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**Policy Brief: 11<sup>th</sup> February, 2026**

# **Diet Is Medicine, But Access Is Policy: Strengthening Diabetes Self-Care in Ghana**

A policy brief to the Government of Ghana and policy-level actors



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## Executive Summary

This policy brief is developed with funding from the University of Huddersfield, United Kingdom. The findings and policy recommendations reported in this brief are based on evidence from interviews and focus group discussions conducted during a diabetes dietary self-care co-creation workshop with about 110 participants encompassing persons living with diabetes, family caregivers, health professionals (diabetes specialist doctors, nurses, and dietitians), policymakers/policy implementers, journalists, faith/religious leaders and community stakeholders.

The findings reveal that:

1. Knowledge of diabetes dietary self-care exists, but adherence is structurally constrained.
2. Family caregivers experience high emotional burden and receive conflicting information in their caregiving roles towards their loved ones with diabetes.
3. Health system barriers and financial hardship significantly impede diabetes self-care.

The policy recommendations include:

- Strengthening dietetic capacity.
- Decentralising diabetes services and enhancing referral pathways or protocols.
- Championing family caregiver integration.
- Leveraging digital health tools to track dietary self-care or adherence among persons living with diabetes and support family caregivers.

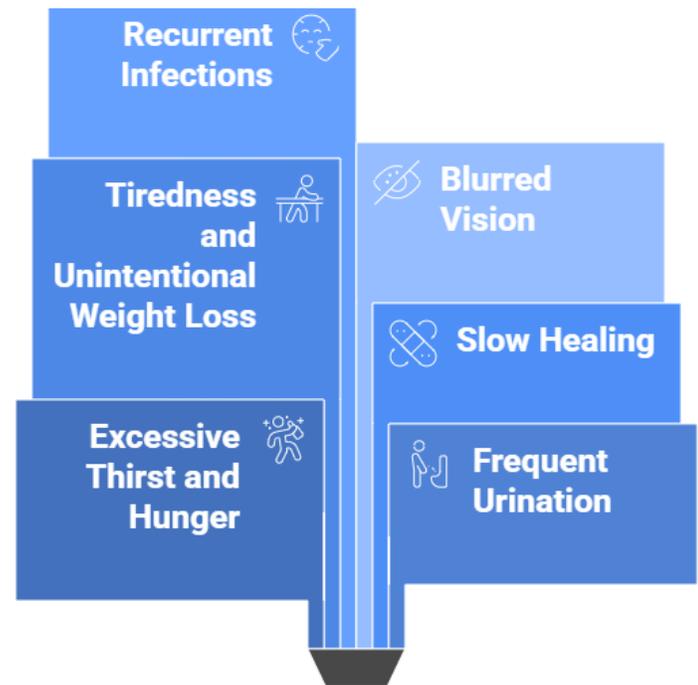
## What is type 2 diabetes mellitus?

Type 2 diabetes mellitus (T2DM) is a non-communicable disease that is characterised by high blood glucose level [1]. According to the International Diabetes Federation (IDF), T2DM is the most common type of diabetes worldwide, accounting for approximately 90% of all diabetes cases [2]. While T2DM is generally regarded as 'adult' diabetes, evidence show that its global incidence rate increased from 117.22 (per 100,000 population) in 1990 to 183.36 (per 100,000 population) in 2019 [3].

### **T2DM is a serious public health concern**

In Ghana, the national prevalence of T2DM ranges between 2.80% to 3.95% [4]. However, there are regional variations in diabetes prevalence (which is predominantly T2DM). For example, the Western region has a T2DM prevalence of 39.80%, the Ashanti region has a prevalence ranging from 3.8% to 25.20%, and the Central region is 24.60% [4,5]. As such, addressing T2DM is critical to improving the health and wellbeing of the Ghanaian population.

