World Health Organization
REGIONAL OFFICE FOR Africa

WHO COUNTRY COOPERATION STRATEGY 2008-2011

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ABBREVIATIONS

ADB	:	African Development Bank
CCS	:	Country Cooperation Strategy
DOTS	:	directly-observed treatment short course
DPs	:	development partners
DWHIS	:	District-Wide Health Insurance Scheme
GBS	:	General Budget Support
GDP	:	Gross Domestic Product
GHS	:	Ghana Health Service
GPRS	:	Growth and Poverty Reduction Strategy
HIPC	:	heavily-indebted poor country
HIRD	:	High Impact Rapid Delivery
IGF	:	internally-generated funds
IMCI	:	Integrated Management of Childhood Illness
IPO	:	International Programme Officer
IST	:	Intercountry Support Team
JICA	:	Japanese International Cooperation Agency
MDBS	:	Multi-Donor Budget Support
MDGs	:	Millennium Development Goals
MOFEP	:	Ministry of Finance and Economic Planning
MoH	:	Ministry of Health
NCD	:	noncommunicable disease
NHIS	:	National Health Insurance Scheme
NHIF	:	National Health Insurance Fund
NPO	:	National Programme Officer
5YPOW	:	Five-year Programme of Work
SBS	:	Sectoral Budget Support
STI	:	sexually-transmitted infection
SWAp	:	sector-wide approach
UNDAF	:	United Nations Development Assistance Framework
UNDP	:	United Nations Development Programme
UNESCO	:	United Nations Educational, Scientific and Cultural Organization
UNICEF	:	United Nations Children's Fund
USAID	:	United States Agency for International Development
VPD	:	vaccine-preventable disease
WB	:	World Bank
WCO	:	World Health Organization country office
WHO	:	World Health Organization

PREFACE

The WHO Country Cooperation Strategy (CCS) crystallizes the major reforms adopted by the World Health Organization with a view to intensifying its interventions in the countries. It has infused a decisive qualitative orientation into the modalities of our institution's coordination and advocacy interventions in the African Region. Currently well established as a WHO medium-term planning tool at country level, the cooperation strategy aims at achieving greater relevance and focus in the determination of priorities, effective achievement of objectives and greater efficiency in the use of resources allocated for WHO country activities.

The first generation of country cooperation strategy documents was developed through a participatory process that mobilized the three levels of the Organization, the countries and their partners. For the majority of countries, the 2004-2005 biennium was the crucial point of refocusing of WHO's action. It enabled the countries to better plan their interventions, using a results-based approach and an improved management process that enabled the three levels of the Organization to address their actual needs.

Drawing lessons from the implementation of the first generation CCS documents, the second generation documents, in harmony with the 11th General Work Programme of WHO and the Medium-term Strategic Framework, address the country health priorities defined in their health development and poverty reduction sector plans. The CCSs are also in line with the new global health context and integrated the principles of alignment, harmonization, efficiency, as formulated in the Paris Declaration on Aid Effectiveness and in recent initiatives like the "Harmonization for Health in Africa" (HHA) and "International Health Partnership Plus" (IHP+). They also reflect the policy of decentralization implemented and which enhances the decision-making capacity of countries to improve the quality of public health programmes and interventions.

Finally, the second generation CCS documents are synchronized with the United Nations development Assistance Framework (UNDAF) with a view to achieving the Millennium Development Goals.

I commend the efficient and effective leadership role played by the countries in the conduct of this important exercise of developing WHO's Country Cooperation Strategy documents, and request the entire WHO staff, particularly the WHO representatives and divisional directors, to double their efforts to ensure effective implementation of the orientations of the Country Cooperation Strategy for improved health results for the benefit of the African population.

Dr Luis G. Sambo
WHO Regional Director for Africa

EXECUTIVE SUMMARY

The World Health Organization Country Cooperation Strategy (CCS) defines the medium-term (six-year) strategy for the work of WHO with Ghana and is guided by national and international public health priorities. It provides a framework for cooperation between WHO, Ministry of Health and development partners, and forms the basis of biennial workplans defining WHO's expected results and activities in the country. This second generation CCS (CCS II) covers the period 2008-2011.

The Ghanaian economy has been growing by 5.5% per year since 2004. As a result of this steady growth and initiatives outlined in Ghana's growth and poverty reduction strategies, the incidence of poverty has declined from 52% in 1992 to 29% in 2006. Ghana's current goal is to achieve middle-income status by 2015.

