1-1-2010

The impact of stakeholder collaboration on effectiveness of health program implementation in Ghana

Samuel Kwami Agbanu
Walden University

Walden University

COLLEGE OF MANAGEMENT AND TECHNOLOGY

This is to certify that the doctoral dissertation by

Samuel Kwami Agbanu

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. James Goes, Committee Chairperson
College of Health Sciences Faculty

Dr. Marilyn Simon, Committee Member
College of Education Faculty

Dr. Thea Singer, Committee Member
College of Management and Technology Faculty

Dr. Mona Hanania, School Representative
College of Management and Technology Faculty

Chief Academic Officer

David Clinefelter, Ph.D.

Walden University
2010

The Impact of Stakeholder Collaboration on Effectiveness of Health Program Implementation in Ghana

by

Samuel Kwami Agbanu

Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
Applied Management and Decision Sciences

Walden University
May 2010

ABSTRACT

Healthcare providers increasingly recognize the importance of collaboration among stakeholders in cost-effective healthcare delivery. While collaborative relationships offer great advantages, little research has addressed their relevance in an international development aid context, particularly in sub-Saharan Africa. The region is a major recipient of international development support, yet health indicators on HIV/AIDS, malaria, tuberculosis, and child and maternal mortality indicate the health of the region is among the weakest worldwide. This sequential mixed method, descriptive study of a USAID-funded community health program in Ghana examined the nature of collaboration among six stakeholders and impact of this collaboration on effectiveness of program implementation. Stakeholder and resource dependence theories provided conceptual frameworks for analysis. Data were collected through surveys and interviews of officers of participating organizations (POs) and community health officers (CHOs). Surveys were analyzed using means, standard deviations, and *t* tests, while coding and themes determination were adopted for the interview data analysis. Results from both sources were integrated. Findings indicate both POs and CHOs perceived human relationship factors as more critical than physical resources. Collaboration, shared decision making, and frequency of communication in the relationship were perceived to substantially improve CHO skills and rural healthcare quality. Recommendations include active development of strong trust and dialogue in future relationships. These results could have important implications for positive social change by identifying the bases for collaborative success in providing impoverished rural communities with cost-effective and quality healthcare to address critical community health needs.

The Impact of Stakeholder Collaboration on Effectiveness of Health Program Implementation in Ghana

by

Samuel Kwami Agbanu

Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
Applied Management and Decision Sciences

Walden University
May 2010

ProQuest LLC
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106-1346

DEDICATION

I dedicate this work to Elikem, my youngest daughter and to my late parents, Papa and Taklu. What an incredible difference all three made in my life!

ACKNOWLEDGMENTS

I would like to express my appreciation to several individuals that have made my academic journey at Walden a success. First is Dr. Jim Goes, who was my mentor and chair of my dissertation committee. Although with the "miracle" of online we have never met, Dr. Goes' incredible help and patience has been the foundation for my success. I am extremely grateful to him. I also greatly appreciate Dr. Marilyn Simon and Dr. Thea Singer, both of whom served on my committee. They provided timely and quality reviews of my dissertation drafts. If your dissertation committee is made up of these three, you are blessed indeed! I count myself blessed to have the trio.

My wife, Florence, suspended much of her comfort to support me during the trying period of my study. Using this section to thank her will not be enough, but that is all I have! Florence, I love you and deeply appreciate your help, and may God richly bless you. Thank you to all my kids, Elorm, Elikem, Sedem, and Dziedzorm.

Let me also express my thanks to a good friend and colleague, Prof. Habib Mahama of Australian National University who constantly encouraged me through this period. I thank also my cousins Harry Agbanu of University of Ghana, Kingsley Adams, Ernest Aglo of CEPS (Aflao, Ghana), and Daniel Fiadonu of Australia. You guys were great. I also thank my mother-in-law Mma and my mum, Nda for their support. To the Lighthouse Chapel International members and pastors at Irvington, New Jersey I am grateful. Thanks also to all my Walden friends who made this journey a communal one. Finally and above all, TO GOD BE THE GLORY!

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1: INTRODUCTION TO THE STUDY

Collaboration between health organizations has become a common and successful approach in successful health care delivery (Frey, Lohmeier, Lee, & Tollefson, 2006; Halverson, Mays, & Kuluzny, 2000; Longoria, 2005; Reason, 1999). Collaborative relationships involve independent organizations coming together to work jointly on health programs by leveraging their resources and skills (Pfeffer & Salancik, 1972; Stefl & Bontempo, 2008; Wampler, Frank, & Karen, 1996). The primary objective of such relationships is to solve complex health problems that are beyond the scope of any one organization. In addition, joint working relationships provide platforms for the various organizations to bring diverse voices and ideas regarding approaches and strategies that could ultimately lead to comprehensive health care (El Ansari, Phillips, & Zwi, 2004). Additionally, such partnerships can also result in improved organizational performance (El Ansari, et al.; Briggs & Martini-Briggs, 2009; Hord, 1986).

One factor that has accounted for the development and the increasing interest in collaboration in the health care sector is the diversity of health related skills (Briggs & Martini-Briggs, 2009; Halverson et al, 2000; Silvestre, Sue, & Allen, 2009). Another factor is the increasing pressure on the limited health resources (Abernethy, Chua, Grafton, & Mahama, 2007; Halverson, et al.; Stefl & Bontempo, 2008) and the need to make effective use of such resources. Also, health care stakeholders, particularly consumers, now demand higher quality and cost effective health care from their health organizations (Longoria, 2005; Renzaho, 2008). The changing demography (Martins &

Maisonneuve, 2006) and the transforming role of technology in health care delivery also play significant roles (Wampler et al., 1996).

Effective collaborative relationships must include individuals and groups who will be affected by, or whose actions can also affect, the outcomes of the relationships (Freeman, 1975; Gully, Stainer, & Stainer, 2006; Yue, 2008). The most effective collaboration relationships include the affected individuals in the decision-making process and give them essential decision-making information (El Ansari & Phillips, 2001; Akukwe, 1999). The inclusion of such groups in decision making can also strengthen their commitment and ownership to the objectives and goals of the relationship (El Ansari & Phillips; Akukwe). Commitment and ownership are essential for meeting shared goals effectively (Bernstein, 2002). Besides, collective commitment and ownership to programs could be a precursor to collective action and participation, which together can increase the possibility of program effectiveness and success.

Moreover, collaborative relationships must also recognize and include the voice and inputs of stakeholders of the health program (Akukwe, 1999; Bernstein, McCreless, & Cote, 2007; Mosquera, Zapata, Lee, Arango, & Varela, 2001). According to Chopra and Ford (2005), the most valuable stakeholders determine their health priorities and also know the appropriate methods for achieving them. According to Akukwe, by recognizing the value of their inputs, stakeholders can also be empowered to take ownership of the program.

Few studies exist on interorganizational collaboration among health care providers in sub-Saharan Africa (El Ansari & Phillips, 2001a; 2001b; El Ansari et al.,

2004); however, these studies provide valuable insights into the nature of the relationship among country-level health professionals, particularly sharing of skills, resources, and collective decision making. The concentration of these few studies on local health professionals makes it difficult to understand how the relationship works when diverse organizations such as NGOs, government health institutions, external funding agencies, and program stakeholders are collectively involved in a health program implementation.

The current state of healthcare in sub-Saharan Africa amplifies the critical need for this study. HIV/AIDS, Malaria, and Tuberculosis (TB) constitute the three most devastating diseases on the continent. The G8 Summit held in 2000 referred to these three diseases as the "three priority diseases of poverty" on the continent. In 2007, 67% of the world's HIV/AIDS cases and an estimated 75% of all HIV-related deaths occurred on this continent (UNAIDS, 2008). In 2006 the continent was also responsible for 212 million of the overall 247 million episodes of malaria worldwide (World Malaria Report, 2008). Worse still, the region was also home to 91% of the malaria related deaths, and of these deaths "85 percent were of children under 5 years of age" (World Malaria Report 2008, p. viii).

Tuberculosis resulting from HIV/AIDS infections also account for high death rates in some countries in the region (Awofeso & Schelokova, 2008; Lawn, Myer, Bekker, & Wood, 2006; Mukadi, Maher, & Harries, 2001; WHO, 2000). According to the WHO, with regard to TB, "of the 9.4 million incident cases in 2008, an estimated 1.2-1.6 million (13-16%) were HIV-positive, with best estimate of 1.4 million (15 %). Of these HIV-positive cases, 78% were in the African Region" (WHO, 2009, p.5). Given the

stark realities of these health indicators, exploring the impact of collaborative relationships on effective health program implementation was valuable.

Consequently, in the present study, the primary focus was to explore how these types of organizations and institutions cooperate on the implementation of externally funded health programs in sub-Saharan Africa. Using a descriptive, mixed method, I examined the perceptions of participating officers of health organizations in a representative United States Agency for International Development (hereinafter USAID) funded health program in Ghana. Ghana has been a long-term beneficiary of USAID funding and support in several health care programs, while the state of the country's healthcare is similar to those of most countries in the region. Conducting the study in Ghana provides healthcare professionals an important opportunity to share their findings in other affected nations. In this introductory chapter, I provide the background to the study, introduce the research problem and the research questions that guided the research, and review theoretical frameworks that structure the analysis. The chapter also includes an examination of the nature of the study, social change implications, and definitions of technical terms.

Background of the Study

In this section, I examine deficiencies in health care in sub-Saharan Africa, the role of external organizations particularly in funding health care, and interorganizational collaboration in health care delivery.

USAID and Health Care in Sub-Saharan Africa

Sub-Saharan Africa holds 10 % of the world's total population (Kalipeni & Zulu, 2008; World Development Report, 2009) but this region's inhabitants suffer disproportionately from serious disease. For example, in 2007, 67 % of the world's HIV/AIDS cases occurred in sub-Saharan Africa, together with 75 % of all HIV-related deaths (UNAIDS, 2008). Although women make up about half of the total HIV cases worldwide, in sub-Saharan Africa, 60 % of those suffering from HIV are women (Gichaara, 2008;UNAIDS, 2008; Umeh, Essien, Ezedinachi, & Ross, 2008; Ware et al., 2009; World Bank, 2008). Of the 2 million children under the age of 15 living with HIV/AIDS worldwide in that year, 90 % lived in this region (UNAIDS, 2008).

Tuberculosis and malaria also present enormous health problems in sub-Saharan Africa. Of the 247 million cases of malaria occurring worldwide in 2006, 212 million occurred in there, together with 91 % of all malaria-related deaths (World Malaria Report, 2008; Kiszewski et al., 2007; Teklehaimanot, Singer, Spielman, Tozan, & Schapira, 2005). Estimated 8.8 million new people contract tuberculosis annually, and 7.4 million of those patients reside in Asia and Africa (Awofeso & Schelokova, 2008). Life expectancy in sub-Saharan Africa is predictably low: In 2005, life expectancy at birth for men was 48 years and for women was 50 years, figures that contrast sharply with European life expectancies of 69 years for men and 77 years for women (WHO, 2007).

Various factors contribute to this health crisis. Health resources at the disposal of sub-Saharan countries, particularly financial resources, are insufficient to meet the health needs of the population (Ekortarl, Ndom, & Sacks, 2007; Kiszewski et al., 2007;

Komatsu, et al., 2007; McDaid, Knapp, & Raja, 2007). In 2005, for example, global spending on malaria stood at $841 million (Kiszewski et al.). According to Kiszewski et al., this spending represents about 20 percent of the amount needed, and this trend will likely continue to 2015. Annual budget for health services in relation to other sectors is also relatively small. According to McCoy et al. (2005), in 2001 "thirty-one African countries had total annual per capita health expenditures of $20 or less" (p. 18). The World Development Report (WHO, 2005) also indicated that Nigeria allocates 3 % of its annual health resources to health while Ghana allocates 2.3 % of GDP to the sector.

In addition, more than half of the region's population earns less than one dollar a day (WHO, 2007; Owusu, 2004), constraining access to basic health services (Mbagaya, Odhiambo, & Oniang'o, 2005; Nabyonga-Orem, Karamagi, Atuyambe, Agendas, Okuonzi, & Walker, 2008). Another significant contributor to the region's inadequate healthcare is the emigration of healthcare professionals from sub-Saharan Africa to advanced countries such as the United States, Canada, and the United Kingdom (Arah, 2007; Kirigia, Gbary, Muthuri, Nyoni, & Seddoh, 2006). According to Arah, although sub-Saharan Africa appears to have a higher disease burden worldwide, it has only three percent of health professionals. Yet statistics show that as at 2000, Ghana lost 1,639 (56 %) of its total health professionals, South Africa 7,363 (21 %), Mozambique 1,334 (75 %), Morocco 1,334 (75%), and Angola, 2,102 (70%) (Clemen & Petterson, 2006).

In response to this healthcare crisis, international aid efforts to support healthcare in sub-Saharan Africa have increased over the last few years (Costello & Osrin, 2005; Gottret & Schieber, 2006; OECD-DAC, 2008). In 2001 and 2002, members of the

Organization for Economic Co-Operation and Development (OECD) allocated 12 percent of their total aid to sub-Saharan Africa and, by 2005-2006, that allocation had risen to 16 percent (OECD, 2008). Between 1980 and 2000, and 2000 and 2006, growth in health aid to the continent also went up from 9 % to 15 % annually (OECD, 2008). Global Health Partnerships (GHPs) also provided technical and financial support for the prevention and eradication of HIV/AIDS, malaria, and tuberculosis (Capobianco & Naidu, 2008; WHO, 2007): in 2005-2006, a total of $5.3 billion USD was committed to this effort (OECD-DAC, 2008).

The United States provides aid to the region through bilateral arrangements (Atukwe, 1999; Owusu, 2004; Pfeffer et al., 2008). The United States Agency for International Development (USAID) is the primary administrator of this aid, which funds healthcare in the key areas of HIV/AIDS, malaria, tuberculosis, child and maternal health, reproductive health, and nutrition (USAID, 2007; OECD, 2008; Owusu, 2004; Pfeffer et al., 2008). USAID also is involved with other U.S. agencies to manage the U.S. President's Emergency Plan for AIDS Relief (Almquist, 2009; Wechsler, 2008). In 2008, the USAID allocated 1.6 billion USD for the treatment of HIV/AIDS; 712 million USD for HIV/AIDS prevention programs, and 953 million USD for care activities (USAID, 2007; Wechsler). Sub-Saharan Africa also is the focus of the U.S. President's Malaria Initiative (Almquist). Since its inception, the program has provided 1.2 billion USD to reduce malaria-related deaths by 50 % in specific countries in the region, including Ghana (USAID, 2007; Wechsler).

Interorganizational Collaboration in Health Care Delivery

The health care sector has been undergoing a major transformation over the past decades (Abernethy et al., 2007; Halverson et al., 2000). Significant changes in demography, the impact of technology, limited health resources, increasing demand from stakeholders for quality and affordable health care, the complexity of providing health care (El Ansari & Phillips, 2001a 2001b; El Ansari et al., 2004; Halverson et al., 2000), and the diversity of health care skills have together transformed the approach to delivering health care. Martin-Rodriguez, D'Amour, and Ferrada-Videla (2005) argue:

> By bringing together in real time the competencies, experiences and judgment of a variety of professionals, organizations are trying to respond to a reality that is becoming increasingly complex in terms of both the knowledge and the working methods that are being applied. (p. 132)

Martin-Rodriguez et al.'s position therefore underscored some of the key areas that most collaborative relationships focus on.

Collaboration between health organizations entails joint working relationships on health programs, with the principal objective of achieving shared goals more effectively than could be achieved independently by each organization (El Ansari et al., 2004; Halverson, et al., 2000; Longoria, 2005; Reason, 1999). Halverson et al. (2000) stated that organizations bring to the relationship their individual resources, competencies, time, and the essential resources towards the relationship. This collaboration can result in the achievement of their collective health objectives.

Furthermore, collaboration among health organizations can result in greater organizational performance. There is the potential for mutual benefits and greater outcomes for all participating organizations (Ansari et al., 2004; Longoria, 2005).

Stakeholders, particularly consumer stakeholders, will receive quality, cost-effective health services. Collaboration among health organizations can solve complex health problems (Mizrahi & Abramson, 2000). By collaborating, organizations can utilize limited resources more effectively and provide diversity in approaching health programs (Mizrahi & Abramson).

Strong and effective collaboration must include input from identifiable stakeholders (Ansari et al., 2004; Akukwe, 1999; Freeman, 1985). Such groups and individuals must be included in the decision-making process (Bernstein, 2002), and essential information needed for effective decision making should be shared with them (Ansari & Phillips, 2001; Ansari et al., 2004; Akukwe, 1999). According to Abernethy et al.(2007), it is essential that "communication channels to be opened up to encourage debate and consideration of alternative perspectives with a view to reaching some level of agreement over the priorities to be pursued" (pp 17-18) in order to make the participation effective.

The involvement of actual health program stakeholders in the planning, prioritization, and the final implementation process can significantly influence the effectiveness of such programs (Akukwe, 1999; Clare & Cox, 2003; Chopra & Ford, 2005). Chopra and Ford (2005) argued that such an inclusion will help stakeholders "define who they are, what they want, and how they can get it" (p. 386). Stakeholders can help determine issues that are important to them (Clare & Cox) through the negotiation of their unique health priorities (Chopra & Ford; Akukwe). They can also be an essential source of gaining information on factors that can either inhibit or improve the

implementation process, including information on non-health factors (Akukwe). According to Akukwe, non-health factors can play valuable roles in the success or failure of programs. Finally, by their participation, stakeholders have collective responsibility for ensuring that program implementation is effective (Chopra & Ford; Akukwe).

The review of literature (El Ansari et al, 2004; Akukwe, 1999; Clare & Cox, 2003; Chopra & Ford, 2005) shows that collaboration among health care organizations has important advantages; however, researchers have conducted few studies into the subject in sub-Saharan Africa. Specifically, there have been limited studies on the collaboration among health care organizations that implement externally-funded health programs. A literature search revealed only one article that had focused directly on community participation in externally funded health program (Akukwe, 1999). The other few studies found in the literature concentrated on specific diseases (Pawinski & Lalloo, 2006; Webster, Hill, Lines, & Hanson, 2007; Wyss, Moto, & Callewart, 2003) rather than a broad range of health objectives. El Ansari and Phillips (2001) and Ansari et al. (2004) investigated collaboration among health professionals in a primary health care setting in South Africa.

This gap in the literature creates a need for timely research into the problem. The study filled the knowledge gap by examining the extent to which health care stakeholders involved in USAID funded health programs in sub-Saharan Africa collaborate in the delivery of such programs, focusing on how elements of participation and communication strengthen the relations. In this study, I also examined how the involvement of frontline community health professionals in such interactions influences their overall effectiveness.

I examined these issues in the context of a USAID-funded Community Health Planning and Services Technical Assistance (CHPS-TA) program in Ghana.

Problem Statement

USAID has funded health programs in many countries, but few studies have examined the extent to which collaboration between USAID, health-related government institutions, NGOS, and local communities in recipient countries has influenced effective implementation of the programs. Specifically, there has been no detailed work on USAID aid supported health programs in Ghana detailing whether and how USAID, the government of Ghana, and other related stakeholders collaborate on the design and implementation of the health programs and how the collaboration affects the effectiveness of the implementation process. Without this knowledge, it is difficult to understand the dynamics of the collaboration, effective characteristics of the collaboration, and possible impact on the performance of local health professionals and health outcomes. This gap in the literature creates a need for more focused research to examine this problem. The current weak state of health in sub-Saharan Africa demonstrated by health indicators on HIV/AIDS, Malaria, Tuberculosis, life expectancy, and communicable and incommunicable diseases further underscores this urgent need. This problem was examined within the context of a USAID funded CHPS-TA program in Ghana which is focused on the training of Community Health Officers (CHOs). This mixed method, descriptive study investigated the nature of collaboration and the influence of this collaboration on participants' perceptions of program effectiveness and outcomes.

Purpose of the Study

The purpose of this mixed method, descriptive study was to explore the nature of collaboration among health care stakeholders who are engaged in the USAID-funded CHPS-TA program in Ghana to understand the impact of the collaboration on the effectiveness of the implementation process. This study also explored the potential impact of participatory decision making and communication in improving collaboration among health stakeholders. Finally, the study examined the extent to which CHOs have been included in the implementation of the CHPS-TA program and how their involvement improved their effectiveness and the entire collaboration process. Knowledge of the collaboration process and its potential effect on the effectiveness of health program implementation can assist in the formulation of quality health programs. Surveys and personal interviews were used to collect the data.

Nature of the Study

The study employed a mixed method, descriptive design. Broadly, a mixed method allows for both quantitative and qualitative research methods to be used together (Creswell, 2003; Jick, 1979; Johnson & Onwuegbuzie, 2004; Scott, 2007). This combination reduced the weaknesses associated with using either quantitative or qualitative approaches in isolation. The individual strengths of the two methods in one study led to greater confidence in the validity of the findings (Johnson & Onwuegbuzie; Scott; Trochim & Donnelly, 2007). The under-researched nature of the research problem informed the choice of mixed method. The adoption of the mixed method approach not only enabled a description of the perceptions of participants, but it also provided a

measurement of the extent to which they shared particular perceptions or responses. This method also offered a complete view of the nature of the collaboration between participants, and the method opened the research further to the discovery of unpredicted perceptions, trends, or issues.

According to Creswell (2003) there are six different methods of mixing both quantitative and qualitative data. In this study, I selected the sequential explanatory mixed method was selected for this study. The sequential explanatory method entails the collection of quantitative data first, followed by qualitative data (Creswell, 2003). According to Creswell, in this approach, "the priority typically is given to the quantitative data, and the two methods are integrated during the interpretation phase of the study" (p. 215). By using the sequential approach, the qualitative data can provide great insight into the quantitative data through the experiences of participants (Creswell).

I adopted a descriptive design for this study. Descriptive designs are useful for examining "what is going on or what exists" (Trochim & Donnelly, 2007, p. 5) about a phenomenon. The use of the descriptive approach led to a detailed examination of the perceptions of participating officers of health organizations about how their collaborative relationships helped improve the implementation of the CHPS-TA health program.

In 1999, the Ghana Health Service (GHS) and some of its partners experimented with the Community Health and Planning Services (CHPS) health program in Navrongo. The core objective of the CHPS was to "promote the idea that communities can be active participants in the provision of their own healthcare" (CHPS-GHS). The CHPS program encourages local community involvement, interaction, and participation in the delivery of

their healthcare. Communities participate in the program by determining the administration and direction of the healthcare delivery process based on their specific local circumstances, resources, and needs. Communities also provide voluntary services and resources for the establishment of community health facilities including the building of a Community Health Compound (CHC), consisting of clinic and a place of residence for the CHO (Nyonator, Jones, Miller, Phillips, & Awoonor-Williams, 2005). A nurse or a community volunteer—trained as a CHO—takes up residency, lives, and works within the community. The 1999 experimental CHPS initiative was both effective and successful at extending healthcare services to deprived rural communities.

In order to extend the CHPS program to other deprived districts in Ghana, USAID funded an extension of the initiative, known as the Community Health and Planning Services-Technical Assistance (CHPS-TA). The current study focused on this USAID-funded health initiative, which started in 2004 and ended in September 2009. The CHPS-TA concentrated on the training of CHOs on basic health care services such as immunization, family planning, HIV/AIDS education, malaria, birth attendance, antenatal and postnatal care, and basic health treatments (GSS, GHS, & Macro International, 2009; Nyonator et al., 2005). The CHOs also act as community-level facilitators, where they encourage increased local community-level utilization of services and products for malaria, maternal and child health, and family planning (Nyonator et al., 2005).

The study population was limited to two subpopulations. The first subpopulation comprises members of participating organizations in the CHPS-TA program, including USAID, GHS and MOH, Population Council of Ghana, CEDEP, EngenderHealth, and

ACNM. The second subpopulation will be limited to CHPS-TA implementers in the Eastern Region of Ghana. This subpopulation consists of CHOs in the Kwahu North and Birim North districts (participating districts) and supervising health officers at the regional, district, and subdistrict levels in the eastern region. The study also used a criterion-based sampling approach to select eligible members of the two subpopulations. The study required participants to work directly on the CHPS-TA program or be a CHO. Purposeful sampling was used to select interview participants (Creswell, 2007). According to Creswell, purposeful sampling is suitable for exploring in-depth experiences of participants.

Singleton and Strait (2005) recommended surveys and interviews as useful data collection instruments in a descriptive study; therefore, these were used to collect data in this study. Two surveys were developed for participating officers and CHOs. Questions in the survey were partly adapted from Bronstein's (2002) validated Index of Interorganizational Collaboration (IIC). Additional questions were also formulated outside of Bronstein's index to address areas not covered in the IIC. This study also used sources in the literature, including Rodriguez, Langley, Beland, and Dennis (2007); McMurray (2006); Berry, Krutz, Langner, and Budetti (2008); Ansari and Phillips (2001a; 2001b); and the theories of Freeman (1984) and Pfeffer and Salancik (1978) as guides to the construction of survey and interview questions.

Questions were closed- and open-ended, concentrating on four major issues: (a) the nature of collaboration, (b) participation in decision making, (c) level and nature of communication, and (d) the involvement of CHOs in the relationship and the impact it

has on their performance. The format of the surveys was that each closed-ended question had a corresponding open-ended question, which allowed participants to express their opinions in a written form. Closed-ended survey questions were used for the quantitative analysis. The open-ended questions were to complement data from the interviews, which together constituted the qualitative portion of the analysis.

I administered the surveys and conducted the telephone interviews. The value and essence of the interview was to seek further insights from participants on the research questions. Telephone interviews worked best for this study because of their cost effectiveness (Creswell, 2007; Singleton & Strait, 2005).

Validity and reliability of the survey instrument is critical for the success of the study (Trochim & Donnelly, 2007). To achieve validity and reliability, the dissertation committee and two knowledgeable experts reviewed surveys. The surveys were also pilot-tested on a small group from the study population. The pilot test helped reveal potential areas of the surveys that needed revisions so that the instruments met the validity and reliability standards (Singleton & Strait, 2005). To certify the validity and reliability of the interview data, I adopted a member checking technique, where participants reviewed completed interviews for accuracy and completeness (Creswell, 2007).

Data from surveys and interviews were analyzed separately. Next, interview data were coded to determine themes deductively for the analysis. Survey data were analyzed using descriptive statistics, which displayed data in frequencies, number of sampled

responses, percentages, means, and standard deviations. Findings from both data sources were integrated to address the research questions.

Research Questions

Consistent with the purpose of the study detailed above, the study answered five questions:

1. What is the nature of collaboration between USAID and its health partners in the implementation of the CHPS-TA program in Ghana?
2. How does the nature of the collaboration influence the effectiveness of the implementation process?
3. How does the level of participation of stakeholders in decision making affect the level of the collaboration?
4. How do the quality, frequency, and amount of communication affect decision making towards the effectiveness of the collaboration?
5. How does the involvement of the Community Health Officers in the decision making increase their effectiveness in their functions?

Conceptual Framework

Stakeholder theory and resource dependency theory provided the theoretical frameworks for understanding the research problem. Freeman (1984) provided significant impetus for stakeholder theory in his often-quoted definition of a stakeholder as any "group or individual who can affect or is affected by the achievement of the organization's objectives" (p. 46). Most researchers and other theorists who use this conceptual framework to analyze organizational relationships agree on the basic premise

of the theory—namely, that in the pursuit of its goals, an organization must sense and respond to the multiple interests of groups and individuals who have a stake in its operations (Freeman, 1984; Gully et al., 2006; Sutterfield, Friday-Stroud, & Shivers-Blackwell, 2006; Yue, 2008). This viewpoint perpetuates the assumption that the overall burden of organizations in meeting and achieving their goals lies in how such organizations relate and manage the diverse interests of their stakeholders.

Resource dependency theory argues that organizations are inherently dependent on environmental agents, such as donors, because these agents provide a critical source of resources for the organizations' existence and survival (Morris, 2007; Pfeffer & Salancik, 1974). The underlying tenet of the theory comes from understanding that "the key to organizational survival is the ability to acquire and maintain resources" (Pfeffer & Salancik, p. 2). In this regard, the manner in which an organization controls such resources determines the success or failure, because "survival is contingent on its ability to gain control over environmental resources" (Boyd, 1990, p. 420). One important way organizations can gain control over resources in the environment is through relationships and collaboration with other organizations that have such resources. Because each organization does not have all the resources it needs to operate (according to basic economic theory), this approach provides a means for organizations in this cooperation to pull relevant resources together to meet their collective goals (Clark, 2007). Collaboration can also reduce cost through the harnessing of collective effort, energy, and resources. It is also valuable for driving collective focus and direction, reducing negative

conflicts, and increasing the potential for achieving goals more effectively than if a single entity pursues such goals.

There is an integrative framework within which both stakeholder- and resource-dependency viewpoints inform this study. Freeman's (1984) definition of stakeholders often applies to groups and individuals within and outside business organizations; however, Mitchell, Agle, and Wood (1997) argued the term might also apply to relationships *between* organizations, as is the case of this study. Stakeholder theory attempts to explain the management of stakeholder relations by a single organization. But its value to this study lies in directing attention to all stakeholders participating in CHPS-TA program having a collective focus on the program goals and how they can work collectively to achieve them. The value of the theory is that all interested parties in the transaction must see themselves as "affected or being affected" by the outcome of the goal in question. Conversely, because all stakeholders stand to lose if the organization does not meet its intended goal, the rational and practical step should be to specify what each party to the relationship must do to attain the common goal. Clark (2007) called this the team-generated or target-centric picture of a problem, where all stakeholders interact to share and understand their view of the problem or target.

In addition, this approach provides opportunity to "brings full resources of the team to bear on the target" (Clark, 2007, p. 15), thus reinforcing Pfeffer and Salancik's (1974) position. A team-generated picture of the target allows all stakeholders to share their knowledge of the target or problem and "better able to identify gaps in knowledge and understand the important issues surrounding the subject" (Clark, p. 15). Clark further

argued that while this approach offers all stakeholders to share their views, it also indicates the need for participants to collaborate on the target or problem.

These views have important implications for addressing research questions of this study, including how the stakeholder organizations engaged in the implementation of USAID-funded health programs must collaborate in decision making, and share essential resources and expertise to achieve the program goals. Further, the stakeholder collaboration and resource dependency theoretical frameworks were also important in addressing how communication of health care program objectives, goals, and feedback strengthened the relationship.

Definition of Terms

Collaboration: "the cooperative way that two or more entities work together toward a shared goal" (Frey et al., 2006, p. 384).

Communication: any means of sharing or transmitting information to stakeholders (Ansari & Phillips, 2001).

CHPS-TA: Community Health and Planning Services Technical Assistance

Participation: shared decision making by all stakeholders (Ansari & Phillips, 2001).

Effectiveness: the "ability to create acceptable outcomes and actions" (Pfeffer & Salancik, 1978, p. 11).

Ghana Health Service (GHS): Ghana Health Service is government of Ghana's health delivery and implementation agency.

Ministry of Health (MOH): Ghana's Ministry of Health responsible for health policy formulation, monitoring, and evaluation.

Partnership: a "formal working relationships among individuals for a specific purpose" (Raik, Siemer & Decker, 2005, p. 263).

Stakeholder "any group or individual who can affect or is affected by, the achievement of the firm's objectives" (Freeman, 1984, p. 25). In this study, stakeholders are organizations that have participated in the health programs.

Sub-Saharan Africa: that part of Africa that is located south of the Sahara and excludes North Africa.

Assumptions

The study worked from the premise that participants would answer survey and interview questions honestly, truthfully, and openly. I assured all participants in the study that their participation was voluntary as a way of soliciting accurate and objective answers that were reflective of their actual experiences. Participants were also guaranteed confidentiality of the responses they provided. A further assumption was that the personal bias, attitudes, beliefs, and experiences of participants could affect their perception of the nature of collaboration, participation, and communication. This assumption was particularly relevant given that some of them reside in urban areas while other participants reside in rural communities. The differences in residence could therefore affect their responses. However, the study's design factored these biases into the final analysis of data, which minimized their potential effects on the study results.

Another assumption was that employing a mixed method, descriptive design to investigate the research problem and address research questions was appropriate. Based on past studies in which mixed methods, descriptive designs were used, it was assumed that data collection instruments of surveys and interviews were reliable and valid in undertaking the study. The use of this approach yielded more accurate and rounded views of participants than either the qualitative or the quantitative approach could offer. Finally, another assumption was that each participant could answer both the survey and the interview questions capably. Survey results and interview outcomes did not demonstrate any indication participants had difficulty fulfilling this requirement.

Scope and Delimitations

The scope of the study was a USAID-funded CHPS-TA of the GHS. The implementation of the program started in 2004 and ended in September 2009. Only participants within this period qualified for participation. This study was also confined to the eastern region of Ghana, where two districts, Kwahu North and Birim North, participated in the initiative. The scope of study also covered only six other organizations—USAID, ACNM, CEDEP, GHS and MOH, Population Council, and EngenderHealth, which participated in the implementation of CHPS-TA. The study participants in the eastern region consisted of CHOs, regional and district health officers, and individuals and employees of the six organizations who had direct roles in the CHPS-TA implementation process.

Limitations

A number of factors limited the study. First, the study population was comprised of two subpopulations: (a) employees of the six implementing organizations, and (b) regional, district, and community health officers in the eastern region (Kwahu North and Birim North). This population was relatively small, given that six other regions in Ghana were also participating in the program. The study employed criterion and purposeful sampling to select the study populations. These methods facilitated the selection of quality participants. However, the methods were neither random nor representative. Both characteristics are important and essential for quality research. The study population and its size, and the sampling methods together decreased the extent of generalization of the study findings to other regions in Ghana, the location of the CHPS-TA program's implementation.

I employed a mixed method, descriptive study in this study. Descriptive studies can provide detailed knowledge of a phenomenon; however, descriptive designs are limited because a researcher has less control over the study variables and the environment. Also, a descriptive study limited the nature and form of data collected. Descriptive data through surveys led to the collection of participants' perceptions. However, this approach could exclude detailed participant insights and contexts within which the participants described their perceptions. Although interviews were conducted with participants to gather the needed insights and contexts, the quality of the interview data depended on the quality of the questions posed and the interviewer (Singleton & Strait, 2005; Trochim & Donnelly, 2007).

The data collection instruments also limited the findings of the study. The study employed Likert-type scales to measure the participants' perceptions. Although Likert-type scales are valuable at providing the degree and intensity of participants' perceptions on the research questions through closed-ended questions, this type of scale can also have a limiting effect. Participants could judge "strongly agree" or "strongly disagree" differently, which could result in imprecise responses. How to interpret the intensity of perceptions, therefore, could be problematic. Additionally, I examined only participants' perceptions on collaboration, participation, and communication in the CHPS-TA program. Further, the study excluded anything that was unrelated to these issues.

I chose to analyze the data using descriptive analyses, which also limited the form of information that could be obtained. Descriptive statistics could result in quality summarization of data in graphs and tables by indicating what the data showed in order to assist the analyses. This form of statistics could also be useful in determining patterns in data. Descriptive statistics determined the degree of association between and among collaborating stakeholders. However, descriptive statistics did not permit reaching conclusions that were beyond what the data provided. This phenomenon placed limitations on the study, as it was difficult to understand why the participants held some perceptions.

Finally, there was a democratic change of government in Ghana in January 2009. Consequently, some government officials who may have been involved with the USAID health program and were potential participants in the study may have left some of the

participating agencies. Therefore, their participation could not be guaranteed. However, efforts were made to locate such officials.

Significance of the Study and Social Change Implications

Results from this study could contribute to quality health care policy formulation and implementation in Ghana and in other parts of sub-Saharan Africa. The CHPS-TA program administrators introduced the program to several deprived districts in Ghana. The program administrators' investigation of the impact of cooperation among interested parties and its contribution to successful programs might lead to quality health care delivery in such districts. The GHS can use this knowledge to formulate quality health policies that encourage collaboration among the identifiable interested parties, and improve participatory decision making and sharing of relevant health information so that CHPS-TA programs can be implemented effectively country wide. GHS will also benefit from reduced cost through harnessing of diverse and collective expertise and resources.

On the other hand, other health policy makers and implementers, funding agencies, and NGOs could also create positive social change by using the knowledge from all identifiable stakeholders in health program decision making and implementation to formulate effective health policies. Policies are the frameworks that direct implementation. A health program implementation framework that focuses on local level participation, collaboration, and information that provide customized local health programs will empower stakeholders to meet the increasing health needs of the deprived communities in Ghana. This method could improve the social, economic, and political lives of these communities.

USAID and other foreign development agencies that support health care, agriculture, and other development programs in Ghana and sub-Saharan Africa often encourage diversity in the implementation process. Implementation of malaria, HIV/AIDS, and child and maternal health programs often include different organizations with diverse expertise. This support from development partners is against the backdrop of limited health professionals and limited health resources (Ansari et al., 2004). These diverse entities can improve health program implementation success by gaining some insight into how to work cooperatively together, and share quality information to enhance decision-making for participatory decision-making. According to El Ansari et al., "Collaboration for health has the promise for provision of more effective, integrated, and supportive service for both users and professionals" (p. 283). Findings from this study, therefore, may provide the GHS, the MOH, USAID, implementing institutions, frontline health professionals, local communities, and local health policy formulators some understanding of the importance of forging cooperative relationships and coordination of resources and expertise towards sustainable health care delivery. These findings can improve the quality of health care provided at the community level through effective and quality family planning, HIV/AIDS, malaria, tuberculosis, maternal and child mortality, nutrition, and other health programs. The program administrators can extend coverage to other communities that need healthcare.

Findings from the study may also influence positive social change through using collaborative engagements between and among the key healthcare stakeholders of the CHPS-TA initiative. Stakeholders, especially local communities, who are the end users of

the CHPS-TA program will be empowered to participate actively in local healthcare planning and decision-making. These communities will also share critical local level information with health policy makers and implementers to enhance the quality and coverage of the CHPS-TA program delivery. The participation of the local communities in goal and health care objective setting can direct the successful and effective CHPS-TA implementation process as well. Local communities can also provide community-level information that can be used to tailor health policies to their specific needs.

In addition, quality healthcare has important implications for overall quality economic, social, and political life. When a community is healthy, members of such a community tend to be more productive in all aspects of their economic, social, and political activities. Using insights from the results of the study, local communities can improve their healthcare and subsequently effect positive change in delivering quality education, farming, small-scale businesses and other local economic activities.

Summary and Conclusion

In this mixed method, descriptive study, I explored collaboration among health organizations in Ghana who are engaged in the implementation of a USAID-funded health program. The study concentrated on investigating the impact of participatory decision-making and communication in strengthening the relationship of, and the effect of involvement in, community-level health professionals in the collaboration process. Because community-level health professionals are an important source of health care delivery in deprived communities in sub-Sahara Africa, understanding their effectiveness

in the context of the collaborative relationships was useful in the formulation of health policies.

The paucity of literature on stakeholder collaboration in health care, particularly in externally funded health programs in sub-Saharan Africa, provides critical essence for the study. Surveys and interviews data were triangulated to address the research problem. Stakeholder collaboration and resource dependence theories provided theoretical frameworks for analyzing the data. The small size of the study populations and the adoption of criterion and purposeful sampling methods decreased the level of generalizability of the findings.

