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It Takes Two to Tango: Ghana Health Service and Civil Society Organisation Collaboration in Health Service Delivery in the Upper West Region, Ghana

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Abstract

This study examines the state of inter-sector collaboration in health care delivery between the Ghana Health Service (GHS) and Civil Society Organizations (CSOs) in the Upper West Region. Data was collected through semi-structured interviews. A combination of probability and non-probability sampling strategies were used to sample thirty-eight (38) respondents for the study. Data was analysed thematically. The study found that the level of collaboration between the GHS and CSOs particularly the local CSOs is weak. This has been attributed to major constraints such as limited capacities, a fragmented civil society sector and lack of effective monitoring mechanisms. These constraints notwithstanding, the study also found that there have been several benefits of the collaboration process. These include capacity building (training of staff of both the CSOs and GHS), and huge capital and social investments in the public health. It is recommended that the GHS build upon existing relationships with the CSOs, especially the local ones.

Keywords: *Collaboration, civil society organizations, health services delivery, Upper West Region*

1. Introduction

Recent decades have witnessed increasing numbers in civil society organisations that support health care institutions in the provision of health services, more especially in less developed countries. As a result, inter-sector collaboration has been touted as key to improving health sector performance and promoting social and economic development (World Health Organization [WHO], 1997). According to Osborne (2000), inter-sector collaborations in the development agenda of most countries have proved to be the most cost efficient and effective means in the implementation of policies. Evidence from case studies also shows that civil society participation and volunteerism are crucial in improving health service delivery (Green, 2007; Atienza, 2004). Accordingly, development policies are increasingly incorporating inter-sector collaborations, right from the design to the implementation and evaluation stages.

Despite the many post-independence accomplishments in health services delivery, developing countries especially in Africa still grapple with numerous health care challenges (Adeleye and Ofili, 2010; Osborne, 2000). Such challenges have always threatened the functioning of the health care systems of these countries. In the face of such difficulties, health-care policymakers have urged more cooperation and collaboration between sectors. The role of CSOs has therefore been heralded under the present era of global development. Collaborations among the various sectors, it is argued, will complement governments' efforts and accelerate development, especially in the area of health.

However, deriving the benefits from such inter-sector collaborations is hinged on a number of factors. It has been observed that a major challenge to the success of such collaboration has been that the concept itself is often misunderstood by the players (Adeleye and Ofili, 2010). In addition, the activities of the collaborators including civil society organisations have often not been well coordinated and harmonized in such a manner that is capable of effecting desired results (Adeleye and Ofili, 2010). As such, the implementation of such inter-sector cooperation leaves much to be desired (Osborne, 2000). At other times too some of the CSOs, especially the international ones, disregard national governments and their development policies and implement/support separate programmes that have little bearing on the health priorities of their catchment areas (Green, 2007; Yeboah, 2003; Osborne, 2000).

Ghana has had its fair share of such collaborations in its health sector with the influx of CSOs, but its experience over the years indicates mixed results (Yeboah, 2003). There is particularly little information in this regard on the Upper West Region. The region has attracted a lot of attention from many CSOs with health-based activities over the years, yet it has consistently

performed poorly in many of the health indicators in the country (Ghana Statistical Service [GSS], 1998, 2003, 2008). This raises questions about the nature of inter-sector collaboration between the GHS and these CSOs and the effect it has on the health sector in the region. The study thus examines the inter-sector collaboration between the GHS and the CSOs within the context of health policy planning and implementation, with the view to finding out the effectiveness and constraints of such collaboration in the Region.

Research Methodology

The study targeted CSOs in the Upper West Region whose area of operation is in health in order to determine the nature of inter-sector collaboration that exists between them and the GHS, and to assess the opportunities and challenges the collaboration entails. Five districts in the region (Nadowli, Lawra, Wa, Sissala East and Jirapa) were purposively sampled for the study. The criteria used for sampling the districts included the types of CSOs operating in the district and the nature of CSO activity in relation to health services support. The CSOs were selected based on the following criteria: *the CSO should have been operating in the region for at least a year prior to the inception of this study, and it should have had health as a major programme area*. Thirty-two (32) CSOs were purposively sampled, including one NGO Network. The GHS was considered as an independent population. Six (6) respondents from the Regional and District Directorates were selected. The District Directorates were involved because they were seen as pivotal in identifying implementation issues relevant to the collaboration process. They are very close to where these CSOs implement their programmes and projects and as a result they were in the right position to provide vital information concerning the activities of these organisations in their districts.

