UNVERSITY OF CAPE COAST

STAKEHOLDER PERCEPTION ON FACTORS INFLUENCING NGO COLLABORATION WITH GOVERNMENT IN HEALTH EDUCATION IN THE TEMA METROPOLIS

BY

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DECLARATION

Candidate's declaration

I hereby declare that this dissertation is the result of my own original research and that no part of it has been presented for another degree in this University or elsewhere.

Candidate's signature: …… Date: ..……

Name: Eric Ebo Sey

Supervisor's declaration

I hereby declare that the preparation and presentation of the dissertation were supervised in accordance with the guidelines on supervision of dissertation laid down by the University of Cape Coast.

Supervisor's signature: …… Date: ……..

Prof. Ernest L. Okorley

ABSTRACT

The providers of health education (HE) have generally included non-governmental organisations (NGOs) and government organisations (GOs). To avoid the duplication of effort and ensure efficiency, it has become necessary for NGOs and GOs to collaborate in the provision of health services.

The purpose of this study was to determine stakeholder perception on factors influencing collaboration between GOs and NGOs based on organisations sampled from the Tema Metropolis in Ghana. From the assessable organisations, key informants were sampled using a simple random technique to select a total of sixty (60) respondents with thirty (30) each from the GOs and NGOs. The study identified the key factors that facilitate successful collaboration between NGOs and GOs to include frequent communication, a good purpose and a favourable policy environment along with the roles and responsibilities that characterise an effective collaboration. The study also discusses the major constraints to NGOs and GOs collaboration to include differing institutional goals, incompatible management processes and intrusive stakeholder interest. It concludes with discussions on the strategies that facilitate NGO and GO collaboration relationships to include parity and participative strategies, open and frequent communication and trust among partners. It recommends guidelines for implementation of collaboration projects to include the adoption of joint monitoring and evaluation teams and the signing of MoUs to cover projects.

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May the almighty God richly bless you all.

DEDICATION

To the ladies in my life; mum, Auntie Sophia; wife, Frema and daughter,

Maame

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LIST OF ACRONYMS

CSO	Civil Society Organisations
HE	Health Education
GOs	Government Organisations
MHD	Metropolitan Health Directorate
MOH	Ministry of Health
MoU	Memorandum of Understanding
NGOs	Non-Governmental Organisations
TMA	Tema Metropolitan Assembly
UNDP	United Nations Development Programme
UNICEF	United Nations International Children's and Education Fund

CHAPTER ONE

INTRODUCTION

Overview

This chapter discusses the background to the study and statement of the problem. The general and specific objectives are listed and significance of the study is described. In addition, the delimitations, limitations and organization of the study are revealed.

Background to the Study

The need for effective provision of health education (HE) in developing countries seeks to provide knowledge, skills, attitudes and values conducive to good health (Ministry of Health [MOH], 2001). This involves the teaching and counselling on healthy living and covers topics such as hygiene, nutrition, smoking, sex education, HIV/AIDS, family planning, malaria, tuberculosis, maternal health, child health, alcohol and drug misuse (Metropolitan Health Directorate, [MHD], 2010).

Research has shown that better health and nutrition raises workers' productivity, decreases the number of days workers are ill and prolongs their potential working lives (World Bank, 2000). It has also found that health and nutrition have long-run effects on productivity and output because they influence children's ability and motivation to learn. Also diseases and

malnutrition in infancy retard mental development, while illness and temporary hunger reduce children's ability to concentrate and keep them away from school.

UNICEF (2011) reported that in Ghana, infant mortality was 78 per 1000 children; life expectancy was 64 years and neonatal mortality rate 30 percent. Ghana's maternal mortality rate was estimated at 450 per 1000 but the total fertility rate was 4 births per female of child bearing age. A high fertility rate is usually associated with high rates of mortality in both mothers and children (MOH, 2001). Only 86 percent of the Ghanaian population has access to improved drinking water sources, 14 percent get adequate sanitation, and 39 percent of under-5 years children are sleeping under treated mosquito nets as protection against malaria (UNICEF, 2011).

In most developing countries, health care provision is the primary responsibility of government through the Ministry of Health. Effective development requires collaboration among different levels of government, the private sector, donor groups and civil society (World Bank, 2000). A comprehensive strategy is simply too demanding for any government or for a single donor. However, since governments are not able to adequately provide health education to all people other stakeholders such as NGOs are also involved. In Ghana, health education is under the jurisdiction of the Ministry of Health (MOH, 2001) but its implementation is through the Ghana Health Service which is the government organisation (GO) responsible. health education is also undertaken by other social partners in the private and NGO sectors. Providers of health education in the public sector are directly under

the control and management of the Ministry of Health while those in NGOs are indirectly under the control of the Ministry of Health.

Providers of health education in Ghana need to collaborate to be able to achieve the ever increasing health needs of Ghana. Over the past several decades, NGOs have become vital players in the field of international development therefore governments and development agencies such as the World Bank are increasingly working in collaboration with them (Clark, 1999).

Statement of the Problem

The need to address the issue of health education in Ghana has become more important than ever. This is because the status of health in developing countries compared to developed countries is very poor (World Bank, 2000).

In an attempt to address these health problems, health education has attracted a number of providers. In Ghana, providers of health education have generally included among others, non-governmental organisations (NGOs) and the Ghana Health Service which represents government (GOs). As such, to avoid the duplication of efforts and to ensure efficiency and effectiveness in health education, it has become necessary for NGOs and GOs to collaborate in the provision of health services in Ghana over the past decade.

Tandon (1991) suggests that organisational collaboration has a critical role to play in improving health education in Ghana. There is, however, limited information about such collaborations in terms of the nature, good practices and challenges in Ghana that could inform theory and practice. This

study therefore seeks to contribute in providing information on NGO and GO collaboration to address this information gap.

General objective

The main objective of the study was to determine stakeholder perception on factors influencing collaboration between NGOs and GOs in the provision of health education within the Tema Metropolis of the Greater Accra Region of Ghana.

Specific objectives

To achieve the general objective of this study, the following specific objectives were formulated:

i. Describe the nature of collaboration between NGOs and government organisations in the provision of health education (HE) in terms of:
    a. area (programmes, project, activities) of collaboration;
    b. Roles/ responsibilities of NGOs and GOs in collaboration;
    c. Nature of collaboration (formality of interaction, signing of MoU, channels of communications);
    d. Reasons for collaboration; and
    e. Benefits of collaboration
ii. Identify factors that facilitate collaboration between NGOs and GOs in the provision of health education;
iii. Examine the key constraints to NGOs and GOs collaboration; and
iv. Provide strategies that can improve NGOs and GOs collaboration in the provision of health education

Research Questions

i. How is the nature of collaboration between NGOs and government organisations in the provision of health education within the Tema Metropolis?
ii. What factors facilitate the collaboration between NGOs and GOs in the provision of health education?
iii. What are the constraints to NGOs and GOs collaboration?
iv. What strategies can be put in place to improve NGOs and GOs collaboration in the provision of health education?

Significance of the study

In developing countries, health education is a concern not only of the government but other social partners such as those in the NGO and private sectors (Omondi, Mutero, Mwarogo and Nduba, 1993). The findings of this study will provide useful information on the nature, strength and weaknesses, and the strategies for future collaboration between the collaborating stakeholders who provide health education in Ghana.

The study will provide direction for formulating policies to support better mechanisms of collaboration among the social partners providing health education in Ghana.

Delimitation

Collaboration seems to be a service-related concept when individuals or organisations work together to a common purpose to achieve a benefit. The growing focus to provide health education has increased the need for

collaboration between the providers of these services which is the government and non-governmental organisations. The factors influencing collaboration between organisations is the scope of this study. The setting was limited to government organisations and non-governmental organisations in the Tema Metropolis of the Greater Accra Region.

Limitations to the Study

The first is the inadequate financial resources to enable the researcher capture all stakeholders in the study area. Secondly, the busy schedule of some of some respondents selected in the sample hindered the distribution and retrieval of all questionnaires. Time played a major role here as meeting especially medical officers directly at the GOs was quite a challenge and questionnaires had to be left and collected at the administration rather after several trips. Finally, due to the use of mostly open ended items on the questionnaire to gather data, there were a few item non-responses and it also required extensive coding. This affected the movement of the researcher and prolonged the research unnecessarily.

Operational definition of some terms

HE: These are health education programmes run by the Ministry of Health through the Ghana Health Service;

GOs: These are composed of Ghana Health Service and its affiliates in the metropolis, including the Metropolitan Health Directorate, General Hospital and Polyclinics that are in charge of the implementation of government health policy in the Tema metropolis;

MHD: Tema Metropolitan Health Directorate that supervises health activities in the metropolis;

NGOs: Non-governmental organisations that operate in the Tema metropolis; and

TMA: Tema Metropolitan Assembly which is in charge of local government.

Organisation of the Study

The study is divided into five chapters. The first chapter looked at the introduction which includes: the background of the study; statement of the problem; purpose or objectives of the study; research questions; significance of the study; delimitation; limitation and organization of the study.

Chapter Two of the study constitutes the review of literature and theoretical perspective. Further, Chapter Three comprises the methodology which covers the design; population; sample and sampling technique; research instrument and analysis. Chapter Four looked at the results and discussion. The final chapter that is Chapter Five includes the summary, conclusion and recommendations. It also brought out the findings of the study and suggestions arising from the study.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

Introduction

This chapter reviews literature on the contribution of NGOs to development, meaning of collaboration, types of collaboration, barriers to collaboration, determinants of successful collaboration, the need to collaborate in health education, the rationale behind organisational collaboration, requirements for organisational collaboration, the characteristics, models, principles, and process of organisational collaboration and the NGO and GO relations. It also looks at the policy environment for collaboration in Ghana.

Contribution of NGOs to Development

NGOs have mushroomed over the past two decades and are key actors in development assistance. As development actors, NGOs have become the main service providers in countries where the government is unable to fulfill its traditional role (Ulleberg, 2009). Kharas (2007) reported that while statistics about global numbers of NGOs was notoriously incomplete, there were an estimated 6,000 to 30,000 national NGOs in developing countries as at 2005. He further reported that aid by NGOs had grown from $41 billion in 1974 to $107 billion by the year 2005, a multiple of 2.6 in 30 years at an average compound growth of 3.1 percent per year.