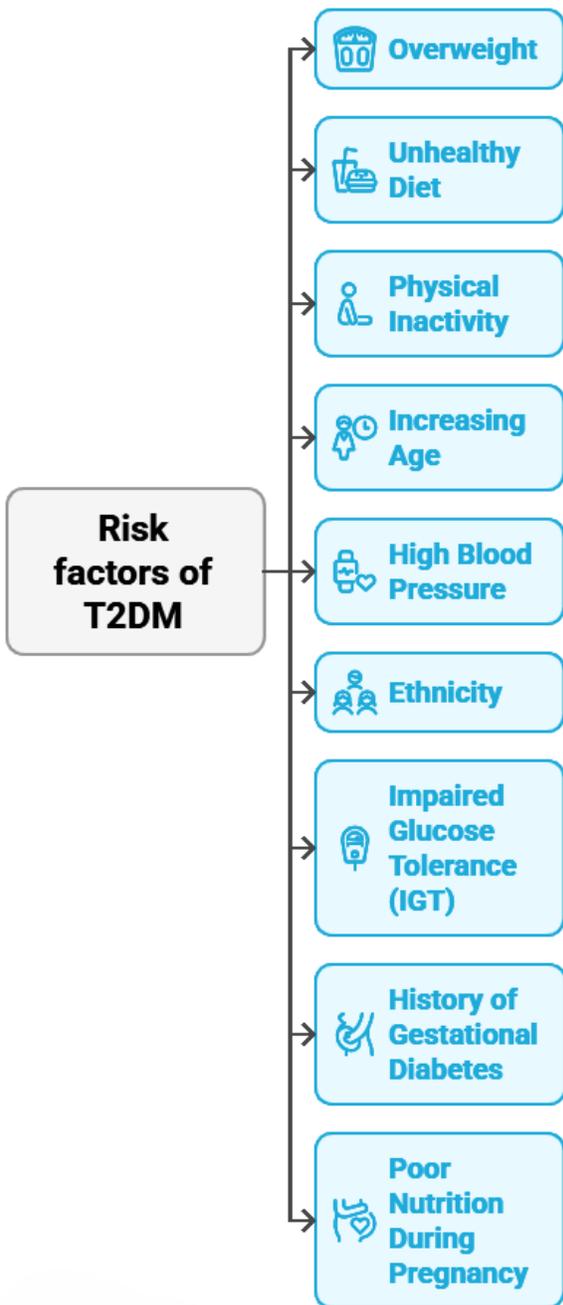
## Typical symptoms of T2DM



## Risk factors of T2DM

The existing evidence [2] indicates that there is a combination of modifiable and non-modifiable factors that increases one's risk of developing T2DM. The non-modifiable risk factors are the factors over which the individual has little to no control. This may include ethnicity, family history of diabetes, increasing age, impaired glucose tolerance and genetic dispositions. However, the modifiable risk factors are all those over which the individual has some level of control. They include unhealthy dietary habits or choices, high blood pressure, obesity and overweight, sedentary lifestyle,

and physical inactivity. This is where dietary self-care or self-management or ‘adherence’ comes to play.



## Dietary self-care adherence in managing T2DM: diet as medicine?

There is abundant evidence that show the significance of proper dietary practices for persons living with T2DM. For example, good dietary adherence increases glycaemic control by three folds [6]. Additionally, high adherence to good dietary practices reduces the risk of depressive symptoms among persons living with T2DM [7]. Consequently, persons living with T2DM are required to consume diets rich in whole grains, fruits, vegetables, legumes and nuts, while restricting the consumption of alcohol, refined grains, red and processed meats, and low sugar-sweetened beverages [8].

So, yes! Proper dietary adherence or self-care can act as medicine and contributes to effectively managing T2DM. As nutrition advocate Ann Wigmore famously observed, *“the food you eat can either be the safest and most powerful form of medicine, or the slowest form of poison.”* Used judiciously and alongside clinical care, this “food-as-medicine” orientation can help reduce treatment burden and improve glycaemic control.

