Devolution and Deconcentration in Action

A Comparative study of Five Municipal Health Directorates in Ghana

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I hereby declare that this thesis has not been and will not be, submitted in whole or in part to another University for the award of any other degree.

Signature……..

Date:……..

UNIVERSITY OF SUSSEX

RONALD ADAMTEY

DOCTOR OF PHILOSOPHY

DEVOLUTION AND DECONCENTRATION IN ACTION: A COMPARATIVE STUDY OF FIVE MUNICIPAL HEALTH DIRECTORATES IN GHANA

SUMMARY

Decentralisation policies have been adopted by most countries in Sub-Saharan Africa in the expectation of improved service provision. The benefits expected are two-fold: a) decentralisation will lead to better *coordination* and *collaboration* between different parts of the state at the local level and b) decentralisation will lead to increased *consultation* and responsiveness of local governments to their citizens. In this thesis I seek to explain why these benefits are realised in some contexts and not others. In most parts of Sub-Saharan Africa, the predominant form of decentralisation is a combination of devolution and deconcentration. Often these two policies are ambiguous and sometimes contradictory. What are the processes through which such mixed systems work?

This thesis attempts to understand how mixed systems of devolution and deconcentration work in practice through a comparative study of Five Municipal Health Directorates in Ghana. The study explores the three sets of relationships that are critical for decentralisation to work well in such mixed systems a) between the Health Directorate and the District Assembly administration, b) between the Health Directorate and the elected members of the District Assembly and c) between the Health Directorate and selected civil society organisations working on health. The work is based on detailed qualitative interviews in the five municipalities.

The main finding is that informal ties between the Health Directorate and the three sets of actors mentioned above are helpful in explaining why coordination and consultation seem better in some municipalities than others. Four kinds of ties are found to be important: ethnic/tribal links, family/kinship/neighbourhood relations, political party affiliations, and old-school networks. These ties between Municipal Health Directorates and senior officers of the Municipal Assemblies were found to facilitate Municipal Health Directorates' access to District Assemblies' Common Fund, which was controlled by the Municipal Assemblies. The existence of these ties between Municipal Health Directorates and elected Assembly members of Municipal Assemblies were found to enhance the quality of Municipal Health Directorates' policies and helped to gain public support. Finally, such ties between Municipal Health Directorates and leaders of selected Civil Society Organisations that

mobilised around HIV and AIDS programmes were found to facilitate implementation of Municipal Health Directorates' policies around HIV and AIDS.

The thesis' contribution is that it shows that informal linkages between different local bodies and between local government and civil society organisations seem important for improved coordination and collaboration among various actors, and better consultation with elected representatives of citizens and leaders of CSOs for effective service delivery at the local level.

Dedication

I dedicate this work to my cousin, Mr Peter Defie, and his wife Madam Agnes Prah, who have been the ***pillars*** in my life. A few lines might be helpful to explain why I dedicate the work to them.

They have changed me from a farmer, fisherman, and a hunter into a scholar.

When I completed Middle School in 1984 the thought of furthering my education was out of the question because my mother was so poor that she could not afford to further my education. At the time, I did not know who my biological father was so I did not have a father who would think about educating me beyond the Middle School level.

As a result, I took to midnight hunting, fishing, and farming to survive.

A friendly letter that I wrote to one of my brothers in the city incidentally caught the sight of Mr. Peter Defie. He was so impressed that he felt I could do well in school and become more helpful to humanity if I had the help. With the support of his wife, he offered to help me and sent an emissary with transportation to bring me to him in the city.

Because of them, I am no longer holding a cutlass (machete), fishing nets or a single-barrel gun with a hunter's lamp stuck to my forehead roaming the forests in the middle of the night when everybody is asleep. I am now holding *a scholar's Pen*.

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List of Abbreviations

ABC	Abstinence, Faithfulness, and Condom use
AIDS	Acquired Immune Deficiency Syndrome
APPP	Africa Power and Politics Programme
ART	Antiretroviral therapy
BLDS	British Library for Development Studies
BMC	Budget Management Centre
BV	Beauty in Virginity
CEPRESE	Centre for Policy Research and Social Engineering
CHPS	Community Health Planning and Services
CRC	Constitutional Review Commission
CSD	Centre for Sustainable Development
CSO	Civil Society Organisation
DACF	District Assemblies Common Fund
DANIDA	Danish International Development Assistance
DCO	Disease Control Officer
DDNS	Deputy Director of Nursing Services
DFID	Department for International Development
DHMT	District Health Management Team
FUGI	Future Generations International
GAC	Ghana AIDS Commission
GETFund	Ghana Education Trust Fund
GoG	Government of Ghana
HIPC	Highly Indepted Poor Country
HIRD	High Impact Rapid Development
HIV	Human Immunodeficiency virus
HMA	Ho Municipal Assembly
HMHD	Ho Municipal Health Directorate
IDS	Institute of Development Studies
IMF	International Monetary Fund
MA	Municipal Assembly
MCD	Municipal Coordinating Director
MCE	Municipal Chief Executive
MCH/FP	Maternal and Child Health and Family Planning
MDGs	Millennium Development Goals
MDHS	Municipal Directorate of Health Services
MLGRD	Ministry of Local Government and Rural Development

MMDAs	Metropolitan, Municipal and District Assemblies
MoH	Ministry of Health
MP	Member of Parliament
MPO	Municipal Planning Officer
MSSD	Most Similar Systems Design
MTDP	Medium Term Development Plan
NCCE	National Commission for Civic Education
NDC	National Democratic Congress
NGO	Non governmental organization
NHIS	National Health Insurance Scheme
NJMA	New Juaben Municipal Assembly
NJMHD	New Juaben Municipal Heatlh Directorate
NMP	New Public Management
NPP	New Patriotic Party
OMA	Obuasi Municipal Assembly
OMHD	Obuasi Municipal Health Directorate
PHC	Primary Health Care
PHN	Public Health Nurse
PLWAs	People Living with HIV/AIDS
PM	Presiding Member
PMCT	Prevention of Mother to Child Transmission
PNDC	Provisional National Defence Council
PPMED	Policy Planning Monitoring and Evaluation Department
RCC	Regional Coordinating Council
RDCs	Resident District Commissioners
RDHS	Regional Directorate of Health Services
SAP	Structural Adjustment Programme
SIF	Social Investment Fund
SMA	Sunyani Municipal Assembly
SMHD	Sunyani Municipal Health Directorate
SSF	Social Support Foundation
TB	Tuberculosis
TMA	Techiman Municipal Assembly
TMHD	Techiman Municipal Health Directorate
TTC	Techiman Traditional Council
USA	United States of America
USAID	United States Agency for International Development

WAPCAS	West African Programme for Commercial Sex Workers Assistance And Support

Chapter 1

Introduction

1.1 My inspiration for this research

The inspiration for this research came from my experience as Assistant Development Planning Officer of the Ga District Assembly, Amasaman in the Greater Accra Region of Ghana over a decade ago.[1] I performed a wide range of duties including preparing development plans, recording minutes during general Assembly meetings, and writing speeches for the District Chief Executive.[2] I also had responsibility for the transport office when the transport officer travelled.

I was intrigued by the difference between the official and unofficial rules for allocation of transport. The release of the Assembly's vehicles to heads of decentralised departments such as education, agriculture, and health was governed by the Local Government Act (Act 462 of 1993). Normal practice was for department heads to write a letter requesting a vehicle to the District Chief Executive, copied to the Transport Officer. The Chief Executive's approval for the release of vehicle was based on the Transport Officer's determination. In most cases, the Chief Executive would approve on condition that the requesting officer would fuel the vehicle, and 'smile' the driver.[3]

I noticed that the Director of Health Services had easy access to the Assembly's vehicles. In addition, health issues considered at general Assembly meetings readily received the approval of the Presiding Member, the Chief Executive, District Coordinating Director, and

[1] The Ga District was one of the 3 administrative districts that constituted the Greater Accra Region at the time. The national capital, Accra, is located in the Greater Accra Region. Throughout this study I will use the phrase 'District Assembly' and 'the Assembly' interchangeably. The District Assembly is made up of two major groups. The first group comprises Executive Officers (the District Chief Executive, District Coordinating Director, District Planning Officer, District Budget Officer and the supporting staff). The second group is made up of Elected and Government Appointed Assembly members.

[2] The District Chief Executive is the head of the Assembly appointed by the President of Ghana. He is the Mayor of the District.

[3] A term used within the Assembly to mean that a senior officer will tip a junior officer or buy lunch for him or her.

most Assembly members.[4] During this period the Director of Agriculture did not enjoy the same level of support from the Assembly or transport department and I wondered why.

Discussions I had with senior staff revealed that the Chief Executive and the Health Director were good friends and were members of the same political party (the National Democratic Congress (NDC)), while the head of Agriculture Department was not a friend and belonged to the opposition party (the New Patriotic Party (NPP)). The existence of informal ties appeared to influence the allocation of resources and this sparked my interest in how they could facilitate or undermine improved service delivery within the decentralised system in Ghana.

I saw the way in which strong informal relationships such as ethnic or tribal links, family, kinship or neighbourhood relations, political party ties and old-school networks could facilitate the work of public officers in a variety of public organisations as they collaborated in their efforts to deliver effective and responsive services to the poor. I also observed that informal ties at the local level had the power to undermine the efficient and effective use of resources even where formal legal and institutional arrangements existed for the coordination and effective delivery of services by different state institutions.[5]

This thesis attempts to understand how informal relationships operate in mixed systems of devolution and deconcentration through a comparative study of Five Municipal Health Directorates in Ghana. The study explores the three sets of relationships that are critical for decentralisation to work well in such mixed systems a) between the Health Directorate and the District Assembly administration, b) between the Health Directorate and the elected members of the District Assembly and c) between the Health Directorate and civil society organisations working on health. The work is based on detailed qualitative interviews in the five municipalities. The main finding is that four kinds of informal ties between the Health Directorate and the three sets of actors mentioned above are helpful in explaining

[4] The Presiding Member is the Speaker of the General Assembly.
[5] In this study, the 'local level' is the 'Municipal level'. This is important as the term "local" level can mean different things to different people in various countries (Appiah 2005: 17).

why coordination and consultation seem better in some municipalities than others. These are ethnic/tribal links, family/kinship/neighbourhood relations, political party affiliations, and old-school networks.

This is how I organise this chapter. Following my inspiration for this research, I will describe decentralisation in Ghana with a focus on expectations of the decentralisation reforms. This discussion covers the devolved Assemblies and deconcentrated Health Directorates. I then point out conflicts in the decentralisation system with specific reference to the two major legal frameworks under which decentralisation reforms have been implemented, these are the Local Government Act 462 of 1993, and the Ghana Health Service and Teaching Hospitals Act 525 of 1996. The conflicts in the legal arrangements manifest in challenges of collaboration and coordination between the Assemblies and the Health Directorates. I therefore discuss problems of compliance with central government directives for the utilisation of the District Assemblies' Common Fund which is one area where there are problems with coordination and collaboration, and therefore the focus of this study. After this, I present an overview of existing studies on the District Assemblies and the Health Directorates and point out gaps in these studies. I then present my research questions, the approach I adopt for this study and the key arguments of the thesis.

1.2 Decentralisation in Ghana: Devolution and Deconcentration

The Ghanaian decentralisation reforms were made in the expectation that decentralisation would a) promote collaboration and coordination between decentralised institutions (World Bank 2004; Oxhorn 2004; Saito 2003; Oyugi 2000; Republic of Ghana 1993b; 1996a), and b) encourage consultation with citizens, whose lives are affected by policy decisions, to participate in shaping the outcomes of policy (Olowu 2006; Olowu and Wunsch 2004; World Bank 2004; Rondinelli 1981; 1983a; 1983b; 1990a; 1990b; Smith 1985; Maddick 1963).

The two areas subject to reform were local government and healthcare although they were decentralised in different ways 'devolution' for local government and 'deconcentration' for

healthcare. These terms are explained in more detail in chapter 2.In Ghana there are two separate pieces of legislations under which healthcare decentralisation has been implemented (Ayee 2008b; Sakyi 2007). The Local Government Act 462 of 1993 devolves healthcare delivery to District Assemblies by virtue of the fact that they are the main political authority at the local level. The second law, the Ghana Health Service and Teaching Hospitals Act 525 of 1996, deconcentrates healthcare delivery to Health Directorates at the local level.

1.2.1 Devolution and Local Government in Ghana

Local government systems had been in existence in Ghana throughout the colonial period and post-independence era (Inanga and Osei-Wusu 2004). In 1989 the Provisional National Defence Council regime, under the populist government of Jerry Rawlings, gave a new face to decentralisation and local government in a way that attracted a lot of interest of Ghanaians who began to actively participate in the governance process of the country (Singleton 2006).

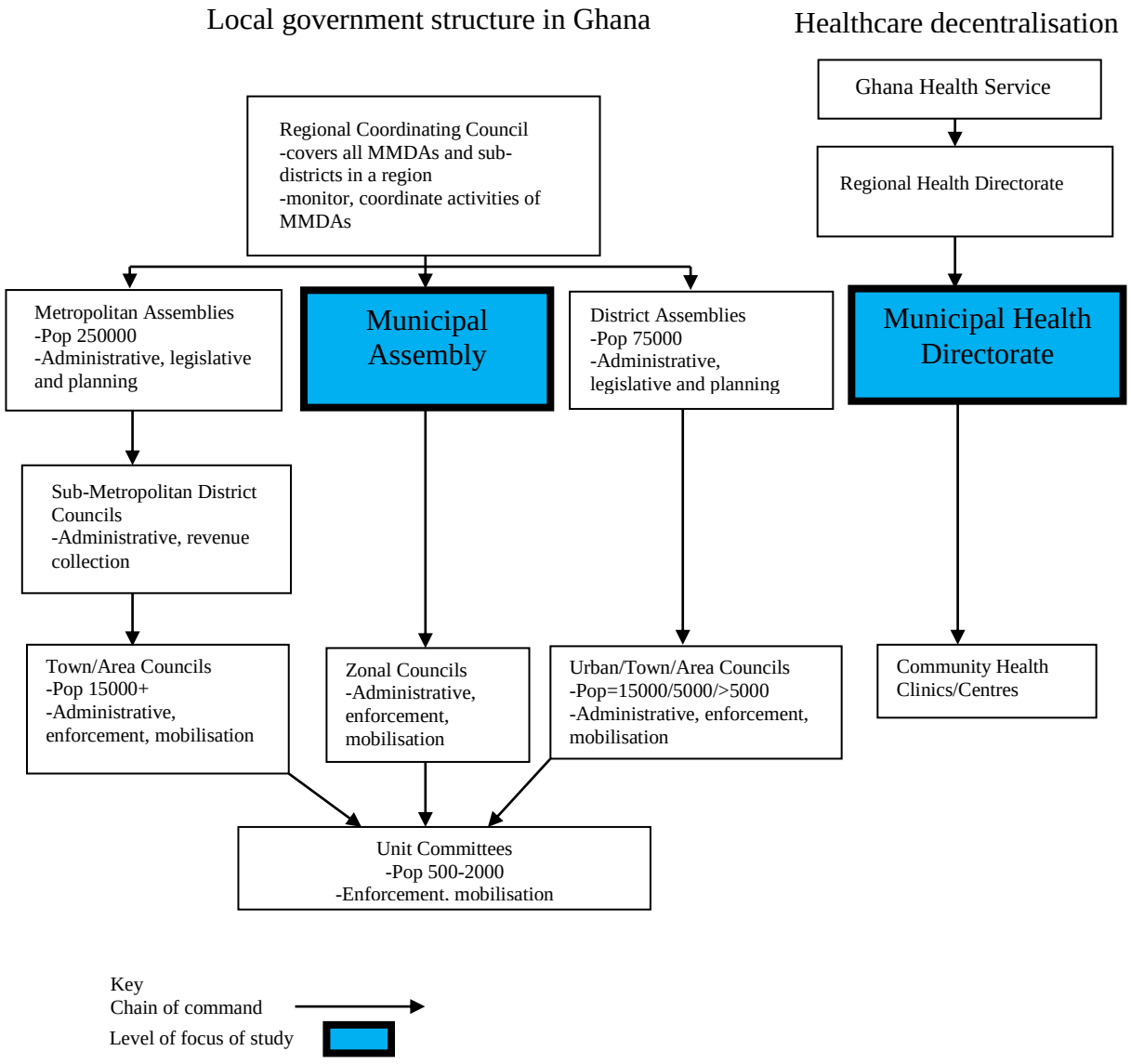
At the time of conducting this research there were 10 administrative regions in the country.[6] For each administrative region a Regional Coordinating Council (RCC) forms the highest political authority (see Figure 1). Each administrative region is further divided into districts for which the RCCs have responsibility for monitoring, coordinating and evaluating the overall performance of the districts.

At the district level the District Assembly is the main political authority (Republic of Ghana 1992; 1993b) and depending on the population, it may be termed a District (population of 75,000), Municipality (population of 95,000), or Metropolitan Assembly (population of 250,000 and more) (see Figure 1).[7] The Assemblies are the planning authorities which have overall responsibility for the development of areas under their

[6] There are debates to split a number of large regions for the purposes of administrative ease.
[7] Municipal Areas are further divided into a number of Zonal Councils which are also divided into several sub-District structures (Unit Committees). For the District Assemblies, they are divided into Urban/Town/Area Councils with the Unit Committees at the bottom (refer to Figure 1). The Unit Committees serve as rallying points of local support for the development objectives of the Assemblies.

jurisdiction (Republic of Ghana 1993b). They are responsible for the general economic and social development of the district. They are also in charge of the development of basic infrastructure and provide municipal works and services.

Figure 1: Local government structure and healthcare decentralisation



Sources: Republic of Ghana (1993b); and PPMED (Ghana Health Service), April 2009

In accordance with the local government system, in principle, the Assembly should have power over all decentralised departments which would include Health Directorates (see First Schedule, Section 38 of Act 462) (Republic of Ghana 1993b). Section 10 (1) of Act 462 provides that a District Assembly shall exercise political and administrative authority in the district; provide guidance; give direction to, and supervise *all other administrative authorities in the district*. This implies that the Health Director should be under the authority of the Chief Executive. In practice however this does not seem to be the case as is explained in the following sections.

1.2.2 Deconcentration of Healthcare delivery in Ghana

Till the 1980's healthcare delivery in Ghana was fairly centralised. To understand the rationale and implications of deconcentration of healthcare in Ghana a brief history of the role of public health in the country would be useful.

Healthcare delivery during the colonial period focussed more on curative than preventive healthcare (Senah 2001). When Ghana gained independence in the late 1950s, the existing healthcare system had seven important features: (i) the principle of cost-sharing, (ii) largely curative and urban oriented, (iii) central government as the largest provider of health service, (iv) subordination of indigenous healing systems to Western medicine, (v) a disadvantaged north in the provision of health infrastructural services, (vi) health outcome of life expectancy of 48 years, and (vii) infectious and parasitic diseases took a heavy toll on the life of children and adults (Senah 2001: 84). These characteristics of the health system left by the colonial administration have not changed much since then (Oppong and Hodgson 2010; Witter et al. 2007; Buor 2003; Asenso-Okyere et al. 1998; Asenso-Okyere 1995).

Currently healthcare in Ghana is provided by both public and private hospitals, clinics and health centres. About 92 per cent of urban residents have access to healthcare and in the

case of rural dwellers it is 45 per cent.[8] Over 60 per cent of the population depends on public healthcare which has until recently focused on curative health.

Comparatively, public health facilities are poorly equipped in terms of human capacity and modern medical technology. Salaries are low and the incentive to work is not attractive enough for health workers so many health professionals choose to work in the private health sector or migrate outside the country (Agyepong et al. 2004; Agyepong 1999; Asenso-Okyere et al. 1998).

Private providers of health services are made up of four sub-groups: Non Governmental Organisations (NGOs) with a focus on public health services such as family planning and HIV and AIDS education awareness (Kyerekoh et al. 2002), missions or religious groups, for instance the Roman Catholic Church, the Islamic or Ahmadiya Mission, and the Presbyterian Church, these provide both preventive health and curative services. The third sub-group is the private for profit providers which mainly provide curative care. The last sub-group comprises traditional medical practitioners who also provide mainly curative care. Generally, the private health facilities provide better quality service as they are better equipped, they also pay better salaries and incentives such as better housing for their staff; consequently they are able to attract skilled staff.

The problems experienced by Ghana's healthcare system range from underfunding[9] to institutional inadequacies (Sakyi 2007; Larbi 1998; Asenso-Okyere 1995; Cassels and Janovsky 1992). The effect of inadequate funding as a consequence of the economic crises that hit the country in the late 1970s, coupled with inefficient use of available resources has been the delivery of poor health services. The response of the government in the early

[8] Accessibility is defined as living within one hour travel time by any means from health facility (Republic of Ghana 2002c).

[9] The government has had difficulty in funding the health sector and therefore relies heavily on donor support. Waddington (1992) has shown that the level of donor funding has risen from about £3m in 1984 to over £11m in 1990. This constitutes an average of 45 per cent of total government health budget. Additionally the Ghana Health Service (2005a) shows that the proportion of national health budget earmarked from donor sources is over 60 per cent in 2001; 50 per cent in 2003; and 45 per cent in 2004. All these flows are not adequate to sustain health care for the entire population.

1980s which was driven by World Bank and International Monetary Fund (IMF) conditions was to reform the health sector as part of general public sector reform under a Structural Adjustment Programme (SAP) (Akonor 2006; Singleton 2006; Amponsah 2001; Oppong 2001; Boafo-Arthur 1999). A number of reforms were therefore implemented from the mid 1980s through to the 1990s. Major changes were a shift of emphasis from curative to preventive health care;[10] a shift from user fees to health insurance in healthcare financing;[11] and decentralisation of health care delivery (Republic of Ghana 2006c).

Healthcare delivery has been administratively decentralised within Ghana's local government system[12] since the mid 1980s. It involved a transfer of administrative authority for health service delivery from the central Ministry of Health (MoH) to Regional, Metropolitan, Municipal and District Health Directorates (refer to Figure 1) with the intention to make health services more responsive to local health needs (Republic of Ghana 1993a). In tune with the New Public Management (NPM) approach, a Ghana Health Service was established by Act 525 of 1996 as an autonomous executive agency charged with responsibility for implementing national health policies under the direction of the Minister of Health. The responsibilities range from preventive, curative, restorative, and promotional care at the regional, district, sub-district, and community levels. The Ghana Health Service as a public service body receives public funds but its public sector employees are not part of the civil service. The Municipal Health Directors do not follow civil service directives, rules and procedures as they deliver health care at the decentralised

[10] The approach to healthcare now emphasises preventive care where communities take steps to reduce and prevent the occurrence of common diseases (Republic of Ghana 2001a; 2004c). In order to minimise the occurrence of diseases, a major component of the preventive health policy is devoted to the implementation of a programme of Community-Based Health Planning and Services (CHPS) across the country (Nyonator et al. 2003) The CHPS programme seeks to bring health workers and local people close together to work to prevent diseases (Ghana Health Service 2005c).

[11] A National Health Insurance Scheme (NHIS) has been introduced with the passage of the National Health Insurance Regulations (L.I. 1809) in 2004 to replace the user fee policy. This shift is to address the problem of limited access to healthcare as most poor people could not afford to pay under the user fee which is popularly known by Ghanaians as 'cash-and-carry' which was introduced in mid 1980s (Republic of Ghana 2003b; 2004b; Abbey 2003; Nyonator and Kutzin 1999). At the time of the introduction of the NHIS in 2004 about 80 per cent of the people resident in Ghana could not afford to pay out-of-pocket at the point of service use (Witter and Garshong 2009; Witter et al. 2007; Republic of Ghana 2004a; Waddington and Enyimayew 1989).

[12] This comprises the District, Municipal, and Metropolitan Assemblies (refer to Figure 1).

levels. According to the Ghana Health Service (2008), this autonomy is aimed at providing healthcare managers a greater degree of managerial flexibility to work at the lower levels in the districts.[13] This flexibility could not be achieved if the Health Service worked within the civil service rules.

In line with the decentralisation programme, there are 10 Regional Health Administrations (regional level) and 170 District Health Administrations (district level) and several Sub-district health offices. This means that District, Municipal and Metropolitan Health Directorates exist at the same levels as District, Municipal and Metropolitan Assemblies (Republic of Ghana 2006b) (refer to Figure 1). The District Director of health is formally responsible for the implementation of the policies and decisions of the Ghana Health Service Council. He is answerable to the Director-General through the Regional Director of Health Services in respect of health matters and to the District Chief Executive on matters relating to administration (Republic of Ghana 1996a).

1.3 Conflict within the decentralised system

A basic structural conflict was created by Act 462 and Act 525, neither of which defines how the Assemblies and the Health Directorates should work together. Act 462 makes the Chief Executive the overall head of the Assembly but Act 525 does not address how the Health Director should report to the Chief Executive. This is due to a lack of clear distinction between the terms "health matters" and "matters relating to health administration" as stated in Act 525 (Republic of Ghana 1996a: 13). As a result most District Directors of Health tend to hold strong allegiances to their Regional Directors particularly as the Ministry of Health is their main source of funding.

The enactment of the Local Government Service Act (Act 656) of 2003 does not appear to have made the attempt to effectively address these structural and legal contradictions between Acts 462 and 525. The Act 656 focuses more on how the Regional Coordinating

[13] http://www.ghanahealthservice.org/aboutus.php?inf=Background (accessed on 06.08.08)

Councils (RCCs) and District Assemblies (DAs) work with relatively weak reference to the Health Directorates or Act 525 in that sense, this is evidenced from the ways in which various sections of Act 656 make reference to the Health Directorates or provisions in Act 525 (see Republic of Ghana 2003c); these are:

- Section 4(e) which states that the Local Government Service Council shall "assist the Regional Coordinating Councils and the District Assemblies in the performance of their functions under the Local Government Act, 1993, (Act 462), the National Development Planning (Systems) Act, 1994, (Act 480) and under any other enactment;
- Section 5(c), the "governing body of the Service is the Local Government Service Council. The Ghana Health Service shall be represented on the Council by one person";
- Section 6(j), "The Council shall have general management and control of the Service and shall work in consultation and close co-operation with other services of the public service;
- Section 15(6)(c), "Establish, with the approval of the Council, systems for effective interservice and sectoral collaboration and co-operation between the Service, the Education Service, the Health Service, the Forestry Service and any other Services, to harmonise local government programmes and avoid duplication; and
- Section 23(1) which states that "the departments of a District Assembly, shall be headed by heads of department of the District Assembly who shall be responsible for the efficient and effective performance of the functions and responsibilities assigned to the departments", and (2) which also provides that "the heads of departments are answerable to the District Chief Executive through the District Co-ordinating Director."

The various provisions fail to harmonise the conflicts in Acts 462 and 525. In fact, apart from the provisions in Section 15(6)(c), which seeks to set the basis for collaboration between the Health Directorate and the District Assembly, Section 23(1) and (2) appear to perpetuate the existing contradictions as it is unclear as to how the autonomy granted the

heads of the decentralised departments of the District Assembly under Section 23(1) is to be exercised with respect to the chain of authority, command and reporting system under Section 23(2), given that the Health Directorate remains strongly aligned to the Ghana Health Service through the Regional Director of Health under Act 525.

Consequently, and in spite of the fact that healthcare delivery has been devolved to the Assemblies, in practice the Health Directorates wield a lot of influence mainly as they appear to be independent from the Assemblies' budget controls (Crawford 2010; Bossert and Joel 2002).

Another potential reason for conflict between the Health Directorates and the Assemblies is that of all the decentralised departments, the Health Directorates appear to maintain a strong allegiance to their ministry. In addition, the Health Directorates control a part of the health budget beyond the control of the District Assemblies (Crawford 2010; 2009; Cassels and Janovsky 1992).

The nature of Ghana's local government system and decentralised healthcare implies that a mixture of devolution and deconcentration should operate simultaneously under two conflicting legal and institutional provisions (Ayee 2008a; 2008b; Sakyi 2007; Mayhew 2003). This combination of devolution and deconcentration with conflicting institutional and legal arrangements characterised by unclear definition of roles among the key actors is not uncommon in Africa (Chikulo 2004; Jeppsson et al. 2003; Oyugi 2000; Mutizwa-Mangiza and Conyers 1996).

1.4 The District Assemblies' Common Fund

An example which illustrates the difficulty involved in implementing directives is the District Assemblies' Common Fund (DACF). The DACF was provided for under Section 252 of the 1992 Constitution. "The section requires Parliament to make provision annually for the allocation of not less than five per cent of the total revenues of Ghana to the District Assemblies for development and the amount paid into the District Assemblies Common

Fund" (Ayee 1995: 297). The law instructs the Assemblies to collaborate with the Health Departments and allocate part of the DACF to the Health Directorates for HIV and AIDS programmes.[14]

Section 9 of the District Assemblies' Common Fund Act (Act 455) of 1993 empowers the Minister of Finance, in consultation with the Minister for Local Government and Rural Development, to specify how the Assemblies expend the Fund (Republic of Ghana 1993c). In line with the implementation of the directive, the Minister of Finance and the Minister of Local Government and Rural Development directed all Assemblies to focus their share of the Fund in two areas: health and education (Ayee 1995). This was implemented in 1994. But as noted by Ayee (1995: 301):

> The history of Ghana is replete with measures which were meant to be temporary but become permanent. The directives to the Assemblies certainly seem likely to become a permanent feature of the District Assemblies' Common Fund, especially since the Act establishing the District Assemblies' Common Fund stipulates that no expenditure from the fund may be made without the consent of the Minister of Finance acting in consultation with the Minister of Local Government.

The directive has become permanent as Ayee (1995) predicted. Under the directives in force at the time of conducting this research, one per cent of the fund is to be devoted to HIV and AIDS programmes. Many Assemblies however have had difficulty complying with these directives and enforcement by central government appears to be ineffective.[15]

It would seem logical that the conflicts in the legislation would prevent effective collaboration between the District Assembly responsible for funding the programmes and the Health Directorates responsible for managing the programmes. However, this has not always been the case and, just as I observed personally, there has been some cooperation between the two organisations leading to successes with HIV and AIDS programmes.

[14] The *DACF* and *the fund* will be used interchangeably in this study.

[15] Apart from problems with collaboration and coordination between the Municipal Assembly and the Health Directorate around the DACF, other routine administrative coordination activities between them seem to have broken down. For example, the District Health Management Teams which are supposed to be one of the formal platforms for the two institutions to collaborate appeared to be weak. Many of the DHMTs did not have representatives from the Assemblies and Civil Society Organisations and were therefore only constituted by health officials.

Given the lack of clear direction within the formal provisions of the legislation the reasons for this success require further exploration.

1.5 Overview of studies on District Assemblies and Health Directorates.

In an effort to understand why the relationship between the two organisations would sometimes work in spite of the weaknesses in the formal systems I turned to the literature pertaining to the District Assemblies and also decentralisation in general.

None of the Ghanaian studies investigated the way in which devolved Assemblies collaborated and coordinated service delivery efforts with other deconcentrated stakeholders. Much of the work on decentralisation in Ghana by scholars such as Abbey et al. (2010)[16], Awortwi (2010a; 2010b); 2010c; Crawford (2008); Inanga and Osei-Wusu (2004); Ayee (1986; 1995); Crook and Manor (1998); and Crook (1994) focused on other aspects of District Assemblies and their performance. For example the work by Crook (1994) analyses the relationship between decentralisation, democratisation, and performance of District Assemblies. He shows that Assemblies were not responsive enough to the needs of most people, and argues that the factors that might explain poor performance are a) excessive control over staff and finances by central government; b) clash between national policies of retrenchment and power of central government agents; and c) the non-partisan nature of Assemblies. All these "weaken their legitimacy to assert their authority over tax collection mainly due to unresolved contradictions between notions of community based self-help, voluntarism, and representative district authority" (Crook

[16] Abbey et al. (2010) focus on the processes of empowering civil society to play a role in promoting accountability around the utilisation of the fund. They argue that in spite of the fact that civil society had a role to play in the formulation of budgets, implementation, monitoring and evaluation of public expenditure; the impact of Civil Society Organisations (CSOs) in these areas is not yet felt in Ghana. Their argument was informed by what they refer to as weaknesses in the administration of the fund to include: delays in allocation and disbursement to District Assemblies; lack of transparency in selecting projects/contract awards; central government interference in the use of the fund; weaknesses in the formula for the allocation of the fund; and non-consultation of community members in the selection of DACF projects. They make a case for CSOs to "trace the flow of resources from origin (the Consolidated Fund) to destination (i.e. to the District Assemblies) and determine the location, scale, and anomalies (if any) of disbursed funds" (Abbey et al. 2010: 76).

1994: 339). He does not address the issue of cooperation with other decentralised departments.

Scholars who did focus on the Assembly appeared to assume that Assemblies would perform well if issues of finance and central government interference were resolved (see for example Crawford 2009; Inanga and Osei-Wusu 2004; Ayee 1986; 1995; Crook and Manor 1998; and Crook 1994). However, having funds available to the Assemblies does not necessarily mean that they will reach the target population as intended. For example, Abbey et al. (2010) do not track the distribution of DACF by the District Assembly to other destinations such as health services in any depth and overall the disbursement of funds at the local level has not received adequate attention. This is one area of research which could improve our understanding of collaboration and coordination between the devolved Assemblies and deconcentrated Health Directorates.

In terms of research into the decentralisation of healthcare, much of the work has concentrated on analysis of issues of health financing, and how the capacity of Health Directorates at the local level affects healthcare delivery (Witter and Garshong 2009; Sakyi 2007; Agyepong 1999; Larbi 1998; Coleman 1997; Asenso-Okyere 1995; Cassels and Janovsky 1992; Waddington and Enyimayew 1989).[17] Whilst these scholarly works provide insight into when Assemblies are able to effectively deliver basic services and highlight some of the conditions that may explain when Health Directorates can also do so they do not tackle the issue of collaboration between departments.

1.6 Key Research Questions

Decentralisation has been promoted widely as a way to improve resource allocation, encourage the participation of citizens in the decision making process, enhance governance and improve service delivery. Yet there is evidence to suggest that the impact of

[17] The focus has been on the implementation of user charges and associated challenges, and debating the experiences of implementation of the health insurance scheme as a means to increase access to health care.

decentralisation on services is mixed (Oyugi 2008a; 2008b; Conyers 2007; Grindle 2007a; 2007b; Awortwi 2010a; 2010b; 2010c; Awortwi et al. 2010). In certain contexts, decentralisation has had a positive impact (Ayee 1997; Crook and Manor 1998; UN-HABITAT 2002; Crook and Sverrisson 2003; Kiyaga-Nsubuga 2004; Faguet 2006) but there are instances where it has led to elite capture and inequities in service provision (Shah and Thompson 2004; Ahamad et al. 2005; Robinson 2007a; 2007b; Awortwi 2010a; 2010b; 2010c; Awortwi et al. 2010).

As countries throughout the developing world adopt decentralisation policies, there is an increasingly urgent need to understand the conditions under which decentralisation leads to improved service delivery and one of the areas which has received insufficient attention is the way in which informal ties may prompt cooperation between departments.

This research explores the question *what is the role of informal ties in promoting collaboration and coordination between devolved Assemblies and deconcentrated Health Directorates, and consultation with civil society groups that mobilise around HIV and AIDS campaigns by Health Directorates?* To explore this question, I sought answers to three interrelated questions around informal ties between different parts of the state apparatus and the embeddedness of the state institutions with civil society. I focus on informal ties and embeddedness because these are factors that are largely neglected by the literature in explaining how devolution and deconcentration work together. Informal ties can facilitate collaboration, coordination and consultation but alone are not sufficient to do so since they can also lead to collusion and corruption.

The first question is how have informal ties between officers at the Health Directorates and *Executive Officers* of the Municipal Assemblies enhanced or constrained these two decentralised authorities in collaborating and coordinating their programmes around healthcare delivery? This is an important issue for a number of reasons. Service delivery in mixed systems of devolution and deconcentration requires different state entities to be responsible for various stages in the processes involved so formal processes of coordination will need to be effective for devolution and deconcentration to work together. The process

is critical and can have significant impact on service delivery outcomes. Effective collaboration and coordination becomes imperative for the process to lead to the expected outcomes; however, this may not happen in Ghana as there are conflicts between Act 462 and Act 525. Although the directives for the utilisation of the DACF assume that the Assemblies who control the funds and are responsible for the provision of health service infrastructure will collaborate and coordinate efforts with the Health Departments charged with health service administration this may not occur as the Health Directorates are strongly aligned to the Ministry of Health and the Ghana Health Service and the Assemblies lack control over Health Directorates budgets. I investigate the circumstances under which the Assembly may be willing to collaborate with the Health Directorate and allocate additional funds to the Health Director particularly when Health Directorates are perceived as being financially strong.

The second question is closely related to the first. In which ways have informal ties between health officers and *elected Assembly members* facilitated the consultation with Assembly members by health staff in order to win public support for health programmes? This question is important because Assembly members are the representatives of the local community and express the voice of citizens but again the structural problems between the Assembly and the Health Directorate can limit the ability of elected Assembly members to participate and influence healthcare decisions. So we need to know what efforts are made by health staff to overcome the structural problems and seek the views of citizens, I ask what motivates them to take such steps and what would encourage elected Assembly members to support health staff. In exploring this question I seek to increase our understanding of whether citizens at the local level are able to influence decisions and what challenges exist. The question can further increase our understanding of the commitment of health staff to involve citizens at the local level.

The third question is: how has the *embeddedness* of health officers with leaders of groups within civil society who were known to work on HIV and AIDS programmes (religious groups, traditional authorities; non-governmental organisations) promoted increased

consultation with leaders of these civil society actors by health staff in order to implement health programmes? This question is important because, in spite of statements by public officials, national and local politicians that CSOs play a role in healthcare delivery, there is no formal institutional mechanism for leaders of CSOs and health staff to collaborate. Neither Act 462 nor Act 525 has clear provisions on how health staff should involve CSOs. We know that CSOs can be vehicles for citizens to influence policy even though they are not democratic representatives of citizens. Given the lack of clear institutional arrangement to involve CSOs, I investigate the circumstances in which health staff and leaders of the selected CSOs work together and ask why health staff would seek to establish and maintain strong ties with leaders of such CSOs also looking at the incentives for leaders of the selected groups within civil society to maintain strong links in the Health Directorate. As we see in chapters 3 and 7, the groups within civil society that were interviewed are those that were known to the Health Directorates and the Municipal Assemblies to be working on HIV and AIDS programmes similar to those being implemented by both the Health Directorates and the Assemblies; they can therefore not be said to be representative of the entire civil society groups in the various municipalities. However, exploring the third sub-question might contribute to promote our understanding of state and society relations and how both the state and society can work together to deliver effective services to the poor.

1.7 Developing the research approach

Much of the literature regarding decentralisation has tended to look comparatively at *countries,* attributing failure or success of decentralisation reforms to a number of factors at the national level such as the political commitment of national leaders and adequate devolution of resources (see, for example, the works of Crook and Manor 1998; Crook and Sverrisson 2003; Bossert and Joel 2002; Bloom and Standing 2001; Bloom et al. 2000; Conyers 2007; Bardhan and Mookherjee 2006). There is relatively little comparative work which examines the performance of decentralised bodies within a uniformly decentralised system with constant factors such as political commitment, devolution of power and resources.

In addition, many studies of health service delivery performance adopt outcome or output indicators, particularly when baseline data is available.[18] Indicators such as infant mortality rates, hospital admission rates or the number of HIV and AIDS patients treated can be useful in assessing performance but are likely to be affected by a range of factors such as the time it takes to get to health facility to receive treatment, efficiency in diagnosis, availability of drugs, and the right usage of medication. Outcome indicators do not allow us to adequately capture the dynamics of the processes involved in collaboration and coordination between devolved Assemblies and deconcentrated Health Directorates and improvements in levels of consultation may not be captured by outcome indicators.[19]

To understand how informal relationships can affect the performance of decentralised institutions, I chose to look at the Municipal level Health Directorates and District Assemblies. Each district has the same decentralised system so these factors are constant, this will enable identification of the factors influencing cooperation and highlight the dynamics of the relationships thus contributing to fill the gaps in current research. To further focus the research I have selected the management of HIV and AIDs between 2000 and 2008 and the distribution of the DACF during this period as this is one area in which cooperation is required and these distributions are measurable.

The implementation of central government directives to Municipal Assemblies for the utilisation of the HIV and AIDS component of the DACF is reviewed to explore (i) collaboration and coordination between the Assemblies and Health Directorates, and (ii) increased consultation of citizens by the Health Directorates in order to win their support for health programmes.[20] Some further information about devolved Assemblies and

[18] See for example, the study of Uganda's success in fighting HIV and AIDS by Asingwire and Kyomuhendo (2006), and the study on the performance of District Assemblies in immunisation programmes in Ghana by Ibrahim et al. (2004).

[19] Consultation of citizens is essential to achieve responsiveness which has been the focus of studies by high profile institutions that seek to measure the performance of local government in Ghana. For example, in a study by AFROBAROMETER (2008b: 6) which sought popular opinions of Ghanaians on the performance of local government in Ghana, local government representatives were seen to be responsive to local people when they "listen to what ordinary people" need and address those needs (see also Crook 1994).

[20] It is worth noting that coordination of healthcare delivery, and achieving more acceptable and responsive health services through active participation of health care users heavily drive much of the healthcare reforms

deconcentrated Health Directorates will assist the understanding of the relationship between the Assemblies and Health Directorates and the subsequent discussion of the impact of informal ties and the ways in which departments collaborate and coordinate efforts.

The combination of devolution and deconcentration is the main feature of Ghana's healthcare system. This parallel system has significantly impacted healthcare delivery, and how the Assemblies and Health Directorates collaborate and coordinate efforts, particularly, around the use of resources such as the DACF. It has also affected how the two institutions coordinate programmes. Evidence shows that performance in terms of coordination between the two institutions varies across the Municipalities following decentralisation even though all the Health Directorates operate within the weaknesses in Act 462 and Act 525. For example, Ibrahim et al. (2004) show that collaboration and coordination between the Ga District Assembly and its Health Directorate have been described as "best practice" in Ghana that other Assemblies are encouraged to emulate. They note that:

> Right from the inception of the National Immunisation Days in 1996, the Ga District Assembly provided more funds for the programme than any other district in the country. The performance of the district was sufficiently significant to be cited as a **best practice** in the Ghana Poverty Reduction Strategy Best Practices Report … The outcome was a very high performance in the programme compared to other districts. The district scored 100% coverage and remained at the top of the scale for several years of the programme (Ibrahim et al. 2004: 65).

Although there is no systematic research into this topic, there is a widely held view in Ghana that most Assemblies are uncooperative with their Health Directorates as far as the Assembly's support in terms of issues around the use of the fund are concerned (Ghana News Agency 2009b). How can we explain such variations in collaboration between these two institutions across the country?

This research will examine the relative performance of health services in five Municipal Health Directorates in Ghana: Ho Municipal Health Directorate (located in the Volta

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of most countries even though evidence suggests that it is difficult to achieve this in most parts of sub-Saharan Africa (Golooba-Mutebi 2005; Akin et al. 2005).

Region); Obuasi Municipal Health Directorate (in the Ashanti Region); Sunyani Municipal Health Directorate (in the Brong Ahafo Region); Techiman Municipal Health Directorate (in the Brong Ahafo Region); and New Juaben Municipal Health Directorate (in the Eastern Region). Examining the comparative performance of five Municipal Health Directorates within the decentralised healthcare system in Ghana enables us to obtain a nuanced understanding of the link between decentralisation and improved services.

To address the research questions, I undertook extensive and in-depth interviews with officers of the Assembly, Health Directorate, and selected leaders of groups within civil society who are sympathetic to Health Directorate HIV and AIDS programmes in these five municipalities. The discussion centred on how ethnic ties, neighbourhood relations, political party affiliations, and old-school networks between them influence how they interact on day-to-day basis in the management of HIV and AIDS between 2000 and 2008.

The method selected focuses mainly on the processes involved in collaboration, coordination, and consultation which I use to measure the performance of the Health Directorates.[21] I focus on the process because of the use of the DACF by the Assemblies and the Health Directorates.

Although I emphasise the measurement of the Health Directorates' performance in process terms, in some instances I extend the discussion and the analysis to cover relevant themes that emerged around selected health service outputs or outcomes. Consequently in Chapter 7, I have assessed performance very fully in terms of the outcomes of HIV and AIDS campaigns geared towards exploring whether the campaigns succeeded in changing local attitudes to the disease. This strategy allows for a more robust discussion of the process variables.

[21] I use *collaboration and coordination* together to indicate *performance*. They may be used interchangeably in parts of the thesis.

The analysis is rooted in the literature on social capital (Putnam 1993), and embeddedness as developed by Evans (1995; 1996a; 1996b) as these explore informal relationships which are largely ignored by the literature and discussion of decentralisation.

1.8 Arguments of the thesis

I argue that informal ties might matter for collaboration and coordination to occur between devolved Assemblies and deconcentrated Health Directorates; further embeddedness of Health Directorates with groups within civil society that mobilise around HIV and AIDS campaigns work to achieve increased consultation with such groups who could influence healthcare decisions on behalf of local people even though they might not represent local people directly. Informal relations seem particularly important when more routine administrative coordination activities such as the constitution and function of the District Health Mangement Teams (DHMTs) which are supposed to be formal platform for coordination between devolved Assemblies and deconcentrated Health Directorates do not seem to work. In Ghana, where formal institutional arrangements for the implementation of decentralisation reforms raise both structural and non-structural problems that constrain collaboration and coordination between different parts of the state, and between the state and society, informal relations and embeddedness might help to overcome the problem. However, informal ties and embeddedness might also facilitate collusion, corruption, and cronyism which can ultimately undermine service delivery efforts. Although the data for this study are drawn from Ghana, the results might help us understand decentralisation reform implementation in many countries in sub-Saharan Africa where the combination of devolution and deconcentration is common in the region, and informal ties form a core part of social organisation. I do not however attempt to generalise the findings as this research is a study of only five cases within a single country (Thomas 2011; Gerring 2007), and the paths of decentralisation adopted by most countries are varied (Awortwi 2010a; 2010b; 2010c). Three related arguments that inform the thesis' main argument are the following:

The first argument is that the structural and non-structural problems that exist as a result of inadequate clarity in the legal and institutional arrangements for collaboration and

coordination can be overcome when good informal relations exist between officers at the Health Directorates and *executive officers* of the Assemblies. The structural issues include relative autonomy of the Health Directorates and issues about who has the capacity and mandate to perform which task at the local level. There is also a major non-structural challenge which is the widely held notion in Ghana that the Health Directorates are financially strong. Whilst the relative autonomy of the Health Department and the notion that the Health Department has enough resources appear to make it difficult for most Assemblies to allocate HIV and AIDS component of the DACF to the Health Department, misunderstandings about capacity and mandate further limit collaboration and coordination between the two institutions. Overall, these structural and non-structural problems seem to undermine the constitution and functioning of the District Health Management Teams (DHMT) as representatives who are supposed to come from the Assembly never show up making the DHMT to only exist in name on paper. Though the non-functioning DHMTs appear to significantly undermine how the Health Directorates work with the Assemblies, this study revealed that Health Directors who had informal ties with *executive officers* of the Assemblies were relatively more successful in obtaining the District Assemblies' Common Fund from the Assemblies even though some of the practices involved in the release of the fund for health programmes could be considered to be corruption or nepotism.[22] Where informal ties were weak, collaboration and coordination were found to be significantly impeded. Good informal ties might therefore be needed in addition to factors such as adequate financial resources; autonomy of local government bodies; and effective legal framework which are suggested as requirements for decentralisation to lead to improving service delivery.

The second argument is that informal ties with elected Assembly members have the potential to facilitate increased consultation with Assembly members. This may weaken the negative effects of central government interferences in the affairs of local governments and replace the influence of personal political ambitions with productivity aimed towards public

[22] The DACF is controlled by the Assemblies. By law, the Assemblies are mandated to release part of the fund to the Health Directorates for HIV and AIDS related programmes in the districts. I use this to measure collaboration and coordination.

benefit. The work of the Assemblies is heavily politicised because the appointment of the Chief Executive plus one-third of Assembly members is by the president of the country. The situation is further worsened by the effects of personal political struggles among both executive and elected members of the Assemblies. All these affect how citizens influence healthcare decisions through their Assembly members as Assembly members are diverted from pursuing the aspirations of their electorates. In taking steps to keep their positions, Assembly members become vulnerable to corrupt practices. Therefore to obtain their support for programmes that might not directly help promote their political agenda can be challenging even when such programmes are beneficial to the majority of local people. The ability of the Health Directorates to expand their informal ties with Assembly members was found to increase the chances that they would support such programmes even when they find themselves in highly politicised Assembly.

The third argument is that despite the lack of clear mechanisms of engagement between the Health Directorate and Civil Society in the current legal and institutional arrangements (particulary given that most of the DHMTs seem to be non-functional), the embeddedness of the Health Directorates by creating good informal relationships between Health Directorates and Civil Society actors can facilitate consultation with CSOs by the Health Directorates. This can help them work together to remove cultural practices, social norms and religious beliefs that may be considered barriers to implementation of HIV and AIDS policy. Those Health Directorates that were adequately embedded within Civil Society were able to remove these barriers. First, they obtained the support of the church to promote debates around condoms; second, they were able to reduce stigmatisation and discrimination against people infected with AIDS, and third, they minimised the dominance of the views of males in matters around sex and health. This argument is based on empirical evidence obtained from the analysis of in-depth narratives by the relevant public officers and Civil Society actors who were involved at various stages in the implementation of HIV and AIDS programmes at the Municipal level.

1.9 The structure of the thesis

Whilst working for local government I observed firsthand the ways in which informal ties sometimes affected the ways in which departments worked together. On the surface, bypassing formal bureaucratic arrangements to make vehicles available to the Health Department could have been deemed a method to facilitate the work of the Health Department. At the same time as health programmes were supported by Assembly members meant the Health Department was not constrained by the acrimony that characterises debates over approval of other projects in the Assembly. However, ignoring formal arrangements for the benefit of only the Health Director could have suggested the existence of nepotism or cronyism against other heads of department.

My interest in how to facilitate better coordination between departments led me to review the legislation where I identified ways in which conflicts within the decentralisation legislation appear to hinder the process of collaboration although for some reason, possibly due to the existence of informal ties, some departments seem to work well together.

A review of the literature relating to both decentralisation in general and the district assemblies in particular revealed a gap in the research as the effect of informal ties on the cooperation between government departments had not been adequately investigated. This has prompted my research which will contribute to the field of study.

I have structured the thesis in eight chapters. Following this chapter, I discuss the theoretical framework in Chapter 2 with a view to providing an understanding of the decentralisation concept and its potential to improve governance outcomes. I highlight the areas in which the literature does not adequately help to explain how devolution and deconcentration work together in practice. Since this thesis questions some of the claims in the neo-patrimonial literature that informal relations always undermine government performance, I explore this literature and discuss the evidence against this claim. I discuss the idea of informal ties within the state which is followed by a review of the literature on social capital (Putnam 1993), which may take the forms of informal relations I discuss to

exist within the state in Ghana and might help explain how devolution and deconcentration can work together. I point to the fact that despite the strength of the idea of social capital and its focus on ties within society, it is not sufficient to explain the relationships between state institutions and civil society actors. The chapter investigates the nature of embeddedness of state institutions, in the theory developed by Peter Evans (1995; 1996a; 1996b) to explain the gap. The idea of embeddedness focuses on the relationships between the state and society but fails to adequately explain relationships between different parts of the state; this is the contribution that I will make with this study by analysing relationships across different state institutions.

In Chapter 3, I present the research approach and methods I used in this study. I explain the research design, the rationale for my choice of healthcare and HIV and AIDS in particular, and why I focus the study at the municipal level. I also explain why I employ the comparative cases approach and how I selected the five cases. I then describe how I operationalise the research variables; the sources of data; data collection techniques, and the respondents interviewed (senior officers in the two decentralised institutions including elected Assembly members and leaders of CSOs). The chapter shows that the data collected are mainly stories in the form of qualitative in-depth narratives.

Chapter 4 is the first of the four empirical chapters, essentially it presents the empirical material. For each of the five cases I describe a) the nature of informal networks between the Health Directorates and their Municipal Assemblies, b) embeddedness of the Health Directorates with Civil Society groups, and c) the performance of the Health Directorates in terms of (i) collaboration and coordination (access to the DACF), and (ii) consultation with citizens. The objective is to present a synopsis of the strength of informal ties, embeddedness and performance as the detailed analysis of causal relationships are examined in chapters: 5, 6, and 7.

Chapter 5 explores how informal ties between the Health Directorates and the Municipal Assemblies facilitated collaboration and coordination between these two different state

institutions. Using the release of the fund from the Assemblies to the Health Directorates as a measure of collaboration and coordination, the discussion will focus on whether or not the Chief Executive released the fund to the Health Department and why. As far as collaboration and coordination between the Assemblies and the Health Directorates are concerned, the chapter shows that both structural and non-structural issues need to be considered since either may significantly undermine how the two institutions work together. These issues are the relative autonomy of the Health Directorate, the perception that the Health Directorates are financially strong, and issues around capacity and doubts about mandate. The chapter goes on to present evidence based on the comparison of New Juaben and Techiman to show that the presence of strong ethnic links, neighbourhood relations, political party affiliations, and old-school ties can be used to overcome these structural and non-structural problems.

Chapter 6 addresses the second question. In what ways have informal ties between health officers and *elected Assembly members* facilitated the consultation with Assembly members by health staff in order to win public support for health programmes? The significant highlight of this chapter is that for consultation to be effective, informal ties must have wider coverage to influence most of the key actors. Wide reaching informal networks have the potential to increase the level of transparency and promote the spirit of collective interests among the actors around healthcare issues. I compare New Juaben and Sunyani in this chapter to show that in addition to networks with *executive officers*, ties with Assembly members can enhance collaboration between the Assembly and the Health Directorate.

In chapter 7 I address the third question which is: how has the Health Directorates' embeddedness with leaders of groups within civil society that mobilise around HIV and AIDS campaigns facilitated increased consultation with leaders of these civil society groups (religious leaders, traditional rulers, and NGO leaders) by the Health Directorates to win their support for HIV and AIDS programmes? The chapter compares Sunyani with Techiman to show how the differences in embeddedness of the Health Directorates might help explain their ability to remove social norms and faith-based or religious practices that

are perceived to be stumbling blocks against the implementation of HIV and AIDS programmes. Altogether socio-cultural norms and religious doctrines present three issues or themes that have the potential to undermine HIV and AIDS policy. These are: the church's position against condoms; stigmatisation and discrimination against people who have HIV or AIDS; and the notion of male dominance over females in issues of sexual and reproductive health. The chapter shows that when health staff are embedded within society and build trust with citizens, it can facilitate the process of dealing with these issues.

The conclusion of the thesis, Chapter 8, contains a summary of key findings from the study and conclusions based on the findings. The chapter revisits the various questions and links them with the findings and the propositions that drive the study. The theoretical significance of the findings in terms of when devolution and deconcentration work together, and the study's contribution to the literature on neo-patrimonialims are discussed. In doing this the chapter highlights the potential of the ideas of informal ties and embeddedness as factors that matter in explaining when devolution and deconcentration work together to produce better governance outcomes. I conclude the chapter by stating that ethnic/tribal relations, family/kinship/neighbourhood links, old-school ties, and political party affiliations might not always produce corruption, cronyism, nepotism, patronage and clientelism. They can be a solution to a) enhance collaboration and coordination between different parts of the state at sub-national level; and b) facilitate increased consultation with citizens in the implementation of health policy. Finally the chapter draws attention to policy implications of the findings, and suggests areas of further research.

Chapter 2

Informal ties and Embeddedness as the 'bridge' between Devolution and Deconcentration: a review of the Literature

2.1 Introduction

Many decentralisation efforts in poor countries, particularly in Sub-Saharan Africa, combine devolution and deconcentration. However, the current literature does not look explicitly at such combined systems. In this chapter I examine the literature on decentralisation paying attention to the factors that explain when and why devolution or deconcentration can lead to better service delivery. I draw on the body of work on social capital, embedded autonomy, and informal relations to develop an approach to understanding the hitherto largely neglected issues of how informal ties can provide insight into when such *mixed systems* work at the local level.

Much of the early literature explains the successes and failures of implementation of decentralisation reforms in poor countries in terms of factors such as inadequate financial resources and poor human resources (Rondinelli et al. 1989; Smith 1985; Maddick 1963). More recent literature highlights socio-political factors to explain the impact of decentralisation. These include political commitment from central governments, issues of elite capture of the reform process, and the legal and institutional framework within which local government bodies operate (Crook 2003; Boone 2003; Robinson 2007a; 2007b). However, even attempts to look at socio-political factors fail to look critically at social and cultural issues such as social capital, embeddedness of decentralised institutions within the societies where they operate, and informal networks across decentralised institutions that operate at sub-national level as having the potential to shape both the process and outcome of decentralisation reforms.

Two of the central claims in the literature are that devolution and deconcentration can enhance coordination of different parts of the local state *and* increased consultation with

local citizens can occur. Together greater coordination and increased consultation are said to lead to responsiveness of decentralisation and contribute to better public services. However these expectations are not being realised so perhaps the ideas of social capital, embeddedness, and informal ties help increase our understanding of when devolution and deconcentration can work together.

To explore the issues I first look at the concept of decentralisation, what the reforms entail, investigate why politicians and governments might choose to devolve and disperse power and functions from the centre to lower levels of government hierarchy and explore the performance of past reforms. Among the issues that seem to explain the performance of decentralisation in the African context are the local cultural, social, economic, and political forces and how they interact and affect day-to-day working of public officers and how public officers interact with public service users. Often the relationships between public officers and citizens in this context are neo-patrimonial in the sense that public officers mostly tend to use their access to the state and control of public resources to benefit sections of society with which they have political, social, and cultural connections. Such actions largely exclude other sections of society and deprive many poor people from benefiting from state resources. This might ultimately undermine performance of decentralised institutions at the local level. Therefore the issue of neo-patrimonialism seems important in explaining the performance of decentralisation. On this basis, I discuss the literature on neo-patrimonialism as this literature helps to explain how and why decentralisation works and show that the study questions some of the claims in this literature. I then introduce the idea of informal ties and discuss the extent to which they can help explain how different parts of the state function at the local level. On the basis of this, I review the debates surrounding informal relations rooting the discussion in the idea of social capital (Robert Putnam 1993). The social capital discussion highlights a gap, in spite of the strength of the literature on social capital; it tends to focus more on ties within society than ties between society and the state. I then examine the concept of embeddedness (Evans 1995) which promises a good explanation of state-society relations. The concern I raise about this concept is that it does not appear to provide us with the nuances of the

influences of informal ties within the state. I conclude the chapter by indicating that the idea of embeddedness (narrowly defined) and informal relations form the basis of the discussion in the rest of the thesis.

2.2 Decentralisation and its forms: devolution and deconcentration

Decentralisation has been defined in many ways.[23] According to Crawford (2010: 94), "decentralisation entails the transfer of power, responsibilities and finance from central government to sub-national levels of government at provincial and or local levels." A common factor of the various definitions is that "decentralisation involves sharing, and sometimes even ceding, of power and authority to lower-level units to act on behalf of the centre" (Oyugi 2008a: iii).

Decentralisation can take many forms, two of which are the focus of this study. The first is devolution which has also been referred to as political decentralisation. The second is deconcentration also referred to as administrative decentralisation[24] (Crawford 2010; Scott 2009; Robinson 2007a; 2007b; Crook and Sverrisson 2003; Cohen 1999). The basic theoretical differences between devolution and deconcentration are presented in Table 1. In this study, I will address these two forms of decentralisation as they are the reforms implemented in Ghana, these comprise the transfer of political and administrative authority from central government respectively to (i) elected local government bodies (Municipal Assemblies); and (ii) non-elected administrative departments of central government ministry (Municipal Health Directorates) at the local level.

[23] For example Smith (1985: 1) defines decentralisation to mean "both reversing and concentration of administration at a single centre and conferring powers of local government…[it] involves the delegation of power to lower levels in a territorial hierarchy, whether the hierarchy is one government within a state or offices within a large-scale organisation." A number of scholars and development organisations seem to agree that decentralisation is the transfer of power, authority, and responsibility by the central government to local government bodies, quasi-independent government institutions, and private organisations for them to deliver services to citizens (Cheema and Rondinelli 2007; Rondinelli 1990a; 1990b; DFID 2008; Devas 2008; Rondinelli et al. 1989). The Centre for Democratic Development (CDD) in Ghana also defines decentralisation as the process of transferring power and resources from central government to the lower levels of government, such as the regions, municipalities and districts in the Ghanaian context (CDD 2005).

[24] It should be noted that a number of scholars make a distinction between devolution and political decentralisation, and also between deconcentration and administrative decentralisation.

2.3 Why leaders adopt devolution: examining the claims

Crook and Manor (1998: 6) define devolution as "when central government cedes power, authority, control, and resources to elected local government institutions." Political or democratic decentralisation also known as 'devolution' is about creating a domain of autonomy involving the transfer of power and resources to lower level elected authorities, which are largely independent of high levels of government (Crawford 2008: 237; CDD 2005:i). One fundamental feature of devolution is that powers and responsibilities are transferred to elected local governments (see Table 1). This is also referred to as political decentralisation (Scott 2009; Brinkerhoff et al. 2007; Wanyande 2004; Blair 2000; Turner and Hulme 1997). Under devolution formally constituted local authorities controlled by elected local councils have the power to pass ordinances having a local application within limits specified by the central government, and they can vary centrally decided policy in applying it locally (Oxhorn 2004; Rondinelli 1990a; 1990b; Rondinelli et al. 1989; Cheema and Rondinelli 1983; Maddick 1963).

Table 1: Basic theoretical features of deconcentration and devolution[25]

Degree of decentralisation	**Political features**	**Fiscal features**	**Administrative features**
Deconcentration	-No elected local government -Local leadership vested in local officials, such as a governor or mayor, but appointed by and accountable to the centre -Voice relationships are remote and possibly weak	-Local government is a service delivery arm of the centre and has little or no discretion over how or where services are provided -Funds come from the centre through individual ministry or department budgets -No independent revenue sources	-Provider staff working at local level are employees of centre, and accountable to centre, usually through their ministries; weak local capacity is compensated for by central employees -Accountability remains distant: the short route of accountability may be weak and citizens may have to rely on a weak long route stretching to politicians at the centre; a strong compact between policymakers and providers can compensate to some extent
Devolution	-Local government is led by locally elected politicians expected to be accountable to the local electorate -Voice relationships can be very strong, but also subject to capture by elites, social polarisation, uninformed voting,	-Subject to meeting nationally set minimum standards, local government can set spending priorities and determine how best to meet service obligations -Funding can come from local	-Providers are employees of local government -Local government has full discretion over salary levels, staffing numbers and allocations, and authority to

[25] These are ideal types as many systems have elements of both systems operating in parallel, and many of the arguments for devolution can also apply to deconcentration and vice versa.

	and clientelism	revenues and revenue-sharing arrangements and transfers from centre -A hard budget constraint is imperative for creating incentives for accountable service delivery	hire and fire -Standards and procedures for hiring and managing staff may still be established within an overarching civil service framework covering local governments generally -Potentially strongest long and shortest routes of accountability, but now also more influenced by local social norms and vulnerable to local capacity constraints and politics

Source: Evans (2004: 22)

The first claim that the literature makes is that devolution can lead to responsive governance outcomes. Local government is said to have the potential to deliver services in line with the demands of local people because development can be effectively tailored to suit local demands (Ayee 2008a; Mitullah 2004; World Bank 2004; Ngware and Ngware 2004; Crook 2003; Blair 2000; World Bank 2000a; Tendler 1997). Chikulo (2004: 133-134) also shows that political decentralisation in South Africa is aimed at enhancing transparency, accountability, and responsiveness. The argument that devolution can lead to responsiveness is based on two assumptions. The first assumption is that local politicians are close to the people so they are in a better position to use local knowledge to deliver appropriate needs. Ultimately, the process can lead to efficiency in service delivery (Smith 1985: 24; Agyeman-Duah 2005: 12). The second assumption is that democratic decentralisation can enable citizens at the local level to hold public officers accountable for their actions as they can vote out councillors that they find to be corrupt or inefficient. The pressure of electoral politics can therefore motivate rational public officers to be more responsive to citizens (Blair 2000: 23; Rondinelli 1981: 598).

