

**Mapping and Capacity Analysis**  
**of the Civil Society**  
**in Sissala East District**

**August 2005**

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## Acronyms

ASUDEV	Action for Sustainable Development
CBD	Community Based Distributors
CHC	Community Health Committee
CHV	Community Health Volunteers
CMA	Christian Mothers Association
CRS	Catholic Relive Services
CYO	Catholic Youth Organisation
DA	District Assembly
DANIDA	Danish International Development Agency
DHMT	District Health Management Team
DSV	Disease Surveillance Volunteers
FEDYAG	Federation of Youth Association of Ghana
FGD	Focus Group Discussion
FOMWAG	Federation of Muslim Woman Association in Ghana
GARFUND	Ghana AIDS Response Fund
GES	Ghana Education Service
GHS	Ghana Health Service
GILLBET	Ghana Institute of Linguistic, Language and Bible Translation
GNAT	Ghana's National Association of Teachers
HIPC	Highly Indebted Poor Country
HIS	Health Insurance Scheme
HIV/AIDS	Human Immune Deficiency Virus/Acquired Immune Deficiency Syndrome
IMCC	International Medical Cooperation Committee
MOFA	Ministry of Food and Agriculture
MoH	Ministry of Health
NADMO	National Disaster Management Organisation
NDC	National Democratic Congress
NGO	Non-Governmental Organisation
NUSS	National Union Sissala Strengths
PAWLA	People Association for Winning Life All-round
PHC	Primary Health Care
PLWHA	People living with HIV/AIDS
PRA	Participatory Rural Approach
PRV	PAWLA Rural Volunteer
SDHMT	Sub District Health Management Team
SHC	School Health Committee
SMC	School Management Committee
SSI	Semi Structured Interview
SWOT	Strengths, Weakness, Opportunities and Threats
TBA	Traditional Birth Attendant
TUTCO	Tumu Teacher Training College
VCT	Voluntary Counselling and Testing
VSO	Voluntary Services Overseas
YARO	Youth Association of Reproductive Order

## **Acknowledgements**

The consultant would like to thank all contributors to the mapping and capacity analysis. Special gratitude goes to the District Health Management Team and members of the coalition of local NGOs, in particular YARO, PAWLA and ASUDEV.

It was, as always, a pleasure to live and work with members of the IMCC house; Solvej, Claus, Sara, Mads, Line, Karsten, Ballon, Bukari, Seidu, Yaa, Issah and Puma.

## **Introduction**

The joint DHMT/IMCC project is situated in the Sissala East District in Upper West Region, Ghana. IMCC has been working in Sissala District since 1997. Originally IMCC focused on primary health activities at sub district level. It was, however, realised that many of the constraints met in the villages and sub district clinics were targeted more effectively and reaching a larger target group through collaboration at district level. Since the second phase of the project IMCC has been a co-opted member of the District Health Management Team (DHMT). DHMT has the overall responsibility for service delivery, monitoring and support, planning, finances and human resources in the district.

In 2003 a midterm review was undertaken which recommended a third phase and in October 2004 a team of Danish and Ghanaian consultants went to Sissala District to draft a new project document. In February 2005 an application for a third phase was sent to IMCCs funding agency, Danida. This application received a positive rejection for the reason that the Danida Civil Society Strategy had not received enough attention. In order to adjust the project strategy IMCC decided to employ a consultant to perform a mapping and capacity analysis of the civil society in Sissala East and the northern part of Ghana.

This report presents the findings of the mission. The report falls in three sections; The civil society in Ghana, the civil society in Sissala East District and recommendations for project strategy adjustments. The first part has not received much attention which is in accordance with the terms of reference.

## Mission objectives

The mission had three objectives.

**Objective 1:** A brief descriptive analysis of the Civil Society in Ghana, with special emphasis on the Northern part of Ghana.

**Objective 2:** Thorough mapping and analysis of the character and organization of the Civil Society in Sissala East. This shall include persons and organizations with influence on and interest in the health status of the target groups articulated in the Project Document.

The analysis should highlight the following components:

- The qualification of the Civil Society organisation
- The influence of the Civil Society organisation
- The resources of the Civil Society organisation
- The credibility of the Civil Society organisation
- The validity of the Civil Society organisation

**Objective 3:** Submission of a report covering Objective 1 and 2 with conclusions leading to recommendations as to how IMCC can adjust to the Strategy for Support to the Civil Society in the developing countries.

## Methodology

The report presents a mapping and capacity analysis of relevant civil society organizations in Sissala East District, Upper West Region, Ghana. In addition, it contains a brief analysis of the general civil society situation in Ghana and in particularly Northern Ghana. The methodologies applied were diverse but mainly qualitative.

Strategies to obtain high validity included active participatory involvement of the civil society in Sissala East District in the mapping exercise. When possible, repetitive contacts with informants, actively seeking cases of invalidation and triangulation were performed. Triangulation is the combination of different data collection methods and multiple informants to illuminate the same thematic issue<sup>1</sup>. More approaches or informants pointing to the same conclusions increase the validity.

## Data collection techniques

The applied data collection techniques are below listed and described.

- Mapping
- Capacity Assessment
- Interviews
  - Individually/group
  - Semi Structured Interview

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<sup>1</sup> Hardon, A. *et al.* (2001). Applied health research – anthropology of Health and Health Care. ISBN 90 5589 191 6.

In depth with key informants

- SWOT technique
- Participant observation
- Available information

## **Mapping**

Mapping of the civil society workshops was carried out with IMCC volunteers and with members of the local NGO coalition in Sissala East District. Both workshops used a participatory approach allowing all informants to contribute. A definition of the civil society was agreed upon and categories such as religious organizations, community based organizations were identified, written on a piece of paper and put on a wall to enhance participants overview. Subsequent participants brainstormed and when a civil society group was identified, it was written down and placed under the category participants agreed on.

## **Capacity Assessment**

There exists a wide range of tools to assess organizational capacity. In this mission a framework to guide and structure the process was developed from mainly the rapid capacity assessment model.

Components of the framework were:

- *Structure* relates to division of labour amongst the staff, lines of communication and lines of command within the organisation.
- *Systems* denote the tools of the organisation including operational procedures and information.
- *Skills* refer to the ability of the staff to apply the systems.
- *Incentives* are the individual and collective motivations of the staff.
- *Strategy* is the attempted alignment of the four components above in pursuance of the objectives with the given resources.
- *Inter-relationships* indicate to what extent and how the Centre relates to other organisations

This framework has been used to guide the assessment and a descriptive analysis of each component has been carried out using semi structures interviews, in-depth interviews and literature review if available.

The model was applied to the civil society organizations met during the mission. However as more organizations that possibly had relevance for the mission emerged, a screening model was developed and distributed to IMCC volunteers who then visited those organizations without involvement from the consultant.

## **Focus Group Discussions**

A focus group consists of a number of people who are of roughly equal status and have some identifiable common interests, characteristics, and shared knowledge. Under the guidance of an interviewer or moderator, they discuss specific questions, or areas of experience. Participants are experts because of their experience or knowledge about the topic to be discussed.

The advantages of FGDs are that they are low-cost, flexible, allow in-depth exploration and they are not time consuming. They are useful in establishing whether the facilitator and the subjects are talking about the same thing (face validity) and internal triangulation or corroboration i.e. verifying

common perceptions<sup>2</sup>. The main disadvantage of FGDs is that minority opinions may not always be expressed, especially in cultures where confrontations or debates are considered improper.

During the mission focus group discussions were used mainly at a community meeting with villagers from Nabugubelle village. In addition, many of the below mentioned methodologies such as SWOT analysis and mapping exercise were utilised as focus group discussions on issues the consultant found relevant.

### **Interviews**

In depth interviews is conducted in order to obtain information that is not appropriate or too extensive and complicated for focus group discussions. The interview can be structured or semi-structured. Semi structured interviews (SSI) is a form of guided interviewing where only some questions are predetermined and new questions can be formulated during the interview. If it becomes apparent during the interview that some of the questions are irrelevant, they can be skipped. It is conducted in a manner that encourages participants to introduce subjects or aspects of subjects that are not anticipated by the interviewer. It does not use a formal questionnaire but at most a checklist of questions as a flexible guide during the interview. The SSI can be carried out either as individual interviews or group interviews.

The above mentioned rapid capacity assessment model was used as a framework to guide SSI with usually two representatives from civil society organizations. In depth interviews was performed with key informants identified by the consultant, IMCC or civil society organizations. For a comprehensive list of organizations and persons interviewed please refer to appendix 4.

### **SWOT analysis**

SWOT analysis aims at identifying the internal Strengths and Weaknesses, and of examining the external Opportunities and Threats. Carrying out an analysis using the SWOT framework can be utilized operational to focus on strengths, minimise weaknesses, and take the greatest possible advantage of opportunities available. It is very effective when it is applied to a specific objective or project but can also be used to analyse the overall organisational capacity of an organisation. To ensure a best possible result in an overall analysis it is important that the group is as representative as possible, including people from different levels and activities of the organisation<sup>3</sup>.

The SWOT analysis was carried out asking participants to do 5 minutes individual work considering the four groups. Hereafter participants in groups discussed and wrote five strengths, weaknesses, opportunities and threats on cards. This was followed by presentation where participants placed the cards in relevant groups and the consultant facilitated focused discussions on arising issues.

During the mission two SWOT analyses were carried out with local NGOs that were identified by IMCC as possible future collaborators, YARO and PAWLA. The SWOT with YARO focused on their capability to carry out Voluntary Counselling and Testing (VCT). The SWOT with PAWLA focused on their general organisational capacity.

### **Observation**

Observation involves selecting, watching and recording behavior and characteristics of living beings, objects or phenomena. Here, observation of meeting procedures, division of tasks and time to talk,

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<sup>2</sup> Erwin, Alexander M. (2000). Applied Anthropology – Tools and Perspectives for Contemporary Practice. ISBN 0-321-05690-6.

<sup>3</sup> The International Federation of Red Cross and Red Crescent Societies “Capacity Building Framework”

leadership culture was performed by both the consultant and IMCC volunteers. After interviews and workshops the observations were discussed.

### **Available information**

Available information used was published articles, Government of Ghana policy documents and various reports including IMCC records of collaboration with the different organisations.

### **Field work**

The Fieldwork was carried out in Ghana in Sissala East District in August 2005 by an external consultant, Stine Lund, a former IMCC volunteer who was also a part of the project extension mission in 2004. The mission was planned and carried out in collaboration with IMCC home- and outgroup.

## Definition of civil society

There is no universally accepted definition of what the term civil society entail. The definitions used by different organisations such as World Bank, danida and the John Hopkins University were discussed and it was agreed that the structural-operational definition from the John Hopkins University was suitable for the mission. According to this, the civil society sector is defined as composed of five entities:

- *Organizations*, i.e., they have some structure and regularity to their operations, whether or not they are formally constituted or legally registered. This means that the definition embraces informal, i.e., non-registered, groups as well as formally registered ones.
- *Private*, i.e., they are not part of the apparatus of the state, even though they may receive support from governmental sources.
- *Not profit distributing*, i.e., they are not primarily commercial in purpose and do not distribute profits to a set of directors, stockholders, or managers. Civil society organizations can generate profits in the course of their operations, but any such profits must be plowed back into the objectives of the organization.
- *Self-governing*, i.e., they have their own mechanisms for internal governance, are able to cease operations on their own authority, and are fundamentally in control of their own affairs.
- *Voluntary*, i.e., membership or participation in them is not legally required or otherwise compulsory.

Excluded are government agencies and legislators, individual businesses, political parties and the media.

## Categories of civil society groups

In the literature there is, as with the definition of the civil society, no universal accepted way to categorise civil society. In addition, the categories are understood and defined differently in literature. As the NGO coalition in Sissala East District and the District Assembly expressed great interested and need for this mapping the categories are defined as the majority understood them. There were some discussions as to what is understood by a local NGO and a CBO, and it became evident from government registries that different departments categorise the same organisation differently.