In chapter 1, I introduced the study by giving information on the background to the research problem, method of investigation, theoretical frameworks, and the significance of the study. In chapter 2, I provide an in-depth literature review on topics such as collaboration in health care delivery, participation and communication in collaborative relationships, health care in Ghana, and the role of USAID in health care in Ghana. In chapter 3, I present the methodology for the study, including the research design, population, sampling technique, data collection methods, and analysis. In chapter 4, I present the data collected from the field while chapter 5 contained the interpretation, conclusions, and recommendations of the entire study.

CHAPTER 2: LITERATURE REVIEW

Introduction

Interorganizational collaboration in health care delivery involves joint working relationships among different health organizations towards the achievement of shared objectives. The rising costs of providing care, demographic changes, technological advances, and expectations of higher results from stakeholders have been among compelling factors pushing organizations in the sector to collaborate. Literature abounds on collaboration in health care delivery. Yet, there is little evidence available about collaboration among health organizations engaged in the implementation of externally-funded health programs in sub-Saharan Africa. Moreover, few studies have examined the effect of the collaborative relationship on the effectiveness of the implementation process. Little research is also available on the role of participatory decision-making and communication among stakeholders in improving the collaborative relationship.

In this study, I explored the nature of collaboration that exists between USAID and its health partners who are engaged in the USAID-funded CHPS-TA program. In particular, the study examined the nature and level of participation and communication among the partners and how these two elements improve the relationship. The study also focused on whether the involvement of the CHOs in the implementation of the CHPS-TA program is related to program effectiveness. The CHOs are frontline health personnel who are located in rural communities and therefore are critical in the delivery of health services to such communities. The following five questions were investigated:

1. What is the nature of collaboration between USAID and its health partners in the implementation of the CHPS-TA program in Ghana?
2. How does the nature of the collaboration influence the effectiveness of the implementation process?
3. How does the level of participation of stakeholders in decision-making improve the level of the collaboration?
4. How do the quality, frequency, and amount of communication improve decision-making towards the effectiveness of the collaboration?
5. How does the involvement of the CHOs in the decision-making increase their effectiveness in their functions?

In this chapter, I reviewed the literature on stakeholder collaboration in health care delivery. The review is organized in three parts. In the first section, I examine literature on stakeholder collaboration and health care delivery in general, and in sub-Saharan Africa in particular. In the second section, I reviewed USAID involvement in health care delivery in Ghana, providing a contextual picture of the setting for this study. Additionally, I discuss the administration and the state of health care in Ghana. Finally, I explore the theoretical frameworks and methods approach used in undertaking the research.

Literature Search Strategy

Searches for academic literature on the research problem were carried out in the Walden University Library and elsewhere, including EBSCO databases (Academic and Business Search Premier), ABI/INFORM Global, ProQuest (Health Medical Complete),

SAGE Full Text (Education and Health), Google, Google Scholar, IMF, WHO, World Bank, and UNDP databases. The search was conducted using a variety of stringed words: "stakeholders and health care", "stakeholders and health care policy", "cooperation and health care delivery", "participation and health care", "involvement and health care", "collaboration and health care", "partnership and health care", "communication and health care", "resource use and health care", "skills exchange and health care", "external health care support", "externally funded health care", "collaboration and foreign aid to health", "USAID and health care", and similar combinations. In addition, Africa and Ghana were added to most of the strings. Whereas the search revealed literature on partnership, cooperation, and collaboration and health care delivery in general, only five publications were available on sub-Saharan Africa. In particular, only one article was found (dated 1999) that focused on external funding and local community participation.

Stakeholder Collaboration in Health Care Delivery

The meaning of the term "stakeholders" varies from user to user, but it is generally used in fields of study to connote relationships among diversified groups of people, institutions, or organizations that have a vested interest in an activity or outcome (Mitchell, Agle, & Wood, 1997). The health sector, like most socially-oriented services, is characterized by a diversity of interested parties (stakeholders)—individuals or organizations, such as hospitals, clinics, physicians, pharmaceutical companies, regulatory and government institutions, communities, and individual patients. In a development aid context, health care stakeholders may also include the organizations or countries that provide the funding for the programs. It may also include the recipient

countries, and government agencies that carry out the implementation of the programs. In addition stakeholders may also involve NGOs, both international and local and the other organizations that may have a role and interest in the overall program implementation, and organizations and groups at the end user level.

According to the health care literature, a collaborative or cooperative relationship among stakeholders contributes to their collective good (El Ansari & Phillips, 2001). The term collaboration (Lindamer et al., 2008; Ryan-Nicholls & Haggarty, 2007; Sharp, 2006) is used interchangeably with "partnership" (El Ansari & Phillips, 2001), "working together," "cooperation", "relationship building" (Rose, Mansour, & Kohake, 2005), and "sharing" (D'amour, Ferrada-Videla, Rodriguez, & Beaulieu, 2005) to show a working relationship towards shared goals.

Specifically, collaboration in health care is based on the principle of "power in numbers" (El Ansari et al., 2004, p. 280). Collaboration involves the joining together of institutions, local communities, citizens, and groups "to combat chronic health conditions, increasing their potential to formulate and implement interventions aimed at strengthening the social fabric" (El Ansari et al., p. 280). Through this joint effort, stakeholders develop a strength that each group cannot achieve individually and separately on their own (El Ansari et al.). According to Eyk and Baum (2002), collaboration among health organizations can be conducted either on project by project basis, long term or short term, ad hoc, informal, or permanent basis.

Partnership is also regarded as a relationship between equal or unequal stakeholders for a common purpose (El Ansari & Phillips, 2001). It is also seen as a two-

way relationship between the organizations concerned where each stakeholder has an active role to play in the design and implementations of the specific health care programs (Berry et al., 2008; Rodriguez et al., 2007). Rodriguez et al. found that partnership should be voluntarily without any force or coercion. However, Rodriguez et al. also argued that in some cases, partnership or collaboration can be mandated or forced. Mandated collaboration is imposed on the parties by a third party, presumably because such a third party is more powerful and has leverage on the other parties that are expected to form such relationship (Rodriguez et al.).

Another perspective is that collaboration is a link or network of interdependence between health care providers. In a qualitative study of a child development health program which was undertaken in four states in the United States, Berry et al. (2008) argued that the collaboration between the agencies in the program is the linkages that bind all the organizations in the delivery process. The structures, relationships, sharing of resources, and expertise available to all the parties are meant to create interdependence among them so that together they can meet the program objectives (Berry et al.). Other writers like Bernstein (2002), Rodriguez et al. (2007), and McMurray (2006) also supported Berry et al.'s idea of interdependence. To these writers, collaboration between health care organizations creates a relationship that will enable them as a group to share scarce and limited resources, and exchange and synthesize varied views on any aspect of the programs. In addition, collaboration will assist the group to coordinate and integrate their diverse functions and responsibilities into a network in a way that will lead to effective and less expensive health care programs.

According to McMurray (2006), interorganizational working relationships between health care stakeholders are based on the principle of reciprocity. Reciprocity involves integration in the delivery of health care where there is "willingness to gift resources to another as part of a balanced exchange over time" (p. 239). This process of reciprocity between the parties further involves "an exchange of rewards that serves as the basis for social interaction" (p. 239). McMurray further argued that the essence of the providers engaging in collaboration is to ensure that reciprocity-based interaction leads to and also results in "joint action where mutual perceptions of the limits of adversarial approach to coordination are premised on the need to tackle an indivisible problem—a problem which is larger than the capacity of any one organization to solve" (p. 239).

Collaboration is also viewed as coordination. In a study of collaboration among people undertaking surgical duties, Xiao et al. (2007) found that coordination of functions and activities is necessary to manage the interdependencies that characterize the different functions involved in the surgical operations. According to Xiao et al., the role of coordination in building the relationship is to act as a bridge for communication, scheduling of functions, and negotiating outcomes.

Although the literature illustrates that there are different dimensions of collaboration, two things are notable. First, stakeholders have a sense that, given the nature and the complexity of health care delivery, they cannot deliver quality and effective service without assistance from other interested parties. Additionally, there is the understanding that roles, resources, functions, and responsibilities must be shared

among the parties (El Ansari et al., 2004). Effective use of these resources is the foundation of the relationship.

Goals of Collaboration

The primary goal of health care provider collaboration is to enable all the parties to work towards a common goal of cost-effective and accessible health care (El Ansari et al., 2004; Briggs & Martini-Briggs, 2009; Hord, 1986). Collaboration is based on the recognition that there are advantages to be gained from collective team effort (Pfeffer & Salancik, 1972; Stefl & Bontempo, 2008; Wampler et al., 1996). Collective effort reduces duplication and waste; synchronizes functions, skills and expertise; and allows for shared vision and responsibility towards that vision.

In a study of health care team effectiveness, Mickan (2005) argued that shared vision and objective stood out as the single most important variable in team cohesion. Mickan's study revealed that when teams have clear objectives, high levels of participation, and emphasize quality and innovation, they will be more effective. El Ansari et al. (2004) stated:

> Collaboration aids in creating a more comprehensive appreciation of the problem or issue among the stakeholders. However, the factual objective and bone fide motive of collaborative efforts is to mobilize a collective power base to promote change, where political and policy processes work together smoothly so that policy changes can be effected. (p. 279)

Rose et al. (2005) seem in support of El Ansari et al.'s position by observing that collaboration leads to shared interest among the parties. Through this relationship the parties are influenced to adopt a collective attitude and approach to program delivery and implementation.

According to Sharp (2006), two primary advantages are realized when there is interdisciplinary collaboration between different health care providers. First, such collaboration affords people and stakeholders wider access to health care delivery by maximizing the limited health care resources available. Second, through the relationship health professionals could pull their skills together to provide patients or clients with quality healthcare at the right time and at the right place.

Collaborative relationships result in the integration of health services and results that could not have been accomplished individually (Longoria, 2005). With complex new diseases emerging daily (Halverson et al., 2000), integrating health skills and resources enables organizations to provide satisfactory solutions rather than attempting to solve them independently. Longoria also argued that when organizations' touting of collaboration as a policy sends strong symbolic signals to employees about the expectations of the organizations in terms of effective outcomes, which affects how groups and individuals work.

Conditions Necessary for Collaborative Relationship

Some conditions are prerequisites to cooperation among stakeholders. A critical condition necessary for cooperation and working together is the common awareness and recognition of a collective objective. El Ansari et al. (2004) argued that collaboration can only occur if it is based on a belief in the creative potential of working together to effect change. Without this common belief, working out details of how to focus on the collective goal will be difficult. El Ansari et al. identified 11 prerequisites or conditions for effective collaborative relationship, a few of which are identified here. There must be

interdependence of roles where partners make inputs into decisions regarding the programs. Partners must be committed to the partnership relationship, which can be achieved if all partners are allowed to participate in programs activities. Partners freely use skills and abilities to the advantage of the group so that program objectives can be met. Consultations among partners must be vigorously encouraged so that participants can be involved in the programs at all stages to ensure effective implementation. Two-way, ongoing information must be disseminated so that quality decisions can be made based on sound information (El Ansari et al., 2004).

Trust is another important element of any collaborative relationship. Trust among partners can strongly impact the responsibility of stakeholders and their desire to ensure that the program goals are achieved. Petasnick (2007) argued that trust and commitment of stakeholders are important in collaboration. He explained that trust involves agreeing on set ground rules for the working relationship and abiding by those rules to ensure that program objectives are achieved. However, Cohn, Friedman, and Allyn (2007) stated that to ensure and achieve trust, stakeholders must disseminate relevant information to members of the group to facilitate smooth relationships.

In addition, Cohn et al. (2007) argued that the integrative relationship between stakeholders is built through structured dialogue. The structured dialogue is a face-to-face dialogue that ensures that providers of health care develop strong trust, create means of effective communication among them, develop a sense of ownership of health care programs, and thereby improve the success and effectiveness of the health care outcomes. Here communication between stakeholders is regarded as an essential ingredient to

sustaining the relationship (Sharp, 2006) because stakeholders are able to share essential information.

In addition, collaboration can impact strongly on the stakeholders' ownership responsibility for the programs. Copley et al. (2007) observed that ownership entails stakeholders taking complete control over the process and structure of the administration of entire programs. Stakeholders can achieve this control by developing goals that project their joint or collective objectives. The stakeholders would prioritize the objectives based on their importance to the client's overall functioning. This approach will create a single direction for all stakeholders as they pursue the overall implementation of specific health programs.

Sense of ownership also impacts the commitment of the partners. When members of the cooperative relationship give no input or not allowed to give their input in the decisions affecting their programs, they may feel they are working for someone else (El Ansari & Phillips, 2001). Shared decision making may lead to greater understanding and commitment to the issues that concern a coalition. Commitment is not uniform and can vary among stakeholders because of levels of resources available to each stakeholder, differences in their objectives and interests, and power struggles among partners (El Ansari & Phillips).

Factors Driving Collaboration in Health Care Delivery

Several factors drive the demand for cooperation and partnership among diverse organizations. Limited health care resources (Berry et al., 2008; Renzaho, 2008) are one important factor. Health care organizations face competing and complex needs of their

patients and other stakeholders. An effective and successful multi-stakeholder approach to health programs in one community provides a model for other stakeholders to follow to save time and money (Rose et al., 2005).

Renzaho (2008) observed that when health care providers operate separately from each other, there is duplication of services, underutilization of resources, and a lack of clear knowledge of the needs of patients. In a study of the effect of diverse cultural and linguistic differences on health care delivery in the state of Victoria in Australia, Renzaho explained that "duplication of services and lack of coordination among mainstream organizations were consistent themes identified by 68.8% of service providers"(p. 230). Renzaho observed that to improve health care and cut down on waste partnership, consultation, and needs assessment should permeate the delivery of primary health care.

Delivering health care has also become complex in nature (Berry et al., 2008). There are different actors, including medical specialties that have become part of the health care delivery system (Cohn et al., 2007). The complexity comes from the economic, legal, technological, and medical transformations taking place in the overall health care delivery system (Abernethy et al., 2007). These factors have aggressively driven demands for quality and effective health care, geographically wide access, and reduced costs of services, which have placed pressure on stakeholders to work together to meet these needs (Abernethy et al.).

Growing demand from funding agencies and patients for greater efficiency and effectiveness of health care delivery has also drives collaboration between hospitals and physicians (Cohn et al., 2007; Halverson et al., 2000). According to Petasnick (2007), the

independent approach taken by both hospitals and physicians in the past to health care seems no longer cost effective. Differences in how hospitals and physicians perceive health care delivery and the individual goal of each of these stakeholders have led to independent approaches to dealing with health issues. For example, while hospitals see health care management from business and profitability perspectives, physicians see it as income-based. Hospitals tend to look at the larger picture, while doctors focus on one patient at a time. These differences lead to independent, and in most cases, divergent approaches to handling health care delivery, thereby affecting overall health care efficiency and effectiveness (Petasnick).

Increased demands for higher improvement from patients, organizations providing funding, and governmental organizations with oversight over health care present major challenges (Cohn et al., 2007). In the face of limited health resources, providing an integrative approach to health care that brings together hospitals, physicians, government agencies, and communities can result in cost effective and stronger health care (Cohn et al.; Halverson et al., 2000). The collaborative relationship, therefore, is influenced by the extent that the goals of the stakeholders can be met most cost effectively.

Participation in Decision-making and Collaboration

Including stakeholders in health care decision-making for the purpose of implementing health programs has become an essential component of health care strategic management in most countries worldwide. Participation is an essential part of the collaboration where stakeholders are actively involved in critical decisions that relate

to the design and implementation of the health problems and the actual programs to be implemented (Berry et al., 2008; Begun, Tornabeni, & White, 2006). Stakeholders pursue dialogue and reciprocity in the discussions of programs about the best and cost effective ways to achieve successful healthcare outcomes (Berry et al.).

Reutter et al. (2005) examined participation and collaboration in health research in poor communities and observed that adopting collaboration and participation among stakeholders is valuable in two distinct ways. First, it allows stakeholders maximum input, particularly stakeholders in communities that would eventually benefit from the programs. Second, there are other factors that impact health care outcomes, and such factors can only be handled with a collaborative approach that encompasses diverse groups and perspectives and enriches decision-making. One way to strengthen involvement is to encouraging early involvement of stakeholders in active decision-making related to programs (Lindamer et al., 2008). One advantage of including stakeholders is that it enables them to know the difference between what health care providers perceive as quality service and what users themselves perceive (Cooper & Spencer-Dawe, 2006).

One question that has not been answered adequately in the literature is whether all stakeholders have the capacity and knowledge to make any meaningful contributions to health care programs. In Africa and in most developing countries, illiteracy levels are high, while educational variations and gaps exist. These factors can have immense impact on the ability of a group to participate meaningfully and effectively. Williams, Durrheim, and Shreta's (2004) study of malaria eradication in Malawi discovered that health care

professionals were not able to utilize scientific findings regarding malaria prevention. Health care professionals who lack the technical expertise to access the scientific findings will only have limited participation in the decision-making process.

Communication and Information Sharing and Collaboration

Sharp (2006) emphasized the importance of sharing of information among team members in any effective health care collaboration. Sharp argued that for partnerships to effective, health care professionals must develop good listening skills towards their colleagues and towards patients and clients. In addition, health care providers must share and communicate essential information that will affect the decisions they make. Information sharing and effective communication among health care providers will reduce misunderstanding and other forms of conflicts.

Communication links the various health care stakeholders together (Sharp, 2006). Muturi (2005) stated that through communication, stakeholders gain a clear understanding of issues concerning the health program. In the process, the stakeholders can participate in making quality decisions. One effective way to communicate is to adopt the two-way approach (Haddow, O'Donnell, & Heaney, 2005; Muturi, 2005). In two-way communication, all parties receive and respond to relevant information. Communication can also involve the use of technology (e.g., email, internet, etc.) to link the various stakeholders (Muturi, 2005; Rose et al., 2005). Sharp (2006) noted that the use of technology in communication can result in improved access and more effective services for patients and clients and the communities in which they live. Communication includes face-to-face discussions of health care programs to identify the goals and

objectives of the programs, implement the process, and identify ways to measure success (Cunningham et al., 2007). A strategic approach to communication is to segment stakeholders and tailor communication specifically to each segment (Muturi, 2005). The advantage in this approach is the ability to identify the scientific and expertise bases of stakeholders, particularly in illiterate communities. El Ansari and Phillips (2001) suggested that communication can be effective in the partnership relationship if it is regular, frequent, and of the highest quality; used to clarify the role and responsibilities of the various partners; and is accurate timely, and relevant to the needs of stakeholders.

While communication is important, in some cases the technical and scientific nature of health programs may make communication between health professionals and other health care stakeholders difficult (Williams et al., 2004). In their study of malaria eradication in Malawi, Williams et al. found that the inability of health care professionals to reduce scientific findings into language that other stakeholders could understand was a major barrier to effective malaria program implementation. Strategic segmented communication as suggested by Muturi (2005) may be a solution.

Expertise and Skill Sharing and Collaboration

Stakeholder collaboration involves the sharing of expertise, skills, and experiences by providers involved in the program implementation (Sharp, 2006). Sharp argued that to be able to provide quality primary health care, different health care professionals each brings their own knowledge and skills to collaborative care. The sharing of skills and experiences leads to collective decision-making and innovation by which stakeholders learn from each other and see competencies of other groups. The

primary advantage of sharing resources and skills is that such competencies will be maximized to the benefit of health consumers (Sharp).

El Ansari and Phillips (2001) argued that the expertise of stakeholders constitutes the primary asset of the relationship. Such an asset must, therefore, be utilized to the advantage of the partnership so that the partnership achieves the targeted health outcome. Yet, this asset can also be a major barrier to the smooth operation of the health partnership, as partners may need to relearn certain skills and knowledge. A solution is to organize workshops to train and retrain personnel so that people will have the desired skills needed to do the job or participate (El Ansari & Phillips).

Community (End User) Involvement

Broadly, in health program implementation, communities where programs are implemented constitute the end users or targets for such programs because they are often direct beneficiaries (Shediac-Rizkallah & Bone, 1998). In the academic literature, the participation of communities as beneficiairies and targets of specific programs has raised three fundamental questions in collaborative relationships. First, to what extent should such communities be included in the implementation process? Second, do such communities possess the relevant knowledge to make meaningful contribution to the implementation process? And which groups should be targeted in the communities?

Generally, literature on end user involvement in the process of health program implementation recognizes their usefulness to meeting the objectives of the program. Communities have been recognized to provide basic resources to support the overall prorgam implementation (Seshadri, 2003; Shediac-Rizkallah & Bone, 1998). Although

funding for programs may come from external sources, end users normally provide local level resources and logistics to complement the external assistances.

The participation of local communities in the process results in first hand knowledge of community-level health factors and circumstances that could be used as inputs for decision-making and designing the overall health program (Akukwe, 1999; Wong, Weeransinghe, Makrides, & Coward-Ince, 2005). Using this local knowledge to design and implement programs reduces misundertandings and conflicts beetween local communities and health progams stakeholders over progam goals and the means to accomplish them. According to Wong et al. (2005), in a study involving health partners and a black community in Ottawa regarding a diabetes progam implementation, some members of that black community were selected to be involved the planning and implementation process. Wong et al. attributed the success of the program to the inclusion of these black community (end users) members because they provided relevant knowledge of the community which was valuable in the effective implementation.

According to Akukwe (1999), nonhealth factors such as socio-cultural issues of communities may also be critical both to understanding actual health conditions in such communities and for ease of the entire implementation. Undertanding cultural factors could be important to a more community relevant and acceptable program. Cultural sensitivities and norms can be serious roadblocks to program acceptance particularly in sub-Saharan Africa (Homsy, King, Balaba, & Kabatesi, 2004; Varga, 2001). Consequently, the participation of local communities can lead to gaining knowledge of critical nonhealth information to increase program acceptance.

Through communtiy participation, user communities can help determine what are their health priorities and how the intended health programs fits into them. By this approach, not only will local communties make critical inputs into the overall health progam implementation, but it can also reduce potential resistance to the entire implementation process (Wong et al.). Also, this method is viable means to encouraging such communities to develop ownership responsbility for the usccess of the prorgams (Seshadri, 2003). According to Seshadri (2003) an important way to accomplish this is to offer such communities specific roles and responsibilites as part of their overall contribution to the process.

To Shediac-Rizkallah and Bone (1998) community participation in the process could also be useful for long term sustainability of the program. They argued that when funding and implementation of specific health ends whether at their scheduled terms or abruptly, the communities could sustain the long term goals of such programs by initiating steps to keep it going. Another way the community could sustain the long term goals of the prorgam is through monitoring (Seshadri, 2003).

Yet, the extent to which communities can play these roles have been questioned. First, it is often difficult to determine the level of technical expertise and knoweldge of local communities on technical and scientific health issues (El Ansari, et al). This situation is particulaly potent in most developing countries such as sub-Saharan Africa where illiteracy is relatively high (Omelewa, 2008). The relevance of such communities in the program implementation decision-making if they lack the requisite technical and scientific knowledge is often therfore downplayed. However, Akukwe (1999) and

Seshadri (2003) argues that while the communities may lack such knowledge, their undertanding of local health, social, economic, and political backgounds could be useful. Consequently, in such situations it will be appropriate for technocrats and health experts to focus on areas the communities can make meaningful contributions.

Health experts and other technocrats have also been criticized for their reluctance to acknolwdge and utilize local community participation. A study by El Ansari et al. showed that while local communities recognized the significant expertise of health professionals, the health professionals had relatively lower percepetion of the skills of the communities in the collaborative relationship. While local communities may not have comparable technical knowlegde, technocrats must begin to identify means of adquately utilizing local community expertise, regardless of the level of refinement or sophistication. According to Shediac-Rizkallah and Bone (1998), if communitiy participation has to be used as a critical component for improving implementation delivery then community–based capcity buiding must be done. This approach will nurture and train community groups in skills relevant to their participation.

However, literature does not adequately address which groups within a specific community that should be included in a health program implementation. Yet, factors to conisider includes the role of the group in the community and its alignment with the program in question; the primary target of the program in the community, whether entire communities or specific groups within it; and the nature and the state of community structures. Wong et al.'s (2005) study focused on black community in Ottawa while El Ansari's work targeted community health volunteers. Homsy et al. (2004) in a study of

traditional health attendants and HIV/AIDS prevention in sub-Saharan Africa relied on traditional birth attendants and traditional healers in the various targeted communities to reach HIV/AIDS patients. These groups were depended on because they had extensive knowledge of their communities and the program targets in the communities (HIV/AIDS patients) and had access to extensive networks useful for achieving the goals of the program .

Based on this review, including local communities in health program implementation could be pivotal to the success of such programs. Stakeholders in local communities, particularly in Africa, need to be part of the decisions making process on programs. Including these local communities will provide information about actual problems they encounter (El Ansari & Phillips, 2001a; 2001b). It will also provide the opportunity for the parties to know what other non-health factors impact on health care effectiveness and outcomes at the local or community-levels (Akukwe, 1999).

Problems with Collaboration

Collaboration can also pose major problems to the effectiveness of health care delivery. Collaboration can lead to potential tension and conflicts among stakeholders over organizational objectives, processes, and perspectives. Lindamer et al. (2008) found that "the natural tension between priorities of different organizations sometimes resulted in conflicts of interest and challenges in identifying mutually beneficial projects, thereby hindering the partnership"(p. 239). Interpersonal conflicts among the partners may also occur (El Ansari et al., 2004).

Problems of commitment can also adversely affect collaborative relationships. When stakeholders begin to have problems with committing time and resources to the partnership, the result may be problems with achieving program goals (El Ansari et al., 2004). Power struggles between and among stakeholders and partners not perceiving a favorable cost-benefit relationship will ultimately affect the smoothness of the relationship (El Ansari et al.).

Other studies (Fitzgerald, 2008; McMurray, 2007; Ryan-Nicholls & Haggarty, 2007) have shown that collaboration in health care delivery may have positive effects if certain factors are addressed. Fitzgerald identified factors such as divided attention among the organizations; that is, organizations are torn between their mother organization objectives and functions and the new partnership. The difficulty of assigning accountability, clear delineation of authority, and problems managing resources can also be potential factors that can affect health provider collaboration (Fitzgerald). Ryan-Nicholls and Haggarty also indicated that when the necessary conditions are unavailable for effective stakeholder participation and involvement in decision-making, outcomes will not be effective.

The Gap in Literature

Although collaboration by health care stakeholders is widely acknowledged in the health care literature, little information exists about its applicability in the context of development aid. In particular, literature is almost nonexistent on how stakeholders that are interested parties to externally funded health programs in sub-Saharan Africa cooperate to implement such programs. Only one study (Akukwe, 1999) directly focused

on externally funded health care delivery. This sole study concentrated on how local community participation leads to effective health care delivery in such communities rather than the involvement of all identifiable stakeholders. Akukwe argued that local participation should permeate all levels of the health care program. Specifically, Akukwe asserted that " donor agencies should focus on ensuring the participation of local communities in setting health priorities, conceptualizing health programs, designing such programs, monitoring and modifying selected programs, and evaluating these programs"(p. 141).

Akukwe (1999) further noted argued that there are advantages to local involvement. Donor agencies are able to consider the significant impact of health and non-health factors on health care outcomes. More importantly, local participation affords donors the chance to work closely with the formal health system, focus on and address health priorities of communities, and empower local residents to take charge of their own health. Finally, local involvement is useful in influencing and drawing local cooperation in the implementation process to ensure that funded programs address local problems and justify the allocation of scarce resources (Akukwe).

Although Akukwe's (1999) study is valuable, it is somewhat dated and limits the relationship to local community participation. This study did not explore the participation of other equally important stakeholders such as implementing agencies (international and local NGOs) and government agencies that occupy critical components of the delivery process. All interested parties must be included because all their perspectives and viewpoints must be blended into a collective and coherent set of ideas, thereby ensuring

collective ownership over its success. The study filled this gap because it explored the relationship among all identifiable stakeholders in externally funded health programs and how that relationship impacts health outcomes. While Akukwe's research was limited to participation, the current study examined the impact of one other element of collaboration: communication.

There are three other relevant studies on stakeholder collaboration in health care in Africa (El Ansari & Phillips, 2001; El Ansari & Phillips, 2001b; El Ansari et al., 2004). These studies highlighted the value of the diversity of skills and expertise that the different stakeholders bring to the table as critical and relevant assets of partnership. Pulling diverse skills together leads to insightful solutions to health care problems (El Ansari & Phillips, 2001b). In their study of nurses' perception of their satisfaction in their partnerships with local communities, El Ansari et al. (2004) found that respondents regarded the demonstrated professional expertise and skills in the relationship as important.

In a second study that involved the participation of four groups (community health workers, health program core staff, "solo" community members, and representatives of voluntary agencies and NGOs), El Ansari and Phillips (2001b) found that participation of all stakeholders provides diversity of input for decision-making regarding the programs. El Ansari and Phillips also established that minority groups such as volunteers and NGOs can be powerful voices in disseminating health care programs by helping communities articulate their preferences and actively participate in the development process. El Ansari and Phillips found that a well-functioning partnership is

characterized by an evolving and dynamic information flow that provides progress updates for all partners.

Studies also revealed that collaboration in sub-Saharan Africa could pose some problems. First, there may be challenges to working together due to the diversity of stakeholders and interests (El Ansari & Phillips, 2001b). Conflicting interests can lead to tensions and misunderstandings among parties. El Ansari and Phillips also found that different levels of stakeholder experiences and skills, where some may not have the requisite experience, could also pose problems in the relationship.

Although these studies (El Ansari & Phillips, 2001; El Ansari & Phillips, 2001b; El Ansari et al., 2004 do not focus directly on externally funded health programs, they have shown the value of partnerships among health care providers to achieving effective outcomes. In particular, the researchers emphasized elements of partnership such as participation, communication, and expertise. However, these studies were limited to micro level collaboration, which highlights individual level working relationships more than the interorganizational perspective. In addition, due to the micro nature of these studies, the complexities regarding external funding of health care, where the funding agencies may dictate how such funds must be apportioned and used and its effect on interorganizational cooperation, were not emphasized. These studies also did not cover the role of governmental agencies and external agencies in the partnership. Given these gaps in the literature (Akukwe, 1999; El Ansari & Phillips, 2001; El Ansari & Phillips, 2001b; and El Ansari et al., 2004), the current research explored the nature of cooperation among stakeholders in USAID funded health care programs in Ghana to determine how

collaboration affects the effectiveness of the program implementation process. The study concentrated on exploring the impact of participatory decision-making and communication in consolidating the relationship. This study also examined the inclusion of program stakeholders in decision-making by determining how their involvement improved their performance.

Overview of Health Care in Ghana and USAID Support

Ghana is a sub-Saharan African country with a population of about 23 million people. The country is located on the west side of the continent (West Africa). The country is bordered on both sides between the Gulf of Guinea and Cote d'Ivoire, and Togo, and Burkina Faso. Led by its first President, Dr Kwame Nkrumah, the country gained independence from the British in 1957. In the eyes of the international community, the country is one of the positive aspects in democratic governance in Africa. The country has been a democracy since 1992, having changed government from one political party to the other twice, with the December 2008 elections being the most recent. The country's economy has also improved significantly over the past 20 years, although the country still lags behind in GDP growth and suffers double-digit inflation (USAID, 2007; UNDP, 2007; World Bank, 2007).

Administratively, the country is divided into ten regions: Volta, Greater Accra, Ashanti, Eastern, Western, Central, Northern, Upper East, Upper West, and Brong-Ahafo. Accra, the capital city, is located in the Greater Accra region. Each region has several districts and local communities that constitute them. At the national level, there

are several ministries that manage the different segments of the country, such as agriculture, finance, health, education, security etc (UNDP, 2007; USAID, 2007).

Two major government agencies control health care delivery in the country: the Ministry of Health (MOH) and the Ghana Health Service (GHS). The primary mandate of the MOH, which is headed by the Minister of Health, is "to improve the health status of all people living in Ghana through effective and efficient policy formulation, resource mobilization, monitoring and regulation of delivery of health care by different health agencies"(MOH, 2009). Among its functions are:

1. Provision of overall policy direction for all stakeholders (players in health delivery); provision of a strong and effective advocacy role in intersectoral action in health delivery; mobilization and allocation of resources to all providers in health delivery services
2. Provision of relevant and adequate information for coordination and management of health services
3. Provision of regulatory framework for all providers of health services
4. Monitoring and evaluation of health services in Ghana
5. Coordination of activities of the agencies, providers, and partners in the health sector (MOH, 2009).

GHS implements the health programs. This agency derives its existence, authority, and operations from Act 525 of 1996 as required by the 1992 Constitution of Ghana. The core of its implementation mandate is to:

1. Implement approved national policies for health delivery in the country

2. Increase access to good quality health services
3. Manage prudently resources available for the provision of the health services (GHS, 2009).

To administer health care, the GHS follows a decentralized system based on five levels: national, regional, district, subdistrict, and community. Hospitals, clinics, health posts, maternity homes, and other health administrators and health care professionals (GHS, 2009) constitute each of these levels.

Ghana has been highly commended by many external aids agencies for carrying out strategies that have resulted in economic growth and reduction in poverty (USAID/Ghana Strategy Statement, 2006; World Bank, 2007). For example, poverty incidence dropped from 52 % in 1992 to 35 % in 2006, life expectancy went up by 57 years, HIV/AIDS overall prevalence among the adult population has been relatively stable at about 4 %, and the enrollment of children in primary education is around 80 %. The country has changed governments successfully through democratic elections since 1992. The country has also received praise for its relative political stability and prevailing peace (USAID/Ghana Strategy Statement; World Bank, 2008).

However, the state of health care in Ghana is not vastly different from other sub-Saharan African countries. The World Health Organization Statistical Information System (WHOSIS) has shown that the country's performance in many key health indicators such as life expectancy, healthy life expectancy, neonatal mortality rate, infant mortality rate, and mortality rates is not encouraging (World Health Statistics, 2007). For example, life expectancy at birth (years) in 2008 is 59, infant mortality rate per 1000

births is 52, under 5 mortality rate per 1000 births is 85, and crude death rate per 1000 population is 9 (U.S. Census Bureau, International Data base).

HIV/AIDS is also on the rise in the country, although not on a scale comparable to other countries in the subregion like South Africa and Botswana (USAID, 2007; UNAIDS, 2008). HIV/ADIS "has become a major health, social and economic issue in accounting for over 40 % of outpatient visits, 12 % of all deaths and resulting in about 140,000 children orphaned" (UNDP, 2007, p. 38). The disease is most prevalent in the economic active age groups: 25-29 (4.2 %), 30-34 (3.7 %), and 40-44 (3.3 %), with high incidence in urban areas than in the rural populations (UNDP, 2007). In 2007, the malaria prevalence rate in the country per 100, 000 population was 15,833. While records show that sub-Saharan Africa alone accounts for about 90 % of total malaria cases that are recorded worldwide, in Ghana the disease "is the first and most important cause of morbidity accounting for 40-60 percent of outpatient visits to public health facilities" (UNDP-Ghana, 2007, p.39).

In addition, the doctor-patient population ratio for the year 2006-2007 was 1: 13,683 while that of the nurse-patient population ratio for the same period was 1:1,451(MOH, 2009). These ratios affect the country's ability to provide good quality and accessible health care services (UNDP-Ghana, 2007). Moreover, the prevalence of several other diseases and conditions such as tuberculosis, infant mortality, and neonatal mortality are still unacceptable. For example, the country has the second largest infestation of guinea worm after Sudan (UNDP-Ghana, 2007). According to UNDP (2007), 57.7 % of Ghanaians have access to a health care facility that is located 30

minutes away from their homes. Critics note that the level of access fails to recognize people's transportation and cost difficulties to get to such facilities (UNDP, 2007).

While several factors (e.g., high illiteracy, poverty, high unemployment, rural/urban development gaps, educational gaps) have been identified as obstacles to the Ghana's effort at effective health care delivery (UNDP-Ghana, 2007), the country has been working diligently to improve the quality, level, and access of care through external aid support. To achieve this objective, six major external service delivery partners—, USAID; Japan International Cooperation Agency (JICA); Department for International Development (DFID); WHO; and Nordic Development Fund (NDF) — assist the government of Ghana, MOH and GHS with financial and other forms of support. These organizations also provide major support for health care delivery at the national, regional, district, subdistrict, and local community-levels. However, this study focused on health programs funded by USAID in Ghana, investigating the nature of collaboration among USAID, the MOH, GHS, NGOs, and frontline health officers.

USAID Aid and Health Care Delivery in Ghana

The U. S. Marshall Plan was a temporary short-term aid program to help devastated Europe rebuild its infrastructure and economy. As the plan ended in 1951, several people raised opposition to the nature and management of the entire U. S. foreign assistance program. The dissatisfaction and criticisms led the U. S. Congress to pass the Mutual Security Act and Mutual Security Agency. These legislations created a common platform for aggregating military and economic aid under one program to manage them more effectively (USAID, 2009).

As part of these measures, the Foreign Operations Administration was established in 1953 to administer economic and technical assistance to countries all over the world. The FOA merged with the International Cooperation Administration (ICA) the following year. ICA oversaw the administration of aid for various economic, social, and political developments and received funds through Development Loan Fund (DLF) (USAID, 2009).

The problem with ICA and DLF was that both of them did not satisfactorily address the long-term development needs of developing countries (USAD, 2009). In addition, both organizations had limited autonomy over their functions, thereby impeding their operations. The United States Agency for International Development (USAID) was established in 1961 to overcome these problems (USAID, 2009).

The John F. Kennedy administration's new U. S. foreign aid policy led to the formation of the USAID. The USAID rectified some of the major weaknesses of earlier aid programs, which many regarded limited in scope and degree. The passage in 1961 of the Foreign Assistance Act to support the work of USAID laid down other objectives. It recognized the urgent need to assist developing countries put their economies on track, improve the economic situations of their people, and become economically independent. The U. S. also recognized the link between the economy of developing countries and the security and economic stability of the U. S. Consequently, the stakeholders needed a more aggressive and focused aid policy. USAID therefore administered U. S. bilateral aid to help developing countries (USAID, 2009; Owusu, 2004; Almquist, 2009).

Between 1961 and 2007, the U. S. Congress passed legislation to strengthen and in some cases expand the work of USAID. The legislation improved the delivery of the USAID in aid to developing countries. USAID received further impetus for its foreign operations during the presidency of Bill Clinton and George W. Bush because these presidents supervised major and drastic directions for U. S. foreign assistance. The Bill Clinton administration arranged aid around sustainable economic development in developing countries (USAID, 2009). U. S. assistance to developing countries focused on extensive economic development, poverty reduction, and the stabilization of world population (USAID). Other related areas included human health, environmental management, and human capacity development.

The events of September 11, 2001, dramatically transformed aid because of a major shift in U. S. aid policy. In 2002, President George W. Bush launched the National Security Strategy, and he expanded U. S. national security to include global development in addition to defense and diplomacy. During this time, the Bush administration included terrorism as a critical U. S. foreign aid priority. The tenure of George Bush was also noteworthy because it led to establishment of the Millennium Challenge Account (MCA). This account made available $5 billion to well-performing developing countries to support critical development projects (USAID, 2004; Almquist, 2009).