Advocates of decentralisation are also cautioned by Smith (1985) about the expectation that responsiveness can be achieved from such reforms as there is a danger that needs at the local level may be misrepresented. Local people whose knowledge influences policy outcomes can be erroneously seen as a "unified mass with common interest" (Smith 1985: 29). If we view society as one unit, we might overlook the fact that the political process is heavily influenced by conflicting class interests and some groups are more capable of

advancing and projecting their interests than others. Responsiveness depends on the individual's point of view based on his needs.

This criticism by Smith (1985) does not expand on the kind of services that societies might need. This might be important as the provision of certain basic services such as health is capable of overcoming class conflict. Healthcare is an essential service that everybody will need in most societies. In the delivery of health services, it may be possible to view society as having a common interest so if local government authorities employ effective mechanisms of participation to arrive at a consensus, healthcare delivery can receive support from many interest groups. Defining what constitutes *common interest* might be possible depending on the context and the kind of service.

The second claim is that devolution can produce strong democracy and civic awareness, and that the development of citizens' political capacity has increased the appeal for devolution in many countries. Political decentralisation allows citizens to engage with state institutions and learn to debate issues to arrive at mutually acceptable consensus. This process can lead to increasing the level of civic consciousness and political development of citizens at the local level. It can also provide a platform for political training of citizens who might rise to engage in politics at the national level and take charge of national public office (Grindle 2007a; Rondinelli 1990b; Slater 1990; Cheema and Rondinelli 1983; Maddick 1963).

However, the argument for the claim of the potential benefits of devolution is contested. Smith (1985: 22-23) contends that to propose that the process of devolution will enable citizens to be politically educated is paternalistic. He argues that voting, standing for elections, and participation in local government business might not be the only source of political education for citizens because the wider social environment affects people's political enlightenment; therefore assuming that local political organisation would be the source of political education will be unrealistic. Smith (1985: 23) explains that it will be problematic to isolate all other factors that contribute to the training of politicians, and it

can be complicated to determine whether councillors who have local experience do better than their counterparts who do not have that experience. Also, given that politics at the national level and the functioning of the national legislative assembly are very different from what prevails at the local level, it might be logical to be cautious about the level of expectation from local governments as political training grounds.

In spite of the fact that the contention Smith (1985) makes has some support, his position has difficulties. He does not shed much light on how political environments in different countries can play a role in providing political enlightenment to citizens. There is evidence to suggest that local governments have been important spaces to increase political education of ordinary people. Across most parts of sub-Saharan Africa, the development of citizens' interest in national politics (in addition to a host of factors such as the history of the struggle for independence) could also be explained by the implementation of local government reforms and governments becoming closer to the people. A number of national political figures have had training at local government level. A good example is politicians who became leaders of newly independent states in Africa. They were the elites who were elected to local councils during the colonial administration.

The third claim is that the process of political decentralisation enables citizens to participate in the decision making process (Crawford 2008; Crook 2003). Grindle (2007a: 6-8) asserts that advocates, political activists, non-governmental organisations (NGOs), and human rights groups have argued that political decentralisation can open up spaces for citizens to participate in decisions that affect their lives. Overall, democracy can be strengthened through active participation of citizens which is one indication of good governance (Katsiaouni 2005; Omiya 2000; Smith 1985).

Nevertheless, scholars such as Golooba-Mutebi (2005); Boone (2003); and Smith (1985) criticise the perception that political decentralisation can promote participation by citizens to influence governance outcomes. For example, Smith (1985: 25) argues that politics at the local levels, as at the national level, is prone to the practical challenges of politics in which

power is always ill-distributed given that "class-based power" exists at the local level as well. It is also true that "privilege and exploitation can be maintained and strengthened through local politics" (see also Friedman and Kihato 2004).

This argument by Smith (1985) is true for devolution efforts in many countries across the developing world. Even though a number of governments in developing countries claim to have devolved power to local governments, such efforts cannot be termed as devolution in the real sense as most of them continue to appoint a substantial number of party faithful to occupy key positions at local government level. As these appointed people are more likely to promote the agenda of the party rather than championing the cause of local people, the practice can undermine devolution and the expectation that the process will promote participation of citizens to shape policy to suit their benefits.

2.4 When can devolution lead to improved service delivery?

The literature raises a number of factors as requirements for devolution to work but the two that are most relevant to this study are the autonomy of local government bodies, and adequate financial resources. Ayee (2004a; 2004b) has argued that the interference of central government in local government affairs constrains effective performance of Ghana's local authorities. Kiyaga-Nsubuga (2004) describes a similar case in the Ugandan situation where the president appoints resident district commissioners who report to the president's office. Tension sometimes ensues between the district commissioners who would like to push the agenda of the president who appointed them, and elected local government members who might also want to promote the needs of their electorates. As a result of central government interference via the appointment of the district commissioners, local authorities could not maintain sufficient independence to pursue their main agenda appropriate to the needs of their people. Adequate political commitment to grant autonomy to local authorities has therefore been argued as an important ingredient to the success of devolution (Smoke 2004; Olowu and Wunsch 2004).

Additionally the weak financial base of local authorities has attracted a lot of interest as it could provide another explanation for poor performance of local government authorities (Crawford 2010: 115; Crook 1994). For example, Chikulo's (2004) study of local governments in South Africa found that inadequate financial resources limited the ability of local authorities to provide basic services. Similarly UN-HABITAT (2002: 9) argues that:

> There must be a link between local financial and fiscal authority to the service provision responsibilities and function of the local government, so that local politicians can deliver on their promises and bear the costs of their decisions.

What seems to have compounded the situation of weak revenue resources is that many local authorities are weak in terms of mobilisation of local revenue by themselves**.**

In the next section, I discuss why national politicians and central government bureaucrats will transfer administrative powers and functions to institutions at the local level, and the conditions under which deconcentration produces the expected benefits. I highlight the fact that claims of efficiency, coordination of programmes and communication between central government and local citizens are among the incentives for adopting deconcentration. In addition, adequate human capacity and the willingness of national officers to support the process can explain when deconcentration can achieve the intended objectives.

2.5 Perceived benefits of deconcentration of powers and functions

Deconcentration is the administrative decentralisation of functions performed by central government and the transfer of those powers to geographically distinct administrative units (Scott 2009; Crawford 2008; Oxhorn 2004; Rondinelli et al. 1989). For Crook and Manor (1998), deconcentration is one of the ways through which administrative power can be transferred away from a central authority to lower levels of government in a territorial hierarchy. Under this arrangement, central government expands its influence by shifting some of its agencies that were originally controlled at the centre to lower levels in the political system but this arrangement enhances the centre's hold on power (Wanyande 2004; Crook and Manor 1998). Under deconcentration a central government transfers tasks to lower level civil servants to execute central government policies. The civil servants in

the administrative offices remain accountable only to persons higher up in the hierarchy (refer to Table 1).

These definitions suggest that with deconcentration, national government transfers part of its functions and power to non-political administrative units at lower levels. Citizens at that level would have limited influence over such administrative units since central government continues to have strong influence in decisions taken by such administrative authorities.

One of the claims in the literature is that, from the public administrative and management perspective, deconcentration can promote inter-governmental coordination at the local level (Turner and Hulme 1997: 156-157). The provision of a service such as health requires a mix of other services including sanitation, water, and roads, so several other government and non-government agencies, and international development organisations play different roles. These other stakeholders operate under different mandates with varied comparative advantages in terms of resources. However, it is claimed that deconcentration of administrative functions facilitates the ways in which these varied actors work together (Wekwete 2007:244). The coordination of programmes offered by deconcentration has been described as "cooperative behaviour" of sub-national governments (Azfar and Kähkönen et. al 2004: 20). Deconcentration can facilitate coordination particularly when donors and development agencies bypass central governments to support development initiatives through CSOs and private independent organisations (Rondinelli 2007: 38-39).

The second argument for deconcentration is premised on efficiency claims that it would promote efficiency on the part of national offices, ministries, departments, and agencies of the state. Part of the hope in achieving efficiency in decision making is that coordination of programmes by state agencies can be more effective as noted by Rondinelli that deconcentration would provide:

> … a means by which the diverse central ministries and agencies involved in development could coordinate with each other; and with local government officials and private organisations within specific jurisdictions. Regions, or provinces, provide a convenient geographical base for coordinating specialised programmes and projects that many developing

> countries are undertaking in rural areas in integrated and coordinated manner (Rondinelli 1981: 598).

The reason is that the process can allow national officers to concentrate on key functions of policy formulation, supervision, and facilitation of implementation from national headquarters so that those day-to-day functions of policy implementation that could be better performed by field officers or local staff do not burden top management. This would allow top management enough time to plan and monitor the implementation of policy in an efficient manner (Blunt and Turner 2007; Jeppsson et al. 2003; Rondinelli 1990a; Cheema and Rondinelli 1983). Efficiency can be achieved because deconcentration, as a management tool, can be employed to reduce or minimise bureaucratic tendencies in decision-making processes which can be common with centralised systems of decision making (Fiske 1996). As governments become closer to citizens they will save time and costs that may be required if citizens visit the national headquarters of government ministries to conduct business (Rondinelli et al. 1989).

The third reason for deconcentration is that it can serve as a communication channel between central government and local people at the grassroots. Rondinelli (1981) points out that deconcentration can provide channels to effectively communicate national policies to remote areas of a country that would otherwise not be aware of government policy due to their location. It can therefore be employed to overcome the dangers of undermining national policy by local elites in areas where central government has a weak support base. The process can provide a face-to-face platform for both service delivery agencies and service users. This has been the rationale behind restructuring and deconcentration programmes across most countries in Africa (Jeppsson et al. 2003).

It is important to note that although deconcentration has the potential to enable central government officers to concentrate on policy making; shorten decision-making processes; and ultimately enhance the performance of both central government staff and staff at the local government level, the strategy could have significant weaknesses. Officers in deconcentrated institutions cannot be held accountable for their actions by citizens at the

local level as they tend to hold strong allegiance to central government. Secondly, the claim that the process can promote coordination appears exaggerated because there is evidence to show that deconcentrated institutions mostly behave like their parent ministries who have a lot of difficulty coordinating their programmes at the national level. In the same way, deconcentrated agencies find it difficult to coordinate with similar agencies and, most importantly, coordinating their programmes with devolved authority at the local level. Given these weaknesses and because of the unique feature of deconcentration, the question that emerges is when can deconcentration work?

2.6 What will make deconcentration work?

Evidence from a number of countries suggests that capacity in terms of personnel and expertise is the most critical condition affecting the success or failure of administrative deconcentration in improving service delivery in poor countries (Scott 2009; Ahmad et al 2005; Mukwena 2004; Crook and Sverrisson 2003; Conyers 2003; Jeppsson et al. 2003). In a study exploring the performance of administrative offices of central government ministries under decentralisation programmes in Namibia, Mukwena (2004) finds that limited institutional capacity of regional and local administrative authorities served to impede the ability of deconcentrated offices to function effectively. He explained that deconcentrated authorities lacked qualified staff in key areas of finance and accounting and human resource management. Similarly, poorly trained and unmotivated staff, and in other cases overstaffing in junior management positions were found to be the main challenges for administrative decentralisation programmes in countries such as South Africa (Wittenberg 2006).

Another factor is that central government officers resist efforts to transfer power and functions to lower level institutions (Cheema and Rondinelli 1983; Mathur 1983). This was Uganda's experience when senior officers at the Ministry of Health initially resisted plans to reform the administrative set up by transferring part of their functions to field officers (Jeppsson et al. 2003). The weak commitment of central government officers to support the transfer of power and functions to district offices can be a stumbling block to the success of

deconcentration. National politicians can be reluctant to transfer key decision making powers to government agencies at lower levels because they might feel threatened that such efforts can weaken their control over affairs at the local level.

The literature on decentralisation suggests that *devolution* will promote democracy and the participation of citizens. The necessary conditions required for these benefits to be realised include non-interference by central government in local government affairs and adequate financial resources. *Deconcentration*, the literature suggests, contributes to making public officers at national and local levels more efficient and effective so they serve as channels of communication between central government and local people. For deconcentration to produce these outcomes, there must be strong institutional capacity of deconcentrated authorities at the local level and national officers should be willing to transfer power to lower level staff.

There are a number of problems however, with the claims of decentralisation, I discuss three of these. First, there is a trend to promote decentralisation although for each of the arguments for decentralisation, there is a counter argument against it. Existing records show decentralisation's performance is poor making it difficult for scholars, governments, and political leaders to adequately make good judgement about decentralisation reforms as a development strategy.

The second issue is that in spite of there being little evidence to support the merits of devolution (at least in terms of service delivery) (Robinson 2007a; 2007b; Turner and Hulme 1997), much effort is made to promote complete devolution rather than deconcentration as the ideal model appropriate for African countries (see Crawford 2008; UN-HABITAT 2002). Scott (2009) has shown that the model of decentralisation promoted in developing countries over the last two decades is political decentralisation or devolution. What this emphasis on devolution seems to overlook is that a mixture of devolution and deconcentration is a common practice in most parts of Africa (Olowu 2006: 231). An

exploration of how these two forms of decentralisation work in parallel might help us to advance both theoretical and empirical understanding of decentralisation in the region.

The third issue is that whilst much of current literature focuses on 'across country comparison' studies,[26] it explains successes and failures of decentralisation to improve service delivery mainly in terms of weaknesses in the system of decentralisation rather than external factors. Much of the literature has focused on factors such as the extent to which reforms are fully implemented; parallel systems of devolution and deconcentration, access to financial resources, the quality of local government staff, and the extent of local government autonomy (see Crawford 2008; 2010; Wunsch 2001). For example, with autonomy of local government bodies, the literature seems to suggest that once decentralised authorities are adequately autonomous from central government controls, reform implementation will work (Mukwena 2004; Mutizwa-Mangiza and Conyers 1996). It has been argued that adequate legal and institutional provisions are needed for decentralisation reforms to be effective (UN-HABITAT 2002; Freedman et al. 2005; Appiah 2005; Avoka 2005a; 2005b). So if we take autonomy of local governments to mean the legal and institutional provisions within which they perform their functions, how can we explain variations in the performance of different decentralised authorities of state within a country where central government controls, in terms of laws and legal framework, can be said to be uniform?

The importance of local cultural, social, economic, and political factors are increasingly recognised by the literature as critical in the performance of decentralised institutions (Booth 2011; Crook and Booth 2011; Blundo et al., 2006; Mungiu-Pippidi 2006). In Africa, the debate around these issues seems to be largely rooted in the literature on neo-

[26] Comparison of the following countries: Uganda, Kenya, Botswana, Tanzania, and Ethiopia (UN-HABITAT 2002), Ghana, Cote D'Ivoire, Bangladesh, and India (Crook and Manor 1998), Chad, Botswana, Uganda, South Africa, Ghana, Nigeria, and Kenya (Olowu and Wunsch 2004), Bolivia, Brazil, South Africa, Uganda, China, India, Indonesia, and Pakistan (Bardhan and Mookherjee 2006), India, Thailand, Nepal, Malaysia, Philippines, Pakistan, Indonesia, and Sri Lanka (Rondinelli 1983b). There are however few works that focus on comparative work examining the performance of decentralised bodies within a uniform decentralised system thus keeping constant factors such as political commitment, devolution of power and resources etc. Examples include Grindle (2007a); Tendler (1997); and Putnam (1993).

patrimonialism. A dominant view is that neo-patrimonialism largely explains the poor performance of governments in Africa and by extension why decentralisation reforms have fallen short of expectations. This study however questions some of these claims. Therefore in the next section, I explore the concept of neo-patrimonialism. I present empirical evidence to show that neo-patrimonial relations can undermine government performance. I will discuss claims that neo-patrimonialism might also produce positive outcomes under certain conditions. The point of departure of this study is partly rooted in the claims that neo-patrimonial relations might promote government performance.

2.7 Neo-patrimonialism and governance in Africa: questioning the claims

The findings of this study question claims of the literature on neo-patrimonialism in Africa which argues that informal relations mostly undermine government performance (see Blundo et al., 2006; Blundo and Olivier de Sardan 2006a; Alou 2006; Bratton and van de Walle 1997).[27] Recent work on politics and governance in Africa has argued for a "developmental neo-patrimonialism"; by using empirical evidence they show how neo-patrimonialism is not necessarily incompatible with developmental outcomes (Booth 2011; Crook and Booth 2011; Cammack and Kelsall 2011). The question posed is 'under what conditions do informal relations, which form the core of social organisation in most countries in Africa and therefore shape behaviour patterns, enable or undermine government performance?' The inspiration for this study arose from my experience with the Ga District Assembly where I witnessed the ways in which informal relations could

[27] In Africa, informal relations such as ethnic ties and family affinity constitute very important factors in the recruitment process for the public service (Grindle 2007c; Evans 1995:49; Grindle and Thomas 1991), and are characterised by corruption (Blundo et al. 2006). These social ties heavily shape the everyday life of government bureaucrats. The ways in which both bureaucrats and citizens mutually accept informal relations makes it difficult to make clear distinction between acts that might be termed to be corruption and those that are not. Sometimes both citizens and bureaucrats feel that what they do is morally justified though such practices may not have official backing from the state (Blundo and Olivier de Sardan 2006a). For example, in the analysis of everyday functioning of the Beninese legal system, Bierschenk (2008: 131) has shown that, due in part to the state's inability to pay decent salary to officers in the legal system, citizens pay legal officers "directly" through what might be termed 'corrupt practices'. As many of those practices are historically embedded in everyday culture such as gift-giving, citizens feel they are socially acceptable. Thus, the nature of informal relations in African societies and bureaucracies makes corruption endemic and systemic in the everyday functioning of African bureaucracies (Bierschenk 2008; Olivier de Sardan 2008; Blundo and Olivier de Sardan 2006a).

promote government performance, which I described in chapter 1, and the empirical evidence from a more recent work by a group of scholars in the Africa Power and Politics Programme (APPP).[28] Following this recent literature, and whilst acknowledging that neo-patrimonialism can undermine government performance, I argue that important forms of informal relations in Africa such as ethnic relations, neighbourhood ties, political party affiliations, and old-school networks can, in some circumstances, promote the public good.[29]

In this study, three conditions appear to be important. First, when government bureaucrats share strong informal ties, they are likely to develop shared interests which go beyond individual interests. The more widespread these ties, the greater the possibility of them contributing to improved coordination. Second, when such ties exist across a large number of bureaucrats and citizens shared interests can develop which can marshal resources from both citizens groups and the state to provide public goods. Third, conferring moral standing by praising individuals who seek to champion the interest of the collective motivates public office holders and individuals to work in the interest of wider society rather than pursuing individual or personal interests.

To make these arguments, it is useful to quickly revisit the concept of neo-patrimonialism and how it has been used to explain polities in Africa. According to Bratton and van de Walle (1997), neo-patrimonialism emerged from Max Weber's term "patrimonial authority" which is present when (i) individuals govern with their own power and prestige, (ii) power is personalised, (iii) ordinary people are treated as an extension of the powerful man's household, (iv) ordinary people have no rights or privileges unless conferred by the

[28] The APPP is a DFID funded research consortium based at the Overseas Development Institute, London that is conducting research on politics and governance in Africa with partner organisations in Ghana, Niger, Uganda, the UK, France and the USA. The chief aim of the APPP is to explore alternative governance solutions that may be effective in dealing with service provision and poverty reduction efforts in Africa (Booth 2011: 2).

[29] This argument is based on the fact that informal relations in Africa are dominated by ethnic and family ties. In contrast to the literature on informal relations in organisation theory and public management in which public officers and bureaucrats get selected or recruited from prestigious and elite educational institutions including high profile universities, their informal relations are largely based on their elitist and professional ties (see for example Grindle 2007c: 112-113; Tendler 1997: 137; Grindle and Thomas 1991).

ruler, and (v) rights, benefits and other privileges are extended to selected "loyal clients" of the patron. In their work on democratic experiments in Africa, Bratton and van de Walle (1997) define neo-patrimonialism as the coexistence of patrimonialism within rational-legal institutions, this is the chief characteristic of political systems in many countries in Africa. Its characteristics are (i) loyalty through informal networks is well knitted into the formal administrative system, (ii) corruption, rent seeking, political patronage and clientelist practices thrive, (iii) parallel and unofficial structures may well hold more power and authority than the formal administration, and (iv) personal relationships … constitute the foundation and superstructure of political institutions (Bratton and van de Walle 1997**:** 62). Similarly, Kelsall (2011: 77) has defined neo-patrimonialism as a system of rule characterised by personal distribution and consumption of public resources among and between a ruler (patron) and his staff (clients) as though they were the private property of the ruler and his staff when public officers and political leaders (patrons) use state resources to the benefit of those who are not in a position to access those resources (clients) in return for political support. In most cases, neo-patrimonialism may take the form of patronage and clientelism (Leonard 2009; Leonard and Pitso 2009; Leonard and Owuor et al., 2009; van de Walle 2007; Bratton and van de Walle 1997: 62).

The characteristics of neo-patrimonialism show that it exists in a symbiotic relationship with established formal and legally accepted institutional arrangements in many African states. The formal institutional structures take their strength from neo-patrimonial practices whilst such practices are sustained by the formal legal rational structures. It is in these processes that rents are created.

The central argument in neo-patrimonial literature suggests that personal ties or informal relations, which form the core of neo-patrimonial relations, undermine governance performance and the production of public goods for the poor (Kelsall 2011; Leonard 2009; Leonard and Pitso 2009; Bierschenk 2008; Blundo and Olivier de Sardan 2006a; Blundo and Olivier de Sardan 2006b; Alou 2006). Blundo and Olivier de Sardan et. Al., (2006) in their work "Everyday Corruption and the State: Citizens and Public Officials in Africa",

give extensive exposition on the nature, form, and characteristics of how corruption, which seems to be largely practiced and embedded within neo-patrimonial relations, might undermine state performance in delivering services to citizens. They note that irrespective of the diversity in the evolution of the post-colonial states in the three countries they studied (Niger, Benin, and Senegal) they found the same or similar forms and characteristics of corruption which are largely related to the informal nature of how the state functions. This suggests that the informal functioning of public institutions, and ultimately the state, in terms of not operating according to formal or official legal and administrative procedures and guidelines which they found to be widespread may be similar across Africa.

Other scholars have also claimed that "neo-patrimonialism allows African politicians to supplement their incomes" through corruption (Kelsall 2011: 77; Olivier de Sardan 1999; Bierschenk 2008).[30] Public sector salaries are low partly due to the unproductive nature of public servants, massive underemployment, and poor performance of the economy (Olivier de Sardan 1999).[31] There is therefore a high temptation for public officers to use illegal means to acquire wealth, and this is when informal ties appear to be useful tools.

[30] Part of the reason is that public sector salaries are low. For example, Bierschenk (2008:111) has noted that in Benin's legal system, "a young judge – who can be responsible for cases involving hundreds of millions of CFA francs earned a basic salary of approximately CFA Fr 80,000 including his basic salary and different supplementary benefits, this is approximately € 122 per month. It was obvious that his income did not enable him to maintain an adequate lifestyle. Due to the introduction of structural adaptation measures, these salaries were lower in 2001 in real terms than they were in 1985."

[31] According to Olivier de Sardan (1999:32) three factors explain the prevalence of corruption in African states. First, the crisis of the African state (the massive employment of unproductive civil servants, followed by the bankruptcy of the employer-state, the irresponsibility and cupidity of the ruling elite) have all contributed to the exposure in broad daylight of corruption in high places, and the incapacity of the state to control "petty corruption" Second, the "under-employment" of civil servants, whether in comparison to their northern counterparts (with whom, owing to "globalisation", they increasingly share the same training and aspirations to a similar style of life), or in the light of the economic crisis (indebtedness, devaluation and structural adjustment), has obliged them to look elsewhere for the resources which are no longer provided by their salaries. Third, development aid has played a somewhat similar role to that of the incomes of the drug and diamond economy, by inducing an inflow of assistantship and clientelism favourable to corruption. The "project system" and the multiplication of NGOs, which have attempted to correct this bias by a greater control of the use of these resources and by partly short-circuiting the state, have amounted to the creation of parastatal enclaves, which secrete in turn their own particular form of corruption. The enormous gap between the salaries paid by development projects and those paid by the state also incites government civil servants to seek complementary resources by illegal means.

Another argument is that since markets are not adequately developed in Africa, the system makes it possible for corrupt African politicians to "use the power of the state to gain a foothold in business." This works as "the majority of ill-informed voters find it easier to evaluate a concrete donation in the form of a private good, such as job or a club good..." (Kelsall 2011: 77; Cammack and Kelsall 2011). Informal ties might therefore be employed to advance personal interests so may be used to undermine development (Leonard 2009; Leonard and Pitso 2009; Fagernäs 2006; Blundo and Olivier de Sardan 2006a[32]; Alou 2006[33]; Grodeland 2005; Smith 2003; Taylor 2003; Hellman and Ndumbaro 2002).

Ethnic mobilisation, which is chief among informal relations in Africa, enables politicians and bureaucrats to be selective in distributing state resources to members of some ethnic groups and impose costs on other groups (Kimenyi and Mbaku 2004; Turton 1997; Leonard 2009; Gantzel 1997; Lewis 1997; Rösel 1997) and there is evidence to support this assertion. An example is the case cited in the former Zaire (now Democratic Republic of Congo) where only President Mobutu's kinsmen occupied important positions and had access to state resources (Evans 1995). Most governments have similarly been criticised as being ethnocentric in the allocation of public resources. This is generally perceived in the development and governance literature as corruption which is commonly agreed to be the "exercise of official powers against public interest or the abuse of public office for private gains" (Shah 2006: 2; Smith 2001; 2003; Kpundeh 1994; Tignor 1993), or in most public offices, corruption might take the form of a "bribe given to a civil servant in return for some favour, the abusive use of public funds to a personal end, or simply dipping into the public purse" (Olivier de Sardan 1999: 27).

Olivier de Sardan (1999: 28) has noted that corruption is a characteristic of neo-patrimonialism and that it "has become, in almost all African countries, a common and

[32] Blundo and Olivier de Sardan (2006a) list informal relations as family ties, neighbourhood relations, old-school ties, and note that they easily result in favouritism and other forms of preferential treatments that systematically exclude others from accessing public resources.

[33] The exploitation of informal relations with judges to influence adjudication of justice in the legal system in Niger as described by Alou (2006) adds to the mounting evidence of how neo-patriomialism is said to undermine government performance.

routine element of the functioning of the administrative and para-administrative apparatus, from top to bottom..." In describing the extent to which corruption has become endemic in African states, largely explained by neo-patrimonial practices in public administration in Niger, Benin, and Senegal, Blundo and Olivier de Sardan (2006a) note that there is a wide gap between the actual functioning of the state and the way in which the state is supposed to function, based on organisational arrangements, legal framework, and the several policy and political declarations in these countries and that the functioning of the state is largely informal.

There is mounting empirical evidence to suggest that neo-patrimonialism undermines governance and this seems to inhibit many scholars, donors, and governments from extending the intellectual and policy debate to consider the possibility that neo-patrimonialism, and by extension informal relations, could promote government performance in many African countries because of the ways in which their societies are structured and function. Increasing our understanding of Africa's socio-political systems may therefore be helpful in developing non-conventional ways to promote the performance of governments on the continent (Booth 2011).

In recent times however, an improved understanding of Africa's socio-political systems has raised questions about the conventional thinking in the neo-patrimonial literature.[34] For example, a body of evidence provided by scholars in the APPP supports this assertion; as noted by Kelsall (2011), "...emerging body of research has begun to question whether clientelism, corruption and rent-seeking are as detrimental to development as once believed..." (Kelsall 2011: 76).

Under certain conditions patron-client relations and rent-seeking may not undermine government performance which is the APPP's claim as stated by Booth (2011: 3), "when

[34] This is particularly important as in many parts of Africa the borderline between corruption and everyday practices is quite thin, and in some cases the actors themselves do not see such practices as corruption as is common with gift-giving, and logics of solidarity networks which are characterised by a general obligation of mutual assistance (Olivier de Sardan 1999: 38-40; Bierschenk 2008).

thinking about pathways towards development, it is worth distinguishing among the different forms that neo-patrimonial rule can take. We should at least consider the possibility that there are forms of the neo-patrimonial state that combine patronage politics with quite a high degree of developmental effectiveness."[35] In their comparative work on governance systems characterised by neo-patrimonial relations across Malawi, Niger, Côte d'Ivoire, and Ghana, Crook and Booth and other APPP scholars suggest that neo-patrimonialism, and by extension informal relations, might not always undermine governance and that recognising and working with the socio-cultural and political realities in Africa would mean neo-patrimonialism is harnessed for "developmental ends" (Kelsall 2011: 76). As noted by Crook and Booth (2011: 99) "greater recognition is needed that "what works" may be rooted in very localised and complex ways of doing things which coexist within forms of governance which, out of necessity, are informalised and penetrated by local arrangements and pay-offs, deals and political clientelism." This is particularly so as informal structures, values, norms and practices on the one hand, and formal functioning of the state on the other hand are interwoven and knitted together over a long period of time and it is likely to remain so for long time to come (Blundo et al., 2006).

As indicated earlier, this study's grounds for questioning the claims in neo-patrimonial literature is that due to the ways in which informal relations work within the African context neo-patrimonial relations might promote government performance. Government institutions in Africa are characterised by informal behaviours in their functions. This is largely explained by ways in which social and cultural practices of most African societies have become part of formal institutional behaviour and practices (Blundo et al. 2006). In some cases, the functioning of the state incorporates certain local values and norms that encourage public officers to seek to promote the interest of the many poor people rather

[35] For example, in the Malawi case, Cammack and Kelsall (2011) explain that the conditions under which neo-patrimonialism promotes developmental outcomes include the following: a) centralised structure which made it possible for individuals or group of persons at top management position and government bureaucrats to define which forms of rent can be created, and also they did the distribution of the rent created at their own volition; b) top bureaucrats were inspired by long term vision not only to create rent but also to ensure that there was discipline to check rent-seeking so that long term expansion of economic growth is achieved; and c) relationship between politicians in government and economic technocrats or senior officers who were adequately equipped to provide technical advice were shaped by effective norms.

than being self-centred and corrupt. Therefore the central argument being advanced in this study is that a better understanding of how African societies work may explain how neo-patromonial relations are capable of promoting the performance of governments.

This study's argument supports the suggestion by APPP scholars that attempts to address Africa's governance problems need to be informed by the general experience that institutions perform well when they are adequately rooted in the social, economic, and political context in which they are located and incorporate local values, norms, and initiatives (Cammack 2011; Olivier de Sardan 2011). This assertion is further supported by Booth (2011: 7) who has noted that "the institutions that work best for public goods provision and development in Africa context are ones that, by design or otherwise, have a local problem-solving character and build on relevant components of the available cultural repertoires, whether in the form of extant beliefs or values or in the form of widely recognised behavioural templates."

Apart from the recent evidence from APPP scholars that neo-patrimonialism can promote governance performance, other scholars have found similar evidence elsewhere, that informal ties between public officers in different state institutions can facilitate their collaboration and coordination of efforts to work and deliver effective services to the poor. Ties between public officers of different institutions and between public officers and citizens can lead to the development of shared interests and aspirations, and contribute to promote accountability of public officers to citizens (Tsai 2007; Granovetter 1983). The work by Tsai (2007) on the activities of solidary groups in rural China is a classical example which shows that informal ties can benefit the wider society. According to Tsai, members of solidary groups are bound by informal ties that are based on shared moral obligations as well as shared interests. A very significant character of solidary groups is that they confer moral standing on public officials in recognition or acknowledgement and appreciation of the good behaviour of public officers when their actions promote the interest of everybody in the community. Moral standing prompts honour and respect for public officials. Tsai argues that "even when formal governmental accountability is weak,

local officials may still have a strong incentive to provide public goods when citizens award them moral standing for doing so" (Tsai 2007: 356).

APPP scholars focus on countries and national level bureaucrats so potentially the conditions under which neo-patrimonialism may produce positive outcomes, such as those described by Cammack and Kelsall (2011) in the Malawian case, might not be applicable to this study which focuses on local level public officers and leaders of a section of civil society actors in the same country. However, the body of work by these scholars provides useful insights to this study as they indicate that neo-partimonialism could be useful to development efforts under certain conditions. Before reviewing a number of conditions that are likely to make neo-patrimonial relations useful in the context of this study, it might be helpful to discuss how the approach I adopt in conceptualising informal relations and neo-patrimonialism and their effects speaks to the ideas of scholars in the APPP and the concept of neo-patrimonialism.

There are two levels of analysis in this study at which the issue of neo-patrimonialism is important. The first level is the relationship between the Health Directorate and the Municipal Assembly including health officers and executive officers of the Assembly. The Health Directorate and the Assembly are two "parallel" decentralised authorities with "equal" powers as per Act 525 and Act 462 respectively. It may not be clear that neo-patrimonial relations exist across the two institutions particularly as the District Health Management Teams (DHMTs) are supposed to provide an equal platform for the two institutions to collaborate. However, with regard to issues around the "control and disbursement" and the "receipt" of financial and other resources, we might view the relationship between the Municipal Chief Executive (MCE) and the Municipal Health Director (MHD) as a "patron" (MCE) and "client" (MHD) relationship which is likely to be influenced by political party, ethnicity and the other informal ties; in this case neo-patrimonial relations exist. This might be so as the MCE is likely to allocate resources to those MHDs who will reward them politically at some point.

The second level of relations providing a good example of neo-patrimonial relations developing is in the relationship between health staff and leaders of selected civil society groups. Health officers, particularly Health Directors, are likely to behave like "patrons" by using the various resources that leaders of the CSOs (clients) need to obtain political support for themselves or their connections such as the MCEs. In these relationships, ethnic ties, political party networks, old-school relations and neighbourhood ties are likely to be influential.

Having described the circumstances in which we may refer to the varied relationships addressed in this study as neo-patrimonial relations I now review the conditions under which neo-patrimonial relations and by extension informal ties, may positively influence government performance.

First is the existence of a dense network connecting health and Assembly staff including both executive and elected members and also between health staff and leaders of the selected civil society groups. All these actors must be connected by as many of the ties as possible. Under such conditions, and since it is likely that each of the ties will have its unique interests, the network is likely to shape and harmonise the various interests to produce shared ones for many actors rather than satisfying the interests of a few. Second, when networks have wider coverage, the greater the chances are that shared interests that are developed would have emerged from a more transparent process. Third, when citizens acknowledge and reward behaviours that seek to advance the interest of the collective, by conferring moral standing as described by Tsai (2007) and Tendler (1997), neo-patrimonialism and therefore informal relations may contribute to achieving developmental outcomes.

2.8 Coordination in mixed decentralised systems: the role of informal ties

My approach in this thesis is to draw on the body of work on social capital, embedded autonomy, and informal ties. The importance of social capital is increasingly recognised in

other aspects of governance, but very little attention is given to how it can contribute to our understanding of decentralisation. The notion of social capital can help shed light on the forms of social organisation in most countries in Sub-Saharan African. Societies in these countries are highly organised around informal networks: friendship ties, family and kinship relations, ethnic and hometown networks, and religious affiliations. These relationships constitute strong forces that shape the life and behaviour patterns of most people. The ways in which societies are organised can support exchange and reciprocal support systems that operate along these informal networks (Crook and Hosu-Porbley 2008; Slater 1990; World Bank 2001). This form of social organisation perpetuates the control of power by public officers who distribute public resources to favour their constituencies. Mungiu-Pippidi (2006: 87) has referred to this kind of control of power and distribution of resources as "particularism" which has been characteristic of societies in most developing countries for many centuries. Social organisation of this type can shape the behaviour of public officers in the performance of formal functions which in turn can shape the way in which formal decentralisation processes operate and how decentralisation process leads to producing the expected outcomes (Brinkerhoff et al. 2007; Hyden 2007; Mungiu-Pippidi 2006; Mayhew 2000; Boone 2003; 1998).

This is particularly important in Ghana where devolution and deconcentration operate in parallel and alliances between officers of Municipal Assemblies (devolved authorities) and those of the Health Directorates (deconcentrated authorities) may make them vulnerable to cronyism, nepotism, and corruption. For example, Mungiu-Pippidi (2006) notes that one of the root causes of corruption in poor countries can be attributed to forms of social organisation in terms of how people relate and the consequent exchange of reciprocal support along informal networks which can affect the distribution of resources. Failure to understand and target the ways in which informal relations shape the behaviour of people accounts for the failure of efforts to fight corruption in poor countries (Hyden 2007). This proposition is further supported by Jeppsson et al. (2003) who shed light on how personal relationships can affect policy implementation. They studied the efforts to deconcentrate health service delivery in Uganda by restructuring the Ministry of Health to delink policy

formulation and facilitation of implementation from actual implementation. Jeppsson et al. (2003) noted that the restructuring exercise could not lead to collaboration between staff of the Ministry of Health and their counterparts in the district offices as expected because the process cut off interaction which is needed for collaboration to occur between centre and the periphery.

Although Jeppsson et al. (2003) refer to relationships between the central and the local levels, their argument is relevant to the current study because they draw our attention to the issue of personal relationships as an important factor that can affect how policy is implemented. I suggest that whether decentralisation reforms produce the expected outcomes or not might depend on the extent to which the design and implementation of such reforms incorporate issues of informal relations in the wider social context within which the reforms operate.

Informal relations that exist within the bureaucracy in Africa might take various forms. Their importance and situational flexibility are likely to vary but what seems to be a consensus in the literature is that they play significant role in explaining the performance of state institutions in Africa (Crook and Booth 2011; Blundo et al. 2006). In Ghana, informal relations that appear to be common among public officers include ethnic relations; political party affiliations; family or neighbourhood ties; and old-school networks. I explore these informal ties in the next section.

2.9 Bringing informal ties back in

Informal ties are relationships between people at a personal level (Coleman 1991). They may include a complex combination of "weak ties (relationship with acquaintances and friends of friends) and strong ties (relationship with friends, relatives, and neighbours)" (Granovetter 1983: 207). Grodeland (2005: 5) has noted that an informal network is an "informal circle of people able to and willing to help each other." Generally what seems to be common to these definitions of informal ties is that they can be grouped into two broad categories. The first is what I will call the *non-voluntary* category. In this group, an

individual will have no choice over a decision to be part of such ties. These may include tribal; ethnic; hometown; and family ties.[36] The second category comprises the *voluntary* group. Voluntary ties are those that people choose to establish. These may include friendship ties, old-school networks, neighbourhood ties, political party affiliations, and religious affiliations. Informal ties remain very important in most parts of Africa as noted by Kimenyi and Mbaku (2004: 113) that "while many changes have taken place in Africa over the last 40 years … little has changed in regard to the attachment and loyalty that individuals have towards members of their ethnic group." As members of an informal network share benefits that accrue to that network, they hold an obligation to it; any failure to promote the interest of the members could result in exclusion from the group. This is what Coleman (1991) suggests when he notes that:

> Social relations are self-sustaining in the sense that incentives to both parties to continue the relation are intrinsic to the relation. The incentives are generated by the relation itself and continuation of the relation depends on it generating sufficient incentives for both parties (Coleman 1991: 2)

The informal ties on which I focus in this study are ethnic ties; family, kinship, neighbourhood or *abusua* ties; old-school networks, and political party connections. An important feature of informal ties is that the benefits that come with membership imply that informal ties are largely personal which I will discuss in more detail in the next section. In reality, the various forms of informal ties overlap in a very complex web of networks. For instance it may be common to find people from different ethnic backgrounds that share the same old-school or political party ties.

2.9.1 Ethnicity and ethnic identities in Africa

Ethnicity or ethnic identities are one of the key social ties in many parts of Africa. Our understanding of the usefulness of such identities and their adaptation in terms of situational or contextual demands and circumstances especially in contemporary Ghana may be enhanced by a bit of exploration of the concept.

[36] Family ties can fit into both *non-voluntary* and *voluntary* categories as in the case of *abusua* in Ghana

There appears to be no consensus on the definition of ethnicity as the concept itself is dynamic and evolving in significant ways particularly in recent times in response to contextual and situational challenges (Young 2004; 1983; Phinney 1990). The definition considered most appropriate to this study is the one put forward by Young (2004). In his work on "Revisiting Nationalism and Ethnicity in Africa" in which he examines the evolving forms and uses of nationalism and ethnicity in the latter half of the twentieth century, Young (2004: 7) suggested that:

> "ethnicity might be conceptualised in terms of three defining elements. Firstly, ethnicity rests upon a variable list of shared cultural attributes. Language is primarily, although not invariably present as a marker; ... Other defining common properties include ancestry and kinship ideologies, cultural practices, symbolic repertoires, or modes of religious observation. Secondly, ethnicity is defined by an active consciousness of collective selfhood. The group is invariably named and its members hold a self-awareness of their collective affiliation; ... Thirdly, ethnicity is defined by boundaries ... whom one is depends upon whom one is not."

Young (2004; 1986) has suggested that the nature of evolution of ethnicity in Africa shows that ethnicity has been socially constructed through a number of ways. These include (a) the partition of Africa into colonies, (b) the ways that colonial powers constituted Africans as ethnic subjects based on tribal lines, (c) the activities of different groups of missionaries in an effort to effectively reach the subject populations using different standards by establishing other forms of ethnic identities largely based on linguistics and dialects in their catchment areas, and (d) the role played by Africans themselves in the construction of ethnicity and ethnic identity.

How Africans organised politics, power and authority during the pre-colonial period explains many of the contemporary ethnic identities. For example, in Ghana, the history of the Asante Empire gives contemporary Ashantis a sense of unique identity separate from the other Akans (McCaskie 1983; Wilks 1961).

Ethnicity is a complex phenomenon and its expression and effect can shape and be shaped by a host of contextual factors, its expression in a particular setting depends upon a wide array of historical, social, economic, cultural, and psychological factors (Young 1983). This is evident from situational flexibility in understanding of the concept and significance of

ethnicity particularly in the period before colonisation, during colonisation (independence struggles), and in the period following independence. Although there was ethnic consciousness among Africans, its mental and geographical boundaries were different from its latter forms following the works of the colonial powers to reconstruct and reclassify ethnicity even though it did not fit this new classification in reality. Pre-colonial forms of ethnicity did not have a clear expression in political terms and to a large extent, it did not have a relationship with the evolution and disintegration of states (Young 1986).

Because ethnic identities are complex, it might be sociologically difficult to make generalisations and conclusions about uses and significance of ethnic identities (Phinney 1990). Notwithstanding this, it appears that there are a number of ways in which the uses of ethnic identities stand out in the African context showing their situational flexibility as noted by Young (2004). For example during the struggle for independence, ethnicity assumed a different significance when viewed from the perspective of instrumentalists. For the instrumentalists, ethnicity was mainly "a weapon in the pursuit of collective advantage, they stress the situational and circumstantial nature of ethnic solidarity, and focus upon competition and interaction" (Young 1983: 660). The instrumentalists' position is supported by evidence of how in some instances, nationalists' struggles employed the concept to mobilise the people to fight for independence. It must however be noted that this was not the general phenomenon across Africa. In some cases as in Ghana, nationalists such as Kwame Nkrumah tried to discourage ethnic segregation in order to pursue a common national identity (Owusu 2006).

In another situation ethnicity played quite a different role. When electoral politics and competition emerged on the continent in the period following independence, ethnic identities and ethnicity provided the foundation and framework for the construction of many political parties. This became possible because leaders of local communities had appealed to ethnic solidarities to establish representative institutions in response to some of the strategies of the colonial administration such as divide and rule and indirect rule. It is in this process that some of the constituencies that local leaders mobilised provided the basis

for establishing political parties to access the state and control public resources. This phenomenon appears to be prevalent in most parts of Africa in recent times. For example, Eifert, Miguel and Posner's (2010) findings from over 35,000 respondents in 22 public opinion surveys in 10 countries revealed a strong relationship between heightened levels of ethnicity and political competition and that ethnic identities can be useful tools with which to compete for and possibly win political power in Africa (Eifert, Miguel and Posner 2010). This partly explains why ethnic identities are predominant in the architecture of politics in Africa (Leonard 2009; Newbury 1992).

Development of ethnic identities in Africa can also be explained by the desire to control trade (Cohen 1966). This is evident in the history of the period of colonisation and post-colonisation. For example, Cohen's (1966) study of the formation of Hausa communities in Yorubaland (Nigeria) suggests that Hausas mobilised ethnic solidarity to control trade in kola from forest areas to savannah regions of the country. Competition and the quest for monopoly and control over the kola trade resulted in them mobilising politically against other ethnic groups to coordinate and protect Hausas engaged in various stages of the trade. The process led to the growth of ethnic and tribal communities of Hausas.

In recent times ethnic solidarity has been expressed in other forms such as hometown associations. Such associations will comprise people from the same town or village who live abroad. The associations are organised with the view to influence socio-economic activities and politics back home (Crook and Hosu-Porbley 2008; Afede-XIV 2005; Steve 2007).[37] Ethnic, clan, tribal and hometown ties have become popular not to control power and public resources but to influence development in villages and cities from which members of these groups hail. For example, the mobilisation of Ghanaians in Germany shows that such groups have strong networks back in Ghana and their influence in the country includes the adoption and support of deprived communities (Steve 2007). They also provide support in healthcare such as the supply of hospital beds, medical equipment,

[37] Steve (2007: 12) lists the most common village/hometown associations such as the Ashanti Akim Kuo, Obo Citizens Union, Oguaa Kuo. He also lists ethnic/tribal associations including Ashanti/Asanteman Union, Brong-Ahafo Union, Ga Union, Fanti Union, Kwahu Union, Akwapim Union.

medicines and training gadgets to health institutions. Crook and Hosu-Porbley (2008) note that in Ghana, hometown associations have a long history dating back to the twentieth century, and since the 1970s and 1980s hometown associations have extended beyond the borders of Ghana as they form overseas branches. The connection between overseas and home branches further enhances their influence back home. In Peki, for example, the Peki Union influenced policy in the District through their support for education, health, and agriculture (Crook and Hosu-Porbley 2008). In Mohan's (2006) view incentives which influence ties and networks associated with hometowns include Ghanaians abroad being able to mobilise and promote development in their hometowns so as to make life comfortable for their immediate and extended relatives. Another reason might be to raise the image of their hometown so that they would not be embarrassed in the event of funerals which are occasions for their friends or colleagues and neighbours to visit their hometowns.[38]

The significant concept of ethnicity most relevant to this study is the construction of ethnicity by people who reside and work in urban areas away from rural areas where their extended families might live. Young (2004: 14) has noted that "in the emergent urban centres, migrants of common cultural affinity form organisations for mutual support in overcoming the multiple challenges of town life: jobs, housing, coping with misfortune." Ethnic affinity has therefore become quite significant in most urban areas in Africa (Young 1983).

Ethnicity is probably a growing factor in structuring social solidarities and collective images of political competition (Young 1983: 659). It is worth noting that given the nature of situational flexibility and the varied significance of ethnicity, there might be fluctuations in its usefulness in countries that have competitive elections and this might vary in line with election cycles (Eifert, Miguel and Posner 2010); this might occur in Ghana. At one level,

[38] Funeral celebrations can be very important to Ghanaians and these funerals are mostly held in villages and hometowns where people have strong kinship attachments. To avoid embarrassment to urban residents and those abroad who might have gained high social status where they now live, they are obliged to fix the situation back home. This may explain why old and dilapidated family houses are quickly renovated and painted in preparation for funerals (see Witte 2003; Clark 1999).

ethnic identities could become important in urban settings. This is when affinity to hometown associations and districts might become an important mobilisation factor to Ghanaians. At another level, political affinity might matter more. In election periods, even though hometown connections might matter (with respect to strongholds of political parties such as NDC – Volta region, and NPP – Ashanti region), it is likely that ethnicity would assume a different significance.

In most areas of the public services across Africa, the people sharing ethnic and hometown connections seem to treat each other in a special way when it comes to official or formal dealings. It is very common to find that people get connected to opportunities such as jobs, contracts, or other resources and support systems as a result of the ties they have with those who have access to those opportunities (see Ghana News Agency 2010a; 2010b).

2.9.2 Family, kinship and neighbourhood networks

The family in most parts of Africa is likely to extend beyond the father, mother and children boundaries or nuclear family. It might include the extended family and neighbours as well.[39] In an urban context in Ghana, it is sometimes difficult to locate the boundary of the family with the emergence of the *new family* or the *abusua* in this study.[40] On this basis, I put family, kinship and neighbourhood ties or the *abusua* into one category because of the blurred boundaries which have developed across these ties in contemporary urban communities in most countries across Africa Hanson (2004). The 'abusua' in Ghana is an Akan word for *family* (African family), and I have adopted this concept for use in this study as culturally understood metaphor for friendship and support amongst workers in most urban areas in Ghana. To help in our understanding of its use in this study it might be worth of additional elaboration.

[39] A neighbour in this study is taken to mean colleagues at work and the people with whom we live in the same neighbourhood in the city. These are people who also live and work away from their kinsmen and families.
[40] I will use *abusua* extensively in this thesis.

The concept of abusua

The abusua is a part of the culture of the Akans in Ghana. In this study I adopt the definition of culture from Swidler (1986: 273) that "culture consists of such symbolic vehicles of meaning, including beliefs, ritual practices, art forms, and ceremonies, as well as informal cultural practices such as language, gossip, stories, and rituals of daily life." In the strictest sense and in the culture of the Akans, the abusua is about the matrilineal family. Members of an abusua have a common blood line through female ancestors. Members of an abusua have rights, privileges, responsibilities and obligations. Among the rights are inheritance to property such as land and other forms of wealth (Berry 1997:9; 1992.). There would be several privileges in the form of support in times of bereavement, marriage, and child outdooring. Enjoying these rights and privileges come with obligations and responsibilities to extend similar support to others in the abusua. However, one does not have to be a beneficiary of the support system before extending support to others, and nephews would expect to inherit from their uncles (brothers of their mothers).

As noted by Swidler (1986: 273), "culture influences action ... by shaping a repertoire or tool kit of habits, skills, and styles from which people construct strategies of action." Most people who reside and work in urban areas away from their immediate families invoke the idea of *abusua* and take the *friends* they make in the cities and colleagues at work as their *abusua* (the new family). This is because the *abusua* (this new circle of friends and neighbours) play most of the role of actual families in terms of the support system they provide.

Faced with challenges or new situations, individuals, groups or societies would develop coping mechanisms to meet the demands or challenges of the time, and strategies adopted are likely to be effective when they are drawn from enduring ways of life or their culture or the "tool kit" as Swidler (1986: 279) puts it. The abusua therefore offers most workers in urban areas in Ghana the means of solving diverse kinds of problems which confront them in everyday life in the city away from their real families. In her analysis of cultural theory,

Swidler (1986) used “strategies” to mean ways in which action is organised which makes it possible for the one who takes such actions to obtain numerous life objectives.

I use this idea of abusua in the study as a strategy which has the potential to bind government bureaucrats between different parts of the state at the local level, and between public officers and leaders of the selected civil society groups in the study. As a cultural practice, abusua could have enduring effects on its members and shape their actions (Swidler 1986).

The difference between abusua as used in this study and the traditional sense of abusua as with the Akans is blood lineage and therefore inheritance rights. Members of an abusua in this study are not related by blood and cannot inherit property of their abusua. The common characteristic of the abusua, as used here, and the traditional abusua is the availability of reciprocal support systems.

In recent times, *abusua* ties have become very important in Ghana because of the benefits that come with them. These include receiving favours and support in various forms from other members of the *abusua*. They also come with obligations that enjoin members of the *abusua* who have access to opportunities to extend them to other members (Alesina and Giulian 2007; Crook and Hosu-Porbley 2008; Clark 1999; Aldous 1962). As Clark noted, in Africa, besides the support that one would receive from key social institutions such as marriage, child naming ceremonies, and bereavement, one’s connections with siblings, cousins, and uncles provide routes to access a wide range of resources and opportunities (Clark 1999). Findings from studies such as that of Palumbo (1992) on marriage, land, and kinship in Nzema (Ghana) contribute to the well established literature on land tenure in Africa that family and kinship ties give access to land.

The benefits of family or *abusua* ties might even extend beyond life; in fact it could also be extended to the dead in terms of providing a decent and befitting burial to the dead (Witte

2003)[41] particularly when that person is considered to have made a tremendous contribution to advance the cause of the *abusua*. Public officers can invoke these obligations and benefits systems to obtain cooperation from other officers they work with. These reciprocal exchanges suggest that family, neighbourhood or *abusua* ties within the state can shape how public officers collaborate to perform statutory functions.

2.9.3 Old-student networks

The primary and secondary schools, and universities or training institutions that people attend can be good roots for the establishment of informal ties. Unlike the *family* (in African sense) or the *abusua* (in Ghana), old-school networks might not be peculiar to Africa but occur in other parts of the world. The benefits that come with membership of an association of a particular educational institution are so huge that it is common in Ghana to hear people say that *if you do not have school-mates then you are unlucky*. Old-school ties can extend beyond classmates to any person who attended that school so it is the name of the school which provides the connection not a personal connection with members in the network from whom support or assistance may be required. Old-school ties between public officers in different institutions can be employed to access opportunities in important contexts. Vidich (1997: 213) has called such ties "institutional cliques." He notes that:

> Each individual within an organisational (bureaucratic) hierarchy possesses informal and formal connections and ties with others in other organisational institutions. The informal connections have their origins in extra-institutional relationships based on such consideration as … old-school ties based on graduation from the same educational institutions or graduating class (Vidich 1997: 213).

These ties can enhance exchanges of reciprocal and mutual support because members might have strong loyalty towards the group. A kind of loyalty rooted in common or shared interest around projecting the image of their former educational institution. In such networks there are members who have access to and control public resources, jobs, and other opportunities that can be extended to other members in the network so that overall the image of their school is promoted (Hanson 2004; Vidich 1997).

[41] The work by Marleen de Witte (2003) on funeral celebrations in Ghana shows how most people can take pride in the fact that they will be given befitting burial because of their *abusua* connections.

An example of how old-school ties can work is described by Crook and Hosu-Porbley (2008) in their work on the Peki Union in Ghana. Their account of Peki Union's efforts to campaign for a district suggests that the success of the Peki Union and the people of Peki to establish a new district might have been aided by a web of old-school connections with key public officers.[42] They show that the then member for Parliament for the Peki area and the then Minister of Local Government and Rural Development are old-boys of Prempeh College (in Kumasi, Ghana) which the former President John Agyekum Kufuor also attended. Additionally a former teacher of President John Agyekum Kufuor was from Peki. The old-school ties enabled the petitioners to gain access to the President which may have contributed to the campaign to establish a district. The old-school factor seems important as the campaign for the district started in the late 1970s but they obtained district status during the Kufuor government between 2000 and 2008. In this case, it was even not university but a secondary school which they attended many years ago that bound them with the president.

2.9.4 Political party ties

Political party affiliations are also likely to strengthen these other ties particularly ethnic relations. For example, in most parts of Africa, there are ethnic groups that are known to have strong allegiance to certain political parties. But this is no surprise as most of the political parties in Africa are rooted in ethnic solidarities (Morrison 2004; Tignor 1993). We find similar examples in countries such as Rwanda where the Mouvement Social Muhutu (MSM) which later become the Le Parti du Mouvement de L'émancipation Hutu (PARMEHUTU) is Hutu-dominated and champions the interest of Hutu ethnic group, while the Union Nationale Rwandaise (UNR) and Ressemblement Démocratique Rwandais (RADER) champion the interests of Tutsi (Newbury 1992). The strong relationship between ethnicity and politics implies that they tend to strengthen one another and strengthen other ties such as religion and old-school networks.

[42] This is one example where hometown association employed old-school ties to advance a cause, an indication of the interconnectedness and overlap between the various forms of informal ties.

The history of Ghana's political development strongly supports this assertion. Chazan (1982) has noted that:

> Ethnic politics, despite severe vacillations in regime types and ideological predictions, have come to play increasingly prominent role in Ghanaian politics since independence in 1957… Control of state power has moved from southern Akan groups during the Nkrumah years; through a Ga-Ewe coalition under the National Liberation Council (NLC); the central Akan (Asante-Brong) alliance of Busia; the ethnically more balanced National Redemption Council (NRC) – Supreme Military Council (SMC) constellation; a minority agglomeration with disproportionate northern representation in the administration of the Third Republic; and finally to heavily Ewe-based ruling clique in the Provisional National [Defence] Council (Chazan 1982: 461).

In recent times in Ghana, the Volta and a large part of the Northern regions are perceived to be the strongholds of the National Democratic Congress (NDC), while the Ashanti and Eastern regions are also perceived to be strongholds of the New Patriotic Party (NPP) (Chazan 1982).

There is an overlap between ethnicity, religion and political party affiliations. It is widely claimed in Ghana that most people in the northern regions of the country are Muslims whilst large part of the southern areas are Christians. On this basis, one is more likely to find Ghanaians from the northern regions who are Muslims and are members of the NDC than it is to find Muslims in the southern regions who are members of the NPP. But there are instances of conflicts. This is when a person from Ashanti region (in the south) is a Muslim and NDC member. It is very common to find tension between such people (often in the minority) and others because it sounds odd for an Ashanti to be a Muslim and belong to the NDC.

A very important product which is likely to result from the informal relations I have described is the issue of *trust* between members who share these bonds. I will define trust in this study as the situation in which an individual in the network is confident to deal with all others who are members of the network in a transparent and honest ways without suspicion or doubt and he or she is convinced that the others deal with him or her in the same way. Trust is needed to sustain informal networks and facilitate the exchange of reciprocal support system within informal relations. The existence of trust might engender

collaboration and development of concerted efforts and shared interest between public officers and service users and among citizens. The body of work that might help us to understand the relationship between trust and informal ties is around the ideas of social capital which I turn to in the next section.

2.10 Exploring the usefulness of social capital

In this section, I explore the idea of social capital which promises an understanding of informal relations within society. The focus on informal relations in social capital is what I adopt in my analytical approach. This is because the forms in which social capital manifest in Ghana which are the focus in this study are family ties, ethnic/tribal relations, political affiliations, and old-school networks. These social relations can facilitate or undermine collaboration and coordination between institutions and affect service delivery.

It appears that there is no consensus among scholars as to who first used the term 'social capital' (see Farr 2004; Harriss 2001; Fine 2001). However, one of the key proponents of the concept of social capital is Coleman (1988) who explains that:

> Social capital is defined by its function. It is not a single entity but a variety of different entities, with two elements in common: they all consist of some aspect of social structures, and they facilitate certain actions of actors – whether persons or corporate actors – within the structure. Like other forms of capital, social capital is productive, making possible the achievement of certain ends that in its absence would not be possible. Like physical capital and human capital, social capital is not completely fungible but may be specific to certain activity. A given form of social capital that is valuable in facilitating certain action may be useless or even harmful for others. Unlike other forms of capital, social capital inheres in the structure of relations between actors and among actors (Coleman 1988: S98).

In his theorisation of social capital, Robert Putnam's notion is that the concept "refers to features of social organisation, such as trust, norms, and networks that can improve the efficiency of society by facilitating coordinated actions" (Putnam 1993: 167). It has also been defined as a set of norms, social networks, rules, procedures, values, attitudes, and beliefs and precedents and organisations. All these enable people to gain access to power and resources that are instrumental in enabling decision-making and policy formulation (Pargal et al. 2002; Serageldin and Grootaert 2000; Woolcock and Narayan 2000; Krishna and Uphoff 2002). Social relations can function as other types of capital: land; labour;

funds; and machinery that are needed in the production of goods and services (Fafchamps and Minten 2002).

Robert Putnam (1993)'s examination of institutional performance of all twenty regional governments in Italy over a period of two decades, finds that regions in the northern part of the country became more successful than those in the southern areas in terms of economic and political development. He argues that the civic nature of citizens in the northern regions with their inherent social capital is the most powerful force that accounts for advancement in governance performance in those parts of Italy as compared with the southern parts. In the southern areas, which he refers to as "less civic" regions, they are characterised by vertical and hierarchical relationships of authority and dependency (Ibid: 88-89). They are plagued with individualism, distrust, suspicion, patronage, clientelism, and civic associations that were less actively involved in community affairs. All these undermined cooperation among people for the mutual benefit of everybody. The outcome is poor governance performance and disadvantaged south when compared with the north (Putnam 1993).

He notes that:

> Citizenship in the civic community entails equal rights and obligations for all. Such a community is bound together by horizontal relations of reciprocity and cooperation, not by vertical relations of authority and dependency. Citizens interact as equals, not as patrons and clients or as governors and petitioners (Putnam 1993: 88).

Communities with social capital work towards the common good of everybody. Trust prevails which enables people to be tolerant of other's choices and opinions. They have strong associations that cut across all sections of the community which serve as structures of collaboration. These structures embody robust norms and values that sustain reciprocal exchanges.

Social capital is something owned by citizens or communities so Putnam's (1993) idea provides useful insight into how informal relations can affect peoples' behaviour towards others. In both the civic and less civic communities in Putnam's study, the channels of social capital are informal ties such as friendship or good neighbourliness. It is from such

relations that trust, cooperation, and norms of reciprocity are established and sustained. Whether social capital, expressed in informal relations, translates into the mutual benefit of everybody largely depends on whether the norms upheld by citizens or communities support or frown on individualism, distrust, suspicion, patronage, and clientelism.

In spite of the strength of the idea of social capital, a number of criticisms are levelled against it. One of such critics is Collier (2002) who argues that as it is possible to use other factors of production (physical capital such as land, labour, machinery etc.) in a negative way which implies that the same thing could be true of social capital. The activities of Mafia groups and rebellious activities associated with civil wars fall in this category because they require the basic components of social capital to function and produce benefits for their members.

Harriss (2001) and Fine (2001) also noted that the potential of social capital to promote development is exaggerated as it seems to de-emphasise the role of the state, and the importance of political bargains and negotiations in development decision making. They argue that the idea of social capital is a modern tool which helps to perpetuate the hegemony of capitalists. They explain that emphasising social capital would mean that the poor and disadvantaged majority are called upon to help themselves; a way to escape criticisms against public expenditure cuts.

The concept of social capital therefore provides fertile grounds for World Bank programmes that seek to bypass the state and accentuate the role of NGOs as key institutions in programme delivery. The World Bank views NGOs as vehicles capable of channelling development funds to poor people rather than using local government authorities. Yet these NGOs and local associations “are not democratically representative organisations, [and] not democratically accountable. They might be attractive because they appear to offer the possibility of a kind of democracy, through popular participation, but without the inconveniences of contestation politics and the conflicts of values and ideas which are a necessary part of democratic politics” (Harriss 2001: 9).

In spite of the criticism by scholars such as Harriss (2001) there are claims, in both the development and governance literature, in the two decades following the work of Putnam (1993) that social capital is a useful concept and that there is a positive relationship between social capital and good governance outcomes (Colletta and Cullen 2002; Dasgupta 2000; Narayan and Pritchett 2000). For example, one of the major conclusions that Isham and Kähkönen (2002) make from their study of water management in Java is that donors are unlikely to achieve positive results if they invest in water projects in communities that have low social capital. In fact, much of the literature on poverty reduction approaches suggests to donor agencies that social capital will continue to be one of the very important ingredients whose neglect could undermine efforts to alleviate poverty (Narayan and Pritchett 2000).

