numerous results were cancelled in light of practices of cheating, and students carrying mobile phones to the examination.

However, performance remains uneven across regions, and gender parity in outcomes does not consistently mirror parity in enrolment. Correlation analysis between pupil-to-trained-teacher ratios and BECE pass rates indicates that regions with lower PTTR generally achieve stronger learning outcomes, underscoring the importance of trained teacher availability (GSS, 2025b).

7.3 From school to work

Situation:

- In 2023 Q3, around 19.7 per cent of young people aged 15–24 years in Ghana were not in employment, education or training (NEET), indicating weak school-to-work transition pathways (AHIES, 2023 Q3).
- NEET rates are consistently higher among young women than young men: in 2023 Q3, 22.2 per cent of females aged 15–24 were NEET, compared with 17.1 per cent of males (AHIES, 2023 Q3).
- There are also marked regional and urban-rural disparities. In 2023 Q3, the NEET rate among 15–24-year-olds was 33.4 per cent in Greater Accra, compared with 8.4 per cent in Bono East, and was higher in urban areas (22.3 per cent) than in rural areas (16.3 per cent) (AHIES, 2023 Q3).

Bottlenecks:

- Skills mismatch, limited job creation, weak career guidance and gender norms constrain transition into decent work.

[28] West African Examination Council (2025)
[29] Ibid.

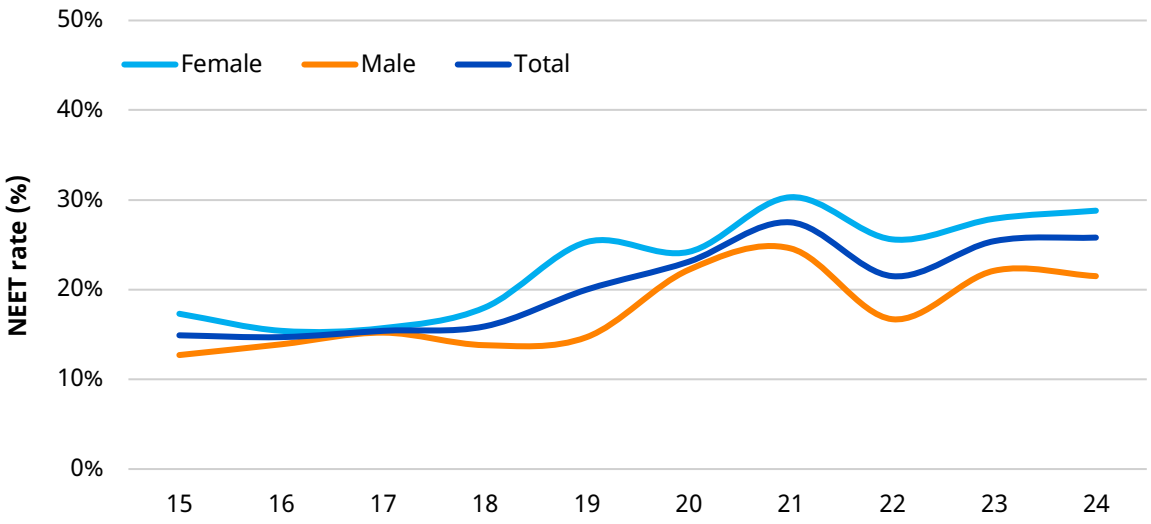
- Girls and young women face additional barriers linked to unpaid care responsibilities, early pregnancy and gender norms, contributing to higher NEET rates.
- Labour market informality and regional inequalities continue to limit sustainable employment opportunities for young people.

The transition from school into work remains a major challenge for adolescents and young people in Ghana. Recent labour market data from the Annual Household Income and Expenditure Survey (AHIES, 2023 Q3) show that, in 2023 Q3, 19.7 per cent of young people aged 15–24 years were not in employment, education or training (NEET). This suggests that almost one in five young people in the age group most closely associated with school-to-work transition was neither accumulating skills nor engaged in productive employment (AHIES, 2023 Q3).

The burden is not evenly shared. Young women are more likely than young men to be NEET. In 2023 Q3, the rate was 22.2 per cent for females aged 15–24, compared with 17.1 per cent for males. Urban youth also faced higher NEET rates than rural youth (22.3 per cent compared with 16.3 per cent), suggesting that labour market exclusion is not only a rural phenomenon but also a significant urban challenge, especially in contexts of congestion, informality and weak job creation (AHIES, 2023 Q3).

The age profile of NEET shows that disengagement becomes much more pronounced after the end of adolescence. While NEET rates remain below 16 per cent between ages 15 and 18, they rise sharply from age 19 onward, reaching 27.5 per cent at age 21 before remaining above 25 per cent at ages 23 and 24 (Figure 7-3). This points to a critical transition period in the move from schooling to work, when many young people struggle to convert educational participation into employment or further training opportunities.

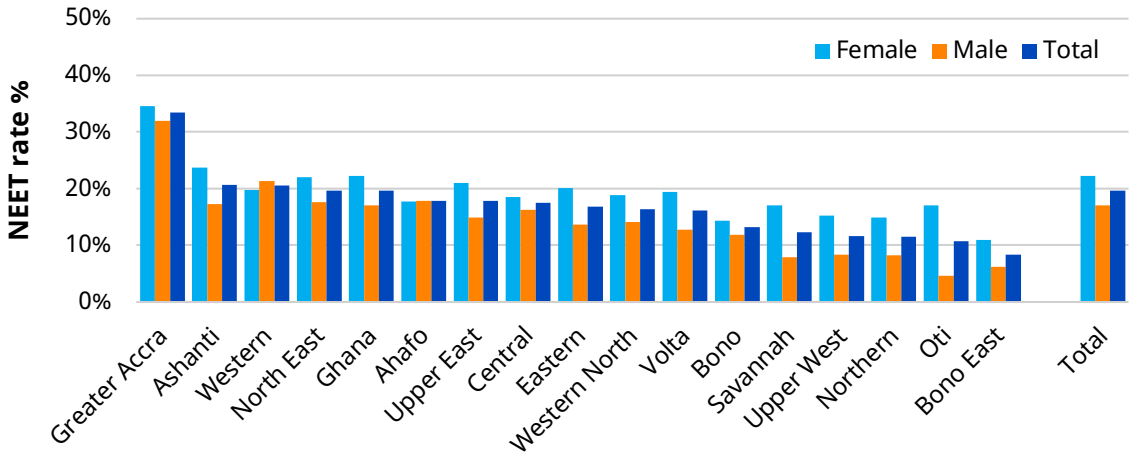
Figure 7-3: National NEET rates by single age and sex



Source: AHIES (2023 Q3 data) retrieved from GSS (2024c).

Regional disparities in NEET are substantial Ghana. In 2023 Q3, Greater Accra recorded the highest NEET rate among 15–24-year-olds at 33.4 per cent, followed by Ashanti (20.7 per cent) and Western (20.6 per cent), while Bono East (8.4 per cent) and Oti (10.7 per cent) recorded the lowest rates. These differences point to uneven transition opportunities across regions and to the importance of local labour market conditions in shaping young people's pathways after schooling (Figure 7-4).

Figure 7-4: NEET rates in 2022, by region and sex



Source: AHIES (2023 Q3 data) retrieved from GSS (2024c).

B Health, sexual and reproductive wellbeing

Adolescence is also a period of heightened health vulnerability, particularly in relation to sexual and reproductive health. The transition to sexual maturity, combined with evolving social norms and uneven access to youth-friendly services, exposes adolescents to risks including HIV infection, unintended pregnancy and early parenthood. These risks are often gendered, with adolescent girls disproportionately affected by early pregnancy and its associated social and economic consequences.

This section examines children living with HIV, patterns of HIV risk and access to treatment, alongside trends in adolescent pregnancy and utilisation of family planning and reproductive health services. It considers how knowledge, stigma, service accessibility and socio-economic conditions influence adolescents' ability to make informed decisions and access appropriate care.

7.4 Nutrition among adolescents

Situation:

- Among women 15-49, adolescents 15-19 have one of the highest prevalence of anaemia in Ghana. Around 43.8 per cent of adolescent girls aged 15–19 are anaemic, 22.6 per cent are mildly anaemic, 19.7 per cent are moderately anaemic and 1.6 per cent severely anaemic (DHS, 2022).

- Around 14 per cent of girls aged 15–19 are overweight or obese, while approximately 17 per cent are thin, pointing to a double burden of malnutrition (DHS, 2022).

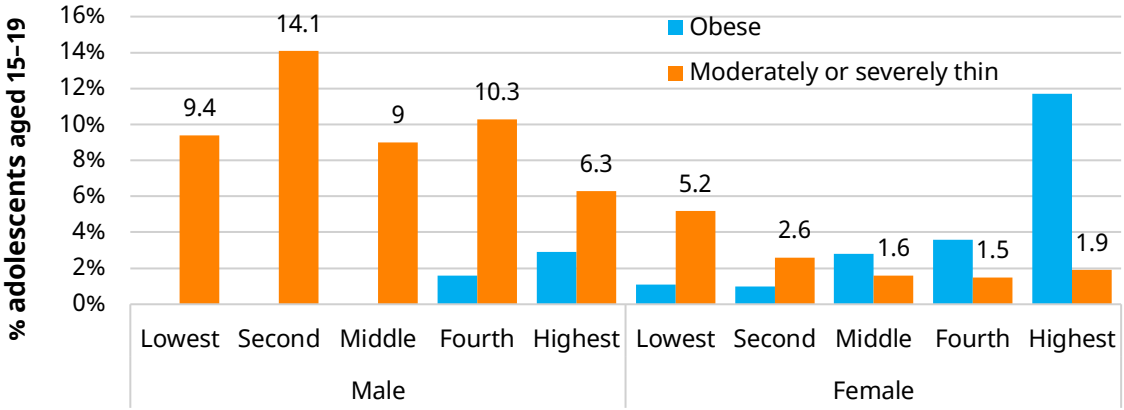
Bottlenecks

- Poor diet quality and micronutrient deficiencies remain significant, especially for adolescent girls, contributing to high levels of anaemia.
- Adolescents are increasingly exposed to unhealthy food environments and greater autonomy over food choices, while policy and programming attention to adolescent nutrition remains limited relative to early childhood and pregnancy.