The compilation of secondary data constituted a desk study. This type of data came from project reports of the selected organisations and the Ghana Health Service. Data was collected from the GHS directorates and the CSOs through interviews. The contact persons that were interviewed from the CSOs occupied senior manager positions.

Results and Discussionns

Nature of CSOs in the selected districts

Table 1 illustrates the types of CSOs. The majority of CSOs are Local/Indigenous organizations, constituting 67.7%, while the remaining 32.3% constitute International CSOs. The strengths each type of organisation brings to the collaborative process with the Ghana Health Services are discussed later in the study. Table 2 gives the distribution of the CSOs by district. The table shows that the majority of CSOs are within the Wa Municipality. The concentration of CSOs within the Wa Municipality is not informed by the health needs of the population of that area but is borne out of the sheer need for physical infrastructure and easy access to some of their partners. Table 3 depicts the sources of funding for the CSOs. The majority of CSOs (71%) rely on foreign donors to fund their operations.

Table 1: Type of CSOs

Type of CSO	No. of CSOs	Percent
International/Foreign	10	32.3
Local/Indigenous	21	67.7
Total	**31**	**100.0**

Table 2: District(s) of operation of CSOs

District	No. of CSOs	Percent
Wa Municipality	11.0	35.5
Nadowli District	5.0	16.1
Lawra District	4.0	12.9
Sissala East District	7.0	22.6
Jirapa District	4.0	12.9
Total	**31.0**	**100.0**

Table 3: CSOs and their Source of Funding

Major Sources	Frequency	Percent
Local Donor Organisations	7	22.6
Foreign Donor Organisations	22	71
Internally Generated Funds	2	6.4
Total	**31**	**100.0**

Contribution of CSOs to Health and the Extent of their Collaboration

CSOs were reported to be contributing immensely to the health needs of the people of the region through their collaborative efforts with the GHS. Table 4 summarizes the specific areas CSOs collaborate with the GHS. As can be observed, the main areas of engagement include, among others, capacity building (training) of the staff of the GHS and other CSOs; supply of equipment and other logistics to aid health service programme activities; health education and social mobilization on key health issues; HIV/AIDS awareness and sensitisation programmes; monitoring and evaluation of health programmes; reproductive health; food supplementation; and relief services. Funding within the health sector has always been dwindling, thus making implementation of activities virtually impossible. The CSOs have played an active role in that direction by providing financial resources to the GHS to run its programmes.

The response of the NGO Desk Officer at the Upper West Regional Health Directorate (UWRHD) summarises the activities of CSOs in the region:

Table4: Areas of CSO contribution to Health in the Region

CSO	Area of Contribution
[I]Catholic Relief Services (CRS)	Ø They operate in FACS (Food Assisted and Child Survival Activities) communities and INAAM (“Integrated Nutrition Action against Malnutrition) project. Ø They support the Service with motor-bikes, bicycles, food, fuel and other logistics. Ø Supported the Districts with Food Aid for the FNI Centre for malnourished children.
[I]Danish International Development Assistance	Ø Supported districts with substantial funds to implement effective preventive measures to improve maternal and child health
[I]World Vision International	Ø Donates long lasting ITN for distribution free of charge to pregnant women. Ø Supplies fuel for organizing Mother-to-Mother support groups’ quarterly meetings and to support Trachoma drug distribution Ø Sponsors the districts’ World Breastfeeding week celebration Ø Donates detergents and other logistics for service delivery Ø Training of TBAs
[I]Japanese International Development Programme (JICA)	Ø Supporting the districts to scale up CHPS. Ø They provide motorbikes, bicycles, radio equipment and medical equipment for CHPS activities and one Nissan patrol vehicle. Ø Training of Community Health Officers (CHOs) for sub-district staff Ø Training on facilitative supervision for the DHA Ø Referral system for selected health staff. Ø The provision of basic equipment for service delivery including an ultra sound machine and an ambulance
[I]Plan Ghana	Ø Supports various health programmes in the districts they operate in. Ø Beside the specific support to the DHA and the District Hospital, a number of local CBOs working in health received support and training on various topics. Ø Until 2005, Plan Ghana focused their support in the Sissala West district, but the NGO has spread their support to the Sissala East and other districts in the region. Ø Plan Ghana in collaboration with Inter-Ministerial Coordinating Committee (MCC) and District Assembly jointly renovated a Voluntary Counseling and Testing Centre (VCT) to support in the expansion of HIV/AIDS activities in the district. Ø They have also recently rehabilitated the hospital maternity block and furnished a ward for children. Ø Constructed CHPS compounds and supported sub-districts with weighing scales for CWC activities. Ø They also donated a Television Set and playing materials for Adolescent Health, and trained TBAs
[L]YARO (Youth Action On Reproductive Order)	Ø Building capacities of groups such as TBAs and DSVs, with special attention to FP and HIV/AIDS campaigns Ø YARO conducts a Peer Education Programme on HIV/AIDS and mobilised communities who were trained as counsellors for HIV/AIDS. Ø Organising durbars to sensitize the people on PMTCT and VCT in the district
[L]Action For Sustainable Development (ASUDEV)	Ø ASUDEV contributes tremendously in mobilising people for VCT services. Ø This local NGO through their school campaigns organises youth groups who come in for counselling and testing.
[L]Rural Action Aid Programme (RAAP)	Ø Assists districts in social mobilization and HIV/ AIDS activities
[I]Action Aid	Ø Action Aid plays a key role leading to the formation of the association of people living with HIV/AIDS in the districts
[L]Hope for the Future Health of Women and Children (HFHWC)	Ø Advocacy and Research, Drug Abuse
[L]Open Hands for Health	Ø Health education especially on drug abuse and reproductive health
[L]Bahass	Ø HIV/AIDS and education on drug abuse
[L]Aged Foundation	Ø Water and Sanitation and education on drug abuse