NGOs have become important actors in development assistance for several reasons. In 1989, they contributed US$6.4 billion to developing countries (including $2.2 billion of official funds), representing some 12 percent of total development assistance (Bebbington and Farrington, 1992). Many NGOs have also demonstrated an ability to reach poor people and innovate to achieve results that are difficult for official government agencies (Clark, 1999). Many of them also represent poorer people and have close links with poor communities.

Clark (1999) has reported a rapid growth in the NGO sector within developing countries such that there are an estimated 18,000 registered NGOs in the Philippines, 3,000 in Brazil while in India, registered NGOs handle 25 percent of all external aid to the country which sums up to $520 million per year. According to the Ghana Health Service (2010) the percentage recurrent budget from government of Ghana and health fund allocated to NGOs, Civil Society Organisations (CSOs), the private sector and other Ministries, Departments and Agencies (MDAs) in the years 2003 and 2004 was 1.6 percent and 1.8 percent respectively.

The non-profit sector has also grown to occupy a significant proportion of the landscape in industrialized countries. Studies reveal that the non-profit sector was estimated at a staggering $1,311 billion in the world's five largest economies (the G5 countries; France, Germany, Japan, the United Kingdom, and the United States) in 1995 (Salamon and Anheier, 1998). This is approximately the same as the publicly guaranteed debt of all developing countries and the same as the Gross Domestic Product of the United Kingdom.

The existence of a vibrant non-profit sector is increasingly being viewed not as a luxury, but as a necessity for people throughout the world. NGOs help to give expression to citizen concerns, hold governments accountable, promote community, address unmet needs, and generally help to improve the quality of life. Moreover, their resources are largely additional and they complement the development efforts of government. They also act in response to failures within both the public and private sectors (Salamon and Anheier, 1998; Bratton 1990).

Significance of collaboration

Researchers have given various definitions for collaboration which are quite different. Collaboration was broadly defined as an effort among groups of people, both formal and informal, to produce an outcome or to accomplish a mutual goal (Gray, 1989). Mattessich, Murray-Close and Monsey (2001) define collaboration as a mutually beneficial and well-defined relationship entered into by two or more organisations with a commitment to a set of common goals, a jointly developed structure and shared responsibility, and mutual authority and accountability. They maintain that relationships based on trust and a shared vision potentially enhance the ability of the parties to achieve qualitatively better outcomes.

Chrislip and Larson (1994) argued that collaboration entails more than sharing information and transferring knowledge, and more important, it entails more than coordinating efforts so each party can achieve its goals. Rather, the aim of collaboration "is to create a shared vision and joint strategies to address concerns that go beyond the purview of any particular party" (Chrislip & Larson, 1994).

Several writers have expressed similar views about the basic features of collaboration. According to Gray (1989), it is characterised by interdependence and participative decision making. Gibbs (1999) regards mutually agreed outcomes and a willingness to share resources such as ideas, time and technical support as critical to successful collaboration. O'Looney (1997) and Wilson (2000) agree on the ultimate objective of collaboration: In the words of O'Looney, "collaboration refers to partnership formation that is believed to bring about change" (O'Looney, 1997), while Wilson considers collaboration to be the most effective tool to "create something entirely new" (Wilson, 2000).

Mostert (1998) also reported that people who collaborated were the ones that created and implemented a plan, and set priority and mutual goal. He further defined it as a "needs of sharing responsibility, getting more cooperation, constructing network and team working". He then described the association among the terms "consultant", "cooperation" and "coordination" and concluded that each of these three terms are a component of collaboration.

Types of collaboration

Tandon (1991) reports that for governments to construct a policy environment conducive to the strengthening of the NGO sector depends significantly on the relationship between the two sectors. Clark (1991) also reported that NGOs can influence main-stream development through operational collaboration with official bodies. This can be facilitated through NGOs working together with government and its agencies. The first form of relationship is where NGOs are in a dependent-client position with the

government. NGOs implement state-prepared programmes and/or receive funding through the State in the form of money, ideas and resources. The second type is adversarial in which there are no common starting points and no wish from either side to search out areas of agreement. The third and most constructive relationship emerging in certain liberal democracies is a collaborationist one which involves a genuine partnership to tackle mutually agreed problems, coupled with energetic but constructive debate on areas of disagreement.

Brown (1990) reported that the State has various instruments it can use, for good or ill, to influence the health of the NGO sector. He further noted that the level of response can be non-interventionist, active encouragement, partnership, co-option or control.

Another view is a deliberate relationship between otherwise autonomous organisations for joint accomplishment of individual operating goals (Rogers & Whetten, 1982). It also represents an on-going and structured relationship between independent organisations for mutual benefit (Green and Matthias, 1997), or 'a structure or process of concerted decision making or action wherein the decision or action of two or more organisations are made simultaneously in part or in whole with the same deliberate degree of adjustment to each other' (Rogers & Whetten, 1982).

Barriers to collaboration

Collaboration is rarely simple and straightforward as it moves through several distinct stages as different parties are involved (London, 1995). Begum (2000) has documented that basic institutional and structural approach to

addressing problems with respect to health sector development differs between government and NGOs. Such differences exist within vision, resources, management, compliance and effectiveness.

Government vision is focused within policies and strategies of overall health development such as a national health policy. However most NGOs focus on specific public health problems, geographic area and targeted population (Begum, 2000). In terms of resources, government has capability to generate own resources plus donor assistance but NGOs are mostly dependent on donations, contracts and donor funding. In management, government is guided by rules and regulations with limited scope for flexibility in operations but NGOs are guided by their organisational constitutions which are relatively simpler and more flexible. Finally, in terms of compliance and effectiveness they indicated that government is generally a centralized bureaucratic structure with the quality of service delivery dependent on the nature of governance. However in NGOs, effectiveness is determined by the ability to mobilize target groups at the grassroots level (Begum, 2000).

Altshuler (2003) reported that what affects the achievement of successful collaboration includes the lack of trust, understanding about confidential information, communication, a common vision and goals, financial management, support from upper management and resistance to change with each other. Mostert (1998) also points out many disadvantages in collaboration such as time, commitment, resistance, differing professional views, lack of collaboration skills, quality of decisions, lack of resources, role ambiguity and duplication of effort, levels of experience and willpower.

Attitudinal barriers are generally evident when organisations in collaboration have beliefs or expectations about the potential outcome when involved in a new task. If such expectations are impractical, they can seriously destroy possible and significant change efforts (Welch, 1998).

Fullan and Hargreaves (1991) also state that collaboration can be a failed solution. They identified three forms of collaboration that are best avoided to include balkanization, comfortable collaboration and contrived collegiality. They indicated that balkanization is a culture made up of separate and sometimes competing groups, jockeying for position and supremacy. It leads to poor communication, indifference, generates arguments and conflicts over facilities and resources.

Comfortable collaboration is a weak form of collaboration that rarely reaches deep down to the grounds, the principles or the ethics of practice. It can get stuck with the more comfortable business of advice giving, and material sharing of a more immediate, specific and technical nature. Such collaboration does not extend beyond particular units of work. It focuses on the immediate, short-term and the practical to the exclusion of long-term planning concern.

Contrived collegiality can be regulated by administrators as it requires managerial guidance and intervention. It is characterised by a set of formal, specific and bureaucratic procedures to increase the attention being given to joint planning, consultation and other forms of working together. Such partnerships are often imposed and organisations deceptively work together under the banner of collaboration cultures.

King (1996) also described a number of reasons why collaboration often fails. Some of the barriers he identifies include; lack of proper facilitation of collaboration, programme inflexibility, linguistic barriers, financial difficulties, lack of adequate knowledge of other institutions' expertise, diversity of institutional backgrounds and cultures, financial constraints arising from extreme reliance on donor funding and a lack of appropriate vision in ventures embarked upon. Levine and Hamaoui (2004) also reported that barriers to collaboration success include mistrust among partner organisations over underlying agendas, political motivations, lack of commitment from senior leadership in organisations, misaligned time horizons among partners, concerns among confidentiality, protection of intellectual property, inefficiencies and other real or perceived charges that hamper information sharing. Moran and Mugridge (1993) have also identified the problems faced by organisational collaboration to include; lack of mission clarity in organisations, absence of a clear funding policy, lack of effective leadership, institutionalisation of activities and lack of community support.

Barriers to organisational collaboration that have also been documented include differences in education, culture, social status, legal jurisdiction, communication style, professional elitism, sex-role stereotypes, role ambiguity and incongruent expectations (Prescott & Bowen, 1985). An effective collaboration should therefore recognize the differences and build on the basis of the respective advantages of government and NGOs (Begum, 2000).

Determinants of successful collaboration

Traditional structures do not facilitate the emergence of key conditions for collaboration, such as a shared decision-making or open and direct communication (Evans, 1994). On the contrary, decentralized and flexible structures stress the importance of teamwork and support shared decision-making to foster collaboration (Evans, 1994). There are several determinants which influence organisational collaboration to make it successful. Evans (1994) postulated three determinants to include systemic, organisational, and interactional factors.

Systemic determinants are elements outside the organisation, such as components of social, cultural, educational and professional systems. Social factors are a source of power differences that may exist between organisations that work together in a team and these factors have an impact on how collaboration practice develops. In fact, equality between organisations is a basic characteristic in collaboration practice (Evans, 1994). This is impeded when there are power differences based on gender stereotypes and disparate social status among the professionals in a team (Mariano, 1989).

Baggs and Schmitt (1997) reported that partners consider power disparity as one of the principal factors that prevent collaboration practice. In addition, Prescott and Bowen (1985) found that a balance of power based on a non-demanding and a non-abusive approach is essential to collaboration between organisations. They also revealed that establishing a collegial atmosphere, where associates are considered equal partners is critical if a collaboration relationship is to be established.

Specific cultural values may also have an impact on the development of collaboration between professional groups. According to Mariano (1989), some work cultures harbour deep values that run counter to the spirit of organisational collaboration. For instance, in health care institutions, a strong cultural affinity for autonomy tends to foster and support individualism and specialization rather than collaboration practice (Mariano, 1989).