Adolescence is a critical period for nutrition, with long-term implications for future wellbeing. It is also a stage at which young people gain greater independence and begin to make more of their own food choices. In Ghana, available evidence points to a double burden of malnutrition among adolescents, particularly girls. According to the 2022 DHS, 43.8 per cent of girls aged 15–19 are anaemic, including 22.6 per cent mildly anaemic, 19.7 per cent moderately anaemic and 1.6 per cent severely anaemic (DHS, 2022).

Furthermore, around 14 per cent of girls aged 15–19 are overweight or obese, while approximately 17 per cent are thin, indicating the coexistence of micronutrient deficiencies, undernutrition and rising risks of overweight and obesity (DHS, 2022). The distribution by wealth and sex suggests different nutritional risks for boys and girls. Among boys aged 15–19, thinness consistently exceeds obesity across all wealth quintiles, whereas among girls aged 15–19, obesity rises sharply in the richest quintile while thinness is more concentrated among poorer groups (Figure 7-5).

Figure 7-5: Percentage of adolescents aged 15–19 who are obese or moderately/severely thin, by sex and household wealth quintile



Source: DHS (2022)

These patterns matter because adolescence is a period of rapid physical growth and increased nutritional requirements, especially for girls. Poor nutrition during this stage can affect school participation, concentration, energy levels and future reproductive

health. High levels of anaemia among adolescent girls are particularly concerning given the links between iron deficiency, fatigue, lower learning capacity and risks in future pregnancy. At the same time, rising exposure to unhealthy diets is contributing to growing levels of overweight and obesity.

As adolescents gain greater mobility and autonomy, they are increasingly exposed to unhealthy food environments, including cheap, highly processed and nutrient-poor foods sold in and around schools. Dietary habits formed during adolescence often persist into adulthood and may also influence future feeding practices when adolescents become parents. Despite the importance of this stage, adolescent nutrition continues to receive less policy and programme attention than nutrition in early childhood or pregnancy. Strengthening adolescent-responsive nutrition interventions, improving school food environments and generating more age- and sex-disaggregated evidence will be important to address both undernutrition and emerging diet-related risks.

7.5 Children living with HIV

Situation:

- An estimated 18,229 children aged 0–14 were living with HIV in Ghana in 2024, including 9,247 boys and 8,982 girls (GAC, 2024)
- This represents a substantial decline since the mid-2000s due to progress in prevention of mother to child transmission, earlier diagnosis and expanded access to treatment
- However, many children continue to survive into adolescence and require lifelong disease management alongside schooling, psychosocial development and social inclusion. In 2024, an estimated 18,850 adolescents aged 10–19 and 37,283 young people aged 15–24 were living with HIV in Ghana (GAC, 2024)

Bottlenecks

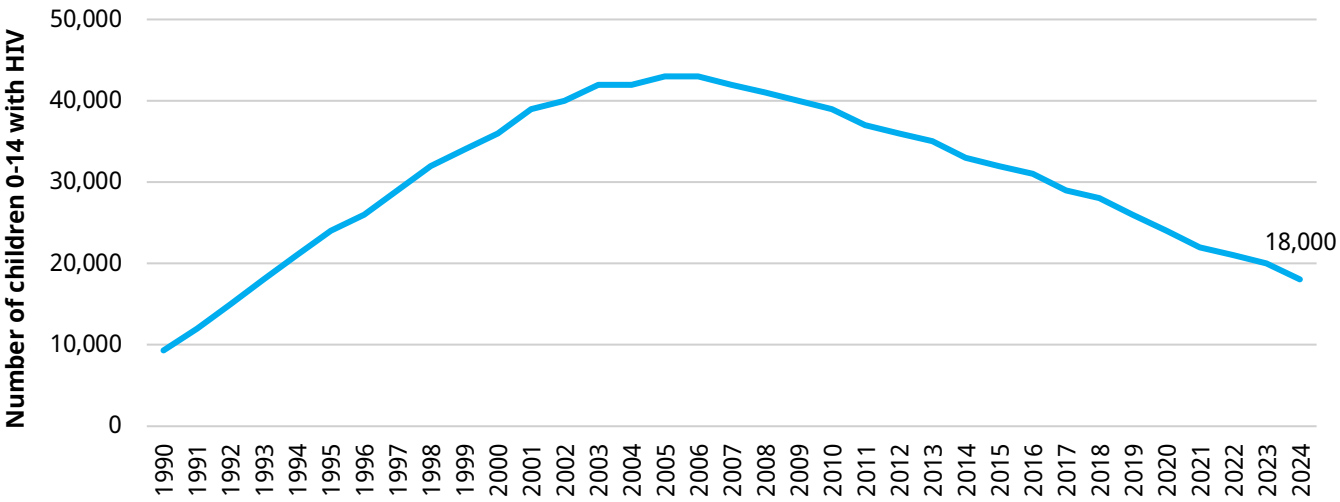
- Adherence and continuity of care remain fragile.
- Stigma, non-disclosure, side effects, distance to service and limited family or psychosocial support constrain outcomes.
- Treatment gaps remain significant: in 2024, ART coverage among children aged 0–14 was estimated at only 35.8 per cent, compared with 47.5 per cent among adults aged 15 and above (GAC, 2024)

For children living with HIV, middle childhood represents a transition from early survival to lifelong disease management at a stage critical for learning, psychosocial development, and social inclusion. Children infected prenatally may enter this stage with a history of recurrent illness or developmental delays, affecting school readiness, attendance and learning outcomes.

The number of children living with HIV in Ghana has declined substantially since peaking in the mid 2000s, as shown in Figure 7-6, reflecting sustained progress in

prevention of mother-to-child transmission, expanded access to antiretroviral medicines, and improved early diagnosis and child survival (see Section 5.1). This trend indicates advancement towards SDG 3.3, which aims to end the AIDS epidemic. Recent investments have strengthened clinical management for children, including expanded early infant diagnosis and viral load monitoring through GeneXpert technology in 136 health facilities, alongside training of healthcare providers on HIV case finding and follow-up care (UNAIDS, 2025). However, despite this progress, a substantial number of children and adolescents continue to live with HIV, emphasising persistent gaps in achieving equitable health outcomes. In 2024, an estimated 18,229 children aged 0–14 were living with HIV in Ghana, including 9,247 boys and 8,982 girls. In the same year, there were an estimated 1,243 new infections among children aged 0–14, including 633 boys and 610 girls, and 1,325 AIDS-related deaths, including 673 boys and 652 girls (GAC, 2024).

Figure 7-6: Trend in the number of children 0-14 years living with HIV, by year



Source: UNAIDS modelled estimates

The burden also extends into adolescence. In 2024, an estimated 18,850 adolescents aged 10–19 and 37,283 young people aged 15–24 were living with HIV in Ghana. Girls are disproportionately affected in these older age groups: among adolescents aged 10–19 living with HIV, 61.3 per cent were female, and among young people aged 15–24, 74.1 per cent were female. The report also estimates 1,823 new infections among adolescents aged 10–19 and 4,732 new infections among young people aged 15–24 in 2024; in both groups, most new infections occurred among females (GAC, 2024).

As children transition from caregiver-managed care to greater self-management, treatment adherence and continuity of care emerge as key challenges, particularly as routine contact with health services may decline as children become adolescents. Antiretroviral therapy (ART) adherence among children and adolescents remains suboptimal, influenced by stigma, non-disclosure, perceived side effects, distance to ART sites and limited family support (Nortey et al., 2024). These challenges are reinforced by gaps in age-appropriate and psychosocial service delivery, as HIV

programmes have historically focused on under-fives, leaving school-aged children and adolescents less visible. Treatment gaps also remain significant: the 2024 estimates indicate that ART coverage among children aged 0–14 was only 35.8 per cent, compared with 47.5 per cent among adults aged 15 and above (GAC, 2024).

At the structural level, persistent HIV-related stigma in households, schools and communities continues to undermine care-seeking, disclosure and psychosocial wellbeing among children. Socio-economic vulnerability and weak integration between HIV, education and social-protection systems further constrain treatment continuity and recovery. While Ghana's engagement with Global Partnership for Action to Eliminate HIV-related Stigma and Discrimination reflects recognition of stigma as a systemic barrier, stigma-reduction and child-responsive services remain limited in scale. If these bottlenecks persist, children living with HIV risk poorer treatment adherence, disrupted learning trajectories, and weakened psychosocial wellbeing as they transition into adolescence.

7.6 Adolescent pregnancy, access to family planning and reproductive health

Situation

- Adolescent pregnancy remains a significant public health and development challenge in Ghana, with important implications for girls' education, health, and future economic opportunities: 15.2 per cent of teenage girls aged 15-19 have ever been pregnant (DHS, 2022).
- Early marriage typically leads to early and repeated pregnancies, exposing girls to significant health risks, particularly as a result of complications from pregnancy and childbirth among young adolescents (DHS, 2022).
- Many adolescents, especially younger girls, have limited knowledge of modern contraceptive methods or face barriers in accessing them. As a result, unmet need for family planning remains high at 31 per cent among girls 15-19 years.
- National policies support adolescent sexual and reproductive health (ASRH).