The health sector reflects the essential contribution of good health to economic prosperity in its 2007 National Health Policy and Five-year Programme of Work (2007-2011) whose central theme is "creating wealth through health". To this end, important health sector reforms have included the adoption of a sector-wide approach in 1997 and development of a national health insurance scheme ((2005) designed to provide universal access to basic health care. A strong health sector dialogue, active participation of development partners and civil society in the sector and institutionalized mechanisms for participation and coordination of partners have contributed to improving health indices in recent years.

Despite this performance, Ghana remains off-target for achieving the health-related Millennium Development Goals. Communicable diseases such as malaria, HIV/AIDS, tuberculosis and vaccine-preventable diseases remain the main causes of child mortality. The country remains prone to outbreaks of meningitis, cholera and guinea worm. Maternal mortality has recently been declared a national emergency and is currently a major priority for government and development partners. Health system weaknesses such as insufficient human resources, especially in rural areas with vulnerable populations, poor access to essential medicines and health technology, and insufficient financing all constrain our collective efforts to achieve MDGs 4, 5 and 6.

In its first generation CCS (2002-2005), WHO focused on health systems strengthening, improving health management and information systems, scaling up priority interventions and health promotion. A broad survey of WHO's partners in Ghana suggested that the performance of WHO core functions during the implementation of CCS 1 was between "good" and "very good". Lowest qualitative scores were obtained for promoting the research agenda and for supporting evidence-based policy. Important challenges identified in the CCS I include insufficient priority given to health systems strengthening, confusion by some programme managers at the Ministry of Health around the WHO's mandate and activities in the country, lack of harmonization among some of the development partners, weak supervision and monitoring and insufficient support for building the technical capacity of WHO country office staff.

CCS II builds on the successes of, and challenges identified in, CCS I. It was developed through extensive consultations with government, development partners and civil society. The CCS II identifies three priority and seven strategic areas which will be the focus of WHO's work in Ghana between 2008 and 2011. The three priority areas include Health

Security; Health System Capacity and Performance; and Partnerships, Governance, Gender and Equity. These, and the seven strategic focus areas, are closely aligned with Ministry of Health's strategic priorities outlined in the National Health Policy and the Five-Year Programme of Work. The CCS 2008-2011 is aligned with Ministry of Health's programmes both chronologically and in substance.

The WHO country office will focus on its core functions to support the Ministry of Health to achieve these strategic priorities. We will continue to develop the capacity of our local staff and to solicit the technical, administrative and financial support of the Intercountry Support Teams, the Regional Office and Headquarters. By focusing on the key elements of Health Security, Systems Strengthening, and Partnerships, we expect that WHO will provide the effective support where it is most needed, and that together we will achieve health-related Millennium Development Goals and realize Ghana's vision of "creating wealth through health".

SECTION 1

INTRODUCTION

The WHO Country Cooperation Strategy (CCS) defines the medium-term (six-year) strategy for the work of WHO at country level. The Country Cooperation Strategy for Ghana describes how the three levels of WHO, namely Headquarters, WHO Regional Office for Africa and Country Office, will work to achieve the country's health sector objectives.

The first CCS (CCS I– 2002-2005) outlined four major areas of cooperation, namely: Health System Strengthening; Scaling up of Priority Health Interventions; Strengthening Health Management Information System and Surveillance; and Health Promotion. These were selected to provide close support to the Growth and Poverty Reduction Strategy 2001-2005, the Medium-term Health Strategy, and the health sector's second Five-year Programme of Work 2001-2006.

This second generation Country Cooperation Strategy (CCS II) builds on the successes and failures of CCS I to increase the effectiveness of WHO and improve its responsiveness to national needs and priorities. The CCS II reflects the changing aid environment embodied in the Paris Declaration and the Accra Agenda for Action. The 2008-2011 timeline of the CCS II was selected to align with Ghana's Health Sector Programme of Work and with the UNDAF which, at the time of writing of this CCS, was to be extended by one year to 2011. The CCS II therefore provides an opportunity for WHO to align with government priorities and harmonize activities with other development partners. The CCS will focus on supporting the priority needs of Ghana for which WHO has a comparative advantage among the development partners.