The professional system has a significant effect on the development of collaboration practice (D'Amour, Sicotte, & Levy, 1999). In fact, professionalization is characterized by the achievement of domination, autonomy and control, rather than collegiality and trust. Therefore, whereas the development of collaboration practice depends on mutual recognition by partners of their interdependence as well as the acceptance of ''grey zones'' where their respective contributions may overlap (Mariano, 1989), the dynamics lead to territorial behaviours within the team (D'Amour *et al*., 1999).

The educational system is a main determinant of organisational collaboration, because it represents the principal lever for promoting collaboration values. Traditionally, organisations have been socialized with a strong professional identification that falls within the boundaries of their respective professions (Reese and Sontag, 2001). This results in limited knowledge as partner organisations may know very little of the practices, expertise, responsibilities, skills, values and theoretical perspectives of each other. Mariano (1989) stresses the need for inter-organisational education programmes to help improve pluralism and promote awareness, sharing and

the integration of the knowledge and practices between organisations in collaboration.

Collaboration also requires a favourable organisational setting. Walsh, Brabeck and Howard (1999) have reported that organisational structure has a strong influence on the development of collaboration practice. Organisational determinants therefore combine attributes of the organisation that define the work environment, such as its structure, philosophy, team resources, administrative support, as well as communication and coordination mechanisms. Successful collaboration requires a shift from traditional hierarchical structures (Henneman, Lee & Cohen, 1995). In fact, traditional structures do not facilitate the emergence of key conditions for collaboration, such as shared decision-making or open and direct communication (Evans, 1994). On the contrary, decentralized and flexible structures stress the importance of teamwork and shared decision-making to foster collaboration practice (Evans, 1994).

An organisation's philosophy and its inherent values also have an impact on the degree of collaboration. The organisation's philosophy must support collaboration practice with other partners. A philosophy that values participation, fairness, freedom of expression and interdependence is essential for the development of collaboration (Henneman *et al*., 1995). According to Stichler (1995), a climate of openness, risk-taking, integrity and trust fosters collaboration attitudes.

The implementation of organisational collaboration requires administrative support (Stichler, 1995). Indeed, the development of collaboration practice between organisations is facilitated by having leaders

who know how to convey a vision of working together (Stichler, 1995), and are able to create a conducive organisational setting (Henneman *et al*., 1995). D'Amour *et al*. (1999) revealed the importance of leadership in the development of collaboration.

One of the key conditions for a successful collaboration practice is the availability of time to interact and of spaces to meet. First of all, a strong collaboration relationship demands that enough time should be available for the partner organisations to share information, develop interpersonal relationships and address team issues (Mariano, 1998). Furthermore, sharing space and working in physical proximity reduces territoriality and facilitates the relationship (Mariano, 1998).

The development of organisational collaboration also requires appropriate coordination and communication mechanisms. This practice can benefit in particular from the availability of standards, policies and inter-organisational protocols such as unified and standardized documentation, sessions, forums or formal meetings involving all partners (Henneman *et al*., 1995).

Interactional determinants are components of inter-personal relationships among team members, such as their willingness to collaborate and the existence of mutual trust, respect and communication. Collaboration by its very nature is voluntary therefore organisations must be willing to commit to the process (D'Amour *et al*., 1999; Stichler, 1995).

According to Henneman *et al*. (1995), group cohesion is a key indicator of the willingness of organisations to work in collaboration. It depends on factors such as previous experience in similar situations and

organisational maturity. In this regard, being receptive to the idea of collaboration and the organisational commitment to a joint collaboration project is an essential element in the development of collaboration (Liedtka & Whitten, 1998). The willingness to work in collaboration includes expectations about collaboration work, beliefs in the benefits associated with collaboration and the partners sharing common and clear objectives (Sicotte, Amour & Moreault, 2002).

Trust is classified as a key element required for the development of collaboration practice (Henneman *et al*., 1995). They further explain that building trust requires time, effort, patience and previous positive experiences. The display of trust towards other partners is essential. They concluded that trust depends on competence, skills, knowledge and experience. Liedtka and Whitten (1998) demonstrated that organisations consider trust indispensable if they are to establish a working relationship. Baggs and Schmitt (1997) also identified that in a collaboration practice, organisations place more trust in partners that are considered more experienced and competent.

Communication is another interactional element that influences collaboration practice (Henneman *et al*., 1995). Mariano (1989) reported that communication skills play a critical role in the development of collaboration relationships among team members. The development of a collaboration practice demands that organisations understand how their work contributes to outcomes and objectives (Mariano, 1989). Moreover, efficient communication is essential, since it allows constructive negotiations with other partners (Henneman, 1995; Mariano, 1989).

Finally, communication is the vehicle for other determinants of collaboration, such as mutual respect, sharing or mutual trust (Henneman et al., 1995).Mutual respect implies knowledge and recognition of the contributions of partner organisations in the relationship (Stichler, 1995). Thus, lack of understanding, respect or appreciation of the contribution of others constitutes a barrier to collaboration (Stichler, 1995). D'Amour (1999) noted that in order to work well in a collaborative setting, partners normally attach much importance to mutual respect.

Need for collaboration in Health Education

Optimal development requires the harnessing of a country's assets including its capital, human and natural resources to meet the demands from its population as comprehensively as possible. The public sector by itself is imperfect to meet all demands. Constitutionally, the state is responsible for providing basic health care to its population. The Ghana Health Service in liaison with other health agencies is responsible for the provision of health care delivery to the people of Ghana which includes an extensive network of hospitals and dispensaries (GHS, 2010).

The strength of NGOs differs among countries. In some countries, NGOs are major contributors to development processes (Clark, 1993). However in other countries, they are weak and play an oppositional rather than a developmental role making governments highly suspicious of their activities. A number of factors influence the development impact of NGOs many of which are determined by the relationship between them and the State (Clark, 1993). Kamara (2011) reported that NGOs run projects while GOs run programs. There is a need for them to collaborate in order for projects to

support programs run to satisfy the needs and benefits for which it is undertaken. He further explains that a project consists of a set of coordinated activities with start and finish dates undertaken to achieve an objective conforming to specific requirements including the constraints of time, cost and resources. A program however is a group of related projects managed in a coordinated way to obtain benefits and control.

A strong voluntary sector does not guarantee a high degree of interaction among NGOs and the public sector. Tandon (1991) reported that where interaction is high, the climate is most favourable for social priorities such as health care delivery. Whether a strong NGO sector encourages governments to pursue such priorities, or assist them attain their objectives has potential importance which hitherto has been largely neglected (Clark, 1993).

Rationale behind organisational collaboration

Partners work together for a common purpose and for mutual benefit. Different organisations and people have a wide range of resources to offer each other. Collaboration is often described as ‘joint activity’ or ‘working together’, where two or more organisations work closely together and share resources and responsibility for common goals and purposes (Omondi *et al*.1993; Green and Matthias, 1997). They further explain that it is intended to increase public value by their working together.

Gray (1989) also defined collaboration as a process in which parties who perceive different features of a problem can constructively discover their differences and search for a resolution that goes further than their limited visualisation of the possibility.

Collaboration also implies temporal accomplishment of jointly agreed tasks, where continued institutional linkage is not important (Bhattacharya & Ahmed, 1995). It is a partnership and not domination of the weaker social partner by a stronger partner. It implies interaction of two or more social partners whose goal is to address a similar social problem. Building collaborations is about working with others to achieve what we cannot achieve on our own. It is a special kind of relationship in which people or organisations combine their resources to carry out a specific set of activities. The process is also described as the pooling together of resources and efforts through strategies, which promote efficiency to meet organisational goals (Adekanmbi, Kamau & Mphinyane, 1996).

According to Wood and Gray (1991), collaboration arises when a group or party of the same problem area engages in a partnership process, using shared rules, norms and structures to decide on issues related to the problem. Welch and Sheridan (1995) identified collaboration as a dynamic framework that attempts to endorse interdependence and parity during the exchange of resources between at least two parties who contribute in a decision making activity that is simulated by cultural and efficient factors to achieve mutual goals.

Collaboration also complements an NGO's programmes by responding directly to specific local needs and priorities for action. For this reason, NGOs need to include collaboration relationships within their overall strategic plan. The practice of collaboration can take place at many levels and for several reasons in different ways. It is increasingly recognized, however, that collaboration should not mean 'sub-contracting', but a genuine partnership

between organisations based on mutual respect, and acceptance of the independence of the collaborating organisations concerning their vision and approaches (Begum, 2000). These arrangements often rest on a formal agreement specifying the purpose of the collaboration, and the allocation of associated responsibilities, risks, benefits, and resources.

In many countries the voluntary sector concentrates on operating its own projects improving the situation in micro-regions but doing little to bring its experience to bear on the government's service delivery or policy making (Bratton, 1990). These projects may be laudable and their worth to the communities served cannot be ignored, but their contribution to the stock of development know-how is meagre. A sizeable voluntary sector which interacts with the public and private sector is able to achieve a significant multiplier effect on its own efforts (Bratton, 1990). Generally, collaboration refers to working together in an encouraging and jointly advantageous relationship.

Requirements for organisational collaboration

Welch (1998) reported that sustaining collaboration relationships requires constant communication about operational definitions and theoretical foundations. He further noted that understanding and practicing collaboration requires various components and dynamics within the definitive framework of collaboration.

A variety of skills are also required for working effectively with others. Welch (1998) noted that organisations in collaboration must understand the goals, objectives and components of problem solving such as problem definition, situation analysis, brainstorming, evaluation of options,

development of an action scheme, strategy accomplishment and assessment of plan efficiency. It is also important that partners in collaboration must have skills to access partners who possess the expertise required in a given circumstance. Partners must also use good interpersonal communication and conflict management skills to assist effective work interaction.

Schon (1987) also states that organisations in collaboration should have opportunities that reflect on their experiences because this allows for examination of perceptions from their practical experiences.

Characteristics of organisational collaboration

Several features of organisational collaboration have been documented by various writers. Friend and Cook (1996) have suggested six principal qualities of organisational collaboration. First, it is voluntary and organisations must accept to work together. Secondly, the process is based on parity which implies that all contribution to the relationship must be valued equally. Thirdly, the process requires a shared goal as participants tend to collaborate when there is a shared target. The process of collaboration also embraces a shared responsibility for decision making. The next principle also states that collaboration includes a shared accountability for results therefore participants who share decisions must also share accountability for outcomes of the decisions. Friend and Cook's (1996) final principle emphasised that shared resources are a foundation of collaboration therefore participants should make an effort to contribute some type of resource.