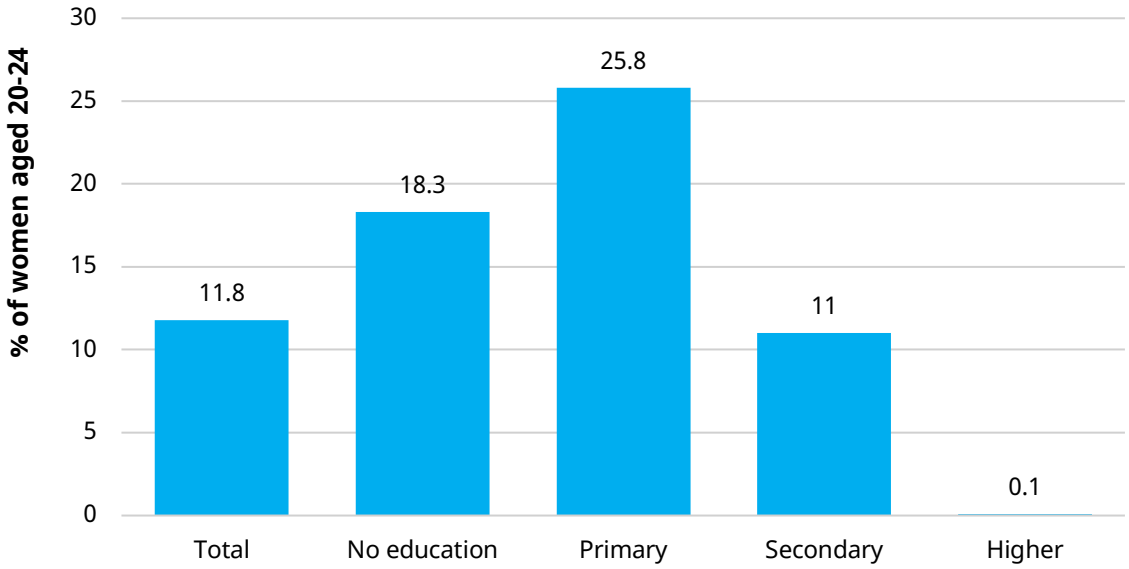
Bottlenecks

- Despite policy support, adolescents face multiple barriers in accessing services like family planning and reproductive services. These include stigma, lack of youth-friendly services, provider bias, cost barriers, and limited confidentiality.
- Rural areas often have fewer health facilities and less access to trained providers.
- Social norms and gender inequality further restrict girls' ability to seek information and services: only 32.4 per cent of adolescent girls aged 15-19 report making independent decisions about their own reproductive health (DHS, 2022).
- Early marriage and school dropout also increase the risk of adolescent pregnancy.

Adolescent pregnancy remains an important public health and development concern. Early childbearing affects girls' education, health, and future economic opportunities. According to the DHS (2022), 15.2 per cent of teenage girls aged 15-19 have ever been pregnant. Adolescent pregnancy is more common among girls from low-income households with 23.1 per cent of teenage girls aged 15-19 have ever been pregnant.

Early marriage remains closely linked to adolescent pregnancy. Among young women aged 20-24, around 12 per cent had a live birth before age 18 (DHS, 2022). UNICEF's child marriage profile for Ghana also shows that most child brides give birth at a young age and are more likely than women who marry later to have several children as young mothers. For two in ten child brides, pregnancy preceded marriage, and three in ten became pregnant within the first year of marriage, underlining the close relationship between child marriage and early childbearing (UNICEF, 2020). Complications from pregnancy and childbirth remain major health risks for adolescent girls. Figure 7-7 shows the percentage of women aged 20-24 who gave birth by age of 18 by education level. The percentage rises to around 26 per cent among those with only primary education and 18.3 per cent among those with no education. Early childbearing drops to 11 per cent among women with secondary education and is almost negligible among those with higher education. This highlights the protective effect of continued schooling.

Figure 7-7: Percentage of women aged 20-24 giving birth by age 18, by education level



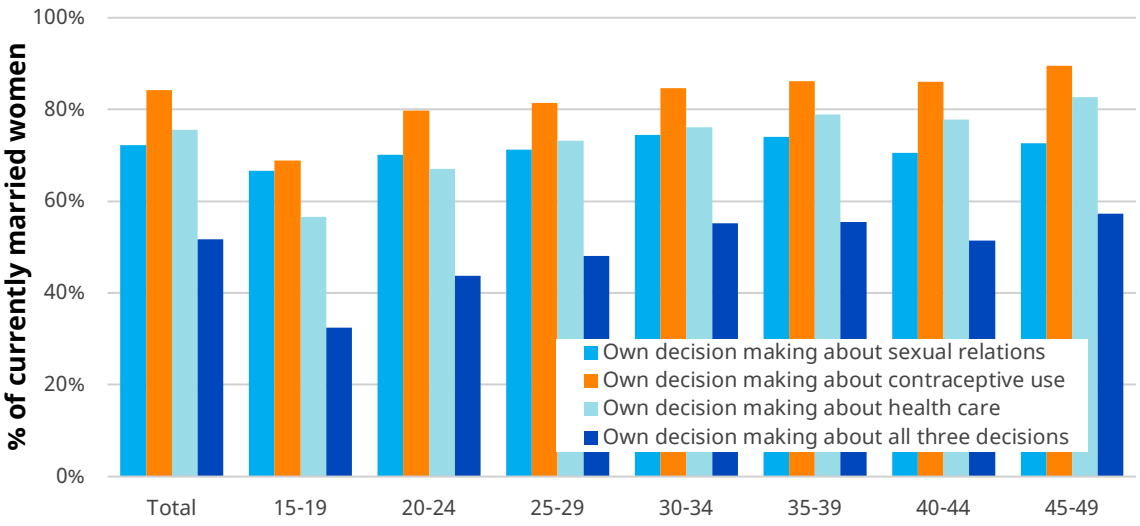
Source: DHS (2022)

Access to family planning and reproductive health services improved between 2014 and 2022, but important gaps remain. Among girls aged 15–19, unmet need for family planning declined from 61.7 per cent in 2008 and 50.7 per cent in 2014 to 31.0 per cent in 2022 (DHS, 2008, 2014 and 2022). However, modern contraceptive use among this age group remained low at 11.2 per cent, indicating that many adolescents who wish to delay or avoid pregnancy still face barriers in accessing effective contraception (DHS, 2022).

Gender norms also play a critical role. As shown in Figure 7-8, only 32.4 per cent of adolescent girls aged 15-19 report making independent decisions about their own

reproductive health, highlighting limited agency. In some settings, discussions about sexuality remain taboo, limiting open communication between adolescents, parents, and health providers.

Figure 7-8: Informed decision making for reproductive health, by age group



Source: DHS (2022)

7.7 Sexual violence against children

Situation

- Sexual violence in Ghana predominantly affects girls during childhood and adolescence: 14.1 per cent of women aged 15–49 experienced sexual violence by any perpetrator (DHS, 2022).
- The highest risk age is around 15 years, coinciding with lower secondary school years and key developmental transitions: 10.3 per cent of women aged 15-19 years report having ever experienced sexual violence by any perpetrator (DHS, 2022).
- Perpetrators are often known to the child, and cases cut across wealth, education and religious groups, though rural girls face higher exposure before age 18.

Bottlenecks

- Under-reporting driven by stigma, fear, and social norms that silence survivors and discourage disclosure.
- Weak coordination across protection, health and justice systems, limiting timely reporting, investigation and survivor-centred support.
- Limited availability of adolescent-friendly services, psychosocial care and safe reporting mechanisms, particularly in rural and underserved districts.

Sexual violence against children remains a critical child protection and public health concern in Ghana. DHS (2022) data shows that 6.9 per cent of women aged 18–29 experienced sexual violence before the age of 18 (DHS, 2022). Further, 14.1 per cent of

women aged 15–49 have reported ever experiencing sexual violence by any perpetrator (DHS, 2022). This highlights that sexual violence in Ghana is predominantly a childhood and adolescent phenomenon.

The age pattern is particularly concerning. The highest reported risk age for first forced sex is 15 years, indicating vulnerability during lower secondary school years (GSS, 2025c). Among women aged 15-18, 10.3 per cent report having ever experienced sexual violence by any perpetrator (DHS, 2022). This timing coincides with critical educational transitions and psychosocial development, compounding long-term consequences for schooling, mental health, and future labour market participation.

Sexual violence is not confined to one socioeconomic or demographic group. Available evidence suggests that it cuts across education levels, household wealth quintiles and religious groups. DHS (2022) also does not show a pronounced rural–urban difference in prevalence: among women aged 15–49, 14.8 per cent in urban areas and 13.1 per cent in rural areas reported ever experiencing sexual violence, while 5.4 per cent and 5.9 per cent, respectively, reported sexual violence in the previous 12 months. Perpetrators are often individuals known to the child, which can make disclosure especially difficult and underscores the need for accessible prevention and response systems in both urban and rural settings.[30]

The consequences of sexual violence for children are severe and enduring, including increased risk of depression, sexually transmitted infections, early and unintended pregnancy, school dropout, and intergenerational cycles of vulnerability. Despite strong legal frameworks including the Children's Act, Domestic Violence Act and related policies implementation gaps persist. Stigma, weak reporting pathways, insufficient victim/survivor-centred services, and limited coordination across social service providers across sectors continue to undermine effective prevention and response.

C Protection and social vulnerabilities

Adolescence is a stage in which exposure to protection risks may intensify. As young people gain mobility and autonomy, they may encounter heightened vulnerability to harmful practices, exploitation, violence and conflict with the law. Structural inequalities, household poverty and weak enforcement mechanisms can compound these risks, particularly for girls, children with disabilities and adolescents living in urban informal settlements.

This section explores child marriage, children in conflict with the law, and adolescents living in street situations, as well as emerging risks linked to digital access and technology-facilitated exploitation. It examines how legal frameworks, institutional capacity and social norms interact to shape protection outcomes. While Ghana has established a comprehensive policy architecture for child protection, implementation

[30] Supported by key informant interviews with specialists in the Department of Sociology (University of Ghana), Ghana Health Service, and Department of Social Welfare (MoGCSP).

gaps, resource constraints and uneven decentralised capacity continue to limit effective prevention and response.