The categories used in this report is

- *International NGOs*  
Usually big resourceful humanitarian development organisations with head offices in other countries than Ghana.
- *Local NGOs.*  
Ghanaian NGOs working in Sissala East District
- *Community based organisations, CBOs*  
Grassroots organisations that are small, cover a limited geographical area within the District and are formed to take care of members own interests.
- *Government initiated civil society organisations*

Community based civil society groups that are formed on the initiative of the government system and that would otherwise not exist.

- *Traditional structures*

Local traditional political, social, cultural or ethnic structures.

- *Religious Organisations*

- *Cultural institutions*

Culture and sport groups

- *Associations and unions*

National and local unions and associations based on members professions with the aim to take care of their own interests. Cover both formal and non-formal sector.

Naturally some of the civil society will fall under more than one category and as such there are many overlapping organizations or structures.

## The civil society in Ghana

In a historical perspective there are an increasing number of varied Civil Society organisations in Ghana and they play a very significant role in their various sectors. The organisations have proliferated during the past quarter century, as have the issues they address. They increasingly employ extensive networks to pursue their activities and to try to influence policies on a broad range of issues. The civil society groups were in the forefront to bring about the beginnings of formal democracy in the early 1990s by for instance opening debates on new political directions.

However civil society generally still remains weak with great regional differences in their number and capabilities. One perspective is the linkage to poverty level, according to the Ghana Poverty Reduction Strategy (GPRS) 70 % of the population in the three Northern Regions live below the poverty line. Of these food crop farmers such as the majority of people living in Sissala East District, have the highest level of poverty. According to the health and demographic survey (1998) 68,4% of the population in Upper West Region have no formal education. In a society with these characteristics the civil society on community level organise themselves mainly for purposes of social, moral and financial security networks and for income generation. The high level of poverty, mortality and morbidity in the three Northern Regions has attracted the attention of international NGOs. They are however mainly operating in Northern Region.

Religion plays an important part of all Ghanaians lives and in the civil society sector. Christianity is strongest in the southern part of the country, while the Northern Regions are predominantly Muslim. The traditional African religions are strong and often intertwine with the more recent religions like Christianity and Islam.

In the health sector Government of Ghana have during the first Five year Programme of Work acknowledged the contributions to the health sector by Non Governmental Organisations. Although the government owns the higher level hospitals, the private sector emerges from district level and below. In 2001 less than half of all hospitals were owned by government with the remaining being mission or private for profit. All health centres were government owned but at community level the services are very pluralistic consisting of Traditional Birth Attendants (TBAs), chemical sellers and traditional practitioners of which some are specialised such as bonesetter and wanzams<sup>4</sup>. It is estimated that 80% of clinical encounters are preceded by an encounter with a community based provider of some sort<sup>5</sup>.

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<sup>4</sup> Traditional healers who perform circumcisions and tribal marks

<sup>5</sup> Ministry of Health, Government of Ghana (2001), "The Health of the Nation".

## The civil society in Sissala East District

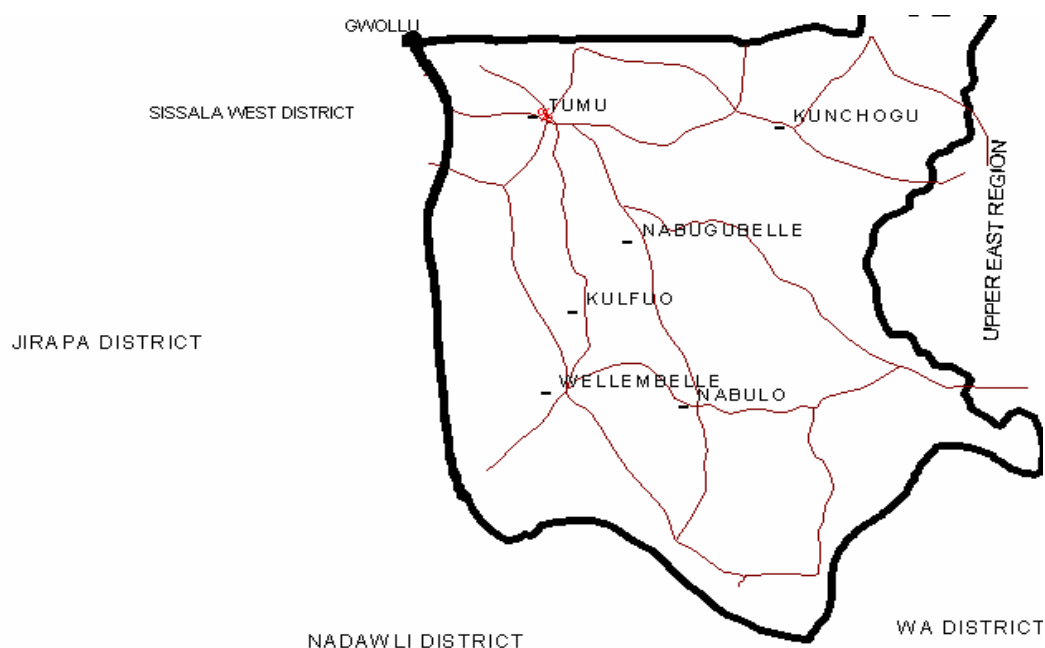
Sissala East District is a rural district located in one of the three deprived Northern Regions, namely Upper West Region; please refer to Appendix 5 for map of Ghana. Sissala District has just split into two districts; Sissala East and Sissala West. The district has low population density and the roads are all dirt roads and most are in a bad condition. Approximately two-thirds of the population are poor subsistence farmers, and 85% of the adult population are illiterate.

The formal health system in the district consists of one district hospital and five Health Centres. The non-formal health sector remains very strong in the villages and the co-operation between the two sectors is quite limited or poor. Generally there is low access to health care.

The civil society in Sissala East District is diverse and dynamic. There is a surprising amount of groupings and organisations on every level from big international NGOs to women groups widely spread to even the smallest most remote communities.

It is impossible to list and capture and describe all the civil society in Sissala East District this document and it is not the scope of the mission. The organisations or groups selected for this report are the ones who are involved in health activities or otherwise identified as relevant for IMCC/DHMT. For an overview of the total identified civil society organisations/groups/structures refer to Appendix 1. There is a concentration of organisations and groups in and around the district capital, Tumu. A few international NGOs have district wide coverage but most organisations work only in selected communities. Most of the Community Based Organisations (CBOs) only have activities in their own community. In the following for some international and local NGOs maps will indicate whether they are district wide or the communities the organisation operates in.

### Sissala East District



## International NGOs

The NGO coalition identified five international NGOs including IMCC. Two, VSO and Peace corps, are presently not involved in health activities. They typically send volunteers to teach at senior secondary schools or support local business initiatives. Besides IMCC the two major NGOs are ActionAid and Plan International Ghana. The two organisations have some common characteristics. Both generate most of their funding from child sponsorships. They do not give individual child funding but rather general community development for the benefit of all children in the community. They are relatively to the surroundings very resourceful with many cars, motorcycles, big offices and permanent staffs. Both have the fundamental strategy that they do not directly carry out project activities but work through partners or specific project funding. The two NGOs have overlapping fields of interests and have for some activities shared the former Sissala District between them. Action Aid is working mainly in Sissala East and PLAN in Sissala West.

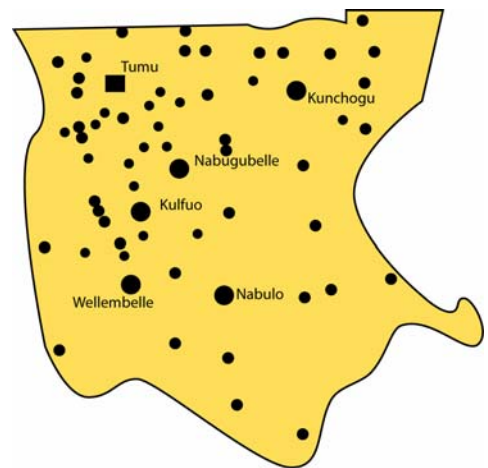
### ActionAid

ActionAid is a world wide British NGO that has been in Ghana for 14 years and presently work in the three Northern Regions and Western Region. There is a regional head office in Tumu Town with 12 permanent staff employed. Activities are focused in Sissala East but cover in principle the whole Upper West Region. Certain activities such as supporting rural volunteer teachers cover both Sissala East and West District.

ActionAid carries out their activities through local partners which can be both governmental and non governmental organisations. A partner is signed on a one to five year contract. Presently ActionAid is partnering with government departments in education and agriculture sectors (GES, MOFA, DA, NCCE and CHRAJ).

Three local NGOs have since 1<sup>st</sup> quarter 2005 been supported on an experimental basis and may in future qualify to become full partners. The organisations are Peoples Action for Winning Life All-round (PAWLA), Action for Sustainable Development (ASUDEV) and TUTRIDEP. PAWLA and ASUDEV are being supported to carry out HIV/AIDS sensitisation and prevention in Sissala East District. According to ActionAid the three organisations still need to develop financial management capacity to become full partners. If an organisation is found worthy to become full partner a Memorandum of Understanding is signed and ActionAid then also gives funds for logistics such as computers, motorbikes and permanent staff. ActionAid also funds proposals from non-collaborating agencies if they fall under their focus areas.

ActionAid sponsors 2000 children in Sissala East and West District. 60% of their funds are used here and the remaining in Upper West Region. Disbursements to partners and specific proposals are made quarterly. According to the finance officer there is not a shortage of funding worthy proposals. They capacity builds some local NGOs in proposal writing and financial management although not on a regular basis.



Quarterly meetings are being held with partners where the last quarter is being evaluated and the next quarter planned. Yearly, in September, a planning and budgeting meeting is being held with partners and relevant NGOs/CBOs.

ActionAid has four main areas of interest; Agriculture and Food Security, Education, Institutional and Capacity Building, Gender Equity. In addition there are two cross cutting issues; HIV/AIDS and Peace Building.

In the HIV/AIDS strategy ActionAid focuses on prevention (through approaches such as stepping stones package and journey of hope) and support programs for People Living With HIV/AIDS (PLWHA). In Sissala District there are presently no PLWHA associations but ActionAid supports the activities of local NGOs within this area. ActionAid monitor the activities carried out by partners.

There are apparently no HIV/AIDS technical expertises or external resource persons attached to ActionAid who promotes some initiatives that are not well documented. For example, a “life oil” is suppose to give AIDS victims appetite and a marenga tree is mentioned to be nutritionally adequate for PLWHA. ActionAid is pro condom use.

ActionAid coordinates their activities through quarterly meetings with their partners and selected other organisations. In addition, activities have been coordinated with PLAN, but ActionAid has not been active in the local NGO coalition nor the District Response against HIV/AIDS.

### **Plan International**

Plan International is a child-focused humanitarian development organization with activities in 41 developing countries, currently 19 of those in Africa. Plan has been active in Ghana since 1993 but started activities in then Sissala District in 2003. Presently Plan works primarily in Sissala West District but in approximately one year they will move to communities in Sissala East District. There are 26 full time paid staffs. Over 80% of funding comes from private donations to child sponsorships.

Like ActionAid Plan carries out all activities through partners but comparably they give the impression to be more active in the field by for instance monitoring of partner organisations.

Activities are coordinated through a Programme Management Team that meet quarterly to review the plans for the next quarter. At community level yearly budget planning meetings are held where the communities prioritise their needs. The planning year is from July to June and planning for the subsequent year starts in January.

PIs primary guiding directions of programmes are Growing Up Healthy, Learning, Habitat, Livelihood and Building Relationships. The Growing Up Healthy component of the programme focuses on strengthening the primary health care delivery system. More specifically, Plan has in the period June 04 to July 05 had a budget for health activities on approximately 860,000,000 cedis<sup>6</sup> for

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<sup>6</sup> 100 cedis = 0,07 DKK

- Strengthening the community based health services: training and support of TBAs, Community Based Distributors (CBDs) of family planning devices, Community Health Volunteers (CHVs), peer educators and daddies clubs
- Support the Ghana Health Service (GHS) in monitoring and supervision
- Support of the immunization program
- Malaria control
- Improve nutritional status of children
- HIV/AIDS care and prevention.