Fullan and Hargreaves (1991) have also described true organisational collaboration cultures as deep, personal and enduring. They noted that

relationships during collaboration are neither bureaucratic in nature nor are they mounted for only specific projects.

The norms of collegiality in organisational collaboration are trust, support, mutual respect and sharing. Wallace and Louden (1994) have also reported that similarities, differences, symmetry, risk sharing, trust, emergence, humility and fair exchange are the characteristics of successful relationships among organisations.

Phillips and McCullough (1990) have explained collaboration ethics in organisations. They noted that members of parity could have different backgrounds, interests and skills but they should all share similar values, belief and goals. They must also be valued and believe that pooling resources of all personnel is advantageous and has advantages for all partners. They reported that organisational collaboration involves the need for cautious situational assessment and analysis, generation of choice solutions, planning and performance of a selected procedure, judgement of programmes, modification of plans and re-assessment of accomplished methods.

Finally, Mostert (1998) noted that understanding the characteristics of organisational collaboration helps participants to work efficiently together. He reported such characteristics of collaboration to include indirect service delivery, professional relationships, communal trust, collective involvement, action for problem solving, collaborative resources, shared goals and collective responsibility. Sveiby and Simons (2002) also reported that collaboration climate tends to improve with age, education level and managerial role of the individuals that lead it.

Models of organisational collaboration

Adekanmbi *et al.* (1996) reported that the features of collaboration models are unique, although some of them blend into each other during implementation. He highlighted on the following models which included; association, shared market, direct intervention or consultancy, shared resources and eclectic models.

He described association as a loose model useful for networking. The thrust of the model is the voluntary coming together of the collaborating organisations based on needs. This model has served as a catalyst for major collaborative efforts and its results may take a long time to come. The main advantage however is that it relies on members trust, contributions and decisions to press forward the agenda for the benefit of all. The commonality of operations and the seeming lack of extreme officialdom tend to provide an atmosphere of friendliness for the success of activities.

The shared market model has a mostly economic goal. Many organisations may be interested in the same market for their programmes while having various levels of strength. The government may have intervention programmes but not the modules to use in carrying them out. Contractual agreements are thus entered into which makes institutions to collaborate on various aspects of their activities. The market is the goal and identified areas of operation are very important when choosing this collaboration model.

In the direct/intervention model, it is common to have an institutional provider such as the state. The needs of the partner organisations are usually much, including the setting up of adequate working structures and determining

strategies for staff recruitment. The expertise and experience of a fully established institution is relied upon. Although this is called a collaboration model, many aspects of the operation hint at a lack of equality between the partners.

Participating institutions in the shared resources model are seen to have common problems and practices and the goal is the utilisation of resources which may include technology, human and other material resources. The market slant of this model appears to be slightly toned down, except for planning and accounting purposes. It is not uncommon for one institution within the relationship to benefit more from the arrangement than its partner and 'swallow' it in the course of the activities.

The eclectic model is a careful combination of the models just discussed based on need and situation. It presupposes the merger of variants of each model for the sole purpose of identifying what is needed, and dropping off what is not needed This may perhaps be the best model of operation in view of its chances and the probability of success.

The World Bank (1996) and Begum (2000) have also reported on four collaboration frameworks in between governments and NGOs. First is the representation model. It involves organisations such as NGOs working jointly with governments by serving as effective linkages between planners or financiers of a project and beneficiaries by participating in taskforces and committees. The second was named as contractual agreements. Under this framework, government requests or assigns NGOs to undertake a specific task on its behalf. Usually, this is achieved through soliciting proposals or one-to-one negotiation. They named the third as patronage. This form evolves when

one institution expresses interest in supporting another institution to strengthen its institutional capacity. Here they bind together to deliver some defined service and also share ideas about a common vision.

The World Bank (1996) named their final model as partnering. This requires the perception that each partner has something to contribute. It framework involved the sharing of both risks and benefits. Its guiding principle was based on commitment to reciprocity, sovereignty and equity.

Principles of organisational collaboration

Effective collaboration between organisations must be democratic, inclusive, free from all kinds of hierarchies and should include all stakeholders (London, 1995). London (1995) further explains that many organisations that adopt collaboration as a strategy to improve their work agree that democracy is the heart of working together and they make an effort to eliminate layers of management and force down authority.

There is also widespread agreement that collaboration must be inclusive to be authentic. Theobald (1987) has documented that that all team leaders of a community must be effectively involved in organisational collaboration. London (1995) also noted that successful organisational collaboration must have its foundation on the commitment of principal leaders such as chief executive officers. The support of high level, visible leaders brings credibility to the effort and is an essential aspect of the partnership (Chrislip & Larson, 1994).

Process of organisational collaboration

Collaboration is a complex process and comprises a number of different components. London (1995) states that the system of collaboration usually moves through several distinct phases starting with an examination of a situation and a finding of the vital issues concerned, a definition of the basic mission, a shared vision and the objectives, a schedule for that plan and finishing with the assessment of answers.

Gray (1989) also identified a three-phase process for collaboration. He first identified the problem-setting phase which is the most difficult. This phase requires a sharing definition of the problem between the partners, the building of a commitment to collaborate, recognising other stakeholders whose involvement may be necessary for success of the endeavour, accepting legitimacy of other parties and the partners deciding on what resources are needed for the collaboration process to proceed. Second is the direction-setting that involves the establishment of ground rules, agenda setting, organisation of subgroups, undertaking of joint information search to establish and consider the essential facts of the issue involved, exploring pros and cons of various alternatives and reaching agreement and settings for a course of action. The final phase is implementation which includes the partners in the collaboration dealing with their constituencies, acquiring the support of those charged with implementing the agreement, monitoring the agreement and ensuring compliance.

Barufaldi and Reinhartz (2001) have also identified essential components that can be used as core process for organisational collaboration. First, there should be a shared vision which can be developed from aims and

objectives of the partners in collaboration. They further reported that this can occur at the beginning of a collaboration process or partners may widen a vision while working together. Next is interconnectivity which links the partners. Finally, they stress that a sufficient financial base to sustain the operation and activities in an organisational collaboration venture is the highest precedence in primarily establishing and nourishing the partnership.

NGO and GO relations

There is no doubt that with increasing demands on the state by the citizens, the state can no longer be the sole provider of goods and services. It is also true that the support and interest in NGOs grow as a result of failure by state agencies to deliver services therefore the state and NGOs need each other. NGOs receive so much attention of late because they are perceived as being able to do things that national governments cannot or will not do (Maslyukivska, 1999).

In NGOs relation with the state, Clark (1991) provides three options; they can complement reform and/or oppose the state. In their role of complementing the state, they act as the implementers of development activities. Thomas (1992) reported that NGOs fill the gaps left by the public service making role of the state becomes more of an enabler rather than the provider of services. In their reforming role NGOs are seen as agents of advocacy and development. NGOs are able to represent the interest of the people they work with and in this case promote health education. Finally, in opposing the state they do it by acting as watchdogs and holding the state accountable. This is achieved through severable methods including lobbying

or even overtly supporting groups which are adversely affected by the policies of the government (Thomas, 1992).

It is clear that NGO-GO relationships are complex and diverse and are likely to affect the management of NGO activities. The relationship is affected by the specific contextual factors which may include the nature of NGOs objectives and strategies, the area of operation of an NGO, the behaviour of the donor and the nature and character of the regime (Turner and Hulme, 1997). These relations also differ from country to country. In some countries some regimes are favourable to NGOs while in others the relations are antagonistic.

However, Tandon (1991) points out that such relationships are rare even when conditions are met. The mutual distrust and jealousy appears to be deep-rooted. Governments always have fear that NGOs will erode their political power and NGOs also mistrust the motivation of government officials. NGOs also mistrust the motivation of the government and its officials.

In order for NGOs to realize their potential contribution and to efficiently manage their activities, a healthy relationship between them and government is essential. This healthy relationship can be conceivable only if both parties share the same objectives. Brown (1990) reported that the State has various instruments it can use, for good or ill, to influence relationships in the NGO sector. The level of response can be non-interventionist, active encouragement, partnership, co-option or control. If the government's commitment is weak, then the NGOs are likely to see collaboration with the government as counter-productive.

NGOs will also not value a positive relationship with government and may choose to go their own way making all attempts to make life difficult for government agencies. In cases however where the government has a positive social agenda which resonates with the NGOs, there is potential for a strong, collaborative relationship. However, even where there is room for cooperation, jealousies and mistrust between NGOs and government is deep rooted.

Though controversial and risky, many of the more strategic NGOs are overcoming their inhibitions and are seeking closer collaboration with governments (Tandon, 1991). In this way, NGOs believe they will be better able to achieve the impact described above, and expose the government to a grass-roots perspective which might otherwise be neglected. However, with closer collaboration there can also be the increased risk of corruption, reduced independence, and financial dependency.

Policy environment for collaboration in Ghana

In order for governments to be able to work effectively with NGOs and benefit fully from the contributions they can potentially make to successful development, it is important that NGOs be freely established and operate without undue constraints; that they be independent of the government; and be transparent and accountable. Similarly, NGOs need to have both the full ranges of powers, privileges, and immunities enjoyed by other juridical persons in the society. When NGOs are transparent and have well-developed mechanisms for accountability, the integrity of each NGO and of the sector itself are ensured.

Government policies determine the enabling environment for NGOs and the roles that they assume (World Bank, 1996). These policies include rights regarding freedom of speech or association, regulatory policies, fiscal policies, funding and partnership relations, and policies regarding consultations with the public and with NGOs (Clark, 1993). Some governments welcome certain NGO activities such as poverty reduction but not others including functions, which may be auxiliary to favoured activities, such as related advocacy.