7.8 Child marriage

Situation:

- Child marriage continues to affect adolescent girls much more than boys.
- Girls from low-income households are far more likely to be married or living in union at a young age. Among girls aged 15-19 in the poorest households, 15.4 per cent are married, compared to only 0.7 per cent of boys (DHS, 2022).
- National laws set the legal age of marriage at 18, and policies promote girls' education and gender equality.

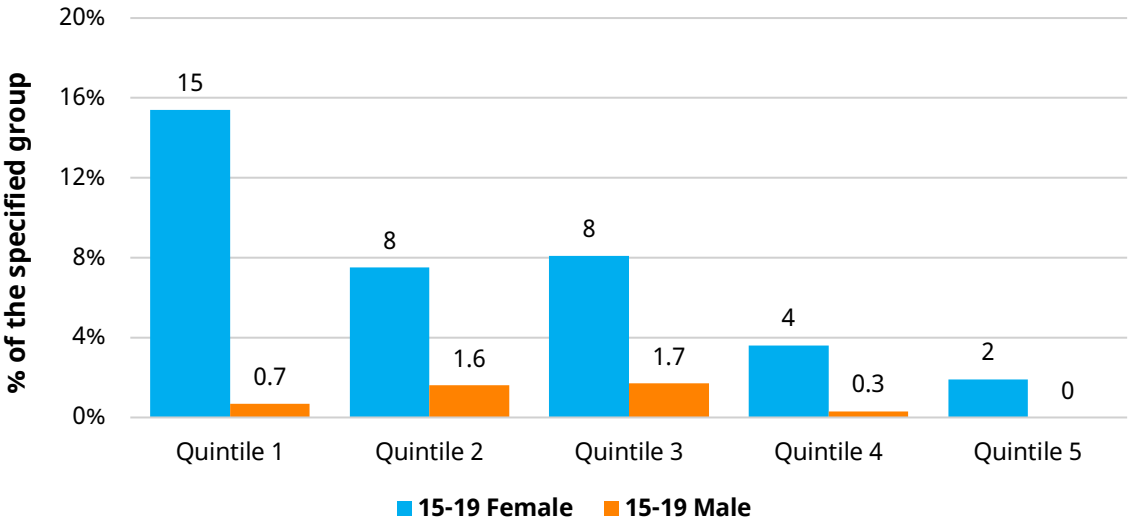
Bottlenecks:

- Poverty remains the biggest driver of child marriage. Families in the lowest wealth quintile face economic pressure that can push girls into early unions.
- Gender norms, limited access to education, early pregnancy also contribute to child marriage.
- Rural and disadvantaged areas are more affected.

Child marriage remains a serious issue affecting adolescents, especially girls, despite Ghana's legal framework setting the minimum age of marriage at 18 and the existence of the National Strategic Framework for Ending Child Marriage (2017–2026). Data from the 2022 DHS shows that girls are far more likely than boys to be married or living in union before age 18 and before age 25. Child marriage is strongly linked to poverty and inequality.

Figure 7-9 shows the percentage of young men and women who are married or living in a union across the wealth distribution. Marriage among adolescent girls is consistently higher than among boys across all wealth quintiles. In the poorest households, 15 per cent of girls aged 15–19 are married or in union, compared to 0.7 per cent of males. Girls from poor households are more likely to marry early, which can limit their education, reduce their future employment opportunities, and increase their risk of early pregnancy and health complications. Boys are affected at much lower rates. Child marriage is more common among adolescents living in rural areas than among those in urban areas. Girls in rural areas face greater economic hardship, and limited access to secondary education, which increases their vulnerability to child marriage. Although the policy framework for ending child marriage is in place, weak enforcement and persistent social and economic pressures continue to undermine progress.

Figure 7-9: Percentage of young men and women aged 15-19, married or living in union, by wealth quintiles



Source: DHS (2022)

7.9 Children living in street situations

Situation

- Ghana lacks up-to-date, nationally representative data on children living in street situations, limiting accurate estimation of scale and trends.
- The last national-level estimate done in 2011 identified over 61,000 children under 18 working on the streets in Greater Accra alone, most of whom both lived and worked on the streets.
- More recent sub-national data from Kumasi in 2021 identified nearly 6,700 street-connected children, with over half aged 13–17 years and significant numbers under age 12 (Chance for Children et al., 2021).
- A substantial proportion of girls are exposed to commercial sexual exploitation, particularly at night.
- Street-connected children engage in diverse survival activities, including casual labour, begging and small-scale trade, though many are not formally engaged in work.
- Migration from rural areas to urban centres remains a key pathway into street-connected life.

Bottlenecks

- Absence of reliable national data and regular enumeration constrains planning, monitoring and resource allocation.
- Predominantly household-based social protection approaches fail to reach children living outside family care structures.

- Limited specialised services and safe shelter options for street-connected children.
- Weak implementation of the newly adopted five-year strategic plan.
- Structural drivers including rural poverty, child migration, family breakdown and cross-border movement remain insufficiently addressed.
- Reactive removal approaches, particularly targeting foreign-national children, have proven ineffective without sustained reintegration support.

Ghana currently lacks up-to-date, accurate national data on children living in street situations. For many years, most reports referenced a 2011 census conducted in the Greater Accra Region by the Department of Social Welfare, which estimated that 61,492 persons under 18 years were working on the streets. Of these, 65 per cent both lived and worked on the streets, with the majority having migrated from rural areas to major urban centres. Some children travelled in the company of adults or peers, while others migrated alone. Children as young as four were found in Ghana's largest cities, including Accra/Tema, Kumasi, Sekondi–Takoradi, and Tamale.

A decade later, in 2021, three NGOs working with street-connected children in Kumasi conducted a headcount of street children in the Kumasi Central Business and surrounding areas.[31] The headcount revealed 6,693 street-connected children aged 0–18 years in both day and night counts. Of these, 2,468 were boys and 4,180 were girls. A total of 972 children were counted at night—397 boys and 575 girls. Over half (50.6 per cent) were between 13–17 years; while 21 per cent were aged 0–5 and 19.2 per cent were aged 6–12 (Chance for Children et al., 2021).

Regarding economic activities, 50.6 per cent of the children were not engaged in any work, while 24.5 per cent undertook casual labour; 10.9 per cent were involved in begging, and 7.4 per cent and 4.3 per cent were engaged in movable and fixed businesses, respectively. Notably, 158 female street-connected children were observed in commercial sexual work (CSW), representing 27.5 per cent of all females counted at night and 16.8 per cent of the total number of children observed at night.

Consistent with findings from the 2011 *Situational Analysis of Ghanaian Children and Women*, many street-connected children are exposed to sexual exploitation, either by adult predators or by peers living on the street. Some children also resort to commercial sex as a means of survival. This exposes them to severe risks, including violence, physical and psychological harm, and sexually transmitted infections such as HIV. Research indicates that many children do not fully understand the concept of sexual exploitation, often viewing sexual activity as a survival strategy or a normal part of street life.

Since 2010, several child-focused policies and interventions—such as the National Plan of Action for Orphans and Vulnerable Children (2010–2012), the Child and Family Welfare Policy (2015), and social protection programmes including LEAP and the NHIS—have

[31] The three NGOs are: Chance for Children, Safe Child Advocacy, Muslim Family Counselling Services

largely adopted household- or family-based approaches. These interventions do not adequately address the specific needs of street-connected children. Critically, the absence of comprehensive statistics on this population—such as their locations, backgrounds, drivers of migration, and specific needs—continues to hinder effective planning and service delivery. In this data vacuum, NGOs have played a leading role in supporting government efforts to respond to the situation (Dankyi, 2021).

In 2024, the Department of Social Welfare, with technical support from the Coalition for Street Connected Children (CSCC) and support from UNICEF and other partners, developed and launched Ghana's first five-year strategic plan for street-connected children. The strategy outlines ten key objectives aimed at addressing the multifaceted challenges faced by both Ghanaian and non-Ghanaian street-connected children.

However, nearly two years after the launch, implementation has yet to begin. At the same time, attempts by some government agencies to remove foreign-national street children from the streets of Accra have been largely ineffective, as the children often return. The expectation is that the Ministry will advance implementation of the five-year strategic plan, which provides a more sustainable and comprehensive framework for addressing the growing phenomenon of street-connected children in Ghana.

7.10 Children in conflict with the law

Situation

- Children in conflict with the law in Ghana are predominantly boys aged 13–17, with the most reported offences including stealing, robbery, assault and defilement.
- The national scale and distribution of children in conflict with the law cannot be estimated reliably because Ghana lacks a centralised national database, and existing data are drawn mainly from a few urban centres such as Accra and Kumasi.
- An inter-agency working group involving social welfare, police, health, education and the courts is in place to help ensure that children's rights are protected throughout justice processes.
- Rehabilitation capacity remains limited: Ghana currently has two Junior Correctional Centres and one Senior Correctional Centre in operation, while a facility in Wa has closed because of deteriorating infrastructure.

Bottlenecks

- The absence of a centralised database and real-time case tracking system weakens planning, monitoring and coordination across the juvenile justice system.
- Severe funding and logistical constraints delay probation work, home investigations, transport of children, and preparation of Social Enquiry Reports.
- Delays in age determination and court procedures can prolong cases beyond the legally mandated timeframe, undermining both child protection and access to justice.

- Limited infrastructure, equipment and opportunities for continuous professional development constrain child-sensitive justice delivery and rehabilitation.