[I]Save Ghana	Ø Environmental Sanitation, Water
[L]Rural Action Aid	Ø Reproductive health and HIV/AIDS
[L]People Action to win life all round	Ø Reproductive Health
[L]Water Vision	Ø Water and Sanitation
[L]Women Integrated Development Organisation (WIDO)	Ø Reproductive health, HIV/AIDS
[L]Wontaa Development Foundation	Ø Education and Sensitisation of Drug abuse
[I]ADRA	Ø Relief Services, HIV/AIDS, Guinea Worm
[L]Better Ghana Management Services	Ø Health education, health promotion and health information
[L]True Vision Ghana	Ø Recruitment of HIV/AIDS orphans for care and aid Ø Community advocacy, sensitisation and awareness on HIV/AIDS
[L]Ghana Red Cross Society	Ø Social mobilization for health care activities, particularly primary eye care and public health emergencies Ø Relief programmes
[L]Centre for Indigenous Knowledge and Development (CIKOD)	Ø HIV/AIDS and Indigenous medicine
[I]Care International	Ø Youth and reproductive health
[I]Netherlands Development Association (SNV)	Ø Water, sanitation and hygiene, and food security
[I]Child-Support Ghana	Ø Child Health and nutrition, and reproductive health
[I]Basic Needs	Ø Rehabilitation of mental health patients and general education on mental health
[L]Sungbawiera Foundation	Ø Youth and reproductive health, HIV/AIDS
[L]Centre for the Development of the People (CEDEP)	Ø Adolescent reproductive health, HIV/AIDS, Family Planning
[L]Social Enterprises Development (SEND) Foundation	Ø Mobilisation of communities to register with the NHIS programme, monitoring of the NHIS, HIV/AIDS, Health Research.

Our achievements could not have been made possible without the collaboration with many stakeholders. Many of these partners have supported the CHPS programme in the form of capacity building, provision of equipment and technical advice. NGOs such as the Catholic Relief Services, Basic Needs, Plan Ghana and World Vision Ghana have provided support in various forms. Funding within the health sector has always been dwindling, thus making implementation of activities virtually impossible. JICA and DANIDA supported the districts with substantial funds to implement effective preventive measures to improve maternal and child health in the districts. JICA for instance, has supported the districts in the region in terms of capacity building, supply of medical equipment and transport for CHPS operations and are still making efforts to provide funds for the construction of a CHPS compound.

To assess the extent of collaboration between CSOs and the GHS, the study adapted from Hogue (1993), Borden and Perkins (1998), and Frey et al. (2006) a simple scale for measuring the extent to which CSOs collaborate in the region to promote health care services delivery. The scale measures the level of collaboration over five stages. These stages are *Networking*, *Cooperation*, *Coordination*, *Coalition* and *Collaboration*. In a ranked order, *Networking* is the least of all the levels of collaboration and involves just an awareness of organisations, loosely defined roles, little communication and independent decision-making. As one gradually moves up the scale, the more one gets closer to *true* collaboration with another. Each of the stages has some requirements that must be met before one could consider oneself as being at that level of collaboration. Organisations could say they are operating at the highest level of collaboration only when they *belong to one system*, *where frequent communication among the group is characterized by mutual trust*, and where *consensus must be reached on all decisions*.