The MCA rewards good governance and democracy (Almquist, 2009). Ghana received $547 million in 2006 for critical development programs towards eradicating poverty. In addition, in the 2003 State of the Union message the President outlined a 5-year $15 billion health fund to combat AIDS, malaria, and tuberculosis in developing

countries (Almquist, 2009; Wechsler, 2008). Thus, while development and terrorism were part of the overall U. S. foreign aid during Bush's tenure, "global health" also occupied prominent place.

Health care in Africa, particularly sub-Saharan Africa, featured prominently in U. S. foreign aid policy. The bilateral aid that accounts for about 30.1 % of total U. S. foreign aid and is managed by USAID is relevant. The $15 billion Global AIDS Initiative and increased funding for malaria, tuberculosis, child survival and maternal health, and other health problems worldwide are part of this aid (Almquist, 2009; Wechsler, 2008). Although other continents such as Asia have their fair share of some of these health problems, sub-Saharan Africa is widely acknowledged as the continent with the most and acute suffering. U. S. foreign assistance to health in general tends to benefit this continent more than any other region. In addition, the U.S President established the Emergency Plan for AIDS Relief specifically to aid Africa (Almquist, 2009).

U. S. support funding for health care in sub-Saharan Africa comes from its contributions to the OECD of which it is a member. The OECD, a group of developed nations such as the United States, United Kingdom, and Canada, has been consistent in their offer of health aid. In particular, annual aid to health has risen over time, with a 15 percent growth annually between the period 1980 and 2006, after a 9 % proportion to the sector during the same period (OECD-DAC, 2008). The organization has given health care a priority to the degree that aid to the sector increased from 12 % to 16 % between 2001 and 2002 (OECD-DAC). Consequently, for the period 2006, total bilateral aid to health amounted to $8.6 billion USD (OECD-DAC), where sub-Saharan Africa has been

the highest recipient. The continent, according to the records of the OECD-DAC, has been the major receiver of its aid to health since 1999, with 2005 to 2006 a typical example where the continent received close to half of the total aid (OECD-DAC). Areas of health where the organization has focused its health attention include HIV/AIDS, tuberculosis, malaria, reproductive health, and other general health programs.

Apart from the OECD, the U. S. is a major supporter of the operations of the World Bank and the IMF, two institutions that have been at the forefront of economic development and health improvement on the continent of Africa. The 2008 World Bank report stated that, overall, its official development assistance to Africa has been steady and occupied strategic priority in its development agenda for the continent (World Bank, 2008). Part of this development assistance was assistance to health care, where the Bank funded several landmark health care programs on the continent such as for HIV/AIDS. For example, in the fight against malaria, the Bank committed about $470 million in IDA resources and trust funds to sub-Saharan Africa from fiscal 2005 to fiscal 2008, more than nine times the volume of resources committed between 2000 and 2005 (World Bank, p. 31).

The primary objective of USAID and the United States Department of State in health care in Africa and Ghana is to "improve global health, including child, maternal, and reproductive health; reduce disease, especially HIV/AIDS, malaria, tuberculosis, and polio; and increase access to improved drinking water and sanitation service" (p. 22). At the core of USAID health care policy is:

> To improve health status in Africa, USAID responds by focusing on increasing the availability effectiveness, and access to quality health care, and on

> strengthening programs by developing, disseminating and advocating the adoption of state-of-art, Africa-appropriate approaches to health improvement. USAID also works to strengthen the capacity of African institutions to plan, manage, implement and evaluate these approaches (USAID/ Africa, 2009).

In the same way that Africa as a whole received a significant proportion of external health funding, Ghana also benefited from these external sources. For the years 2006 and 2007, the OECD offered the country about 12 % of total aid for health care by OECD (OECD-DAC). U. S. bilateral aid to Ghana for health care delivery for the year 2006 was proportionally higher than any other sector (61 %). This favorable trend towards health care has been a consistent ritual with past aid as well. In addition to some of these supports, the U. S. government is also one of the international partners for the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFTFATM), the Millennium Development Goals (MDG) and other such internationally supported health programs (USAID, 2008; Wechsler, 2008).

Regarding strategic health plans and directions, USAID has supported the country's poverty reduction programs, all of which are interrelated to major health measures. The USAID has implemented a collectively developed strategic health document covering the period from 2006 to 2010 in which the government of Ghana and USAID collaborate to improve the health care delivery system in the country. The primary objective of this plan is to strengthen communities' ability to identify health problems, plan and manage health programs, and promote ownership of solutions to health problems (USAID/Ghana Strategy Statement).

USAID has also been instrumental in actual disease eradication, cure, and prevention. As mentioned earlier, the U. S. made available funding to fight HIV/AIDS,

malaria prevention, infant mortality, nutrition, tuberculosis, and several other health problems. Ghana has benefited from aid for health programs, such as settling people with HIV/AIDS, providing nets for malaria prevention, family planning, training of health care professionals and personnel, and providing capacity building in many communities. For example in Ghana, USAID has supported the training of community health officers and traditional birth assistants to work together in remote villages to improve health care, thereby increasing their productivity.

A criticism of externally funded health programs is that NGOs most often focus on implementing health programs that are disease-specific or vertical in nature, for example, HIV/AIDS. This approach to health care, largely operated outside of the mainstream health care systems of developing countries, fragments health systems of those countries, creates potential for waste of limited and scarce resources through possible duplication of functions, and puts pressure on country health monitoring and supervising authorities. In some cases, such externally funded health care programs leave out of health care local stakeholders whose participation may be essential to the success of such programs (Akukwe, 1999). The study, therefore, explored the nature of collaboration among identifiable parties to determine the effect of the relationship on the health program implementation.

Review of Theoretical Background and Methods

This section examined literature on the theories that provide foundations for the analysis of the research questions. Secondly, I reviewed the proposed investigative methods.

Review of theoretical frameworks

The delivery of health care in Ghana involves many stakeholders: the government of Ghana, Ghana's MOH, GHS, funding agencies (e.g. USAID, CIDA, World Bank, DFID etc), international and local nongovernmental organizations (NGOs), district assemblies, district health teams, and local communities that benefit from the health care. There can be potential problems when different organizations offer the same service. There also may be fragmentation of services, resulting in waste of scarce resources, and the possibility of poor quality service (Maeseneer et al., 2008).

In Ghana, health care resources are limited and scarce, and therefore duplication and fragmentation of health care can be detrimental to achieving quality and effective health delivery. Given this situation, health care providers must collaborate and integrate their activities, resources, and functions not only to overcome problems of waste and fragmentation but also to achieve the ultimate result for such programs. Stakeholder theory and resource dependency theory provide valuable conceptual frameworks for analyzing the relationship among these diverse health care providers in Ghana.

Stakeholder theory as is known in its present form owes its origin to Freeman (1984). In postulating his theory, Freeman built it upon the definition that a stakeholder is "any group or individual who can affect or is affected by the achievement of the organization's objectives" (p. 46). The theory redirected the organizational strategic direction from product-led orientations and stockholder focus (Gilbert & Rasche, 2008) to a stakeholder-led view of organizational strategic directions (Freeman) where

organizations focus on meeting the diverse interests of the different stakeholders that have a stake in the organizational outcomes.

The core of the theory is the management of competing interests that either hurt or help the achievement of an organization's goals. Freeman (1984) argued that locating the specific stakeholders and their stakes and incorporating them into the strategic direction in a way that satisfies each stakeholder becomes the boundary for organizational success. If the diverse interests are satisfied, then organizations can guarantee their own success; failure to meet the needs of their stakeholders could be the downfall of the organization. From a purely relationship management perspective, this approach has significant implications for overall organizational goals (Freeman).

As convincing as Freeman's (1984) theory might seem, several criticisms have been leveled against it. Some writers argued that it suffers from vagueness regarding what or who constitutes a stakeholder, as there are narrow and broad definitions of the concept (Fassin, 2009). Fassin observed that the vagueness and ambiguity in the theory is due to the "intrinsic flexibility of stakeholder theory" (p. 117) that lends itself to different interpretations, particularly in terms of stakeholders and the influence they may have on the overall direction of an organization. Some experts also argued about the difficulty of determining whether all stakeholders have the same legitimate stakes in an organization (Gilbert & Rasche, 2008; Mitchell et al., 1997).

Donaldson and Preston (1985) supported the criticism that the theory is vague; the result is that the authors are inconsistent in their explanations of the concepts of stakeholder, stakeholder model, stakeholder management, stakeholder theory. Donaldson

and Preston also argued that a central problem of stakeholder theory is confusion about its nature and purpose. Several researchers (e.g., Donaldson & Preston, 1985; Mitchell et al., 1997; Yassin, 2008) attempted to delineate and reduce discussions of stakeholder theory into descriptive, instrumental, and normative factions. However, the purpose of this review is not to get involved in such debates, but rather to focus on the key frameworks and elements of the theory that speak and inform the core problem of the study: stakeholder partnership and cooperation. Two aspects of Freeman's (1984) theory are especially valuable to this study. These are identification of an organization's stakeholders and their stakes in the organization and the effective management of the different and often conflicting stakes.

According to Okunoye, Frolick, and Crable (2007) a better way to comprehend the theory is to examine it from two angles: the process of engagement and the outcome of the effect of such engagements. The process of engagement may have significant impact on the outcome of such engagement. In the design and implementation of health care programs, the question that arises is the extent that USAID, the government of Ghana, and the other interested parties "engage" themselves. As Okunoye et al., argued, the nature of the engagement impacts the outcome. What kind of engagement process runs through all the stages of the health programs to the point of delivery? Are all stakeholders engaged, or are programs simply dumped on some of the stakeholders by more powerful stakeholders? These leaders must answer these essential questions because the outcomes of the health programs depend upon the engagement process.

Freeman et al. (2004) provided some answers when they suggested that the management of stakeholder relationship should be based on the core purpose of the relationship. Once the stakeholders know the core purpose, they must devise appropriate measures to address it. Bird, Hall, Momente, and Reggiana (2007) supported this view by arguing that stakeholders should focus on what interests drive their relationships. Okunoye et al. (2007) argued an engagement-outcome basis; therefore, it can be argued that how the stakeholders manage their varying interests in the name of the collective goal can affect the overall interests and outcomes of parties to the relationship.

In the context of this study, the focus of collaboration between the various health care parties should be on the common interest in the programs, rather than on trivial factors such as who funded the program or who has the power to determine what. It will not matter, therefore, whether or not local communities in Ghana have the resources or not. Once these communities share the same objective of achieving cost-effective and good quality and accessible health care, such an objective should dictate how all the parties engage in the design of the programs and the subsequent implementation. One important advantage is that it will help stakeholders recognize that common purpose, rather than individual interests should drive the relationship.

Reynolds, Schultz, and Hekman (2006) give these views further credence by managing conflicting interests among stakeholders involves balancing of competing interests. Reynolds et al. further observed that balancing of interests is a prosocial behavior of sharing; that is, cooperation among individuals that results in long-term efficient deployment of resources and less conflict among individuals.

According to Freeman et al. (2004), stakeholder theory is valuable because it "rejects the separation thesis" (p. 364), and instead focuses on developing communities that work hard to deliver value that is central to all participating groups. Freeman et al. further stated that the relationship between the stakeholders should be both mutual and collaborative and create a win-win situation for all involved.

An important part of Freeman's (1984) theory is the "affect and be affected" aspect to the stakeholder relationship. Similar to the balancing of interests (Reynolds et al., 2006), this mutual effect and benefit variables in the relationship has implications for interactions among the parties. There is no one way to manage stakeholder relationships; multi-stakeholder dialogue can be an important aspect of the relationship management (Roloff, 2007). Dialogue creates a platform for mutual discussions of each organization's interests, thereby arriving at common grounds acceptable to all parties. In this regard, organizations in the health care delivery have the opportunity to dialogue as a group focused on achieving a common purpose that minimizes the interests of each group while amplifying the collective interest (Rolof; Freeman).

Synthesizing all these positions, it seems likely that USAID, the government of Ghana, and the other health care stakeholders can achieve common health care objectives if they take several integrative steps: (a) merge their individual interests into one common goal; (b) enable all to share all necessary resources to achieve quality health care (resources, skills, expertise, responsibilities, roles and functions etc); and (c) discuss critical issues that have bearing on the decisions that will lead to the discovery and implementation of acceptable health care plans.

There is a link between the core principles of Freeman's (1984) stakeholder theory and resource dependency theory (Laan, Ees, &Witteloostujin, 2007). In the attempt to meet the varied interests of the stakeholders, one likely problem will be finding available resources to address those interests. Jamali (2008) observed that resource limitations may affect what an organization can do and can place serious constraints on meeting stakeholder interests.

The core thesis of resource dependency theory is that "organizations survive to the extent that they are effective. Their effectiveness derives from the management of demands, particularly the demands of interest groups upon which the organizations depend for resources and support" (Pfeffer & Salancik, 1978, p. 2). Pfeffer and Salancik argued that no organization is completely self-contained; rather, they are interdependent with one another.

The relevance of the core principle of the theory relates directly to the utilization of resources that are central to stakeholder interest management. If stakeholders or organizations in a collaborative relationship have individual resources such as funds, skills, expertise and similar resources, such resources could only benefit the relationship if shared as a group. Laan et al. (2007) suggested that based on the core principles of resources dependency theory, for organizations to secure resources that are vital and critical to their survival, they must "develop tailor–made stakeholder relationships" (pp. 301-302). One way organizations can achieve this is to develop mutual interdependence, coordination, and linkages (Pfeffer & Salancik, 1978). Pfeffer and Salancik conceded that different organizations or stakeholders may have varying interests and resources.

However, mutual interdependence can be coordinated through informal mechanisms and semiformal interorganizational linkages. The advantage of coordination in interdependent relationships is that it can be flexible, thereby encouraging negotiations of how the relationship must be managed (Pfeffer & Salancik).

Developing linkages between organizations as part of the larger stakeholder relationship yields several benefits (Pfeffer & Salancik, 1978). First, linkages "provide information about the activities of that organization which may impinge on or affect the focal organization" (p.145). Second, linkages "provides a channel for communicating information to another organization on which the focal organization depends" (p. 145). Next, linkages help organizations in the relationship to gain support from external elements in the environment. Finally, organizational linkage legitimizes the focal organization (Pfeffer & Salancik).

Pfeffer and Salancik's (1978) position significantly informs the research problem of this study by addressing issues of interdependence and mutual relationship. Health care providers can develop interorganizational linkages and achieve desired health care outcomes if they recognize resource and organizational limitations. The purpose of that relationship is to coordinate limited resources, develop interdependent communication networks for sharing relevant information on the core focus of the relationship. Straub, Weil, and Schwaig (2008) noted that organizations must interact dynamically to control critical resources that maintain their survival. In that regard, stakeholders in the health care delivery in Ghana need to develop such dynamic relationships to control the critical resources needed to achieve health care goals.

Consequently, recognizing that resource dependency theory encourages interdependence between and among organizations (Paulraj & Chen, 2007), the critical choice before health care stakeholders is to develop interorganizational ties (Paulraj & Chen). It is a strategic choice because it has the potential of offering reliable avenue for reaching organizational goals and at the same time meeting the interests of the various organizations in the relationship. The organizations can redirect resources into a shared program.

In sum, both stakeholder theory and resource dependency theory provide a strong basis for analyzing the cooperation among health care stakeholders involved in the delivery of USAID supported health programs. While Freeman's (1984) theory offers stakeholders areas of cooperation, Pfeffer and Salancik (1978) focus on redirection of limited health care resources for achieving health care outcomes. Together both theories assisted in the analysis of how stakeholders integrate their resources, functions, and interests in a way that is collaborative.

Review of methods

Researchers often describe the methodological foundation for this study, mixed methods, as the "third research paradigm" (Johnson & Onwuegbuzie, 2004, p.14). The proposed study will combine qualitative and quantitative research paradigms into a single research approach (Trochim & Donnelly, 2007; Onwuegbuzie, 2002; Bryman, 1984). This approach places itself in the middle between what quantitative adherents call an objective inquiry and a qualitative position, where proponents place emphasis on the value of analyzing a phenomenon (Johnson & Onwuegbuzie). Mixed method research is

therefore meant “not to replace either of these approaches but rather to draw from the strengths and minimizes the weaknesses of both in a single research” (Johnson& Onwuegbuzie, pp.14-15).

While there are significant philosophical differences between qualitative and quantitative research paradigms, it is possible to find areas of commonalities that mixed methods could utilize for quality research. Quantitative researchers pride themselves in the positivist or empiricist ideology, where there is so much emphasis on observable phenomena. According to Bryman, “the paraphernalia of positivism are characterized typically in the methodological literature as exhibiting a preoccupation with operational definitions, objectivity, replicability, causality, and the like”(p.77).

In contrast, qualitative research adherents “argue for the superiority of constructivism, idealism, relativism, humanism, hermeneutics, and, sometimes postmodernism” (Johnson & Onwuegbuzie, 2004, p. 14). The critical and relevant point is that, by adopting a mixed method approach, holders of this paradigm are pushing for joint methods of positivism and the constructivism. According to Johnson and Onwuegbuzie, the advantage is that “it allows researchers to mix and match design components that offer the best chance of answering their specific research questions” (p.15).

The mixed methods paradigm adopts classical pragmatism as a philosophical perspective, as a way of building bridges between the different philosophical positions of the qualitative and quantitative traditions (Johnson & Onwuegbuzie). More importantly however, the mixed methods approach, while recognizing the strengths and weaknesses

of quantitative and qualitative research methods, “in many situations, researchers can put together insights and procedures from both approaches to produce a superior product (i.e., often mixed methods research provides a more workable solution and produces a superior product) (p.17). Consequently, the mixed methods approach “combines quantitative and qualitative research techniques, methods, approaches, concepts or language into a single study” (p.17).

Mixed methods adherents attempt to use “multiple approaches to answering research questions, rather than restricting or constraining the researcher’s choice” (p.17). Accordingly, the core of the method, as was argued by Johnson and Turner is that “researchers should collect multiple data using different strategies, approaches, and methods in such a way that the resulting mixture or combination is likely to result in complementary strengths and nonoverlapping weakness” (Johnson and Onwuegbuzie, p.18). Trochim and Donnelly (2007) also noted that when collecting data for research, researchers must know what the strengths and weakness of each source and methods are, in order to develop a mixed method that is complementary and effective.

Creswell (2003) categorized mixed methods into six main groups, depending on the mixture of the methods: sequential explanatory; sequential exploratory; sequential transformative; concurrent triangulation; concurrent nested; and concurrent transformative. These six strategies represent different mixes of the quantitative and qualitative methods (Creswell). For example, in a sequential explanatory, researchers collect quantitative data first, followed later by qualitative data collection. The purpose is to use the qualitative data to further explain and interpret data collected at the quantitative

phase (Creswell). In contrast, sequential exploratory focuses on the collection of qualitative data first, and then quantitative data later.

In this study, I employed the sequential mixed method, and next collected quantitative data in the form of surveys, beginning with organizations that participated in the USAID-funded health care programs in Ghana. I conducted personal interviews (qualitative) after the collection of survey results and qualitative data analysis. These two methods helped strengthen the outcomes of the study.

Summary and Conclusion

This review of the literature covered key and fundamental issues in stakeholder collaboration and health care delivery. Much of the literature demonstrated that collaboration among interested health care stakeholders is essential and critical in an effective health program formulation and implementation. The studies also revealed that the deeper the collaboration, the more successful the relationship between stakeholders. The nature and level of collaboration positively affects the level of success and effectiveness of programs. Early participation and ongoing involvement by all parties can be helpful in ironing out differences and creating a shared objective for program goals. Stakeholders need to allow free-flowing communication on all issues that affect program delivery.

Although the literature highlighted all of these issues, very few of the studies and articles related directly to health programs in sub-Saharan Africa. In particular, no substantial works address stakeholder cooperation in the formulation and implementation of externally funded health care programs. Notwithstanding, this limited literature

reviewed showed that collaboration among health professionals in sub-Saharan Africa provides a diversified approach to solving the continent's complex health problems. Such programs can be implemented easily by involving local communities in setting health priorities. The local communities can become part of the solution rather than mere recipients of a program implemented by players outside of the locality. Akukwe's (1999) study in particular focused on the involvement of local communities in externally funded health programs.

These studies, however limited, provide fertile ground to explore the effect collaborative efforts on the success or failure of USAID supported health program implementation in Ghana. While these studies limited their focus to internal health professionals or to local communities alone (as in the case of Akukwe, 1999), the study add to this knowledge in a three important ways. First, the study investigated collaboration among diversified groups, some of which are not health institutions. Second, I investigated collaboration within the context of external development programs, where foreign institutions such as USAID play significant roles. Third, the study add to knowledge in this area by investigating the nature of collaboration among all identifiable interest groups—funding agencies, health providers and government institutions, NGOs, and frontline health staffs located within deprived rural communities, and not only a segment. The study is relevant because USAID is funding health programs not only in sub-Saharan Africa, but also in most developing countries. Various institutions, NGOs, and governmental institutions often play different roles in the

implementation process; therefore, researchers must investigate how their cooperation affects the implementation success.

In the next chapter, I describe the research methodology. The discussion covers key methodological issues such as the research population, sampling techniques, research design, analytical instruments, and data collection methods. This chapter also covered the protections provided for study participants.

CHAPTER 3: RESEARCH METHOD

In this study, I explored the nature of collaboration that exists between USAID and its health partners who were engaged in the USAID-funded CHPS-TA program. In particular, I examined the nature and the level of participation and communication among the partners and also how these two elements improve the relationship. I also explored the relationship between the involvement of the CHOs in the implementation of the CHPS-TA program and program effectiveness. The CHOs are frontline health personnel who are located in rural communities and therefore are critical in the delivery of health services to such communities. Gaining this knowledge and insight may lead to more effective health program policy design and implementation in Ghana and in sub-Saharan Africa as a whole.

In the study, I employed a sequential mixed method, descriptive research design. In this chapter, I describe the methodological process for investigating the research problem. I explain the research design, target population, sampling technique, and data collection instruments. Finally, I describe the approach to data analysis.

Research Approach and Design of the Study

The research design of a study is the plan or the blueprint that guides the whole research process and provides a means to addressing the research questions (Adams & Schvaneveldt, 1991; Babbie, 1995; Trochim & Donnelly, 2007). This study utilized a sequential, mixed method approach using a descriptive design. The appropriateness of descriptive design is that it is helpful when detailed knowledge about a specific phenomenon, situation, or events, in terms of their attributes, nature, and characteristics is

needed (Babbie, 1995; Hedrick, Bickman, & Rog, 1993). Descriptive designs also address "what" and "how" rather than "why" questions (Adams & Schvaneveldt; Babbie). According to Babbie, although the descriptive approach to a study requires the researcher to observe and describe the phenomenon of interest, the process of description is more precise, accurate, and carefully done than is usual in casual descriptions. Descriptive studies use both surveys and interviews to collect data. Surveys can result in large samples for the study, while interviews can also provide detailed insights of the experiences of individuals (Babbie, 1995).

A descriptive design provided opportunity to describe the nature of collaboration. It also allowed made it possible to analyze and integrate the perceptions of participating organizations' members engaged in the CHPS-TA health program. This design provided the study detailed knowledge of the nature and the extent of the collaboration, how it functions, how participation and communication strengthen the relationship, and the effect of the two elements on the effectiveness of frontline health staffs. Moreover, a descriptive approach captured the knowledge of the relationship between collaboration and program implementation effectiveness as it really existed, documented in participants' words and responses.

In this study also, I used a mixed method approach. Mixed methods generally combine quantitative and qualitative research methods together in a single study (Greene, Caracelli, & Graham, 1989; Jick, 1979; Johnson & Onwugbuzie, 2004; Scott, 2007; Trochim & Donnelly, 2007). The mixed method approach generated quantitative data for measuring relationships and yielded qualitative data, which enabled deeper, richer

understanding of the responses and opened up the study to unanticipated evidence. Using mixed methods also made it less likely that any particular methodological approach would bias the results.

I applied the mixed method for the study because of a lack of research on the problem. This lack of research therefore demands that the researcher gain a focused, in-depth discovery of the perceptions of the health program implementers and CHOs be through interviews, while achieving a broader understanding through a survey of perceptions of all participants in the sampling frame. Moreover, the mixed method approach enabled a description of the perceptions, and a measurement of the extent to which interviewees shared particular perceptions or responses. This method provided a complete view of the nature of the collaboration between participants and opened the research to the discovery of unpredicted perceptions, trends, or issues. At the same time, the mixed method approach connected the study to theory and the limited evidence on the factors behind program implementation effectiveness, cooperation, communication, and collective decision making.

The approach of this mixed method in the study entailed the collection of quantitative data and qualitative data, respectively, an approach Creswell (2003) identifies as sequential. The priority was placed on the quantitative data. However, the collection of qualitative data later complemented the quantitative data by providing deep and rich insight of participants' experiences of the research problem. Qualitative data helped explain and interpret the findings of a study that were primarily quantitative. The study performed the integration or mixture largely at the interpretation stage (Creswell).

The integration of both quantitative and qualitative data increased confidence in the research findings (Scott, 2007).

I collected surveys and qualitative interviews separately and then integrated. Survey data demonstrated numerically the proportion of opinions of collaboration and related elements among the partners. In contrast, data from the interviews and the open-ended survey questions provided in-depth insight and knowledge about the nature and degree of the collaboration between the partners in the CHPS-TA program. In particular, the qualitative nature of the interviews and the open-ended survey questions provided important socio-cultural contexts in which I examined the closed-ended survey data. Geertz (1973) refers to this context as "thick descriptions" where contexts can throw invaluable light on the understanding of a phenomenon.

Before selecting the research design, I considered, but ultimately rejected three other research methods: narrative, phenomenology, and experimental and correlational designs. In narrative research, the focus is to tell stories as means of understanding the experiences of an individual. Although this approach might provide significant data about the individual's experiences, it does not seek to answer specific questions or nor is it predictive of future behavior. Such studies are also difficult to replicate. These shortcomings, including dependence on qualitative data sources only, made narrative research inappropriate for the study.

Phenomenological study focuses on examining the lived experiences of several individuals together. Phenomenology can provide in-depth knowledge of the experiences of these several individuals (Creswell, 2007). However, the major challenge in

phenomenology is ensuring that the individuals in the study actually experienced the phenomenon in question. Also, while identifying the common experiences of these individuals can be difficult, phenomenology depends largely on subjective data sources, including personal observations and interviews. The viability of phenomenology to the study is largely limited.

For this study, consideration was also given to experimental and correlational research methods. In experimental studies, the objective is to examine the effect of an intervention on a phenomenon by setting up two control groups (Adams & Schvaneveldt, 1991; Trochim & Donnelly, 2007). One group will have the intervention (experimental group) and the other group will not. Changes in the group with the intervention are explained or traced to the intervention (Babbie, 1995; Trochim & Donnelly, 2007). Experimental studies would not be appropriate for the study because using this design would require that a separate control group be set up alongside the CHOs to determine whether the CHPS program has had any significant changes on the CHOs. By so doing, a one would have to assume that a cause-and-effect relationship existed. Rather than assuming a cause-and-effect relationship, I examined participants' perceptions about the nature of their collaboration in the design and implementation of the CHPS program to determine whether the relationship has improved the effectiveness of the frontline staffs.

Population

The general population of this study consisted of individuals involved in managing and supporting USAID-funded health programs in Ghana and in sub-Saharan Africa. The general population also included organizations that were engaged in the

implementation of the programs. However, the study population was limited to employees of the USAID funded CHPS-TA program and employees of organizations participating in this program. The general population also included seven regions in Ghana that have implemented the CHPS-TA program: Eastern, Western, Central, Greater Accra, Brong Ahafo, Volta, and Ashanti. The findings were generalized from the study only to this population and the CHPS-TA program.

The study population was limited to two subpopulations or sampling frames: six participating organizations in the CHPS-TA program and all CHOs in the eastern region of Ghana where two districts, Kwahu North and Birim North, are participating in the CHPS-TA initiative. The participating organizations include USAID, Population Council, CEDEP, EngenderHealth, American College of Nurse Midwives (ACNM), and GHS and MOH. Each employee of these organizations engaged on the CHPS program constituted a unit of analysis.

The size of the six participating CHPS-TA organization is relatively small. This subpopulation comprised a cognizant technical officer who represents USAID on the program; 15 employees from Population Council; and three employees from CEDEP, ACNM, and EngenderHealth, respectively. Fifteen employees at the head office of the GHS with direct responsibility for various aspects of the program—training, logistics, human resource, and monitoring and evaluation—were also included in the study.

The second subpopulation consisted of all health officers participating in the CHPS-TA program in the eastern region of the country. This subpopulation included CHOs in the Kwahu North and Birim North districts and their supervising regional,

district, and subdistrict health officers in the eastern region. Each health officer constituted a unit of analysis. The study adopted criterion-based sampling to select eligible participants for both participating organizations and the study population in the eastern region.

Sampling Procedures

Sampling is the process or method used to select a study population (Trochim & Donnelly, 2007). Although cost considerations can have adverse effect on sample size selection (Babbie, 1995; Singleton & Strait, 2005), a sample must be representative of the entire population to be useful (Babbie; Trochim & Donnelly). A selected sampling method should, therefore, be an objective method for assessing representativeness.

The study employed criterion-based sampling for the two subpopulations. Criterion sampling requires that participants meet researcher-determined requirements (Creswell, 2007). Criterion sampling is critical for quality assurance purposes (Creswell). The primary reason for adopting this sampling method is the relatively small size of each of the subpopulations. Also, the approach led to sampling participants who met the requirements and therefore constituted a rich and quality source of data for the study. Probability sampling was not a useful approach.

Criterion sampling also minimized possible problems with non-responses by including only participants who met the required conditions for participation. The primary criterion was that employees of participating organizations must be working directly on the CHPS-TA program. Additionally, only health officers who were located

in the eastern region and CHOs resident and working in Kwahu North and Birim North districts qualified for participation.

I used Raosoft software to calculate the sample size. Power analysis using the software indicate that with a study population of 87 employees at a 95% confidence level and a margin of error of 5 %, a sample of 72 will be needed. As a security against possible problems with the proportion of unreturned surveys and the potential effect on the achievement of the research objectives, the entire study population was included in the study. Response rates are important because high non-response may affect the reliability of the results. Table 1 provides a breakdown of the study population and the total number of samples for each population.

Table 1

Summary of Sampled Study Population for Survey

	Population size	*Sample*
USAID	2	2
Population Council	15	13
CEDEP	3	3
EngenderHealth	3	3
ACNM	1	1
Ghana Health Service/MOH (Head Office)	15	15
Regional health officers (Eastern Region)	5	5
District health officers (Birim North)	5	4
District health officers (Kwahu North)	5	4
Subdistrict health officers (Birim North)	5	4
Subdistrict health officers (Kwahu North)	5	4
Community health officers (Birim North)	9	9
Community health officers (Kwahu North)	14	14
Total	87	87

Although probability sampling may be useful, Creswell (2007) recommends the adoption of the most useful and appropriate method to gain the utmost data convenience and purposeful sampling during interviews. I employed a purposeful sampling to select interview participants. Using this method resulted in in-depth knowledge of the participants' experiences to complement survey data. I selected and interviewed, via telephone, 17 participants within the two subpopulations. Telephone interviews offered a

relatively inexpensive way to obtain quality data (Creswell, 2007; Trochim &Donnelly, 2007). Table 2 provides a breakdown of the samples from the subgroups.

Table 2

Summary of Sampled Study Population for Interviews

	Population size	Sample
USAID	2	1
Population Council	15	2
CEDEP	3	1
EngenderHealth	3	1
ACNM	1	1
Ghana Health Service/MOH (Head Office)	15	2
Regional health officers (eastern region)	5	1
District health officers (Birim North)	5	1
District health officers (Kwahu North)	5	1
Subdistrict health officers (Birim North)	5	1
Subdistrict health officers (Kwahu North)	5	1
Community health officers (Birim North)	9	2
Community health officers (Kwahu North)	14	2
Total	87	17

Instrumentation

Two standardized surveys were administered: one for CHOs and the second for employees of organizations participating in the CHPS-TA program (See Appendix A for both surveys). Sources in the literature guided construction of the survey questions, and

adaptation of some of the questions from Bernstein's (2002) validated Index of Interorganizational Collaboration (IIC). The study used open-ended and closed-ended questions in the instruments. Closed-ended questions are useful for uniform responses, and they are easier to process and compare (Babbie, 1973). Open-ended questions can clarify and amplify closed-ended questions (Singleton & Strait, 2005). Combining the two techniques enhanced and strengthened the research findings.

This study used a survey with a five-point Likert-type instrument for the closed-ended questions. According to Babbie (1995), Likert-type instruments are useful for "determining the extent to which respondents hold a particular attitude or perspective" (p. 140). Likert-type instruments have the advantage of flexibility, ease for computation, and the capacity to include many responses (Adams & Schvaneveldt, 1991). Use of Likert-type instruments helped determine the aggregate perceptions of respondents on the degree or intensity of a particular research question. Likert responses in the ranged from 1 (strongly disagree) to 5 (strongly agree). Additional open-ended questions in the form of comments revealed information that might have escaped my attention

The two surveys measured participants' perceptions of their collaboration, participation in decision-making, and information sharing. The survey for the CHOs also included questions on their level of involvement in the relationship and how the relationship impacts their effectiveness. The survey for employees of participating organizations (participating officers) contained 17 closed-ended questions while that of the CHOs has 20 closed-ended questions. I grouped the questions under three major variables: collaboration, participation, and communication. Each question had a section

for participants' comments in order to gain detailed insight from the participants. The first part of the survey solicited demographic information (age, education, and gender all in ranges) to determine how the demographic variables were reflected in the responses.

The section on collaboration contained seven closed ended questions. Each question addressed one of the following variables of collaboration:

1. Cooperatively working together (El Ansari et al., 2004; Freeman, 1984; Okunoye et al., 2007).
2. Interdependent functions (El Ansari, 2001; El Ansari et al., 2004; Berry et al., 2008; McMurray, 2006; Pfeffer & Salancik, 1978; Rodríguez et al., 2007).
3. Sharing of resources and skills (El Ansari, 2001; El Ansari et al., 2004; Berry et al., 2008; McMurray, 2006; Pfeffer & Salancik, 1978; Rodriguez et al., 2007).
4. Roles, resource, and skills coordination (Pfeffer & Salancik, 1978; Xiao et al., 2007).
5. Dialogue (El Ansari et al., 2004; Cohn et al., 2007).
6. Common ownership of goals (El Ansari & Phillips, 2001; Copley, et al., 2007; Freeman, 2004).
7. Trust (El Ansari et al., 2004).

The section on participation contained four closed ended questions, with each question focusing on one of the following variables:

1. Shared decision making (Berry et al.; Begun et al., 2006; Reutter et al., 2005).
2. Recognition of individual inputs (Berry et al.; Begun et al., 2006; Reutter et al., 2005).

3. Early involvement in decision-making (El Ansari et al., 2004; Lindamer et al., 2008).
4. Target program user involvement (El Ansari & Phillips, 2001; Akukwe, 1999; Cooper & Spencer-Dawe, 2006).

There were six closed-ended questions on communication, each concentrating on one of the following variables:

1. Sharing information (Cunningham et al., 2007; Muturi, 2005; Sharp, 2006).
2. Improvement in cooperation (Cohn et al.; Pfeffer and Salancik, 1978; Sharp, 2006).
3. Role clarity (El Ansari et al., 2004).
4. Two-way communication (Haddow et al., 2005; Muturi, 2005).
5. Tailored communication methods (Muturi, 2005; Rose et al., 2005).
6. Communication frequency, regularity, and quality (El Ansari & Phillips, 2001).

One additional question was posed for the CHOs in each of the three variables. Each question also had a corresponding question that required additional comments from the respondent. Numeric identifiers were used for all surveys. The identifiers consolidated the security of the surveys and ensured smooth monitoring of returned and unreturned surveys. The survey results provided only aggregate findings without the identifiers in the final studies to forestall any disclosure of individual responses.

Instrument Pretesting and Pilot Testing

Actual administration of the interview protocol and the paper surveys was only conducted after they were reviewed, pretested, and pilot tested. The study's committee

members subjected the surveys to critical review to ensure the consistency and relevance of the final survey questions to the participants. This review covered the survey length, content, format, question arrangement, and randomization of the test questions so that participants would not identify a pattern. Randomization was helpful in ensuring quality responses. After the review, I pilot tested the surveys in the field (see Appendix B for consent). According to Babbie (1995) pretesting is the surest method to ensure early identification and correction of such errors.

I conducted the pilot study with ten participants in the Greater Accra region of Ghana. This pilot study comprised six members of participating organizations and four CHOs. Three instruments were retrieved (two from members of participating organizations and one CHO). The feedback from these respondents led to three revisions to the original instruments. First, an expansion of the background section of the consent form was made to provide more detailed information on some of the organizations that were engaged in the CHPS-TA program. I also made a change to the background of the consent forms to make the context of the study clearer to respondents. For the same reason, the now expanded introduction section contained questions on collaboration. The survey instructions for the open-ended portion included the phrase "please provide reasons or any comments in support of your selected response" rather than "please provide any comments you might have." Feedback from the pilot study revealed that the revised phrasing provided a clear to understanding of the nature of the participants' comments. The revisions to the open-ended section reduced the likelihood of respondents refusing to give any reasons for their choices of the closed-ended questions. Questions

10 and 24 were rephrased for clarity; no changes were made to the interview schedule because it was largely semistructured. The pilot test therefore proved valuable to the collection of responses relevant the five research questions. All data, both pretest data and actual field data were stored on an external, password-protected hard drive (see details of explanation of other data security issues in the Human Participants section).

Validity and Reliability of Data

Trochim and Donnelly (2007) defined validity as "the best available approximation to the truth of a given proposition, inference, or conclusion" (p. 20). According to Babbie (1995), validity is the degree that a purported measure actually reflects correctly what is measured. Reliability addresses the question of repeatability, dependability, or consistency (Adams & Schvaneveldt, 1991; Babbie, 1995; Singleton & Strait, 2005; Trochim & Donnelly, 2007). Babbie further stated that the question of an instrument's reliability is based on whether "a particular technique, applied repeatedly to the same object, would yield the same result each time" (p. 124). Consistency therefore is critical in determining an instrument's reliability.

In general, researchers consider Cronbach's alpha higher of 0.70 or higher an acceptable determinant of an instrument's reliability (Simon, 2006). Cronbach's alpha was calculated on survey responses using SPSS version 16. This reliability measured the internal consistency of the instrument or how individual items related to each other and to the entire instrument. The coefficient alpha for items measuring collaboration, participation, and communication were 0.893, 0.881, and 0.768 respectively, thus ensuring that the instruments used for the data collection met the validity and reliability

requirements. The employment of a mixed method and the subsequent integration or mixture of the quantitative and qualitative data further helped establish reliability and validity for the study. According to Singleton and Strait (2005), multiple measurement of the same concept can increase the validity and reliability of the measured concept.

The member checking procedure validated interview data. Creswell (2007) described the member checking procedure as *"*taking data, analyses, interpretations, and conclusions back to the participants so that they can judge the accuracy and credibility of the account" (p. 208). The member checking procedure in the study entailed the researcher reviewing interview data and interview notes with participants for accuracy. I performed this procedure after the completion of the interview data collection phase. First, I communicated with 14 of the interview participants by telephone to confirm the accuracy of the transcribed interview data, questions, and the answers the participants provided. The last four participants were reached by email. Few changes needed to be made to the actual contents of the participants' responses. Most changes made to transcribed interview data related to grammar and sentence structure. This process ensured that participants approved the contents of the recordings before the data appeared in the study.