Ghana's juvenile justice system is governed by the Juvenile Justice Act, 2003 (Act 653), which sets out the procedures and protections applicable to children in conflict with the law. The Child and Family Welfare Policy (MoGCSP, 2015a) frames juvenile justice as part of an integrated child protection system in which prevention, family-based responses and diversion are prioritised over institutional placement. Successive UN Committee on the Rights of the Child Concluding Observations have flagged Ghana's weaknesses in juvenile justice data, age determination, and conditions of detention as areas requiring sustained reform (UN CRC, 2015; UN CRC, 2026).

Children in conflict with the law are broadly categorised into two groups: juveniles aged 12–17 years and young persons in conflict with the law aged 18–21 years. The scale and profile of children in conflict with the law in Ghana are difficult to determine because there is no centralised national database consolidating information across the Ministries, Departments and Agencies responsible for child protection and juvenile justice. An interview with the Department of Social Welfare (DSW) further highlights this limitation, noting that the Department primarily receives data from Accra and Kumasi, which may not be representative of the national situation. Children living in street situations (see Section 7.9) are particularly visible in police data from Accra and Kumasi, both as suspects of minor offences such as petty theft and as victims of violence and exploitation. Disentangling perpetration from victimisation among this group is a recurring challenge for justice and child protection responders.

The most common offences committed by children include stealing, defilement, assault, and robbery. The pathways into the justice system are closely linked to broader vulnerabilities discussed above: economic pressures and exploitative labour (see Section 6.5) can draw children into theft or hazardous work that brings them to police attention, while limited supervision and family separation increase exposure to peer-influenced offending. According to key informants, there is a higher prevalence of male offenders compared to female offenders, with children aged 13–17 being the most likely to come into conflict with the law.[32] While boys are implicated across all four major offence categories, girls are more commonly associated with stealing and assault. Most of these offences are committed against adults, except in cases of defilement, where victims are typically children and adolescents.

An inter-agency working group exists to ensure that children who come into conflict with the law receive justice while their rights are protected throughout the process. This group comprises the Department of Social Welfare, the Ghana Police Service, the Ghana Health Service, the Ghana Education Service, and the Judicial Service. While this collaboration has contributed positively to achieving its mandate, it faces challenges at both institutional and operational levels. The 2021 evaluation of the Government of Ghana / UNICEF Child Protection Programme (Coram International, 2021) similarly

[32] Bases on key informant interviews with the Ghana Police Service.

identified inter-agency coordination at decentralised level as one of the weakest links in the child protection system, with juvenile justice particularly affected by fragmented mandates, weak referral pathways and gaps in case management.

Funding remains a major challenge. There is inadequate funding to cover essential activities—from major case-management work such as home investigations down to routine operational needs such as office stationery. The absence of vehicles significantly delays home studies conducted by probation officers at the DSW and the preparation of Social Enquiry Reports required by the courts. Similarly, the police face logistical constraints, including vehicle shortages, which sometimes compel them to transport juveniles to courts and remand homes using public transport. In some cases, concerns about escape lead to the use of handcuffs on minors, which is not permitted by law.

Funding constraints further affect the administration of justice for children, particularly in cases where age determination is required. Children without proper documentation must undergo medical age assessments at a cost, which can delay proceedings when funds are unavailable. Such delays can extend beyond the mandated six-month period for concluding cases involving children. When this occurs, cases are discharged, and the child is released. While this protects children from prolonged detention, it can deny justice to victims, especially when the victim is also a minor.

Limited funding also restricts opportunities for continuous professional development. This particularly affects probation officers in hard-to-reach areas, who often also lack the resources and equipment to perform their duties effectively.

Regarding rehabilitation, there are currently two Junior Correctional Centres—one for boys in Swedru in the Central Region and one for girls in Osu in the Greater Accra Region—managed by the Department of Social Welfare. There is also a Senior Correctional Centre in the Greater Accra Region managed by the Ghana Prisons Service under the Ministry of the Interior. A facility in Wa in the Upper West Region has been closed due to deteriorating infrastructure.

7.11 Access to communication technology

Situation

- Young people are the most digitally connected age group compared to children and older adults.
- Access differs by location, especially between urban and rural areas, and by gender, with 61.3 per cent of men aged 15-59 who have used the internet against 46.5 per cent of women.
- Widespread mobile phone ownership and expanding network coverage support high internet use among adolescents.

Bottlenecks

- There is a clear urban-rural gap, with lower access to mobile money and digital services in rural areas.

- Cost of data, devices, and electricity can limit consistent access for low-income households.
- Digital literacy gaps and technology-facilitated safety risks also affect how safely and effectively adolescents use technology.

Adolescence is a period of rapid social, educational, and economic transition, and access to communication technology plays an increasingly important role in shaping these experiences. Digital connectivity influences how adolescents learn, access information, build relationships, and prepare for the world of work. Understanding patterns of internet and mobile access is therefore important to assessing both the opportunities available to young people and the inequalities that may limit their full participation in society.

Evidence from the 2022 DHS highlights a clear gender divide in internet usage in Ghana. The survey shows that men are consistently more likely than women to have used the internet in the 12 months preceding the survey, indicating persistent inequalities in digital access, skills, affordability, and opportunities.

At the national level, internet use remains strongly shaped by both gender and place of residence. In urban areas, 58 per cent of women reported using the internet in the previous year, compared with 74 per cent of men. In rural areas, the proportions were much lower: 24 per cent of women and 46 per cent of men. This means that the gender gap exists everywhere, but it is particularly wide in rural Ghana, where men are almost twice as likely as women to be internet users.

The findings suggest that women face a "double disadvantage": first as women, and second when living in rural or poorer communities. Lower internet access among women is often associated with lower educational attainment, reduced control over household resources, lower smartphone ownership, and time constraints linked to unpaid care responsibilities. Men, by contrast, may have greater labour market exposure, mobility, and purchasing power, which can facilitate digital connectivity.

Internet use rises significantly with education and household wealth for both sexes. However, even among more advantaged groups, men generally retain higher usage rates than women. This implies that closing the digital divide requires more than general infrastructure expansion; targeted gender-responsive measures are needed.

From a policy perspective, the results are important because internet access increasingly shapes access to employment, education, financial services, government information, and social protection systems. If women remain less connected than men, existing social and economic inequalities may deepen. Expanding affordable mobile broadband, improving women's digital literacy, promoting safe online spaces, and increasing access to low-cost devices for women could therefore generate broader gains in inclusion and empowerment.

7.12 Technology-facilitated child sexual exploitation and abuse

Situation

- Children and adolescents in Ghana face significant technology-facilitated risks (content, contact, conduct, commercial), with reported cases of child sexual abuse material produced, accessed and disseminated increasing by 3,050 per cent between 2016 and 2024.
- Adolescents (13–18) and girls are most affected, but other children remain vulnerable through misuse of their personal data.
- The Cybersecurity Act, 2020 (Act 1038) and the National Child Online Protection Framework provide the legal and strategic basis for action.

Bottlenecks

- A major constraint is the insufficient capacity to manage existing data and utilise available evidence on children's online behaviours, which limits understanding of scale, perpetrators and who is most at risk to inform programming.
- Implementation is further hindered by limited funding, inadequate human resources, coordination challenges among CSA teams and partners, logistical constraints, and insufficient timely research to track trends and perpetrator profiles.

Children and adolescents in Ghana face diverse technology-facilitated risks that expose them to exploitation and abuse: The Cyber Security Authority (CSA) categorises these risks into four channels—the *"4Cs"*: Content, Contact, Conduct, and Commercial. While *conduct* risks often stem from young people's own online actions, *content*, *contact*, and *commercial* risks are typically driven by external actors who actively or passively exploit children. Perpetrators may be adults or peers. These risks have increased significantly for children in Ghana. In fact, according to the National Center for Missing and Exploited Children (NCMEC), the cyber tipline reports of child sexual abuse materials being produced, accessed or disseminated from Ghana has increased from 750 in 2016 to 23,626 in 2024.

While Ghana has made progress in collecting data on children's online behaviour – including being among the first countries to conduct the Global Kids Online study in 2019 – there is a significant lack of capacity to collect, manage, and utilise available data and evidence to analyse trends and inform programming (Global Kids Online, 2019; Kyei-Arthur, 2024). This barrier limits understanding of the scale of the problem, the key actors involved, the groups most at risk, consequently preventing effective response. Key informant interviews indicate that adolescents aged 13–18 face the highest risk of technology-facilitated child sexual exploitation and abuse, largely due to their greater access to digital devices and online platforms.[33] Reported cases also show that girls are disproportionately affected, for instance, 48 of 52 cases recorded in the past year involved female victims.[34] Limited access to digital devices does not shield other children from harm. Perpetrators may obtain or misuse children's data to bully, threaten,

[33] Based on consultations with the National Cyber Security Authority.
[34] Based on consultations with the National Cyber Security Authority.

blackmail, or extort them, often without the child's direct involvement or awareness.

Key drivers of technology-facilitated child sexual exploitation and abuse include growing access to digital technologies, limited parental guidance, and low awareness of technology-facilitated risks among children and adolescents. Poverty heightens vulnerability, as children may be enticed by promises of financial support or educational opportunities. However, the absence of comprehensive data makes it difficult to fully understand the relative contribution of each risk factor and other existing or emerging risk factors. Further, even with the currently available data, the lack of proper data management adds to these challenges by preventing the undertaking of trend analysis, impacting monitoring and progress tracking to inform future programming.

National efforts to address online child protection are guided by the Cybersecurity Act, 2020 (Act 1038), which criminalises a range of technology-facilitated abuses against children, and the National Child Online Protection Framework, which outlines the strategic pillars for implementation (Government of Ghana, 2020). The CSA has launched several initiatives, including nationwide awareness campaigns, with a strong focus on Senior High Schools identified as high-risk environments. Activities include an annual cybersecurity competition, the formation of cybersecurity clubs to promote peer learning, the distribution of information materials and reporting channels through schools and social media, and capacity building for educators, parents, children and technology industry actors.