The struggle to come to a regulatory and legislative framework for NGOs in Ghana started back in pre-colonial times. Adongo (2008) reported that laws on voluntary associations were first passed in 1947 to regulate the increased presence of missionary societies and church related religious groups in Ghana. The Nkrumah regime after independence also introduced the non-profit making taxation ordinance which broadened the funding provisions of the colonial period (Adongo, 2008). The trustee's incorporation act of 1962 enabled trustees of voluntary associations to hold land and have perpetual succession. The NLC military regime after Nkrumah passed new taxation laws which recognised non-profit organisations of a pure character and exempted their income from tax on condition that it was not derived from business (Adongo, 2008). The PNDC military regime in specifically PNDC Law 221 stipulated that no person should fund or establish any association for a religious purpose unless such activities are in line with the provisions established by the government failure of which could lead to criminal prosecution.

Opoku-Mensah and Akwetey (2000) reported that a draft national policy on strategic collaboration with NGOs to provide a coherent framework for the management of NGO-Government relations was introduced in 1993 but failed to be passed as law. The policy was to create an enabling legal, institutional and democratic environment for NGOs to contribute effectively to national development and also institutionalized a framework for consultations and collaboration between the government, NGOs and other stakeholders on policies affecting operations in the non-profit sector.

However in 2007, the Government proposed a new Trust and Non-profit making Civil Society Organisations (CSOs) Bill 2007 to regulate the activities of NGOs/CSOs in Ghana. The Ghana Research and Advocacy Organisations [RAO] (2007) called for the Trusts and Non-Profit Making Civil Society Organisations Bill 2007 to be substantially amended. First, to decouple the regulation of public and private Trusts and NGOs/CSOs, secondly to remove all provisions that offend the constitutional right to freedom of association and expression which stifle the operation of NGOs/CSOs in Ghana and finally, that the Draft National Policy for Strategic Partnership with NGOs/CSOs 2004 should form the basis for the development of a separate legislation for NGOs/CSOs.

However, Osei-Opare (2007) emphasized the commitment of the Ghana government in engaging stakeholders through knowledge and experience sharing in carrying forward the development process.

CHAPTER THREE

METHODOLOGY

Introduction

This chapter presents the procedures employed to achieve the purpose of this descriptive research. It includes a description of the study area, research design, the population, sample and sampling procedures, research instrument, pre testing, data collection procedure and analysis of data.

The Study Area

The study was conducted in the Tema Metropolis in the Greater Accra Region of Ghana. The Ghana Statistical Service (2012) reported that the metropolis which covers an area of 220.9 km² is located along the eastern coast of Ghana and has a population of 402,637.

Oduro, Aryee and Abbey (2004) reported that physical access to health facilities in the Metropolis is high with 94 percent of households in the Metropolis having to travel less than half an hour to arrive at a health facility. They further reported that malaria is the leading cause of reported morbidity with the number of reported cases increasing from 45,413 to 58,424 from 1999 to 2004. Pregnancy-related diseases were the third leading cause of morbidity in the Metropolis in 1999 but this was replaced in 2000 by skin diseases (Oduro *et al*., 2004). HIV/AIDS is also the leading cause of mortality and

accounts for a quarter of reported deaths. Child health indicators in the Metropolis are worse than the national average (Oduro *et al*., 2004).

The medical needs of the Metropolis are served by several public and private health facilities. This includes 10 Hospitals, 1 Polyclinic, 3 Health Centres, 70 Clinics, 2 Community Health Planning and Services (CHPS) and 53 Outreach Points. More than half of the clinics (48) in the Metropolis are privately owned by individuals and industries (Oduro *et al*., 2004).

The population to doctor ratio is estimated at over 19,000. This is much higher than the regional average of 2,860 and the national average of 17,489. The population to nurse ratio is 1,073. This is about twice the regional average of 510 and above the national average of 993. MHD (2010) estimates that there are about 87 NGOs operating in the Health sector of which only 41 are registered with the health authorities.

Research Design

This study was set out to investigate the nature, strengths, weaknesses and difficulties of collaboration between the GOs and NGO organisations in Tema. The research design used was a descriptive survey. According to Ary, Chester and Razavieh (1999), a descriptive survey design is appropriate for obtaining social facts concerning the current status of phenomena and also describing the nature of existing conditions in a situation.

On the other hand, Cohen, Manion and Morrison (2011) claim that a descriptive survey design is appropriate for identifying people's perception on social issues. A descriptive survey design enquires into the status quo and

attempts to measure what exist, without questioning why it exists (Ary, Chester and Razavieh, 1990).

Population of the Study

The target population for the study were the GOs and NGOs which provide health education in the Tema Metropolis. Key people in managerial positions such as senior medical officers, heads of departments, heads of units, officers in technical positions, senior nurses and directors of NGOs were surveyed. It was assumed that these people would provide the necessary information given the position in their organisations.

Information pertaining to the number of organisations providing health education was obtained from the Metropolitan Health Directorate (MHD) of the Ministry of Health which is the government unit coordinating the provision of health services in the Tema Metropolis.

Sampling Procedures

Key personnel in management positions from all the government health care and service providing organisations (GOs) and registered NGOs with the metropolitan health directorate that operate in the metropolis formed the population for the study. According to the statistical information obtained from the Metropolitan Health Directorate (2012), there were fifty-seven (57) health personnel at GOs and sixty-one (61) personnel from the registered NGOs with the directorate in management positions.

The number of respondents was arrived at based on what Rea and Parker (2012) suggested that for small populations less than two hundred (200), fifty

percent (50%) of the population should be sampled. From the accessible population, a simple random sampling was employed with each individual on the list provided by the MHD being assigned a number. To enable every individual in the target population have an equal chance of being selected, lottery method with the use of a table of random numbers was used to select thirty (30) respondents each from the GOs and NGOs. This resulted in a combined total of sixty (60) respondents.

Research Instrument

Data for this study came from key informants of the selected organisations. It was collected using a structured questionnaire. Written documents and records including policy documents, annual reports, strategic plans, and handbooks were collected while delivering or collecting the questionnaire. The structured questionnaire was designed by the researcher.

The instrument contained both closed and open ended questions. The questionnaire was developed taking cognisance of the research objectives. Relevant variables were included after a thorough literature search.

The following information was included in the questionnaire; the organisation's roles, health education programmes, areas/programmes of collaboration and responsibilities in collaboration. Other information included was the factors that sustain collaboration, nature and extent of interaction, reasons, benefits, limitations and strategies they perceive best improve collaboration efforts.

Data Collection /Fieldwork

The researcher first obtained an introductory letter from the School of Agriculture of the University of Cape Coast and afterwards proceeded to the Tema Metropolitan Health Directorate for a cover letter.

The researcher distributed the questionnaire personally to the selected respondents in the GOs and NGOs. This was after he had explained the purpose, guidelines and directives on how to complete them. Respondents were assured of confidentiality and were encouraged to give fair and objective answers.

Data Processing and Analysis

The data were classified, coded and analysed with the Statistical Package for Social Sciences (SPSS) software using descriptive statistics such as frequency and percentages. The data were presented using tables.

CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

This chapter presents results and discussions of the study. The analysis is based on specific objectives of the study.

Age distribution of the respondents

Table 1 represents the age distribution of the respondents. The results show that the majority of the respondents (18) were within the age range of 46-52 years. It indicates that more than half of the respondents (55%) were within the age range of 25-45 years. This result is not surprising since the respondents were mid-carrier public and non-governmental organisation staff.

Table 1: Age distribution of the respondents

Age (years)	Frequency	Percent (%)
25-31	9	15.0
32-38	9	15.0
39-45	15	25.0
46-52	18	30.0
53-59	9	15.0
Total	60	100.0

Source: Field Data (2012)

Respondents level of education

Table 2 below shows that the respondents were well educated people. Fourteen (14) of the respondents had postgraduate education with professional or academic certificates and twenty-seven (27) of them were graduates. The respondents with diplomas were seventeen (17). The lowest levels of education among respondents in this research work were the certificate holders which constituted only 3.3 percent of the total number of respondents interviewed.

Table 2: Respondents level of education

Level of Education	Frequency	Percent (%)
Certificate	2	3.3
Diploma	27	45.0
Graduate	17	28.3
Post Graduate Education	14	23.3
Total	60	100.0

Source: Field Data (2012)

The findings are consistent with Sveiby and Simons (2002) who highlighted the effective potential in having highly educated employees. They reported that people with higher education find it easier to influence their own environment. They further state that positional power may influence in a positive way, an ability to share knowledge, influence one's opinion about their own organization and cause them to regard collaboration more favourably. This is further corroborated by Reese and Sontag (2001) whose study on successful inter-professional collaboration showed that education is a

main determinant of organisational collaboration because it represents the principal lever for promoting collaboration values.

Job position

The results showed the distribution of respondents' job position in their Organisation (Table 3). The directors and doctors who formed 42.6 percent were senior staff members with managerial rank in decision making positions. The majority of respondents made of nurses/ matrons (14) and programme/project officers (12) and the remaining 27.9 percent of total respondents held middle level positions in their organisation.

Table 3: Job position of respondents

Position in Organisation	Frequency	Percent (%)
Nurse/ Matron	14	23.3
Project Officer/ Programme Officer	12	19.7
Director	11	18.0
Administrator	8	13.1
Doctor	6	9.8
Research Assistant	5	8.2
Monitoring/Evaluation Officer	4	6.6
Total	60	100.0

Source: Field Data (2012)

The greater percentage of the respondents being in high management positions as either directors or doctors is important given that decisions on collaborations are often taken by them. It is argued that successful collaboration must have its foundation on the commitment of high level

principal or visible leaders to bring credibility to the effort (London, 1995; Chrislip and Larson, 1994). Berteotti and Seibold (1994) however, argued that role confusion and overlapping responsibilities can get in the way of collaboration.

Respondents working experience

Table 4 shows the frequency distribution of the working experience of the respondents. The table shows that only 18.3 percent of the respondents had working experience less than 6 years. The remaining 81.7 percent of the respondents had working experience of more than 5 years with the greater majority having working experience above 20 years. The second highest category was 11-15 years which had 23.3 percent of the respondents interviewed. The least category of the working experience was 16-20 years which constituted 11.7 percent of the respondents interviewed.

Table 4: Working experience of the respondents

Working experience	Frequency	Percent (%)
1-5	11	18.3
6-10	12	20.0
11-15	14	23.3
16-20	7	11.7
Above 20	16	26.7
Total	60	100

Source: Field Data (2012)

Sveiby and Simons (2002) argued that it takes time to build up experience and the social networks necessary for effective sharing in collaboration. This is important as the results came from people with of considerable experience and in positions that require them to collaborate with other organisations in their duties.