Following the work of Putnam (1993), the very first work that explores the impact of social capital is an edited book by Grootaert and Van Bastelaer (2002). They provide empirical findings to show that poverty alleviation and rural development programmes have been facilitated by social capital. In this book, Krishna and Uphoff (2002) measure social capital and explore its impact on development. They studied sixty-four communities in the State of Rajasthan (India) in which they interviewed over 2000 respondents made up of all categories of local people. Even though they found other factors to be important, they claim that social capital emerged strongly as the most important explanation to better water resources management and cooperation among farmers. Similarly Fafchamps and Minten (2002) find greater impact in economic terms, on agricultural trading in Madagascar where traders who have good personal connections with both their suppliers and consumers can increase their return on investments. Additionally, Pargal et al. (2002) found that social capital enabled communities to collectively and voluntarily mobilise for garbage disposal in municipalities in Dhaka (Bangladesh) when municipal authorities failed to provide that service effectively. Narayan and Pritchett (2000) also found a strong relationship between social capital and the adoption of improved farming practices; increased incomes to

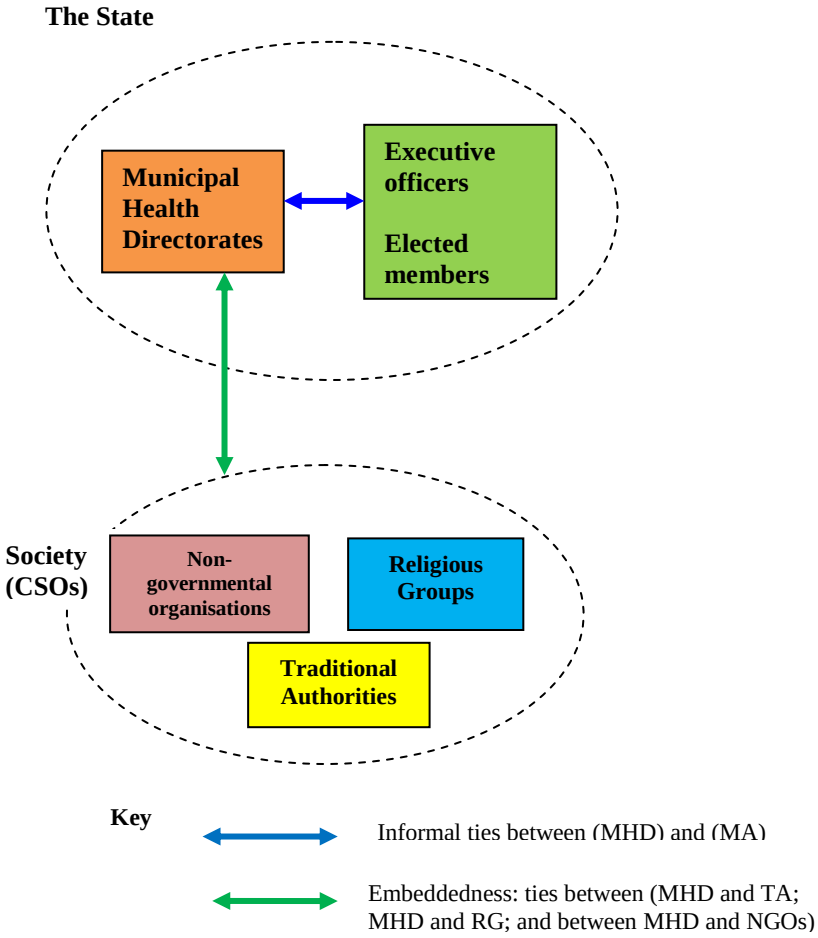
farming households; and improved management of public water supply system and rural roads in villages in Tanzania.

In a study by Widner and Mundt (1998) on 'Researching Social Capital in Africa', they attempted to apply the theory of social capital to analyse local government performance in Botswana and Uganda. Among their findings was that the norms of social capital that were correlated in Putnam's Italian case did not cohere in their two African cases. In addition, they found no causal relationship between social capital and government effectiveness in the two countries. They also found that measures of trust were lower in Botswana than in Uganda, although Botswana's economic and democratic performance are better than Uganda. What we learn from these findings is that social capital explanations of Africa's predicaments rely on inadequate assessments of African norms and fail the test of accounting for intra-African variations in performance.

In this thesis I embrace the idea of social capital to understand informal relations within civil society. The concept of social capital expands our understanding of how Civil Society Organisations (CSOs) work and the potential contribution CSOs can make to improving governance outcomes in terms of better service delivery. I focus on the form of social capital that can exist amongst leaders of Non-governmental organisations (NGOs), Traditional authority (TA), and religious groups (RGs). I depict this in Figure 2 below.

As the literature on social capital focuses more on ties within society, the work of Putnam (1993) and other scholars does not seem to provide adequate insight into the dynamics of state-society relations. This gap is however addressed by scholars such as Evans (1995; 1996a; 1996b) and Tsai (2007) with the concept of embeddedness which explains networks between state institutions and society (see Figure 2). The idea of embeddedenss therefore offers the basis for understanding of ties between decentralised authorities and society. This is the subject of the next section.

Figure 2: The theoretical framework: social capital, embeddeness and informal ties



2.11 Exploring state-society relations: the concept of embeddedness

I will now turn to the concept of embeddedness. The vertical relationship between state institutions and society has been conceptualised as embeddedness. The embedded relationship is defined as "a concrete set of connections that link the state … to particular social groups with whom the state shares a joint project of transformation" (Evans 1995: 59). It is the building of relations of trust and networks of collaboration (Evans 1996a; 1996b). According to Evans "people working in public agencies are closely embedded in the communities they work with; creating social capital that spans the public private divide" (Evans 1996b: 1130). So embeddedness is a type of network that develops between

public officials and private actors in society so that both groups develop shared aspirations and interests (refer to Figure 2).

Tsai (2007) also notes that embeddedness occurs when ties that cross the public-private divide develop among citizens and public officials. The ties can be that public officials are members of solidary groups; born in the local area; live in the area; and engage in activities that local people engage in. In such circumstances citizens and public officials are likely to develop shared interests that can shape their behaviour.

The term embeddedness as used in this study is drawn from Peter Evan's notion of *embedded autonomy*. In his work on the role of states in newly industrialised countries in promoting information technology, Peter Evans argues that the state's role is important in economic transformation in the production of collective goods such as sewage system, roads, education, and health (Evans 1995).[43] The state's ability to effectively facilitate the delivery of these services to its citizens can partly be explained by the extent to which the state embeds itself within society. When a state becomes embedded without asserting its independence, it may be vulnerable to capture by powerful businesses and elite groups. Conversely, when the state is highly independent without connecting well with businesses, it may not have access to useful information or access to private actors in policy implementation (Evans 1995; 1996a; 1996b; Schneider 1998).

Evans (1995; 1996a; 1996b) shows that embeddedness plays a significant role in successful cases of development programmes in developmental states such as Korea, China, and Taiwan. Local ties which bind local level public officials with business entrepreneurs on joint projects of rural industrialisation explain the high performance of rural industrialisation (Evans 1996a). According to Evans (1996b) "the central role of ties that cross public-private boundaries in China's transition success story echoes the pivotal role of embeddedness in ... the transformation of the economies of East Asia" (Evans 1996b: 1123).

[43] Brazil, India, and Korea

The extent to which state-society relations can contribute to the production of public goods is also supported by Tsai (2007) in a study of solidary groups in China. Tsai has argued that when public officials are embedded within society it is likely that officials and citizens will "share a common set of ethical and moral obligations. Members of clans, churches, fraternal organisations ... have strong obligations to the collective" (Tsai 2007; 356). Embeddedness therefore has the potential to provide good incentives to public officers to be responsive to members of their communities. This is more likely to occur when solidary groups (clans, churches, fraternal organisations etc) offer rewards to public officers in terms of "high moral standing for providing public goods, and impose sanctions on those public officers who fail to do so" (Ibid: 356).

Similarly, embeddedness might be what Tendler (1997) shows to have contributed to the success of preventive health programme in Ceára state (Brazil). According to Tendler, preventive health agents embedded themselves in the community by offering "assistance to mothers with mundane tasks not directly related to health" (Ibid: 37). In addition to the fact that health agents are drawn from regions in which they work, they developed good personal relations with mothers by assisting them with cooking, cleaning, and child care. Over time, mothers came to see them as friends they could trust and share personal problems with. These relationships facilitated the work of the health agents (Tendler 1997).

My study focuses on the embeddedness of staff at the District Health Directorate with local leaders of religious groups, NGOs, and traditional councils (Figure 2). It is worth stating that in the area of state-society relations, the principal focus of this thesis is on a narrow form of embeddedness between public officials and selected social actors. These selected groups within civil society may appear to champion the cause of local citizens as I seek to explore in the third sub-question, however, this research is not about citizenship and my definition of embeddedness does not cover the entire universe of state-civil society relations. For these reasons, the extensive literature on 'citizen voice' and 'state-society relations' in public service provision has not been used. Whilst the broader literature on

citizen participation, power and accountability provided a backdrop to my study, for example works such as that of Leach and Scoones (2006); Leach, Scoones and Wynne (2005); Goetz and Jenkins (2005); Kabeer (2005; 1994); Cornwall (2004); Gaventa (2004); Licha 2004; Narayan et al. (2000), this study is about a more narrow set of state-society relations.

Embeddedness might not always lead to the production of public goods. As noted by Evans (1995; 1996a; 1996b), states vary based on their internal structures and how those structures relate to society. States vary in their capacity to function based on what their internal structures enable them to do so embeddedness could lead to corruption and the deprivation of citizens as is common with predatory states. Characteristically, predatory states lack the ability to prevent individual incumbents from pursuing their own goals. Personal ties are the only source of cohesion, and individual maximisation takes precedence over the pursuit of collective goals. Ties to society are ties to individual incumbents, not connections between constituencies and the state as an organisation. When ties between individuals and bureaucrats are not institutionalised they become undependable and they are more likely to produce spontaneous outcomes (Evans 1995)[44].

The concept of embeddedness does not adequately explain the relationship between public officers in different state institutions and how their interaction can affect the ways in which devolution and deconcentration work together. In addition, Evans (1995) does not sufficiently research the processes of decision making by businesses and state officials as a result of the ties between them. He does not explain the actions of public officers when business owners fail to comply with reciprocal terms of the ties (Schneider 1998). Another weakness of Evans' idea of embeddedness is the proposition that state institutions will require social organisations to embed with for such a relationship to yield good outcomes; Tendler's (1997) case in Ceara shows that embeddedness can produce positive outcomes when public officers establish ties with social actors on the individual level.

[44] It is in recognition of the weaknesses of embeddedness that Evans (1995) proposes the idea of 'embedded autonomy,' so that whilst the state seeks to embed itself within society, it should be able to maintain adequate autonomy to minimise the risk of capture.

In spite of the weaknesses of the body of work relating to embeddedness, I adopt the idea as it assists our understanding of state-society relations. Evan's (1995) concept of embeddedness is that the state embeds itself in society through ties between ministries and private industries or business groups and the process of negotiations and cooperation between the ministries and private businesses is institutionalised. In this study, I use embeddedness in a very narrow sense. I focus on ties between decentralised departments and leaders of groups within civil society who were known to the Health Directorates and Municipal Assemblies to be working on HIV and AIDS programmes at the local level. In addition, in the concept of embeddedness as used in this study, the channels of interaction and negotiations are not institutionalised unlike what Evans (1995: 12) notes in his developmental state where what binds the state to society are concrete set of ties which "provide institutionalised channels for continual negotiation and renegotiation of goals and policies." Even though the way I use Evan's (1995) idea of embeddedness is in a much narrow sense and cannot be said to be adequate reflection of state and society relations, to a certain extent, it provides us with an idea about how the decentralised departments of the state at the local level might relate with a section of society. In Ghana, embeddedness of decentralised authorities with society will take the form of family ties, ethnic or tribal relations, and old-school networks between public officers and citizens. Embeddedness has the potential to contribute to the performance of decentralised institutions and by extension, devolved authorities and deconcentrated institutions of state can collaborate and coordinate development programmes at the local level if they establish strong relations with societal actors. This is more likely to occur when norms of high moral standing prevail. As noted by Tsai (2007; Tendler 1997), the existence of opportunities for public officers to be accorded respect and appreciation for acting in the interest of the larger community can contribute to minimise corruption.

2.12 Conclusion

In this chapter, I have reviewed the literature on decentralisation. I explored when and how devolution and deconcentration can work at sub-national level. I also explored the concept

of neo-patrimonialism, and indicated that my findings in this study question some of the claims in the literature on neo-patrimonialism. I discussed the kinds of informal ties that might develop within the state which have the potential to shape how public officers relate to each other and also how public officers and leader of CSOs relate. I examined the ideas of social capital to understand ties within society, and the idea of embeddedness for insights into state-society relations.

The chapter has shown that current literature on decentralisation, social capital, and embeddedness might not be enough for us to understand how and why a mixture of devolution and deconcentration work better in some regions of Ghana than in others. The literature on decentralisation focuses more on relations between central government (the centre) and local government authorities (the periphery) and assumes that decentralisation will work once we get the centre-periphery relations right. Most importantly, this assumption is based on comparisons across countries. With respect to the literature on social capital, it focuses on ties within society; scholars of social capital seem to view social capital from a normative perspective suggesting that social capital cannot be created in societies that lack it. The idea of embeddedness relates to state-society relations but scholars of embeddedness (like the first group of scholars who focus on conditions required for decentralisation to work) also assume that when the relations between state institutions and civil society actors are right the state can work better. However, the idea of informal ties suggests that ethnic and tribal ties; political party ties, old-school relations and family, kinship or *abusua* ties can help explain the inadequacies of the literature on decentralisation, social capital, and embeddedness and show how and when dual systems of devolution and deconcentration can work.

We also see in this chapter that the concept of neo-patrimonialism can play important role in explaining how mixed systems of decentralisation work. What this suggests is that corruption, cronyism, and clientelism might be common in mixed systems of decentralisation where informal relations heavily shape day-to-day functioning of decentralised authorities. Based on empirical evidence from other scholars such as those in

the APPP, we also see that informal relations might not always undermine the performance of governments and that they are capable of producing positive governance outcomes.

In spite of the weaknesses of the literature on decentralisation; social capital; and embeddedness, there are important aspects of each that cannot be overlooked. All decentralised state institutions at the local level need well qualified and highly motivated personnel to function. They also need adequate resources and logistics to enable them to deliver basic services to their citizens. Since central government has an important role to play in ensuring that these factors are available to all local governments, the centre-periphery relationship needs to be right for decentralisation to work. When these vary across the Municipal Health Directorates (MHDs), they can explain how MHDs perform. The nature of relations between MHDs and civil society (embeddedness) will shed light on coordination and collaboration between the MHDs and CSOs in the design and implementation of health policy. Additionally, the level of associational life and political enlightenment of civil society can help us understand how accountable and responsive health officers will be to citizens. Neo-patrimonial relations may not always undermine development. The literature on decentralisation, neo-patrimonialism, social capital and embeddedness therefore offers useful insights to understand how devolution and deconcentration work simultaneously. In the next chapter I present the way in which I conducted this study.

Chapter 3

Exploring Informal ties and Embeddedness: A Methodology

3.1 Introduction

In this chapter, I describe the research design and the methods employed to explore why and how devolved and deconcentrated institutions are able to work together to deliver better health services in Ghana. The specific questions I explore with the research design are: a) how did informal ties between officers at the Health Directorates and *executive officers* of the Assemblies enhance or constrain how these two decentralised authorities collaborate and coordinate efforts to implement HIV and AIDS programmes? b) in which ways did informal ties between officers in the Health Directorates and *Assembly members* (particularly elected members) facilitate the consultation with Assembly members in order to win public support for HIV and AIDS programmes? and c) how has the *embeddedness* of Health Directorate with civil society organisations (CSOs) (religious groups, traditional authorities, and non-governmental organisations) promoted increased consultation with leaders of CSOs by the Health Directorates in order to implement HIV and AIDS programmes that are more acceptable to citizens? I employed a comparative case study approach to examine variations in the ways in which five Municipal Health Directorates (MHDs) worked with their Assemblies over a period of eight years (2000 to 2008) to implement HIV and AIDS programmes; this is the main focus of this thesis. The data I present in this thesis are mainly in the form of narratives or stories told by the various actors who are central to health care delivery at the municipal level. They are officers of the MHD; executive officers and elected Assembly members of the Municipal Assembly; and leaders of Civil Society groups. I will focus on their informal relations, their views on the influence of their relations on the management of HIV and AIDS, the impact of their relations on the allocation of the HIV and AIDS component of the DACF, and the participation (through consultation) of citizens in the planning and delivery of HIV and AIDS programmes.

This chapter is organised as follows: in the next section I explain the rationale for my choice of health care, why I chose to focus on HIV and AIDS in particular and reasons why I focus on the municipal level. I then explain why I employed the comparative cases approach and how I selected my cases. I will follow this with a description of how I operationalised the research variables, the sources of data, data collection techniques, and the respondents interviewed. The conclusion of the chapter is in the final section.

3.2 The health sector and HIV and AIDS

Decentralised departments such as education and agriculture both present equally good cases to improve our understanding of whether informal relations can contribute to better local level service delivery. I chose health and a specific focus on HIV and AIDS because, as noted by the World Bank (2004:1), it is a service "which impacts directly on the wellbeing of people especially poor people" and is crucial for the achievement of the other development outcomes, such as the Millennium Development Goals (MDGs) (Republic of Ghana 2007c; World Bank 1993; 1994b). It might be in recognition of this that three out of the eight MDGs are health related (Wilson et al. 2005; Haynes 2007).[45] Additionally, the right to good healthcare is one of the rights given in chapter 6 of the "Directive Principles of State Policy" (Republic of Ghana 1992: 31).

The first reason for selecting HIV and AIDS is that the disease receives unique treatment in Ghana because: (i) HIV and AIDS is one of the diseases, apart from malaria, which has been given specific allocations by the directives of the Administrator of the District Assemblies' Common Fund (DACF) to the District Assemblies for its utilisation. It therefore requires cooperation between devolved and deconcentrated institutions; and, (ii) HIV and AIDS is the health issue which is on top of the list of priorities for controlling communicable diseases in Ghana (Ghana Health Service 2004a; 2005d; Ministry of Health 2008a; 2009a). The government, as a consequence of these characteristics, directs all

[45] Haynes (2007: 150) has listed these three as (1) reduce child mortality by two-thirds, especially among children under five years, the worst affected group, (2) 'improve maternal health', and (3) 'combat HIV and AIDS … and other diseases.'

stakeholders to collaborate and coordinate their actions to fight the disease (Republic of Ghana 2004e). It therefore requires negotiation between health care providers and care and support givers on the one hand, and the general public and people living with AIDS (PLWAs) on the other hand, even though the role of stakeholders such as religious groups in combating the disease can be very controversial (Haynes 2007).

I also chose to focus on HIV and AIDS because of the challenge the disease poses to development. According to UN-HABITAT (2002), 70 percent of all HIV and AIDS cases in the world occur in Sub-Saharan Africa. About 25 million Africans were estimated to be living with AIDS in 2003 and 2.2 million died from the disease in the same year (Sachs 2005). Currently, approximately three-quarters of the world's annual HIV and AIDS deaths occur in Africa, with women now disproportionately affected (Howe 2000; Ilkkaracan and Jolly 2007). The disease is considered to have contributed to reducing the life expectancy of people in Sub-Saharan Africa from 54 to 47 years. It has the potential to affect human capacity and reduce productivity in Africa, particularly in agriculture which employs between 65 and 70 percent of the workforce. This disease can thus affect Africa's food security and export earnings (UN-HABITAT 2002). The burden of the disease on families can be tremendous as Wilson et al. (2005: 110) indicated that "in the highest prevalence countries, the unprecedented number of orphans is threatening to overwhelm the capacity of extended families and countries to provide adequate care". This is because out of the 15 million children orphaned by HIV and AIDS, 12.3 million or more than 80 percent are in Sub-Saharan Africa.

Another reason for choosing HIV and AIDS is the many misconceptions and superstitions about the disease that may be propagated by some churches (Charismatic, Pentecostal and the Catholic churches) in Ghana. Common misconceptions such as those preached by my own pastor consistently over a period of years, are that HIV and AIDS are a punishment from God meted out to promiscuous people or sinners; and condoms cannot contribute to reducing the spread of the disease. I have been disturbed about these misconceptions for a long time because these 'religious' teachings are flawed. Scientific evidence is clear about

the ways through which HIV can be transmitted.[46] I hope to shed light in this study on how we can get societies to change their attitudes in a positive way to help promote programmes around HIV and AIDS.

3.2.1 Why focus on the Municipal level?

The research is focused on 'municipalities,' an administrative unit between the larger metropolitan areas and smaller and rural district units in size. The populations of the municipalities are growing fast due to an influx of people from rural areas looking for jobs. The rise in population has come with concerns about the spread of HIV and AIDS, and local politicians use awareness campaigns in the municipal areas to win electoral support. There are also a number of civil society groups (churches, mosques, and NGOs) in the municipal areas that mobilise around health (Kyerekoh et al. 2002). I chose not to focus on metropolitan areas because they are centres of large business corporations, major health facilities, and large populations. As a result, issues in the metropolitan areas are highly politicised and the focus of national politics. Choosing the metropolitan areas might have meant that a mixture of national politics and several other issues could have blurred our understanding of decentralised local health care delivery. I did not focus at the district level because most of the District Assemblies are rural and are losing their populations to urban areas so there is little mobilisation around health by civil society groups at the district level. Mobilisation by CSOs is central to the study's attempt to understand the role of civil society in health care delivery.

Because of the complex dynamics of governance issues that HIV and AIDS raise, there is a tendency among scholars to study cases where efforts at addressing the disease have been successful or failed.[47] This approach can be helpful when the focus is on outcome or output indicators and baseline data is available for before-and-after design strategy. I have not adopted this approach in the current study since my focus is on the processes involved in

[46] A number of scholars have shown that heterosexual intercourse is the predominant mode of transmission of HIV in most countries (Chamratrithirong et al. 1999; Camara 2000; Abreu et al. 2003; Kist 2007).
[47] An example is the work on Uganda by Asingwire and Kyomuhendo (2006).

policy implementation rather than on these indicators. Additionally, I have compared five cases rather than a single example.

3.2.2 Comparative case study design

I have adopted a comparative case study approach that can expose and illuminate the strength of informal ties as a factor which could explain why and how devolution and deconcentration work in parallel within a uniform decentralisation system. This study is a comparative case study of five deconcentrated Health Directorates and their devolved Municipal Assemblies specifically considering HIV and AIDS programmes between 2000 and 2008. I conducted a comparative case study for the following reasons. Firstly, there are five cases that have consistent health data and stable geographical boundaries during the period under investigation. At the time of my fieldwork, there were 30 MHDs, and 19 of these had been upgraded from 'District' to 'Municipal' status in 2007; there were a further 6 newly created MHDs which were created in 2007 by altering the boundaries of some of the existing districts. The changes in boundary and population mean that information on health services and social relations from such municipal areas might not be consistent and reliable over the 8 year period being studied. I therefore selected 5 'old' municipalities whose boundaries had not altered. These are the Ho, Obuasi, Sunyani, New Juaben and Techiman municipal areas (see Figure 3).

Secondly, in terms of health care delivery, the 5 share a number of characteristics because of their location and associated activities.[48] They are tourist destinations and big commercial centres and all have HIV and AIDS management high on the health care agenda. For example, the New Juaben Municipal area recorded an average prevalence rate of 7 percent between 2000 and 2007, which is double the national average (Ghana News Agency 2009a). The disease accounted for an average of 4.2 percent of deaths annually

[48] This fits the "most similar systems design (MSSD)" approach (Landman 2000: 27). The objective of the MSSD is to compare cases that have common characteristics and try to neutralise what might differ across them and at the same time highlight the important differences that might explain political outcomes across them (Landman 2000).

between 2000 and 2008.[49] In the case of Obuasi, it accounted for an average of 2.5 percent of deaths annually during the same period (OMA 2006a; OMHD 2008).[50] Figures in the other cases were also high. Sunyani recorded 2.0 percent, with 2.8 percent in Ho and 3.1 percent for Techiman.[51] These figures suggest that there would be a big incentive for the Health Directorates, Municipal Assemblies, and Civil Society groups to collaborate and coordinate their efforts to manage the disease, with the potential for collaboration and coordination, the dependent variable, to vary across the cases.[52]

[49] Interviews with New Juaben Municipal Health Director on 20th October 2008; Director of Faith and Hope in Koforidua on 22nd October 2008; Director of 4-Ghana, in Koforidua on 22nd October 2008; Director of Mathew 25 House in Koforidua on 21st October 2008.

[50] Interviews with Director of Social Support Foundation, in Obuasi on 17th June 2009; and Director of PACA, in Obuasi on 19th June 2009.

[51] Interviews with Sunyani Municipal Health Director on 12th May 2009; Deputy Director of Virgin Club, in Sunyani on 18th May 2009; Chief of Sunyani Traditional area, in Sunyani on 7th May 2009; and HIV and AIDS Focal person (Sunyani Municipal Assembly), on 14th May 2009.

[52] Choosing these municipalities therefore agrees with what is suggested by Johnson and Reynolds (2005: 87) that "cases are chosen for the presence or absence of factors that a political theory has indicated to be important" (see also Gerring 2007). Similarly, Burnham et al. (2004: 62) add that "exploiting the logic of comparison means choosing cases that isolate one or a small number of factors that appear relevant in producing a particular political outcome."

Figure 3: Map of Ghana showing study areas

Key

Ho
Sunyani
Techiman
Obuasi
New Juaben

Based on the criteria that were employed, cases were only selected if their boundaries had not been altered during the period under investigation. I concentrated on municipal areas characterised by high populations in transit because they are major transport hubs, tourist destinations and two of them are located close to Ghana's borders with neighbouring countries.[53]

[53] There is a general perception in Ghana that such towns were at a relatively higher risk in terms of their potential to record high HIV and AIDS prevalence rate (Ghana News Agency 2003c). The Director General of Ghana AIDS Commission (GAC) has expressed concern about the vulnerability of municipalities and towns located close to the borders in terms of the spread of the disease. She noted that the country's neighbours, such as Cote d'Ivoire; Togo and Nigeria had high HIV and AIDS prevalence rates of between 6.0

However, this approach to the selection of my cases may contain some bias. Since the selected cases have HIV and AIDS as the top health issue and personal relationships between the various actors vary due to the length of time each of the actors have known each other, it may appear that the cases favour my argument that informal ties and embeddedness matter for collaboration and coordination to occur in the implementation of HIV and AIDS programmes. To overcome any possible bias, I have limited inferences to data obtained from the in-depth interviews and relevant documents from the various Municipal Assemblies, Health Directorates, NGOs, and national data on health. I have also made an effort to identify, discuss and address any potentially competing explanations for causal relationships between the dependent and independent variables.

In the analysis of these cases, I have paired two cases for each research question. For the first question, which explores the relationship between informal ties and collaboration and coordination, I have compared New Juaben and Techiman because they show extreme values on the performance scale I have used (Gerring 2007: 89). Out of the five cases, New Juaben stands out as the *best* case in which the presence of good informal relations across the Assembly and the Health Directorate contributed, to a large extent, in facilitating coordination between the two institutions. On this basis therefore, the case in Techiman becomes the appropriate candidate to compare with New Juaben which stands out as the *worst* case. Weak informal networks between the Techiman Municipal Assembly (MA) and the Health Directorate significantly undermined how the two institutions worked together.

To address the second research question, relating to the politics of participation of citizens through consultation with elected Assembly members, I compared New Juaben and Sunyani. Out of the five Chief Executives, the *reluctance* of the Chief Executive of the New Juaben MA to undermine elected Assembly members appears unusual. It is very common to hear of Chief Executives frustrating elected Assembly members who are considered ‘problematic’ because they want to be firm and objective in the Assembly. The

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and 11.0 per cent (Ghana News Agency 2003c; Ghana News Agency 2009a). The implication of the director’s views is that there is the high possibility of this spilling over into municipalities close to the borders.

Municipal Chief Executive (MCE) in New Juaben did not undermine Assembly members which enabled them to influence policy; involving them was helpful to the MHD. I selected New Juaben on this basis as the situation challenges widely held perceptions about MCEs in Ghana. The Chief Executive of Sunyani's behaviour can be considered the direct opposite of that of New Juaben (out of the four remaining cases), so Sunyani was identified as the appropriate case to compare with New Juaben. The strategies employed by the Chief Executive of the Sunyani MA to weaken the voice of elected Assembly members compare well with New Juaben, where elected Assembly members were supported and able to influence policy.

To address the third question, which is the consultation of civil society in order to break down traditional and religious barriers in the fight against the HIV and AIDS pandemic, I compared Sunyani and Techiman. These two municipalities are just 60 km apart or about 1 hour's travel by road, so are effectively *next-door neighbours*; they are both dominated by the Brong/Bono ethnic group. In spite of this closeness, there are huge differences between how CSOs mobilise to influence health policy. Comparing them gives a better appreciation of the influences of well organised civil society.

The other two cases, not selected for comparison, are Obuasi and Ho. In terms of coordination of programmes, Obuasi appears to be fairly similar to New Juaben. In the case of the role of the Health Directorate's embeddedness in overcoming norms and practices that undermine HIV and AIDS programmes, the Techiman case fairly represents what I found in Ho. Even though Ho and Obuasi were not selected, I drew on them in the discussion in relevant sections of the thesis.

3.3 Operationalisation of the research variables

(a) The dependent variable

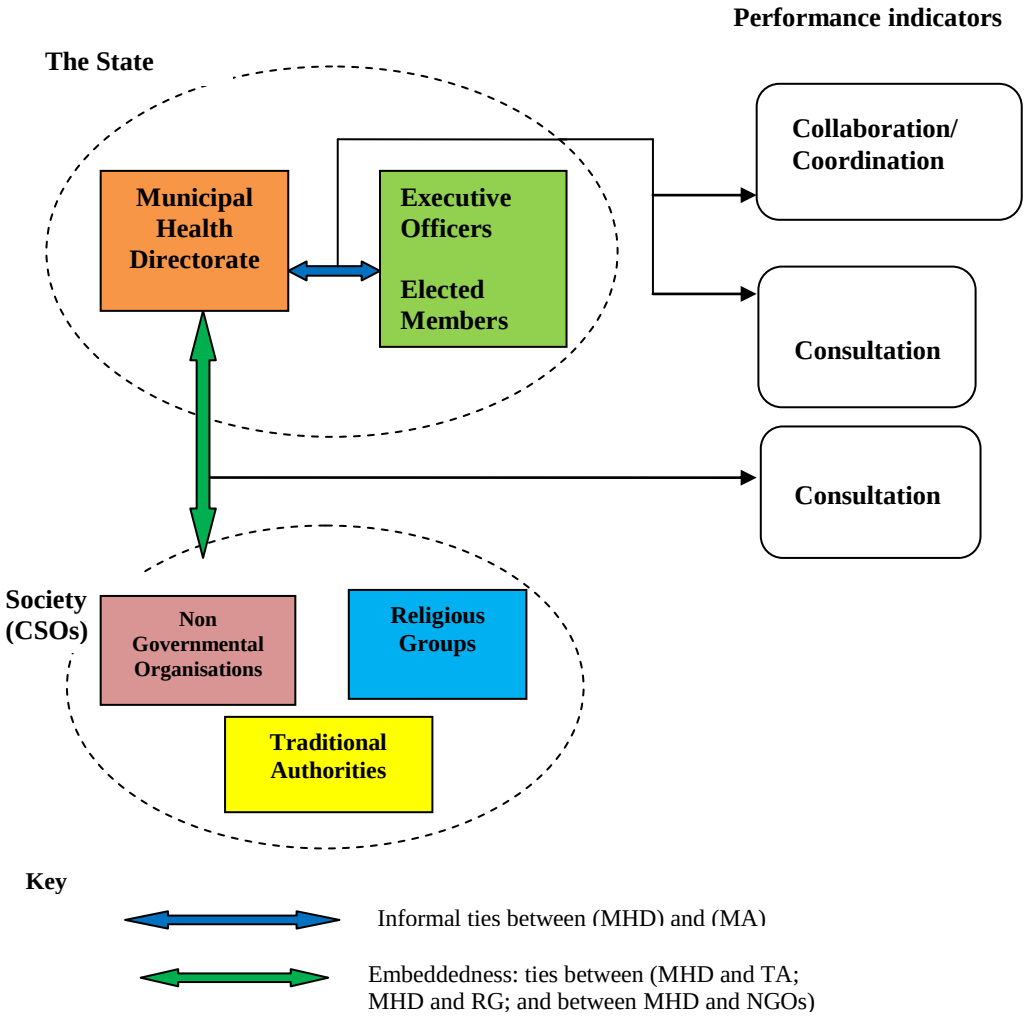
The decentralisation programme is expected to promote collaboration and coordination at the local level so the analysis of negotiations and interactions between the Health Directorate and the District Assembly with regard to the utilisation of the DACF can

provide a good understanding of how devolution and deconcentration work in Ghana. Consequently the dependent variable in the current study is the differential performance of the Health Directorates in two dimensions; collaboration and coordination, and consultation (see Figure 4 below). The first dimension is the collaboration and coordination between the MA and the Health Directorate. In general terms, collaboration can mean "two or more parties actively and voluntarily working together to achieve common objective" (Webb 1991: 229; Bramwell and Sharman 1999; Vigoda 2002). Coordination can also mean "working together more closely and effectively" (Webb 1991: 229). I have used collaboration and coordination together in this study to mean all the activities that enable the various actors at the local level to pursue a unified and harmonised agenda for HIV and AIDS.

I measured collaboration and coordination in terms of the accessibility of the District Assemblies' Common Fund (DACF) by the Health Director (see Figure 4). Access to the DACF looks more attractive as a good proxy for collaboration and coordination because the District Assemblies are legally bound to release part of the fund to the Health Directorate for HIV and AIDS programmes. The directive for the utilisation of the fund specifies that 1 percent of the value released to each Assembly should be allocated to HIV and AIDS programmes (implemented by the Health Directorate).

Although I focus mainly on the DACF, I have attempted to do some amount of exploration into more routine administrative work which would require that the health officers and Municipal Assembly officials will collaborate to work. This is to strengthen the analysis and discussion of the more formal means of collaboration around the DACF.

Figure 4: Operationalisation of the theoretical framework



One of the objectives of decentralisation is to make governments more responsive to the needs of citizens; therefore the second component of the dependent variable is the extent to which health staff consult with elected representatives of citizens and selected groups within civil society in order to obtain their views for the design and implementation of HIV and AIDS programmes. Even though consultation does not mean responsiveness, it is the

first step towards responsiveness.[54] Consultation with local people by the Ghana Health Service is the rationale behind the implementation of the Community Health Planning and Services (CHPS) programme; and it is the main strategy outlined in the HIV and AIDS policy to manage the disease (Republic of Ghana 2003a; 2004e; 2006b; Ghana Health Service 2005c).

Consultation has been defined as involving citizens for the purpose of consensus building in the decision-making process (Freeman 1996; Cuthill 2001). I use consultation in this study to mean seeking the views of citizens' on the design and implementation of HIV and AIDS programmes. I have looked at consultation at two levels. The first is the consultation with elected Assembly members by health staff. Although I use elected representatives of citizens (Assembly members), I acknowledge that these Assembly members may not necessarily represent citizens as the process of getting elected into the Assembly is fraught with numerous issues, and the risk of Assembly members pursuing personal agendas could distract them from advancing the cause of their electorates. The second is consultation with leaders of selected civil society groups by health staff (refer to Figure 4 above). Just like the elected Assembly members interviewed, leaders of the selected groups within civil society who were interviewed are not necessarily representatives of all civil society groups in the various municipalities as they were the ones who were known to the Assemblies and Health Directorates to be the groups that worked on HIV and AIDS related activities. They may not therefore represent citizens in that sense.

It might be worth stating that although I do not focus on investigating citizen needs directly; my research examines the responsiveness of Health Directorates to citizen needs indirectly. An underlying assumption in this research is that both Assembly members and selected groups within civil society are representative of citizens and articulate their interests. Two factors led to this indirect examination of responsiveness. First, capturing citizen needs would have required developing a methodology, probably surveys which

[54] The Health Directorates can therefore achieve responsiveness to local peoples' health needs mainly through consultation with local people whose lives are affected by the decisions of the Health Directorates (Republic of Ghana 1993a; 1993b; 1999a; 2000a; 2006a; 2006b; Ghana Health Service 2003c).

limited time and resources did not allow. Second, because of the focus on HIV and AIDs campaigns, local priorities might not have been consistent with public health concerns. In fact, HIV and AIDS campaigns were geared towards challenging and changing local social attitudes, behaviours, norms, and practices towards the disease, and thus would be in conflict with local beliefs and behaviours.

(b) The independent variables

The independent variables I have used to explain the Health Directorates differential performance are: (i) the informal ties Health Directorate officers have with *executive officers* of the Assembly or *elected* Assembly members and (ii) the extent of Health Directorate officers' embeddedness with leaders of civil society groups (see Figure 4).

3.3.1 Establishing informal ties and embeddedness

The relationships I refer to as *informal ties* in this study are based on one or a combination of the following: ethnic or tribal relations, family, kinship, neighbourhood or *abusua* ties, old-school networks and political party affiliations. When these relationships exist between officers in the Health Directorate and those in the MA, I refer to them as *informal ties* but when they exist between officers in the Health Directorate and leaders of civil society organisations, I refer to them as *embeddedness* (see Chapter 2, and Figure 4). I considered these ties in the analysis only when they prompted interviewees to interact both in private and official levels in the performance of their statutory duties.

To establish the existence of these ties, I asked interviewees about their ethnic and tribal background, family history, educational history and history of residence in the municipality. I also asked them to indicate the political party they belonged to.[55] I then asked if they were connected through any of the ties they mentioned to the other interviewees (see questionnaire in Appendix B). To verify the relationships cited, I

[55] With respect to officers who had not been at a post in the Assembly and the Health Directorate from 2000, I used several sources to obtain data on the ties they had with all other respondents.

conducted interviews with the people referred to. For example, when I asked one of the Health Directors about the ties he had with officers in the Assembly, he related that:

> The person I am likely to contact in the event of issues or problems concerning my work or even outside my job are my *abusua*, these are the MCE, MCD, and Planning Officer. I would say the top people at the Assembly. I have sought their support for them to accompany me to funerals on a number of occasions, and when they came on such occasions they supported me with funds. In the same way I have also attended funerals with them and supported them with funds. It is like you scratch my back and I also scratch your back [Health Director, 20th October 2009].

I then validated the Health Director's *abusua* ties to the MCE, Municipal Coordinating Director (MCD), and Municipal Planning Officer (MPO) by interviewing each of them. The MPO confirmed his ties with the Health Director stating:

> It is true that we have formed a kind of family here because of our job. The Health Director has attended funerals with all of us here, and we have also done the same thing to him. That is how it is. You establish a new family wherever you are transferred to work because the people you work with are the first point of call when you need any support. I have done that for the 25 years of my professional life [MPO, 20th October 2009].

I infer from these statements that informal ties exist between these people. I refer to this kind of relationship as neighbourhood or *abusua* ties.

3.3.2 Determining the strength of informal ties and embeddedness

To determine the strength of informal ties and embeddedness in the analysis, I calculate the number of existing ties as a percentage of all possible ties that one could have with other interviewees. I interpreted the strength of informal ties and embeddedness using the following scale: ***strong*** (≥ 70%); ***medium*** (40%-69.5%); and ***weak*** (≤ 39.5%). The four types of informal ties I used in the analysis are (i) ethnic relations; (ii) neighbourhood or *abusua* ties; (iii) old-school networks and (iv) political party ties.

To calculate the strength of informal ties between Health Directorate and *executive officers* of the MA I used the following procedure:

- Ethnic ties are represented by '**E**'
- Neighbourhood relations are represented by '**N'**
- Old-school ties are represented by '**O'**
- Political pary ties are represented by '**P'**
- Number of officers from the Health Directorate is **3**
- Number of officers from the Assembly is **4**
- Number of informal ties each officer can have is (**4 ties** x **4**) = **15 ties**

- This means the number of ties each case could obtain would be (**16 ties** x **3**) = **48 ties**
- Therefore, number of all existing (**Y**[56]) ties as a *percentage* of all possible ties (**48 ties**). This shows the strength of ties (see Table 2).

I used the same procedure to calculate the strength of informal ties between officers of the Health Directorate and elected Assembly members (see Table 6 in Chapter 6), the Health Directorate's embeddedness with CSOs (Tables 7 and 8 for ties with NGOs and other CSOs respectively in Chapter 7).

Table 2: Strength of informal ties: Health Directorate and executive officers of Municipal Assembly

Health Department		Municipal Assembly				%
		MCE	MCD	MPO	HIV/ FP	
Ho	Health Director	-	E, N	N,P	-	(15/48) = **31.25%**
	Deputy Director of Nursing Services or Public Health Nurse	E	E	N,P	E	
	Disease Control Officer	P	E,P	E	E,P	
Obuasi	Health Director	E, N, O,P	N,P	N,P	N,P	(24/48) = **50.00%**
	Deputy Director of Nursing Services or Public Health Nurse	N	N	E, N	E, N	
	Disease Control Officer	N,P	N,P	E,P	E,P	
Sunyani	Health Director	N	N	N	N,P	(23/48) = **47.91%**
	Deputy Director of Nursing Services or Public Health Nurse	E, N,P	E, N,P	N,P	N	
	Disease Control Officer	E, N,P	E, N,P	N,P	N	
Techiman	Health Director	-	E, N,P	-	-	(9/48) = **18.75%**
	Deputy Director of Nursing Services or Public Health Nurse	-	E, N,P	-	-	
	Disease Control Officer	-	E, N,P	-	-	
New Juaben	Health Director	E, N,P	E, N,P	N, O,P	E, N,P	(35/48) = **72.91%**
	Deputy Director of Nursing Services or Public Health Nurse	E, N,P	E, N,P	N,P	E, N,P	
	Disease Control Officer	E, N,P	E, N,P	E, N,P	E, N,P	

Source: Author's construct, July 2010

[56] The existing ties are the ties that each officer would say he/she has with other officers.

3.3.3 Determining collaboration and coordination: access to the DACF

Collaboration and coordination between the Health Directorate and MA is measured by the level of access to the DACF. The Chief Executive of the Municipal Assembly controls the fund.[57] Given that the funds were released to the MCEs[58], I asked the Health Directors whether the Chief Executives released the funds to them or not each year between 2000 and 2008. I sought a 'Yes' or 'No' answer. I then used *percentages* (the number of years that MCE released the fund to the Health Director as a *percentage* of the 8 years under investigation). I have used the following scale to interpret access level: ***high*** (≥ 70%); ***medium*** (40%-69.5%); and ***low*** (≤ 39.5%) (see Table 10 in Appendix H).

3.3.4 Determining the extent of consultation with citizens

To measure consultation, I used the involvement of citizens (elected Assembly members) and civil society actors (leaders of NGOs, religious leaders, and traditional rulers) in the design and implementation of the Health Directorate's HIV and AIDS programmes. I established the level of consultation using a three-stage procedure. In the first stage I compiled HIV and AIDS activities designed to manage the disease between 2000 and 2008 (see Table 11 in Appendix I). The sources of these measures include High Impact Rapid Delivery (HIRD) plans; interviews with Health Directors, Disease Control Officers, Public Health Nurses, Deputy Directors of Nursing Services, HIV and AIDS focal persons, elected Assembly members, and leaders of civil society groups. The other source of information was the MAs' Medium Term Development Plans (MTDPs).

In the second stage, using HIV and AIDS activities I had identified, I asked elected Assembly members whether they were consulted by the Health Directorate during the

[57] Elected Assembly members are supposed to be part of the allocation process but this is largely determined by the MCE.

[58] The release of the funds to the MCEs was critical to the analysis of access, because one factor that might have affected whether the Chief Executives would have been able to release the fund to the Health Directors was the issue of delays in the release of the funds from the central government (the Common Fund Administrator) to the Chief Executives. The Common Fund is released by the fund administrator quarterly, but it is very common for releases to be delayed. When this happens, the Chief Executives would not be in a position to allocate any funds to the Health Director for HIV and AIDS programmes even if they had good relations.

preparation and implementation of those activities. I obtained answers to this question at two levels. Level one was a 'Yes' or 'No' answer to obtain the proportion of elected Assembly members who were consulted. Based on the responses, I calculated the *percentage* of Assembly members who were consulted out of the total number of elected Assembly members interviewed (see Table 12 in Appendix J for proportions of elected Assembly members consulted).

Similar to the elected Assembly members, I asked leaders of civil society groups who were known to be working on HIV and AIDS programmes whether officers at the Health Directorate consulted with them about the HIV and AIDS programmes. I sought a 'Yes' or 'No' answer. I then had a discussion of the responses to understand (i) what role they played if they were consulted, and (ii) why they were not consulted if the response was 'No'. I determined the level of consultation using the *percentage* of the number of leaders of CSOs that were consulted out of the total number of leaders of CSOs interviewed (see Table 13 in Appendix K). The general pattern of informal ties, embeddedness and performance across the cases is shown in Table 4 (Chapter 4). In Table 3 I present a composite table showing details of how I arrived at the general pattern of informal ties, embeddedness and performance across the cases.

This table (Table 3), shows how the summary Table 4 (in Chapter 4) was obtained. In Table 3, for each of the cases, for example Ho, the overall strength of the independent variable (informal ties) is obtained by taking the *average after summing up* the *strength of ties with executive officers* and that of the *elected Assembly members*. This same process is used to obtain the strength of embeddedness; and the level of performance in terms of consultation. It is only the level of collaboration and coordination that this method of averaging the sums does not apply to. Data in the cells for collaboration and coordination have been brought from Table 5 (Chapter 5).

These data show the nature of ties existing between the various officers. For example, in Ho, the overall score for informal ties is 28.95% suggesting that officers do not have many

of the ties in common, thus they have weak ties. In New Juaben for example, the overall score of 69.78% (strong) suggests that most of the officers have many of the ties in common which is likely to facilitate how they collaborate and coordinate programmes as argued in this thesis.

Table 3: Details of performance across the cases

Hypotheses	**Cases**				
	Ho	**Obuasi**	**Sunyani**	**Techiman**	**New Juaben**
INFORMAL TIES					
Executive Officers	(31.25%) weak	(50.00%) medium	(47.91%) medium	(18.75%) weak	(72.91%) strong
Elected Assembly members	(26.66%) weak	(26.66%) weak	(36.66%) weak	(10.00%) weak	(66.66%) medium
Informal ties - overall	average is 28.95% **weak**	average is 38.33% **weak**	average is 42.28% **medium**	average is 14.37% **weak**	average is 69.78% **strong**
EMBEDDEDENSS					
NGOs	(33.33%) weak	(40.74%) medium	(44.44%) medium	(15.55%) weak	(52.77%) medium
Chiefs and religious leaders	(50.00%) medium	(44.44%) medium	(50.00%) medium	(11.11%) weak	(55.55%) medium
Embeddedness - overall	average is 41.66% **medium**	average is 42.59% **medium**	average is 47.22% **medium**	average is 13.33% **weak**	average is 54.16% **medium**
PERFORMANCE					
a. Collaboration/ coordination *(access to DACF)*	low (33.33%)	medium (66.66%)	high (77.77%)	low (33.33%)	high (88.88%)
Consultation *(Elected Assembly members)*	(30.00%) low	(60.00%) medium	(30.00%) low	(30.00%) low	(60.00%) medium
Consultation *(NGOs/Traditional authority/religious groups)*	(50.00%) medium	(66.66%) medium	(57.14%) medium	(29.28%) low	(85.71%) high
b. Consultation - overall	average is 40.00% **medium**	average is 63.33% **medium**	average is 43.57% **medium**	average is 29.64% **low**	average is 72.85% **high**

Note: The percentages for the **hypotheses** and the **performance indicators** are interpreted as follows: (A) **Informal ties**/**embeddedness** is strong if (≥ 70%), medium (40%-69.5%), and weak (≤ 39.5%). (B) **Access to DACF** is high (≥ 70%), medium (40%-69.5%) and low (≤ 39.5%). (C) **Consultation** is high (≥ 70%), medium (40%-69.5%), and low (≤ 39.5%).

3.4 Sources of data

In my fieldwork I used ethnographic tools for data collection. I conducted fieldwork in two phases.[59] Phase one was between October 2008 and December 2008, and the second phase was between April 2009 and December 2009.[60] I used a number of tools including questionnaires and a voice recorder. Recording the interviews was necessary since the responses were narratives so I could not capture everything through note taking (Kelly (2006a).

I used different semi-structured questionnaires for each of the respondents (see Appendix B for the questionnaire).[61] I started the interviews by first identifying and interviewing a number of key informants[62], which provided me with a lead to information about discussions around the use of HIV and AIDS funds by the Assembly and Health Directorate, stories behind the formation of some of the NGOs, and the relationships between some NGO leaders and key officers in both the Assembly and the Health Directorates.

I located my key informants at business centres in each of the municipalities.[63] I asked the operators of the business centres about where to find influential people who had lived in the municipalities for 15 years or more, particularly retired civil servants, chiefs, and other

[59] Ethnography here is adopted as defined by Berg (1995: 88) "to involve extensive fieldwork of various types including participant observation, formal and informal interviewing, and document collecting…"
[60] The first phase enabled me to test my research instruments to see how appropriate they would be in obtaining the relevant data. I also used this period to establish the necessary networks with key informants and officers in the Health Directorates and in the Assemblies.
[61] See also Appendix Q for the list of the main interviewees and dates I interviewed them.
[62] The key informants include retired civil servants and Commissioners of Oath who served as licensed letter writers. The Commissioners of Oaths are persons who have the authority of the Supreme Court to certify documents for citizens. They also advise and assist people in the preparation of legal documents.
[63] These are small shops/kiosks that operate secretarial services such as photocopying of materials, scanning, and typesetting and printing of documents. In addition to these services, they offer telephone facilities for people to make and receive calls. These centres attract people from all backgrounds in terms of education, qualification, ethnicity, religion and politics. All kinds of issues are discussed in such areas particularly when there are a lot of people waiting for their turn or especially when there is a power cut and customers will have to wait until there is power for them to be served.

opinion leaders.[64] These other interviewees helped me to gather information about the MAs, the MHDs, and CSOs. They directed me to Assembly members who have lost their seats. All the key informants confirmed that HIV and AIDS was a significant health issue in the municipalities. The key informants provided valuable information about the activities of the MAs, MHDs, and Civil Society organisations regarding the disease.

To gain the trust and cooperation of the Health Directors, I went to the Ghana Health Service head office in Accra to inform the office of the Director-General of the Service about the research, and to seek his consent to go to the districts and interview the Health Directors. I was given the approval and a letter was sent through the respective Regional Directors to the District Directors informing them of the research and requesting them to grant me access to the data I needed and also grant me interviews (see Appendix A for a copy of the letter). I needed this 'key' to access the Health Directors for two reasons. First, the Health Directors might not have cooperated with me given that I sought to ask questions around how they used informal ties to negotiate for collaboration and coordination in the districts. They could have been hesitant because they might have thought that such information might expose what can be considered clientelistic and patronage issues. The second issue is about the type of data I needed. Information around the use of financial resources is considered confidential by most public officers in Ghana and such data could equally expose corruption and inefficiency of public officers. Thus such information could not be released to me without the consent of superior officers at the headquarters of the Ministry of Health in Accra.

At the MHDs, the respondents interviewed were the Director, Deputy Director of Nursing Services (DDNS), Public Health Nurse (PHN), and Disease Control Officer (DCO); all of whom are located in the same building. Although I interviewed several other officers from the Health Directorates, my analysis focused on the Director, DDNS, PHN, and DCOs because they are the top officers involved in the day-to-day administration of the Health Directorate. Consequently, they were responsible for making the key decisions concerning

[64] Out of the 14 people I interviewed in each municipality, three were Commissioners for Oaths and Licensed Letter writers. Five were retired Assembly members who had lost their seats, and six were Chiefs.

mobilisation of financial resources and coordination, and collaboration with other stakeholders in health care decision-making at the municipal level. The Director was in charge of the management and day-to-day administration of the municipality. I interviewed the DDNS or PHN because all the other unit heads reported to her. The DCO was also included because of her regular interaction with NGOs that mobilised around HIV and AIDS. The responsibilities of the DCO also include developing HIV and AIDS programmes and coordinating outreach activities undertaken by NGOs, in addition to her role as coordinator of NGOs. The head of clinical services division is one of the highest ranking officers; however as I did not seek to collect clinical data she was not a relevant respondent so I did not interview her.

In the Assemblies, I made an effort to interview the MCEs but they were not available.[65] I interviewed the Coordinating Director, Planning Officer, and focal person for HIV and AIDS. The MCEs are important because, as the political heads and representatives of the President of the Republic of Ghana, they initiate and endorse the release of funds to the other decentralised departments including health. Similarly, the Municipal Coordinating Director is the chief civil servant at the municipal level who advises the MCE on matters of civil service administration. As the chief administrator, the coordination of the activities and programmes of all the decentralised departments is his responsibility. The Municipal Development Planning Officer is in charge of the preparation of the Medium-Term Development Plans, and head of the Municipal Planning and Coordinating Unit. Coordinating the activities of the HIV and AIDS programmes of the Assembly is the responsibility of the HIV and AIDS Focal Person. He is therefore responsible for issues related to NGO activities around HIV and AIDS, and collaboration between the Assembly and the Health Directorate.

[65] Even though the Municipal Chief Executives were not available for interview, I used other sources to obtain data about their informal relations with officers at the Health Directorate. The MCEs who were in office between 2000 and 2008 had handed over when their party (the New Patriotic Party – NPP) lost the 2008 general elections to the National Democratic Congress (NDC). I was informed that most of these MCEs had either left the country or their whereabouts were not known. Their telephone numbers did not work even though I made efforts to contact them.

To investigate how citizens participated in HIV and AIDS management decisions, I also interviewed 10 of the elected Assembly members (out of the total number of Assembly members which range between 46 and 52 for the various Assemblies), and 5 of the government appointed members of each of the Municipal Assemblies. Assembly members are representatives of citizens so their views can help us to understand the influence citizens have on the HIV and AIDS programmes implemented by the Health Directorate and the Assembly.

Finally, with regard to civil society involvement I interviewed leaders of selected Civil Society Organisations (CSOs) who were known by the Assemblies and Health Directorates to be working on HIV and AIDS programmes. In Ghana, CSOs range from professional associations to NGOs and religious organisations (Amankwah 1996; Tackie 1996; Drah 1996a; 1996b). In this study, the three civil society groups that are most relevant are religious groups, NGOs, and traditional authorities. I included CSOs because evidence suggests that they play a significant role in the fight against HIV and AIDS (ActionAid 2007). Most NGOs provide educational campaigns and care and support for PLWAs and they are able to penetrate the hinterlands, to which government officials are unable to go, to reach PLWAs. The importance of CSOs is recognised by influential NGOs such as ActionAid, whose findings from studies into ways to address HIV and AIDS in Ghana support the idea that CSOs should be key stakeholders (see Table 9 in Appendix C) (ActionAid 2007: 93).

The main religious groups comprise Christians, Muslims, and members of African traditional religions. The Christians are particularly vibrant and vocal which is evident from the numerous Charismatic and Pentecostal churches in all the municipalities. These are mainly offshoots from the orthodox churches (Presbyterian, Catholic, and Methodist churches). They are popular with the middle-aged segment of the population (aged from 19-49), who are more sexually active and therefore the group to whom HIV and AIDS campaigns might be relevant. I have therefore focused primarily on Charismatic and Pentecostal churches because they mostly preach against condoms; I deliberately selected

the religious leaders.[66] In places I deem *successful municipal areas*, I selected those religious leaders who were known to have changed their views from opposing condom awareness programmes to supporting such programmes. In the *not so successful areas*, the religious leaders who still opposed condoms were selected for interview. Religious leaders were selected because they can be very influential in promoting sexual and reproductive health programmes or acting as barriers to such programmes.

For the NGOs, I obtained their details and contact telephone numbers from the HIV and AIDS Focal persons at the MA, Health Directorates, and my key informants. I used this information to compile a composite list of all the NGOs from which I removed those who could not be contacted. I then randomly selected approximately 50 per cent of the remaining NGOs for interview; on average, this led to 4 NGOs being interviewed in each municipality.

Traditional rulers or Chiefs are the custodians of cultural practices and social norms in Ghana and can be very influential in implementing sexual and reproductive health programmes. Identifying the chiefs for interviews was straightforward as usually in Ghana there is only one paramount chief in a municipality and he is the head of the traditional council. One chief made headlines in the Ghanaian media when he publicly condemned the use of condoms and advocated abstinence as the best way to combat the spread of HIV and AIDS (Ghanaian Chronicle 2004). This chief claimed that HIV and AIDS advertisements were misleading people and that their real goal was profits for businesses and companies that manufacture and supply condoms. As chiefs are highly respected, his comments attracted huge criticism from senior politicians and leaders of NGOs as undermining efforts to stop the spread of HIV.

[66] The numbers I selected for each of the cases are: 1 (Ho); 2 (Obuasi); 1 (Sunyani); 1 (Techiman); and 2 (New Juaben).

In addition to in-depth interviews with these interviewees, I attended General Assembly meetings of New Juaben, Ho, and Obuasi.[67] My main goal was to understand how Assembly members discuss issues and make policies. Before I attended each of the Assembly meetings, I spent time with various people in order to capture issues around HIV and AIDS. I wanted to understand citizens' perceptions about how the disease should be managed and how public officers respond to local people's views (Payne 1999). I employed direct observation techniques (non-participant overt-observation) to obtain the data I needed. This technique helped preserve the principle of informed consent (Bailey 2007; 1996; Payne 1999; Punch 1994).

Attending the General Assembly meeting was very helpful because it enabled me to a) understand how political and partisan the District Assembly and Local Government system is, even though the law provides that it should be non-partisan and b) ask the Assembly members about the behaviour of the MCDs, MCEs, and the Presiding Members (PMs)[68] and how they felt about the PMs' handling of the meetings. After each of the meetings, I followed up with in-depth interviews of Assembly members as they fall within what Payne (1999: 32) describes as a "captive community" within "institution and work-based communities". I obtained their contact telephone numbers from the Assemblies' registry and randomly selected at least half of those who have been in office for 2 or 3 terms.[69]

I also collected secondary data from the MTDPs of the Assemblies, Minutes of General Assembly meetings, and a number of national documents relating to health. However, using

[67] The meetings were held on the following dates: New Juaben (8th July 2009 at the Assembly hall at 10.46am); Ho (27th July 2009 at the Assembly hall at 10.20am); and Obuasi (5th August 2009 at the Assembly hall at 10.40am) (Plates 1, 2, and 3 in Appendix D show the researcher at the Assembly meetings). Before I attended the meetings, I first introduced myself to the Presiding Members, Coordinating Directors and Chief Executives. In all the meetings I attended, the Presiding Members first informed the Assembly members about my presence as a researcher and an observer, and then I was invited to explain the research to them and my objectives for sitting in the meeting. I also explained that I would follow up with individual interviews with members. Consequently I was able to openly record my observations. This could have introduced bias because the Assembly members might have behaved differently because they knew they were being observed (Bailey 2007; 1996; Payne 1999; Johnson and Reynolds 2005).

[68] The PM is the Speaker of the General Assembly. His role is similar to the Speaker of Parliament

[69] Elected Assembly members who had been in office for more than one term were more relevant because they were in a better position to provide information on the history of issues in the Assembly. They were therefore the best source to obtain information about the MCEs during the NPP administration.

secondary data can have weaknesses as it might not be appropriate in terms of timeliness or the purpose for which such information was organised or compiled (Silverman 2005). In addition, secondary data can be incomplete and biased because record keepers might only document data "that are not embarrassing to them, their friends, or their bosses; that might reveal illegal or immoral actions; or that disclose stupidity, greed, or other unappealing attributes" (Johnson and Reynolds 2005: 231; Creswell 1994). This could explain why the HIV and AIDS Focal person at Techiman and Obuasi, and Municipal health accountants at Ho and Techiman were reluctant to give me the information on the list of NGOs that are funded by the Assembly. I needed to use my own personal ties[70] to obtain information when necessary. In spite of these weaknesses, there are good reasons to use secondary sources, including the fact that this data is 'cheap' since it has been already organised (Johnson and Reynolds 2005).

Some limitations

This study has a number of limitations. First, the analysis does not cover the specific value of the DACF that was transferred from the Assembly to the Health Directorates. An analysis of this data could enhance the determination of how successful the Health Directors were, because it can support the claim made by the Health Directors that the MCE released the funds to them. As is the case presently, it is possible that some Health Directors might not have received the funds, but they were able to cover up for their MCEs in order to maintain their relationships. I did not however focus on the actual value of the fund because most MCEs were uncooperative when it came to issues around the DACF so obtaining such data can be very difficult.

[70] I have good personal ties with all the Planning Officers of the Municipal Assemblies which I developed during Training and Workshop programmes organised by the Department of Planning (of which I am a member) at the Kwame Nkrumah University of Science and Technology, in Kumasi. These were held for Planning Officers and Budget Officers of the Assemblies. I also have good friendship ties with all the Deputy Planning Officers at the Assemblies as they were students I had taught in the university. I also have friendship ties with the Chief of Techiman, this network was established during my role in a team that assisted the Techiman Traditional Council to promote tourism.

Second, my research focused on HIV and AIDS, and it is possible that the dynamics of health care delivery with diseases such as malaria or programmes such as child immunisation will be different. It is not possible to judge if my findings would hold for other health areas. However, the findings may hold in the implementation of programmes such as CHPS, which requires good collaboration and coordination of efforts between the Assembly and the Health Directorate. The Assembly's responsibility is to construct the CHPS compounds whilst the Health Directorate sends health personnel and health equipment to the CHPS compounds. These have to be implemented within conflicts in existing institutional arrangements.

Third, I focused on the relationships between officers in the MHD and those in the MA even though three of my cases (Ho, New Juaben, and Sunyani) have Members of Parliament (MPs) who are also ministers in the government, who might have played a role in sustaining such ties. I did not include the MPs in the analysis because MPs are unlikely to be part of the day-to-day decision-making between the MHD and the MA as they are ex-officio members of the Assembly; there are also claims of tension between most of the MPs and their MCEs relating to the use of the DACF. Extending the analysis of ties to cover the MPs might blur our understanding of the effects of ties between the MA, MHD and CSOs on collaboration and coordination among these actors in health policy implementation.

3.5 Conclusion

I conducted this study using a comparative cases approach. This approach enabled me to delve beneath the surface of people's informal relations to examine the ways in which informal relationships shape the interaction between devolved Assemblies, deconcentrated Health Directorates and Civil Society actors in their efforts to deliver health services. All of these would have been difficult to capture using surveys or other types of data.

Having provided insights into the research and methodological approach to the study, I now turn to the analysis and findings in the subsequent four empirical chapters. In the following

chapter 4 I will present the field data which shows the general pattern of informal ties, embeddedness, and performance across the cases.

Chapter 4

Informal ties, embeddedness, and performance of Health Directorates

4.1 Introduction

Two expected outcomes of decentralisation are the collaboration and coordination of programmes between devolved Assemblies and deconcentrated Health Directorates; and increased consultation with citizens by Health Directorates. However, conflicts in legal and institutional arrangements may constrain effective collaboration and coordination between different parts of the state, and between the state and civil society at sub-national level. In examining the performance of healthcare delivery in this study the existence and quality of informal ties and embeddedness help to determine how the expected outcomes may occur in various municipalities in Ghana.

Having described how I conducted the study in Chapter 3, in this chapter, I present the data to show the pattern of informal ties, embeddedness, and performance across the five cases. My objective here is to show that the strength of informal ties and embeddedness varies across the cases. Additionally, I hope to show that performance of each of the Municipal Health Directorates also varies. In order to avoid monotony and duplication I do not go into detailed description of relationships between the nature of informal ties and embeddedness on the one hand, and the performance indicators on the other hand, as this is addressed in Chapters 5, 6, and 7 where I compare selected cases. In certain cases, however, especially those that were not selected for comparison, the discussion is a bit more detailed.

This chapter is organised as follows: after the introduction, I present each of the five cases in turn. For each of the cases, I present the pattern of (a) informal ties (between the Health Directorate and the Municipal Assembly), (b) embeddedness of the Health Directorate with groups within civil society working on HIV and AIDS, (c) coordination and collaboration between the Health Directorate and the Municipal Assembly (using the release of the DACF by the Municipal Chief Executive to the Health Director), and (d) the consultation

with (i) elected Assembly members; and (ii) leaders of the civil society groups working on HIV and AIDS by officers at the Health Directorate.

Generally, of the five Municipal Health Directorates, New Juaben stands out as the best performing case (see Table 4)[71]. Informal ties and embeddedness are strong and medium respectively. This is based on the number of existing ties as a percentage of all the ties being considered. Collaboration and coordination are also high, and this is measured as the number of years that the MCE released the fund to the Health Director out of the 8 year period I investigated. In addition, the percentage of Assembly members and leaders of CSOs who were consulted with by health staff is high in New Juaben. Comparatively, the worst case is Techiman which is at the extreme end of informal ties and embeddedness scales (weak for both criteria) and records low collaboration and coordination, and low consultation with citizens (see Table 4). Obuasi and Sunyani performed well similar to New Juaben. Whilst Obuasi recorded medium collaboration and coordination, Sunyani recorded high. But both cases recorded medium consultation. The difference between Obuasi, Sunyani and New Juaben is that whilst all three had medium embeddedness with CSOs, New Juaben had strong informal ties with the Assembly, whilst ties with the Assembly were respectively medium and weak for Sunyani and Obuasi (see Table 4). Ho's case is similar to Techiman except that consultation with elected Assembly members and leaders of the selected civil society groups in Ho by the Health Directorate is better than Techiman; it is medium in Ho and low in Techiman (see Table 4). In the next section, I present the detailed data for each of the cases. The discussion will be preceded by a description of the profile of the cases to include the following characteristics: population, political party activities, traditional authority, and NGO activities around HIV and AIDS.