The Authority also plans to integrate cybersecurity and digital hygiene into the pre-tertiary curriculum through collaboration with the National Council for Curriculum and Assessment (NaCCA), with future expansion to tertiary institutions in partnership with the Ghana Tertiary Education Commission (GTEC).

Despite these efforts, implementation is constrained by limited funding, inadequate human resources, coordination challenges among CSA teams and institutional partners, including the private sector, logistical challenges, and the need for timely, rigorous research to track trends, identify at-risk populations, and understand perpetrator profiles. It is critical to strengthen law enforcement and victim support to ensure that children at risk of or experiencing technology-facilitated child sexual exploitation and abuse can receive required assistance in a timely manner. Education and parenting programmes will be key to keep children and young people safe online.

D Forward-looking considerations

Adolescence represents a pivotal period for Ghana's demographic dividend. Over the next decade, the intersection of a growing youth population, labour market pressures, urbanisation, climate stress and digital transformation will significantly shape adolescent trajectories. The continued expansion of the adolescent population will intensify pressure on secondary education systems and labour markets. Ensuring that increased access to JHS and SHS translates into meaningful learning and employability will require stronger alignment between curriculum, technical and vocational pathways, and emerging labour market opportunities. Without accelerated job creation and skills

matching, there is a risk that NEET rates could rise, particularly in urban areas.

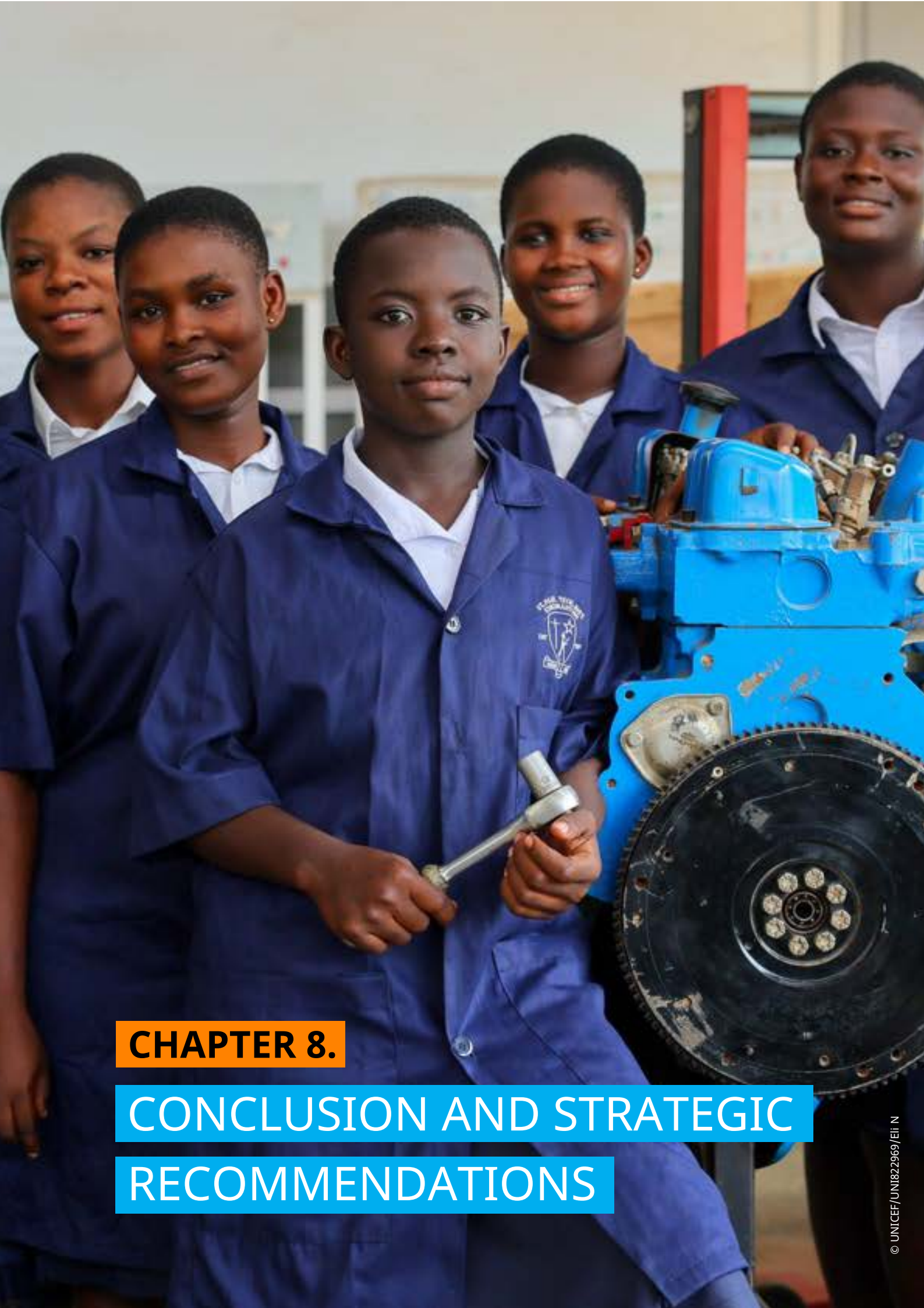
Rapid urbanisation may deepen inequalities between adolescents with access to quality services and those living in informal settlements. Urban poverty, combined with limited youth-friendly services, may increase exposure to early pregnancy, exploitation and contact with the justice system. Urban-responsive planning, targeted youth services and stronger community engagement will be increasingly important to prevent widening disparities.

Climate-related livelihood disruption is likely to affect rural adolescents disproportionately, accelerating migration and increasing exposure to informal and precarious work. In contexts of economic distress, girls may face heightened risks of early marriage or pregnancy. Integrating climate resilience into youth employment strategies, education planning and adolescent health programming will help mitigate these emerging vulnerabilities.

Digital transformation presents both opportunity and risk. Expanded connectivity offers potential for improved learning access and stronger administrative data systems, yet unequal access may deepen disparities between urban and rural children. Earlier exposure to digital environments without guidance from parents, caregivers and teachers also introduces new protection challenges, including online exploitation. Embedding digital literacy and online safety into secondary education, alongside strengthening coordination, including with the private sector, law enforcement, victim support and data systems, will be essential to ensure that technological expansion supports rather than undermines child wellbeing.

Gender dynamics will shape how these structural trends affect adolescents. While both girls and boys face risks during the transition to adulthood, adolescent girls often experience compounded disadvantages linked to gender norms, child pregnancy, unpaid care responsibilities and restricted mobility. These constraints can limit girls' participation in education, skills development and economic opportunities, particularly during the transition from school to work. At the same time, boys may face pressures related to labour market entry, migration and exposure to hazardous work or violence. Applying a gender-responsive and adolescent-intentional lens will therefore be essential to ensure that policies and investments address the distinct risks and opportunities facing girls and boys.

Ultimately, realising Ghana's demographic dividend will depend on integrated approaches that track adolescent transitions and identify emerging risks early. Improved and up-to-date disaggregated data by age, sex, disability and geography will enable more responsive policy dialogue and ensure that structural shifts over the coming decade translate into expanded opportunity rather than heightened vulnerability for Ghana's adolescents.



CHAPTER 8.

CONCLUSION AND STRATEGIC RECOMMENDATIONS

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8 Conclusion and strategic recommendations

Since ratifying the Convention on the Rights of the Child in 1990, becoming the first country in the world to do so, Ghana has made significant advancements in child survival, access to social services, and the development of legal protection frameworks. ANC coverage has expanded to near-universal levels, skilled birth attendance has risen from around 43 per cent in the 1990s to 88 per cent by 2022, neonatal mortality has declined substantially, and primary school enrolment is high. Ghana has progressively formalised its social protection architecture through the Social Protection Act (2025), and the ISS approach represents a meaningful institutional step toward integrated service delivery. These are genuine achievements and a foundation worth building on.

A central finding running through all chapters, however, is that overall progress masks deep and persistent structural inequalities. Under-five mortality varies nearly fourfold across regions. Multidimensional poverty affects more than 80 per cent of children aged 0 to 4, yet public spending on this age group is the lowest across the lifecycle. Only 4 of 261 MMDAs meet minimum social welfare staffing requirements. These are not marginal gaps at the edges of an otherwise functioning system; they reflect structural choices about where resources flow and whose needs are prioritised.

Four cross-cutting themes connect the evidence presented across the lifecycle chapters. First, expanded service coverage has not consistently translated into improved quality, continuity, or equity of outcomes, a pattern visible in ANC (Chapter 4), nutrition and health services (Chapter 5), primary education (Chapter 6), and reproductive health (Chapter 7). Second, children's risks are cumulative and interconnected: the developmental gaps that inadequate nutrition, unsafe water, incomplete birth registration, and limited stimulation open in early childhood are the same gaps that persist and compound through middle childhood and into adolescence. Third, the structural forces identified in the country context, including rapid urbanisation, fiscal constraint, climate volatility, and a growing youth population, are already shaping children's trajectories and will intensify over the coming decade. Fourth, persistent evidence gaps across every chapter constrain the ability to monitor child wellbeing, target investments, and hold systems accountable.

The sections that follow discuss the key findings across the lifecycle, set out the evidence gaps and systemic bottlenecks that cut across them, and then bring together a single set of strategic recommendations spanning the lifecycle and the cross-cutting system reforms needed to accelerate progress toward the full realisation of children's rights.