According to Plan the activities are carried out with the involvement of DHMT personnel. On community level volunteers are educated and Plan operates with Traditional Birth Attendants (TBAs), Community Based Distributors (CBD) and Community Based Volunteers (CBVs) who more or less have the same responsibilities as the Ghana Health Service Disease Surveillance Volunteers (DSVs). Each Plan village has a Community Health Committee (CHC). Plan partners adopt and implement the Plan project framework.

Plan partners are the same government agencies in education and agriculture as ActionAid (GES, DA, MOFA). In addition the local NGOs TUTORIDEP and YARO are partners. YARO is being supported on a one year agreement to carry out Plan activities in ten selected communities. Two of these, Jijen and Lilixe, in Sissala East District.

Coordination of health activities with Plan is according to IMCC records difficult. For example, the budgets for training and motivation of volunteers are significant higher than DHMT can afford. This has created a competitive situation where GHS volunteers do not want to work because they are feeling under-privileged. The Plan CHVs are given drugs such as paracetamol and chloroquine, a concept that has already been tried and found not suitable by DHMT. In addition, Plan did not discuss expanding the CHV's responsibility in advance with DHMT. Plan volunteers report to PLAN rather than DHMT and they are being monitored by PLAN. As a result Plan trained volunteers are perceived as Plan and not DHMT volunteers. The problems has been sought solved by IMCC/DHMT but as with ActionAid Plan has not been very receptive to adjustments in their project strategy. At the meeting during this mission it however became evident that Plan are aware of the above mentioned problems. Plan participated in the local NGO coalition meeting which ActionAid did not.

#### *Comments and recommendations*

*ActionAid and PLAN are organisations with a high level of qualification, influence and resources. The main problems identified are pertaining coordination of activities and collaboration with DHMT. The two organisations give the impression only to participate in coordination and planning of the district health response according to their own needs and not being receptive to suggestions for adjustments from DHMT. This creates problems with credibility and trust between them, other civil society organisations and the Ghana Health Service.*

*PI and AA are major funders that have a great influence on health activities in Sissala East District. It is crucial that the collaboration and coordination around planning, budgeting, training and monitoring the districts health response is enhanced. This is particularly obvious with regards to selection and training of community health volunteers and the districts HIV/AIDS response. So far coordination has been on ad hoc basis. Part of the problem possibly lies in the fact that DHMT is not taking the leadership role.*

*It is recommended that*

- *IMCC/DHMT creates a forum for coordination of District health activities between DHMT and NGOs working with health.*
- *IMCC/DHMT advocate for ActionAid and Plan to participate actively in the overall district coordination and planning of health activities*
- *IMCC/DHMT advocate that especially Plan adjust training of volunteers, creation of community health committees and monitoring in line with Government of Ghana policies.*
- *IMCC/DHMT participates in the yearly planning and budgeting meetings of ActionAid and Plan.*
- *IMCC capacity builds local NGOs and CBOs to obtain funding for their activities through submitting proposals to ActionAid and Plan.*

## **Peace Corps**

Peace Corps is an American NGO that sends volunteers to developing countries on two years contracts. The volunteers receive a minimum wage and are typically involved in creating local initiatives in the area of tourism, micro credit or health. Presently there are no Peace Corps volunteers in Sissala East District but in September 2005 a local NGO, YARO, will receive a health volunteer.

Peace corps volunteers do not get distributed to specific positions before arrival in Ghana and therefore the capacity of the future volunteer is not known.

### *Comments and recommendations*

*IMCC and YARO are planning a collaboration to create a functioning Voluntary Counselling and Testing (VCT) unit in Sissala East District. Although it is not know what training, age, gender and general capacity the peace corps volunteer will have, there is an opportunity to ensure that the volunteer is interested in HIV/AIDS and specifically VCT. Peace Corps volunteers are not allowed to drive on motorcycles, which is another reason for the volunteer to focus on VCT since activities will be based in Tumu .*

### *It is recommended that*

- *IMCC and YARO contact Peace Corps and advocate receiving a volunteer that has VCT capacity and/or interest.*

## **Local NGOs**

Nine local NGOs were identified and five of these have health activities. YARO, PAWLA, ASUDEV. Two others CMA and FORMWAG are religious organisations and will be described as such later. Common for the organizations are that they have an organisational structure where they rely on volunteers with few or no permanent staff. Some has offices and one or two computers, all have bank accounts but generally low capacity in management and proposal writing.

Most of the local NGOs have volunteer staff. It is however important to realise that in Ghana when a person are volunteering for an organisation something is usually expected. It does not necessary have to be per diem but could be a durbar by the end of the year or travel money, what is called “small appreciations” or “motivation”. Likewise many of the members of the local NGOs see the NGO as a carrier possibility.

## Youth Action on Reproductive Order, YARO

YARO is a local non-political, non-religious NGO which is active in the health and education sectors in the three Northern Regions. It was started in 1999 by local schoolteachers and nurses focusing on safe reproductive health. YARO has offices in two regions, a head office in Tamale and since 2002 an office in Tumu, Sissala East District. Until 2005 members of YARO in Tumu were volunteers, but in January 2005 YARO started a collaboration with Plan which gave the opportunity to employ four full time paid staffs. They are a coordinator, a secretary, an accountant and a field officer (two males and two females). There are six so called supporting volunteers of which half are university students who use YARO as a educational training ground. For obvious reasons they are only active during leaves and their support is not regular. They are considered volunteers but sometimes YARO contributes to their university/school fees. Other YARO volunteers are mainly students and teachers.

The coordinator also functions as field staff and according to YARO this is in order to cut down on funds used for permanent staff. Each YARO community has two focal persons and a number of peer educations and volunteers under those. YARO estimate them selves to 5000 members in Sissala East and West.

Some YARO activities are district wide but since the collaboration with PLAN ten villages has been selected, eight in Sissala West and two in Sissala East, Lilixe and Jejen. In addition YARO has activities in Kong, Sakai, Bugubelle, Wellembele, Pieng. YARO has a modest office, two computers, one printer and two motorbikes.

Historically YARO has received funds from YARO Headquarter in Tamale, Ghana AIDS Response Fund (GARFUND), District Assembly, ActionAid and GES.

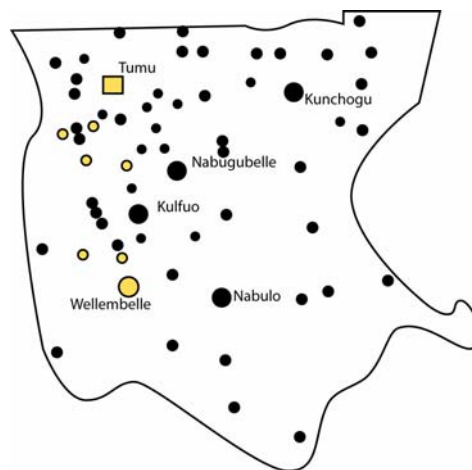
YARO has a board with five members that hold quarterly meetings. There is a written constitution and in 2002 it was official registered as a NGO at the general registrar in Accra.

YARO staffs meet on a daily basis in the office and there is a monthly planning meeting. Communication and division of labour is mainly done on a ad hoc basis when staff and volunteers pass by the office.

By profession the coordinator is a university graduate in agriculture. The six supporting volunteers are two graduated from Senior Secondary School, one teacher and three university students. Two of the university students (biological studies and mathematics/statistics) graduate this year and are hoping to join YARO as permanent staff. The last permanent volunteer was present during the mission, he studies development studies at Tamale UDS. The accounts officer, a woman, is trained at the polytechnic and she also takes part in coordination and planning of activities.

YARO has five main areas of work:

- 1) Teacher trainings on reproductive health in the seven teacher training colleges in the three northern regions.



- 2) Adult Reproductive Health programme in ten selected communities, Jijen and Lilixe being in Sissala East. PLAN has given the responsibility to carry out their “growing up healthy” activities in those ten communities. PLAN monitors the activities. The plan is to expand to more communities next year.
- 3) HIV/AIDS prevention workshops with hairdressers, barbers, wansams.
- 4) Micro finance to women groups for poverty reduction. This year 20 million cedis has been distributed to 38 people who each receive 450,000 cedis and some training. Beneficiaries are from Pieng, Jijan, Lilixe. It is a revolving fund started by YAROs internally generated funds.
- 5) School based clubs such as virgin clubs, good health programs, sporting programs and clean up campaigns. There are YARO clubs in all Junior and Senior Secondary Schools, the vocational school and Tumu Teacher Training College. In the ten Plan villages the clubs also exist on primary school level. YARO today is a youth group consisting of young people in Tumu who are not involved in the school based clubs. The term YARO ambassadors is used to denote any person active in YARO activities.

As part of the Plan Growing Up Healthy domain YARO are planning to carry out a survey of knowledge, practices and coverage in the ten chosen villagers. Plan is providing the methodology and they will collaborate on the analysis.

YARO is very active in the attempt to organise and coordinate the activities of local NGOs in the district. During the mission the YARO coordinator was elected chairman and the YARO accountant as accountant. Especially the connection between YARO and the other local NGO ASUDEV seems strong. Presently, the collaboration between YARO and GHS is almost non-existing although YARO have used health professionals for some HIV/AIDS activities.

#### YARO and VCT

IMCC is considering entering a direct collaboration with YARO to create a functioning VCT unit in Sissala East District. During this mission two initiatives took place, a SWOT analysis on YARO capacities to carry out VCT and a meeting between Tumu District Hospital (TDH), YARO and IMCC.

The agenda of the meeting between TDH, YARO and IMCC was primarily to link the possible collaborating partners and to have preliminary indications of interest and discussions of a possible structure of a VCT unit. There are presently five GHS trained VCT counsellors but no functioning VCT unit. TDH did receive funds from the Ghana Aids Control Programme to renovate facilities but the renovation did not meet the required standards (the money was used to renovate regular consultancy rooms). Hence, counselling is primarily done in clinical cases where HIV is suspected. Both the doctor and the three GHS counsellors present were very enthusiastic about the idea of involving YARO counsellors. This was a very important signal to YARO and IMCC.

A possible structure discussed was a collaboration where GHS counsellors functioning as the permanent staff connected to the VCT unit and YARO counsellors participating in a roadster where each volunteer has one or two days/afternoons at the VCT unit. With time a possible mobile VCT unit could be attached.

It was agreed that additional trainings of both GHS and YARO counsellors was needed and that IMCC have if the project is extended has the capacity to ensure qualified technical support for the development of a locally adapted VCT organisational structure and organising of a counsellor

training. Experiences have shown that the two week GHS trainings are not sufficient for this purpose but rather three weeks trainings followed by VCT experience and subsequent follow up trainings are needed. The GHS counsellors felt that generally the local NGOs were better at sensitisation and support to people living with HIV/AIDS.

A SWOT analysis was carried out to assess whether YARO actually have the capacity to enter a collaboration on VCT. The analysis focused on the internal strengths and weaknesses and the external opportunities and threats of YARO carrying out VCT activities. For a comprehensive list see Appendix 2. The main strengths identified were related to the systems and structures of YARO. They feel YARO has adequate management system, good division of tasks between staffs, lines of communication, office equipment such as computers and printers, motorbikes and established links to at least ten communities. YARO felt they have a strong link to and trust of the communities. Available human resources for VCT was identified as a strength and when this was challenged by the consultant YARO felt confident that they could identify suitable volunteers to train as lay counsellors. It was agreed that the lay counsellors should be permanent in the district and have that as their main activity within YARO. Weaknesses included limited time, lack of computer skills, weak skills for writing proposals, lack of technical VCT knowledge, lack of funding for motivation of lay counsellors and trainings. Planning skills was identified as both a strength and weakness. YARO identified opportunities mainly in the involvement of and collaboration with other departments and organisations such as IMCC, GHS and Sissala East District Assembly. Threats were related to the issue of poor coordination possible leading to partners pulling out or VCT being established by other organisations. Also stigma, lack of confidentiality and brain drain and high turn over of health professionals was mentioned.