Data Collection

Accessing Study Participants

Relationship for purposes of the study was established with program coordinators from USAID, Population Council, EngenderHealth, ACNM, and CEDEP to gain access to the respective employees of these institutions. I gave assurance to the employees that

their participation in the survey and interviews was voluntary. The participants received sufficient information about the nature and the objectives of the study to help them decide if they would participate. Participants did not receive any material or financial incentive for taking part in the study.

Sampling was based on employee records obtained through the various contacts. This record showed clearly the names of employees and their responsibilities with the CHPS-TA program. Depending on the mode suggested by the partners, I contacted the sampled employees either by email or surface letter, inviting them to participate in the proposed study (see Appendix B for letter of invitation for participation). The letter also included a brief explanation of the nature and objectives of the study. Participants chose web or paper survey forms. I assured participants of the confidentiality of the surveys. Participants learned at the initial stage that their acceptance to participate in the study (see Appendix C for informed consent) was informed consent, although they would have to provide their consent at the time of participation as well.

Consequently, participants received informed consent forms (see Appendix C), which they signed at the time of their actual participation. Web surveys had the inscription “By clicking the button below, you are providing consent to participate in the study” located in the first page of survey. This must be clicked for approval. Similar space was available on the paper survey, and participants were provided consent by ticking this space. I also informed the participants that this study had no anticipated risk or physical harm to them. Participants could withdraw from the study at any time. They were also not under any compulsion to respond to all questions in the survey.

Heads of human resource and monitoring and evaluation of the GHS/MOH were the primary contacts for getting access to all participating employees of the GHS: regional, district, subdistrict, CHOs, and other employees who are engaged in the program. I used telephone contact as the most cost-effective and appropriate means of making initial contacts with these participants. I obtained the telephone numbers through the partner contacts.

Survey Administration

For participants with internet access, I directed them to a SurveyMonkey link www.surveymonkey.com where they could provide their responses. Instructions on how to complete the surveys appeared on the first page, while the actual questions followed. Consent to participate in the study was part of the first page of the web-based survey. For participants using the paper copy, they were delivered sealed envelopes containing the survey. I retrieved the surveys when participants finished completing them. The first page of the survey had informed consent, which, and the participants had to check the box there before proceeding to the actual survey. Hand delivery forestalled any postal delay problems given the unreliable nature of postal services in Ghana. According to Babbie (1995), the personal delivery approach can yield high survey return rates, although it may be costly.

Follow-Up Procedure

Follow up for both the web and paper surveys were adopted to increase the response rate. Most follow up for the paper copy came from telephone usage because telephone (cell) access and usage are almost countrywide in Ghana. Beginning two weeks

after the initial administration of the surveys, participants who did not respond to the surveys received weekly follow-up calls. This weekly reminders continued for four weeks until a reasonable proportion of surveys were retrieved. Participants who had already responded received thank-you calls for their participation.

Participants who accessed the web-based survey received follow-up e-mails one week after the first posting. Participants who had not yet access the web-based survey received emails encouraging them to complete the survey. Follow-up emails continued on a weekly basis for four weeks until required proportion of web surveys had been completed.

According to Babbie (1973), although response rates may differ and be affected by several factors, "a response rate of at least 50 percent is adequate for analysis and reporting. A response rate of at least 60 percent is good. And a response rate of 70 percent is very good" (p. 165). Response rate is important because low response can affect the reliability of the proposed study. Based on the power analysis, a 50 % distribution return rate will be adequate for analysis.

Interviews

Selected CHOs and members of participating organizations participated in semi-structured interviews after the initial surveys (see Appendix D for interview protocol). I used purposeful sampling to select 17 participants. Creswell (2007) recommended convenience and purposeful sampling for interview participants. Through the organizational partners, initial contact was made with selected CHOs and members of the organizations requesting their participation in the interview. During the second contact, I

scheduled the telephone interviews. I made both contacts either by email, surface letter, or telephone call.

Each participant signed informed consent both for the interview and for the audio recording of the interview (see Appendix B for informed consent for audio recording). According to Creswell (2007), audio recording is essential to ensure the collection of accurate data. Creswell also recommends that researchers take notes during the interview to complement the recordings. I informed participants that the recording of the interview was for purposes of the study only and that no part of the conversation would be disclosed to any individual or group. With the exception one interview that was done by telephone, the rest were conducted in person which was also not recorded (policy of the organization the participant belonged did not allow recording). A professional transcriber produced transcripts of the recorded interviews. The transcriptionist signed the data confidentiality consent form (see Appendix E). Each interview session lasted between 30 and 45 minutes. Questions in the survey were adapted and expanded for the interview. The questions focused on the participants' perception of the nature and the degree of collaboration, communication and participation, and involvement of frontline health staffs in the collaboration process. I took notes during the interview to prevent lost data in case of audio and recording problems. I used the member checking approach described earlier to review the notes with respondents to check their veracity.

Data Analysis

Quantitative Data Analysis

Prior to analysis, data was reviewed, cleaned, and edited the quantitative data (closed-ended survey data) to ensure completeness. Also I made extra effort during the entire data collection to ensure that participants answered questions fully and completely. A student version of the Statistical Package for the Social Sciences (SPSS) provided analysis for the data, where descriptive statistics were generated to understand the perceptions of respondents on collaboration, participation, communication, and involvement of the CHOs. The descriptive statistics included tables, charts, standard deviations, means, and frequency distributions. Each closed-ended survey response was analyzed based on the number of responses multiplied by the value of the scales. The mean scores and the standard deviations of responses measured the level of agreement or disagreement with the survey questions. Also, independent *t* tests were conducted to determine if differences in perceptions between participating officers and the CHOs on the survey items for each research question were statistically significant.

Qualitative Data Analysis

According to Creswell (2007), analysis of qualitative data requires the development of suitable coding schemes, theme analysis, and data representation and verification. In the study, interview data and open-ended responses from the surveys constituted the qualitative data. I adopted this three-stage approach to do the analysis. Each stage of the qualitative analysis is presented below.

Data coding. A professional transcriber produced transcripts of the interview data and open-ended responses. The transcriber signed the data use confidentiality consent form (see Appendix E). Coding schemes were developed using keywords or phrases. The coding schemes were based on identifiers that were related directly to collaboration, participation, and communication, and effectiveness. Each code was derived directly from the literature and the theoretical frameworks.

Themes. In this study, I developed relevant themes deductively (Creswell, 2007) out of the codes that reflected the variables being studied: collaboration, participation, communication, involvement, and efficacy. Meaning condensation and categorization of the themes determined essential themes of the variables to aid the final analysis (Creswell). NVivo 7 software was used to assist the qualitative analysis, particularly the coding, theme generation, and meaning condensation of data. This software is highly recommended for analyzing qualitative data (Creswell).

Data Representation and Conclusions

I displayed data in text format based on the codes, themes, and the data that support each theme based on the research variables of collaboration, participation, communication, and efficacy. Conclusions were based on the themes that emerged and how they relate to the research variables.

Integration of Quantitative and Qualitative Data

The integration of quantitative and qualitative data at the analysis stage was an important stage because it involved the actual mixing of the findings from the two sources (Jick, 1979; Johnson & Onwuegbuezie, 2004; Yin, 2006). Johnson and

Onwuegbuezie identified seven stages for achieving effective data triangulation in the analysis: data reduction, data display, data transformation, data correlation, data consolidation, data comparison, and data integration. The description of qualitative and quantitative provided at the analysis section of this study cover the stages of data reduction, display, and transformation.

According to Johnson and Onwuegbuzie (2004), data correlation involves the correlation of qualitative data into quantitative data and vice versa. Data consolidation entails combining quantitative and qualitative data "to create new or consolidated variables of data sets" (p. 22). While data comparison entails comparing the two sets of data, data integration involves the integration of both data sources "into either coherent whole or two separate sets (i.e., qualitative and quantitative) of coherent wholes" (p. 22).

This study compared the conclusions from the analysis of the interviews and the open-ended survey data and the closed-ended survey data. This comparison helped make conclusions regarding the nature and level of collaboration, whether participation and communication strengthens collaboration, and the effect of these two elements on the efficacy of CHOs. When there were conflicts between the quantitative and qualitative findings, further analysis was done to determine how the differences help extend and amplify knowledge of the phenomenon.

Human Participants

This study adhered strictly to the ethical requirements to research participants in the administration of the surveys and in the conduct of in-depth interviews. GHS and Walden University and GHS Institutional Review Boards (IRBs) granted prior approvals

before data collection begun. Participating organizations affiliated with the CHPS-TA program also granted their approval. Participants received assurances that their participation in the study, for both survey and interviews, was voluntary. Participants signed informed consent forms prior to any data collection.

Electronic and hard copy forms of informed consent agreements were available to participants. In the electronic version, the statement "By clicking the button below, you are providing consent to participation in the study" appeared in the first page of the web link on www.surveymonkey.com. Ticking a space especially provided for consent in the paper copy was sufficient for participants' consent. The consent forms contained information regarding the rights of the participants to withdraw from the study at any time, security for their responses, anonymity and confidentiality, safety of records, and the benefits of the study. As a guarantee of confidentiality, participants were informed that their responses would only be shared in aggregated form to avoid any identification of individual responses.

Electronic survey data was stored on the SurveyMonkey site and protected by a password that known only by the researcher. Data downloaded from SurveyMonkey was stored on a password-protected external hard drive and only available to the researcher. The hard copies of the completed informed consent documents and surveys will be kept by the researcher in a locked cabinet file for three years, after which they will be destroyed by shredding. Third parties connected with data input and analysis received consent to safeguard data (see Appendix D). Extra security ensured that the copies were kept safely during these processes.

Summary and Conclusion

In chapter 3, I described the methodology of the study, which includes the design, target population, sampling, validity and reliability, data collection and instrumentation, and analysis. This chapter contained details of each of these topics. Also, I provided a discussion of how mixed method, descriptive design can address the research questions by providing multiple methodological approach to measuring the relationship between participants in the CHPS-TA program. In this chapter, I also examined pure qualitative methods, experimental and correlational methods but discarded them on grounds that they are not suitable for addressing the research questions. Data collection entailed surveys and the triangulated interviews to provide data for the analysis. Included also are discussions of appropriate steps on how to secure validity and reliability for the data instruments, protect human participations and data. In chapter 4, I will document the results and findings of the study, while in chapter 5, I will present the implications and conclusions of these findings.

CHAPTER 4: PRESENTATION AND ANALYSIS OF DATA

The purpose of this mixed method, descriptive study was to explore the nature of collaboration between healthcare stakeholders that are implementing a USAID-funded CHPS-TA program in Ghana to determine the impact of the collaboration on the effectiveness of the implementation. In this study, I also examined how participatory decision-making and the sharing of essential skills and resources affect the process of collaboration. I explored the role of the Community Health Officers (CHOs) in the implementation process and examined how their participation in the relationship influences their performance effectiveness. Although scholars acknowledge collaboration among healthcare stakeholders, these scholars have not explored its relevance in a development aid context, particularly in sub-Saharan Africa. By exploring these issues, the extent that these factors affect the relationship and their impact on the success of the implementation process were illuminated. Five research questions guided the study:

1. What is the nature of collaboration between USAID and its health partners in the implementation of the CHPS-TA program in Ghana?
2. How does the nature of the collaboration influence the effectiveness of the implementation process?
3. How does the level of participation of stakeholders in decision-making affect the level of the collaboration?
4. How do the quality, frequency, and amount of communication affect decision-making towards the effectiveness of the collaboration?

5. How does the involvement of the CHOs in the decision-making increase their effectiveness in their functions?

Chapter 4 presents the overall data analysis of the study to address these research questions.

I conducted the study in two phases: quantitative (surveys), followed by the qualitative data collection (face-to-face interviews). The study covered a total population of 87 ($N = 87$) comprising six (6) subpopulations for the quantitative phase and 17 interview participants drawn from the subpopulations. The quantitative phase lasted four weeks and the interviews covered a three-week period. This study also involved pilot tests, results reported in chapter 3, on the survey instruments and interview schedules before they were used in the main study. This process ensured that participants find the reviewed surveys concise, understandable, and easy to follow.

To present the results of the study, this chapter is divided into quantitative and qualitative phases. I used the quantitative data to explore and demonstrate numerically the perceptions of participants on the five (5) research questions, and used qualitative results to offer detailed and valuable insights into these perceptions. Through this multiple approach, a complete view of the research questions through integrating the two results was gained.

Changes in Study Sample

In the original study plan outlined in chapter 3, the total sample size planned for the study was 103. However, I reduced this number to 87 because of unanticipated events in the course of actual data collection. Prior to the start of the study, most of the

participating organizations confirmed the number of participants for their organizations. However, it became evident as the data collection process progressed that some of the participants did not meet the requirements necessary for participation.

In the case of USAID, the study population changed from five participants to two. This change, although unavoidable, proved the most painful because of the central role of USAID in the study. Although the five participants identified for the intended sample were Cognizant Technical Officers on USAID health programs in Ghana, only one (1) of them ended up being directly responsible for the CHPS-TA program. As a result, only this officer and the supervisor of USAID health programs in Ghana who also has responsibility for the CHPS-TA were qualified to participate in the study.

The intended sample for the American College of Nurses and Midwives (ACNM) changed from three to one because only one consultant worked directly on the program. The other two officers who were originally in the proposed sample ended up being resident in the US office of ACNM. They also had no direct responsibility for the CHPS-TA program implementation. The result of these sample changes, particularly the limited involvement of USAID in the study, is a more limited ability to generalize the study's findings beyond this particular setting.

The composition of study participants also changed in districts and the subdistrict participants of Birim North and Kwahu North. Instead of seven participants for each district and sub district as initially planned, only five had participated directly in the CHPS-TA programs. The CHO study size changed in Birim North from 16 to nine because of changes that to the structure and administration of that district by central

government. This structural change resulted in the transfer of some of the CHOs to a different district. The final study population size for the study therefore stood at 87.

Quantitative Results

Data Collection

The purpose of the quantitative phase of the study was to explore the perceptions of participants on the five research questions. The survey relied on both closed- and open-ended Likert- type questions, enabling a numerical demonstration of the proportion of members of participating organizations and CHOs that held a specific opinion. The total study population was 87 out of which 67 participants actually responded to the surveys. This number was comprised of members of participating organizations (n = 48) and CHOs (n = 19). There were six sub populations, each of which recorded varying response rates (see Appendix F for the response rates).

The survey period lasted four weeks. After consulting with contacts in each participating organization in the first week of the study, potential participants who met study requirements and completed informed consent received their survey packets. Retrieval of the completed surveys followed by a week, once some of the participants had completed their surveys. Retrieval continued until it became clear that no more completed surveys were available.

Pilot test

As explained in chapter 3, prior to the actual use of the survey instruments to collect the data, a pilot study was conducted. Of the ten surveys administered, only three were returned (one by a CHO and two by members of participating organizations). This

return rate was lower than anticipated. However, participants recommended few changes. Most of the recommended changes focused on the instructions for filling the survey rather than the substance of the instrument itself. Appropriate changes were made based on these recommendations.

Survey reliability and validity

Apart from using multiple methods to ensure study reliability and validity (Singleton & Strait, 2005), Cronbach's alpha was also calculated for the survey instruments to evaluate and ensure the stability of all the items within the survey. Cronbach's alpha .70 or higher is considered acceptable determinant of an instrument's reliability (Simon, 2006). I calculated Cronbach's alpha on the survey responses using SPSS. The alphas for items that measured collaboration, participation, and communication were 0.89, 0.88, and 0.76, respectively, indicating high stability.

Survey Analysis

Participants rated each survey item on a 5 point, Likert-type scale of 1(strongly disagree) to 5 (strongly agree). Descriptive statistics including mean (μ), standard deviation (σ), frequencies, and percentages were calculated for all the 20 closed-ended items. The items were grouped under the five (5) research questions. In order to assess the strength of responses to each survey item, a μ value that is below 3.0 indicates low rating, below 4.0 is moderate rating, while a mean value of 4.0 and above indicates high rating or score. In addition to assessing the strength of responses based on mean values, *t* tests were also performed for each Research Question. The tests were to assist in determining if the differences in perceptions between participating officers and the CHOs

were statistically significant. Also, I performed descriptive analysis for the demographic variables of age, gender, years of participation, and educational background (see Appendix E for complete demographic results). The results of the frequencies and percentages are available in Appendix F. Missing data in each question in the Tables were questions that were not answered.

Demographic Variables

Demographic variables of age, gender, years of participation in the program implementation, and the level of education were collected from participants and analyzed. The objective of the analysis was to determine if these variables would provide insight into how participants responded to the survey items. Yet, the actual analysis of the responses revealed only the educational levels of participants had significant impact on their responses. Analysis of the level of education showed that whereas all the CHOs have nursing school certificate because it is the requirement for the position, 58% of the participating officers have Postgraduate degrees (including Masters Degrees).

Findings

Research Question 1

What is the nature of collaboration between USAID and its health partners in the implementation of the CHPS-TA program in Ghana?

The primary aim of this research question was to explore the perceptions of participating officers and the CHOs on key elements of collaboration using the ten survey statements as bases. The ten statements were also derived from the literature. Table 1 below provides the mean (μ) and the standard deviation (σ or *SD*) values for the

responses of the participating officers. The mean values for this group ranged between 3.6 and 4.6, while the standard deviation range was 1.0 to 2.9. These results indicated an overall moderate to high rating by this group on all ten survey statements. Table 2, which provide the values for the CHOs indicate mean values ranged from 3.3 to 4.4, while the standard deviation ranged from .45 to 1.7. The CHO results also demonstrate moderate to high rating for all the ten questions. Taken together, both results suggests participants generally had moderate to high rating for the survey questions, which also indicates their overall agreement with the ten core elements.

The *t* test was performed on the scores for the ten items for the participating officers and the CHOs. The result (with 95% confidence interval, $t = 0.694$; df = 18; $p = 0.496$; with $p > .05$) showed differences in their perceptions on these items were not statistically significant.

Table 3

Survey Responses by Participating Officers regarding the nature of collaboration between USAID and partners

Statements	Mean	*SD*	*N*
1. There is trust among the groups working on the program	4.6	2.1	40
2. Group members engage in dialogue in the process of working together	4.3	1.5	44
3. Groups involved in the implementation of the program are working together towards meeting goals of the program.	4.0	1.1	48
4. Roles and responsibilities towards the implementation of the program are shared among the different groups engaged in the program	3.8	1.0	48
5. Groups involved in the implementation view the ultimate success of the program as their collective responsibility	3.8	1.0	48
6. There is coordination of expertise and experiences	3.8	1.4	46
7. Information provided help indicate clearly the individual roles and responsibilities of groups working on the program	3.7	1.3	47
8. Resources and expertise needed for the implementation of the program are shared towards meeting the goals of the program	3.7	1.0	48
9. There is coordination of resources	3.7	1.1	48
10. There is coordination of the different roles and responsibilities	3.6	1.0	48

Table 4

Survey Responses by CHOs regarding the nature of collaboration between USAID and partners

Statements	Mean	*SD*	*N*
1. Resources and expertise needed for the implementation of the program are shared towards meeting the goals of the program	4.4	1.3	18
2. Group members engage in dialogue in the process of working together	4.4	1.7	18
3. Groups involved in the implementation view the ultimate success of the program as their collective responsibility	4.3	1.4	18
4. Groups involved in the implementation of the program are working together towards meeting goals of the program	4.2	.45	18
5. There is trust among the groups working on the program	4.2	1.3	18
6. Roles and responsibilities towards the implementation of the program are shared among the different groups engaged in the program	4.8	1.4	18
7. There is coordination of the different roles and responsibilities	3.9	1.5	18
8. Information provided help indicate clearly the individual roles and responsibilities of groups working on the program	3.8	1.4	18
9. There is coordination of expertise and experiences	3.8	1.4	46
10. There is coordination of resources	3.7	1.1	48

Summary

As shown in Tables 3 and 4, overall, participating officers and the CHOs gave moderate to high ratings for all the ten survey questions. This result suggests both groups believe core elements of collaboration were present in the working partnership between

USAID and its partners. However, based on the individual mean scores of the survey items, both groups rated high only three, *trust, dialogue,* and *program implementers working together to achieve the goals of the program*. The high rating of these items suggests both groups believe these factors were deeply expressed in the relationship than the rest of the elements.

Among the participating officers who responded to these items, majority hold higher degrees (Master and Doctorate) while a lesser group with bachelor degree. This factor did not matter for the CHOs because the prerequisite for a being a CHO is nursing certificate. This difference in educational qualification implies that higher degree holders tend to rate these factors higher than participants with less education.

By contrast, the items *coordination of resources, coordination of expertise and experiences, coordination of the different roles and responsibilities* and *information for indicating roles and responsibilities* received moderate ratings from both groups. This moderate rating suggests participating officers and the CHOs perceived these elements on the same level of intensity and importance. Separately, however, CHOs rated the following items more highly than other items: roles and responsibilities towards the implementation of the program are shared among the different groups engaged in the program, resources and expertise needed for the implementation of the program are shared towards meeting the goals of the program, and groups involved in the implementation view the ultimate success of the program as their collective responsibility. These items, however, received moderate ratings from members of participating organizations. This difference in the rating between the two groups suggests

that, while the CHOs perceived these elements to be strong in the relationship, participating officers saw their strength moderately.

A majority of participating officers who responded to these items hold higher degrees, with smaller percentage holding bachelor degrees. All CHOs hold the mandatory nursing certificates. While educational qualification appeared to play fewer roles in the response of the CHOs, higher degree holders tend to rate moderate these items among the participating officers. However, between the two participating groups who responded, majority were involved in the program implementation for more than two years. This difference also indicates participants with longer involvement in the program rated these items moderately (participating officers) and higher (CHOs).

Research Question 2

How does the nature of the collaboration influence the effectiveness of the implementation process?

Building on the first research question, Research Question 2 sought to determine if the nature of the relationship between USAID and its partners impacted the effectiveness of program implementation. Only one survey item addressed this question. Table 3, which records the responses of both groups, shows high mean rating for this single item. This rating suggests common agreement between the participating officers and the CHOs. This common agreement was corroborated by *t* test result which revealed that there was no statistically significant differences in their perceptions ($t = 0.49$, $p = 0.62$).

Table 5

Survey Responses by Participating Officers and CHOs regarding the nature of collaboration and its influence on the effectiveness of the implementation process

Statement	Mean	*SD*	*N*
Working with other colleagues from other organizations on the program implementation has made the implementation process more effective than if it had been done by ONE organization.			
Responses by Members of Participating Organizations	4.3	1.5	45
Responses by Community Health Officers	4.5	1.3	18

Summary

As reported, the high mean scores suggest both participating officers and the CHOs believed that cooperation among partners yielded greater effectiveness for the program implementation than if a single organization had undertaken the implementation. However, standard deviations value for the two groups suggests some variance in this response within both groups. Greater disagreement on the item was evident in the response of the participating officers than the CHOs.

Research Question 3

How does the level of participation of stakeholders in decision-making affect the level of the collaboration?

In order to address the extent of involvement of participants in decision-making and its effect on the relationship, the participants answered four survey questions. Table 5 provides the mean rating for participating officers. One item received a high rating of 4.0, and the remaining three items received moderate ratings. Table 6 provides responses of the CHOs. In their case also, one item received a high rating of 4.1 while the rest received moderate scores. *T* tests performed on all the responses for the four items did not identify any statistically significant differences in perceptions between the two groups on all these elements ($t = 0.151$; $df = 6$; $p = 0.884$, $p > .05$).

Table 6

Survey Responses by Participating Officers regarding the nature and the level of participation in decision making and its effect on the level of cooperation

Statements	Mean	*SD*	*N*
1. My overall view is that the effectiveness of the decision-making contributes the success of the implementation of the program	4.0	1.5	46
2. There is shared decision-making towards the implementation of the program	3.8	.95	48
3. Inputs of all interested parties in the implementation of the program are considered before final decisions are made	3.4	1.1	48
4. All identifiable groups or stakeholders are involved in decision-making at the time the program is being implemented	3.4	1.1	48

Table 7

Survey Responses by Community Health Officers regarding the nature and the level of participation in decision making and its effect on the level of cooperation

Statements	Mean	*SD*	*N*
1. My overall view is that the effectiveness of the decision-making contributes the success of the implementation of the program	4.1	1.3	18
2. Inputs of all interested parties in the implementation of the program are considered before final decisions are made	3.9	1.5	18
3. There is shared decision-making towards the implementation of the program	3.8	1.5	18
4. All identifiable groups or stakeholders are involved in decision-making at the time the program is being implemented	3.6	1.5	18

Summary

As shown in Tables 6 and 7, both participating officers and the CHOs gave a moderate to high rating to all the four items. This rating suggests there was collective decision making among the program participants. The results further indicate participants perceived the collective decision-making process as having had a positive impact on the effectiveness of the implementation process. In support of this perception, both groups rate higher the item my overall view is that the effectiveness of the decision-making

process contributes to the success of the implementation of the program. Demographic analysis indicated that out of the participating officers who responded, a majority hold higher degrees while the rest hold bachelors.

The items there is shared decision-making towards the implementation of the program, inputs of all interested parties are considered before final decisions are made, and all identifiable groups or stakeholders are involved in the decision-making process at the time the program is being planned received moderate ratings from the two groups. This result suggests that elements needed for effective decision making received lower ratings. This moderate rating contrast with the high rating both groups gave to the item that showed overall decision making had significant effect on the success of the program implementation.

However, the standard deviation for the item there is shared decision-making towards the implementation of the program was .95 for participating officers and 1.5 for the CHOs. This difference in value indicates there was more variability in response on this item among CHOs than among participating officers. Answers to the question inputs of all interested parties are considered before final decisions are made, resulted in a standard deviation of 1.5 for the CHOs and 1.1 for the participating officers. This difference suggests greater disagreement on that item among the CHOs than among the participating officers. Also, the item all identifiable groups or stakeholders are involved in the decision-making process at the time the program is being planned received standard deviation of 1.5 from the CHOs while it received 1.1 from the participating officers. Based on this difference, there seem to be greater disagreement among the

CHOs. Of those who responded to all these items from both sides, the demographic profiles discussed earlier did not change.

Research Question 4

How do the quality, frequency, and amount of communication affect decision-making towards the effectiveness of the collaboration?

Five survey questions addressed this question. Table 8 present the results for participating officers. Ratings for the five items indicate moderate to high mean scores, ranging from 3.3 to 4.6. Table 9, which records the responses of the CHOs, also indicates moderate to high ratings of 3.6 to 4.2 mean scores. Both results suggest general agreement among members of both groups on the elements in the information sharing process. Statistically, *t* tests did not find significant difference in the perceptions of the participating officers and the CHOs on all the five elements ($t = 1.440$; df = 8; $p = 0.187$, with $p > .05$).

Table 8

Responses by Participating Officers regarding the quality, frequency, and amount of communication and its effect on decision-making towards the effectiveness of the collaboration

Statements	Mean	*SD*	*N*
1. Sharing of information among the group members improves the level of cooperation	4.6	.95	47
2. Information to assist decision-making for the implementation of the program is shared among the groups	4.1	1.7	44
3. Overall, methods used for sharing information on the program are appropriate for all groups	3.7	1.5	46
4. Feed back on the information provided is solicited from all group members	3.7	1.5	46
5. Provision of essential information for decision-making making during the implementation of the program is timely, regular, and quality	3.3	1.6	46

Table 9

Survey Responses by Community Health Officers regarding the quality, frequency, and amount of communication and its effect on decision-making towards the effectiveness of the collaboration

Statements	Mean	*SD*	*N*
1. Information to assist decision-making for the implementation of the program is shared among the groups	4.2	1.8	17
2. Feed back on the information provided is solicited from all group members	4.2	1.9	18
3. Overall, methods used for sharing information on the program are appropriate for all groups	3.8	1.8	18
4. Sharing of information among the group members improves the level of cooperation	3.6	1.4	18
5. Provision of essential information for decision making during the implementation of the program is timely, regular, and quality	3.6	1.4	17

Summary

Research question 4 was used to explore the perceptions of participants on the extent that information shared among program participants was of the right quality, came in the right frequency, and amount and how these elements helped improved the level of cooperation among the partners. Although overall, the responses from both groups suggest moderate to high rating for all the five items, responses to individual items indicate differences in mean scores for both groups. These differences are demonstration of the level of intensity and importance of the elements. The item *information to assist effective decision-making for the implementation of the program is shared among groups working on the program* received high rating from participating officers (mean value of 4.1) and the CHOs (4.2). According to this result, study participants believed the information they needed for making effective decisions on the health program were disseminated effectively. A majority of participating officers who responded to this item hold higher degrees.

However, analytical results revealed a disparity in ratings by participating officer and CHOs on the statement: *sharing of information among the group improves the level of cooperation*. Participating officers scored it higher while it received moderate rating from the CHOs. This result suggests participating officers saw the information sharing process strongly improved their working relationship than was perceived by the CHOs. While this variance suggests differences in how each group received information and how it improved their working relationship with other partners, it might be a further indication of differences in their roles and responsibilities. For participating officers who

responded to this item, majority held higher degrees. All the CHOs hold nursing certificates.

In contrast, the CHOs rated higher than participating officers the question *feedback on the information that was provided was solicited from all group members*. The participating officers gave the question a moderate rating. This result suggests that the CHOs believed feedback was strong in the information dissemination process, while the participating officers view feedback in a somewhat less strong fashion. Finally, both groups rated as moderate the questions *provision of essential information for decision-making was timely, regular, and of high quality* and *overall, methods used for sharing information on the program are appropriate for all groups*. Together both groups seem to believe the timeliness, regularity, and quality of information they received was only moderately strong. In the same way, they did not also believe methods that employed to disseminate the information were equally very strong. The uniformity in the ratings of these items by both participating officers and the CHOs indicates areas where both groups believe there need to be major improvement. In the case of these two items also, the demographic profiles of participants who responded were the same as explained in the preceding paragraph.

Research Question 5

How does the involvement of the CHOs in the decision-making increase the effectiveness of their functions?

Four questions explored the perceptions of the CHOs on the extent of their involvement in the decision-making process and its impact on their performance. Only

question 1 was applicable to both participating officers and CHOs. This item (Table 9) received moderate rating from participating officers and the CHOs (Table 10). All the three questions that applied only to the CHOs received high mean scores.

Table 10

Survey Response by Participating Officers and CHOs regarding the involvement of CHOs in the decision-making and its effect on CHO effectiveness

Statements	Mean	*SD*	*N*
1. Community Health Officers make inputs Into decisions relating to the implementation of the implementation of the program			
Participating Officers response	3.6	1.7	46
CHO response	3.7	1.7	18

Table 11

Survey Responses by CHOs regarding the involvement of CHOs in the decision- making and its effect on CHO effectiveness

Statements	Mean	*SD*	*N*
1. As CHO, information provided to me to assist my decision making in the implementation of the program has helped improved my performance significantly	4.6	1.6	17
2. As a CHO, my involvement in the decision making process has enhanced significantly my performance	4.0	.88	19
3. As a CHO, my inclusion in the cooperative work with other groups engaged in the implementation has enhanced the performance of my duties	4.0	.88	18

Summary

Research Question 5 was used to explore the extent of involvement of the CHOs in the implementation process and its impact on their performance. Overall, CHOs rated higher three of the survey items that applied to their involvement in the process. Their high rating suggests that their inclusion in the implementation process, decision-making, and information they received had any significant influence on their performance.

Yet, both participating officers and the CHOs rated moderate the item that sought to explore their inputs into program decisions. Additionally, this item received the same standard deviation from both groups suggesting the same level of disagreement. In the case of this item, the demographic profiles were same as the items examined earlier.

Summary of Quantitative Results

In research question 1, I explored the perceptions of study participants regarding the nature of collaboration between USAID and its health partners in the implementation of the CHPS-TA program. Three results are evident in the ratings of the ten survey items by participating officers and the CHOs. First, trust, dialogue, and collective working were elements in the relationship that both groups scored high. This suggests agreement between the two groups about the importance of these elements. In addition, the CHOs rated high sharing of resources, expertise, and roles but the participating officers scored these elements moderate. Thirdly, both groups also gave moderate ratings to coordination of resources, expertise, and roles. Although there seemed some differences in the mean values, results of *t*-test performed did not find statistically significant differences in the perception of the two groups on all the items. However, between the two groups of respondents, demographic factor of education seemed to play important role in their respective responses.

For research question 2, I examined the perceptions of study participants on whether the nature of collaboration influenced the effectiveness of the implementation process. A single survey item addressed this question. Based on the high rating of the item by both groups, it was evident that participants perceived that working cooperatively

with other stakeholders had yielded significant effectiveness for the implementation process. The standard deviation however showed there was greater disagreement of the item by the participating officers than the CHOs. However, *t*-test did not find significant difference in perceptions. Among the participating officers who responded, majority hold postgraduate (including masters) and doctorate degrees, whereas all the CHOs hold nursing certificates.

Using research question 3, I explored the views of the study participants on the level of their participation in decision-making and its impact on the level of effectiveness of the collaboration. Results showed moderate rating of factors of collective decision-making, shared inputs into decision-making, and the involvement of all identifiable stakeholders in the process. However, participants rated high the impact of effective collective decision-making on the effectiveness of the program. These results suggests that while participants were in high agreement that an effective participatory decision-making might provide an important avenue for achieving effective implementation of the program, the actual elements that should make this possible moderately existed in the relationship. *T* test results also did not find any significant differences in the opinions of the two groups. Finally, based on the relative higher standard deviations, it appeared that CHOs expressed greater disagreement on all the items than the participating officers. Lastly, I noted the respondents' answers to these items largely by their level of education and experience, which might have had a strong impact on their responses.

With regard to research question 4, I explored participant's views on whether sharing of program information came in the right quality, the right frequency, and in the

amount expected and how this helped improved the level of cooperation among the partners. Based on the high ratings from both groups, collaborators shared information to assist program decision-making adequately. Two demographic variables of education and years spent on the program impacted on this question. Majority of the participating officers who responded to the items hold higher degrees, while all the CHOs hold nursing certificates. However, both groups spent more than two years on the program.

Whereas the CHOs rated high the item on feedback, participating officers scored this element moderately. This results indicate differences in how each of these groups perceived feedback. Among the participating officers who responded, majority had higher degrees in addition to more than two years of participation in the program. For the CHOs, there were more females than females, while most spent more than two years on the program as well.

However, both groups gave moderate rating to the timeliness, regularity, and adequacy of information dissemination. Similarly, they also scored moderate the appropriateness of methods for sharing information. These uniform ratings suggest an agreement on the intensity of these factors. Participating officers gave a high rating to the way information sharing methods helped improve cooperation, while the CHOs rating it moderately. Again, this difference in the scores demonstrates the degree of intensity of this characteristic. The *t* test analysis did not reveal statistically significant differences between the two groups on all five items.

Finally, using research question 5, I investigated the involvement of the CHOs in the implementation process and its effect on their performance. Participating officers

answered only one of these questions. CHOs answered all four questions. There was moderate rating by both groups of the item on the involvement of the CHOs in decision-making. However, the CHOs rated higher their involvement in the program implementation, and sharing of information and their significant impact on the effective performance of their functions.

Qualitative Results

Data collection

The face-to-face interviews included 17 participants (see Appendix H breakdown of participants for interviews). Out of this number, six were males and 11 were females. All four CHOs who participated in the interviews were certified nurses, a required certification for the position of CHO. For members of participating organizations, apart from one participant who holds a bachelors degree, the rest of them hold postgraduate (including masters) degrees. In addition, all participants in the study had been engaged in the CHPS-TA implementation for the entire four-year period of the program. These variables were given consideration in the analysis in cases where they seemed to relate to the responses of the participating groups.

Prior to the interviews, I contacted selected participants by telephone to identify a place and time convenient for the interview. Apart from the representative for CEDEP, who requested that the interview be conducted at the University of Ghana, I conducted all the other interviews in the offices or work places of participants. I conducted the interview of the USAID representative on telephone while I was in New Jersey.

Interview sessions lasted between 25 and 55 minutes. All interviews were audio-recorded using Sony Recorder, with the exception of the USAID interviewee. The interview with the USAID participant could not be recorded because the organization's administrative policy did not permit it. Interviews were semi structured (see Appendix D). However, each participant's level in his or her organization influenced the phrasing of the questions. Probing questions followed based on the answers that participants provided. I posed probing questions in order to gain further insights from participants.

I completed all interviews within three weeks. I took only handwritten notes in the interview with the USAID officer. In the case of the other 16 interviews, I transcribed the audio tapes for each interview. I discussed details of the transcripts on telephone with 12 of the participants. The remaining four interviewees went sent emails, requesting for comments and approval (refer to the member checking process explained in Chapter 3). Member checking resulted in very few changes, most around basic grammatical and sentence constructions errors rather than the substance of what participants had said in the interviews.

In the course of each interview, I took handwritten notes as a precaution against loss of audio clarity during the interview process or loss of all the entire interview data. Following validation of transcripts by each participant, I undertook a process of coding and themes determination. In the study plan in Chapter 3, open-ended responses from the surveys were to form part of the data for the qualitative portion of the analysis for the study. However, comments provided by participants in the open-ended section of the

surveys did not provide useful responses. Consequently, I depended entirely on interview data for the qualitative analysis.

Qualitative Data Analysis

To ensure comparison and integration, the five research questions addressed in the quantitative section also formed the basis for evaluating the qualitative results. This study used Creswell's (2007; 2003) recommended approach of analyzing qualitative data. This study provided detailed information on this approach in the analysis section of Chapter 3. The approach typically involves five steps: (1) transcription of recorded and opened- ended survey comments (2) determination of codes and frequencies (3) determination of themes and patterns (4) analysis of the themes and patterns that emerge (5) identification of the relationship of qualitative findings with quantitative findings (Appendix K has themes for each research question).

Findings

Research Question 1

What is the nature of collaboration between USAID and its health partners in the implementation of the CHPS-TA program in Ghana?

Collaboration among implementers of the CHPS program

Interview question 1 (see Appendix D for interview questions) asked participants if there was collaboration among stakeholders in the implementation of the program. Fourteen out of the 17 participants, including all the participating CHOs, believed other participants collaborated on their answers (see Appendix D for how collaboration was defined in the interview). Participants observed that daily and periodic interactions

assisted groups to work jointly on the program. The weekly, monthly, quarterly, and annual program review meetings that participants attended facilitated the interactions significantly. Participants also noted that these meetings were useful for encouraging teamwork, interdependence and solidarity, and common responsibility for the achievement of the program goals.

Elements that created effective collaboration

Focus on common goals

All participants (17) recognized that focusing on common goals not only strengthened their partnership, but it also made it easier to implement and achieve program goals. In addition, most respondents said focusing on common goals reduced conflicts and self-interests, which could have interfered with the smooth implementation of the process. According to an official of international NGO, collective focus on the program goals inspired collective responsibility and ownership towards achieving the program goals.