According to Yeboah (2003), two of the great pillars of sustainable collaborations are *mutual trust* and *respect*.

Mutual trust comes along with *sharing information* on a voluntary basis, full disclosure of financial and other resources, and joint planning and implementation of health programmes. Another question that is very important in defining the levels of collaboration is whether the collaborators *belong to the same system* or not. A CSO will belong to the same system with the GHS if that organisation is a health CSO or has health as one of its major programme components. These organisations should also share common resources such as transportation, office premises, and personnel. During the survey it was observed that only two CSOs, JICA and Better Ghana Management Services, were identified to be at the highest level of collaboration with the GHS after assessing them based on the requirements for that level. JICA for instance, uses the premises of the GHS at the Regional Health Directorate and shares personnel with them. JICA has been the implementing body for the Community-based Health Planning and Services (CHPS) initiative in the region, and supports the programme with both human and financial resources. There is therefore joint planning and implementation of health programmes between JICA and the GHS. The Better Ghana Management Services on the other hand is a local CSO whose major programme area is health education. It relies on the GHS to recruit its personnel. This has the aim of ensuring that the right calibre of personnel is recruited for its programmes.

Another element of collaboration that is worthy of note is the way and manner in which roles are assigned to partners in the collaboration. At the level of networking and cooperation, loosely defined roles characterise the collaboration. At this point, joint decision making is very rare and members are not under any obligations to be accountable to each other. The higher levels of collaboration have somewhat well-defined roles. Most of the organisations that were involved in this study found themselves at various levels of the collaboration scale owing to several reasons, but especially due to differing organisational capacity (financial, material and human resources). The GHS and the CSOs were given the same scale to establish the level at which they collaborated. There were slight variations in the responses given. At one hand, some of the CSOs indicated a level at which they collaborated with the GHS which did not conform to what the GHS indicated on those organisations. The difference has always been a step above or below what the CSO established. However, considering the thin line that separates one level of collaboration from the next, if one were to carry out a test of significance, perhaps, the variations would not have been significant.

The GHS tended to place most of the ICSOs at the highest level of collaboration when those CSOs themselves did not think their collaboration had reached that level. Tables 5, 6, 7 and 8 provide a summary of the levels of collaborations as indicated by the CSOs and the GHS. Most of the CSOs were found to be at the lower end of the collaboration scale. The intensity of each level of collaboration increases gradually to the fifth level of collaboration. Here, the GHS and the CSOs, despite their

Table 5: Level of CSO Collaboration (CSO Respondents)

Extent/level	Frequency	Percent
Networking	4	12.9
Cooperation	12	38.7
Coordination	10	32.3
Coalition	3	9.7
Collaboration	2	6.5
Total	**31**	**100.0**

Source: Authors' Field Data, 2012

Table 6: Level of CSO Collaboration (GHS Respondent)

Extent/level	Frequency	Percent
Networking	8	25.8
Cooperation/Alliance	10	32.3
Coordination/Partnership	4	12.9
Coalition/Partnership	5	16.1
Collaboration	4	12.9
Total	**31**	**100.0**

Source: Authors' Field Data, 2012

Table 7: Type of CSO And Level of Collaboration with the GHS (CSO Respondents)

Extent/Level of Collaboration with the GHS						**Total**
Type of CSO	Networking	Cooperation	Coordination	Coalition	Collaboration	
International/Foreign	0	1	7	1	1	**10**
Local/Indigenous	4	11	3	2	1	**21**
Total	4	12	10	3	2	**31**

Source: Authors' Field Data, 2012

Table 8: Type of CSO and Level of Collaboration with the GHS (GHS Respondent)

	Extent/Level of Collaboration with the GHS					**Total**
Type of CSO	Networking	Cooperation	Coordination	Coalition	Collaboration	
International/Foreign	1	1	1	3	4	**10**
Local/Indigenous	7	8	3	2	0	**21**
Total	8	10	4	5	4	**31**

Source: Authors' Field Data, 2012

differences and priorities, recognized they could gain mutual benefit from joint planning and implementation of health programmes.