[71] This table is a summary of Table 3 so essentially, it presents the same data and implications as in Table 3

Table 4: Summary of performance across the cases

	Cases				
	Ho	**Obuasi**	**Sunyani**	**Techiman**	**New Juaben**
a.* INFORMAL TIES - *overall	weak	weak	medium	weak	strong
(ai) Executive Officers	weak	medium	medium	weak	strong
(aii) Elected Assembly members	weak	weak	weak	weak	medium
b.* EMBEDDEDNESS - *overall	medium	medium	medium	weak	medium
(bi) NGOs	weak	medium	medium	weak	medium
(bii) Chiefs and religious leaders	medium	medium	medium	weak	medium
PERFORMANCE					
***a. Collaboration and Coordination** (access to DACF)*	low	medium	high	low	high
b. Consultation	medium	medium	medium	low	high
(bi) Consultation (elected Assembly members)	low	medium	low	low	medium
(bii) Consultation (CSOs)	medium	medium	medium	low	high

Note: (A) **Informal ties**/e**mbeddedness** is strong if (≥ 70%), medium (40%-69.5%), and weak (≤ 39.5%). (B) **Collaboration** and **Coordination** - high if (≥ 70%), medium (40%-69.5%) and low (≤ 39.5%). (C) **Consultation** is high if (≥ 70%), medium (40%-69.5%), and low (≤ 39.5%).

4.2 New Juaben

New Juaben, the main tourist destination in the Eastern region of Ghana is the best performing case among the five cases studied. It had a population of 136,768 in 2000 and with a growth rate of 2.6 percent, it is projected to be a little above 160,000 in 2007 (Republic of Ghana 2005d). About 65 percent of the population is concentrated in Koforidua, the municipal capital. The municipality is heterogeneous in terms of ethnicity and religion. The several ethnic groups include Akans (52 percent), Ga-Adangbe (21 percent), Ewes (15 percent), and ethnic groups from the northern parts of the country constitute (12 percent). In terms of religion, the municipality is predominantly Christian (about 83 percent). Moslems constitute 6 percent and those of traditional faith constitute 11 percent.

The municipality has been the stronghold of the New Patriotic Party (NPP) which lost the 2008 general elections. The NPP has retained the parliamentary seat for the New Juaben constituency in the 1992, 1996, 2000, 2004, and the 2008 elections.

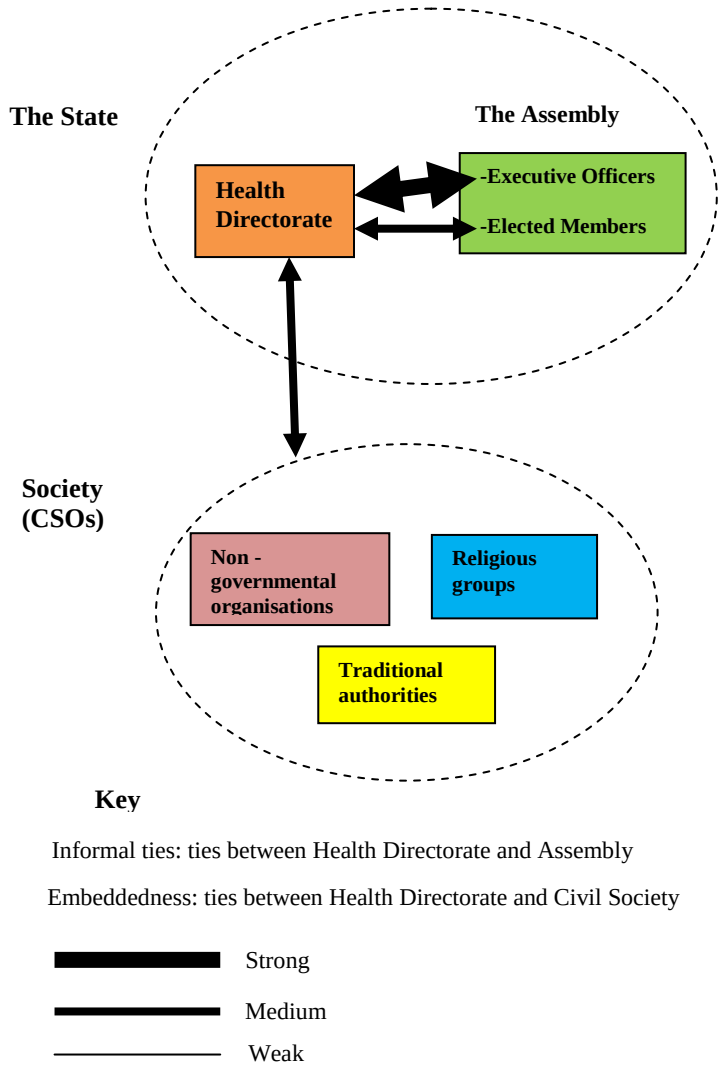
The New Juaben Traditional Council is headed by a Paramount Chief. Durbars and other gatherings organised by the Paramount Chief are effective platforms for the promotion of healthcare in the municipality by the Municipal Health Directorate, Civil Society Organisations, and the New Juaben Municipal Assembly.

A number of private, not-for-profit voluntary and non-governmental organisations complement the efforts of the Assembly and Health Department in a number of ways. Among them are Enowid Foundation; Human Development Foundation; Redemption Youth Relief Association; Lamp of Peace Association; Mathew 25 House; 4-H Ghana; and Rural Watch. These NGOs are engaged in a wide range of activities including HIV and AIDS awareness campaigns, youth development, and community development schemes.

4.2.1 Informal ties with Municipal Assembly

The overall strength of informal networks between officers at the Health Directorate and the Municipal Assembly is strong (69.78 percent). In terms of ties with *executive officers* of the Assembly, it is strong (72.91 percent) (refer to Tables 2 and 3 in chapater 3, Table 4 in this chapter and see Figure 5 below.

Figure 5: Informal ties and embeddedness in New Juaben



Even though ethnic ties are relevant, neighbourhood bonds or the *abusua* are predominant in the municipality. Each of the three officers from the Health Directorate has *abusua* ties with all the four *executive officers* from the Assembly, and all of them have ethnic ties with three of the officers of the Assembly apart from the Planning Officer. However, the Planning officer and the Health Director were school mates in the former Soviet Union in the 1980s. Each of these officers indicated that *abusua* ties are important to them and they

are keen on maintaining those ties. On the average *abusua* relations have been in existence among these officers for a period of 6 years. For example, one of the officers from the Health Directorate explained how long he has had *abusua* relations with officers of the Assembly and why he would do everything possible to maintain those relationships.

> I have been working here for the past 10 years away from my immediate family so I have established a new *abusua* with the people I work with here. As far as my job is concerned I work with a lot of institutions but the first on the list in terms of my frequency of contacts and interaction is the Municipal Assembly. Therefore the top officers are the people who have become important part of my new *abusua*. I know they also see me in the same light. So I receive most of the support that my immediate family would give me from them and I also do the same to them [Staff of the Health Directorate, New Juaben, 27th October, 2008].

The officers at the Assembly made similar statements about the *abusua* ties they have with their counterparts from the Health Directorate. According to one of them:

> Those whom we work with have become our special friends and everything. We see ourselves more as *abusua* than work colleagues. Having worked here for 5 years I have become close to people such as the Health Director and his staff and we all look up to each other in times of social needs. We have supported one another in many ways that I cannot even remember and list to you. You will not tell me you can remember all the good things you have done to the people who are close to you and what they have done to you. But I will say one of the ways is support during funerals or church programmes for fund raising etc. [An Executive Officer, New Juaben Municipal Assembly, 6th November, 2008].

The fact that these officers work in the city away from their immediate and extended families would mean that they lack support in times of need so it sounds logical that those people that they work with and interact with on daily basis would become their *abusua* from whom they would expect support and to whom they would also offer their support.

The data on informal ties with elected Assembly members suggest that the ties are medium (66.66 percent) (refer to Figure 5 and see Table 6 in Chapter 6). According to the officers from the Health Directorate, Assembly members constitute one important group of stakeholders whose roles matter a lot in what the Health Directorate does towards delivering better health services to the people. As one of them stated:

> The fact is that you cannot bypass the Assembly members and think that you will be able to do anything meaningful in the communities. Some of them are very influential and most are highly respected in their electoral areas. Most people develop a sense of belonging and ownership when they find that you are working with their Assembly member. So we do everything to maintain good relationships with the Assembly members. We attend all kinds of functions when they invite us and they attend ours especially Christmas and New Year parties [A staff, New Juaben Municipal Health Directorate, 28th October, 2008].

The recognition of the Assembly member as a stakeholder with a critical role to play in the implementation of health policy would suggest that fostering the relationship between officers of the Health Directorate and the Assembly members becomes a significant issue to the Health Directorate staff who have the statutory mandate and are responsible for health service administration. As one of the officers said, many Assembly members are highly respected by the people in their electoral areas. Therefore once the Health Directorate get the Assembly members to support their programmes it would be easy to get the people as well. As I show later in Chapter 6, the Health Directorate employed these ties with the Assembly to access additional funding for most of its top priority projects geared towards promoting responsiveness to citizens.

Apart from ethnic, *abusua*, and old-school ties that exist across the Health Directorate and the Municipal Assembly, over 80 percent of officers in these two institutions are bound by strong political party ties.[72] They belong to the ruling New Patriotic Party (NPP). The strong party affiliation further strengthens the other ties. As I show in Chapters 5, 6, and 7, the existence of a complex overlap of party ties with ethnic, and old-school networks seems to have contributed in significant ways to promote and also undermined how the devolved Assemblies and the deconcentrated Health Directorates implement HIV and AIDS programmes.

4.2.2 Embeddedness of the Health Directorate with CSOs working on HIV and AIDS

New Juaben Municipal Health Directorate is one of the four cases that recorded medium embeddedness with civil society (refer to Figure 5 and Table 4 in this chapter). In a discussion with leaders of NGOs, Directors of three of the four NGOs indicated that they have two of the three types of ties with the Health Directorate.[73] The ties are ethnic (they

[72] It must be noted that most of the interviewees were not prepared to disclose their political party affiliation (especially the Health Directors, Coordinating Directors and some Assembly members). Those who were willing to disclose their party affiliation were those who said they were members of the NPP. It was more difficult for those who belong to the NDC to disclose it. This might be due to the fact that the NPP was in power at the time I conducted the interviews. It was easier for most of the interviewees to say they belonged to the NPP than say they were NDC members. This may be necessary for protection of jobs and positions. I used other sources to obtain these data. To make the analysis stronger, I have decided to include the information in the thesis. For ethical reasons and to preserve the confidentiality of my informants, the names and party affiliations will not be included in portions of the thesis that will be published in future.

[73] Mathew 25 House, 4-H Ghana, and Faith and Hope Foundation.

are all Akans from Juaben) and *abusua* networks. The leader of one of the NGOs even has old-school ties with two officers at the Health Directorate (see Table 7 in Chapter 7). She explained that:

> The Deputy Director of Nursing Services (DDNS) and I have been friends and neighbours for over 10 years. We were in the nursing training school and we have been working together after school. I have also worked with Mr. Boateng for over 5 years. All of the officers at the Health Directorate are brains behind the establishment of this NGO. In fact, the DDNS inspired me to do this when we worked in the hospital and we found a lot of people with the disease and there seemed to be no help for them. Because of this, officers at the Health Directorate have always made me part of what they do towards fighting HIV and AIDS [A leader of NGO, New Juaben, 16th Sept., 2009].

The leader of another NGO also added that:

> The Health Director and I come from the same village. We attend the same church. In addition to these relations, we have worked together for over 6 years. I was a key advisor to the Municipal HIV and AIDS Committee for over 5 years since 1998 until I left to set up this NGO. The Health Directorate has relied on us to implement HIV and AIDS programmes, and currently we do Tuberculosis (TB) as well because the Health Director said HIV, AIDS and TB go together. Even though we don't have funds for TB, I do it [A leader of NGO, New Juaben, 16th Sept., 2009]

Health staffs also have medium ties with traditional authority (see details of data in Table 8 Chapter 7). In addition to the *abusua* ties that officers at the Health Directorate have with members of the Traditional Council, one of them was the focal person for the Health Directorate's HIV and AIDS awareness programme which started in 2005 targeting market women in the areas of prevention of mother to child transmission (PMCT). According to a member of the Traditional council:

> The first people I look up to in times of bereavement include Mr. Boateng and his staff. The next group include the Municipal Chief Executive and other key officers of the Assembly. In the same way I am also invited by these people when the need arises. Mr. Boateng is my personal friend and you can ask him. I go to him anytime. I have personally championed the cause of women concerning HIV and AIDS. I mobilise the market women for talks by the Disease Control Officer. They leave their wares and come because of me. As you know women are more vulnerable and also issues about transmitting to children by pregnant women have become important. Because I am a Queenmother, the Health Directorate uses me to get health matters discussed with the paramount chief who is also keen on reducing HIV and AIDS in New Juaben [Member, New Juaben Traditional Council, 21st Sept., 2009].

The study revealed that ties between staff at the Health Directorate and women who are members of the traditional authority have been in existence for over 10 years. My impression is that these ties are very important to the health officers as they enable them to reach women with programmes that seek to prevent mother-to-child transmission of HIV

and AIDS. Their relationships also enable them to receive good support from the paramount chief.

With regard to political party ties, officers in the Health Directorate are strongly connected with most of the leaders of NGOs. Most of them are NPP members. In addition, leaders of the religious groups I interviewed are NPP. This further strengthens the Health Directorate's ties with the CSOs. It is only the paramount chief who is NDC member. Generally, party ties between officers in the Health Directorate and leaders of civil society organisations are strong.

4.2.3 Collaboration and coordination: access to the DACF

The New Juaben Municipal Health Directorate is one of the two cases in which there is a high level of collaboration and coordination between the two decentralised institutions (refer to Table 4 and see Table 5 in Chapter 5). The Health Director had good access to the fund. He received it consistently from 2000 to 2004, and between 2004 and 2008. It was only in 2005 and 2006 that he did not receive an allocation (see Table 5 in Chapter 5). Compared with the other cases New Juaben performed well given that there was no consistency in receipts of the fund by Health Directors in the other cases between 2000 and 2004. It is only Sunyani which registered some consistency but it was only so for the period between 2000 and 2003. Why this might be so is discussed in Chapter 5 where I compare New Juaben with Techiman.

4.2.4 Consultation with elected Assembly members and HIV and AIDS CSO leaders

I compiled a composite table of programmes aimed at managing HIV and AIDS (See Appendix H for details of the process and see Table 11, Appendix I showing the programmes) and I asked the elected Assembly members whether they were consulted by officers from the Health Directorate in the development and implementation of those programmes. Out of the 10 elected Assembly members I interviewed, 6 of them indicated that they were consulted (see Table 12 in Appendix J). This suggests that consultation with Assembly members is medium. Among these elected members is one whom I consider to

be the most active member during the General Assembly meeting. His views, which give good indication of the nature of consultation which the Health Director undertakes, are presented below:

> Mr. Boateng sees Assembly members as partners as far as dealings with HIV and AIDS in Koforidua are concerned. He always calls us to his office to discuss visits to our electoral area before the outreach team comes. I think he does that because he respects us and he knows that we can help him. He even asked me if I could first explain the 'know-your-status' campaign to my people during my meetings with them.[74] He has not undertaken any programme without letting us know about it. Take for example the issue about National Health Insurance registration. He used us a lot [Elected Assembly member, New Juaben, 16th Sept., 2009].

The views of one of the interviewees at the Health Directorate about this Assembly member's explanations of why elected Assembly members are consulted further show that consultation is acceptable in the municipality. According to this officer, the Health Director organised training on 'community entry techniques' for the outreach team not only for the 'know-your-status' and voluntary counselling and testing campaigns but also for immunisation and other public health campaigns that require that they visit the communities. She explained that:

> Our director has always insisted that we are cautious not to bypass the community leaders when we go for immunisation and other visits. He organised training for us to be able to know how to get to the people. We are able to do this easily because we use the Assembly members and the chiefs [Staff of Health Directorate, New Juaben, 18th Sept., 2009].

The story of another elected Assembly member Hon. Alhaji Alhassan Mahama also echoed the acceptable level of consultation by the Health Directorate.[75] His story gives further credence to the claims by other Assembly members and staff at the Health Directorate that elected Assembly members are very important to the Health Directorate. His story is presented below:

> The Director of Health and the manager of the National Health Insurance Scheme (NHIS) relied heavily on me to educate my people about the NHIS. I was able to do it so well that my electoral area recorded the highest registration for the scheme. I was therefore awarded two citations. This has never happened in this municipality and I am very proud about that. As a result of this recognition I am doing the same thing to create awareness about HIV and AIDS and propagate the message about the use of condoms in my electoral area. This is what the Health Director wants me to do. I do it every Friday at the mosques around the

[74] This is a national programme which encourages people to go for voluntary counselling and testing to know their HIV-status. It is one of the major areas that the Health Directorates have focused their resources.

[75] Hon. Alhaji Alhassan Mahama gave his consent for me to mention his name and publish his picture with his citations which is presented in Appendix N.

> municipality [Hon. Alhaji Alhassan Mahama, Elected member for KNT community C and D electoral area 16th Sept., 2009].

I discuss how this level of consultation with elected Assembly members seemed to have enabled the Health Director to obtain additional funds for health projects in Chapter 6. This, I hope, would enhance our understanding of how elected Assembly members influence decisions around HIV and AIDS management in the New Juaben municipality.

With respect to consultation with leaders of civil society groups who worked on HIV and AIDS programmes, of the 5 NGOs I interviewed, 4 of them indicated that the Health Director consulted them around HIV and AIDS issues (see Table 13 in Appendix K). The Director of one of the NGOs claimed that he was one of the leaders who were requested by the Health Director to include tuberculosis in HIV and AIDS programmes. He indicated that:

> The Health Director always invites us for meetings to discuss HIV and AIDS especially how to provide care and support for people with the disease. He organises training workshop for our volunteers who work in the communities to be able to detect and identify HIV, AIDS and TB patients. He has been a key advisor to my NGO and I also consult him a lot [Head of an NGO, New Juaben, 16th Sept., 2009].

4.3 Sunyani

Sunyani, the Brong Ahafo regional capital is becoming the centre for international conferences because of its reputation as the cleanest city in Ghana. The 2000 Population and Housing census shows that the population of the municipality is about 179,000 with a growth rate of 3.8 percent (Republic of Ghana 2005d). The population is fairly split between males and females (about 50 percent each). The population is however young with those in the 15-64 year group constituting about 57 percent. With respect to ethnicity, the Brongs/Bonos dominate (about 74 percent). There are however several other minority ethnic groups. In terms of religion, Christians constitute the majority (about 82 percent), followed by Moslems (12 percent). The rest comprises of those of traditional faith and atheists.

Results from the 2008 Presidential and Parliamentary elections suggest that Sunyani is a stronghold of the ruling NDC. In fact, when the first round of voting could not produce a clear winner between the NDC and the NPP, it was one of the constituencies in the Brong Ahafo region that gave the NDC a win following a run-off. But there are also claims that Sunyani can swing to either NDC or NPP at anytime as some of the founding fathers of the NPP come from the Brong Ahafo region.

The Sunyani Traditional Authority is the seat of the paramount chief of the traditional area. It is one of the influential traditional councils in the Brong Ahafo Region as the bulk of Ghana's cocoa is produced in the region. The traditional council's views on health matters are heavily shaped by its role as the custodian of culture, traditional norms and values.

Over 80 percent of NGOs and Community Based Organisations (CBOs) in the municipality were into HIV and AIDS programmes ranging from education campaigns to the provision of care and support and economic empowerment of people living with AIDS (PLWAs).

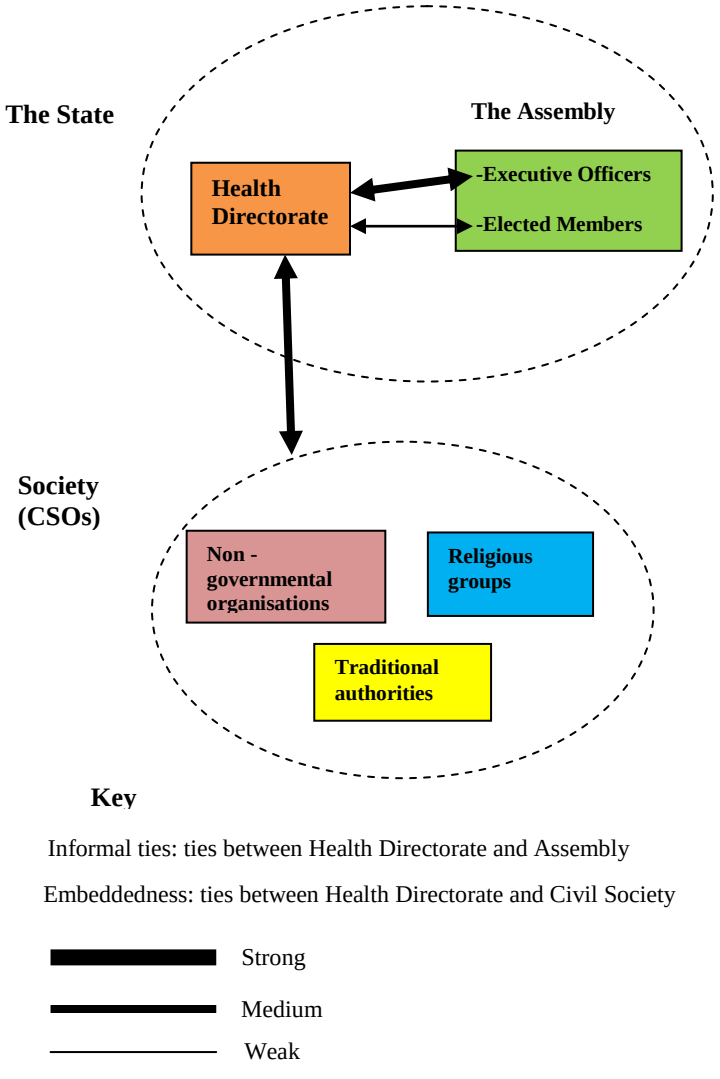
4.3.1 Informal ties with Municipal Assembly

The strength of informal ties between the Sunyani Municipal Health Directorate and the Assembly is medium, and ties with *executive officers* alone are also medium (refer to Table 4 and see Figure 6 below). Unlike New Juaben where ethnic ties are common among the various actors, two officers from the Health Directorate relate with only two out of the four officers from the Assembly on ethnic lines (refer to Table 2 in Chapter 3). Just like New Juaben, *abusua* relations are very common. Reasons such as support during bereavement explained why most of them maintain those *abusua* ties. What is unique with informal relations between staff from the Health Directorate and those in the Assembly is that some of them employ it as a form of collateral security to acquire loans and property. For example one officer from the Health Directorate said:

> Because of my friendship ties with officers at the Assembly, I used three of them as guarantors to apply for a loan. I did this in 2004, 2006 and 2008 and each time I use the same people. The bank just needed someone who would vouch for me to say that I can be trusted. I have also guaranteed loans for some of them. I know that other members of staff also do the same thing [Officer, Sunyani Municipal Health Directorate, 21st October, 2008].

This suggests that *abusua* ties are important and that most of the officers trust one another, and as indicated in the literature on informal ties, trust is one of the important ingredients that are required for the sustenance of personal relationships (Tsai 2007; Putnam 1993). For any of them to stand as guarantors for loans would mean that the persons involved took great risk because if the loans are not repaid the guarantors would be held liable. Also for the beneficiaries to honour and pay back the loans means they cherish their relationship with their guarantors and they would not conduct themselves in a way that would undermine that relationship. In addition to all the other forms of support that *abusua* ties provide the officers in Sunyani, its relevance when it comes to accessing personal loans from banks would mean that such ties would be sustained for a long time.

Figure 6: Informal ties, embeddedness in Sunyani



In the case of ties with elected Assembly members, health officers have *weak* ties with them (refer to Figure 6 and Table 3 in Chatper 3, and Table 4 in this chapter). The two important bonds are around ethnic and *abusua* relations (see Table 6 in Chapter 6). None of the health staff have old-school bonds with them. But what is striking is that informal ties enable Assembly members to borrow and lend money. One of the Assembly members explained that:

> There are people at the Health Directorate who lend me money anytime I needed money urgently. I see them as the people I can trust who will not let anybody hear about this. There are other people who will not give you such support when you need it but they will go about telling others about how broke you were and that you came to them to borrow money. I will not go to anybody I do not trust that is why I know where to go if the need arises [Elected Assembly member, SMA, 16th September, 2009].

Officers from the Health Directorate indicated that they would be willing to lend money to those with whom they had good *abusua* ties.

In terms of political party affiliation in Sunyani, whilst the Health Director is a member of the ruling National Democratic Congress (NDC), the Chief Executive belongs to the New Patriotic Party (NPP). The Municipal Coordinating Director is also a member of the NPP. In addition, about 80 percent of Assembly members are NPP members (refer to Table 2 in Chapter 3). This made it difficult for the Health Director to work with the MCE and the Assembly members. The data however show that political party ties across the Health Directorate and the Assembly is strong overall just like the case in New Juaben. This is because other officers at the Health Directorate are NPP members. This is a significant difference between Sunyani and New Juaben where all the officers in the Health Directorate are NPP sympathisers. The difference in political parties helps to explain the weak collaboration between the Health Director, responsible for decision making, and the Municipal Chief Executive (I explore this in detail in Chapter 6). It also helps to explain the inability of the Health Director to consult with and obtain the support of the 80 percent of Assembly members who are NPP members.

4.3.2 Embeddedness of the Health Directorate with CSOs working on HIV and AIDS

Generally the strength of embeddedness of the Health Directorate within civil society is medium (refer to Figure 6), and Sunyani is one of the four cases that recorded medium embeddedness with CSOs (refer to Table 4). Regarding ties with NGOs alone leaders of three NGOs out of five have both ethnic and *abusua* ties with the two officers in the Health Directorate (see Table 7 in Chapter 7). They are from Brong which is the major ethnic group in the municipality. Apart from the *abusua* ties which four of the NGO leaders have with the Health Director, none of them has ethnic ties with the Health Director. The Health Director is from Akwapim in the Eastern region. Essentially, their *abusua* bonds are around mutual and reciprocal social support systems similar to those found in New Juaben and the other cases. It is interesting to note that the leader of one of the NGOs did not have *abusua* ties with the Health Director given that it seemed to be common with other NGOs. She explained that she would not consider the Health Director as one of the persons from whom she would receive support in the event of funerals, church harvest, and weddings. However, this did not mean that she did not have good working relations with the Health Director. This is how she explained it:

> The Health Director and I work well and he has endorsed my proposals for funding to do HIV and AIDS programmes. We know each other very well for about 6 years except that we do not have that kind of personal relations. I won't say he is an *abusua* as you put it. But I won't say the same thing about the Public Health Nurse and the Disease Control Officers. These are people who invited me for their private functions and I also did the same in the past and we shall continue to do so. I will say these are part of my *abusua*. So I won't say that he endorses my proposals because we are friends. The Ghana AIDS Commission requires that our proposals are endorsed by him to show that we are recognised and credible NGO [A leader of NGO, Sunyani, 4th May 2009].

For the leader of this NGO to indicate that she and the Public Health Nurse and the Disease Control Officer mutually support each other and that she did not have that informal arrangement with the Health Director means that first, *abusua* ties mean a lot to her, and second, there are boundaries that define the extent of neighbourliness in terms of who falls within one's *abusua* networks and who falls outside of that.

In terms of embeddedness with other civil society actors (heads of traditional authority and religious leaders) Sunyani compares well with Ho, Obuasi, and New Juaben recording medium informal relations (see Table 8 in Chapter 7). There is equal strength of ethnic

relations and *abusua* ties between the Health Directorate and traditional authority and the church. The nature of embeddedness seemed to have played a major role in the implementation of HIV and AIDS policy in Sunyani. I explore this in Chapter 7 where I discuss how the Health Directorate uses its informal ties with civil society actors to remove social norms that can undermine the implementation of HIV and AIDS policy in the district.

The Health Director in Sunyani has weak political party ties with leaders of civil society groups. Whilst he is NDC member, the paramount chief and leaders of religious organisations are NPP sympathisers. In addition, about 80 percent of all leaders of NGOs belong to the NPP. Unlike the Health Director, three other officers in the Health Directorate have NPP ties with leaders of CSOs. This might have compensated for the Health Director's weak ties with them because overall, there is increased consultation of CSOs around HIV and AIDS programmes by the Health Directorate.

4.3.3 Collaboration and coordination: access to the DACF

The Health Director in Sunyani also performed well. He is in the high access category (refer to Table 4 in this Chapter and Table 5 in Chapter 5). The Sunyani case is interesting because allocations to the Health Director were intermittent. He received the fund continuously for three years from 2000 with no receipts in 2004. He received allocation again in 2005 and 2006 with another break in 2007 and then allocation was made to him again in 2008 (see Table 5 in Chapter 5). Given that there were breaks in allocation for only two periods, the Health Director could perhaps have obtained his allocations during these periods if he had been more diligent. I base this observation on the assumption that the existence of a 'sister-city relationship' with a local government authority (District of Nanaimo) in Canada may have highlighted the way in which the Chief Executive allocated funds.I explain this when I compare Sunyani with New Juaben in Chapter 7.

4.3.4 Consultation with elected Assembly members and HIV and AIDS CSO leaders

Consultation with elected Assembly members by staff from the Sunyani Municipal Health Directorate is low (refer to Table 3 in Chapter 3 and Table 4 in this Chapter). Out of the 10 elected Assembly members, only 3 of them indicated they have been involved by the Health Directorate in various ways with programmes to manage HIV and AIDS (see Table 12 in Appendix J). There is inadequate evidence to show that the Health Director uses Assembly members to push his programmes through the Assembly. The evidence suggests that the option of using the Assembly members might not be attractive to staff at the Health Directorate due to heavy politicisation of the Assembly resulting in episodes of the Chief Executive frustrating the work of Assembly members.

All three Assembly members consulted with by the Health Directorate indicated that they have been involved at the community level in the mobilisation of the people in their electoral areas for campaigns to promote condoms. For example, one of them explained that:

> I led a team of leaders of NGOs and staff from the Health Directorate to undertake public campaigns in the main lorry station which is in my electoral area. Since my people like me, when they see me to be part of any activity then they will come around to listen so I have played a key role in this respect. In addition to the campaigns at the lorry stations, I have also helped the Health Directorate to promote condom related issues in my church [Elected Assembly member, Sunyani, 5th May 2009].

Even though only few of the Assembly members claimed to have been actively involved or consulted by the Health Directorate, they seemed to have made a useful impact on the promotion of condoms in the Sunyani municipality. I present evidence of this when I compare Techiman and Sunyani (in Chapter 7).

In spite of the low consultation with elected Assembly members, the strength of consultation with leaders of HIV and AIDS civil society groups is medium (refer to Table 4 and see Table 13 in Appendix K). It seems that although staff at the Health Directorate could not effectively use Assembly members to influence health issues in the Assembly, civil society provided a viable alternative. This appears to have worked well as we see in Chapter 7. The health officers used leaders of civil society actors to help remove the

negative perception that most people have about HIV and AIDS as a disease; people infected by the disease; and condoms as one of the means to minimise the spread of the disease.

4.4 Obuasi

Ghana's major gold mining city is Obuasi. According to the 2000 Population and Housing census, the population of the municipality as at the end of 2005 is 195,000. It is estimated to have an annual growth rate of 4 percent mainly due to the influx of migrants into the municipality as a result of mining activities (Republic of Ghana 2005d). About 48 percent of the population falls in the dependent age cohort (0-14, and 65+). The potential labour force is a little over 50 percent. In terms of ethnicity, it can be referred to as cosmopolitan constituting many ethnic groups. It is an Akan dominated municipality, therefore cultural practices of the Akans predominate.

The municipality has been a stronghold of the New Patriotic Party (NPP) which has won a majority of parliamentary seats and also presidential votes for the NPP in the past three elections. Obuasi municipality is part of the Ashanti Kingdom but it has its own paramount Chief and a number of sub-chiefs as heads of the various communities and ethnic groups.

Because of the mining activities and the high prevalence of HIV and AIDS in the municipality, there are a number of NGOs (about 6) and Community Based Organisations (about 15) that mobilise around the disease. Essentially they provide public education and awareness campaigns. A number of them also provide care and support facilities to people with the disease.

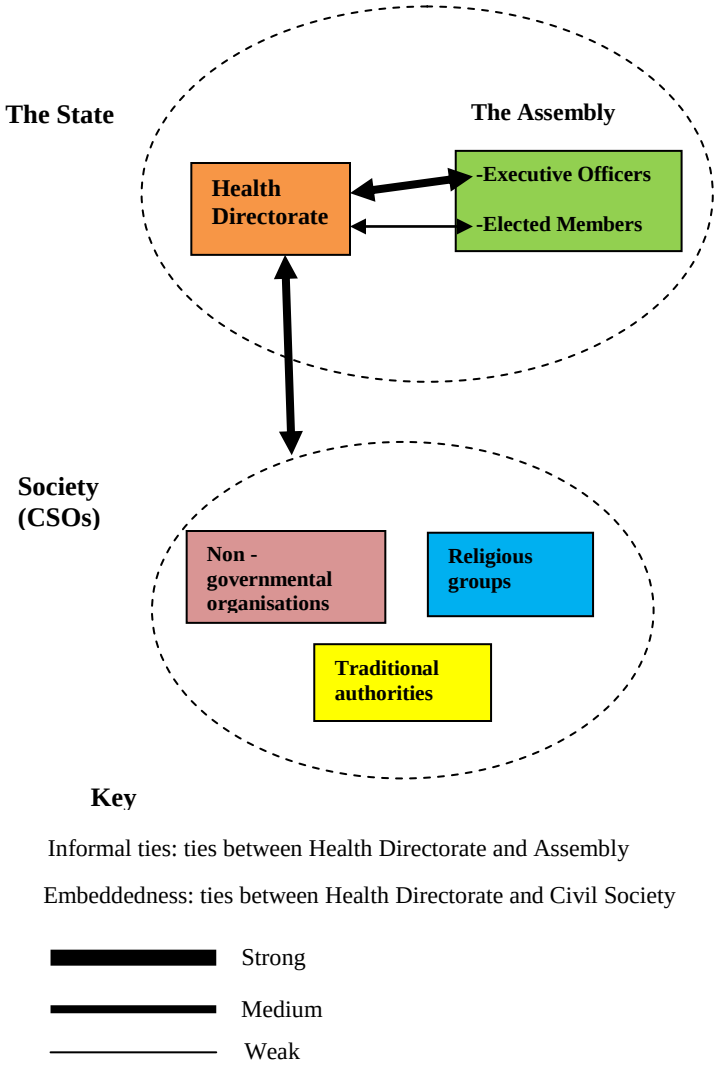
4.4.1 Informal ties with Municipal Assembly

Generally, there are weak ties between the Health Directorate and the Assembly. With respect to *executive officers* of the Assembly, the strength of ties in Obuasi is medium like Sunyani (see Figure 7 and refer to Table 3 in Chapter 3 and see Table 4 in this Chapter). Obuasi is similar to Sunyani in terms of ethnic ties. According to the data in Table 2

(Chapter 3), two officers from the Health Directorate have ethnic ties with two officers from the Assembly. One difference between Obuasi and Sunyani is that old-school is one of the ties that exist between the Chief Executive and the Health Director in Obuasi. This is the similarity between Obuasi and New Juaben. These are the two cases in which old-school ties between the Health Directorate and the Assembly emerged in the analysis.

Ties with elected Assembly members are weak in Obuasi (see Figure 7). Both Obuasi and Sunyani have medium ties with Executive Officers of the Assembly, and both have weak ties with elected Assembly members (refer to Table 4 and also see Table 6 in Chapter 6). This implies that there is wide difference between Obuasi and New Juaben where ties with Assembly members are medium.

Figure 7: Informal ties and embeddedness in Obuasi



Political party ties in Obuasi are generally strong. Just like the case in Sunyani where the Health Director is a member of the opposition NDC, a high ranking officer at the Health Directorate (Deputy Director of Nursing Services - DDNS) in Obuasi belongs to the NDC. In spite of this, there is no evidence to suggest that the DDNS's membership of the NDC affected collaboration between the Health Directorate and the Municipal Assembly. Collaboration is strong partly because the Health Director who is the main decision-maker is NPP, which makes it easy for him to work with the Chief Executive and the large proportion of Assembly members who are NPP.

4.4.2 Embeddedness of the Health Directorate with CSOs working on HIV and AIDS

The nature of Health Directorate's embeddedness in Obuasi is medium, similar to the case in Sunyani and New Juaben (refer to Figure 7 and see Table 3 in Chapter 3 and Table 4 in this Chapter). In Obuasi, however, two out of three NGOs have both ethnic and *abusua* networks with two of the officers from the Health Directorate (see Table 7 in Chapter 7). The ethnic bond is Ashanti and in fact, the Ashantis constituted the largest proportion of the population in Obuasi at the time of this research. There was no evidence of ethnic relations between leaders of all the NGOs and the Public Health Nurse. Even though ethnic relations enhance *abusua* bonds, most officers in Obuasi have good *abusua* ties without ethnic ties.

Informal ties between the Health Directorate on the one hand, and the church and traditional authority on the other hand are also medium. There are instances where there are ethnic bonds but no *abusua* ties. Conversely there are also instances where *abusua* ties exist yet they did not have ethnic relations (see Table 8 in Chapter 7).

With respect to political party ties between the Health Director and leaders of CSOs, there is an equal split. Leaders of religious groups split equally for NPP and NDC. Apart from this, the paramount chief is NPP and about 70 percent of leaders of NGOs are NPP members. This gives the Health Director strong NPP ties with leaders of HIV and AIDS CSOs.

4.4.3 Collaboration and coordination: access to the DACF

The Health Director in Obuasi also performed well even though there were inconsistencies in disbursements similar to Sunyani. However, the Obuasi case suggests there is a relationship between when the funds are allocated and the election calendar in the country suggesting that the elections influence the Chief Executive's actions.[76] According to Table 5 (Chapter 5), the funds were released in 2000. There were no releases in 2001 and 2002, then there was a release in 2003 when preparations were underway ahead of the 2004 elections. The Health Director received the funds again during the election year and the year after. The cycle started again with a break in 2006 and a release in 2007 ahead of the elections in 2008 with a further release in 2008 during the elections.

4.4.4 Consultation with elected Assembly members and HIV and AIDS CSO leaders

The picture in Obuasi in terms of the Health Director's consultation with citizens is similar to the level of consultation in Ho and Sunyani (medium) (refer to Table 4 in this chapter). However, there are striking differences between Obuasi and New Juaben. Six out of the 10 elected Assembly members were consulted by the Health Directorate (Table 12 in Appendix J), although the Health Directorate has weak ties with elected Assembly members (refer to Table 6 in Chapter 6). The weak informal ties did not constrain the Health Directorate's efforts to make Assembly members participate in programmes to address HIV and AIDS in the municipality. Obuasi's case appears to be unique which might be explained by the fact that the Obuasi Municipal Assembly is also actively involved in HIV and AIDS awareness creation in the municipality evidenced by the numerous sign boards spread all over the municipality (see Appendix N). Obuasi is the only case in which the Municipal Assembly has erected these sign boards to create HIV and AIDS awareness. The role of the Assembly might partly explain why most Assembly members are consulted by the Health Directorate.

[76] Elections were held as follows: 3rd Presidential and Parliamentary elections (2000); 4th Presidential and Parliamentary elections (2004); and 5th Presidential and Parliamentary elections (2008).

The consultation with those groups within civil society working on HIV and AIDS is medium (refer Table 4). All the three active NGOs and a very influential religious leader claimed that they participate in all the programmes initiated by the Health Directorate to manage HIV and AIDS.[77] According to the leader of one of the NGOs:

> One of the key programmes to address HIV and AIDS is the development of HIV and AIDS Work Place Policy by the Municipal Assembly. The Health Directorate and NGOs actively pushed and lobbied the Assembly to do this in 2005. It was not like the Assembly would not do it but the issue was how soon? So we lobbied to facilitate it. Another example of the active role NGOs play was that we saved over 200 PLWAs in 2007. We had a hint that prayer camps were keeping these 200 or more PLWAs. You see, they had been indoctrinated to believe that HIV and AIDS were spiritual diseases and that the devil was responsible, and those pastors claimed that they could pray for them for healing. Someone secretly informed us that the PLWAs were being abused. They were being starved, beaten to confess their sins that they were promiscuous so their sins will be forgiven and so on. So together with the Health Directorate, we raided 3 prayer camps to release those PLWAs [Head of an NGO, Obuasi, 17th June 2009].

The Municipal Coordinating Director, Planning Officer, and the HIV and AIDS focal person at the Assembly all indicated their awareness of the joint lobbying of the Health Directorate and NGOs to get HIV and AIDS policy drafted by the Assembly. According to the Focal person for HIV and AIDS, coordination of efforts by the various actors, especially among NGOs, the Assembly, and Health Directorate, is important to the Assembly. This is because of the threat the disease poses to the municipality as a mining area which attracts all kinds of people from all over the world, particularly from neighbouring countries such as La Cote D'Ivoire, Togo, Burkina Faso, Mali, Liberia, and Nigeria.

4.5 Ho

The location of Ho on the Ghana-Togo border makes the municipality a popular transit point in the Volta region. It has a population of 200,000 with a growth rate of about 1.3 percent. The municipality's population is estimated to reach 217,000 by 2008 with about 37 percent resident in urban areas whilst the rural population is estimated to be around 63 percent (Republic of Ghana 2005d).

[77] According to my key informants, this pastor was 'powerful' in terms of his religious capabilities. They claimed that he had a prayer camp which attracted all kinds of people from Ghana and outside of Ghana to seek solutions to their problems including finding cure for HIV and AIDS.

The Ho municipality is located in a region considered a stronghold of the National Democratic Congress (NDC) because the founder of the NDC, former President Jerry Rawlings hails from that region.

The Ho Traditional Council is very influential in the municipality partly because the office of the Volta Regional House of Chiefs is located in the municipality. Local chiefs therefore play a significant role in the fight against HIV and AIDS in the district. Their durbars are good platforms for NGOs to mount educational campaigns especially during festivals when all kinds of tourists arrive in the municipality.

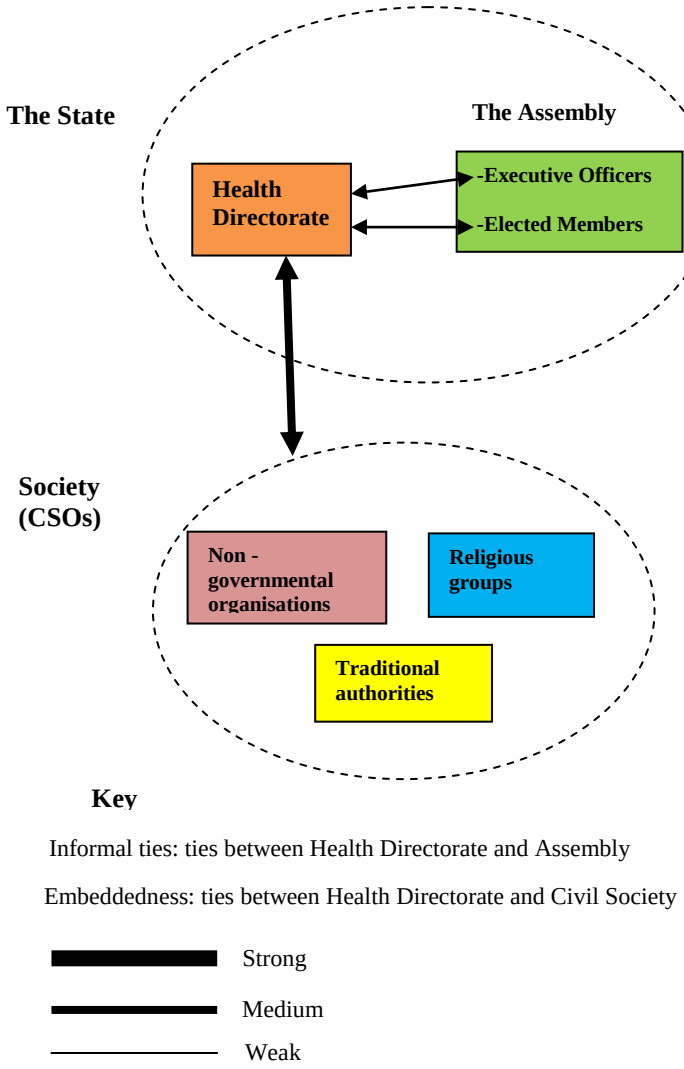
There are a number of NGOs in the municipality that mobilise around HIV and AIDS. One of such NGOs (FUGI – Future Generations International) is among 17 NGOs selected by the United States Agency for International Development (USAID) as partner in the fight against HIV and AIDS. In spite of the fact that NGOs are doing well in the Ho District, most of them are concentrated in the municipal capital thereby neglecting the remote communities.

4.5.1 Informal ties with Municipal Assembly

In Ho, ties between the Municipal Health Directorate and the Assembly are weak (28.95 percent) overall (refer to Table 4, and see Figure 8 below). Ethnic ties are predominant but these did not promote good neighbourliness or *abusua* relations. Ho's case is interesting because Ho is in the Volta region of Ghana and there is a popular perception among most people in Ghana that the people from the Volta region see themselves as 'brothers' and 'sisters' or one big 'family.' This long held perception arose because, compared with other parts of Ghana, the Volta Region appears to have fairly homogenous people with very blurred ethnic lines. It is common to find that different people from the Volta region easily relate to each other when they meet in other places such as Accra or Kumasi, and consider themselves 'family' irrespective of which part of the region they come from. In most offices across the country, there is the common perception that those from the Volta region

treat their neighbours from the region with special kindness. On this basis, I expected to find informal ties to be strong or at least strong *abusua* ties which should be pushed by strong ethnic solidarity.

Figure 8: Informal ties and embeddedness in Ho



This finding is equally surprising because according to the data in Table 6 (Chapter 6), informal ties with elected Assembly members were also weak (refer also to Table 4). Although over half of the Assembly members have ethnic relations with the staff at the Health Directorate this could not strengthen *abusua* ties.

Ho is similar to Techiman where political party ties across the Health Directorate and the Municipal Assembly are not as strong as New Juaben, Sunyani, and Obuasi (the three with strong NPP ties). In Ho, both the Health Director and the DDNS are affiliated to the NDC whilst key officers in the Assembly are NPP members (refer to Table 2 in Chapter 3). The weak political party ties may well explain why the other ties are weak. Overall, this may have contributed to poor collaboration between the Health Directorate and the Assembly given that 80 percent of the Assembly members belong to the NPP.

4.5.2 Embeddedness of the Health Directorate with CSOs working on HIV and AIDS

Ho is one of the four cases in which the Health Directorate had medium embeddedness with selected groups within civil society (refer to Figure 8 and Table 4). The staff at the Health Directorate have medium *abusua* ties with religious leaders and the chief. They also have strong political party ties with leaders of the church and the traditional ruler. However, their weak ties with leaders of NGOs eventually resulted in medium overall embeddedness (see Tables 7 in Chapter 7 showing ties with leaders of NGOs. A point of interest with Ho is that all the religious leaders and the paramount chief are NDC members. Most of the leaders of NGOs and officers at the Health Directorate were sympathisers of the opposition NDC.

4.5.3 Collaboration and coordination: access to the DACF

Coordination between the Health Directorate and the Assembly in Ho is low as evidenced by low access to the fund (refer to Table 4). The periods during which releases were made to the Health Director also coincided with the three periods of elections (see Table 5 in Chapter 5). The funds were released in 2000; 2004; and 2008. The conclusion I draw from Ho's case which staff from the Health Directorate, the Assembly and key informants alluded to is that the elections are the major incentives for the Chief Executive to release the fund to the Health Director. For example, one officer from the Health Directorate related the election calendar to the release of the fund as follows:

> We do not bank our hope on the fund because what we know is that we only receive it during election times. The Chief Executive will not tolerate any attempt to ask for the fund during

> non-election times. The impression this creates is that the fund comes for us to be able to do a lot of things to make the people vote for whichever government that is in power. This applies to both the National Democratic Congress (NDC) and New Patriotic Party (NPP). They all do the same thing. This is unfortunate because the Health Directorate is non-political and non-partisan. We are supposed to deliver health services to everybody so if they tie the release of the fund to elections it makes me feel very uncomfortable [An officer from Health Department, Ho, 17th October 2009].

4.5.4 Consultation with elected Assembly members and HIV and AIDS CSO leaders

Ho is the third case in which there is low consultation with elected Assembly members by officers in the Health Directorate (refer to Table 3 in Chapter 3 and Table 4 in this Chapter). It appears that officers at the Health Directorate did not have the incentive to use elected Assembly members mainly due to the nature of the relationship between *executive officers* of the Assembly and the Health Directorate. I realised from my interviews with the Director of Health and the Public Health Nurse that there is a kind of tension between the Health Director and the Chief Executive.[78] It looks like an issue of personality clash or clash of authority which might be due to attempts by each of them to assert their authority as provided by Act 462 and Act 525 respectively for the Chief Executive and the Health Director. This might be one reason why the Health Management Team only seemed to exist on paper in terms of membership and did not have all the members as provided by law, and as indicated by my key informants in the Health Directorate and the Assembly, it is the core staff of the Health Directorate that constitute the Health Management Team and perform the functions. Just like the case in Sunyani, officers at the Ho Municipal Health Directorate tend to connect more with civil society actors to promote health programmes.

4.6 Techiman

Ghana's major market centre for food crops is Techiman. The municipality is an important transit point for long distance heavy duty vehicle drivers from Mali, Niger, Chad, and Burkina Faso. The population of the Techiman municipal area for 2007 is estimated to be 207,545 based on a projection from the 2000 Population and Housing census with a growth rate of about 3 percent (Republic of Ghana 2005d). About 55 percent of the population was

[78] Tension as used here means misunderstanding or disagreement.

made up those aged between 15 and 64 years, and the dependant population (children up to 15 years and the aged who were above 65 years) constituted 45 percent. About 57 percent of the population was engaged in farming and other agricultural related activities.

In terms of ethnicity and religion, the Techiman municipal area may be termed highly heterogeneous partly due to the high migrant population. The population is made up of several ethnic groups including Akans (64 percent), the Mole Dagbon (23 percent), and several other minority ethnic groups. Christians constitute 68 percent, Moslems constitute 21 percent, with the rest practising traditional religion.

The Techiman municipal area has been the stronghold of the opposition NDC (now the ruling party). During the 1992 general elections, the NDC won the Techiman South seat. In the 2000 elections, the party again won the Techiman South seat. The NDC won the parliamentary seats for both Techiman North and Techiman South constituencies in the presidential and parliamentary elections in 2004. In the case of Techiman North, the NDC has won two out of the three presidential and parliamentary elections.

The Techiman Traditional Council (TTC) also offers its durbars to various stakeholders in health care as platforms to promote their agenda in health. The TTC is one of the influential traditional authorities in Ghana.

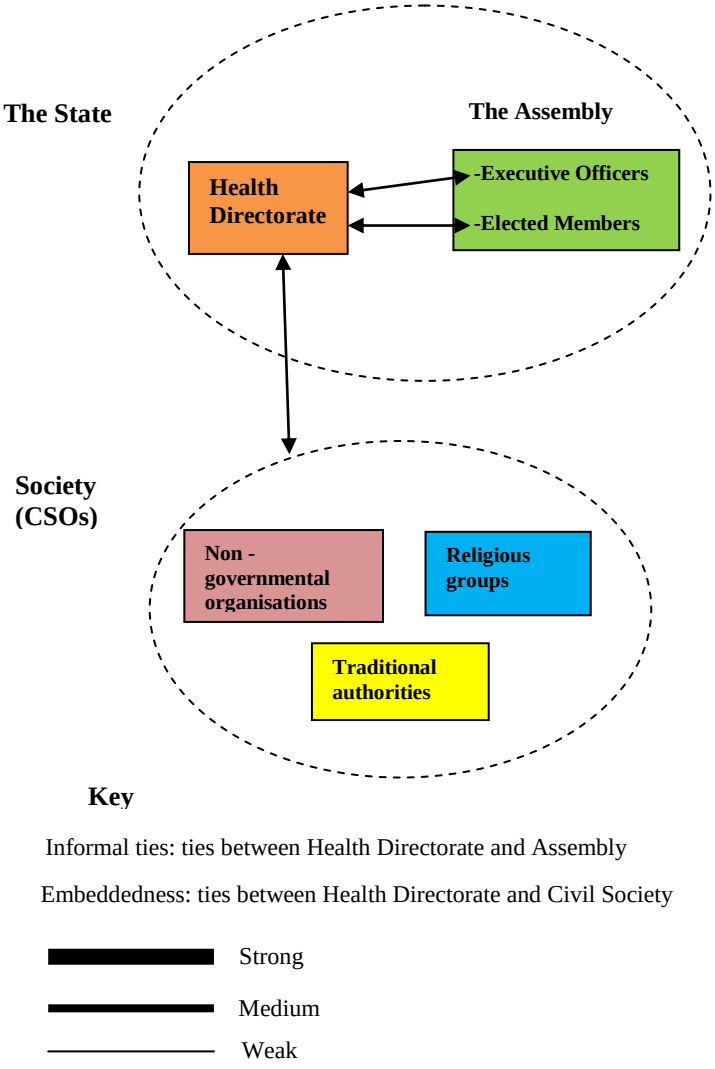
Techiman is the municipality with the largest number of NGOs and CBOs that mobilise around HIV and AIDS as compared with the other four cases. It has as much as twice the number of NGOs in Sunyani and Ho.

4.6.1 Informal ties with Municipal Assembly

Techiman is unique in the sense that it is the only case to be at the bottom of the scales for performance, informal ties and embeddedness. It has weak informal ties with *executive officers* of the Assembly; elected Assembly members; leaders of NGOs; traditional authority; and the church (see Figure 9 below and refer to Table 3 in Chapter 3 and Table 4

in this Chapter). It performed poorly in terms of access to the fund and consultation. In a later section when I compare Techiman with New Juaben in a discussion of access to the fund, and also when comparing Sunyani with Techiman in the discussion of norms and beliefs around HIV and AIDS, I show that one main explanation for the weak informal ties might be that the Health Director and Deputy Director of Nursing Services were new in Techiman (less than 2 years in office), whilst the Coordinating Director is also less than two years in Techiman.

Figure 9: Informal ties and embeddedness in Techiman



Given that two of the three officers from the Health Directorate are new, it is not surprising to find weak informal ties with elected Assembly members as well (refer to Figure 9 and see data in Table 6 in Chapter 6). Only three out of the ten elected Assembly members have *abusua* ties with the Disease Control Officer, and each of the officers has ethnic ties with two each of the Assembly members. All the officers at the Health Directorate noted that they have weak ties with elected Assembly members. According to one of them;

> I only know about six elected Assembly members. In 2008, there were some issues about HIV and AIDS patients whose family wanted to throw them out when they realised that they had the disease. We had to do a lot of negotiations with those families to resolve the matter so it was through those negotiations that I got to know those Assembly members who brought out the issue. Since that time a kind of friendship bond has developed between us here in the Health Directorate and those Assembly members [Staff, Techiman Municipal Health Directorate, 22nd September 2009].

The officer who said this added that since 2008 those elected Assembly members have started to contribute to creating awareness about the disease to minimise discrimination and stigmatisation of people who have HIV or AIDS.

Only 3 of the elected Assembly members indicated that they have *abusua* relations with the Disease Control Officer. Those who indicated that they have developed friendship ties with the Health Directorate noted that the relationship was established since 2007 during the process of joint negotiations between them and the Health Directorate to stop those families from throwing out people with the disease. According to one elected Assembly member:

> I drew the attention of officers of the Health Directorate to the issue in 2007 when they came for Voluntary Counselling and Testing programme. Since the issue was delicate, we agreed that we meet the family together with the Health Director, and the other Assembly member who identified similar thing in his electoral area to resolve the issue. Since then we have been close to these officers at the Health Directorate [Elected Assembly member, Techiman Municipal Assembly, 18th September, 2009].

Techiman is the only case (out of the 5 cases) in which political party ties are weak between officers in the Health Directorate and *executive officers* at the Assembly. All three officers are affiliated to the opposition NDC. The only political party tie they have in the Assembly is with the Municipal Coordinating Director who is NDC. Given that the Municipal Coordinating Director is only 2 years in the Assembly (just like the Health Director and the DDNS), their influence is weak because the Chief Executive has 80 percent of Assembly

members who are NPP. The weak political party ties may also be due to the weak ethnic ties across the Assembly and the Health Directorate. I discuss these relationships and how the Assembly and the Health Directorate collaborate in Chapter 5.

4.6.2 Embeddedness of the Health Directorate with CSOs working on HIV and AIDS

With respect to ties with NGOs, all the staff in the Health Directorate indicated that these were very formal. According to them, they only meet leaders of a few NGOs in the course of their application process to access financial support from the Ghana AIDS Commission or the National HIV and AIDS Control Programme. This is how one of them perceived the work of the NGOs and his relationship with them,

> I hear there are several NGOs in Techiman working around HIV and AIDS. Those known to me are the five I mentioned but they only come here to endorse their proposals. I do it for them because I do not want them to think I want to frustrate them, but I hear there is rivalry and competition among them [A staff in Health Directorate, Techiman, 17th November 2008].

Analysis of political party connections show that most of the leaders of NGOs do not share anything common with officers in the Health Directorate as about 60 percent of them belong to the NPP. This might be the reason why most of the NGOs are not consulted by the Health Directorate, and it also supports the Health Director's comments that the NGOs are several and difficult to consult with. It is interesting to note that the paramount chief and leaders of religious groups are all NDC. In this Techiman is similar to Ho where the paramount chief, religious leaders and Health Director belong to the NDC.

4.6.3 Collaboration and coordination: access to the DACF

Techiman is the second case in which the Health Director's access to the fund is low suggesting that coordination is low and therefore performance is low (refer to Table 4). The Health Director performed well between 2000 and 2004 even though he was not successful in 2001, he performed poorly between 2004 and 2008 receiving no allocations at all showing weak performance overall (see Table 5 in Chapter 5). The Health Director's inability to access the fund in 2008 is interesting because this was one of the election years and, following the logic from the other four cases, the Chief Executive may have been expected to allocate funds as one way to win votes. However, as I show in Chapter 5 when

I compare New Juaben with Techiman, it appears that good informal networks might be required by Health Directors to access the fund even if Chief Executives want to push their party's agenda.

4.6.4 Consultation with elected Assembly members and HIV and AIDS CSO leaders

Consultation with elected Assembly members is low (refer to Table 4). According to my respondents in the Health Directorate, it is difficult to consult with Assembly members because most of them have just come to the district and need time to get to know them. They claimed that consulting with Assembly members about the disease would only be effective if the Assembly members also view HIV and AIDS as a top priority issue, something they have not yet observed. This was what one of them said about working with the Assembly members:

> None of the elected Assembly members has come to talk to us about the disease. I know it is an issue here in Techiman because of the location of the municipality but it looks like the Assembly members have a different priority. I have had the chance to meet some of them and the issue of the disease came up. This was about cases in two electoral areas where some people with the disease faced rejection, stigmatisation, and discrimination. So we visited these electoral areas and had discussions with the Assembly members and the families of those people to stop them from doing that [A staff at the Health Directorate, Techiman, 18th November 2008].

Another staff member in the Health Directorate also intimated that the template for the preparation of the High Impact Rapid Delivery (HIRD) plan also limited any efforts to do extensive consultation with citizens.[79] According to him:

> The template comes from Accra and we are supposed to fill-in. Even though we are told that two representatives from the Assembly should be members of the health management committee, nobody comes from the Assembly. At least some of the elected Assembly members could be the representatives but they do not come for meetings [A staff at the Health Directorate, Techiman, 17th November 2008].

Interview results from the Assembly members support the finding that consultation is low in the Techiman municipality. Only 3 out of the 10 elected Assembly members indicated that they have meetings with staff in the Health Directorate (see Table 12 in Appendix J). One of them explained that:

> Each time I go to the Health Directorate to ask about when the CHPS compound in my electoral area would be completed and health staff sent to us, the issue of HIV and AIDS

[79] This is the health plan which all Health Directorates are supposed to prepare. The Ghana Health Service provides a template to guide in the preparation of the plan in line with donor funding arrangements.

> comes up and we discuss ways to address the disease. I remember that the Health Director asked me about how best to deal with stigmatisation and discrimination against people with the disease. I suggested to him that NGOs needed to be given enough financial resources to do so. I said that because it is the NGOs that are close to the people in the communities. He promised to take this up but I have not heard anything yet [Elected Assembly member, Techiman, 19th November 2008].

When I asked the Assembly members about why they are not consulted by the Health Director, one of them had this view:

> I do not know why. Sometimes I only find staff from the Health Directorate undertaking immunisation in my electoral area without my knowledge. Because they do not tell me to inform the people, they come to meet empty houses most of the time because this is a farming community and the people leave for their farms. I heard the old director had a motor accident and died and a new director has come but I have not seen him in my electoral area yet. I only saw him on one or two occasions at the Assembly [Elected Assembly member, Techiman, 29th November 2009].

All the 5 NGOs I interviewed claimed that the Techiman Municipal Health Directorate did not consult them about plans to manage HIV and AIDS.

4.7 Conclusion

In this chapter I have discussed the nature of informal ties that exist between the Health Directorate and the Assemblies. I also discussed the extent to which the Health Directorates are embedded with society. I have shown that the strength of informal ties and embeddedness vary considerably across all the cases. The chapter has also described how each of the Health Directorates performed in terms of the level of coordination through access to the fund; and consultation with Assembly members and leaders of civil society groups all geared towards coordination of programmes to make them more responsive to citizens. Findings from the in-depth interviews and analysis of documentary data suggest that (a) there is a relationship between the informal ties which the Health Directorate has with the Assembly and Health Directorate performance (in terms of access to the fund), and (b) the embeddedness of health staff with leaders of CSOs seems to explain the ability of health staff to overcome socio-cultural norms and beliefs that can undermine the implementation of HIV and AIDS policy. I hope to show these relationships in the three subsequent chapters.

Chapter 5

Collaboration and Coordination: the Role of Informal Ties

5.1 Introduction

In this and the next two chapters I will explain the variation in ties and performance that were outlined in chapter 4. In this chapter, I examine the extent to which informal relations can explain variations in performance in terms of collaboration and coordination between the Municipal Health Directorates (MHDs) and Municipal Assemblies (MAs) in the implementation of HIV and AIDS policy in Ghana.

The evidence presented here suggests that in order for mixed systems to work, informal relationships matter and where Health Directors do not have access to the DACF poor relations exist. Informal ties are necessary but not sufficient conditions to encourage good cooperation as they can lead to corruption, nepotism, and cronyism in service delivery. Evidently good relations may promote both good and bad outcomes.

I will use the DACF as a tool in understanding the extent to which coordination occurs between departments as the fund is managed by the MA although the MHD has a right to a percentage of those funds for activities related to health. I will show that the implementation of formal directives from the Administrator of the DACF, which provide that the Municipal Chief Executive (MCE) must release 1% of the Assemblies share of the DACF to the MHD for HIV and AIDS programmes, are constrained by a number of structural issues. These include the relative autonomy of the MHD; the widely held notion that the MHD is financially strong and lack of clarity regarding who has the capacity and mandate to perform which task. These structural challenges might be due to confusion between the Local Government Act, Act 462 of 1993 and the Ghana Health Service and Teaching Hospitals Act, Act 525 of 1996. The empirical evidence presented in this chapter suggests that these problems can be overcome: health directors who had and were able to

use informal relations with the *executive officers* of the Municipal Assemblies were able to access their share of the DACF. Where informal ties were weak, these problems could not be overcome. I focus the discussion on the Health Director and the MCE as they are the two senior officers in these two decentralised institutions who take most of the decisions relating to the DACF.