Question 3 (see Appendix D) asked participants about their involvement in setting the goals and its impact on how they related with other people. Some of the participating officers said key program objectives were determined at higher organizational level of which they were not part. However, once organizational leadership articulated the overall goals of the program, officers focused on its achievement in concerted manner. A USAID representative said it was a normal USAID funding policy that organizations participating in programs it funds work together to meet the overall program goals. This required each organization to perform their unique functions based on their unique expertise but in an

interdependent manner with other organizations. Four other participants said although focus on collective program goals was critically important, achieving it required that all stakeholders were treated equally and fairly. Also, a stronger relationship would be built if the views and opinions of all the stakeholders received equal importance.

Involvement in decision-making

A majority of participants also admitted that engaging all identifiable stakeholders in the decision-making process not only created a strong sense of togetherness, but it also led to collective responsibility towards meeting the program goals. However, a CHPS regional coordinator in the eastern region explained that the decision-making process and participants in that process depended on three factors: the position a person holds; functions or responsibilities; and the extent of the complexity of the issues. According to this participant, he or she never helped make any high-level decisions about because of his or her position. Only the regional director of health, because of his or her position and role attended such meetings. The official further noted that CHOs normally made village-level decisions, while the districts would attend the regional meetings.

According to a representative of the MOH, although most donor organizations like USAID appeared to encouraged diverse views on issues the degree of flexibility in making changes and inputs into such decisions was normally limited. Donors often predetermined some decisions and plans before the program begins and changing such decisions was often not easy. This approach normally restricted participants on the extent of decisions that they could change particularly within the context of their local situations and circumstances.

CHOs and decision-making

All four CHOs noted stated that their knowledge of community-level healthcare issues put them in a unique position to engage the local communities and the traditional authorities in decision-making and planning. However, their relatively low education and skills limited their involvement in higher-level policy decision-making. However, GHS official explained that periodically, high performing GHS invited CHOs to such meetings to gain insight from them. The official stated that given the large number of CHOs and the resource implications, it was often not easy to invite all the CHOs to the review meetings. A district director of health for one of the districts observed that CHOs participation in the community and district level review meetings was not because of their low education and skills. Rather, at those levels not only were their contributions more valuable and specific to the district, but they saved their voices from being drawn out at a larger gathering.

Yet, the demographic profiles indicate that the educational level of the CHOs may have specifically played significant role in their limited participation in higher level or policy decision-making. All the CHOs were holders of nursing certificates as compared to participating officers, most of whom had higher degrees. Apart from higher degrees most of this group were also experts in their respective field such as development, public health, health curriculum development, finance, and management. With the current level of the CHOs, it was most unlikely they were invited for such policy meetings. Their relevance at the community-level however was not contested because of their unique knowledge and training in basic public health issues.

Pulling together of resources and skills

Participants also noted that the combination of diverse resources, skills, and experience was a factor that encouraged partnership and successful working relationship. Almost all the participants conceded that none of the organizations (CEDEP, MOH, GHS, ACNM, USAID, EngenderHealth, or the two districts) possessed the requisite skills or resources to implement the CHPS program effectively. With this fact in mind, participants had little choice than focus on the relationship as a mechanism for pulling all the resources and skills together to do the implementation. For example, one participant mentioned that whereas CEDEP, a local NGO has extensive expertise in community mobilization and change, Engender Health has skills in community health training. GHS provided human resources and sometimes infrastructure, local communities provided labor and infrastructure, while Population Council provided expertise in handling equipment and other related issues, ACNM provided curriculum development, and USAID a large chunk of the funding. A liaison officer with EngenderHealth stated that without this varied expertise on board, a lot problems would have emerged, thus derailing the smooth implementation.

The CHOs said without the expertise of most the stakeholders it would have been very difficult to function and provide the needed grass root health care delivery. According to all four CHOs, the training and refresher programs that provided by most of these organizations facilitated their effective job performance. In addition, the provision of basic equipment such as refrigerators for keeping medications and solar panels, and

other equipment made their work relatively easier. One district director of health summed up everything this way:

> To be honest with you, but for these interventions, it will have been difficult: thinking about the training and orientation of CHOs and other training programs that have been organized for them, and the provision of basic equipment. It will have been impossible for the District or for that matter the GHS to provide those equipment. So the vibrant CHPS compounds that we have now are as a result of the collaboration.

Flow of information

Most participants also observed that the flow of information from the CHOs in the local communities through the districts to the senior policy makers and back to the districts and sub districts strengthened the working relationship. Access to information not only improved the quality of decisions, but also improved the overall implementation process. Participants explained that information flow further eliminated gaps that could have hampered the smooth coordination of roles and resources.

Yet, three out of the four CHOs who participated in the interview complained that while stakeholders constantly sought information, feedback on such information gained was relatively low. However, most participating officers said while the process of information sharing and feedback between their offices and CHOs in the grassroots must be greatly and regularly improved, feedback to the CHOs was often determined based on their decision-making needs. Most of them stated that feedback the districts from which the CHOs operate normally received feedback, and the districts passed them on to the CHOs. The director of one of the districts stated that while they often made conscious efforts to communicate with the CHOs, the links between the CHOs and the district need improvement.

Trust

Almost all the participants mentioned that there was strong trust among the implementers. The high level of trust resulted in the smooth planning, management, and implementation of the program. However, most of the participants were surprisingly reluctant to expand their views on the nature of the trust and how it was nurtured. This seeming reluctance was probably due to fear of either exposing an official or the possibility of victimization by people in authority. One CHO remarked that the nature of their culture made it difficult to speak openly about issues of trust, honesty and similar virtues. However, a senior official said mistrust between international NGOs and their local counterparts occasionally occurred which was attributed to leadership style clashes and territorial protection. Officials from different organizations made efforts to protect the interests of the organizations they represented.

In addition, private-public approaches to administration also created conflicts. Private institutions and government organizations worked differently and once an organization from the other side interfered with that approach, mistrust, conflicts, and misunderstandings developed. Nevertheless, a senior official of one participating organization explained that mistrust was not widespread; and even in the few occasions that it emerged, they were quickly resolved through dialogue among the parties. Also, a top official of Population Council noted that the layout of the office space where most of the stakeholders had their staffs working together in one place fostered trust and encouraged the spirit of cooperation.

Dialogue

Nine participants and all the CHOs mentioned that the monthly, quarterly, and annual review meetings created opportunities for participants to dialogue with other stakeholders. Frequent dialogue reduced conflict, and created transparency and improved the relationship. Yet, most participants agreed that such frequent dialogues took place at the senior or at the policy level. The CHOs normally had limited participation. Although all four CHOs said they normally participated in the district and sub-district level meetings, they contested the extent to which their views received serious weight in the larger decision-making process. They attributed the situation to the level at which they operated (community-level) and their perceived low educational background.

However, the CHOs said due to their experience and knowledge of the community health system they were able to influence the process of dialogue with the local community members on health issues. They noted however that the final authority for decision implementation lay with the district. A regional coordinator for CHPS observed that due to the decentralization of the administration of health, CHOs participation in dialogue on critical CHPS issues usually received serious attention at the district level. Their concerns and decisions were normally handled at that level, while those that could not be handled were relayed to higher authorities in the region for action.

Nature of USAID programs

Participants regarded the nature of USAID program as an instrument for cooperation. A top official of Population Council said USAID organized periodic meetings between the partners as a way to share information and review the progress of

implementation. This official further explained that such meetings helped gain insights into difficulties and future outlook of their respective roles and functions. In addition, a USAID official stated that during such meetings partners were encouraged to work out areas of divergences in order to achieve a concerted and interdependent approach to the implementation process.

Varied views of collaboration

Differences however emerged between the perceptions of CHOs and most participating officers over the actual nature of the collaboration. Most of the CHOs (3 of 4) interviewed saw the provision of basic equipment for the CHPS compounds, training, and the observation visits by some stakeholders like Population Council staff, Engender Health, USAID, and GHS staffs as indications of collaboration. A CHO for example said that, in her view, once the CHPS program is ongoing, she could only conclude that partners were collaborating.

Further questioning revealed CHOs had limited or no roles in major program decision-making process such as planning, review meetings and sharing of critical program information at national and central level. The CHOs said they were rather active at the community-level, managing community-level relationships through the holding of periodic durbars (durbars are social gatherings where entire village communities meet to deliberate on issues) and meetings with community leadership on public health issues. Most participating officers said the CHOs' view of the collaboration might appear narrow because they operated at the community-level. This further limited the extent of their interactions with other members of the program. Participating officers however were able

to explain that, meetings, conferences, and other face-to-face interactions, combining resources and expertise, sharing of common goals was the strong basis for building their cooperation.

It is noteworthy that this difference in perception between the two groups may be attributed to the roles that each group played in the process. All the CHOs operated at the end user end of the program, where the need for resources and experiences of partners may be critical. Once these essential resources became available, they may conclude there was cooperation. However, the participating officers because of their relatively high expertise were engaged in higher-level policy decisions. Relationship and teamwork therefore could be essential.

Inadequate Collaboration

Four participants, however, did not think there was sufficient collaboration among partners. They attributed the limited cooperation to misunderstanding of the concept of CHPS or its goals. While some of the organizations believed CHPS was curative, others thought it was preventative. In addition, other organizations thought it should embrace health promotion in its totality. This misunderstanding led to confusions about the most effect ways to utilize the resources.

A top GHS official said this confusion has resulted in some local communities demanding other health resources such as clinics and hospitals as part of the CHPS, although this was completely outside of the CHPS concept. Also, some of the CHOs performed medical roles that they were not expected to perform. To resolve this problem, some of the participants suggested that any future external support for health should be

placed in the health pool. GHS and their health partners could then collectively determine the use based on the local priorities of the country.

In addition, two of the participants noted that much of the collaboration appeared to be among high-level policy makers (horizontal relationship) rather than top–down and bottom- up relationships. They mentioned that the cooperation and interaction appeared to be limited to the experts and policy makers, which effectively limited the involvement of other equally relevant stakeholders particularly community-level groups. This approach did not provide the necessary social contact needed for an effective cooperative work with the communities.

In addition, some of the participants said there were conflicts between some of international and local NGOs over which group wielded higher authority and power. This conflict created misunderstanding on important program issues. It also diluted the atmosphere for cooperation.

Summary

Qualitative results for research question 1 suggest that participants believe there was strong collaboration among stakeholders. Active face-to-face interactions among program implementers resulted in effective cooperation. Interactions among participants through weekly meetings, program review meetings, and conferences aided not only program planning and decision-making but also created good opportunities for active cooperation. In addition, the multifaceted nature of the program implementation process, pulling of diverse resources and expertise, focus on program goals, trust and dialogue, and USAID mediation were some of the elements that fostered collaboration. Some

participants expressed concern about misunderstanding of the CHPS concept and its objectives, mistrust, and other forms of conflicts, which did not help, improve the relationship.

Research Question 2

How does the nature of the collaboration influence the effectiveness of the implementation process?

Impact of the collaboration on the effectiveness of the implementation process

Majority of participants (14 of 17) believed had they not engaged in the cooperation with other stakeholders, the level of success achieved in the program would not have been possible. One factor identified as key for the perceived success was the focus of all the implementers on the common goals. This focus dictated roles and responsibilities where partners depended on other partners to execute various parts of the program. According to the Chief of Party (head of the partners engaged in the CHPS-TA) another important factor was the aggregation of diverse expertise and resources held by the separate stakeholders. This official further noted these elements impacted strongly on the commitment of all the parties to the collectively agreed objectives and approach resulting in the success that the program achieved.

Areas of the implementation affected by the collaboration

Interview question 7 (see Appendix D) asked participants specific areas of the program implementation that they thought the relationship significantly affected. Majority (16 of 17) mentioned basic health equipment, training and orientation of CHOs in areas of public health, community mobilization, and sharing of expertise by the

different organizations. In addition, some participants mentioned that community-level health had improved considerably. A senior GHS official in charge of nursing observed that through the relationship, community members that had to travel several miles to attend clinic or receive basic child, maternal, family planning, and other public health assistance now have ready access through the CHPS compounds.

According to a USAID participant, the primary objective for which they supported the CHPS program was to improve the state of health of remote communities that could not easily access healthcare personnel and facilities available in the cities. This officer saw the realization of this key objective through the participation of all the partners resulting in the improvement of public health in the districts where officials implemented the program. A local NGO participant also observed that the collaboration strongly impacted the ability of local communities to mobilize towards meeting their own health needs.

One area that the participants recognized the program's success was the CHPS compounds. All the four CHOs said their individual CHPS compounds have been effective at meeting the needs of the communities because of the cooperative work of all the partners. One CHO stated that before the program, most villages in the district she worked had to travel to receive basic health service but that has changed significantly. One CHO also explained that in the past all the nurses will be "resident in Abirem and they would move once a month to a village and attend to people and come back. Now it is not so. The community members themselves have seen that their health is being well

catered for." A district CHPS coordinator in one of the districts also mentioned that "we rarely have stillborns in our district because of the collaboration."

In addition, all the CHOs saw the significant impact of the partnership on their skills and knowledge. One CHO stated that the level of training and orientation he received during the period of the program implementation has significantly impacted his ability to serve the health needs of the community. Another CHO mentioned that apart from the diversity of training provided, resources and expertise offered by the different organizations had significantly changed her ability to do things she was unable to do earlier.

Summary

Research Question 2 was used to explore qualitatively the perceptions of interview participants on how their cooperation helped improved the effectiveness of the implementation of the program. Participants agreed that the relationship impacted greatly on the success of the program. First, the program's smooth implementation for its entire life span proved that the interactions and cooperation among stakeholders yielded dividends. Participants also noted as successful wide improvement in access to public health in the communities; improvement in the skills of the CHOs; and basic medical equipment.

Research Question 3

How does the level of participation of stakeholders in decision-making affect the level of the collaboration?

Level of involvement of stakeholders in program implementation decision-making

Question 10 (see Appendix D) asked participants if they thought stakeholders participated actively in the decision-making. The overall conclusion (16 of 17) was that decision-making embraced all spectrums of the implementers.

Nature of the participation

Most participants also noted that the level of participation differed. Some of the stakeholders made policy level decisions; others were limited to operational decision-making or district and community-level decisions. A senior official of Population Council observed that participation in decision-making was not uniform. According to this official, three factors affected the capacity of an individual to participate in program decisions: level of knowledge on an issue (person's expertise), whether one was at the headquarters, regional, district or community-level, and the leadership position the person occupies. The official mentioned for example that whereas CHOs participated actively in village level and sub-district level decisions, they were not actively involved in high or policy level decisions, something normally left to senior officers or experts. However, a regional coordinator of health explained that although CHOs may not have knowledge of complex issues and therefore may not benefit from participating in the decision-making process, other officials take information from them to feed into the decision-making because operate at the grassroots level. . Their knowledge of local customs, health situations, local or traditional values, traditional leadership is valuable in making informed program decisions.

Annual CHPS forum and decision-making

Officials identified the annual CHPS forum as critical in the decision-making process. One official of Population Council said that the "CHPS forum was an annual ritual where these implementers come together, review the activities that are being done and carve new ways to improve the implementation." The participants used this forum to share ideas and assess the state of the program. However, the program often operated at the policy level, where senior officials normally meet. CHOs normally had limited representations on such meetings, but the extent of their capacity to influence deliberations was difficult to tell. A regional representative of CHPS explained that such review meetings should rather be occasions to share the experiences of people who were in the districts and villages rather than policy makers using it as an opportunity to deal with issues of policy. However, this official conceded that involving CHOs in some of the decision-making and even deliberations had to be seriously considered based on their level of knowledge and ability to discuss some of the issue. The complexity of some of the subjects may be far above their capabilities.

Two of the CHOs noted their participation in the forum could be useful for sharing their rich end user experiences with policy makers, regardless of their capacity to understand complex issues. However, one CHO said having all CHOs participating in the annual review meetings carried huge resource implications. This participant suggested the policy makers take advantage of the periodic durbars that CHOs normally hold (meetings with entire village community to deliberate and decisions) in their communities to gain firsthand information. All four CHOs observed that even on the

occasions that some of the partners visited, they often had opportunistic motives to satisfy their own organizational objectives. They explained the lack of feedback or the limited feedback from these partners was a possible reason for this suspicion. Overall, three out the four CHOs said they received no or little feedback.

Early involvement in decision-making

In response to question eight, (see Appendix D) whether all stakeholders participated in decision-making at an early stage in the programs, six senior participating officers stated they had participated at an early stage of the program. The remaining nine participants explained their involvement was limited to a later stage in the program. A USAID official observed that there were different levels of the program, beginning with writing of initial project documents. According to this official, at that point only senior officers and experts are often involved in the process. A representative of ACNM observed that at the initial stage of developing the content of the project, it was infeasible to invite lower level participation since preparation required high expertise.

However, all the participants said once they had passed that stage, people were involved in decision-making based on their functional level in the program, knowledge, and their places of work. The USAID official said even if the stakeholders would wish to involve most participants, resource constraints would not permit such action. According to this official, at that stage of the program, senior officers were not even fully aware of who was going to be part of the project. Most of the participants expressed concerns about whether lay people in the communities could influence or make decisions on highly complex technical problems.

Impact of collective decision-making on program implementation effectiveness

Question 11 asked participants about the impact of the decision-making on the program effectiveness. All participants in the interviews (17) said the process had made a significant impact. Most participants said democratic decision-making served the implementation well because it led to collective responsibility for ensuring that the program succeeded. Also, they observed that it made it difficult for stakeholders to abdicate their responsibilities, whiles it also encouraged interdependence of their functions.

The USAID representative observed that the organization's strategy was also partly responsible for the success of the program. According to this official, the organization produced a core document that detailed out the roles and functions and responsibilities of partners. Stakeholders had both individual and collective responsibility to make it work by performing their part. Participants noted that this approach led to constant and active engagement among the stakeholders. It also resulted in a sense of personal responsibility for getting the program goals met.

A senior Population Council official and an official of EngenderHealth supported this assertion. In their view, getting all partners engaged in the process was to avoid breaks in the chain of implementation. Every organization participating in the program's decision-making owned and was committed to ensuring the success of the aspects that were their unique responsibilities. In their view, the seemingly smooth implementation of

the program could be attributed partially to collective participation in decisions and the commitment of decision makers to ensuring such decisions were fully implemented.

A majority of participants however agreed that it was difficult to have the full impact of the program on the communities. Participants explained that changing long held behaviors within a year or two is often not easy. Actual results of behavior change and the actual impact of the decisions made regarding the program implementation will take a longer period to assess. However, the CHOs maintained that although a longer period may be needed to assess the full impact of the program, their daily interactions with the communities indicate a positive outcome.

Problems with participation in decision-making: Predetermined decisions

Ten (10) participating officers believed that some of the organizations came to the decision-making table with predetermined decisions. The officials expected other stakeholders simply to follow. In particular, an official of the Ministry of Health, Ghana's health policymaking body thought most donor organizations, prior to sitting down with other partners had predetermined decisions that they expected other partners to adopt. This approach did not allow for any meaningful decision-making and did not allow full partner commitments to the achievement of the program goals. A USAID official explained that whereas decisions were not normally predetermined, most projects have frameworks within which officials expected partners to operate. Such frameworks, according to this official did not constitute predetermined decisions although the officer conceded it does in some cases limit the extent to which decision makers can move outside that framework.

Problems with lay knowledge

Differences also emerged among participants as to whether communities and the CHOs had the needed expert knowledge to make serious and valuable inputs into key program decisions. Some of the participants identified the high illiteracy in the rural communities as an important obstacle to community involvement in issues that were complex. Similarly, participants noted that most of the CHOs hold nursing certificates, which were not sufficient for influencing complex health program decisions.

However, some of the participating officers noted that undermining local knowledge could be dangerous. They admitted that while such knowledge may not be on the same comparable level as the high expert knowledge they possessed local knowledge at the community and grassroots could be vital inputs for decisions that reflected the needs and circumstances of such communities. All the CHOs agreed that they were limited in their expert knowledge of some of the issues, but they could still influence decision-making in a significantly positive way.

Based on the demographic profiles of the interviewees, it was evident the differences in educational level between the groups influenced the kind of decision-making each of them could participate in. It was evident that the higher degrees of the most members of the participating organizations resulted in their involvement in policy level decisions. In contrast, the CHOs with lower educational background participated in community-level decisions. Both groups, however, had served the full course of the

program (four years), indicating experience with the nature of the program and its effect on resources and decision-making.

Problems of coordination

Although participants observed that the democratic approach to decision-making had helped the program implementation effectively, they also noted that decision implementation was not effectively coordinated. A representative of MOH explained that such a problem emanated from differences about how the current organizational objectives clashed with the current implementation of the program. On the other hand, the representative of ACNM attributed it to the private-public differing approaches to management. According to this official, the public sector has slower and sometimes thick bureaucratic walls to scale, which sometimes created problems of coordination. The private sector, with its business approach results in urgency that seems lacking in the public or government organizations. Blending organizations from these two different approaches was often a difficult task. This official further explained that the problem was exacerbated by the fact that sometimes donors such as USAID had to take instructions from Washington D.C., which also complicated the entire process.

However, a regional coordinator of CHPS attributed such problems to two factors. First, there were too many stakeholders. These stakeholders came in varying sizes, each having its own complex management structures with which to contend. Second, the chain of activities and command between head offices in Accra, through to the regions, and then districts, down to sub districts and finally the communities appeared so long that it made coordination sometimes difficult. Attempting to coordinate the actions of these

diverse organizations coupled with a long loop led to problems. As a way out, this officer suggested that decision-making and implementation must be closer to the beneficiary, , which is the community. The partners could work out how this could the officer.

However, a supervisor of CHOs in one of the districts attributed the problem to individual employee attitudes. This official noted that sometimes laziness, apathy, and similar employee behaviors led them not to take action on decisions or delay the actions. This officer recommended periodic employees reviews, training, and retraining as measures to curb this attitude. All four CHOs agreed that at the community-level, they were normally fully responsible and committed to implementing any program decisions that they were involved in making. However, in many cases decisions had to be approved from the districts that they belong to. Prior approval often times created delays in the implementation.

Resource problems

Resource limitation was one problem that most participants identified as hindrance to the success of the program. Participants agreed that the contributions from the different collaborators made huge difference in the process, although they needed many more contributions. They noted instances of some CHPS compounds lacking basic equipment. In the case of equipment break down, it normally took long periods for repairs or replacement.

The CHOs also noted that lack of resources to support decisions was one major constraint. They explained that when they make decisions at the community-level about

an aspect of the CHPS program, they often needed resources bring about the changes. However, either delay or unavailability of resources affected the smooth operations. They explained that it was sometimes difficult to determine whether the resources were simply unavailable or it was due to break in the chain of resource delivery.

A district director of health agreed that lack of resources to back decisions hindered some aspects of the implementation. The director explained that, at the community-level, the local communities must be sensitized constantly to make simple and less expensive health decisions to reduce their visits to health facilities. However, a senior participating official said that despite insufficient resources, the uncoordinated manner in which participants used resources could be partly responsible for the shortfall.

Summary

Research Question 3 was used to understand the views of interview participants on whether there was collective involvement in decision-making and how it affected the effectiveness of the program implementation. Results showed that majority of interviewees of both groups agreed that there was wide involvement of all identifiable stakeholders in the program decision-making. Officials used meetings, review meetings, and annual CHPS conferences to make program decisions.

However, results also indicated that such decision-making was not uniform. It depended on the level in the organization, functions and responsibilities, and the level of knowledge on the subject matter. Participants also said that whereas senior officers normally design the high-level program documents, lower level employees and CHOs engaged in the operational and community-level decision-making. Participants noted that

the collective participation of all stakeholders in the process helped increase ownership responsibility for the implementation or the program. Participants further said it was easier to implement decisions because all stakeholders made inputs. Finally, participants explained that the participatory approach to decision-making has impacted the overall success of the program. Yet, the capacity of lower level participants to make meaningful inputs into program decisions, resource constraints, and suspicions of predetermined decisions were noted difficulties.

Research Question 4

How do the quality, frequency, and amount of communication affect decision-making towards the effectiveness of the collaboration?

Sharing of program information

Question 12 asked whether sharing of information was effective. All 17 participants interviewed mentioned the effectiveness of the information dissemination. According to an official of the Population Council, the offices of most of the organizations involved in the implementation process were in the same building. This proximity of partners therefore facilitated easy access to relevant information by all parties.

Apart from this proximity, the senior officers of each participating organization met weekly. During such weekly meetings, each representative of the participating organizations received current program status reports, other currently available information, and future expectations. A senior officer of one of the local NGOs explained that although his organization did not get office space where most of the partners were

located, weekly meetings with all parties including USAID closed any information gap among partners.

Dissemination of information to districts

Information was decentralized. As a result, while the district participants did not attend all meetings and conferences, representatives of GHS were expected to brief these members and provide updates. A district director of health observed that information sharing had been largely effective because his district was never behind schedule of events. They did not also experience any information gaps between them and the partners. He explained that it was his outfit's responsibility to relay relevant information to CHOs in each of the communities where the program was being implemented. CHOs overwhelmingly agreed that information gets to them on time and they were often abreast with latest issues.

Most participants however explained it was sometimes difficult to monitor whether stakeholders in the regions, districts, sub districts, and communities got access to information. A USAID official noted that while there was no way to ensure this, the organization relied on individual partners to do their part by passing the information to their employees. The official said that so far, few hitches had occurred; therefore, transmission of relevant information was not only smooth but met the needs of all partners. However, a GHS official said while information sharing was often effective and widespread, some officers sometimes kept information to themselves until the last minute. This attitude, the officer maintained, could not be blamed on the central point

from where the information first emanated, but on apathetic officers at the end of the loop.

Feedback

Most participants expressed dissatisfaction with feedback. They noted that unless someone makes the request, feedback from parties that had information does not come frequently and effectively. With the exception of one CHO, all the rest of the CHOs noted that while they were frequent targets of information gathering by all the parties in the program, they rarely received feedback. According to them, while they often tried to accommodate the frequency visits by partners for information, lack of feedback was a major disincentive.

Six senior officers said while it was most likely that CHOs have had few feedbacks, the problem may be due to three factors. First, the information might not be any interest to the CHO and for which reason there would be no need to give them feedback on it. Second, individual partner organizations collected the information to meet their own organizational objectives. Finally, even if the participants did not receive feedback, the training and refresher programs organized periodically for the CHOs came from information that they provided frequently.

Adequacy of information

A follow up question asked participants if the information shared among stakeholders was sufficient. One senior official responded that in a developing country such as Ghana, access to completely adequate information is a luxury. Most participants agreed however that although they cannot say information was not available, the level of

sufficiency was contentious. An MOH official said that a lot more could have been done to provide update information than they had experienced during the lifespan of the program.

One problem for this inadequacy was the fact that in some cases the information a person needed was simply just not available. Another problem was that it was sometimes difficult to determine what information was available and what was not, due to the uncoordinated nature of the information dissemination process. However, an official of one the international NGOs noted that while information sufficiency was a problem, the methods or medium available to disseminate the information could also be partly responsible. Internet connectivity was very poor and access to the districts and participants in remote villages could only be contacted by mobile telephones. In case of complex information, mobile telephone might not be the appropriate method to use.

Mediums of disseminating information

Most of the interviewees (15 of 17) noted that the methods used to share information included reports, quarterly reports, annual reports, half year reports, letters, telephones, emails, conferences, or workshops. These methods were also effective. Most participants also observed that combining these mediums of disseminating information addressed three needs. First, it was useful in meeting the needs of different partners based on the medium best suited to them. Second, multiple medium helped to present complex and less complex information in the medium that fits the subject. Third and lastly, conferences, review meetings be it quarterly or yearly afforded face-face interactions among partners.

According to a senior officer of a local NGO, conferences were useful because they helped reduce tensions, conflicts, and catalyzed the building of immediate consensus on issues. This officer further explained that such mediums helped to improve the level of cooperation among partners. One CHO noted that meeting with senior officers created a sense of togetherness and team, where all partners discussed issues and shared information.

Summary

Research Question 4 addressed the question of whether information sharing among stakeholders was timely, adequate, came in the right medium, and its impact improving effective cooperation. The qualitative results indicate that majority of the participants perceived sharing of information among program implementers were largely effective. Participants believed that sharing relevant program information also affected collaboration among the implementers positively. First, participants noted that most of the participating organizations shared same office space. This proximity reduced information gap by enabling easy access to participants. It also reduced the length of time to gain access to information.

Most importantly, there were weekly program status reviews, meetings, and annual CHPS review conferences where all stakeholders were invited. These gatherings served as effective platforms for sharing relevant program information through discussions and planning. The study employed multiple media for disseminating program information. These media include telephones, emails, letters, conferences, and face-to-face interactions. Participants saw these approaches as effective in the information

dissemination process. In addition, participants said that the combination of multiple approaches to sharing program information served the needs of diverse participants. The approach also enabled stakeholders to gain from the complimentary role of the different communications methods for improving relationship.

However, the results also seem to suggest that participants had difficulties with feedback. Participants expressed concern that feedback from most participants was inadequate. They also said they did not have sufficient information they needed to make decisions and execute programs. In addition, participants noted that coordination of information sharing was not particularly useful.

Research Question 5

How does the involvement of the CHOs in the decision-making increase their effectiveness in their functions?

Involvement of CHOs in the implementation process

Question 13 asked participants the extent of the involvement of CHOs in the implementation of the program. All the participants said the CHOs were active in the process. Respondents explained that CHOs were the end users of the CHPS program, and therefore their participation in the process was necessary to aid the overall success of the program. By passing, the CHOs meant leaving out the primary actors in the implementation process. A top official of one of the international NGOs explained, "When it comes to CHPS, CHOs are the central or key staff that really coordinates the implementation at the community-level. Without them essentially you cannot talk about CHPS, because they coordinate the village institutions and deliver the services."

CHOs and decision-making

When questions about the extent to which the CHOs were involved in decision-making, most of the participants focused their answers on community-level decisions of the CHOs. In particular, most participants explained that although CHOs may not directly carry out policy level decisions, they were powerful facilitators and decision influencers within the communities. According to a senior nursing officer, within the communities the voice of the CHO was like that of the Director General of Health. The communities respected them for their knowledge and therefore during community health durbars, CHOs assumed prominent roles in decision-making. A sub district head of CHOs asserted that while the policy level decisions may seem above the level of CHOs, during community health durbars, other partners were invited through which valuable community-level information were passed on to them. This provided quality and important grass root input for policy level decisions. The educational background of the CHOs limited their involvement in higher-level decisions.

CHOs and information gathering

Most participants also noted that a key role of the CHOs included collecting essential community-level health, social, cultural, economic and any other information used to make decisions. According to participants, CHOs lived and worked with the community members, and so were sources for first hand information. A Regional CHPS coordinator explained that the "CHOs come directly in contact with community members. Therefore they are able to discuss problems or issues within the community." This senior officer further explained that the CHOs "know the people, they live with the

people; they know how to get into contact with them. So it was very important that they were involved."

All four CHOs and their sub district heads admitted their involvement in the process was pivotal to the program implementation process, including the collection of valuable community or village level information for assisting planning and decision-making. A CHO explained that "we are at the grassroots; we know the people; so by involving us we are able to tell them the people's norms, culture, and some of the practices in the community." One District Director of Health also explained that the CHOs "are working on the ground so their input is mainly on the community structure, the community response, and then expectations, then of course also the environment, the difficulties and problem they will face in the environment in which they are working."

However, most participants also could not tell whether there were formal structures for monitoring the extent that CHOs played their roles effectively. A top official of one NGO said that CHO functions and monitoring came directly under GHS and it was not possible for other agencies to crosscheck on their performance. This official however noted that monitoring visits by other participating organizations to collect information and assess the progress of work revealed that the CHOs were performing their central functions effectively. In one particular district, the director of health observed that periodic monitoring of CHOs were carried out by their sub district and district CHPS coordinators, although access to some of the communities was constrained by bad roads, and other logistical problems.

CHO involvement and impact on performance

Another question asked whether CHO involvement in the process had contributed to an improvement in their performance. Majority (15) said they believe that should be case although they had no evidence to support or to the contrary. The majority of the participants noted that that the CHOs gained immensely from participating in the implementation process. Apart from providing community or end-user information for decision-making and planning, the CHOs were critical bridges between implementers and the local community. A top official of EngenderHealth mentioned her personal knowledge of the CHOs when the program first started and when the program ended. The difference in their knowledge of public and community health showed they had improved considerably. According to this official, although CHOs were not expected to perform complex medical functions, they were able to provide necessary urgent medical attention to the rural communities, before patients attend or visit hospitals.

All four CHOs who participated in the interview said their participation in the entire process was beneficial to them in their day-to-day functions. They identified interacting with other stakeholders as important means through which they gained knowledge of public health problems and the manipulation of certain medical equipment. One CHO noted although they could not presumed to be medical doctors or people with high knowledge of medicine, yet they were able to handle most basic public problems completely or partially. In cases where they are unable to provide full service, they are able to solve urgent problems to overcome medical complications.

Another aspect of the functional effectiveness of the CHOs was their role in facilitating community-level behavior changes. All four CHOs observed that they acted as change agents through their day-to-day interactions with the community members, community opinion leaders, and traditional leaders. They were able to influence health behavior change, although the impact might not felt immediately. Typical examples cited were family planning for men and women, HIV/AIDS, malaria control, maternal and child health issues, nutrition, and basic healthcare such as keeping environment neat and hygienic.

Summary

Research Question 5 was used to explore the views of participants on the level of involvement of Community Health Officers in the decision-making process and the impact of their involvement on their performance. Results of the qualitative study suggest that most participants believed the CHOs had decision-making functions in the program. This study observed CHOs from two perspectives. They were end users of the CHPS program. They were also effective bridges to gaining direct contact with the local communities. This dual role made their involvement necessary and essential to implementing basic public education and care.

Results also appear to suggest that CHOs perceived their overall involvement in the program implementation had facilitated their improved performance. They noted that they were able to perform basic health functions more effectively because of the training and information they received. CHOs revealed further that information sharing and the

CHOs' involvement in the local-level decision-making process had affected their performance significantly.

Summary of Interview Results

I used research question 1 to explore the thoughts of selected participating officers and Community Health Officers on the extent of their collaboration in the implementation of the CHPS-TA program in Ghana. Active interactions and cooperation among participants came through weekly and periodic review meetings. The participants also gained effective cooperation through the annual CHPS review conferences where stakeholders discuss and plan future aspects of the program. Cooperation and teamwork was also built through pulling together of diverse resources, collective engagement towards meeting the program goals, and the intermediary role of USAID. However, there were problems of trust, misunderstanding of program goals, and suspicions that stakeholders who are more influential predetermined decisions, all of which undermined the relationship.

In research question 2, I examined the perceptions of participants on the extent that the cooperation among the program partners affected the effectiveness of the program implementation process. The cooperation was profitable in many areas of the implementation process such as provision of quality public healthcare to communities, improvement in the skills of the CHOs, and provision of medical equipment to support the process of healthcare delivery. The program also affected community-level social change to basic healthcare issues such family planning, hygienic, nutrition, were jumpstarted.

To address research question 3, I explored the opinions of study participants on the level of their involvement in decision-making and its effect on the improvement of collaboration among the program implementers. Participants agreed they engaged in democratic decision-making. Participating officers and CHOs noted that conferences, workshops, and meetings were good opportunities for engagement in the decision-making process. Also, the level of knowledge on a required subject determined how participants were engaged in specific decisions. This approach to decision-making affected greatly the partners' commitment. However, some decisions were predetermined, which defeated meaningful and open discussions on program issues. The different organization objectives of stakeholders also interfered with the decision-making process.

For research question 4, I explored the opinions of participants on sharing of program information, its adequacy, and timeliness. Interview results showed that because most of the organizations were located in the same office building, it made access to critical information easier. In addition, the partners held weekly and other periodic meetings with partners to share important information on the program. Also, the partners found that reports, meetings, conferences, letters, and face-to-face interactions were effective means of communication on the program. Combining these methods further strengthened the communication effectiveness. However, lack of feedback was a noted problem, in addition to the uncoordinated nature of the information dissemination process.

Finally, in research question 5, I examined the views of participants on the extent of involvement of Community Health Officers in decision-making. The CHOs are the

end users of the program and they needed this information to understand how their participation in the process affected their performance. Apart from providing community-level health and non-health information to aid decision-making, CHOs were also critical in the actual program implementation. Their incorporation in the process made it easier to implement the program. However, it was difficult to monitor how they performed these roles because there are no clear structures to monitor them.

Integration of Quantitative and Qualitative Results

The purpose of the first research question was to understand the nature of collaboration between USAID and its health partners in the implementation of the CHPS-TA program in Ghana. The results from both the quantitative and the qualitative studies indicated a strong collaboration among stakeholders in the implementation of the program. Both results shed significant light on the nature of the collaboration and some of the elements in the relationship. However, there were some few areas where they differed. First, the interviews results identified the nature of USAID programs as one of a means of effecting collaboration, which was not apparent in the quantitative study. In addition, although both groups of participants rated trust and dialogue very high in the quantitative study, the qualitative study showed there were significant areas of mistrusts among participants as well. Interview results indicated dialogue was plagued with suspicions that some participants predetermined decisions thereby defeating the transparency needed in any meaningful and effective dialogue. In addition, collective focus on the program was not a straightforward issue because there were clear disagreements over the nature and goals of the CHPS program.

With regard to the second research question, the issue addressed was ho the nature of the collaboration influenced the effectiveness of the implementation process. There was agreement in the quantitative and qualitative results indicating that study participants recognized their cooperation as effective in influencing the success of the program. However, the qualitative result indicated specific areas where the relationship impacted, such as improvement in the health of local communities, which was key goal of the program. In addition, there was provision of medical facilities to help the delivery process, while CHOs evidently improved their skills in community healthcare delivery.

The third research question addressed the question of the level of participation of stakeholders in decision-making affect the level of the collaboration? The results from the qualitative study seem to support the quantitative study that there was good level of collective decision-making in the relationship which also contributed significantly to the improvement in their collaborative relationship. The qualitative study revealed that conferences, workshops, and meetings engaged all parties in the decision-making process. In addition, the interview results also showed that the roles of a person in the implementation process, the operational geography, and the person's level of knowledge on a required subject determined whether a person could participate in a decision. The result suggest therefore that policy level decisions or higher-level decisions were made by experts and other more experienced professionals (in this case participating officers because of their higher degrees), often at the regional and national levels. The CHOs were normally engaged in the district and sub district decisions, largely because of their relatively lower level of education and knowledge of the issues. In addition, the

qualitative results further indicated that suspicions among some of the stakeholders some decisions being predetermined before actual meetings took place and uncoordinated nature of the process of making the decisions affected the participatory nature of the decision-making.

In the fourth research question, participants addressed the issue of how the quality, frequency, and amount of communication affect decision-making towards the effectiveness of the collaboration. Results from both methods of the study seem to suggest that participants shared information to facilitate the program decision-making. Although the quantitative result showed moderate ratings for the suitability of the methods used to share information, the qualitative results specified reports, meetings, conference, letters, and face-to-face interactions as the methods employed. The qualitative result went further to indicate that combining methods of sharing information strengthened the communication effectiveness and met the needs of individual participants. However, there were some contradictions too. In the quantitative result, CHOs rated feedback high while the participating officers scored it moderate. This result contradicted the qualitative result, which seemed to indicate that both groups had serious concerns about feedback. Indeed, the CHOs believed feedback was seriously lacking. In addition, the qualitative results showed mixed perceptions on adequacy of the information participants received, while the quantitative result revealed it was moderately adequate.