Table 5 shows CSOs' responses on the extent of their collaboration with the GHS in the region. Only two CSOs, representing 6.5%, were at the highest level of collaboration with the GHS. If the levels of collaboration are grouped into lower (*Networking and Cooperation*) and higher (*Coordination, Coalition and Collaboration*), more than half (51.6%) of the CSOs engage the GHS at the lower levels of collaboration. This was corroborated by the GHS (as shown on Table 6). Though collaboration between the GHS and the CSOs was higher at the lower levels (*Networking and Cooperation*), comparatively, the GHS rated it higher (58.1%) as against the rating by the CSOs (51.6%).

The differences emanated from the ratings given to the Local and International CSOs. The GHS saw its collaboration with the ICSOs to be at the higher levels of collaboration, while most of the LCSOs were at the lower levels. For instance, from the perspective of the GHS, no local CSO was at the level of "Collaboration" with it, as against one that was identified by the CSOs (see tables 7 and 8). However, four ICSOs were identified by the GHS to be at the highest level. This varied from the situation where only one ICSO identified itself at that level (see tables 7 and 8).

Tables 7 and 8 summarise the levels at which CSOs in the region collaborate with the Ghana Health Service. The responses are grouped under International CSOs and the Local CSOs. This was to aid in identifying issues that were peculiar to the different types of CSOs and what could probably affect the level at which they collaborated. Generally, the responses of the CSOs (shown on Table 7) suggest that collaboration between the GHS and LCSOs tended to be at the lower levels, characterised by *mere recognition of the presence of the organisations*, the *specific roles of the organisations in the collaboration are loosely defined*, there is *little communication* between them (CSOs) and the GHS, and *all decisions are made independently of each other*. In addition to making all decisions independently of each other, those who are at the level of *cooperation* share some information with the GHS, with *somewhat defined roles,* and *communicate formally*. At the higher levels of collaboration, the international CSOs were seen to be doing better than their local counterparts. At this level on the collaboration scale, collaboration is characterised by *frequent and prioritized communication* with the GHS which involved *mutual trust* and *consensus building on all decisions*. These are the levels at which the CSOs share ideas, information and resources with the GHS. Members also have a greater voice in decision making, with defined roles.

The responses from the GHS (see Table 8) presented a different picture with regard to the levels at which it collaborated with CSOs. Just 20% of the ICSOs were said to collaborate at the lower levels of collaboration as compared to the over 71.4% of the LCSOs at the same levels. At the higher levels, 80% of the ICSOs collaborated at that level as against 23.8% of their local counterparts. The differences in responses of the GHS and the CSOs could be an indication of the loose nature of collaboration between the two collaborators. The collaborations between the GHS and the ICSOs also seem to be more active and formalised than that between the LCSOs and the GHS.

It was observed that a CSO's capacity in terms of resource availability has much to do with the extent to which it engaged another in any collaboration. Those organisations at the lower level of collaboration, mostly the LCSOs, expressed their desire to engage the GHS at the higher level but were constrained by the lack of financial and human resources to do so. These LCSOs identified their foreign counterparts to be competitively advantaged because of their huge financial support base, resource mobilisation skills and their technical expertise. About 55% of the CSOs (mostly the LCSOs) identified a situation where the GHS pays more attention to the ICSOs because of their ability to support the GHS financially and in other forms such as the provision of physical health infrastructure. This concern of the LCSOs is supported by Green (2007), Osborne (2000), Yeboah (2003) and Abdul-Gafaru and Quantson (2008). For instance, within the context of the Interest Based Theory, Yeboah succinctly states that a partner in any collaboration process will only cooperate with and coordinate its policies and programmes with another when it sees particular advantages to itself. According to Green (2007), Osborne (2000), Yeboah (2003) and Abdul-Gafaru and Quantson (2008), these advantages reflect in the mutuality of interest, equality and future benefits accruing to the partnership. However, the extent to which a partner will benefit and influence will depend partly but largely on its financial resource strength and technical expertise. Once the ICSOs have the competitive urge over their local counterparts, it is reasonable to think they will have a more effective collaboration with the GHS.

Effectiveness of the collaboration

Collaboration becomes effective if the goals and objectives of collaboration are met or are likely to be met. These goals and objectives are not necessarily that of the individual actors but that of the collective interest of the collaborators. The study relied on the five key characteristics of collaboration as outlined by Osborne (2000) to assess how effective the collaboration between the GHS and the selected CSOs was in the region. According to Osborne (2000), any effective collaboration should exhibit the following characteristics: *clarity of purpose*, *mutual trust and respect*, *investment of time and resources*, *negotiation of roles and responsibilities*, and *long term sustainability*.