Based on the SWOT IMCC and YARO agreed on a possible way forward, and the expectations to and role of IMCC were clarified.

#### Way forward

- Define VCT standards and structure possible with help from an external resource person
- Identification and selection of suitable VCT lay counsellors
- Training of counsellors in VCT
- Training of YARO in proposal writing, ICT and planning skills
- Define motivation for volunteers
- Enhance coordination between actors active in the fight against HIV/AIDS in the district
- Create link with VCT partners i.e. IMCC, YARO, TDH
- Make VCT sensitisation strategy
- Ensure adequate support to PLWHA
- Make funding strategy

The role of IMCC and expectations to the collaboration was discussed and it was agreed that

- Good coordination between YARO and IMCC is important.
- IMCC can assist building human resource capacity
- IMCC can identify and consult relevant VCT resource persons to design adequate VCT structure
- IMCC can fund and organise VCT training of counsellors
- IMCC can advocate for the project within DHMT and at TDH
- IMCC do not fund motivation for volunteers but can assist in creating links to funding agents that do
- Coordinate transport between DHMT and YARO to hard to reach communities.
- IMCC can Spread information about YARO in DK

### *Comments and recommendations*

*The overall impression of YARO was that the NGO has a healthy organisational structure with seemingly good division of tasks between staffs. The permanent staffs and the participants in the SWOT exercise was observed to interact freely and on equal terms with all present at meetings contributing. The organisational systems are adequate although it is suspected that meetings are not as frequent as mentioned and there is room for improvements in planning skills and division of tasks. The staff and volunteers motivation and dedication are genuine and they are observed to be working hard and serious. Their human resource base is quite strong. The six permanent volunteers are a both an asset and opportunity as well as a threat of unequal activity level through out the year.*

*YARO left the impression of being relatively analytical and realistic about the weaknesses and threats of their organisation.*

*The main concerns with YARO is whether they have the time and human resource capacity to carry out VCT on top of all their other activities and responsibilities. The YARO partnership with Plan is a good opportunity for the organisation but for future collaboration with IMCC and TDH it is a threat since Plan historically are known to push their agenda forward with high level of resources. YARO might feel pressured to prioritise PLAN activities and it might create high expectations of finance for VCT volunteers. In addition, the consultant and IMCC had some reservations whether YARO actually can mobilise sufficient qualified volunteers to do lay counselling even though YARO ensures otherwise. A realistic planning and division of responsibilities and tasks within YARO is crucial for the success of the collaboration. During the SWOT analysis the role and expectations to IMCC and TDH was discussed which can assist to prevent future problems.*

*Based on meetings with other organisations during the mapping exercise the consultant and IMCC agreed that although there are some concerns with YARO, it is the local NGO that comparably is best suited and have the greatest possibility to establish a well functioning VCT unit in the district.*

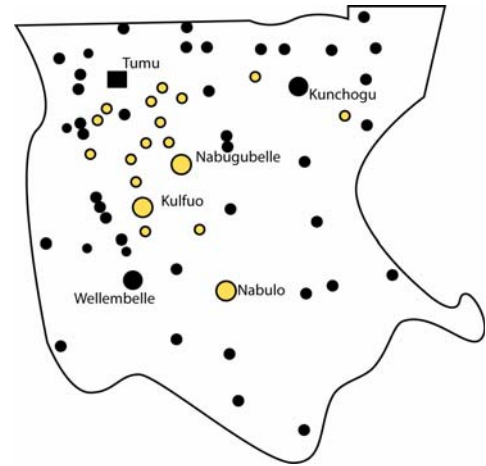
*It is recommended that*

- *IMCC chooses YARO as a partner in creating a VCT unit at TDH*
- *IMCC assists YARO and TDH to define a appropriate structure for VCT in Sissala East District*
- *The roles and expectations of IMCC, TDH and YARO are discussed to avoid conflict of interests*
- *IMCC assists YARO to select qualified volunteers as lay counsellors*
- *IMCC fund and organise VCT training of counsellors*
- *IMCC supports and capacity builds YARO in planning, computer and fundraising skills*
- *IMCC do not fund motivation of lay counsellors*
- *IMCC realises the potential to avoid north-south brain drain by containing Sissala University students in the district through involvement and creation of job possibilities with local NGOs.*

### **Peoples Action for Winning life all-round, PAWLA**

PAWLA is a “warm and vigorous” local NGO started by a school teacher, Alasidongor Baluri Bawa Emmanuel, in 2002. The organisation focuses on HIV/AIDS activities, supporting needy children to stay in school and conservation of the environment. PAWLA also seeks to bridge the gap between civil society and the Sissala District Assembly. In 2003 the NGO was registered at the general registry in Accra. PAWLA have just moved to a new big office. The organisation has one computer and printer but no motorbikes or bicycles. The executive director uses his private motorbike for PAWLA work.

PAWLA has activities in 18 communities in Sissala East District: Pieng, Chinchin, Nabulo, Nabugubelle, Nanchalla, Nankpawie, Banu, Pina, Dimajan, Challu, Kulfuo, Tarsaw, Bujan, Taffiasi, Mwanduonu, Kong, Kowie, Sakai. In addition there are activities in 11 communities in Sissala West District. PAWLA has not implemented the division of the former united Sissala District. PAWLA is currently expanding and have apparently in 2005 opened an office in Lawra, a neighbouring district capital.



PAWLA has five permanent staffs who receive a monthly salary; an executive director, HIV/AIDS officer, Education Officer, Gender Officer (a woman) and Public Relations Officer.

In addition, there are seven permanent volunteers whom PAWLA hopes to employ in the future and who presently receive compensations on an activity basis. PAWLA has 86 so-called PAWLA Rural Volunteers (PRVs) scattered over Sissala East and West District. The PRVs are usually school teachers at the primary level in rural villagers.

The leadership structure of PAWLA is complex and described differently depending on who is asked. At least two different organograms exists and there are conflicting information about organisational structure and gender division. However PAWLA has a very strong father and founding figure in the executive director Alasindongor. There is a seven member board whereof only four are living in Ghana. They are supposed to meet quarterly. There is also a advisory board with the presence of international advisors such as the IMCC project advisor. There are two patrons, and international in Switzerland and the Zini Kouro (a paramount chief).

The division of labour and tasks are done from the head office where volunteer will go when they are in Tumu to get information about their tasks.

Financially PAWLA started out being funded by the founding director and volunteers. A situation the director himself in leaflets describes this way: "He's transferred to Fielmua JSS, where he's even more evangelical and passionate about the starting of the NGO but his economic state was diabolic and hellish!". This has now changed and PAWLA are being supported financially from a long list of agencies both within Sissala East District but also on a national and even international level. According to the financial report (2004) PAWLA in 2002 had an income and expenditure of 2,260,000<sup>7</sup> cedis which in 2004 have risen to 46,416,439 cedis. PAWLA is currently being funded by IBIS, DA, ActionAid, CIDA and through individual contributions.

Most PAWLA staff and volunteers are school teachers and therefore in their training have some skills that are very useful for PAWLA. None of the volunteers met have tried fundraising but the director is planning to make proposal writing trainings. Volunteers identified their own training needs as: being able to create new ideas, computer trainings and discussions on strategies on how to obtain your target.

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<sup>7</sup> 100 cedis = 0,07 DKK

Incentives of volunteers are diverse. Some are teachers who in the rural villages out of real commitment and because there is nothing else to do use most of their spare time on PAWLA activities. Most said they use approximately ten hours per week. Financial motivation for the permanent and PAWLA rural volunteer are contributions from PAWLA according to their work. The permanent volunteers are paid a per diem between 50.000 – 300.000 cedis, the volunteer between 0 – 80.000. During the later SWOT analysis there was a interesting discussion about motivation of volunteers. The volunteers felt that they got positive feedback and encouragement from the executive director but that they still needed more motivation. It was agreed by the volunteers that direct salary or regular per diem was unrealistic but they expected travel money or a yearly durbar.

PAWLA have seven key activities:

- 1) PAWLA/IBIS District Assembly Accountability (good governance) Project. A project that seeks to empower people to be able to hold the District Assembly accountable through community forums where questions can be asked about the relationship to DA and education in how to make demands and community involvement in district planning. As a part of this a community radio programme has been developed and is send every Tuesday on Radio Upper West.
- 2) PAWLA is the local HIPC watch NGO.
- 3) Anti-witchcraft allegation campaign supported by Human Help Development Group (THUHDEG) and German Development Group(GDS).
- 4) Women/child rights programme supported by African Womens Lawyers Association (AWLA). Support to three local women groups: Gbaara ken, Gbaara gunna saa, kendongoworum to create mother clubs and using the Community Capacity Enhancement processes tool.
- 5) Shepard schools (school for life) programme. Education helping deprived and needy children to get into school and helping them to stay in school. The programme is supported by VSO.
- 6) Food security project supported by CIDA and carried out in collaboration with MOFA and the DHA nutrition officer. In addition tree planting, anti bush fiver campaign and environmental sanitation campaigns are carried out.
- 7) HIV/AIDS and reproductive health programme. GLLBERT and PAWLA have been trained by ActionAid and training workshops for PRVs has been held. The PRVs carry out prevention and sensitisation HIV/AIDS talks in the communities. HIV/AIDS materials such as T-shirts, folders and condoms have been distributed. In principle PAWLA works with PLWHA but it is very difficult due to stigmata and there has not been created and clubs, associations or networks. When asked, no volunteers have identified a person living HIV/AIDS.

PAWLA is collaborating with quite a lot of organisations both in Sissala East District and outside. Just to mention some: Ibis Ghana, WB (HIPIC watch), RainBow (research action and information network for the bodily integrity of women), CIDA, AA, DA and SEND foundation. The collaboration with DHA has consisted of the usage of health personnel for HIV/AIDS activities and involvement of the district nutrition officer in the food security project. PAWLA realises the need for a greater coordination of district health response and they take part in the local NGO coalition.

## SWOT with PAWLA

A SWOT on the organisational capacities of PAWLA was performed. Representatives from PAWLA were 11 volunteers/staffs, 4 women and 7 men. Some of them worked in the communities, others at the PAWLA office in Tumu. For a comprehensive list of SWOT please refer to appendix 3. The members of the two groups were all very active in the discussions and IMCC/consultant were impressed by the level of commitment and participation. The director chose not to participate but rather oversee the work of the groups which was a signal of the role and position he has in the organisation. In speech he refers to himself as PAWLA. At time he, in Sissali, intervened in the group work asking participants to write lack of motorcycles and 4WD.

Strengths identified were that most volunteers' speak Sissali, they have an office and a strong willing human resource base of teachers that know how to educate, facilitate and organise workshops. The weaknesses were inaccessibility to reach far communities, that the teachers sometimes had to sacrifice their school job, inadequate computer skills and lack of computers, lack of incentives for volunteers, lack of transport such as motorbikes and 4WD and lack of logistics (raincoats and boots) for volunteers. Opportunities were mainly activity centred and organisational wise the main opportunity identified were networking with other NGOs and relevant partners. Main threats were withdrawal of funding, competition with other NGOs and bureaucracy at the District Assembly which will delay their actions.

Partnerships were identified as both a strength and treat because of the risk of competition for funds to activities within the same field. Other threats were actually weaknesses but never the less very interesting. One, lack of sufficient permanent staffs, led to a question from the consultant of what would happen to PAWLA if the executive director left. All participants responded that this would mean the falling of the PAWLA since he is the sole manager. However, participants also mentioned that if PAWLA had sufficient permanent staff this would downplay the role of the director to a monitoring position.

Interestingly, PAWLA pressed the issue that DHMT should share their plans and budgets to the NGOs operating in Sissala to ensure good planning and coordination of activities among the various stakeholders.