Core missions of the collaborated organisations

Table 5 presents the core missions of GOs. From the table, it can be seen that twenty seven (27) of the responses representing 90.0 percent indicated the provision of healthcare services as the core mission of their organisations. The next most listed was the supervision and regulation of healthcare in the metropolis and the engagement in educational activities which notes 56.7 percent of the responses. Others recorded included providing supports for healthcare (43.3%), the training and continuing education of health providers (16.7%) and policy/ programme implementation (10.0%).

Table 5: Core Mission of GOs

Core Mission of GOs	Number of Respondents	Frequency	Percent (%)
Provision of Healthcare Services	30	27	90.0
Supervision and Regulation	30	17	56.7
Engaging in Educational Activities	30	17	56.7
Providing Supports for Healthcare	30	13	43.3
Training Health Providers	30	5	16.7
Policy/Programme Implementation	30	3	10.0

Source: Fieldwork (2012) *Multiple responses table

Table 6 shows the core missions of the NGOs that were used for the study. The most selected among them was the provision of education on behaviour changes. Thirteen (13) of the responses representing 43.3 percent indicate that their NGOs provided education on behaviour changes. The provision of health materials and services in terms of funding and materials support among others accounted for 36.7 percent of responses while the promotion of health interventions represented 10 percent of the total responses. Influencing health policy and the provision of HIV and sexually transmitted infections prevention, care and support constituted 26.7 percent each of total responses in achieving their goals and objectives. This is because internal structures and processes are important factors in determining whether, when and how collaboration can successfully be developed (Huxham, 1993).

Table 6: Core mission of NGOs

Core Mission Of NGOs	Number of Respondents	Frequency	Percent (%)
Education on Behaviour Changes	30	13	43.3
Provision of Health Materials/Services	30	11	36.7
Promotion of Health Interventions	30	10	33.3
HIV/STI Prevention, Care and Support	30	8	26.7
Influencing Health Policy	30	8	26.7

Source: Fieldwork (2012) *Multiple responses

These findings from Table 5 and Table 6 corroborates the presentation of Kamara (2011) who reported that GOs run programs through the management and coordination of a group of related projects with appropriate strategies and technical guidelines to achieve national health policy goals and objectives.

NGOs however run projects with a set of coordinated activities with deadlines to achieve objectives conforming to specific requirements that support programmes to obtain target benefits. This also agrees with the findings of Campbell (1992) who asserts that mission statements are designed to inspire and motivate organizational members to higher levels of performance to provide them with a sense of mission. Campbell and Yeung (1991) have in further findings established that mission statements guide resource allocation in a consistent manner; and help to create a balance among the competing and often conflicting interests of various organisational stakeholders.

Nature of collaboration between NGOs and GOs

Collaboration patterns are techniques used by the partner organisations to help them work together. The nature of collaboration creates a flexible working environment where authority is shared. It looks at the health education programmes under collaboration in the metropolis and the roles or responsibilities of both GOs and NGOs in the partnership

Health Education programmes

Table 7 shows the health related education programmes that the GOs and NGOs undertake together. The results revealed that STD and Health education were undertaken by majority of the organisations. Twenty seven of the responses representing 45 percent of the respondents indicated that their organisations were undertaking STD and reproductive health education programmes. The second most acknowledged health education programme was the antenatal/postnatal services. Twenty-five of the respondents

representing 41.7 percent showed that their respective organisations were undertaking antenatal/postnatal services. HIV/AIDS came in third with 33.3 percent of the respondents have indicated. This was jointly followed by family planning and malaria programmes at 26.7 percent. The least among the health education programmes was immunization which accounted for only 15 percent of the total number of responses. Some health education programmes listed in the Ghana Health Service programmes manual including tuberculosis control, environmental hygiene, alcohol abuse, drug abuse, nutrition, oral and mental health attracted no NGO collaboration partners for projects.

Table 7: Health education programmes

Health education programmes	Number of Respondents	Frequency	Percent (%)
STD/Reproductive health education	60	27	45.0
Post/Antenatal services	60	25	41.7
HIV/AIDS	60	20	33.3
Family planning	60	16	26.7
Malaria	60	16	26.7
Immunization	60	9	15.0

Source: Fieldwork (2012) *Multiple responses

The spread of programmes undertaken by the organisation corroborates the findings of Antwi (2008) which stated that health education activities should emphasize specific priority health issues including family planning, disease control, immunization, malaria, acute respiratory infections, diarrhoea, environmental sanitation, nutrition, oral and mental health and campaigns for healthy life styles.

GOs Role/Responsibilities in the collaboration

Table 8 shows governmental organisations roles or responsibilities in the collaboration. Twenty one (21) of the responses indicated that the organisations major role was to provide technical assistance. Twenty (20) of the responses forming 66.7 percent agreed that Healthcare Delivery Services was the second common role of the government organisations. Regulation and Monitoring of health projects which constituted 63.3 percent was the third most common role of the government organisations. The other roles or responsibilities of the governmental organisations were Training Health Personnel (53.3%), Infection Testing and Prevention (50%) and Information Management (23.3%). The Metropolitan Health Directorate however had a record of only 41 out of the 87 NGOs operating in the Health sector in the provision of health education programmes as having registered with them.

Table 8: GOs Role/ Responsibilities

GO Role/ Responsibilities	Number of Respondents	Frequency	Percent (%)
Technical Assistance	30	21	70.0
Healthcare Delivery Services	30	20	66.7
Regulation and Monitoring	30	19	63.3
Training Health Personnel	30	16	53.3
Infection Testing and Prevention	30	15	50.0
Information Management	30	7	23.3

Source: Fieldwork (2012) *Multiple responses

Ochido, Gitonga and Kaburu (2007) have stated in their findings that government organisations have the technical capacity and the mandate of the people and it is the custodian of national policy. Mostert (1998) also described

the terms “consultant”, “cooperation” and “coordination” as components of collaboration practice. The government therefore provides technical support to NGOs in the collaboration. Kalis (2000) also stated that the government has a responsibility to ensure that there is the required delivery of services within legislative and policy frameworks. GOs therefore have the primary responsibility to facilitate and direct the design and implementation of service programmes. He further presents that by virtue of its governing responsibility, the government has the role of approving, monitoring, and evaluating the service programmes of NGOs.

NGOs Role/ Responsibilities in the collaboration

Table 9 is a multiple response type and indicates the NGOs roles or responsibilities in collaboration. The table revealed that Project Implementation is the most common role among the NGOs. Twenty eight (28) of the responses representing 93.3 percent indicated that project implementation in collaboration was their organisation role. The second most common role of the NGOs was providing material support. Twenty two of the responses representing 73.3 percent of the respondents indicated that one of the major roles of their organisation was providing material support. The third most common role of the NGOs was funding which constitutes 43.3 percent of the responses. The other major roles of the respondents organisations in order of commonest are programme development (26.7%), data gathering (16.7%) and monitoring and evaluation (13.3%) among others.

Table 9: NGOs Role/ Responsibilities

NGO Role/ Responsibilities	Number of Responses	Frequency	Percent (%)
Project Implementation	30	28	93.3
Providing Material Support	30	22	73.3
Funding	30	13	43.3
Programme Development	30	8	26.7
Data Gathering	30	5	16.7
Monitoring and Evaluation	30	4	13.3

Source: Fieldwork (2012) *Multiple responses

Kalis (2000) also corroborates the role of NGOs in a collaboration by presenting that they deliver services efficiently and effectively within the framework of Government policies, and strategies consulted and negotiated between NGO's and Government. They also work in partnership with Government to achieve common aims and objectives and are accountable to Government for their policies and service programmes. They further state that NGOs have the role to ensure the co-ordination of their own services and engage Government in discussions on the co-ordination of services between the Government and NGO's. The NGO sector, through representative structures is therefore accessible to the Government for purposes of joint planning, information sharing and decision making.

Nature of interaction in collaboration

The underlying differences between GO and NGO beliefs generates actions that define their interactions. Interaction was shaped by government standards, experience, history, type of funding and specific expertise of staff.

Formality of interaction

Table 10 demonstrates the nature of the interaction of the respondents with the organisations they are collaborating with. The table revealed two (2) basic forms of interaction namely formal and informal interaction. However, formal interaction constituted 61.7 percent of the respondents' form of interaction with the organisations they worked with. Formal interactions involved NGOs adhering strictly to rules that govern their operations with GOs. It included the joint planning of health education projects, skill development training to achieve project agenda, keeping to operating procedures, decision-making processes, communication strategies, and financial management of projects to develop the mutual trust and awareness of project activities.

Informal interaction constituted 38.3 percent of the respondents' interaction with their organisations. Informal interaction in the context of this research refers to adhoc relations in response to individual characteristics of NGOs and specific settings and in which they work with GOs. Some NGOs prefer not to enter a formal partnership for reasons that relate to mission, funding, philosophy or expectations of their own stakeholders. These activities lay the groundwork for more interaction and a possible partnership.

Table 10: Formality of Interaction

Nature of Interaction	Frequency	Percent (%)
Formal Interaction	37	61.7
Informal Interaction	23	38.3
Total	60	100.0

Source: Fieldwork (2012)

The results do not agree with the findings of Hasan (2011) who emphasised the importance of informal interactions in collaboration in his findings. According to him, lack of informal interactions hampers collaboration but increased informal interaction leads to an increase in collaboration.

Signing of memorandum of understanding (MoU)

Table 11 depicts the respondents view of MoU signed. The results show that most of the organisations sign MoUs between themselves as many of them operate at the formal level. Forty one (41) of the respondents representing almost 70 percent agreed to MoU signing to set out how a collaboration partnership arrangement should operate. Also, at the informal level, 31.7 percent of the respondents did not find the need for signing MoU with partnering organisations.