Majority of the CSOs interviewed, particularly the local CSOs, downplayed these characteristics of effective collaboration. Most of them bemoaned the lack of *mutual trust and respect* between them and the GHS and among the CSOs themselves. Yeboah (2003) and Osborne (2000) both see mutual trust and respect as the heart of collaboration. Yeboah was very emphatic when he explained that: *it is not only necessary to trust others before acting co-operatively but also to believe that one is trusted by others...this belief is necessary to reinforce the idea that both actors' expectations have converged on co-operative behaviour* (Yeboah, 2003: 40). Osborne (2000) intimates that collaboration can only be successful as long as trust between the actors can be established and maintained. As one of the CSOs clearly stated,' it is sometimes disheartening and frustrating when one does not trust and believe in what you do...it doesn't auger well for this collaboration'. Another CSO stated that, 'because of the lack of mutual trust and respect, you sometimes find it difficult retrieving some vital information from your partner'.

According to the NGO desk officer at the RHD:

it sometimes becomes very difficult to trust some of the CSOs because of the lack of clarity of purpose...some of these organisations don't really seem to know what they are about and in this situation one must exercise some restraint in dealing with them...it is not everything you have to divulge to your partner.

The response of the desk officer to the issue of trust implies that developing an attitude of trust and respect in collaboration depends on the nature and the performance of the actors involved. Perhaps this could be the reason why the ICSOs do not have many problems with the key determinants of effective collaboration because they are perceived to be high achievers as compared to their local counterparts. The lack of clarity of purpose in the collaboration process makes it difficult for the GHS and majority of the CSOs to understand what is expected of them and to work together to resolve problems. As Osborne (2000: 319) puts it, 'clear goals make it easier for partners to work together and raise sensitive issues about each other's role and performance'.

Constraints to effective collaboration

A number of pressing constraints to effective collaboration in the health sector were identified. These constraints varied from organization to organization. The constraints to effective collaboration between the GHS and the CSOs centred on three main issues; capacity, fragmentation and commitment. Effective collaboration calls for adequate capacity of all stakeholders engaged in such an exercise (Osborne, 2000; Abdul-Gafaru and Quantson. 2008; Green, 2007; WHO, 2001). According to the Ghana Health Service and the Coalition of NGOs in Health, however, limited capacities of most of the civil society organisations hampered their effective collaboration with the Ghana Health Service in some of the programmes the organisations have designed themselves. Some of the capacity constraints encountered by CSOs encompass technical know-how or skill, as well as the paucity of resources, particularly financial and human resources. The NGO desk officer at the Regional Health Directorate for instance intimated that most of the CSOs lack the capacity to implement some of the programmes they bring on board and also, they lack adequate capacity for policy analysis and research abilities needed to facilitate proactive engagement with the GHS and other partners:

Some of these organisations do not really have great insights with regard to their mission and may tend to implement programmes that are fragmented and lacking the desired impetus to make any meaningful contributions to the development of health. This may be due to their limited scope and inability to mobilize the needed resources to carry out their projects.

The desk officer's concerns are well elaborated by Abdul-Gafaru and Quantson (2008) and Osborne (2000). In their opinion such limitations in an organisation's capacity make it very difficult for such organisation to make sufficient preparation to understand the issues at stake in the policy process. Most of the local CSOs interviewed indicated that they do not have enough funds to effectively implement their projects. The unreliable nature of donor cash flows was a serious hindrance to their operations. Some of the foreign organisations also had similar concerns but relating their situation to that of their local counterparts, one could conclude that they were better off due to their international network and more reliable financial support from their mother organisations.

Yeboah (2003), Abdul-Gafaru and Quantson (2008), Green (2007) and Osborne (2000) identified fragmented ranks within civil society organisations as one of the challenges that hamper their effectiveness. This also came up strongly during the interviews with the CSOs and GHS. According to a respondent from one of the District Health Directorates:

CSOs in the region may have the common goal of effecting desirable health outcomes and improving upon the socio-economic livelihoods of the people of the region, but if this is driven by parochial, private interests leading to duplication of projects and spreading themselves thin, that common goal will not be achieved.