### *Comments and recommendations*

*PAWLA is an organisation with a dominant founding father figure, the executive director. He is the creator and strength to the organisation but at the same time the organisations greatest weakness and threat. The executive director is a man of many visions and great energy to persuade them. It is not always clear whether something mentioned is a fact and actually happening or it is a future vision or a wish come true. There has been at least one incidence where the director has acted just on the limits of what is acceptable in order to solicit funds. The above have created signs of mistrust and a lack of credibility for the organisation.*

*It was mentioned by volunteers that PAWLA's viability presently depends on the director, a fact the consultant agrees with. The director however is taking the points of critics into consideration and during the mission a university graduate from UDS was employed as full time programme officer.*

*PAWLA is the local NGO who to the largest extend have linked up with external NGOs and agencies and have received quite some connections and funding. The director has a vision and he has stayed in Sissala District to implement it. The SWOT exercise and the meeting with volunteers made it clear that there in PAWLA in deed are*

many dedicated qualified volunteers. This was before not very clear to IMCC since all contacts to PAWLA are through the director.

For the future course of PAWLA it is very important that the director allowed the SWOT analysis to take place and it was uplifting to see the dedication and qualities of volunteers.

Financially there are some concerns. In the financial report of PAWLA all income and expenditure is exactly the same each year with a zero balance. It is noticed that IMCC in February 2004 have supported PAWLA with 1,481,500 cedis for support to PPEs in rural HIV/AIDS activities. It has not been possible for the consultant to obtain confirmation from IMCC.

The greatest potential of PAWLA is the right based education programmes, Shepard schools and HIV/AIDS sensitisation and prevention programmes. As a functioning VCT unit gradually is being created and used PAWLA have through their many village based volunteers a central role to play in the creation of support networks of PLWHA.

It is recommended that

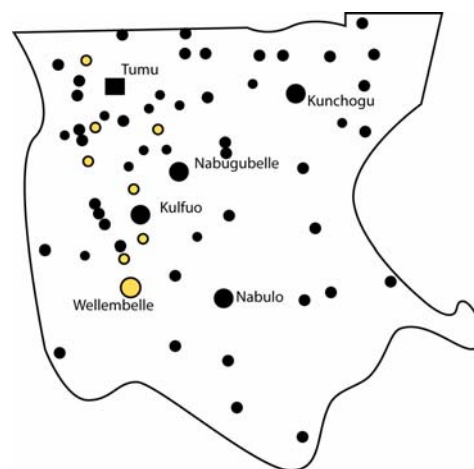
- IMCC collaborates with PAWLA but on the same level as all other NGOs than YARO
- IMCC recognise the potential of PAWLA for population education of health rights, creating and prioritising demands to the health system.
- IMCC advocate for the involvement of PAWLA in PLWHA activities
- IMCC continue to capacity build PAWLA to an organisation with a more healthy leadership.

### **Action for Sustainable Development, ASUDEV**

A new and interesting local NGO is Action for Sustainable Development, ASUDEV. It is a development oriented community based organization aiming to reduce HIV/AIDS, bad social cultural practises and environmental degradation. ASUDEV was formerly called Tumu Youth AIDS Action Club (TUYAAC) and started in 2001, its name changed in 2004. TUYAAC was formed by members of HIV/AIDS clubs in the two senior secondary schools in the district. ASUDEV is registered with the Federation of Youth Associations of Ghana (FEDYAG) and the social welfare office in Tumu. They have an office without electricity and no computers, printer or vehicles.

ASUDEV make quarterly activity plans. There are no permanent staffs; all are working on a volunteer basis. There are five executives and 15 volunteers. ASUDEV have selected ten communities, of these eight are in Sissala East District; Tafiasi, Challu, Tasor, Kong, Kupulima, Sakai, Bugubelle, Wellembelle.

Funding is received from membership contributions, GARFUND and ActionAid. They have just formulated financial procedures for the organisation. ASUDEV is supported by AA on an experimental basis in the same way as PAWLA. They have applied for funding at a number of foreign agencies (the Danish embassy, DIFD) but all proposals were denied.



ASUDEV has a five member board of trustees. In order of authority the organization is lead by a programme co-ordinator, programme secretary, project officers of HIV/AIDS and capacity building, accounts officer and a public relations director. Their motivation is “the joy of doing development work”.

ASUDEV has four thematic areas; HIV/AIDS, Capacity building, Advocacy and Gender. The HIV/AIDS activities are awareness raising, prevention and support and care to PLWHA. ASUDEV also advocate for a functioning VCT facility in the district. The organisation promotes abstinence but also recommends condom.

The organisation seeks to promote women and children rights, speak against negative socio- cultural practices and advocate for women and other vulnerable groups’ participation in decision making at the grassroots and national level. They hold workshops on negative social cultural practices for women groups.

The ASUDEV executives are teachers or SSS graduates. ASUDEV identifies them as being good at HIV/AIDS and advocacy activities.

#### *Comments and recommendations*

*ASUDEV is an organisation with a great organisational development potential. Members are enthusiastic and the organisation has defined a mission, vision and four thematic areas of work. They are however still very young in every sense; the organisation is only two years old, the executives are young of age, their professional training has not reached university level. Generally the organisations capacity does not reach the level of the two other local NGOs.*

#### *It is recommended that*

- *IMCC carry out a SWOT analysis with ASUDEV*
- *IMCC capacity builds ASUDEV to improve proposal writing and assist to identify possible funding agencies*
- *IMCC capacity builds ASUDEV in project planning and management*
- *Support ASUDEV with a computer and printer.*
- *IMCC recognise that if the collaboration with YARO for some reason fail ASUDEV is a worthy second choice to carry out VCT in Sissala District.*

### **Green Sahara**

Green Sahara is an environmental organisation who works with anti-bushfire campaigns and tree planting activities and this report will not use much energy on the organisation.

There are two interesting aspects with Green Sahara. One is that the organisation as the only one directly mentions that a motivation for volunteers is that it is difficult to find good jobs in Tumu and that to engage in more challenging work, many people will join an NGO. The other is that Green Sahara although not involved in health activities felt that DHMT should share their plans and budgets to the NGOs operating in Sissala “to ensure good planning and coordination of activities among the various stakeholders.”

Plan has decided to fund the initiation of a local radio station, “Radio Hope”. It will be run by Green Sahara together with the local youth council.

## Comparable analysis

The organisational structure of the four local NGOs was similar in having few or no permanent staffs and many volunteers. Their leadership culture differed substantially with YARO and ASUDEV having initiative and responsibilities spread over more people and PAWLA depending on the founding father figure. This became especially evident in the observations of how the organisations members interacted during the SWOT exercises and during interviews.

Generally the leaderships of the three organisations were receptive and eager to develop their skills and organisational abilities. All would benefit from leadership trainings with special focus on management, planning and fundraising. Financial management is difficult to assess but never the less an important precondition for the organisations capability to absorb and not misuse funds. As the only organisation YARO had a trained female accountant who gave a strong impression and increased the credibility of YARO.

PAWLA have had the greatest success in attracting funds and networking to organisations outside Sissala East District and even Ghana. However, PAWLA does also have some credibility problems that are not completely targeted or solved.

The logistic situation of YARO and PAWLA is actually not bad although PAWLA with time will need at least one motorbike for the newly employed programme office. ASUDEV needs external input with computers, printers and transportation.

A closer analysis show that in the villages of Kong, Sakai, Taffiasi, Wellembele, Bugubelle, Challu, Tarsaw and Pieng two or all three of the above described NGOs are active. At the same time the hard to reach villages far from Tumu town are not covered by the local NGOs.

The quality and capacity of the staff and volunteers varied. YARO has qualified permanent staffs but their volunteers did not give the same strong impression as the PAWLA volunteers who were very impressive in the SWOT exercise. ASUDEV members have the lowest level of educational background.

YARO and PAWLA have what they call supporting or permanent volunteers. Some of these are university students who use the NGOs as training ground and hope to become full-time paid staff with time. This is interesting in the light of very few Sissali university students actually returning to the District and could help target the north to south brain drain in Ghana.

All three organisations carry out HIV/AIDS sensitization and prevention. There are no PLWHA associations in the district, but ASUDEV and PAWLA are interested in creating support networks. There is still an enormous stigma to target and the consultant did not meet one volunteer who knew or had heard about a specific HIV/AIDS victim.

All three NGOs had limited contact with the formal health system and the previous contact consisted of using health professionals in trainings and education activities. The organisations had no influence or contact with the overall district health planning.

PAWLA and ASUDEV have advocacy components in their strategy and PAWLA is collaborating with IBIS to create civil society demands to the District Assembly. The two NGOs have not incorporated health rights in their advocacy activities, and generally they were not knowledgeable

about what it entails. There is an unused potential of PAWLA and ASUDEV creating civil society demands to the health system through civil society education in health and patient rights.

One overall weakness identified is that they have no overall direction of activities since they are proposal funded and thus create activities based on where funds can be solicited rather than from the organisation's vision. Therefore they spread over unrealistically large geographical and thematic areas.

Generally speaking their major strength is their commitment and local knowledge which creates strong credibility and ownership of the organisation.

#### *Comments and recommendations*

*Based on above analysis it is recommended that*

- *IMCC seeks to enhance both geographical and thematic coordination of activities between the local NGOs working with health.*
- *The district HIV/AIDS response realises the potential of involving local NGOs*
- *IMCC supports local NGOs interested in creating PLWHA support networks with a study trip to for instance LAWRA where such association exists.*
- *IMCC creates a forum where NGOs working with health have an influence on district planning of health activities.*
- *IMCC train local NGOs in health and patient rights and supports them to implement this in already existing advocacy programmes.*

## **Community Based Organisations**

The community based organisations identified were women groups who are formed for micro credit, farming and trading purposes. They are scattered all over the district and even the smallest village will have a few. The local credit union in Tumu has in Sissala East and West District registered 197 women groups with accounts and the number of groups without accounts is probably the same. Usually the groups have organised themselves with a leader, a secretary and an accountant.

Their capacity varies but most groups consists of illiterate farmers and hence there are no records or monitoring of activities. Some groups have received trainings in micro financing from the credit union or local NGOs. A few larger groups in Tumu have constitutions and are registered at the District Assembly Social Welfare Office.

The women groups aim and motivation is solidarity, moral and financial support to each other and risk sharing. It is mentioned that sometimes groups are formed for the benefit of one or two persons but that is considered improper. The foundation of solidarity is reflected in their names which translated have meanings like "Your cry is my cry", "Lets help each other" and "Gather and learn".

With regards to health activities most women groups has some form of community health insurance. Some groups operate with regular monthly contributions of minor amounts (1000-5000 cedis<sup>8</sup>) and

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<sup>8</sup> 100 cedis = 0,07 DKK

have bank accounts with the credit union in Tumu, but often the support is more in-formal with collections from members when a need arise.

A few women groups mention that they do HIV/AIDS activities in the sense that they will advice their family members to take care of AIDS if they for instance are going to a funeral (an occasion where it is believed many extra marital sexual relationships take place). One Tumu based women group of educated resourceful women also went to a community to support another women group, do HIV/AIDS sensitization and donate second hand close. The same group even donated brooms to Tumu district Hospital “because they saw the place needed cleaning”.

Most CBOs have little contact with the formal health system. If they have it is usually at sub district level in the form of receiving health talks from the health personnel.

One interesting observation was that the marked of CBOs is dynamic. If there is a special cause like a big funeral (an occasion it can take up to a year to fundraise for) a CBO will be formed for that specific purpose. After the occasion the group is dissolved.