This chapter sheds light on the politics of intra-governmental relations, which can increase our understanding of how the state actually functions at the local level to deliver services to the poor. The debate on informal networks in conjunction with intra-governmental relations has not received adequate attention among scholars, policy makers and other actors whose interests are geared towards improving the performance of government agencies at the local level. On the basis of the findings in this study, I make a contribution to the growing debate that seeks to promote understanding of how decentralisation works, in particular on how devolution and deconcentration can work simultaneously to improve service delivery.

As highlighted in Chapter 2, the existing literature has focused more on vertical relationships between central government and devolved authority (in this case the District Assemblies in Ghana) in the form of intergovernmental transfers using theories of fiscal federalism; and much of the literature looks at weaknesses in the guidelines for the disbursement of the fund (Abbey et al. 2010).[80] The literature does not adequately discuss how the fund is disbursed at the local level, particularly when there is evidence to suggest that a number of structural issues constrain disbursement of the fund at the Assembly level and that many Metropolitan, Municipal and District Assemblies (MMDAs) fail or refuse to comply with the guidelines and collaborate with their Health Directorates (Abbey et al. 2010: 76; Ghana News Agency 2010f). I investigate why some MCEs comply with the directives whilst others fail to do so.

[80] During the fifth workshop organised by the Public Agenda as part of a series of workshops on fiscal decentralisation in Ghana, participants focused on issues around the constitutional provision of not less than 5% of total national revenues, and indicated that what constitutes total revenue in each particular year before the 5% is applied has remained a controversial issue. One of the key arguments raised at the workshop was that since the revenues are collected and allocated on a quarterly basis, prior to such allocation of the quarterly releases into the fund, Ghanaians should be made aware of what is the quantum of the total revenue for that quarter (Decentralization Agenda 2007).

Here I use the cases of New Juaben and Techiman to illustrate the issues of collaboration and coordination. These provide good contrasts as they are polar opposites; in New Juaben the Health Director was able to access the fund over the 8 year period examined, and there were strong informal ties between officers in the MHD and *executive officers* at the Assembly. In Techiman the Health Director did not enjoy the same level of access despite his efforts.

This chapter comprises ten main sections. In two following the introductory section I discuss how collaboration and coordination between the two institutions can be constrained by reviewing some of the examples from Sub-Saharan Africa and then identifying three issues particular to Ghana. These are a) relative autonomy of the Health Directorate; b) the notion that the Health Directorate is financially strong; and c) capacity, qualification and tasks. I will take each of these issues in sections three, four, and five respectively and describe how and why New Juaben overcame them whilst Techiman failed to do so. In section six I discuss access to the DACF as evidence of the success in Sunyani and what appears to be failure in Techiman.[81] In section seven, I will look at how the Health Directorates and the Assemblies collaborate on more routine or everyday matters around (i) meetings, and (ii) sanitation and malaria control activities targeted at pregnant mothers and children under 5 years of age. Possible explanatory factors to the findings in both Sunyani and Techiman are discussed in section eight. This will be followed by section nine where I describe informal relations between the Health Directorate and the Municipal Assembly in the two municipalities as a factor that suggests explaining the findings in the two municipalities. This section is followed by the conclusion section ten.

[81] The discussion of collaboration and coordination using the DACF would have been enhanced if I had obtained data on the utilisation of the fund for HIV and AIDS campaigns. It would have been possible for me to show whether the success of the HIV and AIDS campaigns have any relationship with health officers' access to the fund. As a result of this limitation, I only use the campaigns around the disease to determine the success of collaboration between health staff and the Assembly members (in Chapter 6), and with leaders of CSOs (Chapter 7).

5.2 Constraints to effective collaboration and coordination

The vast literature on decentralisation gives numerous examples of structural problems that can undermine effective functioning of decentralised agencies (Crawford 2008). The situation across most parts of Sub-Saharan Africa looks similar. For example, in their work on local governance and decentralisation in Zimbabwe, Mellors et al. (2002) found that central government dominance over the affairs of decentralised authorities at the local level helps to explain the poor performance of local government bodies. In South Africa, Chikulo (2007) found that as a result of incomplete fiscal decentralisation, line departments did not incorporate their budgets into the mainstream budget process at the local level, and this undermined the harmonisation and coordination of policy between decentralised agencies at that level. Similarly, Mosha (2007) showed that weak horizontal linkages and coordination contributed to constrain effective development planning at the district level in Botswana, and went on to suggest continuous structural reforms to enhance the cooperation and coordination of efforts by government agencies responsible for development planning. Similarly, the examination of fiscal performance of countries in Francophone West Africa by Korsun and Meagher (2004), revealed that decentralisation failed to deliver the expected benefits mainly due to structural problems as a result of flaws in the design of the decentralisation programme. Korsun and Meagher argued that the design of the decentralisation programme perpetuated the dominance over and excessive control of public officers and elected political figures at the local level through budget and expenditure regulations by central government, politicians and national elites (Ibid).

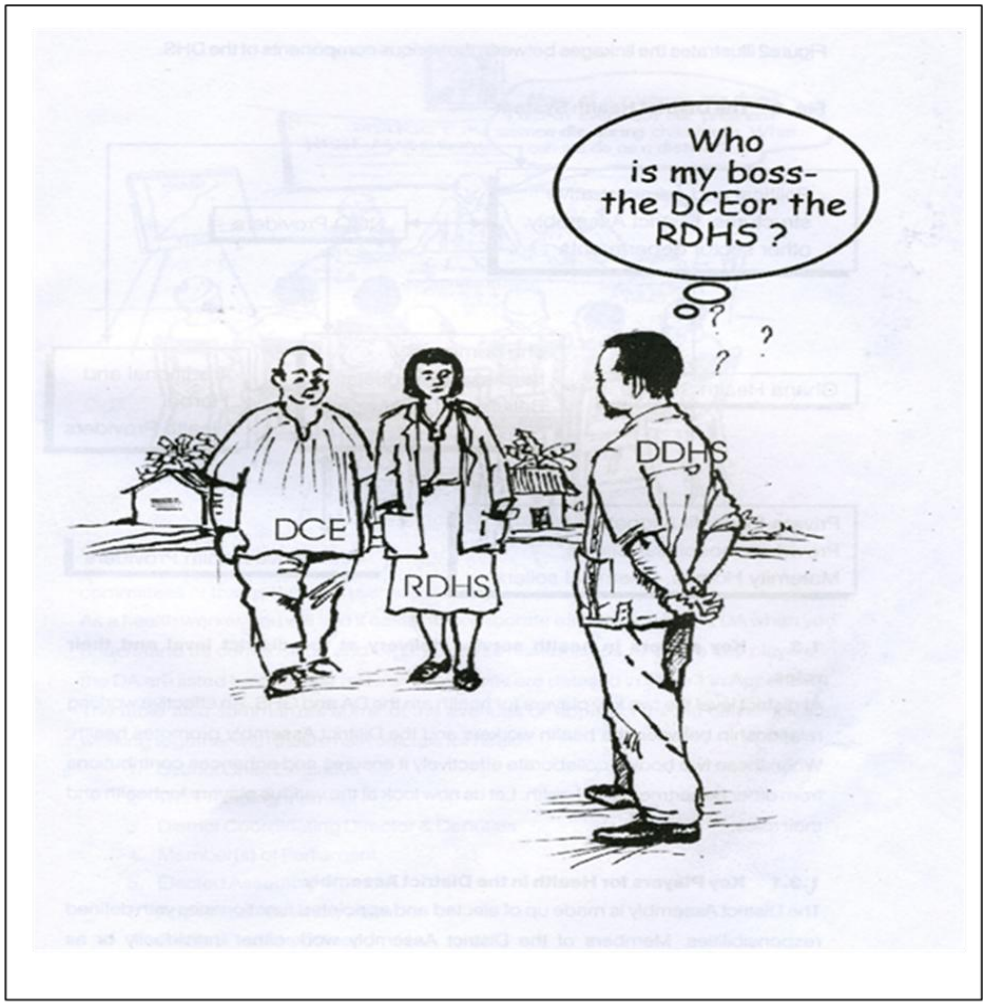
In the current study, a number of structural problems emerged in terms of incomplete fiscal decentralisation and central government controls over local government bodies, similar to those found by Mellors et al (2002); Korsun and Meagher (2004); Chikulo (2007); Mosha (2007); Awortwi (2010a; 2010b; 2010c) elsewhere across Sub-Saharan Africa. Three issues that emerged in this study which appeared to undermine effective collaboration and coordination between the MHDs and the MAs were, a) relative autonomy of the MHDs b)

the widely held notion that the MHDs are financially strong and c) conflicts over capacity, mandate and roles. I will discuss each of these structural issues in the next section.

5.2.1 Relative autonomy of the Health Directorate

In Ghana, under the current arrangements of Act 525, the Health Directors do not have absolute autonomy from the Ministry of Health, thus preventing their absorption into the Municipal Assembly as one of the decentralised departments as envisaged by Act 462. Act 525 provides that the Health Directorate has a strong allegiance to the Ministry of Health (through the Regional Directorate of Health Services) which has its own command structures and channels of reporting mechanisms). As a result, most Health Directors were not clear as to who was their boss, given that Act 462 also requires the Health Directors to report to the MCE. There is inadequate clarity in terms of how the Health Director is expected to relate to the Regional Director of Health Services (RDHS) and the District Chief Executive. Most Health Directors seem to be in a state of dilemma in terms of how they should manage the ambiguities in the laws as portrayed by Ibrahim et al. (2004) in Figure 10 below:

Figure 10: Dilemma of the Health Director in terms of who is his boss

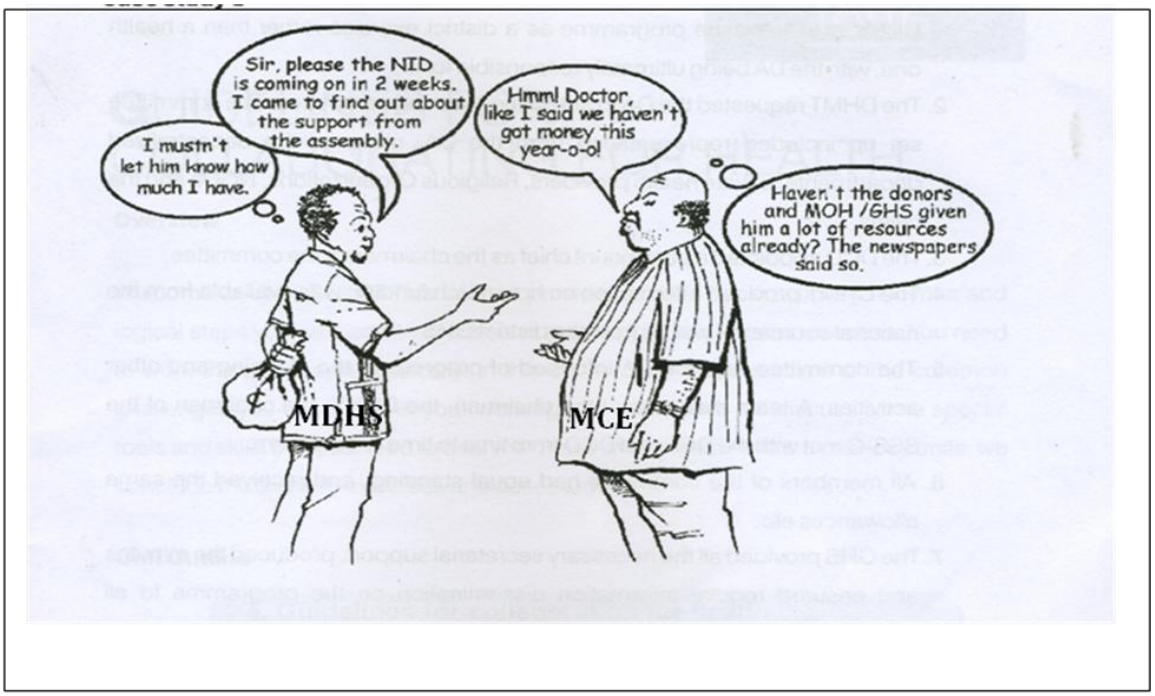


Source: Ibrahim et al. (2004: 9)

The study revealed that the lack of clarity contributed to constrain collaboration and coordination between the Health Directorates and the Municipal Assemblies. This is because the existence of strong bonds between the Health Directors and the Regional Director of Health Services do not give the MCE control over the budgets of the MHDs. The inability of the MAs to control the budget of the MHDs has created relationship problems between these two important public offices at the local level. The way in which many Health Directors manage these relationships may result in personality clashes between staff of the two institutions. Ibrahim et al. (2004) claim that the poor management of these relationships between the Health Directors and MCEs coupled with suspicion and

lack of transparency among them have contributed to eroding the trust that is required for effective collaboration and coordination. This lack of trust is amply demonstrated by Ibrahim et al. (2004) in Figure 11. Trust might be required particularly when the Health Director would have to depend on the MCE for capital investment in health such as the construction of clinics, health centres, CHPS centres, and accommodation for health staff.

Figure 11: Indication of lack of trust between MHD and MCE



Source: Ibrahim et al. (2004: 65)

As a consequence of this lack of trust, Health Directors and MCEs were unable to be honest with one another. Consequently the Health Directors may seek to hide their budgets whilst conversely the MCEs might also be suspicious about resources available to the Health Directors. This suspicion can influence how the MCE responds to requests made by the Health Directors for financial and other forms of support from the Assembly. The apparent suspicion and lack of trust between these two key officers seem to be heightened by the notion held by most public officials and politicians that the MHD is financially strong

although it is not clear if this notion can be empirically justified.[82] This mistrust seems to affect the attitudes of many MCEs and may make them reluctant to release the fund to health; this is considered in the next section.

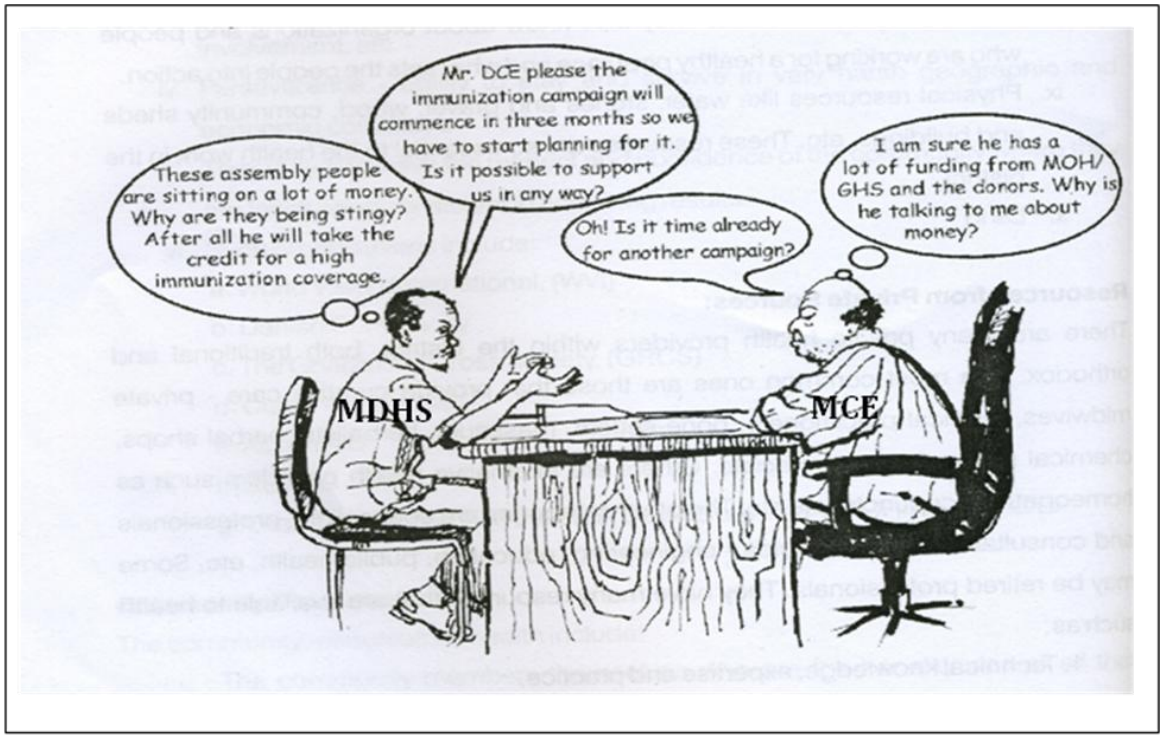
5.2.2 The notion that the Health Directorate is financially strong

The continuous operation of separate budgets and accounting systems by the MHDs combined with the Assemblies' lack of control over the budgets and other resources of the MHDs appears to have created suspicion which has heightened the notion among public officers in the municipalities that the MHD has access to a lot of financial resources. It is for this reason that the Ministry of Health would not allow those resources to be managed by the Assembly. Many Health Directors and MCEs were suspicious of each other, assuming they might lose 'money power' when they were transparent about the amount of money they had, and fearing others might want to share their funds with them (Ibrahim et al. 2004: 39). This kind of suspicion and mistrust appears to have affected how many MCEs reacted to other demands that were made by Health Directors apart from the fund. For example, Ibrahim et al. (2004: 56) have shown that under such circumstances, the Chief Executive might be reluctant to support programmes such as immunisation or even to release funds to provide accommodation for health staff (see Figure 12).

This lack of collaboration and coordination has attracted a lot of interest from major foreign donors to the health sector. For example, the Danish International Development Agency (DANIDA) has funded a number of programmes to promote collaboration and coordination at the local level (Ibrahim et al. 2004). The rationale for DANIDA support suggests that the way in which the various actors collaborate and coordinate with each other can have tremendous impact on the delivery of health services to poor people in Ghana.

[82] Available data from budget statements of Government of Ghana (GoG) does not give a clear picture to suggest that allocations to the Ministry of Health are high and that MHDs are financially strong as compared with other Ministries and their departments at the local level. In fact, one of the budget statements rather shows that the Ministry of Education was allocated 70% of total allocations to all social services whilst health received 27% (Republic of Ghana 2000b; 2002d; 2005c).

Figure 12: Suspicion and mistrust between MHD and MCE



Source: Ibrahim et al. (2004:56)

Further evidence arose of eroded trust between the MHD and the Assembly due to doubts about capacity and inadequate mutual respect for roles and responsibilities to perform them; this is the subject of the next section.

5.2.3 Capacity, qualification and tasks

The behaviour of a number of public officers towards their counterparts appeared to be influenced by how they perceived those that they interacted and worked with on daily basis, and how they were perceived by those people. I observed a lack of mutual respect between many MCEs and Health Directors which centred on issues of doubts about qualifications, expertise, and even statutory mandates. There is the perception among many Ghanaians that the appointment of MCEs is not based on merit but rather on partisan considerations. Whilst there are Health Directors who have the perception that their MCEs are not highly

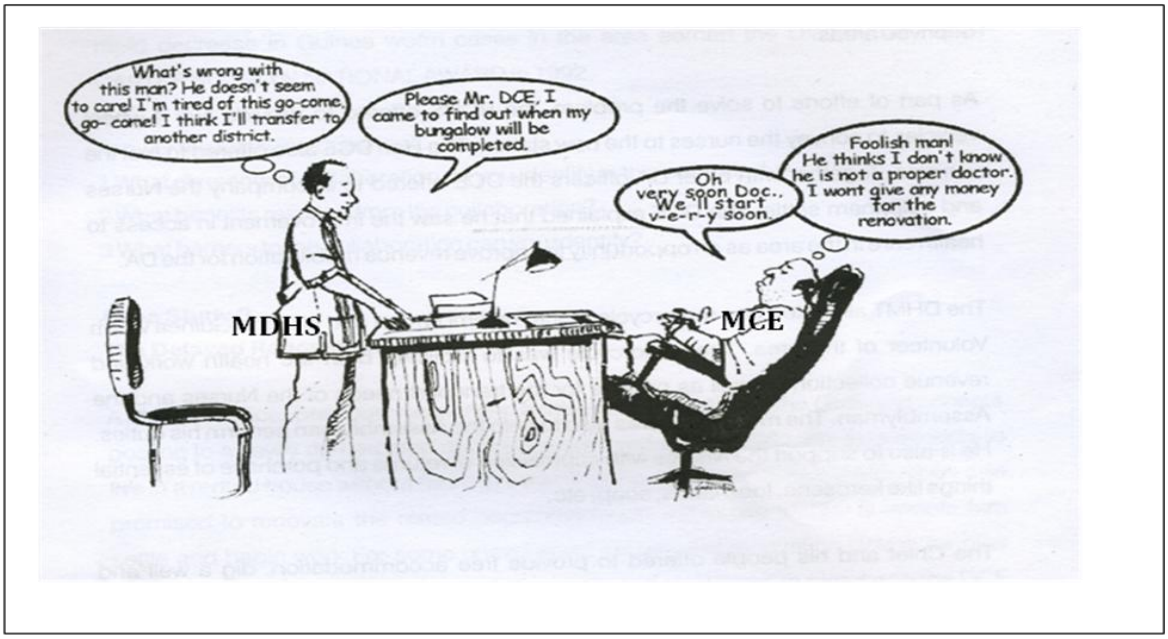
educated, I also found MCEs who thought that their Health Directors were not experts in health. An expression of this scenario is presented in Figure 13 below.

This study has revealed that the mutual lack of respect also contributed significantly to weaken cooperation overall between the Assembly and the MHD. The importance which people (especially Africans) attach to respect shown to them is indicated by Mellors et al. (2002: 9) that:

> In most traditional African cultures, values such as respect for elders, discipline and obligations are customary and important for social cohesion. Even in the context of rapid social change, these values are still evident … leaders are [expected to be] accorded high levels of respect …

Therefore leaders such as the MCE might refuse to cooperate with their Health Directors when they feel that they are not accorded the level of respect they deserve as political heads at the municipal level who represent the President of the country.

Figure 13: Doubts about capability and commitment



Source: Ibrahim et al. (2004: 43)

Having described the structural problems that contribute to making it difficult for collaboration and coordination of efforts at the local level, I now turn to describe how each

of these issues were addressed by New Juaben and Techiman. As each of the issues are considered, New Juaben will be presented first followed by Techiman.

5.3 Relative autonomy of the Health Directorate

In New Juaben there were two Directors of Health between 2000 and 2008; the one in office at the time of my research had taken over from his predecessor in 2005. Neither Health Directors had asserted their authority, as allowed by the budget controls, in their engagement with the Assembly. The analysis revealed that they relied more on informal networks in their day-to-day engagement with the Assembly than the relationship prescribed under the formal institutional arrangements. The results from the analysis in Table 4 (in Chapter 4) show that officers at the MHD had strong ties with *executive officers* in the Assembly (see also Table 2 in Chapter 3). One of the officers I interviewed at the MHD indicated that the former Health Director had very good ethnic, *abusua*, old-school, and political party ties with the MCE and that this relationship enhanced collaboration and coordination between them. The Health Director also indicated that he recognised that overdependence on provisions in the legal and institutional arrangements within the decentralisation programme would not be enough to facilitate collaboration and coordination between the MHD and the Assembly. This was how he explained it:

> You know that two bosses cannot drive the same boat. Even though I am the Director, I make the MCE feel that he is the boss. I am supposed to report to and take instructions from my Regional Director but I do not leave out the MCE even though it is difficult sometimes for me to be able to deal with two conflicting demands. For example, it is difficult to share my time between my regional boss and the MCE when both of them invite me for what they consider to be important programmes and my presence is needed. What I do is that I have taken it upon myself to brief the MCE on every little thing I do. I make sure that he is on top of issues and he feels very comfortable about that because he is able to answer all questions that come from the Castle about the health situation in the municipality.[83] The second thing I do is that whenever I need funds or any support from the Assembly I first have informal discussions with the MCE and the Coordinating Director before I make a formal request in writing. So it is not the letter I write to request the fund but I do my homework well. You understand what I mean? It is all about how you play the game. I know some of my colleagues don't get it. Perhaps they behave as bosses [Health Director, New Juaben, 23rd Oct., 2008].

[83] The castle he refers to is the Christianborg Castle at Osu in Accra. It is one of the remnants of the colonial administration. It used to be the seat of the British colonial administration. It was turned to the seat of Government by the National Liberation Council after the coup in 1966, and it has remained so until now.

The techniques employed by the Health Director in New Juaben, which were confirmed by over 70 percent of my interviewees in the Assembly, suggest that as compared with the formal relations, ethnic or tribal, *abusua*, old-school, and political party connections were more effective in facilitating collaboration in terms of accessing what he referred to as the 'politically sensitive fund.' His indication that he made the MCE feel like he was the boss is evidence of his belief that if he asserts his authority, he might have difficulty in obtaining the cooperation of the Chief Executive. This is because, the mandate of the Health Director under Act 525 makes him the autonomous head of the district (at least in theory) and the requirements stipulated by the Act further align him more strongly with the Ministry of Health than the Ministry of Local Government and Rural Development as provided by Act 462. So if the Health Director had chosen to assert his authority as provided by Act 525 problems of cooperation and collaboration could have arisen.

In comparison, the Health Director of Techiman did assert his authority and engaged in more formal terms with senior officers at the Assembly. My interviews with the Health Director revealed that he was more focused on the resources he received through the vertical relationship he maintained with central government. He did not show so much interest in his relationship with the MCE. The data in Table 2 (Chapter 3) gives evidence of the weak informal ties he had with the Assembly; compared with the score of New Juaben, Techiman's score was low. The Health Director indicated that he and the Deputy Director of Nursing Services had only been in the municipality since the middle of 2007 so the two key officers had been at post in Techiman for less than two years at the time of my research. As a result they only recently commenced establishing ties with the Assembly and other important actors in health care delivery for the municipality. One of the officers at the MHD explained how they related with the MCE as follows:

> The records we have found show that the MCE could not be relied upon for financial support. Because the Assembly has not shown adequate commitment to supporting our programmes, we rely more on the Ministry of Health for the resources we need down here. As I said to you earlier, we are convinced that the MCE does not cooperate with us so we only attend meetings at the Assembly when we are invited and we have the time. But why should we attend meetings when we know that our views will not make any difference? Maybe things will change after sometime; we are all new to each other so perhaps as we become more familiar with each other, we can understand one another and things might be different [Staff at the Health Directorate, Techiman, 26th Nov., 2008].

I corroborated these claims with officers at the Assembly who indicated that the MHD's heavy reliance on the Ministry of Health rather than its links with the Assembly might be because the Assembly had been reluctant to support HIV and AIDS programmes. This situation was similar to that found in Ho where the Health Director maintained a strong relationship with central government structures mainly because his ties with the Assembly were weak. The staff at the Health Directorate in Techiman indicated that they did not have anything to lose as a result of the weak relationship they had with the Assembly given that the Assembly had not been cooperative in terms of making funds available to health and supporting their programmes.

5.4 The notion that the Health Directorate is financially strong

The Health Director in New Juaben indicated that he was aware of the widely held perception that the MHD receives a lot of financial support from donor agencies. He also recognised this belief influenced the levels of cooperation extended by the MCEs when working with the MHD. He said he employed honesty and transparency to dispel this idea among officers at the Assembly. He explained that he was honest and transparent with the MCE in terms of the resources he had at his disposal at every point in time and this enabled trust to build among them. He said:

> Whenever I need funds from the MCE for my programmes, I do not just ask for the whole amount. This does not mean that if he gives me the entire amount for the programme I will not be happy. So for example I will say that Sir, we need so much to undertake a particular programme. Unfortunately we have just this little amount left from the malaria control funds from last year. If you could give us something from the DACF to top it up we would be able to do it well. This is what I did with the Polyclinic project [Health Director, New Juaben, 24th October 2008].

The other people I interviewed in the Assembly corroborated the claims by the Health Director that he informed the MCE of the funds available to him when he presented requests to the Assembly. According to the Coordinating Director, even though one could not say whether the Health Director declared everything he had, his actions helped to increase trust between them.

Unlike New Juaben, and of the five cases, Techiman was the one for which the study revealed strong feelings within the Assembly that the MHD was financially strong and in receipt of a lot of funds from central government. They believed that donor agencies and International Non-Governmental Organisations (INGOs) provided funds directly to Health Directorates, bypassing Ministry of Health controls. This belief may account for the Assembly's reluctance to allocate HIV and AIDS funds to the MHD. For example, one of the officers from the Assembly indicated that:

> My friend, we all know that health has money. The Ministry of Health is one of the ministries that receive a lot of donor funds. All these funds are channelled to the districts outside the control of the Assembly. Nobody knows the contents of the purse of the MHD but everybody is asking questions about the purse of the Assembly, why? [Senior officer, Techiman Municipal Assembly, 20th Nov., 2008].

It is likely that the other officers of the Assembly would have held similar views to this senior officer with regard to the MHD. Similarly, the officers of the New Juaben Municipal Assembly also held this perception, yet it did not influence the Assembly's actions towards health, possibly due to political party ties or because they interpreted and followed the strict meaning of the law.

The belief that the Ministry of Health is one of the most financially strong government ministries in Ghana is widely held. However, there is evidence to suggest that District and Regional Health Directorates receive funding directly from donors and NGOs bypassing central government control (Mayhew 2003). As Awortwi (2010a) and Ayee (2004) noted, one characteristic of decentralised departments at the local level is that they continue to hold on to funds and control their programmes without the knowledge of the officials at the District Assembly. This belief that the Ministry of Health receives a lot of donor funds perpetuates the suspicion that exists between the Assembly and the Health Directorate as depicted by Ibrahim et al. (2004) in Figures 10, 11 and 12. This may be because "the expected integration of health into the District Assembly structure has not occurred partly due to the reluctance of the Ministry of Health to relinquish control over its decentralised units, and partly due to the contradiction in the legal framework for decentralisation" (Larbi 1998: 223). This kind of relationship had an effect on collaboration between the Health Directorate and the Municipal Assembly.

5.5 Capacity, qualification and tasks

In New Juaben I found no evidence of doubts from either the MHD or the Assembly, about capacity in terms of their roles in health care delivery; rather, I found mutual respect between the Health Director and the MCE. The Health Director informed me that he was a Pharmacist rather than a medical officer but I would not have known this from my interviews with the officers from the Assembly. This is significant because most Health Directors are medical officers so an office holder without this qualification could have difficulty in commanding the respect of senior officers of the Assembly (refer to Figure 13).

Moreover, unlike the case of Techiman where the Disease Control Officer at the MHD and the HIV and AIDS Focal person at the Assembly appeared to have difficulty working together, my impression was that there was no tension or misunderstanding between these two officers in New Juaben. My interviews with officers from the Assembly corroborated the existence of mutual respect between them and their counterparts at the MHD. The staff from the two institutions all indicated that each institution has the appropriate capacity and operates within the mandate provided by law. The staff at the MHD indicated that they did not hold the view that their jobs around HIV and AIDS programmes had been taken by the Assembly. The Assembly staff also held the same view. For example, this was how one of the officers at the Assembly explained it:

> Based on my experience from other districts, I will say that those of us in the Assembly know that it is the MHD that has the expertise and mandate charged with health service administration in the district. Under the Local Government Act 462, the MHD is part of the Assembly as one of the decentralised departments with specialised functions. The establishment of the HIV and AIDS Focal person's desk is to complement the efforts of the Health Directorate, and it is not to take away their duties or compete with them. I do not think they will say it is competition. This can arise when there is no understanding of the local government law. You can also have this misunderstanding of duties if there is no mutual respect between the Health Director and the MCE. Some of the Health Directors do not show respect to the MCEs because they think that the MCEs are not highly educated or something like that. When this happens it affects attitudes of the other staff towards the Assembly [Officer, New Juaben Municipal Assembly, 17th Oct., 2008].

Showing respect to the MCE was one of the strategies the Health Director employed to promote collaboration and coordination. It also earned him respect from the MCE. In addition to this, the regular briefings to the MCE enhanced trust between them. This might be why the MCE would be willing to cooperate with the Health Director.

In Techiman, the study revealed that officers in the MHD held the perception that staff in the Assembly had usurped the functions of the MHD even though they did not have the capacity and mandate to perform those roles. For example, one of my interviewees in the MHD had this view:

> Officers at the Municipal Assembly behave as if they are the experts in health. They do everything alone without thinking about us. Perhaps they fear that if they involve us then we will ask questions about the money for HIV and AIDS programmes. We are the experts as far as health service delivery in the municipality is concerned. The Assembly is supposed to support us instead of taking the job away from us and fail to do it well. Even though I am in charge of disease control, I have nothing to do with the Focal Person for HIV and AIDS at the Assembly because I do not want him to think that I want to know what is in his purse [a staff in the MHD, Techiman, 25th Nov., 2008].

When I interviewed the Focal Person for HIV and AIDS in the Assembly, his response confirmed my conclusion that the two sides were not clear about roles and the capacity of their counterparts with regard to HIV and AIDS programmes. This was how he put it:

> You do not have to go to a medical school to know how to do voluntary counselling and testing. So I do not understand why the staff in the MHD think that they are the only people who can do that job [staff member at the Municipal Assembly, 27th Nov., 2008].

When I compare this with the cases in New Juaben and Obuasi where the two institutions jointly conducted activities around awareness campaigns it seems that the MHD and MA officers could not undertake joint activities due to disagreements between them. This disagreement became evident in my presence during an interview I conducted with the Deputy Director of Nursing Services and the Disease Control Officer. A telephone call was received from the Assembly's Focal Person for HIV and AIDS who wanted the kits for testing for HIV and AIDS from the MHD as they were about to conduct voluntary counselling and testing. The Deputy Director of Nursing Services and the Disease Control Officer replied that they would not release the kits to him because he was not an expert and that it is the duty of experts at the MHD to conduct the voluntary counselling and testing.

The Disease Control Officer then put the phone down and asked me to continue with the interview.

This incident adds to the evidence that there are staff in both institutions who do not adequately understand the provisions in current legal and institutional arrangements concerning the implementation of HIV and AIDS policy under decentralisation. According to those at the Assembly, they undertake voluntary counselling and testing exercises as part of their mandate under Act 462. Nevertheless, the health staff thought that the District Assembly staff had taken over their powers and, most importantly, they did not have the expertise to undertake voluntary counselling and testing activities which constitutes one of the major roles of the Health Directorate as provided for in Act 525.

In the next section I will explore the ways in which these structural issues affect the MHD's access to the fund from the Assembly. The discussion will focus on the period between 2000 and 2008.

5.6 Access to the District Assemblies' Common Fund

The data on access to the DACF which is presented in Table 10 (Appendix H) shows that the Health Director in New Juaben received the fund between 2000 and 2004 and then for 2007 and 2008, he received nothing for 2005 and 2006. In all, his success rate between 2000 and 2008 was over 70 percent. This appears unprecedented as most MCEs did not comply with the policy to release the fund to their Health Directors (see Ghana News Agency 2010f). When I asked the Health Director whether his ties could have enhanced his chances of accessing the fund, he said:

> Look, the fact which people in government and people outside of government including the ordinary person in the street know, is that the DACF is a highly political issue and you have to know how to play the game to get it. I get it because I know how to play the game. Through my actions I make the Chief Executive feel that he is in control of affairs. I always treat him with respect. I have also tried to be very honest with him about resources we have and where they come from. As I do all of these things, I am able to win him over most times. Therefore I do not bother myself with the question of whether he will give it to me or not because I know I will get it. Because I know I will get it, I have relied on it to implement not only HIV and AIDS programmes but also other activities as well. I have always used the fund to undertake key activities whose funds are delayed in coming from the Ministry of Health. Even though it

> is 1 %, it constitutes about 20% of our recurrent budget so you see it is always a relief when I receive it [Health Director, New Juaben, 21st October, 2008].

These views of the Health Director suggest that he had confidence that the Chief Executive would allocate his share of the fund to him. However, his confidence is unusual and poses a paradox as to why he was able to receive his funds when other Health Directors did not seem to be successful.

Table 5: Access to the DACF by Health Directors[84]

Years	2000	2001	2002	2003	2004	2005	2006	2007	2008	**(%)**	**Accessibility level**
Ho	Yes	No	No	No	Yes	No	No	No	Yes	**33.33%**	**low**
Obuasi	Yes	No	No	Yes	Yes	Yes	No	Yes	Yes	**66.66%**	**medium**
Sunyani	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes	**77.77%**	**high**
Techiman	Yes	Yes	No	No	Yes	No	No	No	No	**33.33%**	**low**
New Juaben	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	**88.88%**	**high**

Source: Author's construct, July 2010

Notes: Access is ***high*** if $\geq 70\%$, ***medium*** (40%-69.5%), and ***low*** ($\leq 39.5\%$)

(a) Most of them received their allocations during period of elections (e.g. 2000, 2004, and 2008)

(b) Former directors of Ho managed to receive some allocations before leaving in 2005. May be good relations with the MCE? Current director not being successful apart from in 2008 when he received support for NID and he was told it was coming from the DACF

(c) Former director of health in Techiman also received some allocations. Also had some good relations. Current director not been successful even in election year.

Meeting the demands of recurrent expenditure can be challenging when funds from the Ministry of Health are delayed but the health director was not disturbed because he could rely on one-fifth of his recurrent budget, which came from the Chief Executive. My interviews with key officers at the Municipal Assembly further corroborated claims by officers of the MHD that they had access to the fund. According to one of the senior officers at the Municipal Assembly, he would rate the Chief Executive's desire to allocate

[84] As I have already indicated, the Health Directors' success in receiving the DACF from the Chief Executives of the municipal assemblies for HIV and AIDS programmes is how I define accessibility to the Fund. The question I asked the Health Directors was whether the MCEs released the fund to them or not. I sought a '**Yes**' or '**No**' answer. The sum of all the **'Yes'** responses is computed as a percentage of the number of years under investigation, and this is a 9 year period from 2000 to 2008. The percentages of all the '**Yes**' responses obtained in the 11th column of Table 5 show how regular the funds were released to the Health Directors.

funds to the Health Directorate as *excellent*, compared with other municipalities where he had worked before being transferred to New Juaben. He explained this as follows:

> If I compare the other municipalities where I worked before coming here, I would say that we have done excellent work here. We have released the fund to the Health Director from 2000 to this date. I can remember that it was only on two occasions that we were not able to give them money. These were 2005 and 2006. We found that a lot of unexpected demands crept into our budgets during these years and we needed additional resources to be able to meet those demands, but we supported the Health Director in other numerous ways. I do not know if he has told you about all the support we gave him during those years. The fund was released to us very late in these two years you are referring to, and before its arrival the Assembly had already made a substantial financial allocation to the Health Directorate to support various programmes including HIV and AIDS related programmes. So even though you may find that there were no allocations, we supported the programmes of the Health Directorate in other ways [a senior officer, New Juaben, 21st Oct., 2008].

On the basis of this officer's comparison of New Juaben with his experience in other locations, I could conclude that collaboration and coordination in New Juaben was better and performance was high. Although this senior officer did not directly refer to the role of informal ties affecting how the two institutions collaborate, his subsequent comments suggested that informal relations (especially political party affiliations and *abusua* networks) might have strongly influenced the Chief Executive's release of the fund to the Health Director. He said:

> We do it because the law requires us to do so. The Minister for Local Government and Rural Development gives us directives for the utilisation of the fund, and according to the directives, we are supposed to allocate 1 percent each for HIV and AIDS and malaria to the Health Directorate. We have been doing this for a long time including the period you are referring to. So we allocated the fund to the previous director because he was very hard working and reliable. He was very committed to fighting the disease, a cause we are also committed to. The present director is also a very committed and reliable person. He always comes to brief us on key issues in health so the Chief Executive likes him. All these might explain why the Assembly is supportive of his efforts. As the Chief Civil Servant in the municipality, I see it as big responsibility to reverse the trend of high prevalence of the disease in the municipality. Do not forget that the Eastern Region has recorded the highest rate of the disease in the country for more than three years continuously since 2005. There is pressure on me and the only person with whom I can work to correct this is the Health Director. We meet regularly and each time we meet, what occupies the greater part of our time is discussions on strategies to reduce the spread of the disease [senior officer, New Juaben Municipal Assembly, 18th Oct., 2008].

This officer claimed that the Assembly released the fund to the Health Directorate because of the law but his claims suggest that the Chief Executive's behaviour might have been influenced by the informal relations they had with the Health Director. If they acted solely because of the law then one would question why other Chief Executives do not follow suit.

This respondent also indicated that the Chief Executive liked the Health Director because his regular briefings enabled him to respond to the President of Ghana but as the Health Director indicated, those briefings went beyond a formal level of engagement with the Assembly. Most of these discussions took place during informal meetings which were held more than three times a week outside of office hours, and sometimes on weekends when they attended programmes such as funerals together. Meeting three times in a week outside of office hours indicates a very good relationship with the Chief Executive.

The Planning Officer who was an old-school mate of the Health Director also compared New Juaben with other Assemblies to corroborate that the Assembly made the funds available to the Health Directorate. He said:

> In other Assemblies there is always the excuse that the Assembly's resources are inadequate and so the fund has to be used for other things. The Health Directorate would not therefore be given its share when the release arrives. In one of the districts, the Chief Executive kept saying that he did not understand why the Health Directorate should be asking for this fund when it receives so much from the Ministry of Health and other donors. For all this time that I have been in this Assembly, I have not heard the Chief Executive complain about releasing the fund to the Health Directorate. It would interest you to note that the Chief Executive at one of my former stations made us all believe that the Health Directorate is one of the wealthiest decentralised departments at the districts. He always said that the Health Directorates control so much money that the Ministry of Health is not willing to allow the implementation of the composite budget by the Assembly [Planning Officer, New Juaben, 18th Oct., 2008].

I do not have any evidence to suggest that the Ministry of Health is unwilling to support the implementation of the composite budget because it does not want to lose control over its Health Directorates. However, this appears to be a widely held view among the public in Ghana and this perception appears to influence how many Chief Executives work with their Health Directors. With the composite budget system, decentralised departments under the Assembly are supposed to harmonise their individual budgets into one main budget to be implemented by the Assembly. The composite budget is similar to a "mainstream budget" as described by Chikulo (2007: 16) when he showed that line departments did not incorporate their budgets into the mainstream budget at the local level in South Africa due to incomplete fiscal decentralisation. One implication of implementing a composite budget is that the various decentralised departments, such as health, would lose control over their

financial resources to the Assembly, which in turn would reduce the Ministry of Health's control over the Health Directorates.

Although informal ties facilitated the release of the fund from the Municipal Assembly to the Health Directorate, which may have contributed to the implementation of HIV and AIDS programmes by the Health Directorate, there was evidence that informal relations undermined the achievement of beneficial outcomes to the poor. There were practices which suggest that the nature of some of the reciprocal exchanges within existing informal relations might be considered corruption, nepotism, and cronyism. First of all, two influential persons who used to be members of the HIV and AIDS Advisory Committee of the New Juaben Municipal Assembly left after about 8 years in the committee to set up their own NGOs to provide care and support for PLWAs. In addition to the ethnic ties the *owners* of these NGOs have with key officers in the Assembly their work at the Assembly enabled them to establish strong *abusua* ties in the Assembly and the Health Directorate. In fact, one of them has strong old-school ties in the Health Directorate. Furthermore, political party ties across leaders of these NGOs, officers in the Health Directorate and *executive officers* at the Assembly were very strong. As compared with other NGOs, these two NGOs received substantial support from the Assembly for their programmes. They also received tremendous support including training and the supply of resource persons for their programmes by the Health Directorate. Therefore even though informal ties enabled them to access the fund to undertake HIV and AIDS programmes, both the Assembly and the Health Directorate are selective in terms of the support they provide to NGOs mainly due to their ties with them. Other NGOs are excluded from these benefits. Secondly, officers in both the Assembly and the Health Directorate use public resources, such as official vehicles and fuel, to attend private programmes such as funerals, marriages and child naming ceremonies organised by people with whom they have ties. It is illegal for public officers to use official vehicles at weekends but the rules were ignored because these events that officers in New Juaben attend are held on the weekends; again, the uses of public resources only benefit a selected few.

Unlike New Juaben, there was poor collaboration and coordination between the Health Directorate and the Assembly in Techiman. During the eight years under investigation, the Health Directorate only received the fund in three 2000, 2001, and 2004 (refer to Table 5). The Health Director's success rate was only 38%. Based on the response by the Health Directorate staff, I conclude that the Assembly only released the funds to health due to the elections in 2000 and 2004. The Chief Executive's desire to enhance the chances of his party in the elections might have been an incentive for him to commit resources to health. I was told by my key informants in the Assembly that the Techiman Municipal Assembly was particularly 'generous' during these two election periods. This assertion supports the argument in the literature on neopatrimonialism in African elections that most politicians use public resources to advance their political interests (Leonard 2009). Even though access to the fund was low, there is evidence to suggest that HIV and AIDS was the top priority health issue in Techiman (TMHD 2007; 2006; 2002), and my interviews with officers at the Health Directorate and the Assembly also corroborated this fact. One would expect that on this basis, the Chief Executive would have collaborated with the Health Director by making funds available to him for that cause, or at least the share of the fund as mandated by law. It was therefore paradoxical that the Chief Executive did not release the fund to health. According to the Health Director:

> When I came here I realised that we needed additional resources to be able to fight this disease in Techiman and thought to use allocations from the DACF to supplement whatever resources that will come from the Ministry of Health. I also realised from our records that the Assembly only gave the money to the department during election periods. But I was not sure whether the former officers requested it or not on other occasions because the information I came to was scanty. I therefore took the initiative to request it. I made several attempts to get this money to work but I have not been successful. I have written a number of letters to the Chief Executive to remind him about the money but he would not respond. I know that the Assembly will say there is no money so as soon as I hear that the fund has been released to the Assemblies then I will send a letter to the Chief Executive. I also follow this up each time I attend meetings in the Assembly. In spite of all these efforts I have not been successful. I become so frustrated when I write all those letters and I do not receive any response from him. There has been a confrontation between us on two occasions. For example, in 2007 when I went to his office to ask about the money, he told me that he would not put money into areas that would not give him votes. I got angry and left his office and vowed that I would not to go to him or ask for any support from him again [Health Director, Techiman Municipal Health Directorate, 25th Nov., 2008].

According to another senior officer at the Health Directorate they had made a number of attempts to obtain the fund but failed. She explained that the Director informed them at

management meetings about the Chief Executive's attitude towards him. From the views of this senior officer, it was possible to sense frustration in the Health Directorate. She intimated that:

> We all know that the fund is a 'no go area' for the Health Directorate. We do not even think about it when we discuss budgets and sources of funds for our programmes, even programmes to address HIV and AIDS. My boss has written so many letters about this fund, and sometimes when I find him writing the letters I laugh and tell him that it is a waste of time, but he tells me that he would write for it to be on record that he has asked for it. He also tells me that he does it because the directives provide that a proportion of the fund is allocated to us to do HIV and AIDS related work [senior staff member, Techiman Municipal Health Directorate, 24th Nov., 2008].

In the views of another respondent in the Health Directorate, she thought it was of no use for the Director to continue to ask for the money from the Assembly when previous attempts had failed. According to her, the Chief Executive's comments during public gatherings about the use of the Assembly's financial resources show that he would not have welcomed attempts to share it with him. She also indicated that:

> I do not think about the fund when we discuss sources of financial resources for HIV and AIDS programmes in this municipality. The Chief Executive will not give it to us save election time, and there are no indications that he would give this money to us to work. When the director informed us that he had walked out of his office because he said he would only put money into projects that could give him votes, I was not surprised. You will not even find one letter from the Chief Executive explaining why he cannot give us our share. At least he should respond when we make the request. It is very disturbing [a staff member at the Health Directorate, Techiman, 24th Nov., 2008].

What is striking to me is that all the attempts made by officers in the Health Directorate to get the funds and other forms of support from the Assembly were made through formal means such as writing letters. The failure of this approach suggests that reliance on formal relations alone might not be adequate to promote collaboration between the Assembly and the Health Directorate. This contrasts sharply with the case in New Juaben, where the Health Director indicated that he only wrote letters to the Chief Executive as a formality and that whenever he needed additional funds, he would first discuss the issue during informal meetings with the Chief Executive.

Due to the weak personal relationship between the Health Director and the Chief Executive, the existing inadequate formal level of engagement was the only option available for officers of the two institutions to engage with each other. An over reliance on formal

relations might have facilitated the Chief Executive's refusal to reply to the funding requests by the Health Director. For the Health Director to be upset and frustrated to the extent that he walked out of the office of the Chief Executive suggests that the relationship between the two officers was not good. Moreover, this strained relationship filtered down to the other officers in both institutions, which seems to have affected other areas of development in the municipality. For example, it might have contributed to the delay in the completion of a Community Health Planning Services centre at Nkwaeso.[85] My key informants claimed that the project was started by the former National Democratic Congress (NDC) Member of Parliament, but he was not able to continue it when he lost the elections in 2004. Consequently the community leaders and the Assembly member for the Nkwaeso area contacted the Health Directorate to ask the Assembly to complete the project for them, but according to my interviewees at the Health Directorate, poor personal relationships between officers in the two institutions contributed to undermining any joint efforts to get the project completed.

Once again, this case sharply contrasts with the situation in New Juaben where the Health Director persuaded the Chief Executive to commit additional resources for the construction of the Polyclinic building. What was common to New Juaben and Techiman was that informal ties could result in corruption as doubtful practices emerged in Techiman as well. The Techiman Municipal Assembly provided financial support to a few selected NGOs although that list of NGOs was not made public to elected Assembly members. In spite of several appeals made by Assembly members to the MCE for the list to be made available and for information of the proportion of the annual health expenditure allocated to these NGOs, the MCE would not comply. Most of the Assembly members raised serious concerns about this. At the time I conducted the interview a number of Assembly members had appealed to the Techiman traditional council to resolve the issue threatening legal action against the MCE if he did not cooperate with them within 3 months. The issue of the MCE's dealings with selected NGOs could also explain the lack of cooperation between officers at the Health Directorate and Focal Person for HIV and AIDS at the Assembly.

[85] This is a project that has been abandoned even though it is supposed to serve wide catchment area of several villages

Information from my key informants, which I corroborated with sources at the Health Directorate, the Techiman traditional council, and some Assembly members, suggests that the owners of those NGOs have strong party ties with the MCE and that about 60% of their time is invested in mobilising support for the MCE who had plans to contest the parliamentary election in 2008. In addition to these episodes of corruption, it is worth mentioning that the smooth cooperation between the MCE and the Health Directorate in New Juaben, and the unwillingness of the MCE to cooperate with the Health Director in Techiman appeared to be largely due to the nature of informal ties across these institutions. This therefore suggests that cronyism was pervasive in both the New Juaben and Techiman cases even though informal ties had a positive influence in New Juaben.

Having analysed access to the DACF, which is a more formal means of collaboration and coordination between the two decentralised institutions, I attempt to explore routine administrative matters which require day-to-day collaboration between officers in the two institutions.

5.7 Collaboration on day-to-day issues

In all the five cases, collaboration on everyday matters appeared to be strong in the cases where there were dense informal networks across the Health Directorates and the Assemblies. For example, among the routine administrative activities in both New Juaben and Techiman are meetings. In New Juaben these meetings are held on Tuesdays of every week. According to the officials from both the Health Directorate and the Assembly, they refer to these meetings as ‘management meetings’ because all the heads of the various decentralised departments and executive officers of the Assembly meet to discuss general development issues about the municipality.

My interviews with officials from both institutions revealed that the health officers have always attended these meetings which are held on the premises of the Assembly. According to a high profile official from the Health Directorate, he attended the management meetings all the time because the Health Directorate is part of the Assembly. She added that such

meetings provide her with the platform to strengthen working relationship between the Health Directorate and the Assembly, and also with heads of the other decentralised departments. She indicated that:

> I do not like to be absent at such meetings. I ensure that someone from our office will attend if I have to be away from Koforidua for other reasons. Health affects every aspects of development so attending the meetings regularly enables us to understand what is going on in the other departments as far as health issues are concerned. This helps us to develop appropriate programmes together with the other departments. Overall, the meetings help to strengthen our working relationships (High profile officer, New Juaben Municipal Health Directorate, 2nd May, 2012).

Although I could not obtain all the files for the management meetings mainly due to poor record keeping by Assembly officials, the minutes available for the past three years show that officers at the Health Directorate attended the meetings.

In Techiman, I did not find enough evidence to suggest that the health officers were regular at the management meetings which were held on Mondays. The minutes from the management meetings for the past three years that were available show that attendance rate by health officers was once in every month or two as compared with once in every week at New Juaben.

The views of one of the health officers about the management meetings give a good picture about why health officers fail to attend the meetings on regular basis. She explained it as follows:

> Discussions at the meetings are taken over by issues that seek to advance the cause of the party in power rather than the development of the municipality. I see it as a waste of time because no matter what you say at the meeting, someone or a group of people have already made up their mind (Health officer, Techiman, 5th May, 2012).

These comments further confirm the poor working relationship between the Health Directorate and the Assembly in Techiman. They also contribute to explain what one of the health officers referred to as "tension" between him and the MCE which caused him to walk out of the MCE's office and vowed never to go to that office again.

Other activities such as sanitation and health campaigns and malaria control programmes (especially targeted at pregnant women and children) also bring health officers to collaborate with the officers at the Assemblies. According to the Assembly officials, these programmes require the request for the use of the Assembly's vehicles by health officers on daily basis. The process is that health officers would write to the Assembly to ask for a vehicle. The vehicle has to be signed for by the health officer in the morning and after the day's work, the officer will have to sign and return the vehicle.

I found that these processes were not followed strictly in New Juaben yet the health officers had access to the vehicles without any difficulty. When I asked about files which should have letters showing how the vehicles were released to the health officers, I only found a couple of such letters. There was no information which shows that health officers signed for the vehicles in the morning and in the evening after work.

In the case of Techiman, health officials indicated that there was no need to make such a request to the Assembly because the MCE would not cooperate to release the vehicle to them. This response agrees with earlier responses that they gave in an answer to how they collaborate with the Assembly around the DACF. It appears that collaboration was not only weak around the DACF but also on more routine everyday matters in Techiman as compared with New Juaben.

In the forgoing discussions I explained the nature of collaboration and coordination between the two institutions and I gave evidence to support the case that in both New Juaben and Techiman, the kind of informal ties influence the relationship between the Assembly and the Health Directorate. However, the argument in this chapter, that informal relations may play an important role in how the two institutions worked together, and the explanations advanced, raises the question of alternative explanatory factors. These are addressed in the next section.

5.8 Competing explanatory factors

Even though informal ties are important, a number of alternative explanatory factors emerge that cannot be overlooked. Among these factors, those that were employed by Grindle (2007a) in her work in Mexico seem relevant to the current study. The first is political competition at the local level. When Chief Executives are faced with competitive elections and opposition parties have the chance to unseat incumbent Chief Executives, there is an incentive for Chief Executives to perform well by being responsive to citizens' needs. Perhaps this is why most citizens push for electoral politics at the local level in Ghana so that they can elect their Chief Executives and have District Assemblies run on a party basis. This might not apply to my cases since Chief Executives are appointed so citizens struggle to influence who becomes the Chief Executive or to remove a non performing Chief Executive. However, there were instances when local people were able to influence the removal of a Chief Executive. An example is the case in Obuasi where elected Assembly members mobilised and put pressure on the president of Ghana to remove their Chief Executive in 2007; this is very unusual in the country. As a result I cannot conclude that Chief Executives in my cases are pressurised to release the fund to the Health Directors by elected officials.

The second factor suggested by Grindle (2007a) is public sector modernisation in terms of capacity development and service delivery systems. According to Grindle (2007a), performance by local authorities can vary when there are differences in capacity of public officers. In the current study, capacity can play a significant role. I might explain capacity in terms of the knowledge of the Chief Executives and the Health Directors for whom the Ministry of Local Government and Rural Development and the Ministry of Health organise joint workshops. On the basis of this, I would conclude that they are aware of the regulations applying to the way in which the District Assembly system should function. However, it appears that the Municipal Health Director in New Juaben had an understanding of the weaknesses in the law so he employed informal relations to overcome them and work with the Municipal Chief Executive. Grindle (2007a) also suggested that when there are variations in how the service delivery system is restructured through

privatisation or contract arrangements, the service delivery itself can be affected although this might not be enough to explain my findings. According to the current arrangements, the Health Directorate is one of the decentralised departments of the Assembly so their mandate and function as deconcentrated agents of the Ministry of Health are the same.

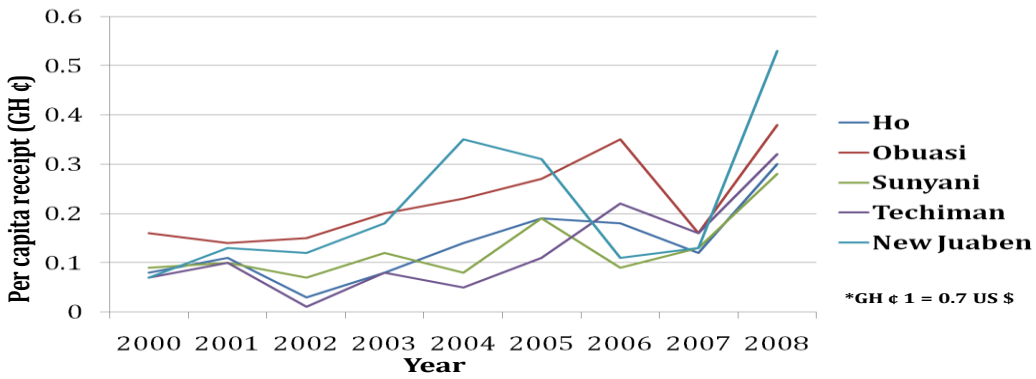
The third factor is state entrepreneurship. Grindle (2007a) further suggests that local governments can perform differently based on the behaviour of public officials in terms of their initiative, drive, ideas, and innovations around the promotion of policy from initiation through to implementation. This might explain the variations in performance in my cases. For example, in New Juaben the personal attitudes of officers in the two institutions played a significant role in how they work together.

The fourth factor is civil society engagement. According to Grindle (2007a) this is the ability of local people to mobilise and hold public officials accountable for how public resources are utilised. In situations where citizens demand better services from public officers, it can put pressure on public officers to be responsive. Again, the extent to which citizens play an active role in the policy process through to implementation and monitoring of policy can affect how local governments perform. In the current study this might be important. It is possible that citizens mobilise and influence how the Health Directorates and Assemblies collaborate; I will discuss this in Chapter 7.

In addition to the factors outlined by Grindle (2007a), there are five other factors that might be worth considering as possible explanatory factors. The first is the relative importance of the hierarchical relationships between the Health Directorates and central government (Ministry of Health). Some scholars might argue that if a particular Health Directorate receives the bulk of its funds from the Ministry of Health then it might not need to maintain good informal relationships with the Assembly to enhance its chances of receiving funds and other support from the Assembly. The opposite might also be true. Nevertheless, my analysis of central government releases of funds to the Health Directors and in depth interviews with officers at the Health Directorates revealed that even though this can be

important, it might not be adequate to explain why New Juaben maintained good informal ties or why Techiman failed to do so. The analysis of per capita central government transfers to the Health Directorates in Figure 14 reveals that between 2000 and 2005, Techiman received the lowest per capita transfer among all the cases (see Table 15 in Appendix O), whilst between 2001 and 2005, New Juaben and Obuasi were the highest recipients. Again, between 2007 and 2008, receipts by Techiman were comparatively lower than New Juaben and Obuasi even though its receipt was higher than Ho and Sunyani.

Figure 14: Per capita central government transfers to cases (GH ¢)



Source: Author's construct, July 2010

As Techiman's receipts were low on average when compared with the other cases, one would expect that Techiman should choose to maintain strong ties with the Assembly to obtain its support, whilst cases such as New Juaben may lose interest in maintaining strong ties with the Assembly but this was not the case.

The second issue is the high prevalence of the disease, which could be a reason for Chief Executives to commit more resources to HIV and AIDS programmes. In this study all five cases had a high prevalence of HIV and AIDS. New Juaben and Obuasi both released funds to the Health Directorate which one might expect but the Chief Executive in Techiman did not follow suit, there was no evidence of the Chief Executive's commitment to fighting the

disease. Evidently the high prevalence of HIV and AIDS does not explain why DACF releases are made.

The third factor that may have contributed to the variation in my cases, is the pressure brought to bear on the Chief Executive of New Juaben for a number of reasons. Firstly, the Eastern Regional Minister initiated a programme to create awareness in the New Juaben Municipality which promoted voluntary counselling and testing for HIV over a period of 5 years (from 2003 to 2008) among residents in Asokore (a suburb of the Municipality). This is credited with the rise in the number of residents going for voluntary counselling and testing services (Ghana News Agency 2010g). In the views of my respondents, the project was successful. Secondly, as the New Juaben municipality is also the Eastern Regional capital, it has been the venue for a chain of high profile sensitisation meetings and workshops to discuss the issue of the use of funds for HIV and AIDS at the district level. One such series of workshops was organised by the Eastern Regional HIV and AIDS Committee, which has shown strong interest in how funds for HIV and AIDS were utilised. This workshop was organised in response to a wave of complaints raised by HIV and AIDS Focal persons and NGOs across the country, and receiving extensive media coverage, which alleged the Chief Executives did not comply with directives to release the funds for the HIV and AIDS programmes. The workshops appealed to the Chief Executives to release funds for HIV and AIDS (Ghana News Agency 2010f; Ghana News Agency 2010h).[86] It is possible that these indirect forms of pressure encouraged the Chief Executive to act and the consequences included the release of the DACF to health and making additional funds available for HIV and AIDS programmes. This assumption might be plausible as there were similar findings in Obuasi and Sunyani. For example, in Obuasi, the activities of AngloGold Ashanti appeared to put pressure on the Chief Executive to commit funds to HIV and AIDS programmes (Ghana News Agency 2010o).[87] Similarly, in the Sunyani Municipality, the sister-city relationship between the Assembly and Regional

[86] A similar workshop was organised for the Parliamentary Press Corps by the Administrator of the Common Fund who noted that some Assemblies may have concealed figures or mixed them up deliberately to avoid being penalised in the event of wrongful utilisation of the fund.
[87] AngloGold Ashanti is the largest gold mining company in Ghana and is located in Obuasi.

District of Nanaimo in Canada might equally have contributed to the Chief Executive's release of funds to the Health Directorate to show the Regional District in Nanaimo that the Sunyani Municipal Assembly is a credible institution with which to be in partnership. The Chief Executive might also have done that to promote the good image of the municipality.[88]

The fourth possible factor would be party ties. Even though the Health Directors, as civil servants, are not supposed to publicly declare their party affiliation, my key informants suggested that one reason why Chief Executives would get on well with their Health Directors could be party networks. The possible influence of political party ties is evidenced from strong party connections between the Health Directors and the Municipal Chief Executives.

The fifth issue consists of the priorities of the Municipal Assemblies. These can drive their development budget allocations, and the utilisation of the DACF which might explain why the Assemblies in Techiman and Ho would flout central government directives for the allocation of the DACF. It is common to hear MCEs complain that the directives undermine their authority and ability to utilise the DACF in line with their local priorities. This could explain why the Ministry of Finance and Economic Planning and the Ministry of Local Government are unable to take action against MCEs who do not comply with the law. Their non-compliance with the law might not signify they are unwilling to collaborate and coordinate their efforts with the Health Directorate, it could simply be a sign that they wish to make efficient use of their meagre resources.

Although these alternative explanations and a number of other factors cannot be disregarded, I would conclude that generally, good informal relations are likely to eliminate conditions of suspicion that may strain the formal relations between the Chief Executive and the Health Director such as we find in Figures 10, 11, and 12. Based on the views of both officers of the Health Directorate and Assembly I suggest that informal ties might play an important role in how the two institutions collaborate. To further increase our

[88] Sunyani municipality has the image of the cleanest city in Ghana. It won the Ghana tourism award for the cleanest city in 2006 and 2007.

understanding of how informal ties shape the formal relationships between the two institutions, I will explore the types of informal ties that existed between the Health Directorate and the Assembly.