The CCS II has been guided by national and international priorities outlined in:

(a) The Millennium Development Goals;

(b) Ghana's third health sector Five-year Programme of Work (2007-2011);

(c) Ghana's second Growth and Poverty Reduction Strategy (GPRS II) 2006 -2009;

(d) The United Nations Development Assistance Framework (UNDAF II 2006-2010) and the Common Country Assessment;

(e) The WHO Eleventh General Programme of Work 2006–2015;

(f) The WHO Medium-term Strategic Plan 2008-2013;

(g) Strategic Orientations for WHO Action in the African Region, 2005–2009.

To develop the CCS II, extensive consultations were held with senior officials of the Ministry of Health, the Director-General of the Ghana AIDS Commission, the leadership of the Coalition of NGOs in Health and the Christian Health Association of Ghana, heads of training institutions, including the Provost of the College of Health Sciences, Principal of the School of Public Health, Rector of the Postgraduate College of Surgeons and Physicians and the Registrar of the Nurses and Midwives Council. The Ministers of Health, Local Government and Women and Children's Affairs were also consulted. Discussions were held with the heads of UN agencies, the World Bank, Department for International Development/ Netherlands Embassy, Danish International Development Assistance, JICA, USAID and the European Union, as well as representatives from academia and trade unions.

SECTION 2

COUNTRY HEALTH AND DEVELOPMENT CHALLENGES

2.1 BRIEF INTRODUCTION TO GHANA

Ghana is located on West Africa's Gulf of Guinea with a total land area of 238 533 km^2 and a total population estimated at 21 029 853[1]. Ghana has ten administrative/political regions which are further divided into 170 District Assemblies. The District Assemblies develop, plan and mobilize resources for plans, programmes and strategies for the development of the district. The political situation is stable, with presidential and legislative elections every four years. The transition of power between political parties took place without any incident in 2000 and 2008.

2.2 BROAD DESCRIPTION OF DEVELOPMENT STATUS AND CHALLENGES

The country's economy is dominated by agriculture and the service sector which contribute 42% and 38% of Gross Domestic Product (GDP) respectively. Ghana's GDP per capita is US$538, and it was classified as one of the 41 heavily-indebted poor countries (HIPCs) in the late 1990s. As a result of good monetary and fiscal policies and a favourable international economic environment, the economy has been growing steadily by at least 5.5% per year since 2004[2]. This positive growth has not been felt by most Ghanaians due to increasing interpersonal, inter-regional, inter-ethnic and gender inequalities. Programmes such as the Lively Empowerment Against Poverty, School Fees Capitation grants, free health care for pregnant women and the National Health Insurance Scheme (NHIS) are being implemented to further reduce poverty levels and disparity and to create wealth. Poverty levels in Ghana decreased from 51.7% in 1991-1992 to 28.5% in 2005-2006. Extreme poverty has also declined from 36.5% to 18.2% over the same period[3].

Ghana developed and implemented GPRS I which resulted in outright debt cancellation of US$2 billion in July 2004 and provided the opportunity for a further US$2 billion to be forgiven in instalments over the next twenty years. The government developed GPRS II 2006-2009 which focuses on "accelerated growth as a means of wealth creation, poverty reduction and equitable social development". The central goal of the country's economic policy is to achieve middle-income status (GDP per capita of US$1000) by 2015. This vision is guided by three strategic pillars: private sector competitiveness, human resource development, and good governance and civic responsibility.

[1] Extrapolated from the 2000 census which revealed a population of 18 412 247 with an annual growth rate of 2.7%.

[2] GDP growth rates: 2000:4.4%; 2001:4.2%; 2002:4.5%; 2003:5.2%; 2004:5.8%; 2005:5.8%; 2006:6.2%; 2007:6.3%; 2008:6.2% (Sources- *Budget Statement and Economic Policies of Government of Ghana).*

[3] Ghana Living Standards Survey (GLSS 5) 2005/2006, Ghana Statistical Service.

2.3 THE HEALTH SECTOR

The health sector adopted the sector-wide approach (SWAp) principles in its 1996 sector reform process with the active participation of government, partners, civil society and the private sector. As a result of this reform, the Ministry of Health (MoH) retained responsibility for policy formulation, monitoring and evaluation, resource mobilization and regulation of health service delivery. The Ghana Health Service (GHS) was created to assume responsibility for service delivery and implementation of the health policies and programmes designed by the ministry. To make the health sector more responsive, all public-owned health institutions, divisions, facilities and agencies were given responsibility for their own planning, budgeting, implementation, monitoring and evaluation. National, regional, district, sub-district and community levels are organized to implement the Five-year Plan of Work (5YPOW) which is developed by the ministry and all key partners/stakeholders. The private sector and NGOs, including the Christian Health Association of Ghana, provide over 40 per cent of health care in Ghana, especially in the rural areas.