#### *Comments and recommendations*

*For the formal health system the CBOs are an excellent forum to reach rural women that is not being fully utilised. This is partly due to health workers not knowing the existence or leaderships of the groups. For example, in one sub-district, Nabugubelle, the In Charge actually had identified civil society groups and made a poster with them at the clinic. However the women groups were not individually recorded but put as “women group associations”.*

*Women and children are vulnerable groups who in any population will have the largest contact to and experience with the formal health system. They know whether a clinic is lacking medicine and have an opinion about how they are being treated by the health personnel. Therefore they are*

*It is recommended that*

- *Sub district health personnel together with the Sub District Health Management Team (SDHMT) perform a mapping analysis of civil society groups in their sub district.*
- *IMCC and sub-district health personnel continue to investigate populations’ perceptions and views on health and service delivery through half yearly PRA studies.*

## **Government initiated civil society institutions**

A category of government initiated civil society organizations was created since it was realized that on community level there are groups that have the entities agreed to define a civil society group but that are created by government institutions and would not otherwise be there. Most prominent are the Disease Surveillance Volunteers (DSV) and the Sub District Health Management Team (SDHMT).

### **Sub District Health Management Team, SDHMT**

The SDHMT consists of one or two persons from each village in a health clinics catchments area. Since each village only have one or two members they only meet each other when summoned to the health clinic. Meetings are held quarterly but often not on a regular basis.

Members are all men and most are farmers and illiterate. Some but far from all speak English. Some members are also unit committee members (the decentralised district assembly representative under

the elected district assembly man of an area). The SDHMT members usually do not receive training from the formal health system.

Members are in principle selected by their community but several members met during this mission were actually appointed by the elders in their village. Hence, they did not on own initiative show interest in the job but saw it as a duty laid upon them by the leadership in the village.

The SDHMT members themselves identify their role and activities as carrying information from the health clinic to the community, organize the communities to clean up the health clinic surroundings, weed and plant trees and to solve problems for the clinic and the communities. It leaves the impression that SDHMT meetings are primarily used for mobilisation of villagers to assist the clinic with practical cores and not being utilised as a forum for information flowing from the villages to the health system. There are examples where civil society demands have been directed to the health centres by DSVs pr SDHMT members. The complaints have been pertaining shortages of drugs at the clinic or the more sensitive area of health workers attitude towards patients. During the mission one incident was observed where a complaint was received defensive and not receptive by the health personnel. The SDHMT rely on the sub district health personnel to take issues up with the district level if needed. The DHMT sub-district parent is suppose to participate in SDHMT meetings.

### **Disease Surveillance Volunteers, DSVs**

It is a ministry of health guideline to train Disease Surveillance Volunteers and this has taken place in Upper West Region since 1999. All sub-districts in Sissala East District have GHS trained DSVs. The volunteers have the same characteristics as SDHMT members and are with very few exceptions men. It is observed that they in average are younger than SDHMT members and a larger percentage are semi-literate.

The DVS are the disease watchdogs in the communities and their tasks are

- To keep community registers on births and deaths
- Notice on and record certain diseases (CSM, polio, measles, neonatal tetanus, guinea worm)
- React on unusual health events
- Refer patients
- Know basic first aid

The DSVs are usually selected and used as volunteers in vertical programmes because they have already received training and they are familiar with the health centres. In the vertical programmes there are often high per diems which on one hand creates a motivation for DSVs but also a risk of lack of commitment for tasks without payment and internal conflicts when for instance not all DSVs in one sub district is needed. This issue has been further complicated with the arrival of PLAN international who are training community health volunteers with the same tasks and responsibilities as DSVs pay but who receive a higher per diem and reports to PLAN rather than the formal health system. Some GHS DSVs are also PLAN community health volunteers.

### **Community Health Planning and Services, CHPS**

CHPS is a national strategy that all districts are obligated to implement and Sissala District (East and West) was in 2004 divided into 31 CHPS zones. The program will be a major focus area for DHMT in the years to come. In June 2005, the first inauguration of a CHPS compound was undertaken in

Sakai community. Three more CHPS zones in Sissala East are expected to be inaugurated in 2005-2006: Nabugubelle, Kunchogu and Bawiesibelle.

The district health system is in the initial phase of implementing Community Health Planning and Services (CHPS). CIHPS is a process of strategic planning and implementation of PHC and family planning activities within a community with the full involvement and participation of the community members. It is a process that emphasizes preventive health care and education through effective communication and community mobilization.

CHPS involves

- Community participation in primary health care and family planning services delivery through Community Health Committees and Community Volunteers.
- Locating CHOs (Community Health Officers are special trained Community Health Nurses) in communities in a community health compound; and
- Mobilizing and re-orienting Ministry of Health and Districts Assemblies to support the initiative at the district level.

In a civil society context the CHPS concept has community health committees and community health volunteers.

The Community Health Committee is composed of representatives from various groups of people from the community traditional leadership. Training of the members of the CHC should take two days and be organized quarterly. The responsibilities of the CHC are:

- Provision of liaison between traditional leaders and health authorities;
- Settling of disputes concerning work of the Community Health Volunteers;
- Organizing communal activities in support of the program;
- Advocating community health and family planning activities;
- Financial management of medical accounts;
- Managing Community Health Volunteers stock of drugs and family planning materials; and
- Supervising bicycle maintenance for Community Health Volunteers

The community health volunteers are men and women who are recruited by chiefs and elders on basis of their commitment to community work. Training of the volunteers should take two weeks and follow up refresher training should be carried out once in every quarter.

The CHV will carry out work under the supervision of the CHC. Their responsibilities are:

- Provision of preventive and curative services for malaria and diarrhea;
- Provision of family planning counseling;
- Referral of serious cases to CHO and clinics;
- Health education using “Road to health Chart”;
- Identifying children lacking immunization and those failing to thrive; and
- Early notification of disease appearance to the CHO.

The CHVs are to serve as the link between the communities and the CHO i.e. the formal health system. The CHPS policy recognises that the existing Ministry of Health volunteer system should be utilised and therefore DSVs and TBAs should be selected to become CHVs.

## Health Insurance

With the launching of the National Health Insurance Programme this area has become a political priority in Ghana. The Government intends to “replace the cash and carry system with a health insurance scheme that would improve financial access to health care in the country”. It is said that the health insurance does not abolish cost recovery but it does abolish cash and carry. The government has chosen to focus on district-wide health insurance schemes and private for profit schemes. The vision is one scheme per district covering all inhabitants and both formal and non-formal sectors. Community level and non-formal health insurance groups are encouraged and supported to collect premiums from the non-formal sector into the district-wide health insurance. All residents of Ghana will be required by law to belong to a health insurance scheme within a specified period of time. The way to encourage people to comply with the law is proposed to be predominantly in the form of incentives rather than by punitive measures.

In Sissala District health insurance is in the initial sensitisation phase. The health insurance contribution is 72,000 cedis a year which in Sissala East District is a high level fee. It covers the beneficiary and children less than 18 years. In Sissala East and West District there is 6555 registered beneficiaries, 865 have paid the premium and 1275 are government employees who are covered through SNITT.

30 communities have formed community based health insurance committees. Because the health insurance office is located at the District Assembly and citizens are required by law to belong to a scheme, the community health insurance committees are perceived solely as a government initiative.

### *Comments and recommendations*

*Common for SDHMT and DSVs are that they are local villagers with low organisational capacity but strong links to their fellow villagers. Their motivation is varying from a sincere and dedicated wish to improve the health status of their village to being appointed to do a job by the village leadership. A common entity is that meetings between health centres and volunteers or SDHMT are on the health centres initiative. Spontaneous or arranged meetings without the involvement of the health centre are difficult because members are one or two representatives from each village in a sub-district.*

*The SDHMT forum is not sufficiently utilised to convey requests and civil society demands to the health system. When it is used as such there are examples where the demands have not been received professionally by the health system. This has in particular been with regards to health personnel attitude towards patients.*

### *It is recommended that*

- *IMCC/DHMT and Plan learn from the experiences with community health volunteers in Sissala West District<sup>9</sup> and seek to avoid the well documented problems when/if introducing PLAN community health volunteers in Sissala West District.*
- *IMCC at DHMT advocate for increased attention on SDHMT meetings to ensure they are being held and serve as a forum for discussion of civil society requests and concerns. This could be done through the sub district parenthood system.*

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<sup>9</sup> PLAN currently works only in Sissala West but are planning to expand to Sissala East

## **Traditional structures**

The traditional system is very strong in sub Saharan Africa and consists of a wide range of structures, some with leadership functions others with spiritual and health related functions. The chieftaincy system functions as a parallel non-formal governing system that for many purposes has more authority than the formal political system. All health interventions and activities must be approved by the traditional power structures.

There are two overall types of traditional medical practitioners: herbalists and spiritualists. The herbalists include bonesetters and Traditional Birth Attendants (TBAs). Their practices may or may not include spiritual rituals. Spiritualists see bodily ailments as manifestations of the spiritual beings and depend highly on rituals. A new breed of spiritualists, the faith healers, is a recent introduction that combines Christian or Muslim rituals with traditional beliefs to treat the sick. In Sissala East District the spiritualists are predominantly a group called soothsayers. They can through offerings of animals contact the spiritual world and predict the future. In the neighbouring Sissala West District there is a famous bonesetter clinic that treats fractures through massaging with herbal water, applying sear butter and casts in between. Interestingly the formal health system refers patients with fractures to the traditional bonesetter clinic.

Most of the structures like the traditional herbal and faith healers are for the population the primary and first choice of health provider. This has been documented by IMCC in several PRA studies also to be the case in Sissala East District.

In spite of this there is little or no collaboration with the formal health system. An exception to this is the Traditional Birth Attendants (TBA) that has been adopted in the primary health care strategy in most African countries.

### **Traditional Birth Attendants, TBAs**

Traditional Birth Attendants are local women who assist women in their village during deliveries. They are illiterate farmers and most only speak sissali. They are a very important group of practitioners in the health care systems and form part of the Primary Health Care strategy of 1978. Most TBAs in Sissala East District have received training from the public health sector in the realisation that most women deliver in the villages without health personnel supervision. The training of TBAs aims at reducing maternal and child deaths and delivery complications through improved ANC service, referral of women at risk of complications and improved hygienic management of deliveries. The TBAs are given a kit box containing soap, razor blades etc. TBAs output is included in the statistics for maternal services.

The TBAs meet quarterly at the sub-district clinic to refresh their knowledge and discuss problems with for example community support. In addition the health workers have contact with the TBAs during outreaches where ANC is to be integrated in the service.

It is important to realise that TBAs are a traditional erhverv that existed before the primary health care strategy and traditionally it is passed from one woman to another when she feels the workload is too heavy or she is getting too old. They are traditional healers and for example always use herpes during deliveries. IMCC research has documented some harmful practices and beliefs. For example that the colostrums is thrown away and the new born child is fed with warm water and sugar, deformed children are put in a hut with smoke to test whether they are human (if they survive they are human) and the umbilical cord is not ligated. The TBAs use to circumcise female children but

they claim this practice is not used anymore. It is said that circumcision of male boys and the scaring of tribal marks is done by wanzams but it is unclear whether the TBAs and the wanzams are the same persons.

#### *Comments and recommendations*

*For community entries, communication and problem solving it is essential for the health workers to be aware of the customs surrounding the chieftaincy system.*

*There is a need to make traditional medicine safe and integrate the service into the formal health system. With the exceptions of the TBAs and the bonesetter clinic the collaboration is not existent. There is in the formal health system little knowledge about the medical anthropology i.e. what are the health seeking behaviours of patients, what is patients perception of health and disease and how do traditional practitioners treat their patients.*

*There are many not yet utilised opportunities for health system interaction with traditional healers but more research is needed. It is a precondition for enhanced collaboration that health workers are interested.*

*It is recommended that*

- *IMCC and health personnel continues to conduct PRA studies in the field of medical anthropology*
- *The research committee prioritise research about the private-public mix*
- *IMCC connects to University of Copenhagen, department for medical anthropology to promote traditional medicine in Sissala East District as a possible research area for a master thesis.*
- *IMCC visits national institutes like the Traditional Medicine Practice Council and the Centre for Scientific Research into Plant Medicine.*

## **Religious Organisations**

As everywhere in Ghana religious organisations are abundant and the spiritual life of people important. Sissala East District is a predominant Muslim area but as it is shown in the mapping there are 14 different Christian churches operating in the district. On a national level church health activities are coordinated in the Church Health Association of Ghana (CHAG) but it does not reach the Sissala East District. The churches and mosques do not organise them selves in for example health committees. In both Muslim and Christian religious organisations it is mentioned that there are moral education in connection with HIV/AIDS prevention. The focus is on abstinence and discouraging adultery. The mission did not identify any religious organisations who recommended condom use but rather they tend to advocate against “the dangers of in moral life”. It was however mentioned that on a individual basis some priests would recommend it. The communication with the formal health system consisted in relaying messages and information about for instance national immunisation days or specific disease outbreaks.