Despite this understanding, only 9.5% of persons living with T2DM in Ghana (Ashanti region) have a good diabetes dietary adherence [7]. This is a concerning development. Against this background, a diabetes dietary adherence or self-care co-creation workshop was conducted to explore the nuances and propose solutions to policymakers.

## What is the aim of this policy brief?

The aim of this policy brief is to present evidence from a co-creation workshop with persons living with diabetes, family caregivers, and health stakeholders in Ghana, highlighting key barriers to diabetes dietary self-care and proposing practical, system-level policy actions.

## What did we do?

A participatory co-creation workshop was conducted to generate patient-centred and system-informed solutions to improve diabetes dietary self-care in Ghana. The workshop brought together about 110 participants encompassing persons living with diabetes, family caregivers, health

professionals (including diabetes specialist doctors, nurses and dietitians), policymakers/policy implementers, religious/faith leaders, journalists, and community stakeholders. Using facilitated group discussions and semi-structured interviews, participants shared lived experiences of diabetes management, identified barriers to dietary self-care, and collaboratively proposed practical strategies for strengthening care delivery. Focus group discussions explored challenges across individual, household, community, and health system levels, while interviews provided in-depth perspectives on caregiving, service access, and treatment decision-making.

The workshop emphasised equal participation, ensuring that patient and family caregiver voices informed solution development alongside healthcare professional perspectives. All discussions were audio-recorded with consent, transcribed verbatim, and analysed using content analysis to identify key themes and actionable policy priorities.

Ethical approval for this study was granted by both the University of Huddersfield's School Research Ethics and Integrity

Committee (SREIC; Approval ID: SREIC/2025/043) and the Committee on Human Research, Publication and Ethics (CHRPE) at the Kwame Nkrumah University of Science and Technology in Ghana (Approval ID: CHRPE/AP/561/25). All prospective participants received an information sheet together with a consent form, enabling them to review the study purpose and provide consent. On the day of the workshop, the key elements of the information sheet and consent form were reiterated to ensure clarity and to confirm verbal consent. All participant data were subsequently anonymised to safeguard confidentiality and protect individual identities.

## Key findings from the co-creation workshop

### 1. Knowledge of dietary self-care exists, but adherence is structurally constrained.

Participants demonstrated strong awareness that dietary self-care is central to effective diabetes management, often describing diet as more important than medication for controlling blood glucose levels. However, translating this knowledge into consistent practice remains difficult. Many individuals reported irregular eating patterns due to work schedules, limited household support for meal preparation, and reliance on convenient but unhealthy foods. Some participants experienced hypoglycaemic symptoms as a result of delayed or insufficient meals, underscoring how structural constraints, rather than lack of knowledge, undermine adherence to recommended dietary practices.

### 2. Family caregivers experience high emotional burden and receive conflicting information in their caregiving roles towards their loved one with diabetes

The co-creation process revealed that while family caregivers play a critical role in diabetes management, they experience significant emotional and practical burdens. Many described caregiving as stressful and exhausting, particularly when combined with other household responsibilities. Their efforts are further complicated by exposure to conflicting information from family members, online sources, and community narratives, including claims about herbal treatments. This fragmented information environment creates confusion and weakens confidence in professional dietary guidance, making it difficult to sustain consistent household-level dietary practices.

### 3. Health system barriers and financial hardship significantly impede self-care

Health system inefficiencies and financial hardship emerged as major barriers to diabetes dietary self-care. Participants reported long waiting times at health facilities, limited availability of dietitians, and centralised services that require patients to travel to higher-level hospitals for routine care. Financial constraints were widespread, with many unable to afford medications, glucose monitoring equipment, or recommended foods. These challenges often result in delayed care-seeking, medication rationing, and inconsistent follow-up.