A common management arrangement has been developed in which partners and stakeholders participate in sector dialogues and develop sector plans. A joint planning, budgeting, supervision, monitoring and reporting framework is available and there is joint ownership of most processes and products of the sector.

In 2005, Ghana introduced the National Health Insurance Scheme (NHIS)[4] to improve financial accessibility to health care. The NHIS is administered peripherally through District-Wide Health Mutual Insurance Schemes (DWHIS). The scheme is tax-based[5] and covers most services offered at the district hospital level. Despite a number of constraints, it has registered over 50% of Ghana's population. In 2008, free maternal care was included in the range of services covered by the NHIS.

Life expectancy at birth is 57.5 years on average (55.4 years for men and 59.6 years for women). Ghana is experiencing an epidemiologic transition with an increasing prevalence of noncommunicable diseases. The major causes of child mortality include malaria, diarrhoea, and upper respiratory infection[6]. HIV infection, hypertension, diabetes mellitus and road traffic accidents are major causes of mortality in adults[7]. Low level of literacy, poor sanitation, under-nutrition, alcohol abuse, sedentary life styles and unhealthy diets constitute the broad determinants of ill-health contributing to high mortality rates.

2.4 BURDEN OF COMMUNICABLE DISEASES

Malaria

Malaria is the leading cause of morbidity and mortality in children, accounting for about 40% of all outpatient attendance at health facilities in 2007[8]. The multiple strategies adopted for malaria control have been moderately successful. Insecticide-treated bednet use by children under five years of age and pregnant women has increased as a result of their distribution during integrated mass campaigns and Child Health Weeks during which over three million were distributed. The antimalaria drug policy was reviewed in 2004 and the artemisinin-based combination therapy became the recommended therapy.

[4] National Health Insurance Act 650 and LI1809; Sept 2003.
[5] NHI is funded by 2.5 % SSNIT contribution of workers; 2.5% value-added tax levy of selected goods and services and minimum premium of 7.2 Ghana cedi (US$ 7.74) per annum from informal workers.
[6] 2007 Annual Report, Ghana Health Service.
[7] 2007 Annual Report, Ghana Health Service.
[8] 2007 Annual Report, Ghana Health Service.

Tuberculosis

Moderate progress has been made in the control of tuberculosis with cure rates for new smear positive TB increasing from 22% in 1996 to 76% in 2006[9]. Case detection (33% for 2007) and defaulter rates (6.4% for 2007) have also been improving since 2001. The high defaulter rate in Western Region (21.8%) is worrisome given the possibility of multi-drug resistant forms of TB. A new integrated policy has been developed to address the challenge of HIV- TB coinfection and the emerging threat of TB drug resistance.

HIV/AIDS/sexually-transmitted infections

The HIV/AIDS epidemic is stable though firmly established within the society. HIV prevalence among pregnant women in Ghana has declined from 3.6% in 2003 to 2.6% in 2007 according to Sentinel Surveys. Strategies including behaviour change communication, prevention of mother-to-child-transmission, the provision of treatment care and support (Highly-Active Antiretroviral Therapy) have been implemented. The major challenges to achieve Millennium Development Goal (MDG) 6 are improving surveillance and scaling up access to treatment.

Neglected tropical diseases (NTDs)

The number of cases of guinea worm has decreased dramatically from 3358 in 2007[10] to 501 in 2008; disease transmission is now limited to the Northern Region which reported 96% of Ghana's total cases in 2008. Microplans have been developed to improve surveillance, case containment and effective vector control. Various water projects have targeted endemic communities. Effective surveillance in recently guinea-worm-freed and high-risk areas and behavioural change are major challenges for eradication.

Other neglected tropical diseases prevalent in Ghana include lymphatic filariasis, onchocerciasis, soil transmitted worms, schistosomiasis, trachoma and leishmaniasis. While trachoma control has attained break of transmission, about half of the country's population is at risk of the remaining four NTDs.