5.9 Informal ties in New Juaben and Techiman

Unlike other forms of informal ties in over 80 percent of all the interviews across both institutions, the respondents were unwilling to disclose their political affiliations, or admit that political party ties influenced how they work. However, I had evidence to suggest that about 70 percent of my respondents in New Juaben have strong political party ties. With respect to other ties the former Health Director had ethnic and old-school ties with the Chief Executive; and he had ethnic and *abusua* ties with the Municipal Coordinating Director. He also had *abusua* ties with the Planning Officer. According to the Health Director at the time of my research, before he took over he had been the Municipal Pharmacist for over 8 years. During this period, he established *abusua* ties with the Chief Executive. He added that the Planning Officer was his friend at school and they have established *abusua* relations as a result of them being in Koforidua together. He said:

> As the Municipal Pharmacist, I worked closely with the then Health Director. As a result I know most of the key people who were his friends and in his networks. These persons include the Chief Executive and other key officers in the Assembly. All these officers have also become my personal friends. The Chief Executive and the Coordinating Director and I are Ashantis. I see these officers at least twice in a week. For the past five years, our programmes around HIV and AIDS have made my personal relations with the Coordinating Director very strong. It is an issue we talk about each time we meet. I also know the Planning Officer very well. If you ask him he would tell you. We have been friends for about 30 years. We were in graduate school in the former Soviet Union in the 1980s. We have maintained friendship ties till today. Even before he was transferred to Koforidua we were in touch and we met regularly. His coming to Koforidua has further strengthened our relationship [Health Director, New Juaben, 23rd Oct., 2008].

The Coordinating Director also confirmed that he and the Health Director had ethnic relations and that in addition to this they supported each other socially as good neighbours would do. He explained that:

> We all come from here and my village is not far from that of the Health Director's. But the most important thing these days in Ghana is that the people you work with become your neighbours because you tend to seek for support from them and you in turn provide them with support when the need arises. So the Health Director and I have been doing this for a long time now. Talk about support during funerals, church programmes or weddings etc. Since

> 2004 or so, the senior officers at the Health Directorate are those I contacted when I needed any help that is not official [Coordinating Director, New Juaben, 18th Oct., 2008].

The existence of ethnic ties, *abusua* relations, and old-school ties between the Health Director and the executive officers of the Assembly was further corroborated by the Municipal Planning Officer. He explained that:

> I have known Mr. Boateng for over 20 years. We were mates in school in the former Soviet Union so since we came back to Ghana, we have kept our friendship. We have always been in touch and we met regularly even when I was working in other districts. But our friendship has become stronger and our meetings have become more regular since I was transferred to Koforidua. I am also aware that he has good relations with the Chief Executive and the Coordinating Director. All these relations make it easy for us to work together. Sometimes things are done before the letters follow, you know what I mean. But other officers such as the Deputy Director of Nursing Services and the Disease Control Officer also come here regularly. We attend funerals and other social activities together. We see ourselves as a family or *abusua* here in Koforidua. We support one another in various ways [Planning Officer, New Juaben, 18th Oct., 2008].

The findings from the various discussions with officers in the Health Directorate and the Assembly suggest that the Health Directorate was well integrated into the Assembly and that informal channels were a comparatively important space for engagement by officers in the two institutions. The Health Director was more interested in emphasising the use of personal ties to get to the Assembly than the formal level of interaction and engagement. In the same way, the Coordinating Director and the Planning Officer were equally enthusiastic about how they related to the Health Director and his team on an informal level rather than on a formal level.

In all their responses, with the exception of the Coordinating Director, none of them made any mention of the formal provisions such as Act 462 or Act 525 as the reason for their collaboration with the Health Directorate. From the views expressed by the Coordinating Director, one can see that his indication of him being on the same page as the Health Director with regard to HIV and AIDS was influenced by attitudes of respect and the behaviour of the Health Director. Under such circumstances it is most likely that trust can eliminate any suspicion that might arise.

If I compare the kinds of informal ties I observed in New Juaben with those in Techiman, I find that informal ties in Techiman were indeed weak (refer to Table 4 in Chapter 4). Out of the three informal ties that I considered, three officers at the Health Directorate had ethnic and *abusua* ties with only one officer at the Assembly, the Coordinating Director (see Table 2 in Chapter 3). Similarly, political party connections between officers in the Health Directorate and the Assembly were weak. Conversely, the Municipal Chief Executive had strong party ties with over 60% of leaders of NGOs. This might explain why only a few selected NGOs received funding from the Assembly. Generally, the picture of informal ties between the two institutions might be summarised by the Health Director's description of his relationship with the Chief Executive:

> The relationship between me and the Chief Executive cannot be described as the best one. I thought the fact that HIV and AIDS is a big issue in Techiman could bring us to work together but it is not so. I told you I got angry and left his office because of his attitudes towards me about the Common Fund issue [Health Director, Techiman, 26th Nov., 2008].

A manifestation of the weak informal ties was the confrontation in 2007 between the Health Director and the Chief Executive about the fund, and the refusal by officers in the Health Directorate to release the voluntary counselling and testing kits to the Focal Person for HIV and AIDS at the Assembly.

5.10 Conclusion

In this chapter I have shown that informal ties can contribute to explaining how different decentralised authorities collaborate and coordinate programmes implementing health policy in Ghana. I have demonstrated that structural problems which result from conflicts in the provisions in Act 462 and Act 525 can be overcome when good informal relations exist between officers of the Health Directorate who work under a deconcentrated mandate and their counterparts at the devolved Municipal Assembly. The role played by informal relations in facilitating the allocation of the DACF by the Assembly to the Health Directorate cannot be overemphasised.

These effects of informal ties, which are influenced strongly by political party affiliations, raise ambiguities about the significane of political party ties. On the one hand, political party ties help to channel public resources along partisan lines which implies that those who are outside of such networks might not have access to those resources. This way, we might conclude that patron-client relations and for that matter neo-patrimonialism undermines effective use of public resources. On the other hand, channelling funds along partisan networks help to make resources available to clients (Health Directors in this case) from patrons (MCEs), and such resources might enable the Health Directors to implement more programmes that can benefit the poor granting that the Health Directors would do so. If this is the case then we might conclude that it is a positive outcome of neo-patrimonialism.

Even though informal ties can produce positive outcomes, they may result in corruption and nepotism, which can undermine the implementation of not only HIV and AIDS programmes but the delivery of other basic services. These findings are supported by other scholars who have shown that at the local level, the relationships between the Health Directorate and the Assembly are "quite often fluid" and are mainly informal. Given that other decentralised departments also compete for funds from the Municipal Assemblies, one's "success in receiving an allocation [of funds] depends on … individual lobbying ability" (Mayhew 2003: 79), which has the potential to both promote and undermine the delivery of services to the poor.

So far I have focused the discussion of collaboration and coordination between the Health Directorate and the Assembly on senior officers so the conclusions I draw on the performance of the Health Directorate are based on ties between the highest ranking officers. The impression that one might gain from this chapter is that it is only ties between senior officers that matter, but the relationship between the Health Directorate and the Assembly goes beyond senior officers in health and *executive officers* of the Assembly. Depending on the issue in hand, the role of other members of the Assembly can also be important. Officers in the Health Directorate might also need good informal ties with Assembly members to be able to efficiently coordinate their programmes with the

Assembly in order to win public support. As we have seen in this chapter, the existence of informal ties can be counterproductive; they can bring cronyism, patronage and ethnicity to the workplace. One way to minimise these weaknesses might be to broaden networks to make decision making more transparent. This is when extending informal ties to cover Assembly members might help and this will be the focus of Chapter 6.

Chapter 6

Consultation with elected representatives: the realities

6.1 Introduction

The activities of Municipal Assemblies in Ghana are heavily politicised and characterised by collusion and corruption. Act 462 empowers the president of Ghana to appoint the Municipal Chief Executive and 30 percent of the members of the Assemblies. These appointees often seek to promote the interests of their party at the local level rather than providing for needs of local citizens (Crawford 2010). In this chapter I compare New Juaben and Sunyani Municipalities and argue that expansion of informal ties between officers of the Municipal Health Directorates (MHDs) and elected Assembly members can facilitate the consultation of Assembly members by health staff. This can increase transparency and minimise corrupt practices associated with informal relations in the coordination of HIV and AIDS programmes. It can also limit the weaknesses of heavy politicisation of Municipal Assembly programmes.

Although coordination of programmes between decentralised departments and the Municipal Assemblies (MAs) may appear easy to achieve, empirical evidence from the current study suggests that in practice, it can be difficult. This is particularly so when such programmes do not directly promote the agenda of the party in power and the personal political ambitions of the Municipal Chief Executive (MCE). In addition, many Assembly members might not support the coordination of programmes unless those programmes bring development to their electoral areas and promote their political ambitions. One of the implications of weak coordination of programmes is that it can undermine efforts to achieve responsiveness even though the decentralisation programme is expected to lead to more responsive governance outcomes (Smith 1985). As far as the implementing of HIV and AIDS policy in Ghana is concerned, the coordination of programmes at sub-national level can be shaped by the politicisation of the Assembly. However, it appears that the ability of the MHD to expand its informal networks to include elected members of the

Assembly can help the Health Director to overcome the weaknesses attributable to the party politics in the Assembly, increase transparency, and achieve increased involvement of Assembly members in the design and implementation of HIV and AIDS activities.

In Health Directorates, such as New Juaben, where health officers had good informal ties with both *executive members* and *elected* Assembly members, they were able to minimise the weaknesses of central government interference. They were also able to coordinate their HIV and AIDS programmes with their MAs by pushing their programmes into the Assemblies' priority list through increased consultation of Assembly members.

When informal ties are strong with only *executive officers* but weak with *elected* Assembly members, they are unlikely to be effective tools that can be employed to overcome the negative impacts of party politics in health care decisions. In such cases the MCE may be able to push his personal and party agenda through the Assembly (especially when the party and MHD agendas conflict) rather than the Assembly responding to the needs of the wider population. Sunyani was one such case. Politicisation of the Assembly was also present in New Juaben, but the difference between New Juaben and Sunyani was that the staff at the New Juaben Municipal Health Directorate were able to establish good informal links with the Assembly through both the *executive officers* and *elected* Assembly members which appeared to neutralise, or at least minimise, the potential negative effects of how the Assembly was politicised. In the Sunyani case the Health Directorate's strong ties with only the *elected* Assembly members made it difficult for the officers to use the Assembly members to push health programmes through the Assembly. The inability of the elected Assembly members to influence policy in the Assembly suggests citizens' were unable to make the Sunyani Municipal Health Directorate and the Assembly adequately respond to their needs as far as HIV and AIDS issues are concerned.

Advancing my argument in this chapter, I contribute to the debate surrounding citizens' participation and representative democracy in the governance process supporting the

argument in the literature that electing representatives to the Assembly might not be enough to guarantee that they can promote the needs of citizens.

I organise the chapter into eight sections. Following this introduction, in section two, I explain the main criticisms of the District Assembly system in Ghana. In section three I describe the steps taken by officers in New Juaben Municipal Health Directorate and those in Sunyani Municipal Health Directorate to overcome the weaknesses of party politics in the Assembly. This will be followed by section four where I will show that the ability of health staff in New Juaben to overcome the influences of party politics enabled them to push HIV and AIDS programmes into the Assembly's budget. The example of Sunyani will be used to illustrate a case where coordination was more difficult to achieve. I then discuss competing explanatory factors to the differences in the findings between New Juaben and Sunyani. After this, I describe how officers in the Health Directorates and the Assemblies were informally connected in the two municipalities which may explain the achievement by the Health Directorate in New Juaben and the failure of the Health Directorate in Sunyani. In section seven I describe the challenges that might affect how elected Assembly members perform. The conclusion to the chapter is in section eight.

6.2 Politicisation of Ghana's District Assembly system

Most advocates of devolution argue that elected representation can provide channels for citizens to influence decisions that affect their lives (Agyeman-Duah 2005; Conyers 2007; Ayee 2008a; Republic of Ghana 1993b; 1996a). The interference in the affairs of local authorities by central government through the appointment of key officers has been heavily criticised in the literature as one of the factors that explain the failure of decentralisation in many developing countries especially in sub-Saharan Africa (Crook 1994; Crook and Manor 1998; Conyers 2007; Robinson 2007a; 2007b; Ayee 1995; 2008b).

In Ghana, the appointments of one-third of members of the District Assembly and the Municipal Chief Executive by the President have been criticised as undermining the democratic and non-partisan objectives of the local government and decentralisation

programme.[89] Election of all the Assembly members and the MCE has been advocated as an alternative. For example, according to Agyeman-Duah (2005), in spite of approximately two decades of decentralising to local governments in Ghana, the process has been undermined as a result of the inadequate participation of citizens and the lack of accountability of local government officials. There appears to be an assumption in the literature that democracy can be effective when all the Assembly members, including the MCEs, are elected. Citizens will be able to hold public officers accountable by rewarding those who perform well with votes to retain them or voting out non-performing ones. Nevertheless, we do not know whether, in practice, current elected Assembly members are able to influence the governance process, to justify the election of all Assembly members.

The criticisms of Ghana's decentralisation system seem justified. The decentralisation programme is expected to be non-partisan yet the President's appointments provide him with strong party influence and control over the Assemblies. There are also claims that various political parties sponsor the election of Assembly members.[90] As noted by Agyeman-Duah (2005: 1):

> Under both the National Democratic Congress (NDC) and the New Patriotic Party (NPP), Ghanaians have behaved like the ostrich, pretending not to see that political parties do sponsor members of the Assembly and DCEs/MCEs, and the 30 percent of the President's appointees to the Assembly are party members.

The decentralisation programme was expected to enable citizens to participate in decisions affecting their lives but this does not appear to have happened. In the current study, the findings suggest that some Municipal Health Directorates (such as New Juaben) were able to overcome the negative effects of central government interferences in the business of the Assemblies whilst others such as Sunyani could not. This is the subject of the next section.

[89] The Chief Executive is nominated by the President and approved by two-thirds of members of the Assembly present and voting. In some cases, the Assemblies did reject the President's nomination.

[90] It is interesting to note that senior politicians themselves acknowledge that the non-partisanship of the Assemblies is a charade and an exercise in self-deception. For example, the Former President John Kufuor and Former Attorney General (now Presidential candidate of the NPP) openly acknowledge this (Ayee 2008b).

6.3 Overcoming the weaknesses of party politics in the Assembly

The New Juaben Municipal Health Directorate managed to overcome party politics issues in the Assembly to coordinate and harmonise programmes with the Assembly. New Juaben is one of the cases in which the Health Director had access to the District Assemblies' Common Fund. It is interesting to ask why in the same municipality health staff were able to harmonise their programmes with the Assembly and get the Assembly to fund additional projects. According to the staff at the Health Directorate, each time they wanted to push programmes into the Assembly budget, they would have informal meetings with the Assembly members in their villages and electoral areas to discuss the issue and win their support prior to Assembly meetings. One of them explained how this was done:

> Sometimes when we discuss issues with senior officers at the Assembly, what they say is that once we get the support of the Assembly members then the job is half way done. Since we have established good friendship ties with them, we take the opportunity to discuss why we would like them to support our programmes by forwarding the projects to the Assembly as if it was their initiative. If you take the Polyclinic project for example, we just phoned and called them and told them about it. We agreed to meet and we all met one weekend to discuss the issue. It was during that meeting that we got their support. For the programmes to support condoms, setting up Voluntary Counselling and Testing, and training of health staff, we met them sometimes in a group and at other times we met them individually in their electoral areas to discuss and lobby them. Once we got some of the Assembly members to support us, we had separate discussions with the chairpersons of the Social Services Sub-Committee and Finance and Administration Sub-Committee as well. Having done all these then we know that our programmes would go through the sub-committee stage to the Executive Committee which we would have handled already so the programmes finally appear on the agenda for the General Assembly [A staff at the Health Directorate, 15th October, 2009].

According to another staff member of the Health Directorate they used this approach to get funding for other programmes from the Assembly. Most elected Assembly members prefer physical projects that are visible which will help them in re-election so to get their support for non-physical projects usually requires more than formal working relationships with them. I got the impression that the ability of the staff at the Health Directorate to connect directly with elected Assembly members made a huge difference. One of the staff from the Health Directorate explained that:

> We invite the Assembly members who are our friends to our end of year parties and also to private parties we organise at home. We also attend their private parties during Christmas and New Year. We always praise them for the support they give us each time we have the opportunity to do so in public during durbars whether they are there or not. As we do all these, it makes it easier for us to receive their support when we need it [A staff at the Health Directorate, New Juaben, 15th October, 2009].

This type of story did not emerge in the Health Directorate in Sunyani even though I asked them specifically about these.

Senior officers of the Municipal Assembly and elected Assembly members supported the claims that were made by officers at the Health Directorate. According to most of the officers of the Assembly, the Assembly had a lot to do with limited resources. As a result lobbying by heads of decentralised departments to get Assembly members to push for their programmes in the Assembly was beneficial.

The strategy that the Health Director and his officers employed to lobby Assembly members included inviting Assembly members to speak at public gatherings and parties. All the Assembly members I interviewed noted that the Health Director acknowledged and showed appreciation to Assembly members each time they did things to promote health in their electoral areas.[91] Publicly applauding Assembly members for promoting the collective interest of their communities helped to achieve more. This echoes what Tsai (2007) described as moral standing which local communities in China extend to public officers who promote the interest of the larger community.

This indicates that the existence of good informal ties can facilitate successful lobbying and explains why officers at the Health Directorate were more successful in obtaining the support of Assembly members. The support of Assembly members helped the Health Director to win the support of the Chief Executive during the period that he lobbied the Chief Executive prior to debates around those projects in the Assembly. The Chief Executive's reaction influenced how the Presiding Member steered the debates which subsequently led to those projects being approved for funding.[92]

[91] Alhaji Alhassan was presented with two citations for his role in encouraging the people in his electoral area to register for the National Health Insurance Scheme. According my key informants the Health Director was very instrumental in this award (see Appendix M).

[92] The Presiding Member as the Speaker of the Assembly is elected from among the members of the District Assembly. In most cases a member of the ruling party wins such office. But I found instances in Obuasi and New Juaben where the party in government (NDC) and the main opposition party (NPP) negotiated. Members of the opposition party accepted to approve the President's nominee for the office of chief executive. In return

In contrast to the case in New Juaben where both the Health Director and the MCE belong to the same political party, the Health Director and MCE in Sunyani belong to different political parties (refer to Table 2 in Chapter 3). Their relationship was affected by the personal political ambitions of the Chief Executive, Presiding Member, and most Assembly members which resulted in instances of personality clashes among the Chief Executive, Presiding member, and Assembly members. The Chief Executive sought to hinder the Assembly members he perceived as threats to his personal ambition to become member for parliament, and also push the agenda of his party in the municipality. All the elected Assembly members said they were unable to influence decisions at the Assembly due to the Municipal Chief Executive's manipulation of Assembly business. Consequently, citizens did not seem to adequately participate in health care decisions in the Sunyani Municipality. According to one of the Assembly members:

> The MCE has managed to get *his people* to be chairpersons of the important sub-committees. These Sub-committee chairpersons therefore work for the MCE such that issues that the MCE does not like would not pass through to the Executive Committee for consideration and then brought to the general Assembly for deliberation. Since these sub-committee chairpersons are in the Executive Committee, it makes it easier for the MCE to determine what happens. There are so many instances when we asked in the General Assembly about issues that came up at sub-committee level but never appeared in the agenda for Assembly meetings. Discussions in the Assembly follow the agenda for the day and the agenda is set by the Executive Committee which is chaired by the MCE. Once the agenda is exhausted the business of the day ends and nothing can be done about it. The main objective has been to push the party's agenda and to ensure that the party maintains its popularity at the grassroots. As a result issues which came to the general assembly for discussion ended up to be those that promote the party's agenda [Elected Assembly member, Sunyani, 5th May, 2009].

Over 80 percent of the Assembly members claimed that they were scared of the Chief Executive because he could cause them to lose their seats. As one of them explained:

> Since 2000, the MCE funded the campaigns of my opponent to contest the elections against me. Unfortunately for him, my people like me so each time they vote for me that is why I have been in the Assembly for all the three terms. On one occasion, my opponent came to inform me about it. A number of people also came to inform me that the MCE had brought money to be shared for people to vote for my opponent. They told me that they would take the money but they would not vote for him. About 5 Assembly members have been victims and they all lost their seats. Three of them are women [Assembly member, Sunyani, 5 May, 2009].

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for this, members of the ruling party also voted for a member of the opposition party for the office of Presiding member.

The MCE had the power to push the party's agenda due to his party ties and the support of the one-third of members of the Assembly who are government appointees. He also sponsored about 10 party members to contest the District Assembly elections in 2006 and 6 of them won giving him substantial support from the elected Assembly members. He also got his party member elected as the Presiding Member of the Assembly. All these steps made it easier for him to push his agenda through in the Assembly even when some members strongly opposed his decisions.

Similar to the New Juaben case, the Presiding Member also played an important role in Sunyani where he supported the MCE on most issues. This effectively limited the opportunity for elected Assembly members to influence decisions if they might oppose the Chief Executive's agenda. As the Standing Orders provide, the Assembly members are supposed to 'catch the eye' of the Speaker of the Assembly (the Presiding Member) and it appeared that he used this provision to the advantage of the Chief Executive.[93] According to about 80 percent of the elected Assembly members, the Presiding Member decided not to 'see' those members who opposed the agenda set by the Chief Executive. Based on events during the Assembly meeting, it appears the way in which the Presiding Member (PM) steers the meeting shapes the outcome as the Assembly members who were known to be vocal and opposed the Chief Executive were not 'seen' by the PM even though they raised their hands and sometimes called out the PM's name to draw his attention.[94] It serves to explain why the Health Director in New Juaben lobbied Assembly members and the Presiding member. Two examples of projects where the PM used this strategy to support the Chief Executive's agenda are given below. The first case was narrated by one of the Assembly members:

> The MCE was able to cause the Municipal Assembly to commit an amount of 150,000 Ghana Cedis to supplement an electrification project (street lights) some three months before the Presidential and Parliamentary elections in 2008. He insisted that the 350,000 Ghana Cedis which the central government had brought for the electrification project was inadequate and that he needed the 150,000 Ghana Cedis to pay for labour cost. Most Assembly members opposed this. We suggested that the 150,000 Ghana Cedis should rather be used to complete an office for the National Health Insurance Scheme which was about 60 per cent complete and had been abandoned for lack of funds for the NHIS to move in. We argued that this would

[93] Catching the eye of the Speaker means you should be able to attract his attention.
[94] They were Hon. Raphael Cubagee; Hon. Stephen Agyekum; Hon. Evelyn Kumi Richardson.

> save the Assembly from paying the exorbitant rent for the office which had been rented for the NHIS. In spite of our opposition to this, the MCE was able to push this agenda through when it came to voting because the Presiding member refused to see the several of us who raised our hands to oppose the motion [Elected Assembly member, Sunyani, 5th May, 2009].

In the second example, all the 5 government appointees informed me that between 2000 and 2004 and between 2007 and 2008, the award of contracts for the construction of two clinics and one health centre met heavy opposition in the Assembly because there were procedural issues involved that the contract award process did not follow. The Presiding member refused 'to see' those who opposed the motion which was eventually carried through.

All the Assembly members indicated their frustration in the Assembly as their views did not reflect in the Assemblies' programmes. They noted that they saw themselves as 'rubber stamps' in the Assembly to only vote to endorse agendas that were aimed at promoting the political aims of the party in power.

The Chief Executive's control over the Assembly seemed to undermine the powers of Assembly members. Whilst it was comparatively easy for health staff in New Juaben to use Assembly members to get programmes into the Assembly's budgets, it was difficult for the Health Director and his staff in Sunyani to do the same.

6.4 The success in New Juaben and the failure in Sunyani

During the period under study, between 20 per cent and 25 per cent of the New Juaben Municipal Assembly's annual budget for HIV and AIDS went to programmes that originated from the Health Directorate. For example, according to the Second Medium Term Development Plan that was being implemented at the time of my research, out of the 18 programmes that were being implemented by the Assembly, three of them had come from the Health Directorate attracting about 25 per cent of funds meant for HIV and AIDS

programmes (NJMA 2006).[95] This appears unusual when compared with the case in the other municipalities who did not enjoy the same success.

Although capital investment in health was part of the mandate of the Assembly it did not automatically commit resources to areas considered priorities for the Health Directorate. One of the staff at the New Juaben Health Directorate described their achievement as follows:

> Since 2002, we have found very clever ways to make sure that some of the very important things we want to do get into the Municipal Assembly's budget for the year. I will say that our success rate is between 50 and 60 per cent each year. We are very proud about this because if you understand how the decentralisation system works, you will realise that we have done well. Don't forget that others equally compete with us for the same resources. Apart from the support we need for programmes, most of the health projects require huge capital outlay. We do not build clinics and health centres, it is the Assembly that does those things but it does not mean that if we sit back the Assembly will build the clinics for us. Even if the funding is coming from donors, we need some lobbying to get projects [A staff at the Health Directorate, New Juaben, 15th October, 2009].

The Health Director used the Polyclinic project to illustrate his claim that they needed lobbying to get projects funded by the Assembly. He explained that:

> The issue of the Polyclinic came onto our drawing board just at the time my predecessor handed over to me around 2004. I remember the first time I mentioned it to the MCE his reply was that it was too early since there was not money in the system due to the election we just had. I kept pushing on and one day he agreed that we should meet at his office to look at the issue. As soon as I realised that the green light was coming I got some of the Assembly members whose names I would not like to mention here to support the idea. In that meeting, it was tough because some of them argued that if the Assembly approved that project it would mean that that electoral area would benefit from more projects than others because the market project had already been approved for the same electoral area. Some of them even said the regional hospital was too close to where the project was proposed to be located. In the end we managed to get the votes in favour of the project. If you were in the meeting you will think it was just the debate and the voting that day that made the difference. The truth is that I had done my homework and lobbied well before that meeting [Health Director, New Juaben, 15th October, 2009].

I observed from interviews with senior officers that Assembly members who voted for the Polyclinic project had strong informal ties with officers at the Health Directorate. This further explains the Health Director's claim that he did his 'homework.' He was able to do

[95] These were (i) Training of community health volunteers in home based care practice; (ii) Establishment of 2 Voluntary Counselling and Testing centres; and (iii) Promotion and sale of condoms in non-traditional outlets such as supermarkets, funeral grounds, internet cafes, drinking spots, markets, and chop bars (local restaurants) (see Table 11 in Appendix I).

his ‘homework’ effectively due to his informal ties with executive officers at the Assembly and strong ties with elected Assembly members. The nature of ties between the two institutions suggests that the Health Directorate was well connected with the Assembly which made it fairly straightforward for him to get his project approved. Elected Assembly members also supported the Health Director’s claims that lobbying was needed to get projects accepted. One who was very vocal in the Assembly (popularly called ‘MP-member of parliament’) explained that although each of them would try to win projects for their electoral areas they also needed to lobby amongst themselves to vote. Those who had been persuaded by the Health Director also lobbied their colleagues in the Assembly which involved ‘reciprocal voting’ when Assembly members negotiate for support with their colleagues and they in turn vote for them when their projects come up.

Even though lobbying and ‘reciprocal voting’ can be said to be helpful it could be viewed as collusion, corruption and nepotism since only a few officers could lobby and benefit from it. The advantages were limited to those belonging to the complex web of ethnic, *abusua*, and ruling political party linkages. Between 2000 and 2008, over 60 percent of the Assembly’s annual budget was allocated to lobbyists with ties to the Chief Executive and Presiding Member rather than the official Medium Term Development Plan.

One of the explanations as to why a proportion of the annual budget is spent sustaining patron-client relations is the role of the Presiding Member. Following investigations of how the Health Director’s Polyclinic project was accepted, it emerged that the votes of the Assembly members alone could not have influenced the project; the support of the PM was crucial in this regard. It was highly unlikely that the PM would steer the debate against the Chief Executive so once the Health Director secured the support of the Chief Executive, it was probable that the PM would support such projects.

From my observations at General Assembly meetings the PM was unlikely to oppose the Chief Executive. The Assembly members could debate the issues but the Chief Executive could push his agenda through so the Health Director needed the support of the Chief

Executive and the Presiding Member. For example, during the discussion of the sessional address presented by the Chief Executive, most of the Assembly members opposed two issues that came up in the address but they were carried and the Chief Executive won.[96] The first was the fact that twenty-one Social Investments Fund (SIF) projects had been awarded on contract without the involvement of Assembly members in the process.[97] The second issue was the Chief Executive's proposal that the eleven sanitation sites which had not been contracted out be contracted to Zoomlion (Gh.) Ltd because the company had performed well with the twenty-two sanitation sites previously awarded to it.[98] Some of the members were of the view that the contracts could have been awarded to 'other private companies'.[99] However, those who opposed were heckled by both the government appointees and some of the elected members. Ultimately the Chief Executive was able to push this proposal through with over 65 per cent of the members when the motion was put to vote.[100] These two examples imply that the Chief Executive could have found ways to reject the Health Director's Polyclinic project and other requests even if they had the support of most Assembly.

Compared with New Juaben municipality, the coordination of programmes was more difficult to achieve in Sunyani. This may have occurred because, although both Health Directors had access to the DACF, the Health Director in New Juaben had additional resources whilst his counterpart in Sunyani did not. As I show later in this section although officers in both Health Directorates had medium informal ties with *executive officers* at the Assembly, officers in New Juaben also had strong informal ties with *elected* Assembly

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[96] Sessional address delivered by the Municipal Chief Executive, Hon. Alex Kwaku Asamoah at the 1st Ordinary Meeting of the 3rd Session of the 5th New Juaben Municipal Assembly held on Wednesday, 8th and 9th July, 2009 at the Municipal Assembly Hall.

[97] At the time of the meeting, SIF projects had been awarded on contract and contractors had been working on the projects for about five months yet most Assembly members did not know about the names of the contractors involved, the contract sum, details of the NJMA's contribution in respect of each project as well as the beneficiary community contribution to the various projects

[98] This was private company which had been contracted by the New Patriotic Party (NPP) government to manage sanitation in most parts of the country.

[99] Those who shared this view were Hon. George Boakye Yiadom, Hon. Fadilu, and Hon. Alhassan Kassi

[100] The MCE had the support of the Sanitation Sub-Committee chairman, Hon. Ibrahim Amu, and Hon Kwaku Okyere even though Hon. George Boakye Yiadom called for an evaluation report on the performance of Zoomlion (Gh.) Ltd before contracting out the remaining sanitation sites.

members also whilst in Sunyani these ties were only at the medium level (refer to Table 4 in Chapter 4).

According to the officers of the Sunyani Municipal Health Directorate, their counterparts at the Municipal Assembly did not show adequate commitment to coordinate programmes with them to fight HIV and AIDS in the municipality. They indicated that this was evident from the Medium Term Development Plans (MTDPs) of the Assembly. Interviewees at the Health Directorate doubted the commitment by the Assembly to fight the disease. This was how one of them put it:

> We wanted the Assembly to commit more resources for programmes to reducing discrimination and stigmatisation against PLWAs. Especially we would like more support to be given to NGOs who are on the ground doing this job. We have achieved a lot in making people accept PLWAs and to empower PLWAs to live productive lives. But we cannot rest on our oars. This has to be consistent and intensified. In 2005 we wrote to the Assembly about this and we also raised it in the meetings when health issues appeared on the agenda. During the celebration of World HIV and AIDS Day in 2006 and 2007, the Regional Minister, the Chief of Sunyani and some prominent people were at the durbar and we emphasised that NGOs and Health Directorate need to be supported by the Assembly to continue to work to change peoples' attitudes towards PLWAs. The MCE also mentioned in his address that the Assembly was committed to this cause and that additional resources would be allocated for this. But the actions we expect to follow these promises have not been seen. So we only talk about it but nothing happens [Staff of Health Directorate, Sunyani, 4th May, 2009].

These claims of poor commitment by the Assembly and difficulty in obtaining additional support for HIV and AIDS programmes were supported by the Assembly members and the leaders of NGOs who claimed the provisions in the MTDP for 2006 and 2009 did not translate into actual programmes. The plan indicates that:

> To mitigate the increasing trend of HIV and AIDS in the Municipality, the Health Director worked in close collaboration with CSOs in the Municipality and the Municipal Assembly to educate the populace on the dangers of HIV and AIDS menace, and the need for civil society to team up with Health Director to control the menace [Sunyani Municipal Assembly 2006a]

Even though all Assembly members noted the joint efforts of the Health Directorate and the NGOs in the fight against HIV and AIDS, many of them were unable to support the Health Director to push any of his programmes into the MTDPs for additional support. This poses the question of why other municipalities (such as New Juaben where HIV and AIDS is top priority health concern) were able to mobilise concerted efforts with their Assembly members when Sunyani could not. The answer to this question may lie in the differences between how officers at the Health Directorates related with elected members in their

Assemblies. However, there are other competing explanations to this that cannot be overlooked.

6.5 Competing explanations: New Juaben and Sunyani

In addition to the factors discussed in Chapter 5 which could account for findings of success in the New Juaben case, it seems the Assembly members themselves were keen to fight HIV and AIDS within the municipality which might explain why the Health Directorate obtained their support. The fact that New Juaben topped the prevalence rate for the country was not pleasant news to many people including the Assembly members. This explanation seems plausible because Obuasi was another case in which Assembly members showed strong interest and commitment to HIV and AIDS issues because of its high prevalence there. So it was possible that as the New Juaben Assembly members perceived the disease as a top priority health issue to which they were committed to reducing, their attitudes would be positive and so conducive to supporting related initiatives and programmes.

In spite of suggestions that there is inadequate evidence to show that prioritisation of expenditures occurs at some of the Assemblies (see Crawford 2010: 115), the prioritisation of programmes could be another explanation to why Sunyani Municipal Assembly seemed uncooperative with the Health Directorate with regard to HIV and AIDS programmes. The Sunyani Municipal Assembly appeared focused on improving urban sanitation to keep the city clean and ultimately prevent diseases such as malaria, and the Assembly is under pressure to maintain the status of the cleanest city in the country. This would suggest that the MCE's focus on sanitation rather than HIV and AIDS might not indicate that he was unwilling to work with Assembly members and the Health Directorate to curb the disease.

The higher proportion of women in the New Juaben Municipal Assembly compared with Sunyani could further explain why health staff in New Juaben were able to use Assembly members to pass HIV and AIDS programmes whilst their counterparts in Sunyani could not

do so. Women constituted about 15 percent of the membership of the New Juaben Assembly which had an active Women and Gender Sub-Committee to champion the cause of women in the municipality. Findings from studies in other Assemblies in Ghana by Crawford (2009: 68) shed light on the fact that weak Women and Gender sub-Committee with limited support of the Executive Committee could help explain why support for HIV and AIDS programmes in some Assemblies would be weak. There were less than 10% female Assembly members in Sunyani and the Women and Gender Sub-Committee was weak compared with that of New Juaben.

Although these competing explanations cannot be discounted, evidence from the current study suggests that the differences in how Health Directorates in both New Juaben and Sunyani are informally connected to their respective Assemblies explain the success of the New Juaben Health Directorate and relative failure of the Sunyani Municipal Health Directorate to promote their programmes with their Assemblies.

6.6 Informal ties with the Assembly: the contrast

6.6.1 New Juaben

In New Juaben, the Municipal Health Directorate effectively connected to the Assembly via two routes. The first route was via the *executive officers* and informal ties between the Health Directorate and executive officers of the Assembly have already been described in Chapter 5. The second route is via *elected Assembly members.* In this section I describe the nature of informal ties that existed between the health staff and *elected* Assembly members in more detail.

Informal ties between Health Directorate and elected Assembly members

Overall, there were medium informal ties between officers at the Health Directorate and elected Assembly members (see Tables 4 in Chapter 4 and Table 6). Just like the other four cases, the important forms of ties were *abusua* and ethnic relations. New Juaben was the only municipality with old-school ties between two officers at the Health Directorate and elected Assembly members. In fact 4 out of the 10 elected Assembly members and the

Deputy Director of Nursing Services were colleagues at secondary school, and 5 out of the 10 elected Assembly members were also in secondary school with the Disease Control officer (see Table 6).

In Table 6 the 10 elected Assembly members interviewed constitute 100 percent and out of this number, those who have each of the three informal ties being considered are represented by the figures in percentages under those ties. For each of the ties, the average score which shows the strength of that particular tie between health staff and Assembly members is taken. This average is from the sum of what each health officer has scored. For example, in the case of Ho, the strength of old-school tie between health staff and Assembly members is 0%, whilst it is 30% with neighbourhood ties and 50% for ethnic tie (these are the average scores for each of these ties). The average scores for each of the ties are then summed up and their averages taken (last colum of Table 6). This represents the overall strength of informal ties between health staff and elected Assembly members. Informal ties are considered to be **strong** when the score in the last column is 70% and above; **medium** (40%-69.5%); and **weak** (≤ 39.5%). The stronger the ties the stronger the relationship whilst weak ties imply weak relationship (see Appendix E for details of the process I used to construct Table 6).

Table 6: Strength of informal ties between Health staff and elected Assembly members

Case		Elected Assembly members						
		Old-school tie		Neighbourhood relation		Ethnic tie		Municipal average
Ho	Health Director	0%	0%	30%	30%	60%	50%	(0%+30%+50%)/3 = 26.66**%**
	Deputy Director of Nursing Services or Public Health Nurse	0%		40%		50%		
	Disease Control Officer	0%		20%		40%		
Obuasi	Health Director	0%	0%	60%	50%	60%	30%	(0%+50%+30%)/3 = 26.66**%**
	Deputy Director of Nursing Services or Public Health Nurse	10%		50%		0%		
	Disease Control Officer	0%		40%		40%		
Sunyani	Health Director	0%		50%		0%		
	Deputy Director of							(0%+60%+50%)/3

	Nursing Services or Public Health Nurse		0%	0%	70%	60%	80%	50%	= 36.66**%**
	Disease Control Officer		0%		60%		70%		
Techiman	Health Director		0%	0%	0%	10%	20%	20%	(0%+10%+20%)/3 = 10.00**%**
	Deputy Director of Nursing Services or Public Health Nurse		0%		0%		20%		
	Disease Control Officer		0%		30%		20%		
New Juaben	Health Director		0%	30%	100%	90%	80%	80%	(30%+90%+80%)/3 =66.66**%**
	Deputy Director of Nursing Services or Public Health Nurse		40%		100%		90%		
	Disease Control Officer		50%		80%		60%		

Source: Author's construct, July 2010

Apart from the political party affiliations, old-school ties, and ethnic relations that existed between elected Assembly members and staff at the Health Directorate, when I asked the elected Assembly members to describe the kind of neighbourhood or *abusua* ties they had with officers at the Health Directorate, each of the 10 elected Assembly members gave similar description. Their responses centred on giving and receiving mutual support and assistance during social events such as funerals. For example, this was how one of them described it:

> Most of us in the Assembly organise and attend funerals when we are invited. Mr. Boateng and Sister Evelyn and others invite us to go to their villages with them when they had funerals. These are people most of us in the Assembly will turn to when we need support. Other Assembly members have also invited officers from the Health Directorate and they honoured the invitation. It is not like you attend every funeral but you are selective to go and support whoever that has supported you in the past or the people you can trust to obtain support from them when you need it. This is how life in Koforidua has become. You support your friends and they also support you. When we attend funerals, no matter how little your donation is it helps to reduce the cost to the family [Elected Assembly member, New Juaben, 14th October, 2009].

Organisation of funerals and burial rites are very important to most people in Ghana and funerals form the basis around which many people establish *abusua* ties. There are several reasons for this; first funerals are very expensive to organise so it has become a means of judging the social status of families in Ghana leading to competition and escalating costs.[101]

[101] Majority of the people in Ghana pride themselves on the class and status of people who honour their invitation to attend funerals or other social activities. In fact, the status of a family might also be judged according to the number of high ranking or influential personalities that attend their funerals. They are seen as

The second reason is that because it is expensive people rely on the support of their neighbours or the *abusua* who are mostly colleagues in the office or in the city where they live and work. The more neighbours who attend your funeral, the higher the chances that donations will defray the costs incurred. Therefore the people who offer support might also receive support in future when the need arises.[102]

Reciprocal support during funerals, marriage, and child-naming ceremonies helps to sustain informal ties and promote good working relationships between health staff and their counterparts in the Assembly. However, the support system produces patronage and corruption when public resources such as official vehicles and fuel are used in the process, these negative qualities may also sustain the ties.

According to my interviews with the one of the senior officers at the Health Directorate in New Juaben, his association with elected Assembly members was motivated by the new approach to healthcare delivery that focused on enabling citizens to influence healthcare decisions according to their needs. He noted that the Assembly members were one important group of public officials and local politicians who can play a very useful role in helping the Health Directorate to be responsive to local citizens. He explained that:

> Even though most of the Assembly members and I are from the same ethnic group, we have gone a step further to strengthen our relationship with good neighbourliness. They respond in a group to come to offer their support when any of our officers invites them. In the same way we also do the same to them. I am happy with this relationship because it is part of our strategy to get people in the various communities to make inputs into our programmes and we cannot do this effectively without the Assembly members. So I believe that good neighbourhood relations is the stepping stone for us in the Health Department to be able to deliver healthcare to the people according to their needs [Senior Health Officer, New Juaben, 16th October, 2009].

Due to the schedules of this senior officer at the Health Directorate we had to meet four times to enable me complete the interviews with him. Throughout these interviews he

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important by their folks back in their villages when the Health Director or Deputy Director of Nursing Services goes to their village at their invitation. Apart from that, having good *abusua* ties with the Health Director means that you are likely to be in his company for a number of important public functions, and all these could contribute to improving one's social standing.

[102] There is still a third factor which is that funerals can offer most people the opportunity to make money. The reason is that when the donations are higher than the expenditure one incurs then the excess money becomes what I call 'profit,' and in fact there are people who look forward to this.

referred to his belief in maintaining informal ties with people he worked with as an important tool to employ when dealing with politically sensitive issues, or under conditions when legal and institutional provisions make formal working relations difficult. This is why he felt establishing and sustaining strong informal ties with Assembly members was important to help him to understand and incorporate the health needs of the people into their programmes. In addition, this 'stepping stone' enabled health officers to reach deep into the Assembly and persuade the Assembly members to push health programmes through.

6.6.2 Sunyani

Informal ties between Health Directorate and executive officers

Unlike New Juaben where ties between officers at the Health Directorate and *executive officers* were *strong*, in Sunyani they were *medium* (refer to Tables 2 and 3 in Chapter 3 and see Table 4 in Chapter 4 and see also Table 10 in Appendix G). According to the data in Table 2 (Chapter 3), only the Deputy Director of Nursing Services and the Disease Control officer had both ethnic and *abusua* relations with two out of the four Executive Officers at the Assembly (the Chief Executive and Coordinating Director). Ethnic relations were found to be weak although *abusua* relations were strong but these could not facilitate interaction partly because of the negative influence of weak ethnic ties. If both ethnic relations and neighbourhood ties had been strong this may have enhanced trust and subsequently increased the chances of health staff to obtain the support of the *executive officers*.

Trust that results from good informal ties is likely to promote mutual respect among the key actors in health policy implementation. When one party, especially the Chief Executive, felt the Health Director did not trust and respect him then he would be unlikely to reciprocate. A situation of this kind appears to have contributed to tensions between most Chief Executives and their Health Directors (refer to Figures 11 and 12 in Chapter 5). Comparing the case in New Juaben with Sunyani, trust and mutual respect were evident between the

Chief Executive and the Health Director in New Juaben but not in Sunyani; however, there was no evidence to suggest that the Health Director did not respect the Chief Executive.[103]

Informal ties between Health Directorate and elected Assembly members

With respect to ties with *elected Assembly members*, unlike New Juaben where such ties were *medium*, Sunyani maintained *weak* ties with Assembly members (refer to Table 3 in Chapter 3, Table 4 in Chapter 4 and Table 6 in this Chapter).[104] The informal ties that officers of the Health Directorate had with elected Assembly members were similar to those of the Executive Officers as explained earlier; both ethnic and *abusua* ties were medium (refer to Table 6). Informal meetings during social activities were important to officers of both the Health Directorate and Assembly but they were not as frequent as those in New Juaben. This is evident from Table 6 which shows the score for neighbourhood ties was strong (90%) for New Juaben and medium (60%) for Sunyani. Additionally, whilst the score for ethnic relations for New Juaben was strong (80%), Sunyani's score was medium (50%) (refer to Table 6). These differences may have contributed to the inability of officers at the Health Directorate to connect with Assembly members and obtain their support. This was evident from the words of one of them:

> Because the Assembly members are always looking for votes, they are more interested in physical projects such as schools, clinics etc. As a result there are schools that are scattered all over without enough teachers. There are also some clinics without enough health staff. But HIV and AIDS is everywhere even though it is not tangible. So if they can support efforts to intensify education programmes it can go a long way to help improve the health conditions of the people here. We have raised the issue a number of times at the General Assembly but it looks like Assembly members do not show much interest because they cannot see how this can bring them votes [Staff, Sunyani Municipal Health Directorate, Sunyani, 5 May, 2009].

Assembly members prefer projects that are visible so provide evidence of their performance to help win votes in elections. It would take more than medium strength informal ties to gain their support for intangible programmes which may be useful but may not attract votes. Raising the issue of HIV and AIDS in general Assembly meetings and

[103] My perception of the Health Director is that he was an introvert, calm, and reserved person. He seemed to be the kind of person who would not like to lobby or a person who had poor lobbying skills. Since he was reserved, his attitude might be misinterpreted by the Chief Executive as a sign of disrespect. I would describe him as a direct opposite of the Health Director of the New Juaben municipality who appeared to be an extrovert, more lively and very sociable which made it easy for him to get along with most people and to lobby.

[104] Overall pattern of informal ties and embeddedness are also presented in Table 10 in Appendix G

durbar grounds is not enough to get HIV and AIDS education and awareness programmes through the Assembly. Achieving success can be facilitated by the Health Directorate working through strong informal ties with both executive officers and the elected Assembly members as was the case in New Juaben.

Unlike the case in New Juaben where the Health Director lobbied through the Social Services Sub-Committee, there was inadequate evidence to show that the Health Director in Sunyani worked through the sub-Committees. These channels were not utilised mainly because the informal ties between health staff and Assembly members were not strong enough. As the Chief Executive had strong influence on the chairpersons of the various sub-Committees, one way to achieve success would be to establish strong informal ties with the chairperson of the sub-Committees so programmes would have a chance of appearing at the Executive Committee to be discussed at the General Assembly meeting.

Another factor that may explain why interviewees in the Sunyani Municipal Health Directorate were unable to connect well with the Assembly was the lack of ties with government appointed Assembly members. Lobbying government appointees was one of the advantages which the Health Director in New Juaben had over his counterpart in Sunyani. Most of the government appointees claimed that prior to any official meetings all the government appointees would meet to discuss how they would vote on the issues in the agenda for the meeting. The government appointees indicated that they were lobbied by heads of other departments but not the Health Director.

In spite of the usefulness of links with Assembly members, there were challenges in using them to deliver health services in terms of promoting local people's participation in health care decisions. Most of them had poor capacity; and the process of getting elected into the Assembly appears to undermine their autonomy. Whilst many of the challenges I discuss in the next section were general to both New Juaben and Sunyani, some of them were specific to Sunyani.

6.7 Challenges of Assembly members in New Juaben and Sunyani

The challenges faced by Assembly members in both New Juaben and Sunyani include (i) poor capacity of most Assembly members; and (ii) the processes of getting elected to the Assembly seemed to undermine their independence and effectiveness. In addition to these challenges, the MCEs in Sunyani took a number of steps that dampened the morale of Assembly members.

The literature on decentralisation in Ghana has not given adequate attention to the capacity and calibre of Assembly members in terms of their literacy levels as essential factors which may affect the performance of Assembly members.[105] When I attended the Assembly meeting in New Juaben, I gained the impression that over 50 percent of Assembly members were not conversant with proceedings in the general Assembly and had limited knowledge of the essential legal instruments which govern decentralisation and local governance in Ghana.[106] This constrains their ability to influence discussions including those pertaining to health. For example, of the 46 elected members of the New Juaben Municipal Assembly only about 10 of them spoke during the two-day meetings. Out of the 10 the floor was dominated by three, namely Hon. George Boakye Yiadom, Hon. C. H. Asare, and Hon. Hussein Fadilu. As the total membership of the general assembly was 67, it suggests that majority of the members were there only to 'rubber-stamp' policies.[107]

For example, according to Part 5 Section 21 (sub-section 7) of the Model Standing Orders for District, Municipal and Metropolitan Assemblies (MSODMMAs),

> The mover of an original motion shall always have the right of reply after all the other members have had the opportunity to address the Assembly before the motion is put to the vote (MLGRD n.d).

This was however not the case in practice. Assembly members who proposed motions addressed the Assembly immediately and the motion was put to vote without other

[105] The Standing Orders allow for debates to be held in the local language. However this has been rarely used since some Assembly members do not want to expose their lack of fluency in the local language.
[106] These are the 1992 Fourth Republican Constitution of Ghana, the Local Government Act (Act 462 of 1993), and the Model Standing Orders for District, Municipal and Metropolitan Assemblies.
[107] The members of the Assembly include 46 elected and 21 government appointees.

members debating the issue or the person who proposed the motion having an opportunity for a final word before the voting took place. Only one member questioned this practice although he was heckled by other members. Also the Presiding Member 'did not see' several hands that were raised on a 'Point of Order' to bring the proceedings within the law. Part 5 Section 21 (sub-section 10) of the Standing Orders states that:

> Where a member proposes a motion, the subject matter of which falls within the terms of reference of a Sub-Committee...be referred to the Sub-Committee...and shall not be debated until the Sub-Committee or Commission or Board has considered the matter (MLGRD n. d).

Many of the Assembly members could not refer to this provision to question the Chief Executive when he presented his sessional address and informed the Assembly of his plans to re-award the public toilets on contract at the end of the expiration of the first contract arrangement. He stated in the address:

> I wish to inform you that, the two year public management contracts awarded to private contractors came to an end at the end of June 2009. The Procurement process of re-awarding the contracts has begun and the Hon. Members would be informed of the outcome on completion of the process [New Juaben Municipal Assembly, 2009][108]

This presentation by the Chief Executive generated a heated debate with the government appointees and most of the elected members supporting the Chief Executive. This brought the procedural issues in the Model Standing Orders and the understanding of Assembly members to the fore. Most of them could not contribute to the debate which suggests that they did not adequately understand the procedural issues on how decisions should be reached by the Assembly. Again, a few members argued that since the old contract had ended and a Sub-Committee had been mandated by the Assembly to present an assessment and evaluation of performance of the company, it was out of order to debate re-awarding of new contracts when the Sub-Committee had not yet submitted its report. They referred the Assembly to Part 5 Section 21 (sub-section 10) of the Model Standing Orders, arguing that since an earlier motion had referred the matter to a Sub-Committee, the matter of re-awarding the contract could only be debated and carried when that Sub-committee has presented its report to the Assembly. Although the Presiding member eventually upheld a

[108] Sessional address delivered by the Chief Executive on 8th of July 2009.

'Point of Order' raised by a few members, the reactions of most of the members implied the Chief Executive was uncomfortable with the ruling by the Presiding Member.

The poor capacity of many Assembly members can weaken their morale and limit their motivation to contribute to debates in the Assembly. This became evident during the discussions of a supplementary budget statement by the New Juaben Municipal Assembly. The debate on the budget started at 4.00 pm when most members were already exhausted, many of them left the meeting hall to idle around till the end of the meeting so they could collect their sitting allowances and lunch packs. According to majority of them, pushing the budget to the time that most of them were tired was deliberate so that members would not be able to scrutinise the budget.[109]

The next challenge is the prevalence of clientelism, nepotism, and cronyism involved in the Assembly election process. According to the law, the elections are supposed to be non-partisan (see Appendix P for the provisions in the law) but in practice this is not the case and they are very expensive to contest. According to the Assembly members, it cost them about 700 Ghana Cedis (US$ 500) during the last elections in 2006. Potential candidates had to fund their elections yet Assembly members are unpaid volunteers. Most of them complained claiming the process allowed political parties and influential people to secretly fund candidates. This method was employed extensively by the Chief Executive of Sunyani to unseat incumbent members who opposed him. For example, one of the 'victims' of the Chief Executive's influences explained her case as follows:

> I realised that some of the issues that we raised at Sub-committee level did not appear on the agenda for general Assembly meetings. They ended up at the Executive Committee level. I raised these issues on several occasions at the general Assembly meeting and demanded to know what happened to those issues. I was perceived by the MCE as being anti-government. Most Assembly members believed this because I did not show my political affiliation as a result of my job as a caterer. I supply food and snacks for various functions held at the

[109] According to all the Assembly members I interviewed, another practice which de-motivated them was that minutes of previous meetings were not circulated to them early enough for them to study and prepare for the meetings. Minutes were distributed at short notice and sometimes during the meetings. This makes it very difficult for some of them who can read and are interested to contribute to discussions to do so. This was evident on the second day of the meeting (9th July 2008) during correction of previous minutes for discussion. I realised that only a few of the Assembly members pointed out corrections indicating that they were the only persons who had read the minutes. For Hon. George Boakye Yiadom and others, it has been a deliberate practice by the MCEs to push their agendas without scrutiny.

> Assembly. I also do same for other organisations or associations such as churches and political parties including the NDC. Hon. Ignatius Baffour Awuah (then MCE) and others propagated the idea that I was NDC. Hon. Baffour Awuah therefore sponsored Mr. Justice Obeng but he lost.
>
> During the second elections, the issue of my political affiliation came up again. Hon. Kwame Twumasi Awuah (then MCE) sponsored Mr. Afari Mintah against me and I lost. Somehow this was leaked to the media and I was interviewed by SKY FM about the fact that the MCE used money against me because I was troublesome in the assembly and that I was against him. I told the media that I did not see it that way.
>
> It even got to a point when attempts were made by Hon. Kwame Twumasi Awuah to demolish my restaurant and drinking spot because he said I had illegally acquired the land where I operate my restaurant in spite of the fact that I produced all documents covering the land to show that I had been given the land by the National Commission for Civic Education (NCCE). The matter went to the seat of government in Accra (Osu Castle) that I was NDC and I opposed the MCE. In order to make a strong case against me, Hon. Kwame Twumasi went on to influence the Social Club (Society of the Youth in Sunyani who were mostly NPP sympathisers) to threaten the Member for Parliament for the constituency, Hon. J. H. Mensah (then Senior Minister), that if I was not ejected they would vote against him in the 2004 Parliamentary elections [Former Assembly member, Sunyani, 9th June 2009].

Interviews with some of the 'beneficiaries' of the MCE's support echoed these observations. According to one of them, the MCE and the NPP promised him continuous support if he agreed to contest the election and join the Assembly but they had not honoured those promises. Having realised that he was in the Assembly only to vote for the Chief Executive he decided to step down out of frustration. This was how he put it:

> I was sponsored by the MCE to contest. He promised that he would continue to support me financially in so many ways. I however regret this because I have been unable to be objective during discussions in the general Assembly. I was forced against my will on some of the issues in the Assembly. For example I was against the MCE's idea of taking 150,000 Ghana cedis from the Assembly's coffers to pay for labour cost for the street light project which central government had brought some few months to the general elections. I could however not vote against it since voting was by show of hands and the MCE and the Presiding member and other NPP members would know all who would vote against the MCE [Assembly member, Sunyani, 21st June 2009].

These activities undermine the independence of Assembly members who find themselves under the control of powerful interests. This is why Agyeman-Duah (2005) indicated that Ghanaians behave like the ostrich refusing to accept the reality of the partisan nature of the Assembly. It is also one of the reasons why some scholars have called for partisan electoral politics at the Assembly since it is already happening.

Even though these situations affected the performance of most elected Assembly members the poor performance of Sunyani compared with New Juaben was because the politicisation of activities in the Sunyani Assembly was strong in terms of the personal political ambitions of the Chief Executive, Presiding Members, and the elected Assembly members themselves.

6.8 Conclusion

My aim in this chapter was to show that for the successful implementation of HIV and AIDS programmes by devolved and deconcentrated state institutions at sub-national level, informal ties need a wide span across many actors of both two institutions. The wider the network of informal ties, the more likely the actors within the network will develop common interests around issues and coordinate their efforts to advance their shared interests. What this suggests is that neo-patrimonial relations are likely to shape the governance process in a positive way under the condition that the network covers large number of actors. This raises ambiguities about the positive outcomes of neo-patrimonial relations especially when political party affinity constitutes a key component of such relations. What it means is that it seems political party ties are capable of producing positive outcomes even when they shape how public resources are used along partisan networks.

As we have seen, informal ties have weaknesses such as corruption, nepotism, and clientelistic tendencies thus supporting the claims in the neo-patrimonial literature. These might arise when very few powerful individuals control public resources and determine how such resources are disbursed. This is when we are likely to find political party affiliations undermining government performance as resources might be channelled along partisan networks further suggesting how ambiguous influences of informal relations such as political party ties can be.

Ghana's decentralisation system is a kind of recentralisation through the appointment of the Chief Executive and a third of the Assembly members by the President of the country.[110] Due to these appointments central government appear to retain substantial control over the affairs of local government authorities. One implication of this control is that the Assembly system is highly vulnerable to capture by a few people as the existing institutional arrangements do not seem to be effective to safeguard the interests of the poor who constitute the majority of the population. A way to minimise elite capture might be to increase the number of actors in the decision making process and informal ties have the potential to achieve this.

This chapter has also shown the challenges to Assembly members as representatives of citizens. The voluntary nature of the work of Assembly members may undermine their autonomy and effectiveness. As Assembly members struggle to fund their election campaigns they become vulnerable to capture by powerful interests who may even resort to secret sponsorship of their campaigns in return for political party allegiance.

The relationship between the Assemblies and the Health Directorates has been the central focus of this chapter and the previous chapter 5. In this chapter, the discussion has focused on the potential of informal ties to facilitate consultation of elected Assembly members in the coordination of health programmes. We know, however, that health care delivery at the local level in a country such as Ghana requires the input of more than these two institutions. A third and equally important group of actors is Civil Society Organisations (CSOs). These include religious groups, Non-governmental organisations, and traditional authorities. Norms, practices and belief systems that CSOs such as the church and traditional authorities hold can affect the implementation of HIV and AIDS policy. For the Health Directorate to effectively implement its policy health staff might require a good understanding of the needs of citizens and one important way to do this is for staff of the

[110] Crawford (2009: 58) has noted that in Ghana, "the rhetoric of decentralisation talks of making democracy a reality, the actual reality is about the maintenance of central government control." Similarly, this has been termed by central government retaking from the Assemblies what it had given to them (Awortwi 2010a; 2010b; 2010c).

Health Directorate to embed within society. An analysis of the relationship between staff at the Health Directorate and leaders of CSOs can contribute to our understanding of the performance of the Health Directorate in terms of efforts to achieve increased consultation of leaders of CSOs and win their support for HIV and AIDS programmes; this is the subject of Chapter 7.

Chapter 7

Socio-cultural norms, religious beliefs, and HIV and AIDS: Does embeddedness matter?

7.1 Introduction

In this chapter I argue that embeddedness of the Health Directorate with Civil Society can facilitate health staff consultation with leaders of Civil Society organisations (CSOs) to implement HIV and AIDS policy and overcome cultural practices, social norms and religious beliefs that are considered to be barriers to addressing the spread of the disease.

I compare Sunyani with Techiman to show that Health Directorates that were adequately embedded with Civil Society were able to overcome these barriers. Firstly, they obtained the support of the church to promote programmes around condoms. Secondly, they reduced stigmatisation and discrimination against people infected with HIV or AIDS, and thirdly, they minimised the dominance of the views of males in matters around sex and health.[111] The Sunyani Municipal Health Directorate is one of such cases. In municipalities where the Health Directorates are weakly embedded with Civil Society, they could not overcome these barriers. This is the case in Techiman. These findings are based on the analysis of in-depth narratives by the relevant public officers and leaders of Civil Society groups who were involved at various stages in the design and implementation of HIV and AIDS programmes at the Municipal level.

[111] Stigmatisation in this study is taken to mean name calling of people living with HIV or AIDS (PLWAs). Thus seeing PLWAs as 'scapegoats' (Gilmore and Somerville 1994: 134); significantly discrediting attributes of PLWAs (Holzemer et al. 2006: 52); a mark on someone or group of people that leads to that person or group being viewed negatively (Republic of Ghana 2005b). Discrimination is defined in this study as denying access to support systems available in the community due to one's HIV or AIDS status. This involves the establishment of socio-cultural, psychological, economic and political boundaries within society to separate PLWAs from other citizens thereby excluding them from accessing opportunities and resources needed to enhance comfortable living (Republic of Ghana 2005b; Castro and Farmer 2005; Duffy 2005; Gilmore and Somerville 1994; Walkey et al. 1990).

Based on the findings in this chapter, I make a contribution to the debate that seeks to deepen our understanding of how cultural practices, religious beliefs, and social norms can shape the process and outcome of the implementation of HIV and AIDS and reproductive health programmes. Overall, this chapter contributes to the main argument in this thesis that embeddedness facilitates institutions at sub-national level to achieve increased consultation of citizens in the implementation of national health policy.

Following the introduction to the chapter, I discuss the areas of focus at the global level towards addressing the HIV and AIDS pandemic and explain how Ghana's HIV and AIDS policy is shaped by the global agenda. I then discuss how socio-cultural norms and belief systems can be challenges to HIV and AIDS policy at the global level and also at the national level in Ghana. These challenges are religious beliefs around condoms; stigmatisation and discrimination against PLWAs; and male dominance in sexual and reproductive health issues. As the evidence suggests that embeddedness of health staff with leaders of the selected CSOs and the nature of embeddedness seemed to have enabled health staff and leaders of CSOs to develop joint efforts to overcome the challenges, I describe how the health staff in Sunyani and Techiman were embedded with leaders of CSOs. After this I show that the nature of embeddedness of officers at the Health Directorate with leaders of Civil Society groups appear to have facilitated increased consultation with leaders of CSOs by health officers leading to the development of shared interest around the disease. I then consider each of these three issues and show that health officers and leaders of CSOs in Sunyani seem to have overcome them whilst their counterparts in Techiman did not appear to have been able to do so. This will be followed by a discussion of alternative explanations to the differences between the findings in Sunyani and Techiman. A summary of lessons learnt in the chapter are provided in the conclusion.

7.2 Managing the HIV and AIDS pandemic: the global focus

There are a number of areas of focus at the global level for the management of HIV and AIDS which have attracted the interest of governments, international donor organisations,

scholars who write about the disease, and human rights and advocacy groups that seek to champion the cause of PLWAs. Four areas in the global focus form Ghana's HIV and AIDS policy.

The first is the accessibility to antiretroviral therapy (ART) for PLWAs. Promoting access to ART has gained a lot of support and mobilisation by Civil Society groups in most countries such as South Africa and the United States of America (Mboup et al. 2006). One important theme that recurs in the literature which is also the issue in Ghana is the poor accessibility to treatment opportunities for PLWAs as a result of the high cost of ART drugs (Abreu et al. 2003; Kist 2007). Ghana's HIV and AIDS policy is therefore aimed at making ART facilities available to people who acquire the disease (Republic of Ghana 2004e; Ghana AIDS Commission 2006).

Second is the promotion of the use of condoms. This has been widely accepted as a means to address HIV and AIDS and has informed policy in countries that have been hit hard by the disease (Chamratrithirong et. al 1999; Isarabhakdi 2000). For example, in Thailand, the Ministry of Public Health designed and implemented a programme to promote universal condom use by commercial sex workers (Chamratrithirong et. al 1999). Similarly, the increase in condom use has been employed as the basis to judge Uganda's success story in reducing HIV and AIDS (Asingwire and Kyomuhendo 2006). The promotion of condoms has now become a regular component of Ghana's HIV and AIDS policy.

The third relates to stigmatisation of, and discrimination against, PLWAs (World Bank 2006; Ghana News Agency 2010e). Ghana is pursuing efforts to ensure HIV positive people are accepted, loved, and cared for. The policy has encouraged Ghanaians to show compassion to those who have the disease (Republic of Ghana 2004e; Ghana News Agency 2003c; 2010d).

The fourth is the call for Voluntary Counselling and Testing (VCT) for HIV or AIDS. Expanded HIV testing and counselling is an increasingly urgent policy issue for HIV and

AIDS control in many developing countries. This is a method of alerting people and limiting infection. International agencies such as the World Health Organisation (WHO) and the United Nations Agency in charge of HIV and AIDS also lend their support to calls for expansion of testing. VCT is therefore a major strategy being implemented in Ghana (Ghana News Agency 2010k).