In the final research question, participants were asked to address the question of how involvement of the CHOs in the decision-making increased the effectiveness of their

functions. Results of the quantitative study revealed that both groups perceive that the CHOs were engaged in the decision-making process, while the CHOs also believe their participation in the entire implementation process had improved their performance. Although both groups rated the inputs of the CHOs moderately (quantitative), the qualitative study show that the CHOs were more involved in community-level decision-making, alongside traditional leaders in the community rather than policy level decisions. There was one surprising result from the quantitative study. The CHOs perceived that their input was moderate into the decision-making for the program was moderate. However, in the question that sought to understand how their engagement in the decision-making process improved their performance, the CHOs rated their input higher. While there seem to be some discrepancy, this result seems to compare favorably with qualitative results where all the CHOs said they benefited significantly.

Chapter 4 Summary

I chapter 4, I presented data collected based on the study plan in Chapter 3. In this chapter, I also explored the statistical analysis conducted for the quantitative and the qualitative phases of the study. I collected quantitative data through closed- and opened-ended self-administered surveys of a study population of 87, of which 67 responded. This number comprised 48 members of participating organizations and 19 Community Health Officers. The qualitative portion involved interviews with 17 participants drawn from the study's subpopulations. I analyzed quantitative data by means and standard deviations. Theme determination based on the five research questions constituted the approach for

the qualitative analysis. I integrated results from both phases of the study to provide a complete view of participants' perceptions of the research problem.

In chapter 5, I will detail out the interpretation of these findings. In this chapter, I will also explore the extent that the study results relate with literature review and theory. This phase of the study will state conclusions, including the recommendation of areas of future research and the implications of the study's findings for social change. I will also include in the chapter a discussion of possible areas of future research.

CHAPTER 5: SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

The purpose of this mixed method, descriptive study was to explore the nature of collaboration between healthcare stakeholders that are implementing a USAID-funded CHPS-TA program in Ghana in order to determine the impact of the relationship on the effectiveness of the implementation process. Through this study, I sought to explore participatory decision making and the sharing of essential skills and resources and the effects of these factors upon the collaboration process. Additionally, I investigated the role of the CHOs in the implementation process and the impact of their participation in the relationship upon their performance effectiveness.

The state of healthcare in sub-Saharan Africa is among the weakest worldwide. The continent has the highest HIV/AIDS and Malaria cases alongside related deaths, high Tuberculosis cases related to high HIV/AIDS prevalence, high child mortality rates, and low life expectancy. In the face of limited health resources, most countries in the region benefited regularly from external support from development partners, particularly USAID, to fund healthcare and other development programs. Implementation of such externally funded programs in sub-Saharan Africa and Ghana in particular normally involved diverse stakeholders. Literature reviewed for this study revealed that collaboration among healthcare stakeholders is widely acknowledged. However, little attention has been given to the relevance of the relationship in a development aid context, particularly in sub-Saharan Africa. By exploring these issues of collaboration therefore, I illuminated some understanding of the extent to which these factors affect the relationship and impact the success of the implementation process.

Five research questions guided the study:

1. What is the nature of collaboration between USAID and its health partners in the implementation of the CHPS-TA program in Ghana?
2. How does the nature of the collaboration influence the effectiveness of the implementation process?
3. How does the level of participation of stakeholders in decision-making affect the level of the collaboration?
4. How do the quality, frequency, and amount of communication affect decision-making towards the effectiveness of the collaboration?
5. How does the involvement of the CHOs in the decision-making increase their effectiveness in their functions?

In this final chapter of the study, I will discuss and interpret the findings. In this chapter, I will also explore the extent that the study results relate with underlying literature and theory. In addition, I will present conclusions about the study's findings. I will present limitations of the study, recommendations for future research, and implications of the study's findings for social change. This chapter will also include discussion of possible areas of future research.

Summary of Findings

Using research question 1, I explored the nature of collaboration between USAID and its health partners in the implementation of the CHPS-TA program in Ghana. Ten questions in the survey that reflect core components of an effective collaborative relationship derived from the literature were used to assess the views of the participants.

All ten questions received moderate to high levels of agreement from both participating groups. This rating means both groups believed core components for effective collaboration existed in the relationship between USAID and its health partners. Result of the *t* test did not find statistically significant differences in perceptions between the two groups on all the items.

Individually, however, based on high mean values of 4.0 or above, participating officers placed critical importance on item 1, there is trust among the groups working on the program); item 2, group members engage in dialogue in the process of working together); and item 3, groups involved in the implementation of the program working together towards meeting the goals of the program. CHOs agreed with the members of participating organizations on these three items. They also agreed on the importance of: resources and expertise needed for shared program implementation towards meeting program goals, groups involved in the implementation view the ultimate success of the program as their collective responsibility, and the sharing of roles and responsibilities toward the implementation of the program among the different groups engaged in the program.

However, differences also emerged. Participating officers rated, with means of 3.0 but below 4.0, the item "there is coordination of the different roles of the groups" as their least important element. The CHOs chose "there is coordination of resources" as their least important element. In addition, although participating officers rated trust their most important element, this same factor also exhibited the highest standard deviation in response, therefore the greatest disagreement.

Interview results were consistent with survey results, but provided further insights into important areas of the collaboration. Participants on both sides agreed that the implementers engaged in an effective collaboration to achieve the goals of the program. Participants recognized periodic interactions during daily, weekly, quarterly, and annual CHPS meetings; the collective involvement of all the parties in the decision making; sharing of important program information; the nature of USAID program; and the collective focus of all parties on the goals of the program as important factors that inspired teamwork.

In research question 2, I explored the perceptions of participants about the extent they believe their collaboration affected the effectiveness of the program implementation. Based on the high rating from both groups for the single survey item that addressed this question, it was evident that participants perceived their cooperation had positive impact on the success of the program implementation. The *t* tests, which found no statistical differences in the perceptions between the groups, support this finding. Interview results also support the survey outcome. Participants identified improvement in community-level healthcare delivery and improvement in the knowledge of the CHOs as important indicators of the effectiveness of the partnership.

Research Question 3 was used to gain understanding of participants' views on the extent that their level of participation in the program decision making influenced the effectiveness of the relationship. Four survey items, all based on the literature, reflect core elements of an effective decision-making assessed participants’ view. Both groups scored the four items from high to moderate mean values. This rating means core

elements of participatory decision-making clearly existed in the decision-making process. In addition, participants perceived their collective involvement in the process to have had strong impact on the effectiveness of the implementation process. This perception is supported by the higher score both groups gave to the item *my overall view is that the effectiveness of the decision-making process contributes to the success of the implementation of the program*. Also, the item "all identifiable groups are or stakeholders are involved in decision-making at the time the program is being planned" was least important to the two groups. *T* test results did not find any significant differences in perceptions between the participating officers and the CHOs on all the four items.

Interview results further support the survey results. Participants said they played active roles in the decision-making process through regular and periodic meetings, annual review meetings and in face-to-face interactions. However, interviews also indicated that participants expressed concern about transparency and trust. It appeared the CHOs were normally excluded from policy level decisions because of their relatively low educational background. CHOs normally function at the community-level portion of the decision-making process.

Regarding research question 4, I explored the question: How do the quality, frequency, and amount of communication affect decision-making towards the effectiveness of the collaboration? As in the case of the other research questions, five survey items were derived from the literature to evaluate the perceptions of participants. All five items received moderate to high mean scores from both groups. This result suggests participants' perception that these core elements existed in the decision-making.

The *t* test also did not find statistically significant differences. However, based on high mean scores, participating officers perceived that “sharing of information improves the level of cooperation and information to assist decision-making for the implementation of the program is shared among the groups” as critically essential in the relationship. In addition to the latter item, the CHOs also perceived "feedback on the information provided is solicited from all group members" as important. Both groups viewed *provision of essential information for decision-making during the implementation of the program is timely, regular, and quality* as least important.

Interview results did not contradict these survey results because both groups said there was reasonably adequate dissemination of program information, although improvement was called for. They also viewed the multiple methods for sharing information such as letters, email, conferences, and face-to-face interactions as effective. However, the interview results contradict the survey results on feedback. Most of the CHOs said feedback from most of the stakeholders was ineffective. Despite these varying responses, the survey results were clear: CHOs rated the feedback with high mean scores, indicating agreement.

Finally, research question 5 was used to explore the extent of CHOs’ involvement in the decision-making process and the impact of their involvement on their performance. Four survey items assessed the views of the CHOs. With the exception of the item *Community Health Officers make inputs into program decisions relating to the implementation of the program*, which was given a moderate score by both CHOs and the members of participating organizations, all the rest three items received high mean

scores. Interview results were consistent with these views. These results imply that CHOs played some role in the decision-making process, while their involvement in the process also had a positive impact on their performance. Interview results also confirm that while the CHOs played some role in decision making, such inputs were limited to the districts and the local communities.

Interpretation of Findings

Research Question 1

What is the nature of collaboration between USAID and its health partners in the implementation of the CHPS-TA program in Ghana?

El Ansari, Phillips and Hammick (2001) stated, "An examination of the collaboration and joint working literature does not readily clarify what constitutes evidence" (p.216). This observation implies considerable differences between the nature of collaboration and the kind of emphasis that could be placed on elements that makes it effective. In this study, based on the findings, one important conclusion is that the collaboration between USAID and its partners appeared to place significant emphasis on intangible or soft elements of the relationship rather than the tangible or hard elements.

Evidently, the participants agreed on the following factors: building trust (there is trust among the groups working on the program), dialogues (group members engage in dialogue in the process of working together), collective focus on the ultimate success of the program (groups involved in the implementation view the ultimate success of the program as their collective responsibility), joint working relations (groups involved in the program are working together towards meeting the goals of the program), and shared

roles and responsibilities (the different groups share roles and responsibilities towards the implementation of the program). The foundation for the relationship between these partners therefore could be seen from these human relationship elements rather than from such physical factors as resources.

Generally, the literature on collaborative relationships has often strongly emphasized human relationship (Deschenes, Martin, Hill, 2003; El Ansari & Phillips, 2001; El Ansari, Phillips, & Zwi, 2004; El Ansari, 2003; Kanstan, 2000; Nowell, 2009; Zakus & Lysack, 1998) between partners as the foundation for a successful partnership. However, with regard to the conclusion there are consistencies with past studies. Studies (El Ansari et al., 2004a, 2004b; El Ansari, 2003; Nowell, 2009) suggest shared goals, trust, dialogue, and joint working relations are essential if the collaboration is to be effective. Specifically, Kanstan (2000) found trust as an important element for building strong health program collaboration. In addition, El Ansari et al. (2004) noted collective focus on the key goals of the program by all the collaborators was essential for directing how participants exercise their roles and responsibilities. Also, Poland et al. (2004) discovered participants in a health program collaboration perceived the success of the relationship in terms of how it attained specific health goals and also its "quality of collaborative relationship {e.g., mutuality of benefits, respect, honesty, communication, and sensitivity}" (p.130). In this respect, achieving objectives related to the human relationship issues was equally important.

The emphasis on soft factors of relationship building rather than on actual physical components seems to find direct relationship with Freeman's (1984) stakeholder

theory. The core of the theory is that anyone's active involvement in an organization's activities can help the achievement of an organization's objectives. A person can in turn suffer by the actions of the same group. This theory entails ensuring identifiable interested parties in a program are made part of the program in order to ensure its success. However, Okunoye, Frolick, and Crable (2007) argued that the theory should be viewed more in terms of engagement-outcome relationship. Multi- stakeholder dialogue (Freeman et al., 2004; Roloff, 2007) towards meeting mutual interests will be a critical means of ensuring the engagement. This view suggests emphasis on factors that build and strengthen the relationship than the actual physical resources.

However, the physical resources aspect of the relationship (coordination of roles and responsibilities, coordination of expertise and experiences, and coordination of resources, and sharing resources) appeared to relate directly to resource dependency theory (Pfeffer & Salancik, 1979) than stakeholder theory. The theory focuses more on the interdependence between competing organizations for resources needed to execute their goals. One way to achieve resource sufficiency is to develop mutual interdependence, coordination, and linkages with organizations that have such resources (Pfeffer & Salancik, 1978). While resources and expertise appeared to be moderately relevant in the USAID relationship, they were not as prominent as the softer elements.

The emphasis on human relationship building factors suggests two important implications. First, the findings might be an indication that human relation factors are the critical success factors in this collaborative relationship. Those factors seem to be the key to defining the potential strength and effectiveness of the relationship. Second, the

finding also provides a clear understanding that for a collaborative relationship to be effective there must be strong alignment between the human relationship factors and the physical resources component. Both aspects of the relationship must be effectively blended in order that goals set for the programs are met.

Other findings also emerged from the study. It was also evident from the qualitative findings that there were fundamental problems with trust and dialogue. Mistrust cannot be completely excluded from any relationship. However, Kreuter, Lezin, and Young (2000) stated that the existence of mistrust signified that the relationship was at its early or formative stage or had not matured. This finding implies the USAID relationship may not have matured fully.

But Kreuter et al. (2000) also mentioned that mistrust might be due to differences in organizational philosophies, interests, and goals. This theory seems to find direct link to interview findings, which showed that such differences among participants were responsible for potential mistrusts. However, mistrust could also be due to leadership difficulties (Kreuter et al., 2000) which probably called into question which organization was actually in charge of the program implementation, USAID, Population Council, or GHS. Although interview results seem to indicate that Population Council was in charge of the Technical Assistance component of the CHPS, it was also clear that USAID and GHS assumed varying leadership roles. USAID was the funding agency while GHS controlled implementation at the regional and district levels. The program implementers must embrace a stronger approach to building trust and transparency. El Ansari and

Phillips (2001) discovered the necessity of strong leadership to hold the partnership together.

In addition, the results indicate the educational level and its relationship with the functions of participants can also determine how stakeholders variously perceived each of the elements in the relationship. In support of this view, whereas participating officers rated moderate sharing of resources and expertise, collective ownership of program goals, and sharing of roles and responsibilities, the CHOs believe these elements were strong. Demographic analysis indicated that the educational background of participants, which also influenced the roles, they played probably accounted for the differences. It could be argued, therefore, that the strength of these elements in the partnership was the product of the functions of each group. El Ansari's (2003) study also found that there were differences in perception between experts and community members on some of these elements. While study results yielded no specific reason, the cause might be a combination of what each group does and the perceived limitations of the lower educational background of the community members. The difference could also be the result of the absence of clear demarcation of what roles each group is expected to play in the relationship. The absence of clear roles and functions could hinder the assessment of their effectiveness.

More importantly, this finding indicates these elements were weaker in the relationships. The moderate ratings given by the participating officers find support in the study of El Ansari et al. (2004). In this study, the researchers found that participants in a collaborative partnership rated as average the allocation method for resources and funds

and the sharing of roles and responsibilities. In another study, El Ansari and Phillips (2001) reported that two groups were moderately satisfied with resources allocation or sharing while two groups expressed dissatisfaction.

Moreover, the findings further show that most elements of coordination appeared weak (coordination of resources, coordination of roles and responsibilities, and coordination of skills). The potential weaknesses associated with these elements may indicate that the overall functions and roles were not strongly coordinated. Nowell (2009) found in a study that although coordination is important in collaboration, in that study it did not feature as a "key driver of effectiveness" (p.204).

There may be several reasons why these elements were not strong. First, the relationship between USAID and its partners appeared to be ad hoc or program specific only. This might be an indication that the necessary structures for a collaborative relationship did not sufficiently exist, suggesting it was at its formative stage of development (Butterfoss, Goodman, & Wandersmann, 1993; Kreuter, Lezin, & Young, 2000). According to Kreuter et al., the early stage of development or the preformation stage of collaborative relationships is normally used for formal planning and needs assessment for the relationship. However, these authors stated that collaborative partnerships formed "in response to availability of outside funding, investing in a preplanning phase rarely is an option" (p.53). Kreuter et al. further noted, "Some funders, recognizing the value of this type of preparation, have built it into their funding cycle" (p.53). Yet, there is no clear indication that both USAID and its partners undertook a formal and comprehensive preplanning assessment to know the exact needs and

structures for building a strong partnership. Neither was there any suggestion USAID built in any funding for such a study.

Perhaps even if the relationship matured from preformation stage to formation stage, the following key factors remained unsettled: rules, policies, goals, and missions that make it work. Weak structures and rules might result in conflicts (Kreuter, et al., 2000) which can adversely affect coordination of all roles, functions, resources, and skills. The interview suggest that possible conflicts over the actual goals of the CHPS program.

Besides, even if the collaboration between USAID and its partners were at a fully matured stage which Kreuter et al. refers to as implementation and maintenance stage, other lack of resources and logistics could undermine the effective functioning of the formal structures. Kreuter et al. noted that the challenge here is that the "tasks they must accomplish require skills and resources that are not readily available" (p.54). Whether USAID and its stakeholders had the resources and skills to do this is unclear.

Based on these findings, answers to Research Question 1 indicate that: (1) core elements in the collaboration among internal healthcare providers derived from literature also exist in the externally funded development aid context between USAID and its partners; (2) that soft human relationship elements of trust, dialogue, and working together to achieve the goals of the program are elements of the USAID, whose partner relationships are strong; (3) that elements of the relationship received varying perceptions probably because of the participants' different roles and functions; (4) that the moderate

agreement among all participants on elements of coordination came from weak collaborative structures or immature relationships.

Research Question 2

How does the nature of the collaboration influence the effectiveness of the implementation process?

This question was a follow up to research question 1. The aim was to understand the extent the collaboration between the implementers had impacted the success of the implementation process. Based on the findings, the fundamental conclusion was that collaboration among diverse organizations could result in the achievement of goals that are of common interest to the collaborators (El Ansari, et al, 2004; El Ansari, 2003). This conclusion derived from high mean values from participating officers and the CHOs indicating strong impact of the partnership on the program outcomes. The study identified several highly impacted: improvement in public health; improvement in the delivery of basic healthcare equipment; improvement in the skills and knowledge of CHOs, and instigating a behavior change among the communities. This strong rating is however inconsistent with the findings of El Ansari (2003). El Ansari's study discovered participants in health program collaboration saw the impact of their relationship on the achievement of programs goals in a "moderate to good level."

While this difference between the current study and El Ansari's study appears modest, a number of factors underscore it. First, some studies reveal that outcomes of collaborative partnerships can be difficult to determine because such partnerships have different goals, some short, medium, and long term (Nowell, 2009; Roussos & Fawcett,

2000). Using the wrong terms can therefore affect the outcome. In some cases also, the goals of the relationship are either too broad or too narrow, which could make achievement difficult (Kreuter, Lezin, & Young, 2000). Besides, the variability in the instruments for measuring the effectiveness of collaborative outcomes (El Ansari, Phillips, & Hammick, 2001) could also be an important factor. One instrument may reveal a different outcome than another instrument. Individual level outcomes versus community-level outcomes can equally be a factor (El Ansari et al.) that could also blur the assessment.

An important finding from the study was that CHOs had considerable improvement in their skills and knowledge because of the relationship. This finding does not contradict past studies. A number of studies have shown that partners in a collaborative relationship gain from the partnership by improving and upgrading their skills and knowledge (El Ansari, et al., 2004; Kreuter, Lezin, & Young, 2000). Another study by Hallin, Kiessling, Waldner, and Henriksson (2009) also found out that all the participating groups had increased their skills and knowledge. All these studies therefore suggest that collaboration between diverse partners may be medium for exchanging ideas, skills, and knowledge.

In answer to this research question, there was a strong indication that the partnership had contributed significantly to meeting the goals of the program. Also, CHOs' skills and knowledge have changed considerably. Yet, although participants believed the relationship improved community-level healthcare, the actual impact of the relationship may take a longer period to assess.

Research Question 3

How does the level of participation of stakeholders in decision-making affect the level of the collaboration?

A major conclusion derived from the data revealed the program relationship was characterized by an effective decision-making process, which also contributed to the success of the implementation of the program. This finding is consistent with the literature, which indicates that collective participation of stakeholders in program decision can result in quality program outcomes (El Ansari, et al., 2004; Butterfoss, Goodman & Wandersmann 1993; El Ansari & Phillips, 2001). Literature has equally shown that collective decision-making leads to common responsibility for the implementation of the decisions, since all the parties were involved in the process (El Ansari & Phillips, 2001; El Ansari, 1998). Theoretically, stakeholder theory (Freeman, 1984; Freeman et al., 2004) provided a concrete background for the study's conclusion. The theory called for integration of interested parties to issues that could affect them or for which their actions could also influence.

Yet, contrary to the merit in the above conclusion, another finding of the study revealed three core elements needed for effective collective decision-making were only moderate. These elements include shared decision-making; input from all participants in decision-making, and the involvement of identifiable parties in the early stages of program planning. First, this finding suggests a gap between the perception that collective decision-making might result in program implementation success, and the actual core elements for democratic decision-making. This gap is not strange because a study by El

Ansari et al. (2004) also found only average rating for collective decision-making among health program collaborators.

Secondly, the moderate ratings of the three elements might indicate weakness in the collective decision-making process among USAID and its partners. Several reasons might account for this perceived weakness. Lack of authority by the participants to make decisions could be a major contributing factor (El Ansari and Phillips, 2001). El Ansari's study reported the following results: first out of the total participants, 30 % did not have the authority to make decisions on behalf of their organizations; 45 % had to consult their heads or other levels of authority to make decisions; and only 23 % qualified to make decisions without consultation with any higher power.

In addition, the lack of adequate structures can affect full participation (Kreuter, et al., 2000). Besides, resource and skills availability to support the process could also impede the process. If participants lacked the necessary skills to participate in decision-making, it might result in frustrations (Kreuter, et al., 2000, El Ansari et al.). In addition, lack of resources to back the process of participation could further stifle involvement (Poland et al., 2004). In addition, the willingness of parties to be engaged in the process could also be another factor. This might require the necessary trust, dialogue and atmosphere for decision-making to be present to make the process effective (Nowell, 2009; Kanstan, 2000).

These factors appeared to be supported by themes that emerged from the qualitative data. First, it was discovered that there were suspicions that more powerful stakeholders undermined the value of participatory decision-making by coming to the

decision-making table with predetermined decisions. In addition, most stakeholders' early involvement came only at a later stage of the program planning. The study cited resource constraints as a reason for excluding some of the stakeholders from the process. Participants also believed that some stakeholders did not have the needed expertise to contribute to any meaningful decisions. In particular, most participating officers were unsure of the level of inputs of the CHOs. CHOs themselves confirmed that they were unsure of the weight placed on the inputs that they made to issues at the district levels.

Consequently, strengthening critical components of the decision-making process will require attention from the CHOs and other participants. This strengthening will require genuine commitment to full participation from all parties in the process; provision of adequate resources; and training and process to enhance the process. Also, personnel engaging in the decision-making have to be delegated with the authority they need to make the decisions. Mere availability in the process may not be enough.

To answer this research question, there appeared to be strong decision-making among participants who also contributed to an effective relationship. However, shared decision-making, inclusion of inputs of all parties, and early involvement in the process seem relatively moderate. Strengthening of these areas will be seriously required for a more effective democratic decision-making.

Research Question 4

How do the quality, frequency, and amount of communication affect decision-making towards the effectiveness of the collaboration?

A fundamental conclusion from the study results was the evidence of the ready availability of information sharing to assist participants to make program decisions. This appeared consistent with past studies. Butterfoss, Goodman & Wandersmann (1993) indicated that open communication is critically necessary for a strong collaborative relationship. They also found that "open communication helps the group to focus on a common purpose, increases trust and sharing of resources" (p.324). This study also revealed that frequent meetings and interactions could lead to improved relations among the collaborators, which also reflected the theme expressed in the qualitative portion of the current study. However, according to El Ansari, Phillips, and Zwi (2004) participants in their study found communication effectiveness was only above average. Differences among these findings might suggest that several factors could affect information sharing, which could determine the level of efficacy.

Another finding of this study was the moderate acceptability of the methods used to share information among participants, in addition to the timely, regular, and high-quality nature of the information. This finding indicates some level of weakness with method, approach, and timing of information dissemination. These conclusions are consistent with the El Ansari, et al. (2004) study, which found that participants in health program collaboration gave an average rating to the level of communication and information flow among the groups. Another study by El Ansari and Phillips (2001) revealed the participants' perception that communication was of low quality, was provided infrequently, and was somewhat inadequate. On other hand, El Ansari and Phillips in the same study also found the usefulness of multiple methods of

communication in meeting the needs of participants rather than a single method. This finding appears to share some parallel with the qualitative finding of this study, which revealed participants in the current study also saw employing multiple methods as effective.

Further, the nature of participants' roles and responsibilities affected how information sharing and its effect on the improvement of the relationship. The finding indicated that participating officers saw information they received as having strongly improved their cooperation. Participating officers engage in higher-level program decision-making, while the CHOs seem limited to the community or end-user portion of the process. This difference may have accounted for how each group believed the information received improved the level of cooperation. CHOs believe the effect was moderate. Butterfoss et al. also discovered participants believe information improved their relationship. However, El Ansari and Phillip (2001) found participants believe lack of information can affect the collaboration. A third study by Mannheimer, et al. (2007) discovered that whereas the participants were happy about the quality and level of communication, they did not believe it resulted in quality cooperation.

Consequently, answers to this research question findings suggest the availability of information to assist participants to make decisions. Access to information has led to improvement in the decision-making process. However, the quality and frequency were not adequate. Besides, methods for disseminating the information were moderate.

Research Question 5

How does the involvement of the CHOs in the decision-making increase their effectiveness in their functions?

In relation to this question, a fundamental conclusion from the study was those CHOs as the end users of the CHPS-TA program were moderately involved in the program decision-making. This conclusion appears to share some consistency with findings to research question 3 above. Additionally however, the conclusions revealed a satisfied CHOs group with the impact of their involvement in the entire collaborative partnership, decision-making, and access to relevant program information. This conclusion is significant because it shows end user participation in the relationship could be precursor to effective program implementation (Akukwe, 1999; El Ansari, et al, 2004; 2003; 2001).

These findings find support in the study of Akukwe (1999). Akukwe suggested community members or any end users who are targets of health programs must be included in the implementation process. First, their involvement would lead to their commitment and ownership to the effective implementation (El Ansari, et al; Akukwe). They could provide valuable end community-level information on both health and non-health factors. The El Ansari et al. (2004) study showed that community members in health program partnership believed their involvement in the partnership strongly impacted their performance. In sum, two important findings are relevant to this research question are (1) the input of CHOs or the end users of the program into decisions is

moderate and (2) the participation of the CHOs in the program implementation, including information they received together, strongly impacted on their performance.

Recommendations for Action

Health Policy Makers in Ghana-MOH and GHS

A key finding of the study was that sharing of skills, resources, and coordination of the resources among partners was not strong. There seem to be problems with trust and transparency. Therefore, for a more effective collaboration in the implementation of future health programs on HIV/AIDS, Malaria, TB, maternal and child health, and communicable and incommunicable diseases, GHS and MOH should avoid engaging in cooperative relationships that focused on specific health programs or are ad hoc in nature. Rather, they should consider the option of setting up a permanent and fully resourced department within their individual institutions with sole responsibility of managing interagency collaboration. The value of setting up this department is that while it can be used to evaluate the effectiveness of past collaborative program implementation, it could also be the focal point for developing and nurturing the preparedness of MOH and GHS for future collaborative work. It will also improve dialogue, transparency, and coordination of program activities through engagement with funding agencies like USAID, local and international NGOs, and community-level groups.

Among its core responsibilities, the department will be (1) meeting periodically among themselves to discuss health priorities; (2) deliberate and set health program strategies that reflect Ghana's health priorities; (3) set frameworks for the utilization of health resources in the most effective manner; (4) determine key priority areas where

health programs should be located based on the need of the local communities and the overall health objectives of the country; (5) train and equip all levels of manpower ready to partner with other stakeholders in the design and implementation of health programs; (6) create policy frameworks that incorporate health implementers to engage local community groups and institutions in health program implementation; (7) create an information database that provides up-to-date local health measures for use by the agencies; and (8) create a policy framework that makes relevant contributions to the funding decisions of development partners, and that recognize local circumstances and priorities.

One other outcome of the study was the lack of feedback and strong interaction between participating officers in the central offices and the districts and communities. The GHS should establish regional, district, and sub- district program partnership liaison offices. These offices will be valuable conduits for sharing health information to improve the level of healthcare delivery. In addition, the liaison offices could be starting points for determining health goals and resource and skill needs relevant to specific districts and sub districts. These offices can help improve and strengthen the information exchange and feedback among the communities and the regional and national stakeholders. In addition, these liaison offices particularly the district offices should be empowered with resources and necessary skills to establish community-level partnership groups. The community partnership groups could act as community-health change agents and intermediaries to implementing health programs in such communities.

The findings of the study also revealed the limited capacity of CHOs to impact healthcare decision-making. Given the critical role of these groups in community health delivery, it is highly recommended that MOH and GHS set up training programs to equip and upgrade the skills and capacities of CHOs and community health nurses in general. The training programs must reflect the specific and urgent skill needs of these health personnel in the communities they serve. The periodic training should focus on core health programs and other community-level health issues. This will increase the capacity of the CHOs and the other community health nurses to make not only effective community-level health decisions but also participate effectively and actively in national health forums.

Similarly, customized training and other orientation programs should be designed for the empowerment of local community groups, such as youth and women's groups. These programs should target key areas of capacity building of these groups towards their full and productive engagement in setting local health priorities. The empowerment of key community groups could also be an important avenue for collecting community-level health information and effecting health behavioral change. This approach will further improve the use of community-level skills and knowledge for the improvement of the relationship. Also, GHS must strengthen community-level structures such as traditional political and social authorities and religious groups.

In addition, GHS and MOH should work with external development agencies, local and international NGOs to develop a code of work practices for local and international NGOs. One finding was the suspicion of mistrust between local and

international NGOs. The code of practice will harmonize the activities and operations of both local and international NGOs towards complementary roles that foster quality and effective health delivery. The participation of all stakeholders concerned in setting the codes will help limit infractions.

The study's findings revealed conflicts between local and international NGOs thereby affecting the level of cooperation. GHS, MOH, USAID, and all the major local and international NGOs should consider creating inter-NGO relationships for programs. This agency will facilitate the exchange of local knowledge of local NGO operations and how the international NGOs conduct their businesses.

External Development Agencies and NGOs

Study findings suggest the perception of USAID as a funding agency that often predetermines program decisions. This perception makes change difficult the local health priorities and circumstances. The USAID should consider the option of tapping local health input, particularly from MOH and GHS in program decision-making. The USAID could achieve change through the establishment of a USAID-MOH/GHS consultative group involving key policy- and decision-makers. This group, which will meet periodically, will become a platform to create input for any health programs USAID intends to support. The value of this consultative group is that it reduces future conflicts over program goals; resources; needs; communities where programs must be implemented; and program implementation problems, while ensuring that early input is provided before actual program implementation begins.

Also, the findings revealed mistrust among some of the stakeholders, particularly local and international NGOs. Dialogue and transparency are critical components for establishing trust. For this reason, the USAID should establish an interagency communications platform before and during program implementation. Healthy debates, generation of divergent perspectives on health issues and program strategies should be vigorously encouraged among participants.

In addition, in establishing this platform, USAID should also focus on the provision of quality and up to date information to participants to assist their deliberations. The agencies should establish and maintain an open and transparent communication network to encourage free and unfettered access to information. The organizations should prepare fair and acceptable means for resolving possible problems, while the opportunity for airing grievances should be available constantly. These measure will reduce the suspicions of mistrusts encourage partnership.

Finally, external development partners such as USAID must incorporate local communities and interest groups in such communities in their funding policies. Including their inputs on a regular basis will limit providing funding for a program that does meet local expectations and circumstances. Adopting such policies will however empower local communities to be involved in setting and identifying critical health priorities based on their needs.

Limitations and Recommendations for Future Research

Apart from other limitations of the study outlined in Chapter 1, the current study also suffers from two important limitations. First, there was limited participation of some

stakeholders in the study, particularly USAID. The last minute change in the number of participants from USAID, which is a critical partner (funding agency) in the CHPS-TA program, did not help provide the detailed insight needed from that organization. The funding agency perspective was therefore limited. Secondly, the reduction in the number of participants in the two participating districts (Birim North and Kwahu North) also limits the findings. A larger participation from these districts and the CHOs within would have provided broader views on the research questions. In addition, the study should have included actual community members where the CHOs operate in order to explore their perceptions as well. All these have therefore together limited both the scope of the study and the validity of the findings.

Although adoption of a mixed method provided both a numerical demonstration of participant's views and insights through interviews, basic descriptive analysis created potential problems of quality. The descriptive analysis alone was probably not enough to lead to solid conclusions about the research questions. Additional and different statistical tests could have strengthened the outcomes. Interviewer bias is a major obstacle to quality interview data (Creswell, 2003). While I made every effort to conduct interviews effectively, some biases and flaws remained in the current study. My familiarity with local health conditions, particularly in the remote villages in Ghana, may have influenced the direction or tone of some of the interview questions. These factors could also have serious effects on some of the responses that participants provided.

In addition, the transcriber omitted or replaced unclear words or sentences in the transcription of the audio recordings. Although I informed participants during the

member checking process; however, it is most likely these changes could have some implications for the quality of interview results. Analyzing interview data may also inject some level of bias and subjectivity into the process, since it involved the implementing methods that were not necessarily error free. The use of criterion and purposeful sampling in the study prevented the achievement of random sampling. Together these potential difficulties with the interviews data may have implications for the validity and generalizability of the findings.

The following are recommendations based on these limitations. First, there must be a much wider study covering larger study populations. Including large number of CHOs from different districts and members of participating organizations will lead a different view and more detailed investigation into the issues explored in the current study. In particular, such a study could also explore the perceptions of actual community members and not only the CHOs. This approach will provide a complete view of the end user portion of the study.

A different methodology could also be used to investigate the issues. While the mixed method was useful, it is most likely other potentially effective methods or designs might have revealed greater insights into the nature of the relationship. A correlational study, for example, could establish a cause and effect relationship between collaboration and effective health program implementation. In addition, a more rigors and reliable sampling method such as random sampling could result in a truly representative sample.

Evaluation research should become part of the collaborative relationships. This will provide needed feedback for improvement in other such relationships in the planning

and implementation of development programs. It will also help emphasis areas where the relationship proved effective and redirect focus on aspects that needed to be strengthened in future partnerships. Policy designers should indicate in their plans specific goals of the programs, determine methods that will be appropriate to measure such goals and provide mechanisms for relaying feedback to appropriate users to improve the relationship and the entire program as whole.

Implications for Social Change

As was detailed in the introduction and background sections in Chapter 1, sub-Saharan Africa is home to high HIV/AIDS, malaria, TB, child mortality, malnutrition and low life expectancy problems. The prevalence of these diseases is exacerbated by the limited access to quality health care by most rural communities in Ghana and elsewhere in sub-region. This difficulty is sometimes the result of ineffective management of resources by organizations and individuals tasked with implementing health programs (World Bank, 2005; World Development Report, 2004). In most cases however, the problems may be attributed to lack of collaboration and partnership among these groups and individuals (World Bank, 2005; World Development Report, 2004; El Ansari, et al., 2004; El Ansari, 2003). This results in wastage of limited and scare health resources, inefficiency, and consequently lack of quality public healthcare (World Development Report, 2004).

Whiles the specific economic situation in most sub-Saharan countries differs slightly, the quality and level of access to healthcare appears the same. The level of HIV/AIDS and Malaria and other health indicators such as maternal and child mortality

rates appears to be the same in most of the countries in the region. Consequently, most countries in the region, particularly countries that are in the Economic Community of West African States (ECOWAS) will find these implications highly relevant. There is a close link among the health, economic, and social situations, apart from geographical proximity to Ghana.

This study therefore has important implications for engaging social change in deprived rural communities in Ghana and sub-Saharan Africa. First, the government of Ghana's health institutions will find the conclusions from this study useful to begin an aggressive process of affecting the health status of deprived communities. The Ministry of Health and Ghana Health Service must work out a policy plan that incorporates collaborative relationship into every health program. This approach will result in the inclusion of stakeholders who matter in the process and the actual communities in the planning and implementation of such programs. This will reduce waste, duplication, and result in cost-effective healthcare delivery for local communities through "all hand on deck approach." Access to cost-effective healthcare could set in motion social change in the lives of individual community members and the whole community at large. Economic activities will improve, thereby encouraging improvement in education and socio-political lives of the people.

Study findings also offer important general implications for community group empowerment toward quality healthcare delivery. The inclusion of local communities and health workers within such communities in the process of planning and implementing health programs will help gain their commitment towards taking charge of health

behavioral changes that could ultimately affect their overall health. Local participation in health decision-making can lead to an empowerment of local communities so that they can take charge of providing local health priority setting, and provide critical social and cultural inputs into planning and implementing health programs. Their complete knowledge of their local economic, social, and cultural situations could make it easier for them to determine how best to instigate health behavior change toward quality healthcare. Although such changes may not necessarily be dramatic, small steps of change can result in larger, long-term health benefits, which can affect the quality of economic and social progress in the rural communities.

USAID and the external development partners could also trigger social change by incorporating into their funding policies the inclusions of local communities and special interest groups within such communities. This approach will encourage local communities to be actively involved in setting their own health priorities towards quality health care. Including local community participation in funding policies will make it feasible for development partners to focus more on health and health related behaviors that are of utmost importance to the communities.

Summary

Several researchers have conducted studies on collaboration among country healthcare providers with results indicating improvement in access to health care. Such relationships also utilize diverse and scarce health resources and skills for greater organizational performance. Yet, in the development aid context, particularly in sub-Saharan Africa, little research exists on this type of relationship. Focusing on the USAID

funded CHPS-TA program, the study provided an exploration of the nature of the collaboration among participants implementing the program between 2004 and 2009. The study also examined the impact of the relationship on the program implementation effectiveness. This study examined participatory decision-making and sharing of relevant program information to understand how these factors also affected the collaborative process, in addition to the involvement of the CHOs.

Survey participants addressed five research questions. These include the nature of the collaboration; the impact of the relationship on program implementation effective; the role of collective decision-making in the relationship; the role of quality, timely, and appropriate methods of sharing information in improving the partnership, and finally the inclusion of program end users (CHOs) in the partnership and how that inclusion improved their performance.

This study employed the descriptive mixed method. This methodology involved the administration of self-administered surveys and face-to-face interviews to participants in participating organizations and community health officers. Using a mixed method was useful because it led to demonstrating numerically the perceptions while augmenting such perceptions with detailed insights from the interviews. Stakeholder theory and resource dependency theory provided theoretical frameworks for understanding these issues of collaboration.

Findings indicate that externally funded development programs, including health programs, can benefit from collaboration and the perceived value associated with this relationship Second; there was moderate involvement of the actual users of the program

in the process, a situation that has resulted in improved performance for such officers. Findings indicated that differences emerged between the members of participating organizations and the CHOs over certain elements of their relationship, such as their level of input into the decision-making process, and information flow. All these have implications for policy formulation in health program implementation.

This study recommended that health policy makers and implementers consider developing common collaborative frameworks for developing and nurturing partnerships with other organizations and local communities. I also suggested the development of a mechanism for coordinating partnership resources. In addition, aid agencies such as USAID could create mechanism for encouraging dialogue among stakeholders, while NGOs could develop stable and strong linkages with local communities to foster stronger partnership.