Table 11: Signing of MoU between collaborated organisations

MOU Signed	Frequency	Percent (%)
Yes	41	68.3
No	19	31.7
Total	60	100.0

Source: Fieldwork (2012)

The findings of Oberndorf (2005) emphasized that MoUs for collaboration are signed with the primary purpose of building relationships and should remain uncomplicated and relatively flexible. Paton (2010) stated that MoU may be used where there is a low level of complexity associated with the collaboration arrangement. The findings of McNeill (1994) report it as informal but nevertheless legal agreement between partners that sets out

how a collaboration partnership arrangement should operate. It provides the necessary structure to the collaboration process including the objective, principles and practice framework. It also outlines the role and, tasks to be undertaken, quality and performance monitoring or performance management, agreed protocols or policies and procedures of the responsibilities of the partners.

Channels of communication in collaboration

Table 12 indicates the most frequently used channels of communication. Among the five above named frequently used channels of communication, Memorandum/Letters/Reports was the highest constituting 45 percent of the respondents with Face-to-Face/Meeting being the second highest. The face-to-face/meeting constituted 25 percent of the respondents. The third most frequently used channel of communication was Electronic mail/fax. The electronic mail/fax constituted 13.3 percent percent of the respondents view. The fourth most frequently used channels of communication is the telephone, which constitutes 11.7 percent. The last but not the least most frequently used channels of communication was teleconferencing, constituting 5 percent of the respondents interviewed.

The results are not supported by the findings of Melcrum, (2004) who submitted that common communications methods channels used between organisations working together are email and team briefings. The findings of de Wit (2004) also stated that organisations are increasingly becoming more sophisticated in their use of technology such as mobile phones, email and video-conferencing which enables them to work in partnership.

Other findings have described thoroughly informal communication as crucial for coordination to exist as it depends on human necessities such as the physical proximity, the instinctive need to communicate, the sense of being a member group, perception of each other as a reliable or knowledgeable member, friendship and trust (Subramanian, 2006).

Table 12: Most frequently used channel of communication

Frequently used channel of communication	Frequency	Percent (%)
Memorandum/Letters/Reports	27	45.0
Face-to-Face/Meeting	15	25.0
Electronic Mail	8	13.3
Telephone	7	11.7
Teleconferencing	3	5.0
Total	60	100.0

Source: Fieldwork (2012)

Reasons for collaboration

Table 13 shows responses to the major reasons for the collaboration. The most significant reason for the collaborations was as a result of the donor requirements. This meant that for the organisations studied, there was a requirement that made them work with each other. Twenty-four of the respondents representing 40 percent revealed that Donor requirement was a major reason behind their collaboration. Many donors required that beneficiaries of funds collaborate with other organisations to avoid duplications and leverage their resources. Policy requirement constituted 35 percent of the reasons for collaboration between organisations. Policy

requirement is the system of laws, regulatory measures, courses of action, and funding priorities promulgated by government to regulate the activities of NGOs.

Interactive initiative also constituted 15 percent of the reasons given by the respondents interviewed. This results from dialogue between NGOs and GO to work together on a health education project. Six of the respondents representing 10 percent did not indicate their organizations major reasons for collaboration.

Table 13: Main Reasons for Collaboration

Reasons for Collaboration	Frequency	Percent (%)
Donor requirement	24	40.0
Policy requirement	21	35.0
Interactive initiative	9	15.0
Non Response	6	10.0
Total	60	100.0

Source: Fieldwork (2012)

The results support the findings of Hill and Lynn (2003) who reported that, characteristics of organisations which reflect resource dependency motivations such as donor requirement tend to explain participation in collaboration relationships relatively more often than do variables that reflect rational choice and socialized choice.

Benefits of collaboration

Table 14 presents the benefits of collaboration to government organisations. The most outstanding benefit among all these was being the beneficiary of material support from partner NGOs. Nineteen of the responses representing 63.3 percent responded that their organisations received material support from NGOs as a result of the collaboration. The next most common benefits to the GOs was receiving funding support from the NGOs which formed 46.7 percent of the responses. Receiving educational and training support for programmes formed 43.3 percent of the responses. The other benefits include coordination and monitoring (40.0%), improving trust and communication (40.0%) and access to data/ information sharing (33.3%).

Table 14: Benefits of Collaboration to GOs

Benefits to GOs	Number of Respondents	Frequency	Percent (%)
Material Support	30	19	63.3
Funding Support	30	14	46.7
Educational and Training Support	30	13	43.3
Coordination and Monitoring	30	12	40.0
Improving Trust and Communication	30	12	40.0
Access to Data/ Information Sharing	30	10	33.3

Source: Fieldwork (2012) *Multiple responses

Table 15 presents the benefits of collaboration to NGOs. The most outstanding benefit among all these was training and technical support which constituted 53.3 percent of responses. The next most common of benefits from

collaboration with GOs was recognition and legitimacy and capacity building with each constituting 46.7 percent of responses. Other benefits included access to data and information sharing (36.7%), obtaining funding support (30.0%) and resource support (23.3%).

Table 15: Benefits of Collaboration to NGOs

Benefits to NGOs	Number of Respondents	Frequency	Percent (%)
Training and Technical Support	30	16	53.3
Recognition and Legitimacy	30	14	46.7
Capacity Building	30	14	46.7
Access to Data and Information Sharing	30	11	36.7
Funding Support	30	9	30.0
Resource Support	30	7	23.3
Advocacy Support	30	2	6.7

Source: Fieldwork (2012) *Multiple responses

The results corroborates the findings of Mattessich *et al.* (2001) who reported that collaboration benefits organisations to provide better services to their clients and respond to crisis. The unified set of services helps to improve a system, reduces expenses for functions through the provision of training, technology and support services and satisfies the requirement of funders and other authorities.

Factors facilitating collaboration between NGOs and GO

Table 16 indicates the key factors that contribute to sustain collaboration between NGOs and GOs. Six major factors were identified, each

of which was acknowledged by the majority of respondents. Communication was identified by 26.7 percent of the respondents as the most important factor that needs to be looked at. The programme purpose or aim for the collaboration that enables organisations solve related problems was identified as the second key factor that has contributed to maintain the collaboration and formed 21.7 percent. The policy environment for collaboration was identified as the third key factor that has contributed to maintain the collaboration. Among other factors are making available resources and incentives (15%), stakeholder interest/pressure (11.7%) and structure and process which represented 5 percent of the respondent views.

Table 16: Factors facilitating NGO and GO collaboration

Factors facilitating collaboration	Frequency	Percent (%)
Communication	16	26.7
Programme Purpose	13	21.7
Policy Environment	12	20.0
Resources and incentives	9	15.0
Stakeholder interest/pressure	7	11.7
Structure and Process	3	5.0
Total	60	100.0

Source: Fieldwork (2012)

The results corroborate the findings of Mattessich *et al.* (2001) who specify a list of factors necessary for successful collaboration that includes mutual understanding and respect, informal and personal relationships, open and frequent communication, shared vision, concrete and attainable goals, flexibility and adaptability, and a favourable political and social climate are of

particular importance. This is strengthened by Prefontaine, Ricard, Sicotte, Turcotte and Dawes (2000) who reported that successful collaboration presupposes the existence of two crucial factors: compliance with government interests, and complementarity of parties in terms of resources and expertise. Gray (2002) also identifies a set of principles that underpin successful collaboration, including: understanding the roles and responsibilities, and appreciating the values and skills, of each other; recognising legal obligations and financial constraints; and acknowledging the policy implications of relevant issues.

Constraints to NGO and GO collaboration

Table 17 represents the major factors that limit the effectiveness of collaboration between NGOs and GO. The most influencing factor among all the factors was organisation goals and culture which constituted 28.3 percent of the total number of the respondents interviewed. The second most limiting factor was differing management and administrative processes which also constituted 16.7 percent of the respondents. The other limiting factors included stakeholder pressure and intervention (13.3%), reliability of communication systems (11.7%), Inappropriateness and inadequacy of resources (8.3%), autonomy and interdependence (8.3%), legal and regulatory framework (6.7%), and transparency and accountability principles (6.7%).

The result reinforces the findings of several researchers. Gray (1989) argues that collaboration is not an appropriate approach under certain circumstances. This includes when stakeholders are unwilling to work together, when there is little consensus on action steps or solutions, when substantial power differentials exist, when maintenance of inter-organisational

relationships represents significant costs to partners, or when a legitimate facilitator or mediator cannot be found. Gray (2002) lists several risks she believes collaboration to be susceptible to including: competitive spirit; parochial interest; personal resistance to change; inadequate orientation; negative staff attitudes; differing protocols, structures, systems, cultures and values of individual agencies; lack of shared agendas; exclusion of any important stakeholder from the collaborative process; overload resulting from a continuing stream of new initiatives; and tight timeframes.

Table 17: Factors that constrain NGO and GO collaboration

Factors that constrain collaboration	Frequency	Percent (%)
Organisation goals and culture	17	28.3
Differing management/administrative processes	10	16.7
Stakeholder pressure and intervention	8	13.3
Reliability of communication systems	7	11.7
Inappropriateness and inadequacy of resources	5	8.3
Autonomy and interdependence	5	8.3
Transparency and accountability principles	4	6.7
Legal and regulatory framework	4	6.7
Total	60	100.0

Source: Fieldwork (2012)

Strategies that facilitate collaboration

Table 18 shows the strategies that can improve collaboration of both the governmental and non-governmental organisations. Among these, the respondents clearly outlined parity and participative decision making which constituted 36.7 percent of responses as the most outstanding strategy for

improving collaboration. The other strategies pointed out included shared vision/objectives (30.0%), open and frequent communication (23.3%), trust and respect for partners (18.3%), shared leadership (15.0%), commitment/mutual understanding (15.0%), organisational achievement (13.3%) and finally stakeholder involvement with 11.7 percent of responses.

Table 18: Strategies that improve collaboration

Strategies that can improve collaboration	Number of Respondents	Frequency	Percent (%)
Parity and Participative Decision Making	60	22	36.7
Shared Vision/Objectives	60	18	30.0
Open and Frequent Communication	60	14	23.3
Trust and Respect	60	11	18.3
Shared Leadership	60	9	15.0
Commitment/Mutual Understanding	60	9	15.0
Organisational Achievement	60	8	13.3
Stakeholder Involvement	60	7	11.7

Source: Fieldwork (2012) *Multiple responses

In the opinion of Gray (1989), the success of collaboration depends on the existence of mechanisms including ground rules concerning power sharing and communication, mutual empowerment and collective action, provisions for resolving unanticipated conflicts and signals indicating perceived breaches of faith. Gibbs (1999) has referred to several mechanisms that contribute to the success of collaboration to include: efficient, accountable and transparent organisational structures; standardised procedures; sufficient funds, staff, materials and time; participative decision making; competent leadership; realistic time frames; and a safe, non-threatening work environment.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter summarises the research study and presents a summary of the findings of the study as well as the conclusions drawn from the findings. Recommendations are also made in line with the conclusions to guide stakeholders and outline areas for xfuture research.