2.5 NONCOMMUNICABLE DISEASES AND MENTAL HEALTH

The prevalence of noncommunicable diseases (NCDs) such as diabetes mellitus, asthma, hypertension and other cardiovascular diseases is rising in Ghana as a result of increasing life expectancy, abuse of alcohol, tobacco use, poor dietary habits, inadequate physical activity and increasing stress. Newly reported cases of injuries, cardiovascular diseases and musculoskeletal disease steadily increased from 1998 to 2003 (Report on a national forum on integrated control and prevention of NCDs and injuries, GHS 2005). Currently, it is estimated that NCDs constitute over 20% of all cases of outpatient attendance (Ghana Macroeconomic and Health Initiative). The government's new policy on regenerative health and nutrition is expected to provide the basis for prevention and management of NCDs. This programme focuses on healthy eating, improving food safety, regular exercise, drinking potable water, rest, improving environmental sanitation, improving personal hygiene and ensuring lifestyles that promote health.

[9] NTP Annual Report 2007.
[10] National Guinea Worm Database, 2008.

The recent rise in injuries due to road traffic accidents and violence is worrying. Road traffic crashes and fatalities increased by 3 per cent and 4 per cent respectively in 2006 and 2007 and are estimated to cost the nation 1.6% of its GNP. A National Ambulance Service has been initiated but emergency response services are inadequate.

In Ghana, approximately 650 000 people suffer from a severe mental disorder and a further 2 166 000 from a moderate to mild mental disorder. Yet the treatment gap for severe mental disorders is estimated to be as high as 95% and the gap is even larger if one includes people with moderate to mild mental disorders (WHO country summary series; Ghana 2007). In addition to the lack of access to care, there are issues of serious human right violations against people with mental disorders. Great efforts are being made to address the lack of access to community care, the over-reliance on institutional care, and human right violations through the drafting of a new mental health law. This law is yet to be approved by Parliament.

2.6 MATERNAL AND CHILD HEALTH

Maternal health

The MoH has declared maternal mortality a national emergency and has made MDG 5 a national priority. The Ghana Maternal Health Survey (2007) estimates the MMR to be 451 per 100 000 live births. Ninety-six per cent of pregnant women in Ghana receive antenatal care from a trained provider while only 55 per cent are delivered by a skilled provider. Socio-cultural beliefs and practices which discourage institutional delivery, inadequate knowledge of danger signs of pregnancy, poor referral systems, lack of transportation and communication infrastructure permitting the transfer of obstetric emergencies, inadequate numbers of skilled attendants and lack of equipment and supplies account for the three major delays[11] which are responsible for the high maternal mortality ratios. The Ministry of Health and partners have responded with the introduction of the High Impact Rapid Delivery (HIRD) approach, aimed at using an integrated intervention approach to reduce the morbidity and mortality of mothers and children.

Child and adolescent health

The under-five mortality rate in Ghana is high (111/1000 live births) with worsening neonatal mortality rates. The Demographic and Health Survey 2003 indicates an increase in neonatal mortality rates over the preceding 15 years from 38/1000 live births to 43/1000 live births in 2003. Most childhood deaths are caused by malaria (26%), pneumonia (18%), diarrhoea (18%) and neonatal factors (38%).

Health issues affecting adolescents in Ghana include inadequate nutrition, early initiation of sexual activity, unprotected sexual activity and its consequences – sexually-transmitted infections (STI) and HIV –, unwanted pregnancies and complications of abortion. In addition, adolescents are at risk of substance abuse, mental illness and injuries. Adolescent Health Friendly Services are limited and under-used at all levels.

[11] The three major delays responsible for maternal deaths are (i) delay in the decision to seek care; (ii) delay in transportation to a health care facility; and (iii) delay in receiving appropriate care at the health care facility.

Nutrition

The prevalence of malnutrition remains high but is decreasing. Between 2003 and 2006, the prevalence of stunting among children under the age of five declined from 29% to 22% and that of underweight declined from 22% to 18% between 2003 and 2006. The prevalence of low birth weight among infants with known birth weight also declined from 7% in 2004 to 6% in 2006. The Demographic and Health Survey 2003 shows that 77% of children aged 6-59 months and 47% of women aged 15-49 years were anaemic.