There are volumes of HIV and AIDS literature suggesting that the management of the disease is constrained by a complex mix of cultural practices, social norms, and beliefs that manifest in stigmatisation and discrimination against PLWAs (Esplen 2007; Crentsil 2007; Castro and Farmer 2005; Duffy 2005; Conyers 2003; Baffour 2003; Anarfi 2003; Evans et al. 2003; Mayhew 2000; Gilmore and Somerville 1994; and Walkey et al. 1990). For example in KwaZulu-Natal Province, Maharaj (2001) found that, culturally, most people had the perception that the use of condoms was a sign of infidelity. Such perceptions can encourage stigmatisation and discrimination against people who use condoms and PLWAs thus discouraging condom use and making PLWAs reluctant to declare their status and receive treatment even if ART facilities were made available at a cheaper cost. In Ghana most people are discouraged from taking the VCT services offered by the Health Directorates and from accepting condoms. Policy can be undermined as these perceptions are strongly held. This might explain why Anarfi (2006: 169) has indicated that:

> To be able to design and develop effective programmes to promote reproductive health and reproductive choices, therefore, it has become increasingly necessary to understand more about socio-cultural norms and practices which either promote or act as barriers to adoption of services or acceptance of advice.

Exploring effective ways to address challenges posed by stigmatisation and discrimination appears to elude HIV and AIDS policy in most affected developing countries including Ghana[112] (De Waal 2006; Anarfi 2003; Ghana News Agency 2010c).

Current study findings point to a strategy to help decentralised agencies first identify the obstacles at local level and then identify and incorporate solutions into their programmes.

[112] It has been indicated that HIV and AIDS message is not effectively tailored to suit the various cultures and all segments of the population. Programmes have overlooked efforts to shape societal norms, expectations and perceptions which serve as obstacles to achieving success (see Addai 1999; Gyimah et al. 2006).

This may be facilitated by health staff embedding themselves within the community and building trust amongst the people.[113] Before I discuss evidence supporting the role of embeddedness in overcoming these problems, I first describe how they can affect policy.

To simplify the discussion I address the issues surrounding religious beliefs that discourage the use of condoms, stigmatisation and discrimination against PLWAs, and male dominance in sexual and reproductive health issues separately although there are areas where they overlap.[114]

7.2.1 Religious beliefs and condoms

One of the three strategies of fighting the disease is the 'ABC' approach - Abstinence, Being faithful to one's partner, and Condom use at all times. Most religious leaders however oppose the policy to promote condoms (Adongo and Philips et al. 1997).[115] In a study of HIV and AIDS-related beliefs and behaviour among adolescent and young adult rural-urban migrants in Nigeria, Smith (2004) found that most Christians did not accept the use of condoms mainly due to religious beliefs. Keele et al. (2005) also found that Islamic belief was a major factor in the low condom usage in Matemwe, Zanzibar. The belief is that the Quran teaches against the use of condoms because it means taking human life. In addition, a number of religious leaders argue that creating condom awareness can promote promiscuity among unmarried people. Most members of the Catholic Church in particular would not accept condom use amongst married people (Baffour 2000). This is considered sinful as one of the interviewees indicated:

> Some of the pastors say that when you use the condom it means you have taken life. They say that God's plan is to make the sperms produce children so when the sperms are collected in condoms and they die, it means you have killed human beings and so God will punish you. This is why they say it is a sin to use the condom. Another reason why they do not want to talk about condom is that it will mean that we are encouraging unmarried people to have sex before marriage which they also consider to be sin. They also say young people will also see it

[113] Community in this study is taken to mean the Municipality.
[114] Sexual and reproductive health issues are defined in this study as all the decisions people would make about when they want to have sex, and with whom, whether to use condoms or not.
[115] This is very common among the leaders of the Catholic and Charismatic or Pentecostal churches.

> as our endorsement that they can have sex. They say this also is immoral [A member of Sunyani Traditional Council, Sunyani, 20th May 2009].[116]

This interpretation of the consequences of the use of condom can be frightening to most Christians especially when the pastors preach that this can attract the wrath of God who will punish people who commit sin by not allowing his plan of procreation to work by killing human beings at the very beginning of their lives.[117]

Religion in Ghana is pervasive (Baffour et al. 2010; Addai 1999; Yirenkyi 2000; Gyimah et al. 2006; Sackey 2006), everything that is done is embedded in faith. A prayer is said at the beginning and end of all state functions such as Independence Day celebrations, arrival of foreign dignitaries in the country, and Parliamentary sessions.[118] Government officials and politicians are more accepted when they appeal to religious sentiments of the electorates, and sometimes promotion in public and private offices and access to job opportunities are influenced by religious affiliation. There are a number of churches led by one person who is normally referred to as the 'Founder and General Overseer.' These have persuaded many people in Ghana that the *devil/demon* and witchcraft are the cause of poverty and diseases including HIV and AIDS (for example see Meyer 1995; Agbenohevi 2006). They profess to provide solutions, through prayer, to all kinds of problems. Some even claim to be able to pray for HIV or AIDS patients to be healed and they have established prayer camps in the forest where some HIV and AIDS patients go with the hope to find a cure. Attempts to remain outside of religious circles in Ghana might expose people to stigmatisation and discrimination with labels such as 'you are a devil', 'he is a witch' and 'an agent of the

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[116] 'Sin is explained in the Bible as any behaviour that is contrary to the teachings of the Bible' (A Pastor in Sunyani, 21st May 2009).

[117] They claim the consequences can possibly be either hardship while on earth or it might even lead one to go to hell. According to the teachings of most pastors of charismatic churches in Ghana, hell is a place of torment where sinful people are sent when they die. They claim that the place is made up of burning flames which continue forever so one will continue to burn forever. Most of them, including the pastor of the church I attend, draw from Luke 16:24; Mathew 13:42; Mathew 25:4 etc (Bible verses).

[118] At the time of writing this thesis, the President made a public appeal for a more congenial collaboration between the church and national leadership; and on Friday 12th November 2010, he expressed his appreciation to the church for making the 2010 National Week of Prayer and Fasting successful. On the same day, he had a 'closed door session with the Ministers of the Gospel' and it is believed that the President sought counsel from them in that 'secret' and private meeting (Citi FM 2010b).

devil' (Citi FM 2010a).[119] As a typical developing country characterised by wide scale poverty, diseases, and misery, most of the people in Ghana resort to spiritual/divine (religious) intervention to find solutions to problems in daily life. One reason is that the Ghanaian state has failed to deliver basic services including health to the people. Consequently, religion plays a very significant role in the lives of most Ghanaians both literate and the illiterate. For example, a study of popular opinions on local government in Ghana found that 4 in every 10 Ghanaians would consult religious leaders rather than elected national representatives (Members of Parliament and Assembly members) when they have development problems (AFROBAROMETER 2008b).

The strong influence of religion means the church in Ghana is embedded within government and leaders of the church get appointed to key positions in government.[120] As most people, including politicians, fear the consequences of being labelled, the church's voice has become very strong. As noted by Yirenkyi (2000), the church in Ghana has become more involved in politics now than at any other time in the history of the country. Clearly the influence of church leaders on policy and strategy to manage HIV and AIDS can shape the mindset and sexual and reproductive health choices of most Ghanaians which in turn can affect how successful HIV and AIDS policy is implemented.

The formal 'ABC' approach assumes Ghanaians will accept the message and change their behaviour accordingly but this overlooks the real life situation. The interviewees at the Sunyani Municipal Health Directorate had the view that this approach might not be adequate. They focussed attention on shaping policy toward persuading pastors who

[119] An example is the concern raised by Ghana's Second Deputy Speaker of Parliament, Professor Mike Oquaye in support of the Accra Metropolitan Assembly's plans to clamp down on all 'illegal' churches in the capital. He said that the churches have taken advantage of the fact that most people fear to criticise the church because they might be seen as anti-Christ.

[120] For example Rev. Dr. Mensah Otabil got appointed to the Council of State during the time when the New Patriotic Party (NPP) was in power between 2000 and 2008. Another person who was appointed to the Council of State was Mrs. Gifty Afenyi Dadzie, a strong member of AGLOW, a Women's Christian group. The Council of State is a body of eminent citizens whose responsibility is to counsel the President in the performance of his functions (Republic of Ghana 1992). Another example is that the president at the time of this research, Professor John Evans Attah Mills of the National Democratic Congress (NDC), also had one Reverend T. B. Joshua as his key advisor. It is widely claimed in Ghana that Rev. T. B. Joshua supported Professor Atta Mills in spiritual terms by praying for him to win the presidential elections in 2008.

opposed condom use to change their attitudes and lend their support towards spreading the message of condom use. This view was supported by all the respondents in the Health Directorates in the other municipalities.

7.2.2 Stigmatisation and discrimination against PLWAs

Closely related to beliefs around condoms are socio-cultural practices that cast stigma on PLWAs leading to them being discriminated against in many ways. PLWAs are given many derogatory labels and there are families and health workers who discriminate against them (Antwi and Oppong 2006).[121] Stigmatisation and discrimination against PLWAs has therefore been a challenge to the implementation of programmes addressing HIV and AIDS in most parts of sub-Saharan Africa (Monjok et al. 2009; Dodor 2008; Oye-Adeniran et al. 2006; Fawole et al. 2006). In Ghana, this is particularly important since when stigmatisation and discrimination are reduced citizens can be bold enough to accept VCT, one of the Government of Ghana's key policies to address HIV and AIDS. A study on the nexus between violence and HIV and AIDS in northern Ghana found that stigmatisation and discrimination were the factors undermining efforts to fight the disease. Most people with the disease became "victims of violence because of their HIV status." The violence includes rejection from family homes, insults and name-calling (ActionAid Ghana 2007: 35; Antwi and Oppong 2006).

7.2.3 Male dominance in sexual and reproductive health issues

In Africa, the views of men dominate those of women in matters of sex and reproductive health. This makes women more vulnerable to HIV infection than men. There is evidence to suggest that infection rates are higher among females than their male counterparts due to women's inability to make choices regarding sexual activities and health (Ekanem et al. 2005; Ezumah 2003; Antwi and Oppong 2006;[122] Burgoyne and Drummond 2008). Part of the reason is that in most countries such as Ghana, norms of society expect women to be passive when it comes to sexual issues (Anarfi 2006), but males are permitted to be active

[121] The common perception in Ghana is that PLWAs are immoral, unfaithful, prostitutes, and womanisers.
[122] According to Antwi and Oppong (2006), up to about the 1990s HIV infections in females and males in terms of ratio was 6:1.

and some cultures even allow males to have extra marital relationships whilst in the same society it is considered taboo for women to do so (Frimpong-Nnuroh 2006).

I have discussed the challenges to HIV and AIDS policy implementation. Ideally officers at the Health Directorates would involve citizens in the design and implementation of health programmes. In the case of HIV and AIDS campaigns, the health officials seek to change the behaviour of citizens, and they realised that establishing strong ties with leaders of CSOs would enable them to develop joint efforts and work closely together to facilitate this. In the next section I will compare Sunyani with Techiman. I will describe how the staff of these two Health Directorates embedded themselves with CSO leaders in order to develop joint efforts with them to work to change peoples' attitudes towards HIV and AIDS programmes.

7.3 The nature of Health Directorates' embeddedness with Civil Society

In Sunyani, the strength of embeddedness was medium with leaders of NGOs, religious groups, and traditional authority (refer to Table 3 in Chapter 3 and see Tables 7 and 8 for details of ties with the selected NGOs and other CSOs respectively).[123] The figures show that each of the officers at the Health Directorate had at least two out of the three ties with leaders of civil society groups. In addition, political party ties were strong even though the Health Director is an NDC sympathiser. This is because most of the other officers are NPP and the leader of the traditional council, religious leaders, and 'owners' of NGOs are all NPP.

In both Tables 7 and 8, the strength of embeddedness was obtained by computing the number of existing ties as a percentage of all the possible ties that each case could obtain (see Appendix F). The number of all the ties depends upon the number of NGOs (as in Table 7), or the number of religious groups and traditional authorities (in Table 8) that were selected for the interviews. As these were selected based on them being known to work on

[123] See also Table 10 in Appendix G for overall pattern of informal ties and embeddedness

HIV and AIDS programmes, their numbers vary in each of the cases, therefore they would not have the same denominator. The difference in the denominator was however not taken into account in the computation of the strength of embeddedness. Each case was determined based upon the number of NGOs, traditional authority leaders and religious leaders interviewed. The figures in the last bottom row of Table 7 and the last column in Table 8 show the strength of embeddedness using the following scale: ≤ 39.5% (weak), 40-69.5% (medium), and ≥ 70% (strong). The strength of embeddedness also means the density of ties that exist between health officers and the selected CSO leaders.

Table 7: Embeddedness: Health Directorate and NGOs

	Ho			Obuasi			Sunyani			Techiman			New Juaben		
NGOs	HD	DDNS/PHN	DCO	HD	DDNS/PHN	DCO	HD	DDNS/PHN	DCO	HD	DDNS/PHN	DCO	HD	DDNS/PHNN	DCO
AFRIWEB	E	N	-												
FUGI	N, E	E	N												
CLF	E	N, E	N												
LDF	-	E	E												
SSF				E, N	N	E, N									
PACAI				E, N	N	E,N									
KWDA					-	N									
BV							N	E,N	E,N						
CSD							N	N	N						
6th MWF							N	E,N	E,N						
MH							N	N	N						
WASA							-	N,E	E,N						
FO										E	E	E,N			
ACF										-	-	-			
IFFN										-	-	N			
LPA										-	-	N			
BCSF										-	-	N			
4-HG													E,N	E,N	N
M25H													E,N	E,N	N
FHF													E,N	E,N,O	O
RW													E	E	N
	(12/36) = 33.33%			**(11/27) = 40.74%**			**(20/45) = 44.44%**			**(7/45) = 15.55%**			**(19/36) = 52.77%**		

Notes: HD (health director), DDNS (deputy director of nursing services), PHN (public health nurse), DCO (disease control officer)
*FUGI-Future Generation International *CLF-Cure Lepers Foundation
*LDF-Life Development Foundation *SSF-Social Support Foundation
*PACA-PACA International *KWDA-Kaleo Women's Development Association
*BV-Beauty in Virginity *CSD-Centre for Sustainable Development
*6th MWF-6th March Women's Foundation *MH-Mission of Hope
*WASA- *FO-Frankmay Orphanage
*ACF-Ahenebronoso Care Foundation *IFFN-Inter-Faith Family Network
*LPA-Lamp of Peace Association
*BCSF-Bromkyempem Care and Support Foundation
*4-HG-4-H Ghana; M25H-Mathew 25 House
*FHF-Faith and Hope Foundation
*RW-Rural Watch

Table 8: Embeddedness: Health Directorate and chiefs, and religious leaders

Case		Ho		Obuasi			Sunyani		Techiman		New Juaben			(%)
		Chief1	Pastor1	Chief2	Pastor2	Pastor3	Chief3	Pastor4	Chief4	Pastor5	Chief5	Pastor6	Pastor7	
Ho	HD	E	E,N											(9/18) = **50.00%**
	DDNS/ PHNS	E	E,N											
	DCO	E	E,N											
Obuasi	HD			E, N	E, N	E, N								(12/27) = **44.44%**
	DDNS/ PHNS			-	N	N								
	DCO			E, N	E	E								
Sunyani	HD						N	N						(9/18) = **50.00%**
	DDNS/ PHNS						E, N	E, N						
	DCO						E	E, N						
Techiman	HD								-	-				(2/18) =11.11**%**
	DDNS/ PHNS								-	-				
	DCO								N	N				
New Juaben	HD										E, N	E, N	E,N	(15/27) = **55.55%**
	DDNS/ PHNS										E,N	E,N	E,N	
	DCO										N	N	N	

Source: Author's construct, July 2010

Notes:

Pastor1: Pentecost Church
Pastor2: End Time Ministries
Pastor3: Living Praise Church
Pastor4: Pentecost Church
Pastor5: Roman Catholic Church
Pastor6: New Faith Bible Church
Pastor7: Powerhouse Miracle Worship Centre
Chief1
Chief2
Chief3
Chief4
Chief5

Leaders of the selected civil society groups and officers at the Health Directorate confirmed the existence of these ties. For example, the leader of one NGO explained:

> The Disease Control Officer and the Public Health Nurse are Brongs and so we see ourselves as one people. We see each other almost every single day because several activities bring us together. We meet to discuss upcoming funerals, weddings, and religious programmes and plan to attend or not to attend. Because we are from the same ethnic group, it makes us feel comfortable in each other's company. Apart from the ethnic relations we have, our interest in helping to work around HIV and AIDS in the municipality has also contributed to strengthening the bond between us. We undertake joint programmes most of the time [Director of an NGO, Sunyani, 18th May 2009].

Similarly, the Disease Control Officer had ethnic relations with all the leaders of the NGOs. According to her:

> The Director of Beauty in Virginity has been a good neighbour for over 10 years. We have lived in the same vicinity all this while. We lend support to each other in times of needs such as bereavement, marriage, and religious support. I give here support when her church organises annual harvest. She does the same thing to me. I have also been involved in her NGO work because I have always been a resource person to talk to the girls in her virgin clubs. I do not take any payment from her for doing this and sometimes when our official vehicle is not available I pay for my own transport to go to the schools. During holidays I sometimes skip church service and meet her girls when they have programmes on Sundays [Disease Control Officer, Sunyani, 5th May 2009].

The Disease Control Officer's emphasis on the reciprocal support shows the importance of *abusua* ties between them. Most Ghanaians are likely to measure the strength of *abusua* ties based on how reliable and consistent their neighbours would be when they are bereaved or during weddings when they issue indirect invitations to request support in kind and cash.[124] It was the strength of this *abusua* tie that led the Disease Control Officer to pay for her own transport, to speak with the girls in the virgin clubs, and offer her services as a resource person for free. These are opportunities that NGOs might miss if they do not have good informal ties with resource people. This is one of the factors missing in Techiman, which might have contributed to its poor performance.

[124] From my own experience, when we plan funerals in my village and talk about numbers we would cater for in terms of food and drinks, there are members of our *abusua* who we can be sure will support in cash and in kind.

According to a high profile member of Sunyani's traditional council the ethnic ties he had with the Disease Control Officer and the Deputy Director of Nursing Services enabled them to develop concerted efforts towards fighting HIV and AIDS. He explained that:

> As the traditional custodian of the municipality, everything concerning the development of the people here comes to my palace. Therefore I have been very concerned about this issue of HIV and AIDS and its effects on my people. I have been in touch with Dr. Opare and his team and we have been able to work together to help increase the awareness level among my people. Dr. Opare can come to me anytime and I can also request him to come whenever I need him. In addition to our friendship ties, I was the Chairman of the Hospital Management Board for about 4 years. All these have further strengthened our friendship [Member of Sunynai Traditional council, 7th May 2009].

Through most of my interactions with people in Sunyani, I observed they were proud of their ethnic identities and they showed strong ethnic solidarity towards their people. This might explain their desire to mobilise efforts to help reduce the spread of the disease. There was also strong commitment from the Chief, officers at the Health Directorate, and the Civil Society actors to reduce HIV and AIDS in the municipality.

For Techiman, ties were weak as compared with Sunyani. It was only the leader of Frankmay Orphanage (NGO) who had ethnic relations with all the three officers at the Health Directorate (they hailed from the northern part of Ghana), and *abusua* ties with the Disease Control Officer. In the same way it was only the Disease Control Officer who had *abusua* ties with leaders of three NGOs, Pastors, and the Chief of Techiman (refer to Table 4 in Chaper 4 and see Tables 7 and 8). There were no old-school networks at all. The weak *abusua* ties might mainly be due to the fact that the officers of the Health Directorate were new in Techiman unlike in Sunyani where officers at the Health Directorate had been in office long enough to establish *abusua* ties within the municipality. The Director of Health explained that:

> I am yet to know these people you are talking about because as I said I am new. We only deal at the formal level especially with the NGOs who sometimes come for me to recommend them for funding from the Ghana AIDS Commission and the National HIV and AIDS Control Programme. But I hope that as time goes on we will all get to know each other. My initial impression is that there is so much rivalry and competition going on among the NGOs. This raises the issue about their genuine intentions about fighting the disease [Health Director, Techiman, 25th November 2008].

The short period that health staff had been in post could explain why the strong political party ties between them and leaders of NGOs have not influenced the overall strength of all the ties. All the NGO leaders also stated that the Health Director and the Deputy Director of Nursing Services were less than two years in Techiman. These officers were therefore still learning about NGO activities. This might also explain why staff at the Health Directorate had doubts about claims of the NGOs concerning the number of PLWAs they provided care and support for. The views of health staff might be influenced by the fact that most of the NGOs were 'owned' and directed by single people. The NGOs in Sunyani were also owned by individuals but they were managed by 'Boards' having the Health Director as their Chairman. NGOs that are owned by one person might not be peculiar to only Techiman and Sunyani as observed by Amoako (2008: 4) that "NGOs in Africa are often dominated by individuals, have few members and are prone to minimal transparency and accountability."

The rivalry and competition among the NGOs might explain why the health officers had questions about their claims because there is the perception that NGOs use HIV and AIDS to make money. A study conducted by ActionAid Ghana (2007) in Ghana, found that HIV and AIDS sufferers complained that NGOs used them to make money as indicated by one of the PLWAs, "because of us, people outside send money. We don't see the money. All we know is that the money has been used for us …" (ActionAid 2007: 79).[125]

The analysis of interview transcripts and documentary materials suggest that the embeddedness of staff at the Health Directorates can play a significant role in implementing HIV and AIDS policy in addition to other factors. I discuss these below.

[125] This PLWA might be referring to donors whose interest in HIV and AIDS has come with a lot of funding which NGOs can access. This can be the main incentive for mobilisation around the disease in Ghana and why NGOs might want to register more AIDs victims.

7.4 Effects of embeddedness of Health Directorates on beliefs and norms

To be able to identify the extent to which informal relations between health staff and leaders of the selected groups within civil society may have contributed to the development of joint efforts between them to work together, I asked both leaders of the CSOs and the health officers how the District Health Management Teams (DHMTs) enabled them to work together. None of them indicated that the DHMTs were functional enough. According to one of the senior health officers, for the past 8 years, the DHMT has only existed in name on paper. This was how she described the activities of the DHMT in Sunyani:

> As far as the DHMT is concerned, I would say yes, we have it. At least it exists here at the Health Directorate. However it is only made up of health staff. We do not have any member or representatives from the Assembly and Civil Society Organisations even though they are supposed to send representatives to come. They know about this and we have written to them. It looks like they are just not interested in it. It is one of the reasons why finding other ways to work with the CSOs is important and this is what I mean by developing good friendship and working relationships with them [Health officer, Sunyani Municipal Health Directorate, ...]

Findings from subsequent interviews I had with the leaders of the selected NGOs supported what I found from the Health Directorate that the DHMT did not have the required membership and that other representatives from the Assembly and CSOs did not actively participate in the DHMT. The claims by health officers that the weak nature of the DHMT partly explains the usefulness of embedding themselves within society appear to make sense following the findings from the analysis of the effects of their embeddedness with CSOs.

The Sunyani Health Directorate's embeddedness within the selected aspect of civil society seem to facilitate the consultation with leaders of the selected civil society groups by health staff and about 57 percent of leaders of those CSOs were consulted in the design and implementation of HIV and AIDS programmes (see Table 13 in Appendix K and Table 14 in Appendix L). The increase in consultation appeared to have contributed to the development of shared interests around the disease which seems to have helped overcome the challenges discussed in the previous section and influenced the behaviour of Health

Directorate staff. For example, one of the respondents at the Health Directorate indicated that based on experiences and lessons he had gained from working with people at the local level, and dealing with beliefs around health, he has adopted a strategy of embedding himself within the community as this makes it easy to involve the community and deliver more responsive services to citizens. He claimed that his approach has yielded good results. He said:

> Through my own Pastor, I became friends with other Pastors that I know to have opposed condoms so it was easy to talk about HIV and AIDS issues with them. We talked freely about condoms during the times we had together, and these meetings were very informal so they trusted me that our campaigns to promote condoms would not necessarily encourage people to engage in premarital sex. Sundays after church service, they give me their pulpits to explain our programmes to the congregation. In the same way my frequent attendance to NGO meetings as a Board member eroded all formalities between us. We all trusted each other so it was easy to coordinate our efforts in that respect. Again a high profile person in the Sunyani traditional council has become my friend and I can go to him anytime. So it made it easy for me to get him to attend all the public campaigns we organise [A staff at the Health Directorate, Sunyani, 14th May 2009].

The Pastors' offer of their pulpits to the health staff and leaders of NGOs for health campaigns is a demonstration of trust and acceptance that their message would not conflict with the church's doctrine about morality. The embeddedness of health staff with leaders of the churches might have contributed to the establishment of trust between them but it will take time for trust to be established and maintained for it to yield such outcome. Similarly, for staff at the Health Directorate to be able to get a very influential member of the Sunyani traditional council to attend their programmes means that this high ranking member of the traditional council was accessible to them privately or they had good personal ties with him or her otherwise it is unlikely to get the support of such a person.

Another popular elected Assembly member also supports the claims that the change in attitudes of residents in Sunyani could not have been possible without informal ties between officers at the Health Directorate and civil society actors. He explained using the example of the case of the Zongo community that:

> Leaders of NGOs and health officers were able to get the leaders of the Zongo areas to accept open discussions about condoms because I know they are good friends and they have become familiar with each other. I think the whole issue is about familiarising yourself with the people to eliminate any suspicion and win peoples' trust. That is what health officers have done with leaders of NGOs. I have seen senior health officers on a number of occasions with leaders of

> influential NGOs outside office or formal working hours which make me believe that they are good friends [Elected Assembly member, Sunyani, 6th May 2009].

Trust might explain why the Zongo community was easily accessible to the Health Directorate and NGOs as NGO leaders would not be able to hold private discussions about sexual and reproductive rights with women without the approval of their husbands. Gaining the approval of the men for open discussions about the right of women to make choices concerning sex and reproduction also appears to suggest that some men may be chaning their attitudes about how they dominate in matters surrounding sexually transmitted infections and ways to manage them. This suggestion is supported by one of the leaders of the Zongo community who said:

> For over four years now, we have all worked with the staff from the Health Directorate and leaders of NGOs who come here to help create awareness that women should be able to say how many children the family should have or how many wives their husbands should have. A woman should also be able to say when she wants to have sex. It is not that we were against such efforts in the past and that Muslim men would like to dominate women. It is the teaching of Islam that women must be submissive to their husbands. Islam also allows the man to marry more than one wife. Sometime ago it was not possible to raise this discussion in the Zongo community. But now most women are gradually being able to do so because the men are tolerating the views of their wives and women in general [Opinion leader in the Zongo area, Sunyani, 6th May 2009].

As the teachings of Islam allow a man to marry more than one wife, these comments suggest the attitudes of some Muslim men may be changing as they allow their wives to hold views concerning the number of women they should marry. If this is the case then it is a positive consequence of the collaboration between the Health Directorate and Muslim men. It also suggests the successful embedding of the Health Directorate within civil society which enabled staff at the Health Directorate to win the trust of the leaders of the Zongo areas and for them to allow a discussion of this kind.

In Techiman, unlike Sunyani, there was low consultation with leaders of the selected CSOs, poor coordination of programmes between the Health Directorate and those Civil Society Organisations, and consequently a lack of concerted efforts towards the challenges that confront HIV and AIDS policies. All the leaders of the 5 NGOs claimed that the officers at the Techiman Municipal Health Directorate did not consult with them about plans to

manage AIDS (see Table 13 in Appendix K and Table 14 in Appendix L). According to the leader of one NGO:

> My NGO provides care and support for PLWAs. We do voluntary counselling and encourage people to go for testing, and I know that there are other NGOs that also do the same thing. Even the Health Directorate also undertakes voluntary counselling and testing. The Health Directorate has not made any effort to coordinate our activities so we can fight the disease together [Director of NGO, Techiman, 27th November 2008].

This Director's view suggests that coordination of NGO activities, which is a key responsibility of the Health Directorate, is weak in Techiman. This may be due to weak ties between health staff and leaders of NGOs because the staff in the Health Directorate and leaders of NGOs had not known each other for long as most of the health officers have spent less than two years in Techiman. As these NGOs conducted their activities in isolation from each other and considering the reservations that staff at the Health Directorate had about NGO activities, it can be difficult for them to mobilise concerted efforts towards addressing the issues that constrain implementation of HIV and AIDS programmes in the municipality.

The study also revealed that politicisation of NGO activities in the municipality might have contributed to weakening the consultation with and mobilisation of NGOs around the disease. A staff member of one of the private radio stations in Techiman revealed that leaders of NGOs known to be members of the New Patriotic Party (NPP) received funding from the Assembly between 2000 and 2008 when the NPP was in power. In fact Minutes of the General Assembly meetings show that Assembly members called for the list of NGOs receiving support from the Assembly to be made public but this was not carried out by the Chief Executive (TMA 2003a; 2003b).[126] The Chief Executive's unwillingness to make the list public provided further grounds for Assembly members to call on opinion leaders, traditional authority and the clergy to monitor the use of HIV and AIDS funds (see TMA 2003b), and this might have caused NGOs to lose the support of Assembly members. The

[126] See TMA (2003a) 'Minutes of the First Ordinary Meeting of the Second Session of the Techiman District Assembly held on 7th July 2003.' In addition, see TMA (2003b) 'Minutes of the First Ordinary Meeting of the Second Session of the Techiman District Assembly held on 8th July 2003.' This might be why the Focal Person for HIV and AIDS at the Assembly was reluctant in giving me the list of NGOs in the Municipality. When he later gave me the NGOs verbally, I realised that I could not trace some of the NGOs. Their telephone numbers did not work and some of them who accepted my call would not grant me interviews.

Assembly members have great influence within the community and without their support NGOs could lose the trust of community members in their programmes to promote condom acceptance, and empower women. This interviewee added that the politicisation of NGOs was extended to their radio station in 2006. He said:

> In 2006 we had a schedule with a high profile international NGO which paid for airtime to create awareness about HIV and AIDS in Techiman. Unfortunately some people started pointing accusing fingers at our radio station that we were anti NPP because we made the government unpopular since our programme created the impression that government was not doing enough in Techiman as far as prevention of HIV and AIDS was concerned. We therefore stopped the programme even though the NGO had paid for the airtime, so that we would not be seen as anti-government [Staff from a media house, Techiman, 17th November 2008].

The extension of politicisation of NGO activities to media houses provides further evidence of weak coordination and poor mobilisation of efforts between the Health Directorate and the NGOs towards addressing HIV and AIDS in Techiman. If municipality residents had seen NGOs conducting joint programmes with health staff playing a leading role, they would have been less likely to misunderstand their message. This did not happen as health staff were not strongly embedded with the leaders of NGOs who were supposedly on the ground and in touch with the people.

In the previous sections, I have explained the nature of embeddedness between health officers and leaders of CSOs and shown that the nature of health staff embeddedness enabled them to develop joint efforts with leaders of CSOs to implement HIV and AIDS policy. In the next section, I show how this was achieved in Sunyani as compared with Techiman where weak embeddedness largely explain the inability of health staff and CSO leaders to work to achieve success.

7.5 Overcoming religious beliefs against the acceptance of condoms

The Health Director in Sunyani and leaders of CSOs succeeded in changing the attitude of the church to condom use. Considering the influence that religious belief can have on people's choices this is a huge achievement. This is how one of the respondents in the Sunyani Health Directorate explained it:

> We have worked with the NGOs to break through myths about condoms. We have been able to get some of the pastors to openly talk about condoms in church. We are now able to even carry both male and female condoms to demonstrate how they are used when we are invited by Men and Women Ministries of the church for health talks and this has been going on for about 4 years now. If you knew the situation from the late 1990s to around 2004, you will appreciate that we have achieved a lot. So I can confidently say that the situation now is far different from what I came to meet in the early part of 2004. When I came to Sunyani in 2004, I realised that the municipality was high transit point and there was the danger that most people could be at risk of contracting the disease. However, most people would not openly talk about it. The worst culprit was the church. I realised that there were a number of NGOs who were committed to this cause. I also realised that the NGOs effectively coordinated their activities. I saw this because I am also a member of their Board. I also realised that leaders of some of the NGOs were Christians and members of churches whose pastors opposed condoms. I therefore took advantage of my position as a member of their Board to use these NGOs to break this religious barrier. As I speak to you now, HIV and AIDS is discussed more openly than in the past. A lot more people voluntarily go for counselling and testing [An interviewee at the Municipal Health Directorate, Sunyani, 22nd May 2009].

Documentary evidence supports the claims made by this Health Directorate respondent that condoms are now more acceptable than in the past. The study revealed that the rate of condoms acceptance is high especially among men. Whilst 18 out of 20 men would accept condoms in 2007, it is only 1 out of 20 women would do so in Sunyani during the same period (Sunyani Municipal Health Directorate 2007). A shift from the difficulty to talk about condoms to the demonstration of the use of condoms in Christian congregation is remarkable. For the Health Directorate to be able to do this continuously for four years means that many residents in the Sunyani municipality are changing their attitudes in a positive way towards the use of condoms (Sunyani Municipal Assembly 2006a; 2008b).

According to the Sunyani Municipal Health Directorate (2007), the proportion of the population that sought VCT increased by about 15 per cent each year between 2000 and 2008. Additionally, people diagnosed as HIV positive became confident to declare their status and form associations for the purposes of receiving care and support from Non-governmental organisations (NGOs). For example, the number of PLWAs registered by the NGOs increased from a total of 216 between 2000 and 2004 to about 437 between 2005 and 2008 (Sunyani Municipal Health Directorate 2007). Many families now accepted family members who were HIV positive.

The evidence of a shift in the position of many churches in the Sunyani municipality was supported by a Pastor of one of the Charismatic churches whose views changed. Initially the church did not want to encourage discussions around condoms because that would mean the church was encouraging sin among the people. Following the NGO and the Health Director's HIV and AIDS awareness campaigns in the municipality from 2004 he changed his mind because he realised that unmarried and young persons in his church would engage in sexual activities irrespective of them being in the church. He added that between 2000 and 2008, there were over 75 pregnancies and illegal abortion related complications among young persons in Sunyani including his church. He indicated that in spite of the fact that the church punished those concerned, there was the possibility that such things could happen. He explained how the church had changed to now support the idea of campaigns for condoms this way:

> I have personally taken it upon myself that I will spread the message about condoms. Since 2005, I have incorporated sex education into the programme of our youth ministry. We invite staff from the Health Directorate to come and have a talk with the youth. This was difficult to do in the past because I had the conviction that young and unmarried persons could fall prey to sexual temptations that can lead them to commit sin. But I also know that there is the likelihood that some of my members could fall to this temptation so if they use condoms then we can be sure that at least they will not get infected or even prevent unwanted pregnancy. But I always ensure that I emphasise that the adolescent must stay away from pre-marital sex each time I preach my sermon [A Pastor at Sunyani, 10th June 2009].

This pastor's views are a departure from the conventional teaching of the church that advocates that young and unmarried Christians would keep away from engaging in sexual activities until marriage. This thinking is what informs the abstinence 'A' component of the institutional strategy which appears to be difficult to achieve. Most religious leaders are gradually accepting that it can be difficult to get unmarried people to abstain from having sex so pastors are able to promote condom use. However, others might have the view that it is unreligious for leaders of the church to encourage the use of condoms. One such instance is given by Haynes (2007) that a Buddhist monk in Thailand who supported the idea of condoms was criticised because it was not right for a cleric to do that.

The results from in-depth interviews with leaders of NGOs and extensive analysis of documentary material on HIV and AIDS management in Sunyani provide further evidence

that from around 2004 to 2008, the general attitudes of religious leaders and the Christian public towards campaigns for condoms have been positive when compared with public attitudes during the period between 2000 and 2004 (Sixth March Women's Foundation 2007; Centre for Sustainable Development 2006). A director of one of the NGOs claimed that when she set up the NGO in 1996, she was faced with the challenge as to whether her strong Christian beliefs and principles would conflict with her programmes around HIV and AIDS and whether she should support campaigns for condom acceptance. She indicated that although she set up the NGO in 1996 by undertaking programmes to create HIV and AIDS awareness among women it took about 8 years before she could openly show her support for such campaigns. She said:

> I started supporting campaigns for condoms as a means to reduce the spread of HIV and AIDS since 2005. I am aware that some of the pastors have changed their position on this. I am a strong Christian myself and I am a leader of the women's ministry in my church. I have been brought up with strict Presbyterian principles and discipline. As a woman with adolescent children, I therefore thought it was ungodly to openly support campaigns and debates around the acceptance of condoms. My belief at the time was that if we did that then we had given our approval to young people to get into immoral activities. But I was not the only person who held this view. Most women in our church also thought the same way. But due to what I have learnt from my engagement with health officers and other religious leaders, I now hold a different perception which is that supporting campaigns for condoms do not necessarily conflict with Christian teachings. I know that other women have also changed to accept that condoms must be discussed and endorsed by everybody. Through our collaborative work with other NGOs such as Beauty in Virginity, and Mission of Hope, we visit churches and speak openly about condoms. We even distribute condoms at durbars and it makes people laugh. I could not do this some 5 years back [Director of an NGO in Sunyani, 18th May 2009].

To change from a fear of breaking strict discipline rooted in religious ethics to open distribution of condoms at durbar grounds suggests a fundamental change in attitude of such an influential person, a leader of the women's group in her church. These actions 5 years earlier would be seen as breaking Christian principles which could have cost her reputation and the trust she had built over several years as women's leader and a mother. She could not therefore risk doing this if she was not convinced that she could do that and still retain the respect and trust of the other women, her own family and the public. Her belief that other women have also changed their perception and attitudes towards condoms suggests that programmes around condoms are increasingly receiving support of religious people.

The evidence of change in perception of religious people is further supported by attitudes of the church towards leaders of NGOs who started condom awareness campaigns between early 2000 to about 2005. The account of the experiences of NGOs at the beginning and the support they have received later from the church was described by one NGO director as follows:

> I had some bad experience in 2002. Some parents criticised me on religious grounds that I was encouraging adolescents to engage in premarital sex which was a sinful act because I was talking about condoms to young people. It was true that I did educate the young people in the virgin clubs about the use of condoms. Ideally, I encouraged them to remain virgins till they marry but the fact is that we could only control them to some extent when they are in the Senior Secondary School (SSS). When they leave the SSS it can be difficult to control them and since they might have sex without you knowing, I thought that it was right to expose them to this so that they would be safe. But some parents did not understand me initially. My philosophy was that if we are able to 'catch-them-young' and instil responsive sexual behaviours into them, they would grow to become responsible adults.
>
> I also aimed to reduce teenage pregnancy among young girls aged between 8 and 25 years. The good thing however is that the situation is different today. I think that some of the parents have come to understand that we can be Christians and talk about condoms without going to hell. Can you believe that the fathers of two of the members of the club who are pharmacists now provide us with condoms for distribution in schools? You won't believe this but these are Christians also. Most parents also support us with funds to organise our meetings where we provide health education talks. We meet every two weeks on Sundays to keep them active and busy so they would not be idle and get into doing things that could expose them to bad company [Director of an NGO in Sunyani, 18th May 2009].

This respondent's indication that the same parents and churches who criticised her in the past now support her NGO, in cash and in kind, further supports the claim made by officers from the Health Directorate that by using open discussions of HIV and AIDS and condoms in the church NGOs and the Health Directorate had been able to change people's perception about condom use in the municipality.

Comparing the case in Techiman with Sunyani reveals that the Health Directorate and civil society actors in Techiman did not perform well in overcoming religious beliefs that constrained efforts to promote condoms. The rate of condom acceptance was low when compared with Sunyani. For every 40 men that would accept condoms, there was only 1 woman who would do so, and this has been the situation each year between 2003 and 2008 (Techiman Municipal Health Directorate 2005; 2006; 2007).

The low rate of condom acceptance might be due to the poor organisation of programmes by NGOs and the Health Directorate. Activities of the numerous NGOs in the municipality were fragmented and poorly coordinated mainly due to rivalry and competition among them. NGOs competed for PLWAs because the more PLWAs an NGO has the better its chances to obtain financial resources from donors. Officers at the Municipal Assembly and the Health Directorate had doubts about the intentions of NGOs due to the rivalry and competition amongst them. According to one of the officers at the Health Directorate:

> I have been here for about two years but I hear there are several NGOs doing virtually the same thing. They all claim to have associations of PLWAs to whom they provide care and support but you hardly find them coordinating programmes. I have also been informed about some NGOs fighting over HIV and AIDS patients because those patients have left one NGO or another to join a different association of PLWAs under a different NGO. If they aim at improving the lives of PLWAs why won't they share ideas and resources? [A staff, Municipal Health Directorate, Techiman, 21st August 2009].

Most of the leaders of the NGOs agreed that there was rivalry among them. According to one director, this rivalry was due to the way the Municipal Assembly treated the NGOs, offering financial support to a few selected ones and leaving out others. This helps to explain why NGOs would perceive each other as rivals and compete for resources. This finding suggests that there are no collaborative efforts between the staff in the Health Directorate, the Assembly, and NGOs around HIV and AIDS in Techiman. It is difficult to understand why the staff from the Health Directorate had reservations about the claims of the NGOs and their activities in the municipality. I discuss these reservations later in this chapter but it is useful to understand that funding drives NGO leaders' concern at the loss of a PLWA to another NGO. The lack of combined efforts among the key actors might explain why there are practical difficulties with promoting the campaigns to promote condoms. A member of the Techiman Traditional Council (TTC) said:

> The Catholic Church in Techiman is strongly against discussions about promotion of condoms. Apart from the Catholic Church, we have over 100 new churches, what people call Pentecostal or Charismatic Churches, which I call 'one-man churches,' which would not encourage such discussions. Most people also see these churches as 'heaven bound' and they preach about sin and hell and all that. HIV and AIDS is a big health concern here but how can we manage this when some of these young pastors tell us that we will promote premarital sex when we talk about condoms. We will be deceiving ourselves if we think young people would not have sex and they will abstain. We hear of stories of teenage pregnancies in the church here and there. There are even stories of some of the church leaders having affairs in the church. Why don't we help everybody to leave a safe life? [A member of Techiman Traditional Council, 19th November 2008].

The views of this member of the TTC concerning promiscuity in the church may not be restricted toTechiman but can help us to understand the challenges of campaigns to promote condoms within Techiman.[127] The views further support my assertion that the other two components of the 'ABC' strategy to fight HIV and AIDS in Ghana may be ineffective since it might be difficult to get people to abstain from having sex, the first component. It is also unlikely that people will restrict their activity to one sexual partner the perception held by my respondents in Sunyani, which is anticipated by the second component of 'ABC'. What these views suggest is that the third component of the 'ABC' strategy (condoms) might be more acceptable to most people in Ghana. This is why the TTC has called for sensitisation of citizens to change religious beliefs that can undermine efforts towards promoting the use of condoms (Techiman Traditional Council 2007).

Involving the general public in the fight against the disease is particularly important to all the interviewees who have concerns about stigmatisation and discrimination against people with the disease. In addition to the success of promoting condoms in Sunyani, the study revealed that stigmatisation and discrimination against PLWAs has been minimised in Sunyani as compared with Techiman. I describe this next.

7.6 Addressing stigmatisation and discrimination against PLWAs

The level of stigmatisation and discrimination has been reduced in Sunyani. As I indicated in an earlier section of this chapter, the number of people who went for voluntary counselling and testing and the number of people who have HIV and AIDS registered by all the NGOs increased significantly between 2000 and 2008. According to my key informants, the increase in the registered number of PLWAs might not be due to new infections but rather because people have become confident to publicly declare their status due to a change in the attitudes of the public to accept them. The Executive Director of one

[127] A cursory survey of the media in Ghana reveals that there are several stories of premarital pregnancies among young persons in the church and also stories of pastors defiling church members (see Daily Guide 2010; Ghanaian Journal 2010; Ghana News Agency 2010m).

of the NGOs indicated that stigmatisation and discrimination have been minimised mainly due to the collaborative activities undertaken by NGOs and Health Directorate. He claimed that they have achieved a lot especially in the Zongo areas.[128] He explained that:

> Until 2004 onwards there was a kind of silence and myth about the HIV and AIDS disease among the people in the Zongo communities. Those who had the disease were hiding because they were seen as immoral people who had been punished by God. Family members would not want to be associated with PLWAs because it was demeaning to the whole family. PLWAs could not go to the market or buy things or come to public gatherings. Some people even would not shake hands with PLWAs for fear of being infected. Until around 2004, the Zongo areas were 'no-go' zones for most NGOs because the Imams were strongly against activities that sought to expand Christianity in the Zongo community. Initially they did not understand the work of the NGOs around HIV and AIDS and some of the Islamic teachings that see sex as sacred made it difficult for open discussions around sex as the main cause of the disease. But we have been able to break this silence and most people in the Zongo areas now talk about the disease in public. Most people are also happy to go for VCT services. I can lead you to homes where PLWAs are living with their families because this is no longer secret and the PLWAs themselves are able to come out. But it was in the same communities that PLWAs were hiding and nobody would like to show you who and where they were [Director of an NGO, Sunyani, 18th May 2009].

Breaking the taboos surrounding sexual activities and HIV and AIDS in the Zongo area is important to fighting the disease. All the respondents claim that PLWAs in the Zongo areas publicly declared their status, and families openly accepted them. This claim suggests that attitudes towards PLWAs in the Zongo in particular and Sunyani in general have changed from the earlier situation between 1990s and early parts of 2000. The Zongo areas' acceptance of HIV and AIDS related programmes might have been influenced by the approach that one of the NGOs employed. This was how the leader of this NGO explained it:

> We identified 50 orphans due to HIV and AIDS in the Zongo for support in education. The support includes payment of their fees; provision of school uniform; footwear; meals; books; and pencils. In addition to these, we adopted one of the Islamic Schools in the area for support. For twice in every year since 2005 we provide books and teaching aids to them. All these have helped to allow us access to the Zongo areas [Director of NGO, Sunyani, 18th May 2009].

The strategy for accessing the Zongo communities through the provision of support to orphans showed the Imams and leaders of the Zongo areas that activities around the HIV and AIDS pandemic were in good faith and that the leaders of NGOs and health staff did

[128] Zongo communities were predominantly inhabited by people of Islamic faith.

not aim at religious indoctrination or efforts to convert Muslims to the Christian faith. This explains why people's perception towards the disease and NGOs activities changed.

An influential member of the Sunyani Traditional Council was particularly impressed by the positive change in attitudes of the general public in the municipality towards PLWAs. This is one area which my respondents from the Techiman Traditional Council believed has not changed in Techiman. According to the member of the Sunyani Traditional Council, continuous stigmatisation and discrimination against the people who have the disease would worsen their plight and expose others to risks of infection because those who have the disease might go into hiding. He explained that:

> I can say that for the past five years or so most people in Sunyani are able to openly declare their status when they are diagnosed to be HIV positive. This has come as a big relief because the more we call HIV positive people with funny names the more we expose all other persons to the risk of infection. You know that HIV positive persons can still look healthy therefore anybody can fall in love with them and because they fear to be rejected, they would not tell you their condition. In the past, it was like a taboo to talk about the disease due to several superstitions we all heard about. People even called it 'Abidjan disease' because it was mostly those who came from the Ivory Coast who were found to have come home with the disease. Women who had it were called 'prostitutes' and the men who had it were called 'womanisers' and nobody would like to come near such people [A member of Sunyani Traditional Council, 7th May 2009].

The views of this respondent have mirrored a number of influential NGOs such as ActionAid-Ghana. The danger of stigmatisation is that it can compel PLWAs to migrate to reside in other cities in the country or even outside the country, and keep their status secret thereby exposing innocent people to risk of contracting it from them (ActionAid Ghana 2007). A change in perception among residents of Sunyani also means that people's knowledge about the causes of HIV infection had improved and that most people had come to know that sexual transmission is not the only means of getting infected and that those people who acquire HIV might not necessarily be prostitutes in the case of women or womanisers as with men.

As compared with Sunyani, stigmatisation and discrimination against PLWAs were high in Techiman. The Health Directorate and NGOs' performance in this respect was low as

compared with the achievements of NGOs in Sunyani. A number of stories attest to this and one of such experiences was given by an officer at the Health Directorate. She said:

> I think the public in Techiman is too judgemental especially the Christian community. People who know they have the disease are hiding because they are called by all kinds of derogatory names and their families will not want to have anything to do with them. The common perception among most people is that those who have the disease have slept with several men or women. So people feel shy to be seen at the VCT centres. The number of people who go for VCT services show that most people are not willing to patronise this service even though it is one of the important programmes the government is implementing to address HIV and AIDS [Interviewee at the Health Directorate, Techiman, 17th November 2008].

Rejection by extended family members can lead to serious consequences given the nature of the support system that extended families can offer to their members in an African context (Hanson 2004; Witte 2003; Clark 1999; Aldous 1962). Most people in Africa, and Techiman in particular which is a farming community, rely heavily on cheap labour from extended family members and acquaintances. Extended families can also provide emotional support so most people in Africa would not conduct themselves in a manner that can lead them to lose this bond. This might increase the likelihood of HIV positive persons keeping their status secret so as not to be rejected by their extended families. Two examples were given by another respondent from the Health Directorate about cases of AIDS patients who were rejected by their families where efforts to get the families to accept those people back failed:

> There were two instances in 2005 and 2007 I can remember. In 2005, a woman was forced to move into a village on the Nkoranza road when she realised she had the disease because her family would not accept her. She told me that she was a trader in textiles and so she went to Abidjan to bring the textiles to be retailed in Techiman. I met this woman in the village during our immunisation tours. She was in a very bad condition. I took the contacts of her family and I contacted her brother who informed me that the family had promised to be supporting her whilst she was in that village. But I realised during subsequent visits to the village that the families had not honoured this promise. I do not know what happened again to her but I never saw her again and the villagers did not know where she had left for. What happened in 2007 was a similar case but this one was a truck driver. According to his wife, the husband had moved to Tamale and she had not seen him for a long time [Interviewee at the Health Directorate, Techiman, 21st November 2008].

There are many similar stories of families rejecting PLWAs in Techiman but space does not allow them to be presented here. What we see in these two instances are: firstly, both victims were abandoned by their families, and secondly, they relocated to live in places

where their status might be kept secret. The possibility of these people infecting others with the disease can be high but they were forced by the circumstances to take that option.

In the next section I turn to the issue of male dominance in sexual and reproductive health matters. The Health Directorate and civil society actors in Sunyani have been able to influence many residents in the municipality to accommodate the views of women concerning issues about their sexual lives. In Techiman however, male dominance in sexual and reproductive health matters was more prevalent and there is inadequate evidence to suggest that the Health Directorate and CSOs have been able to reverse this.

7.7 Overcoming the notion of male dominance in sexual matters

The leaders of three NGOs and a member of the Sunyani Traditional Council informed me that there had been changes in the attitudes of commercial vehicle drivers towards programmes of NGOs that sought to empower women to take decisions about their sex life. This is an indication of acceptance of the debate that seeks to promote the voice of women in matters around sex and health. For example, the leader of one of the NGOs indicated that they have focused on bringing the men into the discussion because they realised that they could not be successful without involving the men. This attempt was initially frustrating because the men would not attend such programmes. He explained that:

> In 2002 when we mounted a public address system at the lorry station and hung banners during one of our public campaigns, some of the commercial vehicle drivers removed the banners.[129] One particular driver I know very well said that our instruments had blocked the way of passengers who wanted to board his vehicle. We distributed condoms but only few of the drivers collected them. None of the drivers' mates collected the condoms because they feared that their masters would see them as *bad boys*.[130] There was no woman who came forward to pick the condoms. We were not disturbed and continued with such programmes. These days when we do such programmes and distribute condoms, women are able to come forward to collect them even though you will think they are joking, we know they use them. Most people no longer feel shy about these things today [Leader of an NGO, Sunyani, 8th May 2009].

[129] He said what they had written on the banners was 'Women, say yes to condoms! Men respect views of women.'

[130] Driver's mates in Ghana are driver-apprentices. They are responsible for getting passengers to board their vehicles and the collection of the fares from the passengers. They will do this job for three or four years whilst they learn the skill to drive. You will have to show a good character and respect to your master before he will teach you how to drive. Your master might not be happy to see you accepting condoms in public. It would mean that you are not respectful, and you are not prepared to learn the job to become responsible person.

That women may collect condoms in public places such as vehicle terminals is an indication of their gradual empowerment, and the consequent erosion of male voices in matters of sexual behaviour. As women develop an interest in condoms and possibly encourage their sexual partners to use them, it can reduce infection among the people. My interviews with female Assembly members supported the view that men in the municipality had changed their perception about women in matters concerning sex. For example one of the Assembly women, explained that the nature of campaigns organised by the Health Directorate and civil society groups were so intensive that most women have been enlightened about their sexual rights. She said until recently around 2003, it was not possible for women to discuss matters of sex and HIV and AIDS in public because of fears of being labelled. She described what she called the 'new woman' in Sunyani as follows:

> I know that the new woman in Sunyani can now ask a man to use a condom during sex and she will not feel shy. These days even some married women ask their husbands to use condoms when they go out and fall into the temptation of sleeping with another woman. I know all these because I am a married woman and we know that it is possible for our husbands to sleep with other women. These days some pastors, even our pastor, tell us that we should put condoms in the bags of our husbands when they go on trek. So when my husband is travelling I put condoms in his bag. We laugh over it but I am serious about it. You cannot prevent it so you tell your husband to be sensible and behave in a safe way. Today, women do this and their marriages are working. If you did this in the past, your husband could be angry with you and the consequences could be a divorce [Elected Assembly member, Sunyani, 13th May 2009].

The views of this Assembly woman give us an idea of the extent to which women in Sunyani could go to get their voices heard. Their ability to do this also shows that men had become more accommodating of the views of women but their views are premised on the misconception that it is only men who bring HIV and AIDS into the matrimonial home. The call by religious leaders for women to put condoms in the bags of their husbands when they travel is significant as it is a further indication of acceptance of the message about condoms by religious leaders. As I explain later in this chapter, the presence of other factors in Sunyani might have also contributed to the gradual empowerment of women.

Although leaders of CSOs have contributed tremendously in working with health staff to overcome cultural practices and norms that undermine HIV and AIDS programme implementation, the organisation of many NGOs raises concerns about their primary

purpose. About 80 percent of the NGOs are 'owned' by individuals and have no system of accountability. This was possible because leaders of these NGOs were connected to key people in the Sunyani Municipal Assembly mostly through political party and *abusua* lines. Consequently, they receive a lot of support from the Assembly without evidence of accountability or reporting to the Assembly. Some of the Assembly members are sceptical, questioning the dramatic increase in the number of NGOs that seek to provide care and support to PLWAs. Some Assembly members suggest that operating an NGO is a 'business', this suggestion was supported by a group of people I interviewed who purported to be HIV positive and benefitting from NGO support. They claimed that they were asked to pose as PLWAs for a group photograph used to obtain funds. In return they would receive a percentage of the funds although these did not materialise.[131]

In Techiman, Municipal Health Directorate and civil society actors had been unable to implement effectively coordinated programmes around condom acceptance or to reduce stigmatisation and discrimination against PLWAs. They had also failed to influence a reversal of the perception of male superiority over females in matters of sexual and reproductive health. This was revealed by all the leaders of the NGOs. Their views are represented by one of the NGOs leaders who said:

> Most females in Techiman do not have the confidence to make decisions and choices about when to have sex and with whom. This is particularly common with female unmarried adults and commercial sex workers. I have worked with commercial sex workers to encourage them to insist that their clients use condoms but they tell me that if they insist on it they will not get any customer. This is very disturbing and that is why I am being supported with funds by the West African Programme for Commercial Sex Workers (WAPCAS) to help commercial sex workers in Techiman. We also have an association of PLWAs with 156 members and some of them say that their partners beat them up when they insisted that they use condoms. Some of them also said if they insist their husbands can go and sleep with other women because they will allow them to do so without condoms [Director of an NGO, Techiman, 27th November 2008].

These views were also held by three of the commercial sex workers at different locations of the municipality.[132] They all said for the sake of keeping their clients, they would not insist

[131] I found similar incidence in New Juaben. This appears to be common and most poor people are likely to be victims.

[132] I did not use any rigorous method to select them. I just walked into their apartments randomly for interviews.

on condoms but if any of their clients would like to use it they would welcome the idea. The commercial sex workers fear of losing customers confirms the strong influence of Techiman males who patronised the services of sex workers. The weak economic power of these women eroded their bargaining and negotiation powers (Mill and Anarfi 2002).

This can be difficult to reverse using only the formal approaches of mounting public campaigns to push for empowerment of women or promote the rights of commercial sex workers. The dominant choices of males were significant because it affected commercial sex workers and married women in Techiman who feared losing their husbands to other women if they insist that their husbands use condoms. This is the opposite of the case in Sunyani where women were able to assert their influence without fear of damaging their marriages. Considering the dependence of most married women on their husbands for their livelihoods in a developing country such as Ghana, most women would not want to risk their marriages over the issue of condom use.

My interviews with all four media houses in Techiman gave me fair understanding of general public perception, these results also support the notion of the dominant voice of males over females in matters concerning sex and reproductive health in Techiman. For example, a Programme Manager of one of the radio stations in Techiman explained that:

> When we run programmes about sex education, HIV and AIDS, and ways to reduce it, we have a segment of the programme when we make the listening public to phone in to either ask questions, contribute ideas, or say anything they have about the topic. For the past 6 years or so, I can say that 8 out of 10 of the callers for a day are men. Most of the men can call and say that they do not enjoy sex when they use condom that is why they do not like it. Others can even call and say it is not disgraceful if a man is found sleeping with other women apart from his wife but it is more disgraceful for a woman to be caught doing so. There have been times when men phoned in and said one way to know that your girlfriend or wife sleeps with other men is when she starts talking about condoms. You will not find a single woman who can phone in to say anything to support the views of women [Programme Manager of Radio station, Techiman, 17th November 2008].

The other three media houses in the Techiman municipality that run similar programmes all alluded to these views that women would not have the courage to phone into such programmes to make a contribution in support of their views because of the social construction of the role of women. The views of men, as indicated by this respondent, show

that a woman who phones in to express views about condoms may be seen as immoral by the people around her including other women.

This finding supports those of other scholars. For example in a study of social norms in Thailand, it was found that "condoms generally represented mistrust and promiscuity, while not using condoms symbolised trust and loyalty to one's partner" (Caouette et al. 2000:17). This finding also supports the evidence of low rate condom acceptance between males and females in Techiman (Techiman Municipal Health Directorate 2005; 2006; 2007).

Central to the discussion so far is the significant role played by the joint efforts of health officers and CSO leaders in combating the spread of the disease even though some NGOs might engage in corrupt practices. Embedding health staff with Civil Society leaders by employing good informal relations with CSOs can result in the development of shared goals between health staff and leaders of CSOs.[133]

7.8 Overcoming socio-cultural norms: alternative explanations

Several other contextual factors could have contributed to Sunyani's success and Techiman's failure. One explanation is the presence of Nurses' Training College and a Polytechnic in Sunyani. Due to these training institutions there were more educated women who were trained and enlightened; most of them resided in private accommodation and hostel facilities scattered across the municipality. Their interaction with other women could have led to increased awareness where women begin to question issues around male dominance. Additionally, their awareness of HIV and AIDS might be high since they are more educated in current issues and this might have contributed to increasing awareness levels among them, changing their perception and the attitudes of people they mixed with towards AIDS victims as they interacted with them.

[133] It might be worth mentioning however that in some situations embeddedness was prior to the changes that have occurred around these cultural practices and religious beliefs. This was where ties were ethnic and old-school based. There were also iterative processes of embeddedness around the changes in these factors. This was where ties were mainly of the *abusua* type.

The second is that, as compared with Techiman, the population of Sunayni appeared to be more stable so the same people were likely to be exposed to the variety of programmes organised by the Health Directorate and CSOs over a period of time increasing the opportunity for such programmes to influence them.[134] In the case of Techiman, because of its characteristic as a high transit town, the population turn-over was high. Therefore at any point in time, there could be a new set of people to whom the HIV and AIDS programmes needs to be administered making it difficult for a good assessment of the impact of such brief programmes.

The third is that the Sunyani Health Directorate's access to the fund might have enabled it to undertake more programmes than Techiman where access to the fund was comparatively low. As I discussed earlier in Chapter 5, Sunyani was one of the cases which had high access to the fund. Following the assertions of the Health Director in New Juaben that the fund increased financial resources at his disposal which enabled him to undertake more programmes, we could conclude that the same would be true for Sunyani which was also able to do more when compared with Techiman.

The contribution of these alternative explanations to the differential performance in Sunyani and Techiman cannot be overlooked. However, it would require a systematic and extensive study into them to establish their direct relationship with norms and beliefs that shape HIV and AIDS related policies.

7.9 Conclusion

I have endeavoured to show how the embeddedness of officers of the Health Directorate with leaders of the selected civil society groups can facilitate the development of joint efforts required to shape cultural practices, social norms, and religious beliefs that may serve as barriers to the fight against HIV and AIDS in Ghana. The Sunyani case suggests

[134] Example include educational campaigns by artists publicly declaring their HIV status and asking Ghanaians not to shun the company of PLWAs since the disease can be contracted accidentally.

that where the Health Department is strongly embedded within civil society, consultation with CSOs can be high which might enhance joint efforts to change attitudes of citizens towards HIV and AIDS programmes in a positive way. The Techiman case demonstrates the difficulty experienced in shaping cultural practices and belief systems towards the disease when health staff are weakly embedded with leaders of CSOs. Consultation with NGOs can be poor particularly when NGO work is fragmented and poorly coordinated. Strong embeddedness is likely to facilitate the development of shared interests and appropriate tools of intervention to address HIV and AIDS even though such strategies might not suit all segments of society.

Findings in this chapter both challenge and support the claims in the neo-patrimonial literature. There can be both good and bad outcomes of informal relations as I show in the overall assessment of neo-patrimonialism in the concluding chapter (Chapter 8).

In this chapter, we find that informal relations which may have been influenced by political party links seem to play significant role in making resources available to the selected NGOs from both the Health Directorate and the Municipal Assembly. If these resources are utilized as claimed by the NGOs then they are likely to implement quality campaigns to help fight the disease. In addition, increased consultation and subsequent development of joint efforts between health officers and NGO leaders appear to have been facilitated by their informal ties. It can be said that these are positive effects of neo-patrimonial relations and for that matter informal ties.

The fact that it is only selected NGOs who received support from the Health Directorate and the Municipal Assembly support the claims in the neo-patrimonial literature that informal relations produce corruption. NGOs are unlikely to be accountable with the resources they receive partly due to the way they are organised. Most of them were operated by individuals making it highly possible that their use of those resources might be channelled to advance personal interests or even support personal political ambitions of the

patrons from whom the resources are obtained particularly if the resources were channelled along partisan considerations.

We also learn from this chapter that in the implementation of healthcare policy at the local level under the decentralisation programme in Ghana, informal relationships among the various actors seem to play significant role, directly or indirectly, shaping both the process and outcomes. Decentralised authorities and local government bodies might have sufficient resources, well qualified staff, autonomy to use their resources; and many other factors identified in the decentralisation literature as necessary for decentralisation to work, but the politics of informal relations seem likely to have a tremendous effect on the outcomes and consequently affect how well decentralisation works.

It is also clear that the approach to addressing HIV and AIDS in Ghana might have to go beyond the 'ABC' approach. Exploring ways to identify, understand, and incorporate the complex socio-cultural factors that can influence peoples' sexual and reproductive behaviour needs to be given policy attention. This might require that health officers adequately embed themselves within the community in which they are located. I explain this further in Chapter 8 where I present the summary and conclusions of the findings from the study.

Chapter 8

Summary and Conclusions

8.1 Introduction

My aim in this research has been to explore how decentralisation, in the form of a mixture of devolution and deconcentration, works in practice by examining the case of health services in Municipal Assemblies in Ghana. Many countries in sub-Saharan Africa adopted decentralisation policies in the expectation of improved service provision. The benefits anticipated were two-fold; the first was that decentralisation would lead to better coordination and collaboration between different parts of the state at the local level. The second was that decentralisation would lead to increased consultation with citizens by local governments so that public officers can be more responsive to citizens. The predominant form of decentralisation adopted by these countries is a combination of devolution and deconcentration. However, as I show in this thesis, the combination of devolution and deconcentration in Ghana creates structural problems for the working of sectoral departments as well as Municipal Assemblies particularly in getting better coordination and collaboration among the various actors at the local level. This mixture of devolution and deconcentration also seems to constrain local governments' ability to increase consultation with local people. These effects are largely due to ambiguities in two major laws under which the Assemblies and their Health Directorates operate (Act 462 and Act 525). The reason for ambiguous laws is most likely political, to avoid privileging one group over the other, but to leave it to be sorted out through politics at the local level. It could also be a means to enable central government to control local government affairs.