8.1 Key findings across the lifecycle

Pregnancy and birth

Pregnancy and birth remain critical entry points for shaping both immediate survival and long-term development, and Chapter 4 shows that Ghana's real gains in service utilisation conceal important limitations in quality and continuity. Antenatal care coverage is near-universal and skilled birth attendance has risen markedly, yet

increased contact with services has not consistently translated into better outcomes. Many women initiate care late or miss key components of the recommended package, and in northern Ghana fewer than one in four women received high-quality antenatal care as defined by early initiation, adequate visit frequency, and receipt of core services (DHS, 2022). The challenge has shifted from expanding access to ensuring the readiness, continuity, and quality of care, particularly for adolescents, poorer households, and underserved regions.

Survival outcomes reflect these limitations. Neonatal mortality has declined to approximately 19 deaths per 1,000 live births, but progress has slowed and deaths remain concentrated in the first week of life, precisely the window in which emergency obstetric readiness and functioning referral systems matter most (DHS, 2022). Adolescent pregnancy, at 15.2 per cent among girls aged 15 to 19, continues to reflect underlying social and economic vulnerabilities that maternal health services alone cannot resolve (DHS, 2022). As Chapter 4 notes, continued population growth and urbanisation will increase demand on maternal and newborn services while fiscal constraints may limit the pace of quality improvement, making the conditions established at this entry point foundational for outcomes across the entire lifecycle.

Infancy and early childhood

The early years represent the most critical period for reducing inequality and building human capital, yet Chapter 5 establishes that children aged 0 to 4 experience some of the highest levels of deprivation, and that early risks are cumulative. Inadequate nutrition, unsafe water and sanitation, incomplete birth registration, limited stimulation, and gaps in care interact to widen developmental disadvantages before children reach primary school, disadvantages that subsequent chapters document as they persist and compound. The under-five mortality disparity between Greater Accra, at 20 deaths per 1,000 live births, and Oti Region, at 72 per 1,000, reflects not just differences in health system capacity but the broader inequalities in household income, infrastructure, and geographic access documented in the country context chapter (DHS, 2022). Malnutrition, including stunting and micronutrient deficiencies, remains a significant concern and is concentrated among poorer households and northern regions.

Two structural features stand out. First, incomplete birth registration limits access to services and legal protection at the stage when both matter most. Second, the misalignment between need and investment is stark: more than 80 per cent of children aged 0 to 4 are multidimensionally poor, yet this age group receives the lowest public investment across the lifecycle, LEAP has limited coverage of them, and Ghana still lacks a statutory child or family cash benefit for early childhood. Taken together, these findings point to a systemic underinvestment in early childhood and insufficient integration across health, nutrition, WASH, early learning, and social protection systems, compounded by the risks that urbanisation and environmental degradation pose for young children in informal settlements and climate-affected communities.

Middle childhood

Middle childhood is the stage at which early investments are tested, and Chapter 6 examines whether they are reinforced or undermined during primary schooling. For many children, the answer is the latter. Primary enrolment is high, but this has not translated into strong foundational learning, and many children fail to acquire expected literacy and numeracy skills, reflecting disparities in education quality and resourcing that are closely patterned by region and socio-economic status. The learning environment itself remains constrained: a significant share of learners attend schools without minimum water, sanitation, and hygiene standards, which disproportionately affects poorer and rural communities.

Protection risks during these years are substantial and closely linked to household poverty. Child labour affects approximately 20 per cent of children aged 5 to 17, driven by economic pressures that social protection systems do not yet adequately buffer (GLSS, 2016/17), and violent discipline is near-universal, experienced by more than nine in ten children and legitimised by prevailing social norms. Family separation is also widespread, with 16 per cent of children not living with a biological parent (DHS, 2022). Chapter 6 identifies weak coordination across education, child protection, labour, and social protection as the central systemic gap, one the ISS approach is designed to bridge but which requires stronger district-level implementation to deliver, particularly in northern regions where climate-related livelihood disruption is likely to intensify child labour risks.

Adolescence

Adolescence represents a critical transition to adulthood, and Chapter 7 examines a period when the accumulated advantages and disadvantages of earlier childhood become consequential for life trajectories. Ghana has achieved near gender parity at junior and senior high school level and has expanded technical and vocational pathways, but structural barriers continue to limit opportunities. Junior high school net enrolment remains at 47 per cent, the drop in age-appropriate participation between basic and secondary education is persistent, and the links between education, skills training, and labour market opportunities remain weak, raising the risk that youth unemployment and NEET rates rise as the adolescent population grows.

Adolescent girls are disproportionately affected by early pregnancy and child marriage, which constrain educational attainment and economic participation. Although access to reproductive health services has improved, 31 per cent of adolescents aged 15 to 19 have an unmet need for family planning, and 15.2 per cent of girls have ever been pregnant, reflecting both service gaps and the gender norms documented throughout the report (DHS, 2022). The chapter also highlights a growing presence of street-connected children and increasing adolescent substance abuse, issues on which data are insufficient and which are therefore weakly addressed within current policy and service frameworks. Looking ahead, the growing youth population, climate-related livelihood disruption, and digital transformation will reshape adolescent trajectories, requiring a gender-responsive and adolescent-intentional policy lens that has not yet been consistently applied.

8.2 Evidence gaps across the lifecycle

The analysis in this report repeatedly encountered limitations in the availability, currency, and quality of data on children. These gaps are not merely technical; they constrain the ability to monitor wellbeing, evaluate service effectiveness, target investments, and hold systems accountable, and they fall into four broad categories. Addressing them is itself a strategic priority, and they are taken up again in the discussion of weak data systems as a structural bottleneck below.

- **Outdated core datasets.** Several of the report's foundational statistics rest on increasingly dated sources. National estimates of monetary and multidimensional child poverty derive from MICS (2017/18) and GLSS (2016/17), and there is no recent nationally representative child labour survey, with the most cited figures also drawn from GLSS (2016/17). Given the scale of recent economic shocks, updated estimates are essential to understanding whether child poverty and child labour risks have intensified.
- **Invisible and undercounted populations.** The children most exposed to harm are often least visible in official statistics. Reliable, nationally representative data on children with disabilities remain limited across all ages, particularly for the under-fives, who are not covered by current disability statistics, and existing indicators do not adequately capture the spectrum of functional limitations. There is no up-to-date national data on children living in street situations, with the last national-level estimate dating to 2011, and no centralised database on children in conflict with the law, where existing data are drawn mainly from a few urban centres. Comprehensive data on child trafficking and on the wellbeing of children in residential and alternative care also remain sparse, constraining accurate assessment of scale, trends, and protection needs.
- **Quality and outcomes behind coverage.** Routine systems generally record whether a contact with services occurred, but not its quality or result. This is visible across the lifecycle: antenatal data capture visit counts but not whether the recommended package of care was delivered; administrative early childhood data record kindergarten enrolment but provide no nationally representative insight into the type, quality, accessibility, or affordability of early childhood services; learning outcome data have improved with the National Standardised Tests but still lack tracking by disability status, language of instruction, and over time; and data on violence against children capture exposure but rarely the service response. Urban child deprivation in informal settlements, home to a large and growing share of Ghana's children, is also poorly captured by standard sampling frames.
- **Emerging-risk blind spots.** The risks reshaping childhood over the coming decade are among the least well measured. Adolescent mental health is essentially absent from routine surveys, despite growing concerns around psychosocial wellbeing and substance abuse; the school-to-work transition is under-measured, with education histories not yet systematically linked to employment outcomes; technology-facilitated sexual exploitation and abuse data remain fragmented across police, child protection, and digital-safety systems; and

the specific impacts of climate shocks on children, including schooling interruption, malnutrition, and displacement, are not yet systematically tracked.

8.3 Bottlenecks to advancing child rights in Ghana

Cutting across all four lifecycle chapters, five systemic bottlenecks emerge as the principal drivers of the persistent gap between policy ambition and implementation outcomes. These are not sector-specific failures; they are structural constraints that simultaneously limit the effectiveness of investments across health, education, social protection, and child protection.

Fragmented governance and accountability

Ghana has an extensive legal and policy architecture for children, yet the UN Committee on the Rights of the Child's February 2026 Concluding Observations and national stakeholder consultations alike identify implementation gaps as the principal constraint. Roles and mandates across MDAs, independent bodies, and local authorities are not always clearly aligned. Coordination mechanisms exist but are underutilised or lack decision-making authority, particularly at district level, and multisectoral action on cross-cutting issues such as violence, disability, and climate risks remains weak. This fragmentation reduces accountability and contributes directly to the mismatch between national policy commitments and outcomes on the ground.

Underinvestment in early childhood

Public spending on children is most heavily weighted toward older school-age groups, with those aged 0 to 3 receiving the least investment of any age group, including a reduction in in-kind support between 2015 and 2021, despite facing the highest multidimensional poverty rates (UNICEF, forthcoming). LEAP coverage compounds this: 77 per cent of beneficiaries are aged 19 and over, with virtually no coverage for children under five (UNICEF, 2025f). The structural misalignment between where deprivation is concentrated and where resources flow is one of the most consequential constraints on Ghana's long-term human capital development, and without deliberate rebalancing, cycles of poverty and disadvantage will persist across generations.

Weak decentralisation

Ghana's decentralisation architecture is conceptually sound but operationally constrained. The DACF allocation formula does not systematically channel more resources to poorer districts; fund releases are frequently delayed; and MMDAs generate little own-source revenue (CSPS, 2019). The consequences run through the lifecycle chapters: district health facilities lack the readiness to deliver quality maternal care (Chapter 4); CHPS compounds face staffing and logistics gaps (Chapter 4); social welfare offices operate without functional transport or operational budgets (Chapters 3 and 6); and ISS implementation is weakest in precisely the northern districts where deprivation is most severe (Chapter 3). Last-mile delivery of child protection, social services, and health referrals remains the single most consistent implementation failure across sectors.