Most of the CSOs indicated that they find it difficult to engage in effective collaboration with the GHS because of

their inability to speak with one voice. Although there is a Coalition of NGOs in health who *supposedly* represents the interests of all CSOs, most of the CSOs were unaware of this Coalition, and those that were aware were not certain when the Coalition came into existence. Further investigations, however, revealed that the Coalition has been in existence for more than a decade. The regional secretary and organiser of the Coalition, however, expressed their frustration about the disinterestedness of some of the organisations to join the Coalition, more especially the foreign CSOs. According to Green (2007), the fragmentation comes about possibly because NGOs who are individualistic in their operations may tend to adopt a competitive strategy rather than collaborating with other organisations. This pursuance of individual goals irrespective of collective priorities drives those organisations to pursue the same sources of funding in such an uncoordinated manner that often lead to wastage and outright duplication of projects (Abdul-Gafaru and Quantson, 2008).

Another constraint to the collaboration is the level of commitment to these collaborative efforts. According to Fowler (2000), authentic partnership implies a joint commitment to long-term interaction, shared responsibility for achievement, reciprocal obligation, equality, mutuality and a balance of power among the players.Below are two critical responses on the issue of commitment between the GHS and CSOs:

We have always done our best to open up to the Ghana Health Service but we do not see the GHS doing same to us. (Respondent from a local CSO)

We have established a very cordial relationship with the Ghana Health Service and they have always cooperated with us. (Executive member of the Coalition of CSOs in health)

The apparent contradiction in these responses is explained by the fact that partners in collaboration tend to withhold or present information depending on the extent/level of collaboration between them. About half of the CSOs indicated that the GHS is not genuinely committed to engaging them in the collaborative process. According to them, although there are some efforts at working collaboratively, the GHS fails to recognise the need for a more comprehensive collaboration. Abdul-Gafaru and Quantson (2008) also found this in their study of CSOs in public policy making. For example, some of them admitted that there is some form of communication and information sharing with the GHS, but they found a problem with the regular flow of such information, especially from the side of the GHS. The CSOs noted that at times when such information is provided, it becomes too late or inadequate to use for the intended purpose.

Abdul-Gafaru and Quantson (2008) and Yeboah (2003) are perhaps right when they say that the limited commitment of the State, in this case the GHS, to effective collaboration is further underscored by the absence of a framework to govern collaborations. Maybe, the establishment of an NGO Desk at the Regional Health Directorate to pave the way for effective dialogue with the civil society sector to come out with a framework for the activities of CSOs and the GHS in the region is a welcoming idea.

In addition to these, the GHS identified the lack of complete database on some of the CSOs in the region which affects their monitoring mechanism. Yeboah (2003: 161) sums up the important role effective monitoring plays in the success of health care provision as follows:

Health service provision anywhere in the world is an expensive business. Unless conscious efforts are made by the planner to monitor the progress and standards of work (by all stake holders) *in the health delivery process, only minimal outputs and outcomes may be realised from the scarce resources invested*.

The monitoring system in the region is ineffective. Although that did not come clearly from the responses of the GHS, it could be deduced from the interviews that there was a difficulty in monitoring the activities of some of the organisations. This was attributed to the lack, for a long time, of a *desk* solely responsible for coordinating the CSO sector. The newly established NGO Desk at the Regional Health Directorate is given the mandate to streamline the activities of the CSO sector in the region. The Coalition of NGOs in Health also reported their inability to bring onboard all CSOs in health under that umbrella. This is as a result of the voluntary nature of membership of the Coalition.

It was realized that all the CSOs were in one form of collaboration or the other with other CSOs, either in the Region or outside of it. Though such collaborations are potentially beneficial, they tended to present challenges in the operations of CSOs in the region. The local CSOs were more dependent on the foreign ones for financing and capacity building, than the foreign ones were. This has given the ICSOs an edge over their local ones. Mutual suspicion and mistrust sometimes crop up within these organizations, and relationships sometimes become severed. The helplessness of the local NGOs was evident when one of them asserted that '*it becomes difficult to deal with the situation because they [ICSOs] support you all the time and as the popular saying goes, a beggar has no choice*'. The GHS also exhibited some internal lapses in coordinating the activities of CSOs. While the Regional Health Directorate expressed some reservations about how its district divisions partnered other CSOs in undertaking certain programmes without apprising it with the details, the district directorates also found some faults with their regional directorate in instances where CSOs were sent to their districts to operate without their active involvement. Such happenings have the tendency

of derailing health goals due to the lack of synergy of efforts.