### **Pioneers of Ghana**

Pioneers Ghana is a registered non-denominational non profit Christian missionary organization with activities in eight West African countries with strong bonds to the united states of America as the base is in Florida. There is a national board but in Tumu pioneers consists of Pastor Seth Epton Nyampong and his wife.

The mission is to “glorify God among unreached peoples by initiating church planting movements in partnership with local churches”. They work with five main areas; evangelism, church planting

and discipleship, literature distribution, relief and community development, leadership training and development.

On the pamphlets of pioneers Ghana it is possible to buy different services from the organisation, a PR seemingly pointed towards US citizens. For example, it costs 200 USD a month to support a missionary family, 7000 USD to build a church or health centre and 500 USD for medical supplies for each village outreach. Pastor Seth has just had visitors from USA who bought an medical outreach and free medical supplies was distributed by GHS personnel in Buti and Bagwaala. There is surplus medicine and a outreach to Kasena is being planned. The pastor hopes the free medical outreaches will become a recurrent yearly event.

### **Christian Mothers Association, CMA**

CMA is a national roman-catholic organisation with headquarter in Accra. The organisation consists of women groups scatter over the country and has the aim “to let women be able to take up their responsibilities as mothers and to earn a little”. In Sissala East district there are CMA women groups in Sorbelle, Jinjang, Tafiasi, Sakai, Tumu 1 and Tumu 2.

The activities are governed through a work committee consisting of a District Executive Chair, Secretary and treasurer. General members are local women in the communities and most are illiterate farmers and petty traders. Some of the women’s groups have bank accounts with various banks in Tumu. All groups contribute with 24.000 cedis per month to the local Parish CMA. Generally CMA can be considered a women group with the same entities as mentioned under CBOs but faith based and with a higher monthly contribution than most other groups.

All work is voluntary, but the local groups can contribute to meetings covering for instance transportation. The women groups can receive micro-credit loans through the organisation.

Members have been trained in micro credit practical skills of vocational character such as soap making, dressmaking and cloth dying.

CMA has no direct health activities but all members have been trained on HIV/AIDS prevention and care for the sick. In addition, the women groups have been educated about health insurance.

CMA participates in the NGO coalition.

### **Federation of Muslim Women Association in Ghana, FORMWAG**

The Federation of Muslim Women Association is like CMA a national association with a Tumu branch. It is a organisation based on the Islamic belief and there are approximately 75 members in Tumu, members are only muslim women. There is a national board in Accra and a written constitution but the president of FORMWAG does not have a copy. In Tumu there is a structure called “Gamtjat” who works as a kind of board and consists of the Muslim men. The “Gamtjat” advice the women and support with money. FORMWAGs objective is to increase social and economic empowerment of women.

Meetings are every Friday after the praying time in the Mosque. Members are traders, farmers or teachers. They have received training in HIV/AIDS by PLAN, violence against women by ActionAid and AWLA (African Woman Lawyers Association) invited them to a WS on the same

subject. A training concerning nutrition and mother care is being planned by PLAN. The members' motivation has a religious motive and all work is done voluntarily,

The organisation does health talks both to members of FORMWAG and to the whole community. Themes are HIV/AIDS, malaria, nutrition, childcare, gender and violence. For HIV/AIDS talks they use the "UNDP facilitator's notes". They also clean the hospital surroundings and some times they buy soap for the patients. The organization plans to build an orphanage in the Sissala district, but funds have not been raised. The organisation also conducts literacy classes, English and Arabic.

FORMWAG has no relations to DHMT but the organizing secretary has just been elected as the secretary of the executive board of the local NGO coalition.

### **Ghana Institution for Linguistics and Bible Translation, GILBERT**

The Ghana Institute for Linguistics and Bible Translation is a denominational organisation that embodies all Christian churches. They have an office with nine people, 5 translators and 4 literacy officers and more than 100 volunteers in the various communities in both Sissala East and West. The organisations main objective is "to get the bible translated into the various mother tongues and spread literacy for the illiterate so they will also know the word of God." Their headquarter is in Tamale, the organisation has no written constitution. Activities take place every day except Saturdays and Sundays. Most members are Christian teachers. Volunteers receive a three week's translation course. The office receives funding from the head office in Tamale as well as from local contributions.

Volunteers are motivated by their Christian belief, appreciations like bicycles and raincoats are also distributed.

GILBERT also translates health books to readers and some of the material has been about HIV/AIDS. The organisation has collaborated with DHMT who have used GILBERT for translations during for instance outbreak of diseases.

GILBERT participates in the local NGO coalition.

#### *Comments and recommendations*

*The fact that most churches preach "Abstinence" "Be faithful" and does not ad use "Condom" is beyond the influence of DHMT or IMCC. The religious organisations are never the less an important forum to reach average citizens.*

*It is a concern that Pioneers Ghana is using GHS personnel to distribute free medicine. The main problem is that the medicine is distributed by GHS health professionals and this has previously shown to have a negative impact because villagers do not understand why they later have to pay for the same medicine at the health clinics.*

*It is recommended that*

- *DHMT/IMCC undergoes a dialogue with Pioneers of Ghana and agrees on other ways for Pioneers to convey financial and medical support to communities.*

## **Cultural Institutions and Associations**

Cultural institutions identified were mainly drama and dance groups. The drama groups have been used by the local NGOs in HIV/AIDS awareness raising plays.

Many associations were identified and most professions are organised in an association. Even the local Pito Brewers (the local millet beer) and they actually recently went on strike to raise the price of Pito. The strike lasted until the Tumu Chief intervened and ordered them back to work.

### *Comments and recommendations*

*The University Students of Sissala also has an association and as previously mentioned some students are already involved in the local NGOs as volunteers.*

### *It is recommended that*

- *IMCC investigates possible links to the Sissala Union of University Students for example by involving them in the research committee*

## Recommendations

The civil society organizations, DHMT and the District Assembly of Sissala East District were very interested in the mapping and capacity analysis and felt it would be useful in the planning of their work. The SWOT and mapping workshops have in them selves functioned as capacity building of participants though a process of awareness rising about their organizations.

The main aim of the study however was to draw conclusions leading to recommendations as to how IMCC can adjust to the strategy for Support to the Civil Society in the developing countries. Many recommendations have been made through out the report, some can be implemented immediately and others are not interesting in the context of the project document. The remaining text describes recommended adjustments for the third phase of the IMCC/DHMT project.

Originally, in the first phase of the project, IMCC focused on health activities at sub district level. It was, however, realised that many of the constraints met in the villages and sub district clinics were targeted more effectively and reaching a larger target group through collaboration at district level. Since then IMCC has been a co-opted member of the DHMT, which has the overall responsibility for service delivery, monitoring and support, planning, finances and human resources in the district.

As co-opted members of the DHMT IMCC has a unique position for an innovative approach to enhancing civil society's dialogue with the formal health system. IMCC can advocate within the health system for responsiveness to civil society demands *and* directly create links to the civil society and perform capacity building where needed. Therefore, it is recommended that IMCC remains a loyal partner to DHMT but focus some of their attention to enhancing the dialogue between the health system and civil society. To ensure the success of this IMCC should engage in capacity building activities with local NGOs in order to create a worthy opponent to DHMT.

The role of IMCC volunteers is to create linkages, build capacity and facilitate development processes with both DHMT and civil society.

### **Objective 1: To build health planning, monitoring and implementation capacity in Sissala District Health Management Team**

It is recommended that IMCC/DHMT creates a District Health Forum for dialogue between DHMT and civil society organisations, something DHMT during the mission indicated would be welcome and helpful. The forum could take the form of half yearly meetings with the purposes to

- Discuss and create awareness about DHMT annual plans with stakeholders
- Ensure that DHMT annual plans take into consideration civil society demands
- Involve civil society organisations in the district health planning
- Ensure that DHMT taking the responsibility of the overall health service delivery
- Coordinate health activities in the District.
- Streamline policies in particular training of community based volunteers

It was mentioned by DHMT that a so-called District Health Committee exists. IMCC have not been aware of this and it is recommended to investigate whether it can function as the District Health Forum.

Special attention should be given that PLAN and ActionAid are involved in the district health planning and IMCC/DHMT should participate in their planning and budgeting meeting.

It is recommended that IMCC adjust their core activities at DHMT to focus on linkages between not only different levels of the health system but also between the health system and the civil society. The above mentioned District Health Forum is one activity in this direction. On sub-district level it is recommended that each health clinic together with the Sub District Health Management Team (SDHMT) performs a mapping analysis of civil society groups in their sub district. IMCC and sub-district health personnel should continue to investigate populations' perceptions and views on health and service delivery through half yearly PRA studies.

It would be preferable if the local NGOs working with health are organised and it is recommended that IMCC advocate for this. The newly formed coalition of local NGOs is a possible platform but IMCC can facilitate linkages to the National Coalition of NGOs Working with Health since they are the only member in Upper West Region.

It is recommended that IMCC through the unique position at DHMT advocate within the health system for increased responsiveness to civil society demands.

There is an unused potential of local NGOs (PAWLA and ASUDEV) including health rights in their already existing advocacy programmes. Both organisations have experience with training civil society in how to set demands for the district assembly and it will not take much training to include health rights in their activities. In addition, knowledge of health rights would assist the NGOs to set demands to the health system through the district health forum. It is therefore recommended that IMCC train local NGOs in health rights, how and where to lead civil society demands. It could be interesting to link this activity to training of health personnel in the same thematic issues. It might increase health systems responsiveness to an active civil society dialogue on service provider level.

Another core activity is recommended to be improvement of the overall coordination of health activities in the district. With regards to the coordination of district HIV/AIDS activities, it is recommended to follow the National HIV/AIDS strategic framework. In addition, IMCC/DHMT should continue to capacity build the District Response Management Team and advocate for strong civil society presence in the District Aids Commission (DAC). NGOs should be aware of funding possibilities with DAC. IMCC should advocate that the NGOs working with health improve both geographical and thematic coordination of activities.

It is recommended that IMCC at DHMT advocate for increased attention on sub-district level and civil society demands. For example ensure that SDHMT meetings are being held and serve as a forum for discussion of civil society requests and concerns. Revise the monitoring and evaluation checklist and through raising civil society issues at the weekly planning meetings. It is recommended that IMCC/DHMT continue the sub district parenthood system but focus attention on the collaboration between community and health clinic rather than support on outreaches.

### **Objective 2: To facilitate health-related operational research in Sissala District**

It is recommended that the newly formed research committee involve civil society in the identification and prioritisation of needs for health related research in the district. In addition, the research committee should investigate possibilities of involving the Sissali Association of University students and at least disseminate knowledge about research possibilities in their home district. It might have a positive effect on the north to south brain drain.

### **Objective 3: To build civil society capacity to improve the district HIV/AIDS response**

In line with the national HIV/AIDS strategic framework it is recommended that IMCC capacity builds civil society involved in the fight against HIV/AIDS.