2.7 IMMUNIZATION AND VACCINE-PREVENTABLE DISEASES (VPD)

The WHO has supported the Reaching Every District (RED) approach and vaccine-preventable disease surveillance to achieve an improvement in performance indicators. National coverage with the 3rd dose of the pentavalent vaccine was 88% in 2007 compared to 76% in 2004. Measles coverage was 89% in 2007, up from 78% in 2004; 71% of pregnant women had received at least two doses of tetanus toxoid in 2007 compared to 61% in 2004.

The burden of vaccine-preventable diseases is declining. No measles deaths have been reported following a 2003 national campaign targeting children of less than 15 years of age. Acute flaccid paralysis surveillance for polio eradication remains weak in some regions, decreasing nationally from a rate of 1.7 cases detected/100 000 children in 2005 to 1.52 cases/100 000 in 2007. Despite this deterioration, no wild polio cases were detected in Ghana from 2003 to 2007 as a result of improving routine immunization and integrated maternal/child health campaigns. Ghana successfully presented documentation for polio free status at the 9th annual general meeting of the African Regional Polio Eradication Certification Committee.

2.8 INTEGRATED DISEASE SURVEILLANCE AND RESPONSE AND EMERGENCY PREPAREDNESS AND RESPONSE

Cholera has become endemic in the country and there have been outbreaks every year over the last six years. Nine regions reported a total of 3 386 cases with 108 deaths in 2006 giving a case fatality rate of 3.2%. Access to safe drinking water especially in urban slums is paramount if this situation is to be reversed. Periodic outbreaks of cerebrospinal meningitis occur, particularly in the northern regions of the country and widespread epidemics remain a public health threat.

2.9 ENVIRONMENTAL HEALTH

Access to water and sanitation services is improving; coverage by functioning water facilities in rural areas has risen from less than 30% of the population in 1994 to slightly more than 50% in 2005. Urban water supply coverage is currently estimated at 58%. Providing adequate water and sanitation cannot keep pace with the rapid expansion of urban settlements.

2.10 HEALTH PROMOTION

In Ghana, ageing and changes in lifestyles associated with tobacco and alcohol use, physical inactivity, poor eating habits and road traffic accidents are causing a silent epidemic of chronic diseases in the country. National capacity has been strengthened to plan, implement and evaluate setting-based health promotion programmes for the reduction of the risks

associated with leading causes of death, diseases and disability. Advocacy for the development of policies for promoting healthy lifestyles is now receiving favourable response.

2.11 HEALTH SYSTEM RESPONSE

Health policy, strategies and programme of work

The 2007 National Health Policy proposed seven priority areas to address sector objectives, concerns and challenges:

(a) Promoting healthy lifestyles and healthy environments;
(b) Promoting health, reproduction and nutrition services;
(c) Investing equitably in capacity development for health delivery;
(d) Promoting the use of information for planning and management;
(e) Ensuring sustainable and equitable financing;
(f) Promoting a local health industry;
(g) Ensuring good governance and partnership.

On the basis of this National Health Policy, the third Five-year Programme of Work (5YPOW) 2007-2011 has been developed with the same theme as the national health policy *"Creating wealth through health"*. The focus of the POW is to re-energize and scale up the delivery of priority interventions for human capital development and thereby contribute to wealth creation and poverty reduction in line with the country's GPRS.

The 5YPOW is composed of four main strategic objectives:

(a) **Healthy lifestyles and the environment:** Promoting healthy individual lifestyle, behavioural models, environmental and occupational health and safety.
(b) **Healthy reproduction and nutrition services:** Rapidly scaling up high impact health, reproductive and nutrition interventions targeting vulnerable groups.
(c) **General health systems development:** Strengthening the health system to expand, manage and sustain a high coverage of quality health interventions and services for promoting health, preventing diseases, treating the sick and rehabilitating the disabled.
(d) **Governance and financing:** Promoting good governance and ensuring sustainable financing at all levels of the health sector.

Medicines and health technology

Access to basic essential medicines has improved due primarily to the NHIS. Proliferation of counterfeit medicines poses a huge burden for medicines regulation and therefore the need for the regulatory agency to build capacity in post-market surveillance. Efforts to improve access to medical products and technologies continue to face major challenges in a rapidly changing national and international policy environment.

Institutionalization of traditional medicine into the health system has taken great strides in the country. The Food and Drugs Board, the Centre for Scientific Research into Plant

[12]http://www.moh-ghana.org/moh/docs/reports/