## Participant Voice Box

### Key findings #1

*“When you have diabetes, dietary adherence is more important than the medications.” (PLWD 7)*

*“By the time I get home and prepare my meal, it is always late in the evening... because of this, we are compelled to eat unhealthy foods.” (PLWD 1)*

### Key findings #2

*“Taking care of relatives living with diabetes is sometimes stressful and causes burnout. That is one thing I have noticed. It is very stressful” (FCG 3)*

*“I am a relative who is helping a patient. There are times when you visit the dietitian, and they educate you on the foods to eat. When you return, other relatives see unreliable information elsewhere, which often contradicts what the doctor said, and result in some confusion about what to do.” (FCG 5)*



### Key findings #3

*“The whole municipality had only one dietitian. It is very, very serious. If a whole municipality will have only one dietitian, it's scary” (HPM 5)*

*“The prices are high and even sometimes, if the food is not in season, it's difficult to purchase because the small ones that they have in the market will be expensive and that also affects adherence” (PLWD 2)*

PLWD: person living with T2DM; HPM: Health policymaker;  
FCG: Family caregiver

## Policy action matrix for strengthening diabetes dietary self-care in Ghana

| SN | Recommendation   | Lead Agency   | Key Indicators  |
|----|--|---|---|
| 1  | Decentralise routine diabetes services to primary healthcare facilities (Community-based Health Planning and Services [CHPS], health centres, district hospitals). | Ghana Health Service (GHS); Municipal/ District Health Directorates | Proportion of CHPS facilities providing basic diabetes services; number of primary facilities offering dietary counselling. |
| 2  | Establish clear referral pathways to dietitians and integrate dietary counselling into frontline care.   | Ministry of Health (MoH); GHS                                       | Number of facilities with documented referral protocols; percentage of diabetes patients referred to dietitians.            |
| 3  | Formalise family caregiver involvement in diabetes consultations and education sessions.   | GHS; Facility Managers  | Percentage of diabetes visits with family caregivers present; number of caregiver education sessions conducted.             |
| 4  | Implement short message service (SMS)-based appointment reminders and follow-up systems.   | District Health Directorates  | Number of facilities using SMS reminders; Reduction in missed appointments.   |
| 5  | Deploy additional dietitians and train frontline health workers in basic dietary counselling.  | MoH; GHS Human Resource Directorate                                 | Dietitian-to-patient ratio; number of nurses trained in dietary counselling.  |
| 6  | Expand National Health Insurance Scheme (NHIS) coverage to include glucometers, test strips, and essential diabetes medications.                                   | National Health Insurance Authority (NHIA); MoH                     | NHIS benefit package updated.   |
| 7  | Introduce targeted subsidies or voucher schemes for low-income persons living with diabetes.   | MoH; Ministry of Gender, Children and Social Protection             | Number of beneficiaries enrolled; reported reduction in financial barriers.   |
| 8  | Implement community engagement and misinformation reduction campaigns involving the media, religious, community and traditional leaders.                           | GHS Health Promotion Unit; District Assemblies                      | Number of community sessions held; number of community radio and information systems accurately educating the populace.     |
| 9  | Strengthen community outreach and home-based follow-ups for vulnerable patients.   | District Health Directorates; CHPS Zones                            | Number of home visits conducted; improvement in follow-up attendance.   |
| 10 | Integrate diabetes dietary self-care indicators into routine District Health Information Management System (DHIMS) reporting.                                      | GHS Policy Planning Monitoring and Evaluation Division              | Inclusion of dietary counselling indicators in DHIMS; availability of routine monitoring data.                              |

## Conclusion

Improving diabetes dietary self-care in Ghana requires shifting from patient-blame models to system-strengthening approaches. Patients and family caregivers are ready to engage. What is needed now is coordinated policy action to decentralise services, integrate family caregivers, strengthen dietetic support, and reduce financial barriers. Investing in these measures will improve glycaemic control, reduce complications, and lower long-term healthcare costs.

## Acknowledgements

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