Summary of the study

The study sought to determine stakeholder perception on factors influencing collaboration between NGOs and GOs in the provision of Health Education within the Tema Metropolis of the Greater Accra Region of Ghana. The research design used was a descriptive survey.

Literature was reviewed on the topics to cover both theoretical and empirical requirements. The contribution of NGOS to development, the need to collaborate in health education, rationale, characteristics, requirements, types, models, principles, process, determinants and barriers to collaboration between organisations were all reviewed. The review also looked at the policy environment for collaboration in Ghana.

All key personnel from GOs and registered NGOs in the metropolis constituted the population for the study. The simple random sampling method was used to select a total of sixty respondents consisting of thirty each from NGOs and GOs for the study. A structured questionnaire was employed as the main instrument for data collection and Data was analysed using descriptive statistics such as frequency and percentages.

Summary of key findings

The major findings of the study were as follows;

i. The researcher identified that there is collaboration between NGOs and GOs in the provision of some health education programmes;
ii. Some of the NGOs providing health education were not registered with the MHD which is regulatory body for health provision in the metropolis;
iii. It was observed that GOs are responsible for policy implementation and coordinate with NGOs run coordinated projects to support the health education programs;
iv. It was established that most of the health education collaboration projects were designed and directly implemented by the NGOs but regulation is done by GOs;
v. It was noted that both formal and informal interactions are widely used in collaboration partnerships between the GOs and NGOs. Formal interaction however was more widely used than informal interactions;
vi. The study showed that majority of the collaboration partnerships between the GOs and NGOs are covered by a memorandum of understanding (MoU);

vii. It was noted that both traditional and electronic communication methods such as Memoranda, Letters, Reports, Face-to-Face Meetings, Electronic mail, fax and the telephone were all adopted to facilitate collaboration. Teleconferencing was however not a common communication method between GOs and NGOs;

viii. It was established that collaboration between GOs and NGOs is prompted by donors or is a policy requirement for organisations involved. It is not often an initiative by the partners;

ix. The study identified that the major factors regarded as key for collaboration to succeed between GOs and NGOs were communication, purpose for the collaboration, policy environment, the availability of resources or incentives, stakeholder interest or pressure and structure and process;

x. The strategies that can improve collaboration of both GOs and NGOs are parity and participative decision making with both partners involved in the process and having a shared vision or objectives. In addition, open and frequent communication, trust or respect between the partners, the commitment and mutual understanding towards collaboration projects, organisational achievements, beneficiary satisfaction and stakeholder involvement are all strategies that were listed by respondents as having the potential to improve collaboration;

xi. The study revealed that the major factors that limit the effectiveness of collaboration in organisations are organisation goals or culture, the management or administrative processes and stakeholder or beneficiary interest. Other limitations include sharing or access to

information, communication, inappropriateness or inadequacy of resource, the legal or regulatory framework and transparency or accountability principles;

xii. The study showed that GOs involved in collaboration are often the beneficiaries of supports in the form of materials, funds and education or training. It also helps them to improve their coordination or monitoring functions, improves trust and communication with NGOs and grants them access to data or information sharing.

xiii. The study establishes that NGOs are the beneficiaries of Training or Technical Support from GOs. This partnership helps them to gain recognition and legitimacy, builds their capacity and enables them to gain access to data or share information with GOs. It also enables them to gain government funding support for programmes;

xiv. It established that GOs are engaged in the provision of technical assistance, curative services or healthcare delivery, training of personnel or agents involved in programmes, infection testing and the provision of information in their collaboration with the NGOs; and

xv. It was also established that NGOs are responsible for programme development and the direct implementation of projects. They also provide material support, funding, help with data gathering and also share responsibility for monitoring and evaluation of projects.

Conclusions

i. The study identified that GOs and NGOs collaborate on health education projects such as reproductive health, malaria control and HIV/AIDS education. GOs responsibilities in collaboration was

revealed as fulfilling their mandate of implementing national health policy and NGOs were identified to design and develop projects for collaboration within the framework of government programmes.

ii. It was also revealed that a weak nature of collaboration exists between GOs and NGOs. Interaction including communication methods between the partners was identified to be mainly formal with planning, decision making, design and financial management of projects mainly undertaken by NGOs. Registered NGOs were revealed to have signed MoUs with the MHD to guide the collaboration process.

iii. The study revealed the reasons for collaboration as policy and donor requirements.

iv. It was also established that benefits in the form financial, material and technical support from the partner organisations helps to facilitate organisation collaboration.

v. The study also revealed that difference in organisation culture, administrative processes and the regulatory framework among factors that limit the collaboration effectiveness. It suggests strategies such as shared leadership, frequent communication and participative decision making between partners to improve organisation collaboration.

Recommendations

In view of the findings of the study and conclusions drawn, the following recommendations are submitted:

i. Collaboration should be strengthened through the active involvement of heads of health institutions and NGOs in the provision of health

education programmes. Stakeholders such as philanthropists, CSOs and government should help provide funding for health education programmes that receive little support such as tuberculosis control, environmental sanitation, nutrition, oral and mental health;

ii. Directors at the Metropolitan Health Directorate should be proactive by moving beyond mandate into the design and implementation of projects to achieve programme goals;

iii. Monitoring and evaluation of projects should be regular but undertaken by both NGOs and GOs;

iv. Informal interaction methods should be encouraged between heads of health institutions in the metropolis and NGOs to improve rapport. Heads of health institutions should be actively involved during decision making processes, planning and the financial management of collaboration projects;

v. The Metropolitan Health Directorate should work with the Metropolitan Assembly to compel all NGOs working in the metropolis to register with them to enhance regulation and monitoring;

vi. All collaboration projects should be covered by a Memorandum of Understanding with plans for implementation, monitoring and evaluation that sets out the specific purpose or objectives for the collaboration and demarcates the responsibilities and obligations for each partner;

vii. NGOs must plan, design and implement collaboration projects together with the heads of health institutions with final approval from the Metropolitan Health Directorate to ensure that beneficiaries are the

focus. Projects must have clear outlines on roles of the partners to eliminate differences in culture, administrative and management processes;

viii. Other stakeholders should be consulted during the design phase of collaboration projects to make them have better impact. Clear rules should be set out by the Metropolitan Health Directorate to control against unnecessary interference in collaboration efforts;

ix. Bureaucracy within GOs should also be reduced when working with NGOs which are smaller organisations with less officialdom; and

x. NGOs should be transparent in their activities when working with the health institutions on health education projects to improve trust. Personnel from both GOs and NGOs should show tolerance and mutual respect to each other.

Suggestions for Further Research

This study only begins to reveal the factors influencing collaboration between GOs and NGOs however there are limitations to what the study covers. Some unanswered questions have been exposed in this endeavour. The study fails to yield a definitive answer to the question of whether collaboration offers any benefits in terms of cost effectiveness and technical efficiency over other formal arrangements in terms of attaining project or service delivery goals. Also, can government agencies choose not to collaborate and still be effective? While the study offers some valuable insights, answers to these questions are of considerable importance and I recommend them for further studies.

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APPENDIX A

RESEARCH QUESTIONNAIRE

This questionnaire is to assist the student-researcher to determine factors influencing collaboration between NGOs and government organisations (GOs) in the provision of health education (HE) in the Tema Metropolis. The intention is to identify factors that can help improve NGO – GO collaboration in health education. Your honest response is needed to enable me achieve this intent. Any information you give will be used ONLY for academic purpose.

For the purposes of this study, health education seeks to provide knowledge, skills, attitudes and values conducive to good health of people.

Kindly Tick [√] or State accordingly

Name/Type of Organisation: .....

SECTION I: BACKGROUND INFORMATION OF RESPONDENT

1. Age at last Birthday: .....years.
2. Level of Education: .....
3. Position in the Organisation: .....
4. Work experience: .....years.

SECTION II: FACTORS INFLUENCING COLLABORATION

5. Core mission (role) of the organisation:

   .....

   .....

6. What are the health education programmes of your organisation?

   a.

   b.

   c.

7. Organisations you are collaborating with and the nature of collaboration.

Collaborating Organisation	**Areas/ Programs of collaboration**	**The Organisation's Role/ Responsibilities**	**Your Organisation's Role/ Responsibilities**	**Nature of Interaction Formal/ Informal**	**MOU Signed Yes/No**
a.					
b.					
c.					
d.					

8. What is your *most frequently* used channel of communication with the organisations you collaborate with?
   i. Face-to-face/Meetings [ ]
   ii. Telephone [ ]
   iii. Memorandum/Letters/Reports [ ]
   iv. Electronic mail/Fax [ ]
   v. Teleconferencing [ ]
   vi. Others (Specify) .....

9. What are the key reasons for your collaboration with the organisations you have indicated in Q 7?

Collaborating organisations	Reasons (Tick √ or write to specify)			
	Policy requirement	Internal initiative	Donor requirement	Others [Specify]
a.				
b.				
c.				
d.				

10. What are the key benefits of your collaboration with the other organisations in health education?

Collaborating organisations	Benefits to your organisations	Benefits to the collaborating organisation
a.		
b.		
c.		
d.		

11. What key factors would you say have contributed to sustain your collaboration with other organisations in health education?

Collaborating Organisation	Key factors/conditions that have contributed to maintain your collaboration
a.	
b.	
c.	
d.	

12. What key factors would you say have limited the effectiveness of your collaboration with the other organisations in health education?

Collaboration Organisation	Limiting factors/conditions
a.	
b.	
c.	
d.	

SECTION III: STRATEGIES THAT CAN IMPROVE

COLLABORATION

13. In your view, what do you think your organisation can do to improve its collaboration with other organisations health education?

a) ……

……

……

b) ……

……

……...

APPENDIX B

MAP OF THE TEMA METROPOLIS