Conclusion

The results of this study contribute to scholarship on international development by revealing important understanding of the nature of collaboration among partners implementing a health program funded by an external aid agency. Much of the literature in Chapter 2 concentrated heavily on collaboration among participants in internal health programs contexts. The findings shows that collaboration can occur in any such a setting as well. Similarly, the study reveals that elements needed for a strong collaborative relationship such as resource and expertise sharing, participatory decision-making, and information sharing are not limited to internal health programs alone. It extends to development aid as well.

Literature is scarce on the involvement of end users in collaborative relationships and how their involvement can help improve program effectiveness at the end-user level. This study demonstrated that end user involvement yields some valuable benefits for both the implementers and the end users. While there is often the temptation to undermine the skills and capabilities of end users in the relationship, their involvement resulted in knowledge of "on the ground" information which is always useful for important decisions.

Another contribution to the literature is the use of a mixed method approach to investigate these problems. Almost all the studies in the field have concentrated on either qualitative or quantitative study. This study, although at a modest level, does show that a mixed method is an effective way to explore perceptions in order to arrive at a more rounded view of the collaboration.

REFERENCES

Abernethy, M. A., Chua, W. F., Grafton, J., & Mahama, H. (2007). Accounting and control in health care: Behavioral, organizational, sociological and critical perspectives. In C. S. Chapman, A. G. Hopwood, & M. D. Shields (Eds.), *Handbook of Management Accounting Research*, Vol. 2. Oxford: Elsevier.

Adams, G. R., & Schvaneveldt, J.D. (1991). *Understanding research methods* (2nd ed). New York: Longman.

Almquist, K. J. (2009). U.S. foreign assistance to Africa: Securing America's investment for lasting development. *Journal of International Affairs*, *62*(2), 19 – 35.

Arah, O. A. (2007). The metrics and correlates of physician migration from Africa. *BMC Public Health*, 7(83).

Asante, A. D., Zwi, A., & Ho, M. T. (2006). Getting by on credit: How district managers in Ghana cope with the untimely release of funds. *BMC Health Services Research*, *6*(105).

Akukwe, C. (1999). Community participation in international health: practical recommendations for donor and recipient organizations. *Pan Am Journal of Public Health*, *5*(3), 137 – 143.

Awofeso, N., Schelokova, I., & Dalhatu, A. (2008). Training of frontline health workers for tuberculosis control: Lessons from Nigeria and Kyrgyzstan. *Human Resources for Health*, *6*(20).

Babbie, E. (1995). *The practice of social research* (7th ed.). Thousand Oaks, CA: Wadsworth Publishing Company.

Babbie, E. (1973). *Survey research methods*. Thousand Oaks, CA: Wadsworth Publishing Company.

Begun, J.W., Tornabeni, J., & White, K.R. (2006). Opportunities for improving patient care through lateral integration: *The Clinical Nurse Leader Journal of Healthcare Management*, *51*(1), 19-25

Berry, C., Krutz, G.S., Langner, B.E., & Budetti, P. (2008). Jump-starting collaboration: The ABCD Initiative and the provision of child development services through Medicaid and collaborators. *Public Administration Review*, *68*(3), 480-490

Betz, N. E. & Hackett, G. (2006). Career Self-Efficacy theory: Back to the Future. *Journal of Career of Assessment*, 14(1), 3-11.

Betz, N. E. (2000). Self-Efficacy theory as a Basis for Career Assessment. *Journal Of Career Assessment*, *8*(3), 205-222.

Bernstein, M. L., McCreless, T., & Cote, M. J. (2007). Five constants of information technology adoption in healthcare. *Research and perspectives on Healthcare*, *85*(1), 17-25.

Bird, R., Hall, A.D., Momentè, F., & Reggiani, F. (2007). What corporate social responsibility activities are valued by the market? *Journal of Business Ethics*, *76*(2), 189- 206.

Black, R.E., Morris, S.S., & Bryce, J. (2003). Where and why are 10 million children dying every year? *The Lancet*, *361*(9376), 2226-2234.

Boyd, B. (1990). Corporate linkages and organizational environment: A test of the resource dependence model. *Strategic Management Journal*, *11*(6), 419-430.

Bronstein, L.R. (2002). Index of interdisciplinary collaboration. *Social Work Research*, *26*(2), 113-126.

Briggs, C.L., & Martini-Briggs, C. (2009). Confronting health disparities: Latin American social medicine in Venezuela. *American Journal of Public Health*, *99*(3), 549-555.

Bryman, A. (1984). The Debate about Quantitative and Qualitative Research: A Question of Method or Epistemology? *The British Journal of Sociology*, *35*(1), 78-92.

Butterfoss, F.D., Goodman, R.M., & Wandersmann, A. (1993). Community coalitions for prevention and health promotion. *Health Education Research, 8*(3), 315-330.

Capobianco, E., & Naidu, V. (2008). A review of health sector aid financing to Somalia. *World Bank Paper*, No. 142.

Cohn, K., Friedman, L.H., & Allyn, T.R. (2007). The tectonic plates are shifting: Cultural change vs. mural dyslexia. *Frontiers of Health Services Management*, *24*(1), 11-25.

Cooper, H., & Spencer-Dawe, E. (2006). Involving service users in interprofessional education narrowing the gap between theory and practice. *Journal of Interprofessional Care*, *20*(6), 603-617.

Copley, J.A., Allison, H.D., Hill, A.E., Moran, M.C., et al. (2007). Making interprofessional education real: a university clinic model. *Australian Health Review, 31*(3), 1-3.

Costello, A. S. & Osrin, D. (2005). The case for a Global Fund for maternal, neonatal, and child survival. *Lancet*, *366*(9485), 603-605.

Clare, L. & Cox, S. (2003). Improving service approaches and outcomes for people with complex through consultation and involvement. *Disability & Society*, *18*(7), 935-953.

Clark, R. M. (2007). *Intelligence analysis: A target-centric approach* (2nd ed.). Washington D.C: CQPress.

Clemen, M.A. & Pettersson, G. (2006). A new database of health professional emigration from Africa. *Center for Global Development, Working Paper*, number 95.

Creswell, J.W. (2007). *Qualitative inquiry and research design. Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Creswell, J.W. (2003). *Research design, qualitative, quantitative, and mixed methods approaches* (2nd ed.). London: Sage Publications.

Cunningham, C., Stephan, S.H., Paternite, C., Schan, S., Weist, M., Adelsheim, S., & Flaspohler, P. (2007). Stakeholders' perspectives on the recommendations of the President's Freedom Commission on Mental Health. *Psychiatric Services*, *58*(10), 1330-1338.

Deschenes, M., Martin, C., & Hill, A.J. (2003). Comprehensive Approaches to school health promotion: how to achieve broader implementation? *Health Promotion International, 18* (4),387-396.

Donaldson, T., & Preston, L. E. (1995). The stakeholder theory of the corporation: Concepts, evidence, and Implications. *The Academy of Management Review*, *20*(1), 65-91.

Ekortarl, A., Ndom, P., & Sacks, A. (2007). A study of patients who appear with advanced cancer at Yaoundé General Hospital, Cameroon, Africa. *Psycho-Oncology*, *16*(3), 225-257.

El Ansari, W.E., Phillips, C.J., & Zwi, A.B. (2004). Public health nurses' perspectives on collaborative partnerships in South Africa. *Public Health*

Nursing, *21*(3), 277-286.

El Ansari, W.E., & Phillips, C.J. (2004). The Costs and Benefits to Participants in Community Partnerships: A Paradox? *Health Promotion Practice, 5*(35), 35-48.

El Ansari, W.E. (2003). Educational Partnerships for Public health: Do Stakeholders Perceive Similar Outcomes? *Journal of Public Health Management, 9*(2), 136-156.

El Ansari, W.E., & Phillips, C.J. (2001a). Partnerships, community participation and intersectoral collaboration in South Africa. *Journal of Interprofessional Care, 15*(2), 215-227.

El Ansari, W.E., & Phillips, C.J. (2001b). Interprofessional collaboration: a stakeholder approach to evaluation of voluntary participation in community partnerships. *Journal of Interprofessional Care, 15*(4), 351-368.

El Ansari, W.E., Phillips, C.J., & Hammick, M. (2001). Collaboration and partnerships: developing the evidence base. *Health and Social Care in the Community, 9*(4), 215-227.

Fassin, Y. (2009). The stakeholder model refined. *Journal of Business Ethics*, *84*(1)*,* 113-135.

Fitzgerald, G. (2008). Can Scotland show the high road to teamwork? *Occupational Health*, *60*(4), 23-25.

Freeman, R.E., Wicks, A. C., & Parmar, B. (2004). Stakeholder theory and "the corporate objective revisited." *Organization Science*, *15*(3), 364-369.

Freeman, R.E. (1984). *Strategic Management: A stakeholder approach*. Boston: Pitman.

Frey, B.B., Lohmeier, J.H., Lee, S.W., & Tollefson, N. (2006). Measuring collaboration among grant partners. *American Journal of Evaluation, 27*(3), 383-392.

Garner, J. T. (2006). Masters of the Universe? Resource Dependency and Interorganizational Power Relationships at NASA. *Journal of Applied Communications*, *34*(4), 368-386.

Geertz, C. (1973). Description: Towards an interpretive theory of culture. In *The Interpretation of Culture*. New York: Basic Books.

Ghana Health Service (GHS), www.moh-ghana.org, retrieved on 02/04/2009

Ghana Statistical Service, Ghana Health Service, & Micro International (2009). Ghana

Maternal Health Survey, Maryland

Gichaara, J. (2008). Women, religio-cultural factors and HIV/AIDS in Africa. *Black Theology: An International Journal*, 6(2).

Gilbert, D. U., & Rasche, A. (2008). Opportunities and problems of standardized ethics initiatives - A stakeholder theory perspective. *Journal of Business Ethics, 82*(3), 755-773.

Glenngard, A.H. & Maina, T.M. (2007). Reversing the trend of weak policy implementation in the Kenyan health sector? A study of budget allocation and spending of health resources versus set priorities. *Health Research Policy and Systems, 5*(3).

Gottret, P., & Schieber, G. (2006). *Health financing revisited. A practitioner's guide.* Washington D.C: The World Bank.

Gore, P.A. and Leuwerke, W.C. (2000). Predicting Occupational Considerations: A Comparison of Self-Efficacy Beliefs, Outcome Expectations, and Person-Environment Congruence. *Journal of Career Assessment*, *8* (3), 237-250.

Greene, J.C., Caracelli, V.J., & Graham, W.F. (1989). Toward a conceptual framework for mixed-method evaluation designs. *Educational Evaluation and Policy Analysis*, *119*(3), 255-274.

Gully, A., Stainer, L., & Stainer, A. (2006). Responsible business decisions: an over-arching framework. *Journal of Public Affairs, 6*(3/4), .

Haddow, G., O'Donnell, C. A., & Heaney, D. (2007).Stakeholder perspectives on new ways of delivering unscheduled health care: the role of ownership and organizational identity. *Journal of Evaluation in Clinical Practice*, *13*(2), 179-185.

Hallin, K., Kiessling, A., Waldner, A., & Henriksson, P. (2009). Active interprofessional education in a patient based setting increases perceived collaborative and professional competence. *Medical Teacher, 31*(2), 151-157.

Halverson, P.K., Mays, G.P., & Kaluzny, A.D. (2000). Working together? Organizational and market determinants of collaboration between public health and medical care providers. *American Journal of Public Health*, *90*(12), 1913-1916.

Hedrick, T.E., Bickman, L., & Rog, D.J. (1993). *Applied research design. A practical guide.* Thousand Oaks, CA: Sage Publications.

Homsy, J. King, R., Balaba, D., & Kabatesi, D. (2004). Traditional health practitioners are key to scaling up comprehensive care for HIV/AIDS in sub-Saharan Africa. *AIDS*, *18* (12), 1723-1725.

Hord, S.M. (1986). A synthesis of research on organizational collaboration. *Educational Leadership, 43*(5), 22-26.

Jacobs, B. and Price, N. (2003). Community participation in externally funded health project lessons from Cambodia. *Health Policy and Planning*, *18*(4), 399-410.

Jamali, D. (2008). A Stakeholder Approach to Corporate Social Responsibility: A Fresh Perspective into Theory and Practice. *Journal of Business Ethics*, *82*(1), 213-231.

Jick, T.D. (1979). Mixing quantitative and qualitative methods: Triangulation in action. *Administrative Science Quarterly*, *24*.

Johnson, R.B., & Onwuegbuzie, A. J. (2004). Mixed methods research: A research paradigm whose time has come. *Educational Researcher*, *33*(7), 14-26.

Kalipeni, E. & Zulu, L. (2008). Using GIS to Model and Forecast HIV/AIDS Rates in Africa, 1986-2010. *The Professional Geographer*, *60*(1), 33-53.

Kanstan, J. (2000). School-Based mental Health Program Development: A Case Study of Interorganizational Collaboration. *Journal of Health Politics, Policy, and Law, 25*(5), 845-862.

Kapiriri, L. & Martin, D. K. (2006). Priority setting in developing countries health care institutions: the case of Ugandan Hospital. *BMC Health Research*, *6*(127).

Kidd, S. Kenny, A., & Endacott, R. (2007). Consumer advocate and clinician perceptions of consumer participation in two rural mental health services. *International Journal of Mental Health Nursing*, *16*(3), 214-333.

Kirigia, J.M., Gbary, A.R., Muthuri, L.K., Nyoni, J. & Seddoh, A. (2006). The cost of health professionals' brain drain in Kenya. *BMC Health Services Research*, *6*(89).

Kiszewski, A., Johns, B., Schapia, A., Dellacollette, C., Crowell, V., Tan-Torres, T., Ameneshewa, B., Teklehaimanot, A., & Nafo-Traore, F. (2007). Estimated global resources needed to attain international malaria controls. *Bulletin of World Health Organization*, *85*(8).

Komatsu, R., Low-Beer, D., & Schwartlander, (2007). Global fund-supported prorgammes' contribution to international targets and the Millennium Development Goals: An analysis. *Bulletin of the World Health Organization*, *85*(10).

Kreuter, M.W., Lezin, N.A., & Young, L.A. (2000). Evaluating Community-Based Collaborative Mechanisms: Implications for Practitioners. *Health Promotion Practice, 1*(1), 49-63.

Laan, G.V., Ees. H.V., & Witteloostuijn, A.V. (2008). Corporate social and financial performance: An extended stakeholder theory, and empirical test with accounting measures. *Journal of Business Ethics*, *79*(3), 299-310.

Lawn, S.D., Myer, L., Bekker, L., & Wood, R. (2006). Burden of tuberculosis in an antiretroviral treatment programme in sub-Saharan Africa: impact on treatment outcomes and implications for tuberculosis control. *AIDS, 20* (12), 1605-1612.

Lindamer, L.A., Lebowitz, B.D., Hough, R.L., Garcia, P., Aquirre, A., Halpain, M.C., Depp, C., & Jeste, D.V. (2008). Improving care for older persons with schizophrenia through an academic-community partnership. *Psychiatric Services*, *59*(3), 236-239.

Longoria, R.A. (2005). Is inter-organizational collaboration always a good thing? *Journal of Sociology and Social Welfare*, *32* (3), 123-138.

Maeseneer, J., Weel, C., Eglisaan, D., Mfanyana, K., Kaufman, A., Sewankambo, N., Filinkenflogel, M. (2008). Funding for primary health care in developing countries. *British Medical Journal*, 336.

Mannheimer, L.N., Gulis, G., Lehto, J., & Ostlin, P. (2007). Introducing Health Impact Assessment: an analysis of political and administrative intersectoral working. *European Journal of Public Health, 17*(5), 526-531.

Martins, J.O. & Maisonneuve, C. (2006). The drivers of public expenditure on health and long-term care: An integrated approach. *OECD Economic Studies*, *43*(2).

Mbagaya, G. M., Odhiambo, M. O. & Oniang'o, R.K (2005). Mother's health seeking behavior during child illness in a rural western Kenya community. *African Health Services, 5*(4), 322-327.

McCoy, D., Chopra, M., Lowensen, R., Aitken, J., Ngulube, T., Muula, A., et al. (2005). Expanding access to antiretroviral therapy in sub-Saharan Africa: Avoiding the pitfalls and danger, capitalizing on the opportunities. *American Journal of Public Health*, *98* (12), 2161-2167.

McDaid, D., Knapp, M. & Raja, S. (2008). Barriers in the mind: promoting an economic case for mental health in low-and middle-income countries. *World Psychiatry*, *7*(2), 79-86.

McIntyre, R. M., Bartle, S.A., Landis, D., & Dansby, M.R. (2000). The Effects of Equal Opportunity Fairness Attitudes on Job Satisfaction, Organizational Commitment, and Perceived Work Group Efficacy. *Military Psychology*, *14*(4), 299-319.

McMurray, R. (2006). From partition to partnership: Managing collaboration within a curative framework for NHS care. *The International Journal of Public Sector Management, 19*(3), 238-249.

Mickan, S. M. (2005). Evaluating the effectiveness of health care teams. *Australian Health Review*, *29*(2), 211-217.

Ministry of Health (MOH, Ghana), www.moh-ghana.org, retrieved on 02/04/2009

Mitchell, R.K., Agle, B.R., & Wood, D.J. (1997). Toward a theory of stakeholder identification and salience: Defining the principle of who and what really counts. *The Academy of Management Review*, *22*(4).

Mizrahi, T. & Abramson, J.S. (2000). Collaboration between social workers and physicians: A perspective on a shared case. *Social Work in Health Care*, *31* (3), 1-24.

Mosquera, M., Zapata, Y., Lee, K., Arango, C., & Varela, A. (2001). Strengthening user participation through health sector reform in Colombia: a study of institutional change and social representation. *Health Policy and Planning*, *16*(2), 52-60.

Mukadi, V. D., Maher, D., & Harries, A. (2001). Tuberculosis case fatality in high HIV prevalence populations in sub-Saharan Africa. *AIDS, 15*(2), 143-152.

Muturi, N. W. (2005). Communication for HIV/AIDS prevention in Kenya: Social-cultural considerations. *Journal of Health Communication*, *10*(1), 77-98.

Nabyonga-Orem, J., Karamagi, H., Atuyambe, L., Bagenda, F., Okuonzi, S.A., & Walker, O. (2008). Maintaining quality of health services after abolition of user fees: A Uganda case study. *BMC Health Services Research*, *8*(102).

Narasimhan, V. & Attaran, A. (2003). Roll Back Malaria: The scarcity of international aid for malaria control. *Malaria Journal*, *2*(8).

Newig, J. Haberl, H., Pahl-Worstl, C., & Rothman, D.S. (2008). Formalised and Non-Formalised Methods in Resource management-Knowledge and Social Learning in Participation Process: an Introduction. *Syst Pract Action Research*, 21.

Nowell, B. (2009). Profiling Capacity for Coordination and Systems Change: The Relative Contribution of Stakeholder Relationships in Interorganizational Collaboratives. *Society for Community Research and Action, 44*(3-4), 196-212.

Nyonator, F., Jones, T.C., Miller, R. A., Phillips, J.F. & Awoonor-Williams, J.K. (2005). Guiding the Ghana community-based health planning and services approach to scaling up with qualitative systems appraisal. *International Quarterly of Community Health Education, 23*(3), 189-213.

OECD-DAC, 2008, www. Oecd.org/dac/stats/health (retrieved 11/10/2008)

Ohmer, M. and Beck, E. (2006). Citizen Participation in Neighborhood Organizations in Poor Communities and its Relationship to Neighborhood and Organizational Collective Efficacy. *Journal of Sociology and Social Welfare*, *XXXIII* (1), 179-2102.

Omolewa, M. (2008). Adult Literacy in Africa: The Push and Pull factors. International *Review of Education, 54*(5-6), 697-711.

Okunoye, A., Frolick, M., & Crable, E. (2008). Stakeholder influence and ERP implementation in higher education. *Journal of Information Technology Case and Application Research*, *10*(3), 9-38.

Onwuegbuzie, A. J. and Johnson, R.B. (2006). The Validity Issue in Mixed Method. *Research in the Schools*, *13* (1), 48-63.

Ott, C.H., Haertlein, C., & Craig, D.H. (2003). A Collaborative Student Affairs and Faculty Health Assessment and Intervention Initiative. *Journal of American College Health*, *51*(6), 257-262.

Owusu, F.Y. (2004). Post-9/11 U.S Foreign Aid, the Millennium Challenge Account, and Africa: How Many Birds Can One stone Kill? *AfricaToday, 54*(1), 3-26.

Parker-Oliver, D., Bronstein, L.R. & Kurzejeski, L. (2005). Examining Variables Related to Successful collaboration on Hospice team. *Health & Social Work*, *30*(4), 279-286.

Paulraj, A. & Chen, I.J (2007). Environmental Uncertainty and Strategic Supply Management: A Resource Dependence Perspective and Performance Implications. *Journal of Supply Chain Management*, *43*(3), 29-42.

Pawinski, R.A. & Lalloo, U.G. (2006). Multisectoral responses to HIV/AIDS: Applying research to policy and practice. *American Journal of Public Health*, *96*(7), 1189-1191.

Petasnick, W.D. (2007). Hospital-physician relationships: Imperative for clinical enterprise collaboration. *Frontiers of Health Services*, *24*(1), 3-10.

Petti, C. A., Polage, C. R., Quinn, T.C., Ronald, A.R., & Sande, M. A. (2005). Laboratory Medicine in Africa: A Barrier to Effective Health Care. *Clinical Infectious Disease*, 42, 377-382.

Pfeffer, J. & Salancik, G.R. (1978). *The external control of organizations: A resource dependence perspective*. NY: Harper and Row.

Poland, et al. (2004). 'Working at the margins' or 'leading from behind'?: a Canadian study of hospital-community collaboration. *Health and Social Care in the Community, 13*(2), 125-135.

Rabionet, S. E., Santiago, L.E., & Zorilla, C.D. (2009). A Multifaceted mentoring model for minority Researchers to address HIV Health disparities. *American Journal of Public* Health, *99*(1), 65-70.

Raosoft (www.raosoft.com/samplesize) Retrieved on 09/10/2009

Reason, P. (1999). General medical and complementary practitioners working together: The Epistemological demands of collaboration. *The Journal of Applied Behavioral Science*, *35*(1), 71-86.

Renzaho, A. (2008).Re-visioning cultural competence in community health services in Victoria. *Australian Health Review*, *32*(2), 223-235.

Reutter, L, Stewart, M. J., Raine, K., Williamson, D. L., Letourneau, N., & McFall, S. (2005). Partnerships and participation in conducting poverty-related health research. *Primary Health Care Research & Development, 6* (4), 356-366.

Reynolds, S.J., Schultz, F.C., & Hekman, D.R. (2006). Stakeholder Theory and Managerial Decision-Making: Constraints and Implications of Balancing Stakeholder Interests. *Journal of Business Ethics*, *64*(3), 286-301.

Rodríguez, C., Langley, A., Béland, F., Denis, J. (2007). Governance, power, and mandated collaboration in an interorganizational network. *Administration & Society*, *39*(2), 150-193.

Roloff, J. (2008). Learning from multi-stakeholder networks: Issue-focused stakeholder management. *Journal of Business Ethics*, *82(*1).

Rose, B.L., Mansour, M., & Kohake, K. (2005). Building a partnership to evaluate school-linked health services: The Cincinnati School Health Demonstration Project. *The Journal of School Health*, *75*(10), 363-369.

Roussos, S.T & Fawcett, S.B. (2000). A Review of Collaborative Partnerships As A Strategy for Improving Community Health. *Annual Review of Public Health*, *21,* 369-402.

Ryan-Nicholls, K.D., & Haggarty, J.M. (2007).Collaborative mental health care in rural and isolated Canada. *Journal of Psychosocial Nursing*, *45*(12), 37-45.

Sanders, D. & Chopra, M. (2006). Key Challenges to Achieving Health for All in an Inequitable Society: The case of South Africa. *American Journal of Public Health, 96*(1), 73-78.

Scott, D. (2007). Resolving the quantitative-qualitative dilemma: a critical realist approach. *International Journal of Research & Method in Education*, *30*(1), 3-17.

Seshadri, S.R. (2003). Constraints to scaling-up health programmes: A comparative study of two Indian states. *Journal of International Development, 15,* 101-114.

Sharp, M. (2006). Enhancing interdisciplinary collaboration in primary health setting. *Canadian Journal of Dietetic Practice and Research, 67,* 4-8.

Shediac-Rizkallah, M.C. & Bone, L.R. (1998). Planning for the sustainability of community-based health programs: conceptual frameworks and future directions for research, practice and policy. *Health Education Research, 13*(1), 87-108.

Siegel, K., Narayan, K.M., V., & Kinra, S. (2008). Finding A Policy solution to India's Diabetes Epidemic. *Health Affairs*, *27* (4), 1077-1090.

Singleton, R. A. & Strait, B.C. (2005). *Approaches to social research* (4th ed.). New York: Oxford University Press.

Silvestre, A., Sue, V.M., & Allen, J.Y. (2009). If you build it, will they come? The Kaiser Permanente Model of online health care. *Health Affairs*, *28*(2), 334-344.

Stefl, M.E., & Bontempo, C.A. (2008). Common competencies for all healthcare managers: The Healthcare Leadership Alliance model. *Journal of Healthcare Management*, *53*(6).

Straub, D., Weil, P., & Schwaig, K.S. (2008). Strategic dependence on the IT resource and outsourcing: A test of the strategic control model. *Information Systems Frontiers*, *10*(2), 195-210.

Stern, R. (2008). Stakeholder theory & Media management: Ethical framework for news Company Executives. Journal of Mass Media Ethics, *23*(1), 51-65.

Tan, D.H.S., Upshur, R.E.G. & Ford, N. (2003). Global plagues and the Global Fund: Challenges in the fight against HIV, TB and malaria. *BMC International Health and Human Rights*, 3.

Teklehaimanot, A., Singer, B, Spielman, A., Tozan, Y., & Schapira, A. (2005). *Coming to grips with malaria in the new millennium*. London: Earthscan.

Trochim, W. K, & Donnelly, J.P. (2007). The research methods: Knowledge base. New York: Thompson Publishing.

UNAIDS 2008 Report

UNDP (2007). Ghana Human Development Report

Umeh, C.N., Essien, E.J., Ezedinachi, E.N., & Ross, M.W. (2008). Knowledge, beliefs and attitudes about HIV/AIDS-related issues, and the sources of knowledge among health care professionals in southern Nigeria. *The Journal of the Royal Society for the Promotion of Health, 128*(5), 233-296.

USAID.gov/about_usaid/usaidhist.html, retrieved 02/10/2009

USAID/ Africa: Health & Family Planning-usaid.gov/locations/sub-

sahara_africa/sectors/health, retrieved 01/10/2009

USAID HIV/AIDS Country Profile for Ghana, September 2008 report.

USAID/Ghana Strategy Statement: Empowering Ghanaians through Partnerships to Build a Prosperous Nation (2006).

USAID Country Health Statistical Report Ghana (2007).

US Census Bureau-International Data Base, retrieved 10/10/2008.

Wampler, J., Frank, D., & Karen, F. (1996). Strategic alliances: An integrated health system alternative. *Frontiers of Health Services Management*, *13*(1), 53-66.

Ware, N.C., Idoko, J., Kaaya, S., Biraro, I.A., Wyatt, M.A., Agbaji, O., et al. (2009). Explaining adherence success in sub-Saharan Africa: An ethnographic study. *PLOS Medicine*, *6*(1).

Webster, J., Hill, J., Lines, J. & Hanson, K. (2007). Delivery systems for insecticide treated and untreated mosquito nets in Africa: Categorization and outcomes achieved. *Health Policy and Planning*, *22*(5), 227-293.

Wechsler, J. (2008). International AID treatment program to lose temporary status. *Pharmaceutical Executive*, *28*(5).

Williams, H.A., Durrheim, D., & Shretta, R. (2004). The process of changing national malaria treatment policy: lessons from country-level studies. *Health Policy and Planning*, *19*(6), 356-370.

Wong, J., Wong, S., Weerasinghe, S., Makrides, L., & Coward-Ince, T. (2005). Building community partnerships for diabetes primary prevention: lessons learned. Clinical *Governance: An International Journal, 10*(1), 6-14.

World Bank Annual Report (2008).

World Bank (2008). *The World Bank's commitment to HIV/AIDS in Africa. Our agenda for action*, 2007-2011. Washington D.C: The World Bank.

World Bank Annual Report (2007)

World Development Report (World Bank, 2009)

World Development Report (World Bank, 2005)

World Health Organization (2009). Global Tuberculosis Control: A short update to the 2009 report. Geneva.

World Health Statistics (WHO, 2007)

World Health Report (2007; 2008)

World Malaria Report, WHO (2007; 2008)

Wyss, K., Moto, D.D., & Callewaert, B. (2003). Constraints to scaling-up health

related interventions: The case of Chad, Central Africa. *Journal of International Development*, *15*(1), 87-100.

Xiao, Y., Kiesler, S., Mackenzie, C. F., Kobayashi, M., Plasters, C., Seagull, F.J. et al. (2007). Negotiation and conflict in large scale collaboration: A preliminary field study. *Cogn Tech Work*, *9* (4), 171-176.

Yin, R. K. (2006). Mixed methods research: Are the methods genuinely integrated or merely parallel? *Research in the Schools*, *13*(1), 41-47.

Yue, A.R. (2008).Acquired disability and returning to work: Towards a stakeholder approach. *Journal of Workplace Rights*, *13*(1), 73-91.

Zakus, J. & Lysack, C. (1998). Revisiting Community Participation. *Health Policy and Planning, 13*(1), 1-12.

Zere, E., Moeti, M, Kirigia, J., Mwase, T., & Kataika, E. (2007). Equity in health and health care in Malawi: analysis of trends. *BMC Public Health*, 7(78).

APPENDIX A: SURVEYS

Community Health Officers Survey

Please respond to the following items about yourself. **Your responses will not be identified with your name**.

Gender:

1. Female
2. Male

Age range:

1. 18-25
2. 26-35
3. 36-45
4. 46-55
5. 55 or older

Highest level of Education:

1. Senior Secondary
2. Nursing School
3. Bachelors Degree
4. Postgraduate(including Masters Degree)
5. Doctorate (PhD, DD, etc)

Number of years of involvement in the CHPS-TA program:

1. Less than 1 year
2. 1-2 years
3. 2-3

4. 3 years or more

Collaboration

Directions: Please rate your level of agreement with the following statements on a scale from one to five by circling the appropriate number. Be sure to give only **ONE** response for each item, circling "3" if you are unsure. Please add any comments relating to your responses in the spaces provided. Read each statement carefully before responding and be sure to check all items.

1 = Strongly Disagree
2 = Disagree
3 = Neither disagree nor agree, or unsure
4 = Agree
5 = Strongly Agree

Introduction: In this study, collaboration is defined as the process of working together with other groups and people on the CHPS program implementation in order to meet the goals of the program.

Q.1 Groups involved in the implementation of the CHPS program are working together towards meeting goals of the program

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about groups working together on the implementation of the CHPS-TA program:

Q. 2 Groups involved in the implementation view the ultimate success of the CHPS-TA program as their collective responsibility

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about collective responsibility of the groups towards the success of the CHPS-TA program:

Q. 3 Roles and responsibilities towards the implementation of the program are shared among the different groups engaged in the program

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about sharing of roles and responsibilities of the groups working on the CHPS-TA program:

Q. 4 Resources and expertise needed for the implementation of the CHPS-TA program are shared towards meeting the goals of the program

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about sharing of resources among the groups working on the CHPS-TA program:

Q.5 There is sufficient coordination of the different roles of the groups, resources, and expertise

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about coordination of activities among the groups working on the CHPS-TA program:

Q. 6 Group members regularly engage in dialogue in the process of working together

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about trust among the groups working on the CHPS-TA program:

Q.7 There is a sense of trust among the groups working on the CHPS-TA program

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree

5 Strongly Agree

Please provide any additional comments you might have about trust among the groups working on the CHPS-TA program:

Q.8 Working with other colleagues from other organizations on the CHPS-TA program implementation has made the implementation process more effective than if it had been done by *ONE* organization

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about how cooperation leads to effective outcomes on the CHPS-TA program:

Q.9 As a CHO, my inclusion in the cooperative work with other groups engaged in the implementation of the CHPS-TA program has enhanced the performance of my duties significantly

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about your inclusion in the implementation process and how it has improved your performance as a Community health Officer:

Participation

Introduction: Participation in this study is the involvement of an individual in the program decision-making. It also includes making inputs or contributions into decisions on the CHPS-TA program

Q.1 There is shared decision-making among all parties towards the implementation of the CHPS-TA

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about shared decision-making among the groups working on the CHPS-TA program:

Q.2 Contributions by all interested parties in decision-making towards the implementation of the CHPS-TA program are considered before final decisions are made

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about the consideration of inputs in decision-making of all groups working on the CHPS-TA program:

Q.3 There is early involvement of all stakeholders in decision-making, at the time the program is being planned

1 Strongly Disagree
2 Disagree
3 Neutral

4 Agree
5 Strongly Agree

Please provide any additional comments you might have about the early involvement of groups working on the CHPS-TA program:

Q.4 Community Health Officers are involved actively in the decision-making process

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about the active involvement of Community Health officers in the decision-making process on the CHPS-TA program:

Q.5 What is your OVERALL view of the effectiveness of the decision-making process on the implementation of CHPS-TA program?

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about your overall view of the effectiveness of decision-making process on the CHPS-TA program:

Q.6 As a CHO, my involvement in the decision-making process has enhanced significantly my effectiveness in the performance of my duties.

1 Strongly Disagree
2 Disagree

3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about your involvement in decision-making on the CHPS-TA program and how it has improved your performance:

Communication

Introduction: Communication in this study means the ease of flow of essential information needed to make decisions on the CHPS-TA program implementation.

Q.1 Quality information to assist effective decision-making for the implementation of the CHPS-TA is shared among groups working on the program (Sharing information for decision-making)

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about the sharing of quality of information and its importance in decision-making on the CHPS-TA program:

Q.2 Sharing of information has resulted in improved cooperation between the various program partners

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about the sharing of quality of information and its importance in decision-making on the CHPS-TA program:

Q.3 Provision of essential information for decision-making was timely, regular, and of high quality

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about the provision of regular and timely information needed for making decision on the CHPS-TA program:

Q.4 Methods used for sharing information on the CHPS-TA were appropriate for all groups

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about the appropriateness of the methods for sharing information among the groups working on the CHPS-TA program:

Q.5 Information was provided to indicate clearly the individual roles and responsibilities of each group working on the CHPS-TA program

1 Strongly Disagree
2 Disagree
3 Neutral

4 Agree
5 Strongly Agree

Please provide any additional comments you might have about the usefulness of information to indicate roles and responsibilities among the groups working on the CHPS-TA program:

Q.6 Feedback on the information that was provided was solicited from all group members

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about feedback from the groups working on the CHPS-TA program:

Q.7 As a CHO, quality information provided to me to assist my decision-making in the implementation of the CHPS-TA improved my effectiveness significantly

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about the extent that quality information you received as a CHO improved your effectiveness:

Members of Participating Organizations Survey

Please respond to the following items about yourself. **Your responses will not be identified with your name**.

Gender:

1. Female
2. Male

Age range:

1. 18-25
2. 26-35
3. 36-45
4. 46-55
5. 55 or older

Highest level of Educational:

1. Senior Secondary
2. Nursing School
3. Bachelors Degree
4. Postgraduate (including Masters Degree)
5. Doctorate (Ph. D, DD, etc)

Number of years in the CHPS-TA program:

1. Below 1 year
2. 1-2 years

3. 2-3

4. 3 years and above

Collaboration

Directions: Please rate your level of agreement with the following statements on a scale from one to five by circling the appropriate number. Be sure to give only **ONE** response for each item, circling "3" if you are unsure. Please add any comments relating to your responses in the spaces provided. Read each statement carefully before responding and be sure to check all items.

1 = Strongly Disagree
2 = Disagree
3 = Neither disagree nor agree, or unsure
4 = Agree
5 = Strongly Agree

Introduction: In this study, collaboration is defined as the process of working together with other groups and people on the CHPS-TA program implementation in order to meet the goals of the program.

Q.1 Groups involved in the implementation of the CHPS-TA program are working together towards meeting goals of the program

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about groups working together on the implementation of the CHPS-TA program:

Q. 2 Groups involved in the implementation view the ultimate success of the CHPS-TA program as their collective responsibility

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about collective responsibility of the groups towards the success of the CHPS-TA program:

Q. 3 Roles and responsibilities towards the implementation of the program are shared among the different groups engaged in the program

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about sharing of roles and responsibilities of the groups working on the CHPS-TA program:

Q. 4 Resources and expertise needed for the implementation of the CHPS-TA program are shared towards meeting the goals of the program

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about sharing of resources among the groups working on the CHPS-TA program:

Q.5 There is coordination of the different roles of the groups, resources, and expertise

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about coordination of activities among the groups working on the CHPS-TA program:

Q. 6 Group members engage in dialogue in the process of working together

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about trust among the groups working on the CHPS-TA program:

Q.7 There is a sense of trust among the groups working on the CHPS-TA program

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about trust among the groups working on the CHPS-TA program:

Q.8 Working with other colleagues from other organizations on the CHPS-TA program implementation has made the implementation process more effective than if it had been done by O*NE* organization

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about how cooperation leads to effective outcomes on the CHPS-TA program:

Participation

Introduction: Participation in this study is the involvement of an individual in the program decision-making. It also includes making inputs or contributions into decisions on the CHPS-TA program

Q.1 There is shared decision-making towards the implementation of the CHPS-TA

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about shared decision-making among the groups working on the CHPS-TA program:

Q. 2 Inputs of all interested parties in decision-making towards the implementation of the CHPS-TA program are considered before final decisions are made

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about the consideration of inputs in decision-making of all groups working on the CHPS-TA program:

Q. 3 There is early involvement of all stakeholders in decision-making, at the time the program is being developed

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about the early involvement of groups working on the CHPS-TA program:

Q.4 Community Health Officers are involved actively in the decision-making process

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about the active involvement of Community Health officers in the decision-making process on the CHPS-TA program:

Communication

Introduction: Communication in this study means the ease of flow of essential information needed to make decisions on the CHPS-TA program implementation.

Q.1 Quality information to assist effective decision-making for the implementation of the CHPS-TA is shared among groups working on the program

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about the sharing of quality of information and its importance in decision-making on the CHPS-TA program:

Q.2 Sharing of information improves the working cooperation

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about the sharing of quality of information and its importance in decision-making on the CHPS-TA program:

Q.3 Provision of essential information for decision-making was timely, regular, and quality

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about the provision of regular and timely information needed for making decision on the CHPS-TA program:

Q.4 Methods used for sharing information on the CHPS-TA were appropriate for all groups

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about the appropriateness of the methods for sharing information among the groups working on the CHPS-TA program:

Q.5 Information was provided to indicate clearly the individual roles and responsibilities of groups working on the CHPS-TA program

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about the usefulness of information to indicate roles and responsibilities among the groups working on the CHPS-TA program:

Q.6 Feedback on the information that was provided was solicited from all group members

1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

Please provide any additional comments you might have about feedback from the groups working on the CHPS-TA program:

APPENDIX B: LETTER OF COOPERATION

Stakeholder Collaboration and USAID funded CHPS-TA health program in Ghana

Ph. D. Candidate: Samuel Kwami Agbanu

Dear Sir or Madam:

I am conducting research on stakeholder collaboration and USAID funded health programs in Ghana, as part of my study towards a doctorate in Applied Management and Decisions Sciences (Leadership and Organizational Change Management) at Walden University. The USAID funded health program (CHPS-TA) was chosen because of the longstanding role the organization has played in quality health delivery in Sub-Saharan Africa in general and Ghana in particular. All research will be conducted by me, Samuel Kwami Agbanu, although some data collection will be done by research assistants. The research will be conducted under the supervision of Dr. Jim Goes of the Walden faculty.