Most of the NGOs deal directly with the regional health directorate, and although they work within your district they think they are answerable to the region and not you…this makes it difficult for you to monitor their activities and call them to order when they deviate…this is more so with the international NGOs. (Response of a District Health Director)

Benefits of the collaboration

The constraints notwithstanding, on the whole, the GHS and the CSOs assessed their collaboration as having yielded a reasonable amount of benefits. First, respondents were unanimous on the fact that collaboration in the health sector in the region is an effective way of pooling resources so that larger projects in health or more aspects of a project can be tackled than is possible for an individual organisation or institution such as the GHS. According to Osborne (2000), such leverage of resources is often also a performance measure of local economic-development agencies. The nature of problems facing the region in terms of health is multifaceted, thus requiring a combined response from the collaborators in order to be effective and efficient. The health problems faced by the region, especially rural communities, are often interrelated, overlapping and mutually reinforcing. Hence, solutions aimed at one part of the system are unlikely to be fully successful because of the counteracting impacts of other factors. Collaboration between these key actors is therefore very essential in order to tackle the various causes as well as the symptoms of the problems of health. Also formal or informal joint working or collaborations are seen as important mechanisms to avoid wasteful duplication of effort in the region.

In addition to increasing the scale of available resources, collaborations bring in different types of resources such as information and expertise not available to the GHS. JICA was particularly cited by the Regional Health Directorate as one of the collaborators who have made the necessary expertise and other resources available to the GHS in its implementation of the CHPS concept. In general, the collaboration has enabled the collaborators to gain the benefits of economies of scale in terms of finance and programme implementation. Both the GHS and the CSOs have had the mutual benefit of building the capacities of their respective setups. Staff from the GHS have had the privilege of attending some workshops organised by some of the CSOs in order to build their capacities through training programmes. The CSOs have equally enjoyed such privileges from the GHS.

Another benefit of the collaboration between the GHS and the CSOs is in the area of effectiveness in service delivery. Webb and Elliott (2000) for instance support this by saying that depending upon the nature of the problem, collaboration can greatly increase an individual organisation's effectiveness, especially through improved coordination between and within organisations, hence creating synergy between the various bodies and reducing wasteful duplication. Therefore, both greater output and cost savings might be achieved.

Conclusion

The study examined the extent to which the GHS and CSOs collaborate, the benefits and risks of their collaboration in the Upper West Region. It observed that the interaction between the two sets of organisations has contributed in diverse ways to improve health care in the region. Regardless of the challenges the GHS and the CSOs encounter in their collaboration, a major opportunity for enhancing the collaborative efforts between the GHS and CSOs exists: the presence of the Coalition of NGOs in Health in the region. Although the coalition is not optimally operational, membership is increasing steadily. More organisations now have the confidence in establishing relationships with the GHS because they know there is a body to speak for them when they cannot. The GHS itself has identified the Coalition as an opportunity to streamline the activities of the CSOs to respond to some of the pressing needs of the health sector. The Creation of an NGO Desk at the Regional Health Directorate also presents an opportunity for the GHS to effectively engage the civil society sector in its quest to improve health care services in the region.

What remains to be done to foster effective collaboration between the GHS and CSOs in the region include the following. First, there is the need to streamline the activities of CSOs with that of the GHS through policy. This will not only put in check the kind of organisations that operate in the region, it will also avoid issues of wastage of resources and duplication of project activities. Streamlining the activities of the CSOs will also make it possible to come out with health priorities and programmes that are within the reach of these players.

One area where the GHS has been very weak is the lack of effective monitory mechanism to monitor and control the activities of the CSOs in the region. Perhaps, each of the district health directorates could follow the footsteps of the regional directorate by also setting up desk offices for CSOs within their districts. This could complement the efforts being made by the Regional Desk for NGOs to establish an effective mechanism of monitoring the organisations. The works of the Coalition of NGOs in Health in the region could also play that vital role of monitoring the activities of its members to make sure that they are up to standard. This they could do in conjunction with the GHS.

A more proactive inter-CSO partnership could also be pursued. This may offset some of the challenges faced by these organisations. Some of the CSOs, especially those

that are well endowed with resources and technical expertise, could partner the less endowed, yet potentially vibrant organisations to implement certain programmes. But this should be well managed to prevent the situation were these weak organisations may feel powerless to take part in very critical decision making processes.

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