Weak data systems

The evidence gaps documented above are symptoms of a structural data bottleneck. Key datasets are outdated, with child poverty figures derived from MICS (2017/18) and child labour from GLSS (2016/17), while routine systems record service contacts but not quality or outcomes. Children with disabilities, adolescent mothers, street-connected children, and those in informal settlements are consistently under-represented or invisible in official statistics. Data fragmentation across MDAs limits interoperability, and feedback loops from evidence to policy remain weak: as shown in Chapter 3's analysis of the ISS readiness assessment, implementation gaps persist even when evidence of them is available (Dias et al., 2023).

Harmful social norms and demand-side constraints

Throughout this report, supply-side investments are shown to be insufficient on their own. The adolescence chapter documents how stigma around adolescent health services, low prioritisation of girls' education, and practice of child marriage in certain parts of the country limit uptake even where services exist. The middle childhood chapter shows that violent discipline is sustained by social norms, with most caregivers believing physical punishment is acceptable. Chapter 3 highlights that social protection benefits are often perceived as discretionary gifts rather than rights, weakening accountability and uptake. These demand-side barriers, reinforced by community expectations and cultural practices, interact with institutional weaknesses to reinforce exclusion, and cannot be addressed through service delivery reform alone.

8.4 Strategic recommendations

The recommendations below follow from the analysis set out above. They begin with the cross-cutting system reforms that address the structural bottlenecks identified in this report, since these shape the effectiveness of action in every sector and at every stage of childhood. They then turn to the lifecycle recommendations, which translate those system shifts into concrete priorities at each stage, from pregnancy and birth through to adolescence. The two sets are intended to work together: the cross-cutting reforms create the conditions for progress, while the lifecycle priorities identify where that progress most urgently needs to be realised. Together they reflect a deliberate shift from expanding service coverage toward ensuring equitable access, quality, and continuity of services for children throughout their lives.

Cross-cutting system reforms

1. **Ensure equitable access, quality, and continuity of services.**

   Strengthen Ghana's broad-based national programmes so that they reach and retain the children currently least well served, narrowing the gaps in access, quality, and continuity that fall along lines of poverty, geography, gender, and disability. Public investment in children should be protected and prioritised, with allocation guided by where deprivation is greatest, directing resources, staffing, and support toward the districts and communities furthest behind, including poorer, rural, and northern regions, children with disabilities, street-connected

children, and children in conflict with the law. Raise education and health spending toward international benchmarks (the UNESCO Incheon target of 4 to 6 per cent of GDP, the WHO target of 5 per cent, and the Abuja target of 15 per cent) and revise the DACF allocation formula to channel more resources to poorer districts.

2. **Strengthen and scale up integrated, child-centred service systems.**

Move away from fragmented, sector-specific responses toward integrated systems capable of addressing the interconnected risks children face, from malnutrition and learning poverty to violence, child labour, adolescent pregnancy, and climate vulnerability. The ISS approach provides a platform for this shift, and its expansion to all 261 MMDAs in 2026 is an opportunity. Effective implementation will require clearly defined institutional roles, interoperable referral pathways, enhanced district-level coordination, operational budgets and transport, and routine case management that ensures families can access multiple services in a timely manner. The documented underperformance in northern districts must be addressed as a priority, not deferred.

3. **Strengthen social and behavioural change at scale.**

Addressing harmful social norms is essential to unlocking demand for services; without tackling these underlying drivers, supply-side investments alone will not deliver results. Evidence-based campaigns on gender equality, positive parenting, and school attendance should be scaled, with traditional, religious, and community leaders actively championing norm change. Community dialogue platforms should be institutionalised within district planning processes and the ISS coordination framework. Life skills, sexual and reproductive health education, and youth engagement platforms should be expanded, with adolescent voices integrated into local governance, ensuring that demand-side barriers are addressed as systematically as supply-side ones.

4. **Foster resilient, evidence-informed systems.**

Policy, planning, and reporting must be based on timely and credible evidence. This requires stronger administrative and survey data systems, child-focused monitoring, and expanded use of evidence for targeting interventions and tracking inequities, building on the SWIMS platform and the data governance provisions of the Social Protection Act (2025). Special attention is needed to address the paucity of data on children with disabilities, street-connected children, children in conflict with the law, and adolescents. Accountability must be strengthened at both national and subnational levels to ensure that commitments to children's rights are reflected in implementation, resource allocation, and measurable improvements in outcomes.

5. **Integrate climate resilience across sectors.**

Given the scale of climate-related risk, climate resilience and environmental sustainability should be integrated into sectoral planning, particularly in education, child protection, nutrition, and social protection, ensuring that development strategies account for the long-term impacts of environmental change on children's wellbeing and that social protection systems are increasingly shock-responsive.

Pregnancy and birth

6. Strengthen the quality and continuity of maternal and newborn health services, ensuring all women, particularly adolescents and those in underserved areas, receive the full recommended package of antenatal, delivery, and postnatal care rather than adequate visit counts alone.
7. Invest in the readiness of the CHPS network and primary health care system, addressing staffing, infrastructure, logistics, and referral systems, with particular priority to emergency obstetric and newborn care in northern and rural areas.
8. Expand adolescent-responsive sexual and reproductive health services, tackling the stigma, limited autonomy, and weak service continuity that constrain access for younger mothers.

Infancy and early childhood

9. Introduce a child or family cash benefit covering the 0 to 4 cohort within the social protection system, closing the current gap in income support during the period when nutrition, caregiving, and early learning investments matter most.
10. Expand child health, nutrition, WASH, and early learning services, prioritising the northern regions where stunting prevalence is highest and under-five mortality is more than three times the Greater Accra rate.
11. Accelerate universal birth registration to close the gap between registration and certification rates, including by removing financial barriers to late registration, and expand community-based early childhood development and parenting support programmes.

Middle childhood

12. Improve the quality and inclusiveness of primary education, including teacher training, learning materials, support for children with disabilities, and investment in school WASH facilities.
13. Urgently address social welfare understaffing, raising staffing from the current 41 per cent of minimum required positions and ensuring that more MMDAs meet minimum standards, with operational budgets and transport for case management.
14. Address the structural drivers of child labour, building on the Ghana Accelerated Action Plan Against Child Labour, and strengthen the prevention of and response to violence against children.

Adolescence

15. Expand access to secondary education with financial support and retention programmes, particularly in northern regions and for girls facing early pregnancy and marriage risks, and strengthen school-to-work transition pathways, including TVET and apprenticeships.

16. Accelerate implementation of the National Strategic Framework for Ending Child Marriage and improve access to reproductive health services, addressing the 31 per cent unmet need for family planning among adolescents.

17. Embed digital literacy and online safety into secondary education, strengthen coordination between the Cybersecurity Authority, law enforcement, and child protection systems, and develop targeted responses for street-connected children and adolescent substance abuse.

8.5 Looking ahead

The structural forces shaping children's wellbeing in Ghana, including demographic growth, rapid urbanisation, fiscal constraint, climate volatility, and digital transformation, are already reshaping the distribution of risks and opportunities across the lifecycle, and they will intensify over the coming decade. The children who participated in UNICEF's 2025 foresight workshops named the same pressures and articulated a clear vision in response: equitable services, environmental protection, digital inclusion, and governance they can trust.

Ghana has the legal frameworks, the institutional platforms, and a track record of genuine progress on which to build. What is required now is the political will and sustained investment to close the gap between what is committed on paper and what children experience in practice, particularly those in northern regions, informal urban settlements, and other communities that current systems consistently fail to reach. By building on existing national initiatives and strengthening collaboration between government institutions, development partners, civil society, and communities, Ghana has a strong opportunity to accelerate progress toward the full realisation of children's rights in the years ahead.

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Annex 1 List of key Informant interviews and focus group discussions

Institution	Department / Role	Interview Type	Level
Africa Education Watch	Executive Director	KII	National
Births and Deaths Registry	Deputy Registrar; Statistical Research Unit	KII	National
Community Opinion Leader (Abokobi)	Traditional / community leadership	KII	Community
Department of Children (MoGCSP)	Child Protection	KII	National
Department of Labour	Child Labour Unit	KII	National
Department of Social Welfare (MoGCSP)	Social Welfare Services	KII	National
Department of Sociology (University of Ghana)	Academic / Social Policy	KII	National
Ghana Education Service (GES)	Senior official (Education Service)	KII	National
Ghana Education Service (GES)	Early Childhood Education Directorate	KII	National
Ghana Federation of Disability Associations	Executive Director	KII	National
Ghana Health Service (Family Health / Adolescent Health)	Adolescent Health	KII	National
Ghana Health Service (GHS)	Health systems / maternal and child health	KII	National
Ghana Statistical Service (GSS)	National statistics	KII	National
Ghana Police Service	Domestic Violence and Victim Support Unit		
Ministry of Finance (MoF)	Budget Department	KII	National
Ministry of Finance (MoF)	Budget / Public Financial Management	KII	National
Ministry of Local Government, Chieftaincy and Religious Affairs	Programme Officer; Senior Programme Officer	KII	National
National Cyber Security Authority	Child Online Protection / Cybersecurity	KII	National

Institution	Department / Role	Interview Type	Level
National Development Planning Commission (NDPC)	National Planning and Policy Coordination	KII	National
UNDP	Governance, resilience and inclusive growth	KII	National
UNHCR	Child Protection / Refugee Services	KII	National
UNICEF Ghana	Child Protection Unit	KII	National
UNICEF Ghana	Planning, Monitoring and Evaluation (PME) Unit	KII	National
UNICEF Ghana	WASH Unit	KII	National
UNICEF Ghana	Health and Nutrition Section	KII	National
SDG Platform in Ho	Civil society coalition	KII	Sub-national (Ho)
Adult Focus Group (Abokobi)	Caregivers / adults	FGD	Community
Adult Focus Group (Boi)	Caregivers / adults	FGD	Community
Children's Focus Group (Abokobi)	Children (mixed ages)	FGD	Community
Children's Focus Group (Boi)	Children (mixed ages)	FGD	Community

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