The proposed study will use a descriptive, mixed method design to investigate the nature and extent of collaboration between USAID, Government of Ghana health agencies, Implementing Partners, and Community Health Officers in the design and implementation of the CHPS-TA program. Surveys composed of closed- and open-ended questions will be used to collect data from USAID staff connected to the CHPS-TA program, Ghana Health Service agencies, Population Council and its sub agencies, and Community Health Officers in the Birim North and Kwahu North functional zones in Ghana. Questions in the survey will cover the following areas: collaboration among participants; involvement in program decision-making; sharing of program information; and the efficacy of the Community Health Officers. The survey will be self-administered, with the survey either web based or paper copy delivered to participants by the researcher.

This research has the potential to provide useful results to enhance USAID programs. I would be grateful if you could provide a letter of cooperation in order that I may conduct the study and gain access to USAID partner organizations and archival data.
Thank you very much for your anticipated participation, and if you have any questions about the project, please contact me at (001-973-413-3349) or samuel.agbanu@waldenu.edu.

I promise that the reply and identity of the responses will be treated in strict confidence and will be available only to my research assistants, my faculty assessors, and myself. Any publication thereof will be of statistical nature showing grouped totals of responses.

You are however required to read the following Consent Form, ask questions, and receive answers before you participate in the study.

Original E-mail

From: "Bainson, Kobina" <kbainson@popcouncil.org>
Date: 06/23/2009 08:36 AM
To: Samuel Agbanu <samuel.agbanu@waldenu.edu>
Subject: RE: Letter of Cooperation
Dear Sir/Madam,

Mr. Samuel Kwami Agbanu is a doctorate student doing his thesis in Applied Management and Decisions Sciences (Leadership and Organizational Change Management) at Walden University, USA. Focusing on USAID-funded health programs in Ghana, the study will investigate the nature and extent of collaboration between USAID, Government of Ghana health agencies, Implementing Partners, and local community groups in the design and implementation of the CHPS program.

Population Council, a lead partner in CHPS implementation in Ghana, will collaborate with Mr. Agbanu to execute the research after the Government of Ghana has granted ethical clearance. The Population Council, an international, nonprofit, nongovernmental organization, seeks to improve the well-being and reproductive health of current and future generations around the world and to help achieve a humane, equitable, and sustainable balance between people and resources.

Sincerely,

Dr. Kobina Atta Bainson,

Chief of Party,

Community Health and Planning Technical Assistant Project.

Original E-mail
From: CHARLES SAKYI <sircharles99nl@yahoo.com>
Date: 06/25/2009 01:53 PM
To: Samuel Agbanu <samuel.agbanu@waldenu.edu>
Subject: Re: Request for Participation in survey

Dear Samuel,

Thank you for the interest shown in CEDEP.

We wish to inform you about CEDEP's preparedness to co-operate with you in carrying forward your proposed study so long as it falls in line with the strategic objectives of the Organisation.

We are looking forward to receiving further information on the program and perhaps any further details on whatever assistance you would be needing from CEDEP.

We wish you well in your study.

Thanks and best regards.

Yours sincerely,

CHARLES S. SAKYI
DEPUTY EXECUTIVE DIRECTOR
CEDEP.
+233-244-531552

Original E-mail
From: Richard Killian <RKillian@ghanaqhp.org>
Date: 06/22/2009 06:59 AM
To: Samuel Agbanu <samuel.agbanu@waldenu.edu>, Edward Bonku <Ebonku@ghanaqhp.org>
Subject: RE: Participation in survey

Dear Kwami,

This is to acknowledge our telephone conversations Friday and today, and receipt of your message below and attachment explaining the plans for your PhD study.

Thank you for explaining the steps you've taken in seeking the approval of the ERB for the study.

The Quality Health Partners (QHP) project, which is led by EngenderHealth, will be glad to assist in responding to needs for information that we may be able to provide. In addition to Dr. Bonku, I'm also copying our Senior Manager for Monitoring and Evaluation, Ms. Angela Bannerman, on this message. Please copy both of them on any future correspondences.

With best wishes,
Richard Killian
QHP/EngenderHealth

Original E-mail
From: John Gyapong <John.Gyapong@hru-ghs.org>
Date: 05/23/2009 04:30 PM
To: 'Samuel Agbanu' <samuel.agbanu@waldenu.edu>
Subject: RE: Ethical Clearance for Data Collection

Dear Samuel,
I have attached the requirements for the ethics committee.
In the future please send enquiries to Ms Hannah Frimpong who is responsible for the Ethics Committee. I have copied her on this mail.
Regards
Johnny

++++++++++++++++++++
Professor John O Gyapong
Director
Research and Development Division
Ghana Health Service
P O Box MB-190
Accra, Ghana

Tel: Switchboard: +233 21 679323 or 681109
Tel: Direct: +233 21 681085
Fax: +233 21 226739
Mobile: +233 24 4265081
Email: John.Gyapong@hru-ghs.org
Website: http://www.hru-ghs.org
++++++++++++++++++++++++++

APPENDIX C: CONSENT FORM –PILOT STUDY

Stakeholder collaboration and USAID funded CHPS-TA health program in Ghana.

You are invited to take part in a research pilot study on Stakeholder collaboration and USAID funded health program in Ghana. You were chosen for the study because of your participation in the CHPS-TA program. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part in the study.

This study is being conducted by a Samuel Kwami Agbanu, who is a doctoral student in the School of Management at Walden University.

Background Information:
The purpose of this study is to examine the impact of participation and communication in strengthening collaboration, and how these factors facilitate the effectiveness of Community Health Officers. A USAID funded program, Community-based Health Planning and Services Technical Assistance (CHPS-TA) program, will be used as the focus of the study.

Procedures:
If you agree to be in this pilot study, you will be asked to read and answer a survey that will be delivered to you either in written form or on the web. You will also participate in an audio recorded in depth interview lasting between 30 and 45 minutes. Survey fill out may take the same duration.

Voluntary Nature of the Study:
Your participation in this pilot study is voluntary. This means that everyone will respect your decision of whether or not you want to be in the study. No one at Ghana Health Service, USAID, or Population Council of Ghana or related agencies on the CHPS-TA program will treat you differently if you decide not to be in the study. If you decide to join the pilot study now, you can still change your mind during the study. If you feel stressed during the study, you may stop at any time. You may skip any questions that you feel are too personal.

Risks and Benefits of Being in the Study:
There are no risks associated with participating in this pilot study and there are no direct benefits to participating in the pilot study. However, your participation will play an important role in determining the influence of collaboration on program design and effectiveness, and may help improve health program effectiveness in the future. In the event you experience stress or anxiety during your participation in the study, you may

terminate your participation at any time. You may refuse to answer any questions you consider invasive or stressful.

Compensation:
There will be no compensation provided for your participation in this study

Confidentiality:
Any information you provide will be kept strictly confidential. The researcher will not use your information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in any reports of the study.

Contacts and Questions:
You may ask any questions you have now. If you have questions later, you may contact the researcher by phone (001-973-43-3349), or by e-mail (Samuel. agbanu@waldenu.edu). The researcher's faculty advisor is Dr Jim Goes, (001-541-767-9759, jim.goes@waldenu.edu). If you wish to talk privately about your rights as a participant, you may call Dr. Leilani Endicott (001-800-925-3368). She is the Walden University representative who can discuss this with you. Walden University's approval number for this study is 09-29-09-0356304 and it expires on September 28, 2010.

The researcher will give you a copy of this form to keep.

Statement of Consent:

[ ] I have read the above information and I feel I understand the study well enough to make a decision about my involvement. I consent to participate in this pilot study.

Printed Name of Participant

Date of consent

Participant's Written or Electronic* Signature

Researcher's Written or Electronic* Signature

Please click on this link to access the survey
http://www.surveymonkey.com

CONSENT FORM-STUDY

Stakeholder collaboration and USAID funded CHPS-TA program in Ghana.

You are invited to take part in a research study of Stakeholder collaboration and USAID funded health program in Ghana. You were chosen for the study because of your participation in the CHPS-TA program. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part in the study.

This study is being conducted by a Samuel Kwami Agbanu, who is a doctoral student in the School of Management at Walden University.

Background Information:
The purpose of this study is to examine the impact of participation and communication in strengthening collaboration, and how these factors facilitate the effectiveness of Community Health Officers. A USAID funded program, Community-based Health Planning and Services Technical Assistance (CHPS-TA) program, will be used as the focus of the study.

Procedures:
If you agree to be in this study, you will be asked to read and answer a survey that will be delivered to you either in written form or on the web. You will also participate in an audio recorded in depth interview lasting between 30 and 45 minutes. Survey fill out may take the same duration.

Voluntary Nature of the Study:
Your participation in this study is voluntary. This means that everyone will respect your decision of whether or not you want to be in the study. No one at Ghana Health Service, USAID, or Population Council of Ghana or related agencies on the CHPS-TA program will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind during the study. If you feel stressed during the study, you may stop at any time. You may skip any questions that you feel are too personal.

Risks and Benefits of Being in the Study:
There are no risks associated with participating in this study and there are no direct benefits to participating in the study. However, your participation will play an important role in determining the influence of collaboration on program design and effectiveness, and may help improve health program effectiveness in the future. In the event you experience stress or anxiety during your participation in the study, you may terminate

your participation at any time. You may refuse to answer any questions you consider invasive or stressful.

Compensation:
There will be no compensation provided for your participation in this study

Confidentiality:
Any information you provide will be kept strictly confidential. The researcher will not use your information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in any reports of the study.

Contacts and Questions:
You may ask any questions you have now. If you have questions later, you may contact the researcher by telephone (001-973-43-3349), or by e-mail (Samuel. agbanu@waldenu.edu). The researcher's faculty advisor is Dr Jim Goes, (001-541-767-9759, jim.goes@waldenu.edu). If you wish to talk privately about your rights as a participant, you may call Dr. Leilani Endicott (001-800-925-3368). She is the Walden University representative who can discuss this with you. Walden University's approval number for this study is 09-29-09-0356304 and it expires on September 28, 2010.

The researcher will give you a copy of this form to keep.

Statement of Consent:

[ ] I have read the above information and I feel I understand the study well enough to make a decision about my involvement. I consent to participate in this study.

Printed Name of Participant

Date of consent

Participant's Written or Electronic* Signature

Researcher's Written or Electronic* Signature

Please click on this link to access the survey
http://www.surveymonkey.com

APPENDIX D: INTERVIEW QUESTIONS

Date:

Time:

Interviewer:

Interviewee:

Collaboration

1. Explain the meaning of collaboration or partnership to interviews: Collaboration involves working together; sharing the same goals and objectives of the program and pulling resources, expertise, and functions to achieve it so that all the parties can claim the success.

2. In your view, are all identifiable interested parties involved in the CHPS-TA implementation?

3. How would you characterize the level of cooperation that exists among the groups working on the CHPS-TA program implementation? Do you think all parties are involved in setting the program goals?

4. What key factors do you think strengthen the cooperation?

5. What is the level of interdependence (explain) of roles and responsibilities among the groups working on the CHPS-TA implementation?

6. How are resources shared among the groups? How are skills shared to benefit the entire group? How do you communicate?

7. What are levels of trust and dialogue in the partnership?

8. As a Community Health Officer, how has your involvement with other groups in the CHPS-TA program improved your effectiveness? (APPLICABLE TO ONLY CHOs)

Participation

1. Participation in decision-making is the level to which implementers, regardless of their roles and positions are involved in making decisions on the program. It also includes providing inputs for enriching the decision-making process.

2. How would you characterize the level of participation of groups in the CHPS-TA program implementation?

3. Did the involvement of all identifiable groups in the decision-making process improve the effectiveness of the CHPS-TA implementation? If so, what areas do you think this occurred.

4. Do you think early involvement of all parties in the process is adequate?

5. What was the impact of the collective decision-making on the program implementation effectiveness?

6. As a Community Health Officer, how has your participation in decision-making improved your effectiveness? (APPLICABLE TO ONLY CHOs).

Communication

1. In thinking about essential information needed for decision-making on the CHPS-TA implementation, was the information adequate? Was it quality information? Was it timely, and the right amount of information?

2. Did the information you received improve your decision-making processes?

3. What specific methods were used in sharing essential information? Were they suitable to your particular needs?

4. As a Community Health Officer, how has the quality of information provided to you improved your effectiveness? What of the method used to provide the information? Its timeliness? (APPLICABLE TO ONLY CHOs).

APPENDIX E: CONFIDENTIALITY AGREEMENT

Name of Signer:

During the course of my activity in collecting data for this research: Alfred Abledu will have access to information, which is confidential and should not be disclosed. I acknowledge that the information must remain confidential, and that improper disclosure of confidential information can be damaging to the participant.

By signing this Confidentiality Agreement, I acknowledge and agree that:

1. I will not disclose or discuss any confidential information with others, including friends or family.
2. I will not in any way divulge, copy, release, sell, loan, alter or destroy any confidential information except as properly authorized.
3. I will not discuss confidential information where others can overhear the conversation. I understand that it is not acceptable to discuss confidential information even if the participant's name is not used.
4. I will not make any unauthorized transmissions, inquiries, modification or purging of confidential information.
5. I agree that my obligations under this agreement will continue after termination of the job that I will perform.
6. I understand that violation of this agreement will have legal implications.
7. I will only access or use systems or devices I am officially authorized to access and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

Signing this document, I acknowledge that I have read the agreement and I agree to comply with all the terms and conditions stated above.

Signature: **Date:**

APPENDIX H: SUMMARY OF RESPONSES

Summary of Sampled Study Population and Percentage Responses

	Population size	No. of Responses	Percentage
USAID	2	1	50
Population Council	15	10	67
CEDEP	3	3	100
EngenderHealth	3	3	100
ACNM	1	1	100
Ghana Health Service (Head Office & MOH)	15	13	87
Regional health officers (eastern region)	5	5	100
District health officers (Birim North)	5	3	60
District health officers (Kwahu North)	5	4	80
Subdistrict health officers (Birim North)	5	3	60
Subdistrict health officers (Kwahu North)	5	2	40
Community health officers (Birim North)	9	9	100
Community health officers (Kwahu North)	14	10	71
Total	87	67	77

Summary of Sampled Study Population and Response for Interviews

	Sample	No. Interviewed
USAID	1	-
Population Council	2	2
CEDEP	1	1
EngenderHealth	1	1
ACNM	1	1
Ghana Health Service (Head Office & MOH)	2	2
Regional health officers (eastern region)	1	1
District health officers (Birim North)	1	1
District health officers (Kwahu North)	1	1
Subdistrict health officers (Birim North)	1	1
Subdistrict health officers (Kwahu North)	1	1
Community health officers (Birim North)	2	2
Community health officers (Kwahu North)	2	2
Total	17	16

APPENDIX G: SUMMARY OF DEMOGRAPHIC DATA

Summary of Gender of Respondents of Members of Organizations

	Frequency	Percentage	Valid Percentage	Cumulative Percentage
Female	22	45.8	45.8	45.8
Male	26	54.2	54.2	100
Total	48	100%	100%	

Summary of Gender of Respondents for CHOs

	Frequency	Percentage	Valid Percentage	Cumulative Percentage
Female	13	68.4	68.4	68.4
Male	6	31.6	31.6	100
Total	19	100%	100%	

Overall Summary of Gender of All Respondents

	Frequency	%	Valid %	Cumulative %
Female	35	52.2	52.2	52.2
Male	32	47.8	47.8	100
Total	67	100%	100%	

Summary of Age Range of Members of Participating Organizations

Age range	Frequency	%	valid %	Cumulative %
26-35	4	8.3	8.3	8.3
36-45	15	31.3	31.3	39.6
46-55	23	47.9	47.9	87.5
56 or older	5	10.4	10.4	97.9
No Response	1	2.1	2.1	100
Total	48	100	100%	

Summary of Age Range of CHOs

Age range	Frequency	%	valid %	Cumulative %
18- 25	4	21.1	21. 1	21.1
26-35	7	36.8	36.8	57.9
36-45	3	15.8	15.8	73.7
46-55	5	26.3	26.3	100
Total	19	100	100%	

Summary of Educational Level of Respondents of Members of Organizations

	Frequency	%	Valid %	Cumulative %
Senior Secondary School	3	6.3	6.3	6.3
Nursing School	8	16.7	16.7	22.9
Bachelors (Bachelors in Nursing)	6	12.5	12.5	35.4
Postgraduate (including Masters)	28	58.3	58.3	93.8
Doctorate	2	4.2	4.2	97.9
No response	1	2.1	2.1	100
Total	48	100%	100%	

Summary of Educational Level of Respondents of CHOs

	Frequency	%	Valid %	Cumulative %
Senior Secondary School	-	-	-	-
Nursing School	19	100	100	100
Bachelors (Bachelors in Nursing)	-	-	-	-
Postgraduate (including Masters)	-	-	-	-
Doctorate	-	-	-	-
No response	-	-	-	-
Total	19	100%	100%	

Summary of Number of Years in the Program for Members of Organizations

	Frequency	%	Valid %	Cumulative %
Below 1 year	3	6.3	6.3	6.3
1-2 years	3	6.3	6.3	12.5
2-3 years	9	18.8	18.8	31.3
3 years +	29	60.4	60.4	91.7
No response	4	8.4	8.4	100
Total	48	100%	100%	

Summary of Number of Years in the Program for CHOs

	Frequency	%	Valid %	Cumulative %
Below 1 year	3	15.8	15.8	15.8
1-2 years	3	15.8	15.8	31.6
2-3 years	4	21.1	21.1	52.6
3 years +	9	47.4	47.4	100
No response	-	-	-	
Total	19	100%	100%	

APPENDIX H: FREQUENCIES OF REPONSES

PARTICIPATING OFFICERS

Q1. Groups involved in the implementation of the program are working together towards meeting goals of the program.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	3	6.3	6.3	6.3
	Disagree	4	8.3	8.3	14.6
	Neutral	1	2.1	2.1	16.7
	Agree	22	45.8	45.8	62.5
	Strongly Agree	18	37.5	37.5	100.0
	Total	48	100.0	100.0	

Q2. Groups involved in the implementation view the ultimate success of the program as their collective responsibility.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	2	4.2	4.2	4.2
	Disagree	5	10.4	10.4	14.6
	Neutral	4	8.3	8.3	22.9
	Agree	24	50.0	50.0	72.9
	Strongly Agree	13	27.1	27.1	100.0
	Total	48	100.0	100.0	

Q3. Roles and responsibilities towards the implementation of the program are shared among the different groups engaged in the program.

		Frequency	Percent	Valid Percent	Cumulative Percent

Valid	Strongly Disagree	2	4.2	4.2	4.2
	Disagree	5	10.4	10.4	14.6
	Neutral	3	6.3	6.3	20.8
	Agree	26	54.2	54.2	75.0
	Strongly Agree	12	25.0	25.0	100.0
	Total	48	100.0	100.0	

Q4. Resources and expertise needed for the implementation of the program are shared towards meeting the goals of the program.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	2	4.2	4.2	4.2
	Disagree	7	14.6	14.6	18.8
	Neutral	4	8.3	8.3	27.1
	Agree	22	45.8	45.8	72.9
	Strongly Agree	13	27.1	27.1	100.0
	Total	48	100.0	100.0	

Q5. There is coordination of the different roles of the groups

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	2	4.2	4.2	4.2
	Disagree	6	12.5	12.5	16.7
	Neutral	7	14.6	14.6	31.3
	Agree	23	47.9	47.9	79.2
	Strongly Agree	10	20.8	20.8	100.0
	Total	48	100.0	100.0	

Q6. There is coordination of resources

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	2	4.2	4.2	4.2
	Disagree	5	10.4	10.4	14.6
	Neutral	9	18.8	18.8	33.3
	Agree	21	43.8	43.8	77.1
	Strongly Agree	10	20.8	20.8	97.9
	6.00	1	2.1	2.1	100.0
	Total	48	100.0	100.0	

Q7. There is coordination of expertise and experiences.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	1	2.1	2.1	2.1
	Disagree	5	10.4	10.4	12.5
	Neutral	12	25.0	25.0	37.5
	Agree	19	39.6	39.6	77.1
	Strongly Agree	9	18.8	18.8	95.8
	No responses	2	4.2	4.2	100.0
	Total	48	100.0	100.0	

Q8. Group members engage in dialogue in the process of working together

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	1	2.1	2.1	2.1
	Disagree	2	4.2	4.2	6.3
	Neutral	7	14.6	14.6	20.8
	Agree	22	45.8	45.8	66.7

	Strongly Agree	12	25.0	25.0	91.7
	6.00	1	2.1	2.1	93.8
	No responses	3	6.3	6.3	100.0
	Total	48	100.0	100.0	

Q9. There is trust among the groups working on the program

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	1	2.1	2.1	2.1
	Disagree	5	10.4	10.4	12.5
	Neutral	6	12.5	12.5	25.0
	Agree	20	41.7	41.7	66.7
	Strongly Agree	8	16.7	16.7	83.3
	No responses	8	16.7	16.7	100.0
	Total	48	100.0	100.0	

Q10. Working with other colleagues from other organizations on the program implementation has made the implementation process more effective than if it had been done by ONE organization.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	1	2.1	2.1	2.1
	Disagree	3	6.3	6.3	8.3
	Neutral	8	16.7	16.7	25.0
	Agree	16	33.3	33.3	58.3
	Strongly Agree	17	35.4	35.4	93.8
	No responses	3	6.3	6.3	100.0
	Total	48	100.0	100.0	

Q1. There is shared decision-making towards the implementation of the program

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	1	2.1	2.1	2.1
	Disagree	5	10.4	10.4	12.5
	Neutral	6	12.5	12.5	25.0
	Agree	26	54.2	54.2	79.2
	Strongly Agree	10	20.8	20.8	100.0
	Total	48	100.0	100.0	

Q2. Inputs of all interested parties in implementation of the program are considered before final decisions are made

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	2	4.2	4.2	4.2
	Disagree	10	20.8	20.8	25.0
	Neutral	6	12.5	12.5	37.5
	Agree	23	47.9	47.9	85.4
	Strongly Agree	7	14.6	14.6	100.0
	Total	48	100.0	100.0	

Q3. All identifiable groups or stakeholders are involved in decision-making, at the time the program is being developed.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	3	6.3	6.3	6.3
	Disagree	9	18.8	18.8	25.0
	Neutral	11	22.9	22.9	47.9
	Agree	15	31.3	31.3	79.2

	Strongly Agree	10	20.8	20.8	100.0
	Total	48	100.0	100.0	

Q4. Community Health Officers makes inputs into decisions relating to the implementation of the program.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	4	8.3	8.3	8.3
	Disagree	10	20.8	20.8	29.2
	Neutral	4	8.3	8.3	37.5
	Agree	17	35.4	35.4	72.9
	Strongly Agree	11	22.9	22.9	95.8
	No responses	2	4.2	4.2	100.0
	Total	48	100.0	100.0	

Q5. MY OVERALL view is that the effectiveness of the decision-making process contributes to the success of the implementation of the program.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	3	6.3	6.3	6.3
	Disagree	2	4.2	4.2	10.4
	Neutral	8	16.7	16.7	27.1
	Agree	20	41.7	41.7	68.8
	Strongly Agree	13	27.1	27.1	95.8
	No responses	2	4.2	4.2	100.0
	Total	48	100.0	100.0	

Q1. Information to assist decision-making for the implementation of the program is shared among the groups.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	2	4.2	4.2	4.2
	Disagree	6	12.5	12.5	16.7
	Neutral	3	6.3	6.3	22.9
	Agree	26	54.2	54.2	77.1
	Strongly Agree	7	14.6	14.6	91.7
	No responses	4	8.3	8.3	100.0
	Total	48	100.0	100.0	

Q2. Sharing of information among the group members improves the level of cooperation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	2	4.2	4.2	4.2
	Agree	16	33.3	33.3	37.5
	Strongly Agree	29	60.4	60.4	97.9
	No responses	1	2.1	2.1	100.0
	Total	48	100.0	100.0	

Q3. Provision of essential information for decision-making during the implementation of the program is timely, regular, and quality

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	1	2.1	2.1	2.1
	Disagree	17	35.4	35.4	37.5
	Neutral	10	20.8	20.8	58.3
	Agree	11	22.9	22.9	81.3

	Strongly Agree	7	14.6	14.6	95.8
	No responses	2	4.2	4.2	100.0
	Total	48	100.0	100.0	

Q4. Overall, methods used for sharing information on the program are appropriate for all groups.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	1	2.1	2.1	2.1
	Disagree	10	20.8	20.8	22.9
	Neutral	10	20.8	20.8	43.8
	Agree	15	31.3	31.3	75.0
	Strongly Agree	10	20.8	20.8	95.8
	No responses	2	4.2	4.2	100.0
	Total	48	100.0	100.0	

Q5. Information provided help indicate clearly the individual roles and responsibilities of groups working on the program.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	1	2.1	2.1	2.1
	Disagree	8	16.7	16.7	18.8
	Neutral	6	12.5	12.5	31.3
	Agree	22	45.8	45.8	77.1
	Strongly Agree	10	20.8	20.8	97.9
	No responses	1	2.1	2.1	100.0
	Total	48	100.0	100.0	

Q6. Feed back on the information provided is solicited from all group members

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	2	4.2	4.2	4.2
	Disagree	9	18.8	18.8	22.9
	Neutral	7	14.6	14.6	37.5
	Agree	19	39.6	39.6	77.1
	Strongly Agree	9	18.8	18.8	95.8
	No responses	2	4.2	4.2	100.0
	Total	48	100.0	100.0	

COMMUNITY HEALTH OFFICERS

Q1. Groups involved in the implementation of the program are working together towards meeting goals of the program.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	14	73.7	73.7	73.7
	Strongly Agree	5	26.3	26.3	100.0
	Total	19	100.0	100.0	

Q2. Groups involved in the implementation view the ultimate success of the program as their collective responsibility.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	2	10.5	10.5	10.5
	Agree	10	52.6	52.6	63.2
	Strongly Agree	6	31.6	31.6	94.7
	No responses	1	5.3	5.3	100.0
	Total	19	100.0	100.0	

Q3. Roles and responsibilities towards the implementation of the program are shared among the different groups engaged in the program.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	2	10.5	10.5	10.5
	Neutral	1	5.3	5.3	15.8
	Agree	13	68.4	68.4	84.2
	Strongly Agree	2	10.5	10.5	94.7
	No responses	1	5.3	5.3	100.0
	Total	19	100.0	100.0	

Q4. Resources and expertise needed for the implementation of the program are shared towards meeting the goals of the program.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	1	5.3	5.3	5.3
	Agree	11	57.9	57.9	63.2
	Strongly Agree	6	31.6	31.6	94.7
	No responses	1	5.3	5.3	100.0
	Total	19	100.0	100.0	

Q5. There is coordination of the different roles of the groups

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	3	15.8	15.8	15.8
	Neutral	3	15.8	15.8	31.6
	Agree	9	47.4	47.4	78.9
	Strongly Agree	3	15.8	15.8	94.7
	No responses	1	5.3	5.3	100.0
	Total	19	100.0	100.0	

Q6. There is coordination of resources

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	2	10.5	10.5	10.5
	Disagree	5	26.3	26.3	36.8
	Neutral	1	5.3	5.3	42.1
	Agree	10	52.6	52.6	94.7
	No responses	1	5.3	5.3	100.0
	Total	19	100.0	100.0	

Q7. There is coordination of expertise and experiences.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	5	26.3	26.3	26.3
	Agree	10	52.6	52.6	78.9
	Strongly Agree	3	15.8	15.8	94.7
	No responses	1	5.3	5.3	100.0
	Total	19	100.0	100.0	

Q8. Group members engage in dialogue in the process of working together

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	1	5.3	5.3	5.3
	Neutral	2	10.5	10.5	15.8
	Agree	11	57.9	57.9	73.7

	Strongly Agree	3	15.8	15.8	89.5
	No responses	2	10.5	10.5	100.0
	Total	19	100.0	100.0	

Q9. There is trust among the groups working on the program

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Neutral	4	21.1	21.1	21.1
	Agree	11	57.9	57.9	78.9
	Strongly Agree	3	15.8	15.8	94.7
	No responses	1	5.3	5.3	100.0
	Total	19	100.0	100.0	

Q10. Working with other colleagues from other organizations on the program implementation has made the implementation process more effective than if it had been done by ONE organization.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	1	5.3	5.3	5.3
	Agree	10	52.6	52.6	57.9
	Strongly Agree	7	36.8	36.8	94.7
	No responses	1	5.3	5.3	100.0
	Total	19	100.0	100.0	

Q1. There is shared decision-making towards the implementation of the program

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	3	15.8	15.8	15.8
	Neutral	3	15.8	15.8	31.6
	Agree	10	52.6	52.6	84.2
	Strongly Agree	2	10.5	10.5	94.7
	No responses	1	5.3	5.3	100.0
	Total	19	100.0	100.0	

Q2. Inputs of all interested parties in implementation of the program are considered before final decisions are made

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	3	15.8	15.8	15.8
	Neutral	4	21.1	21.1	36.8
	Agree	7	36.8	36.8	73.7
	Strongly Agree	4	21.1	21.1	94.7
	No responses	1	5.3	5.3	100.0
	Total	19	100.0	100.0	

Q3. All identifiable groups or stakeholders are involved in decision-making, at the time the program is being developed.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	1	5.3	5.3	5.3
	Disagree	4	21.1	21.1	26.3
	Neutral	2	10.5	10.5	36.8
	Agree	9	47.4	47.4	84.2
	Strongly Agree	2	10.5	10.5	94.7

	No responses	1	5.3	5.3	100.0
	Total	19	100.0	100.0	

Q4. Community Health Officers makes inputs into decisions relating to the implementation of the program.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	1	5.3	5.3	5.3
	Disagree	4	21.1	21.1	26.3
	Neutral	1	5.3	5.3	31.6
	Agree	9	47.4	47.4	78.9
	Strongly Agree	3	15.8	15.8	94.7
	No responses	1	5.3	5.3	100.0
	Total	19	100.0	100.0	

Q5. MY OVERALL view is that the effectiveness of the decision-making process contributes to the success of the implementation of the program.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	2	10.5	10.5	10.5
	Agree	14	73.7	73.7	84.2
	Strongly Agree	2	10.5	10.5	94.7
	No responses	1	5.3	5.3	100.0
	Total	19	100.0	100.0	

Q1. Information to assist decision-making for the implementation of the program is shared among the groups.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	2	10.5	10.5	10.5
	Neutral	2	10.5	10.5	21.1
	Agree	12	63.2	63.2	84.2
	Strongly Agree	1	5.3	5.3	89.5
	No responses	2	10.5	10.5	100.0
	Total	19	100.0	100.0	

Q2. Sharing of information among the group members improves the level of cooperation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	2	10.5	10.5	10.5
	Neutral	3	15.8	15.8	26.3
	Agree	9	47.4	47.4	73.7
	Strongly Agree	4	21.1	21.1	94.7
	No responses	1	5.3	5.3	100.0
	Total	19	100.0	100.0	

Q3. Provision of essential information for decision-making during the implementation of the program is timely, regular, and quality

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	1	5.3	5.3	5.3
	Neutral	2	10.5	10.5	15.8
	Agree	13	68.4	68.4	84.2
	Strongly Agree	2	10.5	10.5	94.7
	No responses	1	5.3	5.3	100.0

Q3. Provision of essential information for decision-making during the implementation of the program is timely, regular, and quality

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	1	5.3	5.3	5.3
	Neutral	2	10.5	10.5	15.8
	Agree	13	68.4	68.4	84.2
	Strongly Agree	2	10.5	10.5	94.7
	No responses	1	5.3	5.3	100.0
	Total	19	100.0	100.0	

Q4. Overall, methods used for sharing information on the program are appropriate for all groups.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	2	10.5	10.5	10.5
	Neutral	4	21.1	21.1	31.6
	Agree	11	57.9	57.9	89.5
	No responses	2	10.5	10.5	100.0
	Total	19	100.0	100.0	

Q5. Information provided help indicate clearly the individual roles and responsibilities of groups working on the program.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	2	10.5	10.5	10.5
	Neutral	4	21.1	21.1	31.6
	Agree	11	57.9	57.9	89.5
	Strongly Agree	1	5.3	5.3	94.7
	No responses	1	5.3	5.3	100.0
	Total	19	100.0	100.0	

Q6. Feed back on the information provided is solicited from all group members

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	2	10.5	10.5	10.5
	Neutral	5	26.3	26.3	36.8
	Agree	7	36.8	36.8	73.7
	Strongly Agree	3	15.8	15.8	89.5
	No responses	2	10.5	10.5	100.0
	Total	19	100.0	100.0	

As a CHO, my inclusion in the cooperative work with other groups engaged in the implementation of the program has enhanced the performance of my duties

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Neutral	1	5.3	5.3	5.3
	Agree	7	36.8	36.8	42.1
	Strongly Agree	10	52.6	52.6	94.7
	No responses	1	5.3	5.3	100.0
	Total	19	100.0	100.0	

As a CHO, my involvement in the decision-making process has enhanced significantly my performance

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	1	5.3	5.3	5.3
	Neutral	1	5.3	5.3	10.5

	Agree	13	68.4	68.4	78.9
	Strongly Agree	4	21.1	21.1	100.0
	Total	19	100.0	100.0	

As a CHO, information provided to me to assist my decision-making in the implementation of the program has help improve my performance significantly

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Neutral	2	10.5	10.5	10.5
	Agree	11	57.9	57.9	68.4
	Strongly Agree	4	21.1	21.1	89.5
	No responses	2	10.5	10.5	100.0
	Total	19	100.0	100.0	

Information provided help indicate clearly individual roles and responsibilities of each group working on the program

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	1	5.3	5.3	5.3
	Neutral	2	10.5	10.5	15.8
	Agree	14	73.7	73.7	89.5
	Strongly Agree	1	5.3	5.3	94.7

	No responses	1	5.3	5.3	100.0
	Total	19	100.0	100.0	

APPENDIX J: THEMES

Themes on Collaboration among Stakeholders

Overall Themes	Frequency of Response
Working together	42
Cooperation	10
Collaboration	10
Team	6

Themes on Indicators of Collaboration among Stakeholders

Overall Themes	Frequency of Response
Common ownership of goals	26
Interdependence of roles and responsibilities	16
Diverse expertise & resources	16
Collective decision-making	10
Communication (sharing of relevant information)	10
The nature of the task	9
Benefit of the Program	4
Funding agency requirement	4

Themes on Collective Decision-making among Stakeholders

Overall Themes	Frequency of Response
We meet	21
We discuss	18
Decision-making	10
Dialogue	8
Inputs	8

Themes on Communication among Stakeholders

Overall Themes	Frequency of Response
Communicate	19
Share	18
Information	10

Themes on CHO involvement

Overall Themes	Frequency of Response
Involvement	27
Participation	14
Part of the process	12

CURRICULUM VITAE

SAMUEL. AGBANU
Email: xxxx.xxxx@waldenu.edu

Education

Ph D in Management (Leadership & Organizational Change) - Walden University, 2007-2010.

Master of Business Administration, MBA (PGSM) - Marketing Management Option - 2006

Master of Philosophy (M.Phil) -University of Cape Coast, Ghana-2000

Postgraduate Diploma in Marketing, Chartered Institute of Marketing, UK, 2000

B. A. (Honors) - University of Cape Coast, Ghana-1993

Diploma in Education -University of Cape Coast, Ghana -1993

Teaching Experiences

Adjunct Faculty, Somerset Christian College, Zarephath, NJ –November 2009-date

Adjunct Faculty, Passaic Community College, Continuing Education, Paterson, NJ July, 2009 - present

Faculty/Lecturer, Institute of Management Studies, Accra Ghana -2001-2006

Faculty/Lecturer, Chartered Institute of Marketing Ghana School, Accra Ghana -2000-2005

Faculty/Lecturer, Central University College, Accra Ghana-1999-2000

Assistant Registrar, West Africa Examinations Council-(WAEC) - 1998-1999

Tutor, Eguafo–Abrem Secondary School (Ghana) 1994/5-1998.

Position: Teaching Assistant, University of Cape Coast, Cape Coast, Ghana-1993-1997

Industry Experience

Service Manager: FEDEX, Woodbridge, NJ- June, 2006 to January, 2007.

Role:
Administrative, sales, and leadership oversight over a team of twenty, undertaking transportation and management of customer packages across the United States and other international destinations.
Achieved 5% package breakages and delays when average is 8%. Developed group into workable team meeting all organizational and sectional, and customer goals.
Trained staff and develop personnel requirements
Provided management with inputs for top management decision-making on strategic direction of the company

Chief Manager: Ghana Telecommunication Company (now Vodafone Ghana) -March 2003 to March, 2006. This company is Ghana's national telecommunication leader with millions of dollars in assets.

Role:
Marketing research leader for the launch of broadband internet; interviewed industry experts, designed the research plan; analyzed data, both secondary and primary; provided technical and sales departments with relevant data to assist management decision-making.

Was involved in several marketing research programs that focused on the launch and extension of GT telephone lines, DSL or broadband services, leased lines, and other business-to-business telecommunication products.

Conducted secondary research using available data from the industry for marketing decision-making purposes

Actively involved in product pricing studies for GT's business-to-business products

Developed strategic marketing and sales plans to support these products

Supervised marketing and sales executives

Formulated strategic plans for the reorganization of the company and other departments
Developed and built marketing and sales teams into an innovative group, which led to market expansion and company profitability over a three-year period.

Achieved targeted sales and exceed initial DSL sales of 65% in 2002, and 50% in 2003.
Reduced customer debt holdings by 50%.

Created strategic sales and customer service plans for product launches within the three years.
Trained sales team on customer service techniques and handling of customer complaints etc.

Headed market research teams comprising technical, production, marketing, and communication departments for various market researches, customer surveys, competitor research, customer satisfaction surveys, pricing, and new product launch researches.

Marketing Manager: Internet Ghana Limited- 2000-2003

Role:
Was in charge of all marketing research activities; was the team leader for planning and executing the marketing research activities that resulted in the first ever launch of Digital Subscriber Line (DSL) internet service in Ghana.
Periodically analyzed industry secondary data for IG's strategic positioning
Directed all marketing and sales functions that positioned IG as the leader in internet services during that period
Provided management with needed sales and marketing data for overall management decision-making
Annual evaluation study of IG's products

Assistant Registrar: West African Examinations Council, Accra Ghana, 1998-2000

Role:
Worked as test administrator for senior secondary schools in Ghana.
Supervised many examinations including professional and external ones, directed and liaised with school heads for examination conduct and release of test results.
Conducted exam specific research for improving conduct of examinations
Analysis of examination results for improving subject decision-making in secondary schools