It is recommended that IMCC chose the local NGO YARO as a civil society partner to implement VCT in the district. It is also recommended that the VCT unit is placed at Tumu District Hospital and that a VCT structure involving both Ghana Health Service and YARO counsellors is developed. IMCC support should be primarily technical and capacity building of YARO. IMCC should organise and fund training of VCT counsellors by professional consultants and seek professional advice in the development of a possible structure of the VCT unit. It is not recommended that IMCC contribute with financial motivation for YARO counsellors. However, IMCC should capacity build YARO in identified areas of needs i.e. planning, computer and fundraising skills. In addition YARO needs support in formulation of criteria's for selection of counsellors.

It is recommended that IMCC in addition support capacity building of local NGOs involved in HIV/AIDS awareness-raising and PLWHA networks. The NGOs each have their own strengths and an adequate coordination of activities will enhance the district HIV/AIDS response. ASUDEV and PAWLA are interested in support to PLWHA and HIV/AIDS sensitisation and prevention. FORMWAG is interested in opening an orphanage. DHMT/IMCC cannot directly support all these initiatives but can, through general capacity building, increase their abilities to start needed activities at their own initiative. It is therefore recommended that the NGOs receive support to proposal writing, fundraising techniques, planning and management. ASUDEV will benefit from receiving one computer and printer. IMCC should assist the local NGOs to attract funds from Ghana AIDS Commission (locally administered through DAC), large international NGOs such as ActionAid and Plan International and donors.

## Appendix 1: Civil Society Mapping

*Organisations marked with \* have influence on and interest in the health status of the population in Sissala East District*

I.NGO	L.NGO	CBO	Government initiated Civil Society organisations	Traditional organisation/structure	Religious organisation	Cultural institution	Associations / unions
Plan Ghana*	YARO*	Gbaara Gunna Saa* (L-NGO)	Sub District Health Management Team*	Traditional Birth Attendants*	FOMWAG* (L-NGO)	Kansec Drama Group*	NUSS*
Action Aid*	PAWLA*	Naa bi cholo Ladies and Gentlemen Club*	Disease Surveillance Volunteers*	Traditional Healers Association*	CMA* (L-NGO)	ASUDEV/NC CE Drama Group*	Nurses Ass.*
IMCC*	ASUDEV*	Ne Baala Weeda Widows Association*	School Health Committee*	Wanzams Assosiation*	GILLBT* (L-NGO)	Tutco/PAWLA Drama Group*	Chemical Sellers Ass.*
VSO	Green Sahara	Noinglocholo Association*	School Management Committee	Mangazias*	Pioneers of Ghana*	Nabugobelle Dance Group	Sissala Union of University Students*
Peace Corps	CEDI	Klusu Ye Mi Su*	Community watchdog committee	Chiefs / Elders*	TUTRIDEP (L-NGO)	Sasco Dance Group	Sissala Youth Network in Accra
(CRS*)		Baragunasoq*	Fire volunteers		Local council of churches	Tumu Dance Group	GNAT
		Lapedogole association*	NADMO		Ahmadiyya Woman's Group	Saikai Dance Group	GNAT-LASS
		Precious ladies club*	CHIPS		Methodist Youth	Tafiasi Dance Group	FEDYAG
		Kendongo worum*			Muslims Youth Society		Farmers Ass.
		Nibalawide women association*			Tumu Christian Youth Ass.		Barbers Ass.

I.NGO	L.NGO	CBO	Government initiated Civil Society organisations	Traditional organisation/structure	Religious organisation	Cultural institution	Associations / unions
					Christian Youth Association		Food Sellers Ass
					Catholic Youth Organisation		Local Gin sellers Ass.
					Assemblies of god		Pito-brewers Ass.
					Church of christ		Butchers Ass
					Presbyterian church		Hairdressers Ass.
					Jehova witness		Fitters Ass.
					Regular Baptist Church		Tailors Ass.
					St. Matthew's Baptist church		Cattle dealers Ass.
					Deeper life church		Rescue Group
					Church of Pentecost		Surface Rock Club
					Methodist church		Keep Fit Club
					Bible church of Africa		GPRTU
					Seventh-Day Adventist		
					Roman Catholic church		
					Al-Sunna		
					Orthodox		
					Ahamadiyya		

## **Appendix 2: SWOT with YARO on VCT**

### **Strengths**

- Available human resources
- Effective communication
- Four full time staff
- Office equipment (donated by Plan)
- Mobil (two motorbikes donated by Plan)
- Volunteers in ten communities
- Established structures incl. constitution and registration
- Communities trust the organisation
- Trained community peer-educators (the leader in each community is named Focal Person)
- Established links to communities
- Planning skills

### **Weaknesses**

- Conflict of interest among volunteers
- Limited time
- Information, communication and technology
- Weak skills for writing of proposals
- No VCT technical knowledge/ expertise in health
- Limited mobility – lack logistics for mobile VCT
- Irregular motivation to volunteers
- Lack of funding for transportation, motivation, utilities and trainings
- Inadequate logistics
- Few full time staff
- Planning skills

### **Opportunities**

- Sissala East District Assembly involvement
- Develop trust & confidence of communities
- Focal persons at community level used for VCT sensitization
- Collaboration with other NGO's and organisations i.e. GHS
- Acquire knowledge on counselling
- Save lives

### **Threats**

- Large coverage area
- The possibility that other partners pull out / withdraw support
- Stigma
- VCT established by other organisations (lack of coordination)
- Lack of confidentiality
- Teething problems
- That men do not want to go for VCT
- Brain drain of health professionals
- High turnover of staff at GHS

**Way forward**

- Define VCT standards and structure possible with help from an external resource person
- Identification and selection of suitable VCT lay counsellors
- Training of counsellors in VCT
- Training of YARO in proposal writing, ICT and planning skills
- Define motivation for volunteers
- Enhance coordination between actors active in the fight against HIV/AIDS in the district
- Create link with VCT partners i.e. IMCC, YARO, TDH
- Make VCT sensitisation strategy
- Ensure adequate support to PLWHA
- Make funding strategy

**The role of IMCC and expectations to the collaboration was discussed and it was agreed that**

- Good coordination between YARO and IMCC is important.
- IMCC can assist building human resource capacity
- IMCC can identify and consult relevant VCT resource persons to design adequate VCT structure
- IMCC can fund and organise VCT training of counsellors
- IMCC can advocate for the project within DHMT and at TDH
- IMCC do not fund motivation for volunteers but can assist in creating links to funding agents that do
- Coordinate transport between DHMT and YARO to hard to reach communities.
- IMCC can Spread information about YARO in DK

## **Appendix 3: SWOT with PAWLA on organisational capacities**

### **Strengths**

- Languages advantage
- Willingness by volunteers
- Office premises
- Human resource i.e. many volunteers with educational skills since most are teachers
- Community meetings
- Organisation of training workshops
- Well organized school clubs and easy access to school children

### **Weaknesses**

- Inaccessibility to reach the communities
- Sometimes we have to sacrifice our school jobs
- Inadequate storage facilities like computers and printers
- Lack of communication gadget e.g. telephone
- Lack of incentives for volunteers
- Lack of means of transportation (4WD and motorbikes)
- Inadequate logistics for volunteers, eg. Raincoats and boots
- Lack of teaching and learning materials
- Lack of allowance for part time volunteers
- Lack of sufficient permanent staff

### **Opportunities**

- Organize more clubs on HIV/AIDS
- Expanding activities to more school and communities
- Key members in community are in support of Pawlas activities e.g. the DCE
- Strong public relations; Interact with people
- Solicit funds through proposal writing and partnership
- Networking with other NGO's
- Empowering women and children in the hinterland

### **Threats**

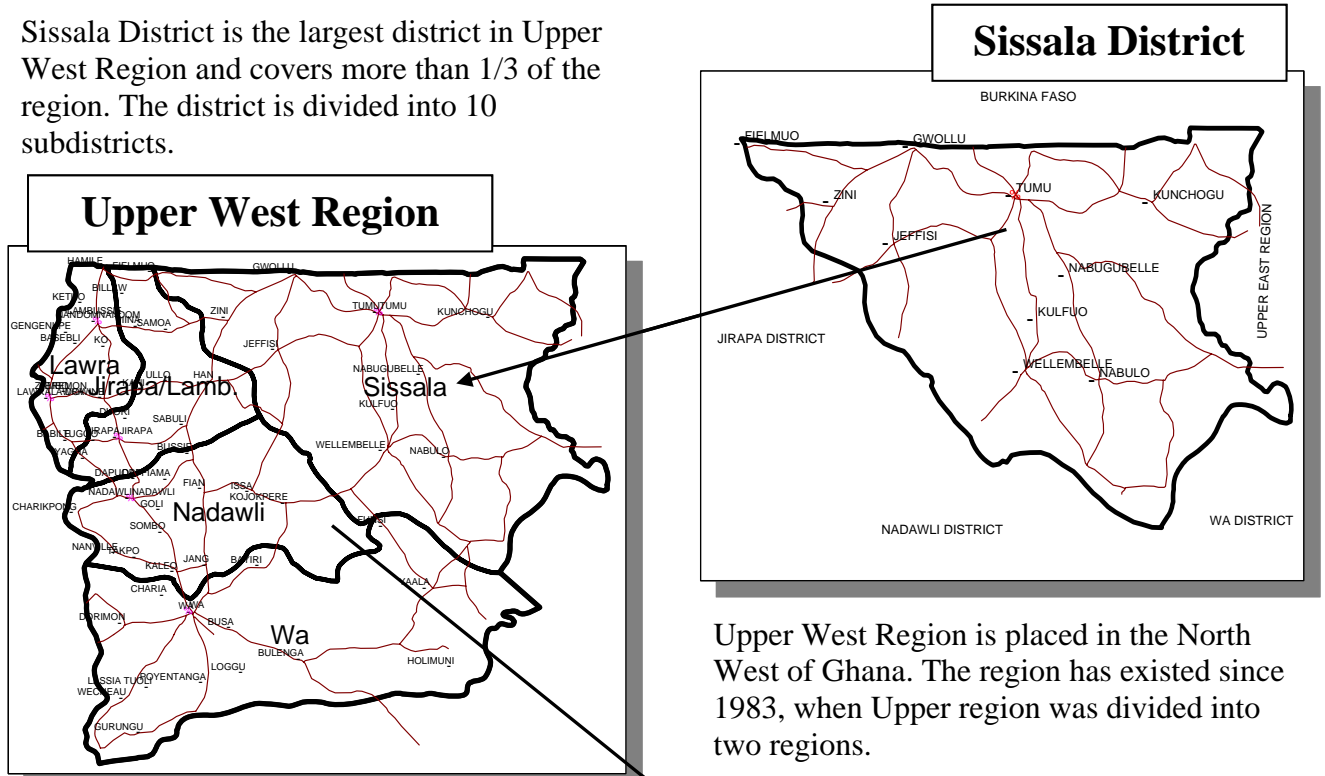
- Lack of funding; withdrawal of funds
- Competition with other NGO's
- Bureaucracy at DA
- No permanent source of funding

## Appendix 4: List of organisations and persons met

- ActionAid
- ASUDEV
- Bawa and Affia
- Ballon
- Christian Mothers Association
- Community meeting in Nabugubelle
- District Assembly
- District Assembly focal person for HIV/AIDS
- District Director of Health Services Thomsen Domba
- District Health Management Team
- FORMWAG
- Green Sahara
- Health Insurance Management
- IMCC volunteers
- Joan Dery
- Laadi Kanton
- Members of Happy Women Group
- Members of Nabicholo Women Group
- Nabugubelle health centre personnel
- National Commission for Civic Education
- NGO coalition of local NGOs
- Pastor Seth
- PAWLA management and volunteers
- Plan International
- Sub-district Health Management Team
- Tumu Credit Union
- Tumu District Hospital, Medical officer in Charge and GHS trained counsellors
- Unit Committee member of Nanchalla
- YARO management and volunteers

## Appendix 5: Map of Ghana

Sissala District is the largest district in Upper West Region and covers more than 1/3 of the region. The district is divided into 10 subdistricts.



Ghana is a country in West Africa. It lies in the middle of the Gulf of Guinea and shares borders with Togo to the East, Burkina Faso to the North and Cote d' Ivore to the West.