So how are these relationships sorted out through politics at the local level? The hunch I had was that informal relationships are important in enabling the local state to work. Thus, the main question this thesis asks is: what is the role of informal ties in promoting collaboration and coordination between devolved Municipal Assemblies and deconcentrated Health Directorates, and consultation with groups within civil society that

worked on HIV and AIDS campaigns by Health Directorates? Two sets of relationships were examined: between officers in different parts of the state, and between public officers and leaders of Civil Society groups.

Overall, the study found that informal relations seem capable of promoting governance performance. Conflicts in the general legal framework that make it difficult for public officers to effectively work in concert, seem to be overcome by public officers when strong informal ties exist among them making it possible for them to work together. Although I did not focus on investigating the adverse impact of informal ties, I also found instances where informal relations between public officers undermined the performance of the local state.[135]

These findings are supported through the documentation of four types of informal ties and their impact on coordination and collaboration; and consultation in the five municipal areas studied. The informal ties are ethnic links; family/neighbourhood/abusua relations; old-school networks; and political party affiliations. These ties between officers at the Municipal Health Directorates and senior officers of the Municipal Assemblies were found to facilitate Municipal Health Directorates' access to the District Assemblies' Common Fund, which is controlled by the Assemblies. The existence of these ties between officers at the Municipal Health Directorates and elected Assembly members were found to enhance the quality of Municipal Health Directorates' policies and helped to gain public support for HIV and AIDS programmes. Additionally, these ties between officers at the Municipal Health Directorates and leaders of HIV and AIDS Civil Society Organisations were found to facilitate implementation of Municipal Health Directorates' HIV and AIDS programmes.

[135] As well documented in the literature, ties and their effects in terms of the reciprocal support system and exchanges can sustain corrupt practices, patronage and clientelism. I present a summary of the various ways in which informal relations seem to positively influence the processes of collaboration and coordination in the answers to each of the three sub-questions in this chapter. I also highlight a couple of examples in the answers to each of the various sub-questions to show that informal relations might undermine service delivery efforts by decentralised institutions at the local level.

The main argument of this thesis is that informal ties and embeddedness matter for mixed systems of devolution and deconcentration to work as it is in such systems that there are likely to be ambiguities in the legal arrangements with high potential for conflicts to occur between different parts of the state, and between the state and non-state actors. To explore this concept thoroughly scholars, policy makers, politicians, donors, and governments who are interested in ways to make decentralisation work might need to extend their focus beyond issues of centre-periphery relations.[136] Much of the existing scholarly work on decentralisation in sub-Saharan Africa appears to be rooted in the assumption that issues of centre-periphery relationships such as local government finance; human resource and technical capacity; and autonomy of local decentralised authorities from central government interferences need to be resolved for decentralisation to work. For this reason their attention has been focused on these issues.

This study shows that resolving these issues might not be adequate for improving basic service delivery by decentralised authorities at sub-national level as issues of coordination and consultation that are assumed still remain in mixed systems of decentralisation. I demonstrate that ethnic links, family/neighbourhood or abusua relations, political party affiliations, and old-school networks can have tremendous impact on how these other factors (finance, human resources, autonomy of local government bodies) contribute to the performance of decentralised institutions. Many earlier studies were comparisons between countries which advocated for complete devolution as the ideal model of decentralisation appropriate to sub-Saharan Africa, but there is inadequate empirical evidence to support this assertion. Empirical evidence from this study shows that within a uniform decentralised system, a combination of devolution and deconcentration can work together to produce the desired outcomes when informal ties within the state are strong and decentralised institutions are adequately embedded with the communities in which they are located.

In this chapter I present summaries of the findings from which I draw key conclusions and highlight their theoretical significance. I have organised the chapter in five main sections.

[136] Relationship between central governments and local government authorities

After this introduction, I summarise the findings in the second section under the following headings: a) coordination and collaboration within the state at the local level; b) achieving increased consultation with elected representatives of citizens; and c) consultation with CSOs, socio-cultural norms and HIV and AIDS. For each of the findings, I draw out the implications for theory particularly to show how they fit with the literature on neo-patrimonialism in Africa with reference to the claims in the neo-patrimonial literature. In the third section I discuss the policy implications of the findings to include the following: a) ways of establishing and harnessing informal relations between different parts of the local state and between the state and civil society actors; b) resolution of conflicts in legal arrangements; c) restructuring of training curricular for public officers; d) adoption of eGovernance mechanisms; e) rethinking competitive elections of all Assembly members and Chief Executives; and f) payment of salaries to Assembly members. I list the areas requiring further research in the fourth section. The general concluding comments are presented in the last section.

In order to enhance our understanding of the findings to each of the three sub-questions and their theoretical implications, some initial observations might be helpful. The conflicts in the legal and institutional arrangements of Ghana's decentralisation programme caused major issues with coordination and collaboration between the Assemblies and Health Directorates. Whilst conducting this study there were two main weaknesses in Ghana's decentralisation programme in general and healthcare decentralisation in particular. First, the President continued to appoint the Chief Executives of the Assemblies; this has been publicly supported by key political figures such as former President Kufuor, former President Rawlings, former Attorney general and now presidential candidate of the New Patriotic Party (Nana Akuffo Addo). Second, the provisions of Act 525 support the strong alignment of the Health Directorates to the Ministry of Health (MoH), whilst Act 462 seeks to give the MCEs authority and control over the Health Directorates. The ambiguity in the laws and the path which the decentralisation programme has taken appears to suit the president. This might be so since the president could not directly attack the powers of the Ministry of Health which appears to be powerful partly because the Minister of Health is a

member of cabinet and also due to claims that the MoH controls huge resources as compared with the other ministries.

The existing arrangement with conflicts in the law is likely to continue for some time. One reason for maintaining this position might be that it allows central government politicians and bureaucrats substantial control over sub-national local government business which might enable them to project personal political ambitions and party agendas at the local level. As these arrangements benefit national level political figures and bureaucrats, the commitment to reform might be strong in theory and in policy (as evidenced in the on-going constitutional review process covering initiatives to strengthen the decentralisation programme), but it may continue to be weak in practice. As noted by Crawford (2009: 58), "the Ghana case indicates that, while the rhetoric of decentralisation talks of making democracy a reality, the actual reality is about the maintenance of central government control." The gap between policy and practice is unlikely to narrow in the foreseeable future.

This assertion is supported by other scholars based on an analysis of the path, history and experiences of implementing decentralisation reforms in many parts of sub-Saharan Africa (Awortwi 2010a; 2010b; 2010c). As informal ties constitute the basic foundation and fabric of the structure of socio-cultural organisation in Ghana, they are likely to continue to shape behaviour patterns of public officers and play an important part of the decentralisation architecture of the country as long as current weaknesses in the laws remain unresolved.

8.2 General findings and conclusions

8.2.1 Coordination and collaboration within the state at the local level

The first question I investigated to explore the performance of the Health Directorates was: how have informal ties between officers at the Health Directorates and Executive Officers of the Municipal Assemblies enhanced or constrained these two decentralised authorities in collaborating and coordinating their programmes around healthcare delivery? I determined

performance in terms of coordination and collaboration between these two state institutions and used the release of the DACF by the Assemblies to the Health Directorates as an indication of coordination and collaboration between them. I based the discussion on the central government's directives for the utilisation of the DACF as these constitute some of the legal and institutional arrangements devised to achieve coordination and collaboration between the Assemblies and Health Directorates in health service provision.

The study revealed that the institutional arrangements introduced to promote coordination and collaboration within the state at sub-national level did not seem to be effective. Interestingly informal connections such as political party ties, ethnic identities, family/neighbourhood/*abusua* relations, and old-school networks did appear to matter to the ways in which the MCEs related to the Health Directors with regard to the DACF.

As we saw in Chapter 5, Health Directors who effectively exploited political party affiliations and *abusua* ties with the MCEs were comparatively successful in accessing the fund. This was reflected in cases such as New Juaben and Sunayni where coordination and collaboration between the Health Directorates and Assemblies was high. In this respect, we might conclude that this is a positive effect of informal relations as they seem to help overcome problems in the implementation of formal directives and facilitate the release of funds to the Health Director.

In the other cases, such as Techiman and Ho where the ties were weak, the Chief Executives seemed to be unwilling to cooperate with their Health Directors to release the DACF to them. The low levels of coordination and collaboration between the two state institutions was reflected in poor performances in both Techiman and Ho. In these two cases, weak informal relations appeared to undermine collaboration and coordination which could be said to be a negative influence of informal relations.

Although weak informal relations seem to make it difficult for the MCEs to comply with central government directives, as in Techiman and Ho, the non-compliance with the law

might not mean it is informal relations that explain it. Perhaps the MCEs did not view HIV and AIDS as priorities. Development priorities of the Assemblies shape the design and implementation of their budgets and therefore the use of their financial resources. Therefore the non-compliance with the law could mean that the MCEs like to utilise the HIV and AIDS component of the DACF for what they consider to be priorities at the local level, and these priorities may sometimes conflict with priorities of central government. Therefore weak informal relations between the Assembly and the Health Directorate might imply better formal relations between the Assembly and some other agency such as the directorate of education or agriculture. This suggests that there are limits to the extent to which informal relations provide explanations to our understanding of how devolution and deconcentration work in practice.

In addition, the release of the DACF to the Health Directors does not guarantee that Health Directors would use such resources for HIV and AIDS programmes. Given the concerns which most people in Ghana have about the inefficient use of funds in many of the central government ministries, especially health, the non-compliance with the directives may well be in the good interest of the majority of people in the districts who are poor particularly if the Assemblies would use such funds effectively.

The ways in which informal relations could promote coordination and collaboration between different parts of the local state point to two issues which are significant to the debate around decentralisation reforms in Africa and the notion that neo-patrimonialism normally undermines government performance. First, this study has shown that the debate around decentralisation reforms may have to be extended beyond issues of centre-periphery relations (relations between central government and decentralised authorities at the local level in terms of autonomy of local governments), the availability of financial resources to local governments, and adequate human capacity. Although these factors are important, informal relations seem capable of heavily influencing how they impact on service delivery by the local state.

Second, the positive outcomes of informal relations as we have seen in chapter 7 are quite interesting as they suggest that informal relations that could be considered neo-patrimonial in nature (such as that which exist between Health Directors and leaders of HIV and AIDS CSOs) seem capable of contributing to positive developmental outcomes under certain conditions. This raises questions about the central claims in the literature on neo-patrimonialism as to whether informal relations are usually detrimental to government performance. In fact, this finding supports the central arguments by scholars in the APPP that neo-patrimonialism in Africa needs a rethinking as it can be employed to promote development. An example is what Cammack and Kelsall describe to have occurred between the mid 1960s and the late 1970s in Malawi when neo-patrimonial relations between president Kamuzu Banda and state bureaucrats, members of parliament, and party functionaries were employed by the president to mobilise economic rent that were in turn channelled into more productive growth of the country's economy (Cammack and Kelsall 2011: 89-90).

Although Cammack and Kelsall's findings are based on national level analysis where president Banda's control of state power and his commitment to discourage corruption made significant difference, their findings help us to understand that more productive outcomes could result from neo-patrimonial relations.

At sub-national level, as in this study, apart from the evidence in chapter 7, in chapter 5, informal relations between the MCE and the Health Director (which might be termed as neo-patrimonial in nature due to the MCEs' ability to use his control over Assembly's resources to influence the Health Directors) seemed to have facilitated the release of funds to the Health Director making him/her have access to additional resources that could be used to implement more programmes.

Undoubtedly, some of my findings support neo-patrimonial interpretations of informal relations: corruption, patronage, and clientelism that can undermine basic service delivery. The nature of collaboration in the release of the DACF was also characterised by corrupt

practices that were sustained by political party ties and *abusua* relations in both high and low performing cases. In New Juaben, the Health Director's access to the DACF was facilitated by reciprocal exchanges maintaining *abusua* ties. However, these were largely financed from public resources including the use of official vehicles and fuel to attend private programmes such as funerals of members of one's *abusua*. Similarly, in Techiman, discrimination at the workplace on the basis of ethnicity, nepotism, and cronyism culminated in the MCE refusing to comply with the law.

In spite of these findings, the neo-patrimonial view of the weaknesses of informal ties should not dominate our thinking of how the state works in many countries in Africa. As scholars such as Booth (2011); Cammack and Kelsall (2011); and Crook and Booth (2011) have shown, and as this study demonstrates, dense informal relations encompassing a wider section of society could promote the development of shared interest around which the local state would deliver basic services more effectively.

8.2.2 Achieving increased consultation with elected representatives of citizens

The second question I investigated was: in which ways have informal ties between health officers and elected Assembly members facilitated the consultation with Assembly members by health staff in order to win public support for health programmes? The study found that there seemed to be increased consultation with elected Assembly members in the municipalities where strong informal ties existed between health staff and elected Assembly members. Conversely, in those municipalities where informal ties between the health staff and elected Assembly members were weak, consultation appeared to be low.

Officers at the Health Directorates in New Juaben and Obuasi who consulted with Assembly members appeared to have achieved three things. First, they obtained the support of elected Assembly members for their programmes; second, they were able to harmonise their programmes with the Assemblies; and third, they obtained additional funding from the Assembly (Chapter 6). The harmonised programmes seemed more appropriate to the shared

interests of health staff and elected members of the Assembly in terms of managing the HIV and AIDS pandemic.

As Health Directors actively involved the Assembly members in the design and implementation of programmes, the Assembly members experienced a sense of recognition and respect. They also had a feeling of appreciation for their role as representatives of their electoral areas. This seems to have motivated most Assembly members to develop sincere intentions and commitment to support programmes that would promote the interest of the public. Officers of Sunyani, Techiman and Ho Health Directorates did not appear to adequately involve elected Assembly members and did not realise any of the three New Juaben and Obuasi achievements. In these municipalities HIV and AIDS programmes were poorly coordinated, highly fragmented, and extensively duplicated. These findings suggest that the wider the network of informal ties across public institutions, the higher the potential for such networks to develop shared interests in public policy formulation and implementation.

In chapter 6, we have seen that informal relations appeared to have facilitated the development of shared interests between health staff and elected Assembly members to change sexual and reproductive health choices of local people. In areas such as New Juaben where consultation with Assembly members was high, the Assembly members helped to get the HIV and AIDS campaigns across to the people in their electoral areas. The same cannot be said about Techiman.

On the one hand, the development of concerted efforts which appears to have led to Assembly members supporting HIV and AIDS programmes may be said to be a positive outcome of informal relations. On the other hand however, changing sexual behaviours may not necessarily be what the majority of local people would like. The programmes around HIV and AIDS campaigns essentially sought to change peoples' sexual behaviour and reproductive health choices which are shaped by norms and cultural practices such as polygamy particularly in Moslem communities. Even in Christian dominated communities

where polygamy is discouraged, there are claims among many people in Ghana that the behaviour of some Christians directly or indirectly promotes sexual activity with multiple sexual partners. There are also Christian leaders who do not support campaigns to promote condoms. If public policy and public service delivery are to benefit poor people, the design and implementation of such policies need to accommodate and work with all these diversities rather than seeking to change them as Assembly members and health officials have done.

Again, the elected Assembly members with whom health staff developed HIV and AIDS programmes may not represent the needs of their electorates in practice as electing them does not mean that they would behave in ways that their electorates would like. Many electorates at the local level have criticised their elected Assembly members on the grounds that Assembly members often champion the agendas of political parties and influential individuals rather than pursuing the interests of poor people who elected them. Majority of elected Assembly members have suffered the consequences by being voted out of office. Therefore there are limits to the positive influences of informal relations between elected Assembly members and health officers. In spite of this, the New Juaben case seems to challenge the claims that informal relations normally constrain the performance of governments. Here we find that they rather seem to facilitate collaboration between health officers and local government elected members.

What we find in Sunyani points to the extent to which informal relations can be damaging to the performance of governments. Health officers and Assembly members in Sunyani appeared to be unable to develop concerted efforts and shared interests to work together partly because of the lack of strong informal relations between them. This lack of unified efforts as I showed in chapter 6 could undermine the design and implementation of health programmes especially if the elected Assembly members genuinely seek to champion the interests of their electorates and when the interest of their electorates support changing sexual and reproductive health choices in line with the HIV and AIDS programmes.

A number of issues hampered the effectiveness of elected Assembly members as representatives of citizens. The first is the position is voluntary so there is no payment of salaries or benefits such as housing and transportation allowances due to other public officers such as Members of Parliament. They only receive a sitting allowance of between GH¢20 (US$13) and GH¢30 (US$20) on average, and there are a maximum of three sittings per year. Nonetheless the demands on Assembly members are huge; as part of their official duties they are expected to organise communal labour, and meet their electorates before and after general Assembly meetings. Outside their official duties, the social and cultural organisation in Ghana also place huge demands on Assembly members. They are expected to attend a host of social functions such as marriage; child-naming; religious functions; and funeral programmes all of which require the Assembly member to pay a token or make a donation in support of the programmes. This of course is one reason why they are invited. In addition, Assembly members are called upon to pay school fees, provide school uniforms and sometimes provide money for food to families. The cost of meeting all of these demands for a volunteer can produce a strong disincentive to many Assembly members to play an active part in advancing the interests of their people.

The second issue is the non partisan nature of the District Assembly system and the ways of seeking election into the Assembly. The current system provides that the District Assembly system is non-political and non-partisan. In practice however, the process is highly partisan and politicised. Political parties and national political figures overtly and covertly sponsor candidates but the process itself is expensive as the role provides no salary so it is difficult for candidates to turn down offers of support from political parties and powerful elites. There is little incentive for people to invest their own personal resources to join the Assembly. However, notions of ‘non-political’ and ‘non-partisan’ themselves are impractical as people are likely to belong to a political party. Some of the political parties are rooted in long held traditions and ideologies; for example the NPP is rooted in Danquah-Busia tradition whilst the Convention Peoples Party (CPP) is built on the socialist-cum-communist ideologies of Kwame Nkrumah. Drawing a line between such strong traditions and neutrality in the Assembly can be difficult. In this context, the non-

partisan and non-political characteristics required for the decentralisation process may not survive for long.

Third, the weak capacity of Assembly members appeared to undermine their ability to effectively participate in debates in the Assembly. Many Assembly members did not understand the provisions of the Model Standing Orders, Act 462, and other provisions in the 1992 Constitution regarding how the District Assembly works; this was evident during the general Assembly meetings. Most of the Assembly members could not draw on provisions in these legal instruments to back their arguments which appeared to affect their ability to influence discussions and shape the outcomes.

Fourth, political ambitions of many Chief Executives caused them to take a number of steps that undermined the role of Assembly members. Some Chief Executives sponsored candidates to contest seats of incumbent Assembly members who were perceived to be vocal or opponents to them. In most cases, as the Chief Executives had resources and influence, their candidates won. This was a predominant practice in Sunyani and Techiman. Chief Executives also influenced the election of chairpersons of the various sub-committees particularly the strategic ones such as Finance and Administration; Social Services; and Justice and Security. As the chairpersons of the sub-committees constitute the Executive Committee, the Chief Executive could ensure members were likely to be sympathetic or supportive. The one-third government appointed Assembly members were also likely to support the Chief Executive providing him with significant control over policy outcomes and Assembly commitments and leaving many Assembly members frustrated and demoralised as a result. This assertion conforms to the findings of other scholars regarding Ghana's decentralisation programme which is excessive dominance of national politicians in local government business and most Assembly members are demoralised because of their inability to influence policy and meet the expectations of their electorates (Abdulai and Crawford 2010; Crawford 2009; Crook 1994).

These findings of issues that hamper the effectiveness of elected Assembly members point to two things. First, they further show that the voluntary and non-partisan nature of the role might deepen the frustration of Assembly members which would threaten the sustainability of this arrangement. Most elected Assembly members can publicly express their frustrations via the platforms created by the increasing number of private radio stations and private newspapers across the country. These frustrations can dampen the morale and enthusiasm of potential Assembly persons. As people lose interest it may be difficult for the District Assemblies to attract high calibre of people. Second, the quality of debates in the general Assembly will be poor as they are captured and controlled by the few Assembly members who understand the legal instruments and are able to express themselves fluently in English and local languages. If the MCE is able to capture those few Assembly members who control debates in the Assembly, then he or she can easily steer the Assembly to advance his or her personal political ambitions and party agenda instead of advancing the interests of ordinary people.

8.2.3 Consultation with CSOs, socio-cultural norms, and HIV and AIDS

The third question I investigated was: how has the embeddedness of health officers with leaders of groups within civil society who were known to work on HIV and AIDS programmes promoted increased consultation with leaders of these civil society actors by health staff in order to implement health programmes? As we saw in chapter 7, in Sunyani where the Health Directorate was adequately embedded with HIV and AIDS CSOs, it facilitated the consultation with leaders of these civil society groups by health staff. Consequently, they seem to have achieved three things: a) they obtained the support of some churches to promote debates about condom use; b) they appeared to be successful in reducing stigmatisation and discrimination against people infected with HIV or AIDS; and c) they were able to minimise the dominance of the views of males in matters of sex and health. None of these achievements are true of cases such as Techiman where the Health Directorate's embeddedness with HIV and AIDS CSOs was weak.

The role of informal relations in producing what might be termed as good outcomes in Sunyani may be further appreciated given how such ties enabled health staff and leaders of the HIV and AIDS CSOs to work. Leaders of these CSOs were already part of the communities therefore establishing ties with such leaders meant that health workers could reach the ordinary citizens with less difficulty. The dense ties seemed to have enabled them to develop trust that appears to be critical in dealing with the churches and ordinary people, particularly men in Muslim dominated communities in the municipality. The trust and confidence that church leaders had in health officers contributed to minimise concerns that allowing campaigns to promote condoms in the church does not imply that HIV and AIDS policy would encourage sexual immorality among young persons and unmarried people according to the churches' standards. Similarly, many men in Muslim communities seemed to have developed trust in health workers and the CSO leaders that their campaigns to help women to make informed reproductive health choices were not in conflict with Islamic teachings concerning the superior role of men in marriage to women.

Despite what might be termed as positive roles by CSOs, there are important issues related to representation and accountability of many CSO leaders. Concerns about how HIV and AIDS NGOs are organised and the likelihood that NGO leaders will become corrupt and less accountable to citizens were common in all the five cases. Most of the NGOs that worked on HIV and AIDS were 'owned' by individuals and lacked formal organisational structures to oversee their activities. The 'owners' of these NGOs have strong ethnic ties, political party affiliations, and *abusua* networks with key officers in both the Assemblies and the Health Directorates so received much of the funding and support from both institutions.

The concerns about NGOs notwithstanding, the case of Sunyani draws our attention to a number of issues. First, it points to the need for state institutions to create strong ties with civil society actors as they are critical for the success of public policy implementation (Abdulai and Crawford 2010; Widner and Mundt 1998). Second, the current HIV and AIDS policy's emphasis on the 'ABC' approach might not be enough to address the

complex and fundamental social and cultural issues that mould the behaviour and life-style of people. Societal norms and beliefs can be difficult to reverse so it would be wrong to assume that citizens would see issues in the same way as governments and donor agencies whose ideologies might be in conflict with those of local people. For example, the idea of male superiority over women in sexual matters is accepted in most societies and often supported by the women themselves; also in most areas of Ghana, mentioning sexual organs and sexual intercourse is considered taboo and unacceptable (Frimpong-Nnuroh 2006). Third, it is worth noting that religion will continue to matter to most people as long as governments fail to provide the basic needs for people to lead decent lives. Increased numbers of people in Ghana are likely to be influenced by religious leaders as evidenced by daily religious advertisements in the Ghanaian media. Religious leaders will therefore have a strong voice in the governance and decentralisation process and with issues of healthcare provision in particular.

8.3 Policy implications of the findings

a) Harnessing informal relations

This study has demonstrated that informal relations and embeddedness seem to be important for devolution and deconcentration to work better. The policy implication here is that ways need to be found to establish and harness informal relations within the state. The focus for policy could be fostering of neighbourhood ties as these are non-ascriptive and can be constructed between officials. One of the ways to achieve this may be to locate the Municipal Assembly and all the decentralised departments that are supposed to be part of the Assembly in one building as many of the Assemblies have started to do at the time of conducting this research. The practice where other decentralised departments are located some distance away seems to exacerbate the problems of weakening ties between these key actors in development in the districts.[137] Housing public officials together can also encourage the attendance to meetings as I found that sometimes the distance and

[137] For example Ho Municipal Health Directorate is located over 1 kilometer away from the Municipal Assembly, and in Techiman, the Techiman Municipal Health Directorate is located over 2 kilometers away from the Municipal Assembly.

transportation issues made it difficult for the health staff to attend meetings regularly at the Assembly.

Another policy focus may be to encourage interaction among public officers at the work place. The common way to do this could be through the creation of coffee points and the establishment of canteen in the office building to serve different food options. In addition, the provision of common room with comfortable seating to either read newspapers or just to relax when workers take intermittent breaks might be useful. All these may encourage workers to interact and build dense friendship ties that are claimed to be essential for team work in organisations (Balkund and Harrison 2006; Kratzer et al. 2005; Brass et al. 2004).

Municipal Assemblies could also institutionalise quarterly get-togethers in their Medium Term Development Plans. Such get-togethers will enable staff to share drinks and food. This might help to promote familiarity and friendship among workers.

In terms of fostering the building of informal ties between public officers and citizens, local governments could organise social functions for public officers and citizens to interact on an informal basis. For example, Municipal Assemblies and the Health Directorates should institutionalise quarterly organisation of sporting activities targeting the sports that local people would like. Municipal Assemblies and the Health Directorates should also institutionalise annual get-togethers to meet citizens and share food and drinks. This idea may appear trivial but it can be an effective policy tool to lay the groundwork to build wide friendship ties which can promote mutual trust and cooperation between public officers and citizens (Tsai 2007; Wade 1988). As trust is established and people get to know one another and become familiar with behaviour patterns of others, it may gradually contribute to erase fears, suspicions, and reservations that may be harboured against others. This view is supported by other scholars who find personal relationships a critical factor in explaining how public officers work together. Jeppsson et al. (2003) make similar recommendation in regard to promoting harmony and collaboration between public officials in Uganda's Ministry of Health and its agents in the districts.

b) Resolution of conflicts in legal arrangements

Many of the problems with healthcare delivery under current decentralisation provisions can be explained by ambiguity and conflicts in the existing legal framework and the on-going initiatives to remove these problems in the existing institutional and legal mechanisms are laudable. The policy implication is that genuine political commitment is necessary for enabling decentralisation to work in practice. This means that ambiguities in the various legal arrangements need to be resolved. For example, the challenges that confront the implementation of the composite budget initiative require increased attention by policy matters and in the debate around fiscal decentralisation. Successful implementation of the composite budget might help to address some of the structural problems affecting coordination and collaboration between different parts of the state apparatus at the local level.

c) Restructuring of training curricular for public officers

Trust between public officers from different parts of the state seems critical to the smooth functioning of the local state. What this implies is that institutional reforms such as restructuring curricular of training need attention. The curricular of existing training and capacity building programmes for politicians and technical staff may need to be revised and restructured to incorporate ideas of social capital, embeddedness, and informal ties. The benefits of social capital, embeddedness, and informal ties; their potential to facilitate coordination and collaboration between different parts of the state; and the ways in which these concepts can promote state-society engagement and make the state to be more responsive to citizens need to be highlighted. Nevertheless, the dangers or weaknesses of informal relations and ways to minimise them need to be incorporated in restructured training curricular for senior level public officers. The top level technical and administrative personnel are most critical to successful reforms due to their proximity and access to the political machinery at the central government level. Programmes should be intensified to help build new skills for politicians and bureaucrats to adjust to the new ethos and expand the space for increased engagement across different parts of the state; and

between the state and non-state actors. In line with the New Public Management (NPM) concept and recent interest in the participation of citizens in the governance process senior managers will no longer be the sole actors in public service delivery. There is evidence to suggest that these changes have contributed to improved management and leadership skills of public managers in Mozambique as part of NPM reforms within the decentralisation system (Awortwi 2010a). Above all, officers must be trained to uphold high levels of professionalism and integrity and be fair to all citizens, a strategy that has been observed to have contributed to the improvement of public officers' work in Mozambique (Awortwi 2010b).

d) Adopting eGovernance mechanisms

Whilst we seek to encourage the establishment of dense informal networks within the state and across the state and society, we need to acknowledge also that informal relations have limitations as some of the findings in this study suggest. Therefore, in general terms, ways to make decentralised authorities at the local level more transparent and efficient might need policy attention. Adopting eGovernance mechanisms appear to be helpful in this regard. These may need to be explored and promoted at sub-national level. Information about public resources, budgets, projects (health, education, agriculture, water, roads etc), and all expenditures could be organised and shared on Information Communication and Technology (ICT) platforms such as Assembly and Health Directorate websites, radio stations and newspapers to be easily accessible and available to citizens. This implies that public officers would need training to improve their ICT skills and equip themselves with mass communication and public relations skills. These skills can facilitate their engagement and interaction with citizens. Similarly, ICT skills of local people need improvement so they would be able to access such public information. These initiatives can help to minimise misinformation and suspicion, and they can increase citizen trust and confidence in public officers (Awortwi 2010b). Overall, e-governance can help reduce corruption, nepotism, and cronyism which characterise service delivery to the poor.

e) Rethinking competitive elections of all Assembly members and MCEs

The issues about competitive election of all Assembly members and Municipal Chief Executives by citizens on political party tickets raise questions about effectiveness of the debates and preparations that went into the design and formulation of the Local Government Act 462 of 1993. A further debate of the issue seems necessary. As this thesis has shown, political parties and powerful elites fund candidates although the process is supposed to be non-partisan and scholars such as Crawford (2010); Awortwi (2010a); and Agyeman-Duah (2005) appear to suggest that competitive election of local government officers can be helpful. Experiences in other countries such as Uganda suggest that vibrant local council elections open avenues for fresh ideas and experience to be introduced into the local governance system at sub-national level. If the pressure of competitive elections and the possibility of losing one's job can motivate local government officials to be responsive and accountable to their electorates, what can be the limits to such policy?

f) Payment of salaries to Assembly members

Finally, the notion of voluntary Assembly work needs to be reconsidered by governments and donor agencies that support decentralisation programme within the country. Again, this issue needs extensive debate among scholars, donor organisations, politicians and governments. How can the payment of full-time salary with benefits such as transportation allowances to Assembly members guarantee their independence and efficiency? Countries such as Uganda pay full-time salary to local government officials, and findings by scholars such as Awortwi (2010b) suggest that the payment of salary to local government councillors contributes to better performances of local government institutions. Whilst the academic community and governments reflect over this issue, it seems to be one of the ways to make Assembly members to be effective as they are likely to be accountable to the tax payers rather than the interest of powerful elites.

8.4 Areas of further research

This study has focused on in-depth analysis of the horizontal relations between decentralised bodies, and between those and a small section of civil society in Ghana. I have looked at only one aspect of this relationship investigating the processes of healthcare delivery focusing on HIV and AIDS policy implementation. There are a number of areas that need further exploration for a fuller understanding of what happens at the local level in terms of how devolution and deconcentration work in practice, and how neo-patrimonial interpretations of informal relations help us to understand how the state works in other parts of Africa and in different service delivery areas. Given the fact that informal relations constitute important part of the state in Africa, and with empirical evidence that these informal relations do not always undermine the performance of the state, a key question then would be what conditions lead to informal ties being positive and under what conditions do they undermine the process of service delivery or lead to negative outcomes? Which aspects of the local state and at which level of the decentralisation system do we have informal relations undermining or promoting service delivery and why? Does the influence of informal ties vary in terms of the nature of service and the kind of institutional mechanism and legal framework regarding the delivery of that service?

In the Ghanaian case for example, ambiguities in the legal framework for health service delivery largely accounts for why informal relations seem very important. For example, the new draft decentralisation policy framework that had been produced at the time of conducting this study in an attempt to address the weaknesses in the Act 462 does not appear to solve the problems. Issues about appointment of MCEs and the lack of clarity of the relationship between MCEs and heads of decentralised departments such as health still remain. In addition, the appointment of one-third of Assembly members has not been resolved and there still remain ambiguities about how the Assemblies and decentralised departments work with civil society groups such as NGOs, CBOs and traditional authorities. There are also no clear indications that these issues have been adequately addressed in the draft report by the Constitutional Review Commission (CRC) that was set

up by the NDC government to review the 1992 Fourth Republican Constitution (see Republic of Ghana 2010).[138]

As both the new draft decentralisation policy framework and the report of the CRC had not yet been approved by parliament, and given that there were ongoing debates for Act 525 to be revised, the prospects are therefore good that further reforms may result in the future. However, based on the findings, the following areas might be of interest for further research.

First, I based my findings on Act 462 before it was revised. Since Act 462 has been revised but not yet approved by parliament, and CRC has also completed its work and the report is pending the approval of the government, the report of the CRC, the new draft decentralisation policy framework, and the debate for the review of Act 525 present a good opportunity for analysis into how the general decentralisation policy framework and the constitution can be updated to effectively address coordination and collaboration problems within the local state that the earlier versions could not address.

Second, this research only looked at coordination and collaboration between the Health Directorates and the Assemblies around the utilisation of the DACF. I focused on whether or not funds were transferred without exploring details of the amount transferred. The next step in the broader research project would be to examine the actual disbursement of the DACF at the Assembly. Studies into conditions under which informal relationships can

[138] Although the CRC has recommended direct and popular election of Metropolitan, Municipal, and District Chief Executives, this is yet to be considered by both cabinet and parliament and there are no indications that this might be implemented anytime soon. There also seems to be a number of ambiguities in various provisions in the new Draft Decentralisation Policy Framework. For example, under administrative decentralisation, one of the policy measures is to ensure an effective integration of sectoral programmes and assets into the District Assemblies to facilitate coordinated programmes through the establishment of district departments. The policy re-emphasises that the District Assembly is the overall state authority at the local level responsible for general development of the district. Issues of relationships between heads of district departments and the MCEs are not clarified. In addition, under political decentralisation and legal issues, one of the policy actions is to review the process leading to the selection of DCEs for further transparency, more citizens' participation and accountability. The nature of transparency, and citizens participation do not seem to be clear from the document leaving it for possible control by central government as before (Republic of Ghana 2010: 16-18; Fiadjoe 2009: 11).

lead to perverse outcomes and corruption can help increase our understanding of the strengths and weaknesses of informal ties as additional factors that can make mixed systems work. Such studies could follow the processes through to the outcomes, thus exploring how the DACF allocation is actually used. As we have seen in this thesis, informal relations are necessary but not sufficient. What additional things need to be in place for improved service outcomes to be achieved whilst employing the strengths of informal relations?

Third, research into how complex socio-cultural factors can promote healthcare provision can be useful. The impact of social norms, practices, and behaviours on implementing HIV and AIDS policy, as shown in the current study, point to the fact that the design and implementation of HIV and AIDS programmes can be hampered by socio-cultural factors. This does not necessarily mean that social norms, belief systems and faith-based practices only undermine health provision rather than promoting them; this could be an area for future research.

Fourth, apart from managing HIV and AIDS, the Health Directorates collaborate with the Assembly on the development of basic infrastructure; services such as water, sanitation and waste management, and issues pertaining to the health impact of mining and other industrial activities. The ways in which the two institutions work in these areas might also help to increase our understanding of how devolution and deconcentration work. The picture created by this study appears to show that Techiman and Ho have not performed well as New Juaben, Sunyani and Obuasi. However we might find different results altogether if other areas of engagement between the Health Directorates and the Assemblies were investigated.

Fifth, the way in which the adoption of a partisan local government system would contribute to making District Assemblies more responsive is another area that might benefit from further research. Such studies could draw on lessons and experiences from countries such as Botswana, Uganda and Nigeria that operate partisan electoral politics at the local

government level. Here there are two issues: a) the election of the Chief Executive, and b) the election of all Assembly members. With respect to the question of whether Chief Executives should be elected by citizens, a former Minister of Local Government recently noted that this would breed incompetence and jeopardise the decentralisation and local government system (Ghana News Agency 2011; Daily Graphic 2010). The concerns of the former Local Government Minister and others who share his views is that democratic elections at the local level could heighten differences and undermine unity in the Assemblies. These need to be empirically explored to unearth the possible options that can be adopted so that the unity in the Assemblies can be achieved even when all Assembly members and MCEs are democratically elected. Perhaps experiences of countries that have adopted partisan electoral politics at the local government level would provide useful lessons on which informed policy could be implemented.

Finally, this study focuses on health so exploring informal networks between the Assembly and other decentralised departments such as education or agriculture may provide rich insights into how devolution and deconcentration work in mixed systems of decentralisation. Do strong informal relations in one area mean other areas are neglected? Or is there a pattern of dense relationships across sectors which build synergy in some municipalities and not others? In other words, do all good things go together?

8.5 Concluding remarks

Through the exploration of informal relationships in the implementation of health policy in the Municipal Assemblies, with a focus on HIV and AIDS, this study makes a contribution to the debate surrounding decentralisation reforms and performance of local government bodies in Ghana. First, the findings provide useful insights into how different state bodies can coordinate and collaborate at the local level. This is relevant to the implementation of policy in other areas of development such as education, water and sanitation, and agriculture which may equally be shaped by informal networks between the key actors involved in the design and implementation of those programmes. Most importantly the findings give us indications of possible outcomes of governance reforms and policy

implementation in countries such as those in Asia and sub-Saharan Africa where informal networks form the core of social organisation.

Second, we learn that making decentralisation work might mean more than simply getting the laws right, providing appropriate human capacity and making adequate financial resources available to decentralised authorities at the local level. This study has shown that the hidden and often subtle but potent forces of informal networks and embeddedness can have a significant impact on how resources are used, even by highly qualified public officers, given the socio-cultural context of Ghana. This is particularly insightful when a group of public officers with a deconcentrated mandate collaborate with others working with devolved authority. Yet the legal and institutional framework that requires the two to collaborate and coordinate efforts remains ambiguous about roles and mandate; and the formal structures of enforcement of state directives remain weak.

Third, the study also contributes to the debate around neo-patrimonialism and corruption within the state in Africa. The various ways in which informal ties seem to facilitate collaboration and coordination at the local level support findings from other scholars that informal relations are capable of promoting the performance of governments in Africa under certain conditions, and in this study, far reaching informal ties seem to be good condition for informal relations to produce positive outcomes. Whilst acknowledging the limitations of informal relations, the study showed that informal relations that may be neo-patrimonial in nature might not always undermine development.

Informal ties and embeddedness can help explain why the provision of services requiring coordination and collaboration between decentralised departments seems to be better in some municipalities than others. They may also explain why some municipalities have higher levels of citizen consultation than others. Even though informal networks and embeddedness have the potential to breed corruption and undermine governance reforms, empirical evidence from this study suggest that informal ties and embeddedness may not always undermine governance performance, and that given the context such as Ghana, they

can contribute to achieving good governance outcomes. In other words, the role of informal ties and embeddedness in enabling devolution and deconcentration to operate in parallel should not be underestimated.

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Appendices

Appendix A: Introduction letter from Ghana Health Service

In case of the reply the number and the date of this letter should be quoted

My Ref. No.GHS/PPMED/08/L52

Your Ref. No.....

GHANA HEALTH SERVICE

PRIVATE MAIL BAG

MINISTRIES, ACCRA.

GHANA.

Tel. 233-21-683565

April 30, 2009

THE MUNICIPAL HEALTH DIRECTOR

Thro': REGIONAL DIRECTOR OF HEALTH SERVICES
EASTERN, ASHANTI, BRONG –AHAFO AND VOLTA REGIONS

RE: CONDUCT OF PhD. FIELDWORK: DATA COLLECTION AND INTERVIEWS
RE: MR. RONALD ADMATEY

I write to introduce Mr. Ronald Adamtey a D.Phil student from the University of Sussex. Mr. Adamtey is conducting his research on the topic 'Improving Health Care through Decentralization: Under what conditions can some Municipal Health Directorates perform better than others? A comparative study of five Municipal Health Directorates in Ghana'.

This comparative study will be carried out in the following Municipal Health Directorates:

- New Juaben Municipal Health Directorate
- Techiman Municipal Health Directorate
- Obuasi Municipal Health Directorate
- Ho Municipal Health Directorate
- Sunyani Municipal Health Directorate

This is to request for your necessary support in granting in him interview and any other relevant information he might require to enable him go through the study successfully. The data collected is agreed to be used for academic purposes and in event of publication your consent and acknowledgement will be given the needed attention.

Thank you.
Yours faithfully,

MR. DAN OSEI
Ag. Director PPME

Appendix B: Questionnaire

Questionnaire for the Municipal Directorate of Health to be answered by the Municipal Director of Health Services

Devolution and Deconcentration in Action: A Comparative study of Five Municipal Health Directorates in Ghana

DPhil research by Ronald Adamtey
Institute of Development Studies
University of Sussex, UK
October 2008

This is an academic research. It has no direct benefit to participants. Participation in the form of interviews is therefore voluntary. Nothing will be published without the consent of participants.

A1. HISTORY OF DIRECTORS (between 2000 and 2008)

A2. How long have you been the Municipal Director of Health Services in this municipality?

A3. How many Directors have been at the Municipality between 2000 and 2008 and how long has each served?

B1. HISTORY OF RELATIONSHIPS AND NETWORKS WITH OTHERS AROUND ISSUES OF HEALTH CARE DELIVERY IN THE MUNCIPALITY (previous directors) (Focus discussion on HIV and AIDS)

B2. Which of these groups/organisations/institutions/individuals did the past Directors have any kinds of relationship with? (tick)

B2.1. NGOs in health care delivery (list specific NGOs)

B2.2. Municipal Assembly (the MCE, MCD or any other key staff)

B2.3. Assembly Members

B2.4. Traditional Authority (the chief/queenmother)

B2.5. Religious groups (churches and mosques etc.)

C1. If there was any kind of relationship with any of these groups/organisations/institutions/individuals ask the following for each:

C2. What kind of relationship? (tick)

C2.1. ethnic

C2.2. neighbourhood-*abusua*

C2.3. old-school

C2.4. political party (NDC or NPP)

C3. When was it established?

C4. Who established it?

C5. Why was it established? (probe for content – purpose)

C6. Why did they need this relationship?

D1. HISTORY OF RELATIONSHIPS AND NETWORKS WITH OTHERS AROUND ISSUES OF HEALTH CARE DELIVERY IN THE MUNCIPALITY (current director) (Focus discussion on HIV and AIDS)

D2. Which of these groups/organisations/institutions/individuals do you have any kinds of relationship with? (tick)

D2.1. NGOs in health care delivery (list specific NGOs)

D2.2. Municipal Assembly (the MCE, MCD or any other key staff)

D2.3. Assembly Members

D2.4. Traditional Authority (the chief/queenmother)

D2.5. Religious groups (churches and mosques etc.)

E1. If there is any kind of relationship with any of these groups/organisations/institutions/individuals ask the following for each:

E2. What kind of relationship? (tick)

E2.1. ethnic

E2.2. neighbourhood-*abusua*

E2.3. old-school

E2.4. political party (NDC or NPP)

E3. When was it established?

E4. Who established it?

E5. Why was it established? (probe for content – purpose)

E6. Why do you need these relationships?

F1. RESOURCES FOR HEALTH CARE DELIVERY

F1.1. What is the total amount of money you require each year to deliver health care?

F1.2. What percentage are you able to get?

F1.3. How much financial resources have you received for health care delivery in the municipality? (please complete the table)

TABLE A: SOURCES OF FINANCIAL RESOURCES

Year	Central Government transfers
00	
01	
02	
03	
04	
05	
06	
07	
08	

F1.4. What legal backing do you have for the mobilisation of internally generated funds?

G1. ACCESS TO THE DACF

G1.1 Do you have access to the DACF? Or Does the MCE release the 1% for HIV/AIDS for you to do health programmes? (please complete table with Yes or No)

Access to the DACF between 2000 and 2008

Year	Releases of DACF for HIV/AIDS (Yes/No)
00	
01	
02	
03	
04	
05	
06	
07	
08	

G1.2. Why Yes or No (Do detail discussion of answers for each year)

H1. IMPLEMENTATION OF CHPS

H1.1. To what extent has the CHPS been implemented?

H1.2. How have the following groups/institutions/organisations/individuals contributed to the implementation of the CHPS?

H1.3. The Municipal Assembly

H1.4. Assembly members

H1.5. NGOs

H1.6. Traditional Authority (the chief/queenmother)

H1.7. Religious groups (and mission hospitals/clinics)

I1. ACCOUNTABILITY ISSUES

I1.1. Which civil society group mobilise to demand improvement in health care in the municipality? (NGOs, churches, mosques, Youth Groups etc)

I1.2. What health issues/grievances/demands around health care delivery have been raised by civil society groups in the municipality?

I1.3. How did you address these issues/grievances/demands?

I1.4. What formal procedures/channels are there for civil society groups to present their grievances/demands around health care in the municipality to you?

I1.5. What formal channels are there for stakeholders in health care delivery to access information about health care in the municipality?

I1.6. What informal channels are there for civil society groups to present grievances/demands around health care in the Municipality?

J1. AWARENESS ABOUT RELATIONSHIP BETWEEN OTHER GROUPS/ORGANISATION/INSTITUTIONS

J1.1. What kind of relationship exist between the following?

J1.2. Municipal Assembly and Traditional Authority

J1.3. Municipal Assembly and NGOs that mobilise around health care

J1.4. Municipal Assembly and Religious groups

J1.5. Municipal Assembly and Donor Agencies

J1.6. NGOs and Traditional Authority (the chief/queenmother)

J1.7. NGOs and Religious groups (churches and mosques)

J1.8. NGOs and Donor Agencies

J1.9. Traditional Authority (the chief/queenmother) and Religious groups (churches and mosques)

K1. PREPARATION OF HEALTH PLANS (Focus on HIV and AIDS)

K1.1. How are plans made? Or what is the process involved in preparing health plans? (*Look for a stage-by-stage process of activities. Look for any inputs from MA, traditional authorities, civil society groups, donor agencies etc).*

L1. HISTORY OF HEALTH PROGRAMMES/PROJECTS
(please complete table)

Year	Programme/project	Funding Agency	Programme/project history -who pushed for it, who initiated it etc
00			
01			
02			
03			
04			
05			
06			
07			
08			

M1. DHMT
M1.1. How does the DHMT operate?
M1.2. How many representatives are from the Assembly and CSOs?

Thank you for your time

Questionnaire for the Municipal Assembly

Devolution and Deconcentration in Action: A Comparative study of Five Municipal Health Directorates in Ghana

PART A to be answered by the Municipal Coordinating Director

A1. RELATIONSHIPS AND NETWORKS WITH OTHERS AROUND ISSUES OF HEALTH CARE DELIVERY IN THE MUNICIPALITY (Focus on HIV and AIDS)

A discussion around the relationship between the MA and the groups/organisations/institutions/individuals listed below around health care delivery.

A1.1. Health issue(s)
A1.2. History and the nature of relationship

A1.2.1. ethnic relations

A1.2.2. neighbourhood ties

A1.2.3. old-school networks

A1.2.4. political party (NDC or NPP)

A2. Architects of the relationship

A3. Relevance of the relationship

A4. How the relationship is maintained

B1. PERSON WITH WHOM CONNECTED

B1.1. Municipal Directorate of Health Services

B1.2. NGOs in health care delivery (list specific NGOs)

B1.3. Traditional Authority (the chief/queenmother)

B1.4. Religious groups (churches and mosques etc.)

C1. ACCOUNTABILITY ISSUES

C1.1. Civil society groups that mobilise around health care in the municipality. The health issues of importance to them and why

C1.2. Methods used to make the claims and why

C1.3. The response of the MA to the demands and why the MA respond the way it does

Thank you for your time

PART B to be answered by Municipal Planning Officer

D1. HEALTH PROGRAMMES/PROJECTS

(Complete Table B below) – Focus on HIV and AIDS if possible

Year	Programme/project	Funding Agency	Programme/project history -who pushed for it, who initiated it etc
00			
01			
02			
03			
04			
05			
06			
07			
08			

For each of the programmes/projects listed, discuss the roles played by any groups/organisations/individuals.

Thank you for your time

Questionnaire for Traditional Authorities to be answered by the Paramount Chief

Devolution and Deconcentration in Action: A Comparative study of Five Municipal Health Directorates in Ghana

A1. RELATIONSHIPS AND NETWORKS WITH OTHERS AROUND HEALTH CARE DELIVERY IN THE MUNICIPALITY

A1.1. Which of these groups/organisations/institutions/individuals does the traditional authority have any kind or relationship with? (Focus on the Chief)

A1.1.1 Municipal Director of Health Service
A1.1.2. NGOs in health care delivery (list specific NGO)
A1.1.3. Municipal Assembly (the MCE, MCD or any other key staff)
A1.1.4. Assembly Members
A1.1.5. Religious groups (churches and mosques etc.)

A1.1.6. ethnic relations
A1.1.7. neighbourhood ties
A1.1.8. old-school networks
A1.1.9. political party (NDC or NPP)

A2. If there was any kind of relationship with any of these groups/organisations/institutions/individuals ask the following:

A2.1. When was it established?
A2.2. Who established it?
A2.3. Why was it established? (probe for content – purpose)

Thank you for your time

Questionnaire for Civil Society Groups (NGOs, religious groups) to be answered by the leaders/heads

Devolution and Deconcentration in Action: A Comparative study of Five Municipal Health Directorates in Ghana

A1. ABOUT RESPONDENT

A1.1. Name:
A1.2. Position:
A1.3. How long have you been the leader/head of this organisation?

B1. BASIC DATA ABOUT ORGANISATION

B1.1. Name of organization
B1.2. Date of establishment
B1.3. How long has this organisation operated in this municipality?
B1.4. Mission statement/Goals and Objectives

C1. MEMBERSHIP AND INCENTIVES FOR BEING A MEMBER

C1.1. Who are the members of the organisation?
C1.2. How do people become members?
C1.3. What incentives do people get to be members? Or why would anybody want to be a member of this organisation?
C1.4. What do members lose if they lose their membership?

D1. FUNDING

D1.1. What are your sources of funding?
D1.2. How did you get access to the source(s) listed?
D1.3. Why do/does these/this source(s) continue to support your activities?

E1. HISTORY OF RELATIONSHIPS AND NETWORKS WITH OTHERS AROUND ISSUES OF HEALTH CARE

E1.1. Which of these groups/organisations/institutions/individuals did the past leader/head have any kinds of relationship with? (tick)

E1.1.1. Municipal Health Directorate (Municipal Director of Health Services)
E1.1.2. Municipal Assembly (the MCE, MCD or any other key staff)
E1.1.3. Assembly Members
E1.1.4. Traditional Authority (the chief/queenmother)
E1.1.5. ethnic relations
E1.1.6. neighbourhood ties
E1.1.7. old-school networks

E1.1.8. political party (NDC or NPP)

E1.2. When was it established?
E1.3. Who established it?
E1.4. Why was it established? (probe for content – purpose)

F1. ACTIVITIES AROUND HEALTH CARE DELIVERY (HIV and AIDS)
F1.1. What activities do you engage in as far as health care delivery in the municipality is concerned?
F1.2. Who are your beneficiaries?
F1.3. Who are your targets/claimants?
F1.4. How do you go about making your claims?
F1.5. If you have any success of influencing health care delivery in the municipality what are they?
F1.6. If there are failures or difficulties as far as your mission statement and goals are concerned what are they?

G1. ACTIVITIES OF THE DHMT
G1.1. Have you been part of the DHMT?
G1.2. Please describe its activities in terms of what you do

Thank you for your time

Questionnaire for elected Assembly members

Devolution and Deconcentration in Action: A Comparative study of Five Municipal Health Directorates in Ghana

A1. BASIC DATA ABOUT RESPONDENT

A1.1. Name:
A1.2. Electoral area:
A1.3. Political party affiliation (optional):

B1. HISTORY OF OFFICE

B1.1. How long have you been in office? (Number of terms: 3 maximum):
B1.2. Why did you decide to be Assembly member?
B1.3. How did you get elected? (look for detailed stories around campaigns and funding):

C1. LIFE IN THE ASSEMBLY

C1.1. Which sub-Committees have you been a member of? (list all):
C1.2. Do you have any experiences to share as far as your job is concerned?

D1. NETWORKS WITH HEALTH DIRECTORATE

D1.1. Which of the following relationships do you have with the officers in health listed?
D1.1.1. Ethnic
D1.1.2. Neighbourhood
D1.1.3. Old-school
D1.1.4. Political party (NDC or NPP)

E1. Health Directorate Staff

E1.1. Health Director
E1.2. Deputy Director of Nursing Service
E1.3. Disease Control Officer

F1. HISTORY OF RELATIONSHIPS

F1.1. Number of years
F1.2. How did it start?
F1.3. How beneficial are these relationships?

Thank you for your time

Appendix C: Suggested actors to be focus for HIV and AIDS in Ghana

Table 9: Suggested actors to be focus for HIV and AIDS in Ghana

Issue: role of state agencies, NGOs, traditional leaders and religious bodies supporting victims of violence and HIV		
Strategic Response		
Upper West	Upper East	Northern
Chiefs/Traditional Authorities: • Identify negative traditional and cultural practices and replace, eradicate or modify them as the case may be • Enact bye-laws through District Assembly Committees and see to the implementation of such laws **Religious Bodies:** • Include the effects of violence and HIV in their sermons **NGOs:** • Strengthen collaboration among service providers • Support state agencies to embark on effective sensitisation on the effects of violence and HIV • Support victims' groups with financial assistance	**Chiefs/Traditional Authority:** • Advocacy and sensitisation of community members • Make bye-laws to enforce acceptance of victims • Accept changes to negative cultural practices **Religious Bodies:** • Counsel victims • Provide Food • Sensitise communities on stigmatisation and discrimination **NGOs:** • Educate and counsel victims • Empower victims economically through training and provision of credit facilities • Open shelters for battered women	**Chiefs/Traditional Authority:** • Create awareness • Modify negative cultural practices • Enforce bye-laws **Religious Bodies:** • Preach against violence and stigmatisation • Support victims of violence and HIV/AIDS e.g. Counselling, supply of food and basic needs **NGOs:** • Create awareness on e.g. stigmatisation, violence, HIV and AIDS • Support victims of HIV and violence with income generation activities and skills training • Support orphans
Issue: What kind of policies, laws etc need to be put in place at national, district and community levels to address violence and HIV?		

Source: ActionAid Ghana (2007: 93). Note: table has been edited by author.

Appendix D: Author in Assembly meetings

Plate 1: New Juaben

Plate 2: Ho

Plate 3: Obuasi

Appendix E: : Strength of informal ties between health staff and elected Assembly members

The process

Number of Assembly members = 10
Therefore each health officer could score = 100 percent for each of the ties
For each of the tie, total score for the MHD = sum of scores for all 3 health staff represented by $\boldsymbol{X}$
For each of the ties, average score for the MHD = $\boldsymbol{X}/3 = \boldsymbol{K}$

This implies that there will be:

$\boldsymbol{K_1}$ (Old-school tie)
$\boldsymbol{K_2}$ (Neighourhood relations)
$\boldsymbol{K_3}$ (Ethnic bonds)

Overall MHD average = $(\boldsymbol{K_1}+\boldsymbol{K_2}+\boldsymbol{K_3})/3$ (see last column of Table 6)

The strength of informal ties is interpreted using the same scale:
strong ($\geq$ 70%); ***medium*** (40%-69.5%); and ***weak*** ($\leq$ 39.5%) (Table 6 in Chapter 6)

Appendix F: Health Directorate's embeddedness with CSOs

(a) Embeddedness with NGOs

The procedure
Maximum score each Health Directorate will obtain depends on the number of NGOs. This is represented by ***Q***
Ethnic ties are represented by ***E***
Neigbhourhood relations represented by ***N***
Old-school relations represented by ***O***

Sum of all '**E'** obtained by each MHD is represented by $\mathbf{X_1}$
Sum of all '**N**' obtained by each MHD is represented by $\mathbf{X_2}$
Sum of all '**O**' obtained by each MHD is represented by $\mathbf{X_3}$
The percentage for each of the cases: $(\mathbf{X_1+X_2+X_3})/\mathbf{Q} * (100\%)$.

The strength of embeddedness is determined by the scale: ***strong*** (≥70%); ***medium*** (40%-69.5%); and ***weak*** (≤ 39.5%).

(b) Embeddedness with religious groups and traditional authority

Maximum score that each of the Health Directorates could obtain would depend on the number of chiefs and pastors with whom the health Directorate had ties. This is represented by **Z**

Sum of all '**E**' obtaine is represented by $\mathbf{T_1}$
Sum of all '**N**' is represented by $\mathbf{T_2}$
Sum of all '**O**' is represented by $\mathbf{T_3}$
The percentage for each case: $(\mathbf{T_1+T_2+T_3})/\mathbf{Z} * (100\%)$

The strength of embeddedness is determined using the same scale.

Appendix G: Overall pattern of informal ties and embeddedness

Table 10: Overall pattern of informal ties and embeddedness

Hypotheses	Informal ties		Embeddedness
Case	Executive members of Assembly	Elected Assembly members	Civil Society OrganiSations
Ho	31.25%	26.66%	(33.33%+50.00%)/2=41.66%
Obuasi	50.00%	26.66%	(40.74%+44.44%)/2=42.59%
Sunyani	47.91%	36.66%	(44.44%+50.00%)/2=47.22%
Techiman	18.75%	10.00%	(15.55%+11.11%)/2=13.33%
New Juaben	72.91%	66.66%	(52.77%+55.55%)/2=54.16%

Source: Author's construct, July 2010

Note: strength of informal ties and embeddedness: ***strong*** (≥ 70%); ***medium*** (40%-69.5%); and ***weak*** (≤ 39.5%)

Table 10 presents a summary of the pattern of informal ties and embeddedness only. Figures in the cells are brought from Table 3 in Chapter 3 (under informal relations and embeddedness). At a glance, they provide a quick picture of how the cases perform in comparison with all others. Health officers have strong ties between them and Executive officers of the Assembly when the number of existing ties as a percentage of all ties is 70 percent or more. Strong ties will be the ideal as they are likely to facilitate how health officers work with Executive officers of the Assembly. Weak ties exist when the score is up to 39.5 percent. In the argument of this study, weak ties are unlikely to promote collaboration and coordination between different parts of the local state.

Similarly, the density of ties between health staff and leaders of the selected groups within civil society show the extent to which health staff are embedded within society. As with ties with Executive officers or elected Assembly members, strong embeddedness is when the score is 70 percentage and beyond.

Appendix H: Determining performance: assessment of HIV/AIDS plans

(i) Compilation of key AIDS management measures

(ii) Determining consultation with elected Assembly members

Based on the contents in table 9, I asked each of the Assembly members whether they were consulted by the Health Directorate or not. I then converted the number consulted into *percentages*. Having obtained the *percentages*, I used the same scale to determine the level of consultation is ***high*** if (≥70%), ***medium*** (40%-69.5%), and ***low*** (≤ 39.5%) (see table 10).

(iii) Determining consultation with leaders of civil society groups

The leaders of civil society groups I used are (i) leaders of NGOs, (ii) traditional rulers or chiefs, and (iii) religious leaders. Based on the contents in table 9, I asked them whether health staff consulted them. I sought a 'Yes' or 'No' answer.

The maximum score that could be obtained by each case would depend on the number of NGOs, chiefs, and religious leaders consulted is represented by '**B'**

When the answer is Yes, it is represented by '**+**'
When it is No, it is represented by '**–**'

For each of the cases, the level of consultation is (sum of all '**+**')/**B** ∗ (100%)

Using the same scale, consultation is ***high*** (≥70%), ***medium*** (40%-69.5%), and ***low*** (≤ 39.5%) (see Table 12 in Appendix J and Table 13 in Appendix K)

Appendix I: Key measures for managing HIV/AIDS

Table 11: Summary of key measures for managing HIV/AIDS across cases

Cases	AIDS management measures	Role of elected Assembly members	Role of known NGOs
Ho	-Train counsellors for Voluntary Counselling and Testing for sub-municipalities -Institute Home-Based Management of PLWA in the municipalities -Identify all NGOs in health since most of them are not known to the health department -Collaborate with NGOs -Ensure collaboration among NGOs	-elected Assembly members did not have any knowledge about health department's plans to address AIDS -they also did not know about NGOs in AIDS operating in their electoral areas -elected Assembly members show no interest in AIDS programmes	-NGOs provide care and support for PLWAs -NGOs provide education campaigns -out of the 3 NGOs, one was not consulted by the health department about AIDS programme preparation or implementation
Obuasi	-Strengthen already Highly Active Anti-Retroviral Treatment centres -Collaborate with all MDAs working in the area of HIV/AIDS -Intensify Heath Promotional activities on HIV/AIDS in churches, mosques, and Faith-Based healing centres -Implement workplace HIV/AIDS policies -Undertake Voluntary Counselling and Testing of the HIV (communities, schools, offices). Know Your Status campaign -Support hospitals to undertake PMCT -Set up committee on HIV/AIDS to oversee the activities of the Ministries, Departments, and Agencies (maiden meeting held in conjunction with the Municipal Response Initiative (MRI) and MDAs to reflect on the achievements and the way forward) -Radio discussions and Advocacy Communication and Social mobilisation activities -Train community-based Surveillance Workers in home-based care and support of clients	-only few of the Assembly members were consulted during field visits by health department in connection with preparing health plan	-out of the 3 NGOs, one was not consulted by health department about AIDS programme preparation or implementation -NGOs responsible for providing care and support for PLWAs -NGOs provide education campaigns
Sunyani	-Change peoples' attitude towards AIDS (stigmatisation and discrimination) -Collaborate with NGOs to educate people about the disease -Intensify Prevention of Mother-to-Child Transmission services -Identify and care for PLWAs -Provide Voluntary Counselling and Testing	-some elected Assembly members did not play any role in AIDS programmes of the health department	-3 out of 5 NGOs were consulted by health department -NGOs provide care and support for PLWAs -NGOs provide education campaigns -most of the NGOs are involved in implementation of AIDS programme by health department
Techiman	-Undertake awareness campaign for behaviour change in schools -Reduce stigmatisation, Cultural and belief systems that undermine AIDS	-elected Assembly members did not know about AIDS programme by the health	-only few of the NGOs are known by elected Assembly members

	programme -Provide Care and Support to PLWA orphans (nutrition and livelihood support) -Encourage the use of ART services -Distribute condoms to commercial sex workers -Coordinate implementation of HIV/AIDS programmes -Train community volunteers for home-based care -Provide Counselling and Testing and PMCT services (use local FM stations) -Organise workshop for Police and Fire Service officers -Collaborate with the Municipal Assembly on District Response Initiative (MRI) -Collaborate with NGOs to facilitate support from global fund to assist PLWAs	department	-most NGOs did not have any idea about AIDS programme in the health department -NGOs provide education campaigns
New Juaben	-Promote the use of female condom by Commercial-Sex-Workers and female hawkers -Promote sale of condoms in supermarkets, funeral grounds, internet cafes, drinking bars, markets, restaurants, hotels -Establish abstinence clubs in schools -Promote HIV/AIDS awareness in mass media -Train community volunteers for Home-Based Care -Support PLWAs to access Anti-Retroviral Treatment -Promote Counselling and Voluntary Testing and intensify Mother-to-Child Transmission services -Provide care and support to Orphans and Vulnerable Children (AIDS affected and infected children)	-most elected Assembly members were consulted to make inputs into AIDS programmes -most elected Assembly members were made to play leading role during outreach visits to their electoral areas	-all 4 known NGOs, were consulted about the health department's AIDS programmes -NGOs provide care and support for PLWAs -NGOs provide education campaigns

Source: Author's construct, July 2010

Note: Compiled from (i) Health plans, High Impact Rapid Delivery (HIRD) plans (ii) In-depth interviews with Health Directors, Disease Control Officers, Public Health Nurses, Deputy Directors of Nursing Services, HIV/AIDS Focal persons at the health departments, and elected Assembly members

Appendix J: Consultation with elected Assembly members

Table 12: Consultation with elected Assembly members

Case	Proportion of assembly members consulted
Ho	30%
Obuasi	60%
Sunyani	30%
Techiman	30%
New Juaben	60%

Source: Author's construct, July 2010
Note: The value in percentage is the proportion consulted out of 10

Table 12 presents the number of electe Assembly members who were consulted with by the Health Directorates. The number is expressed as a percentage of the number interviewed which is 10 in each of the cases.

Appendix K: Consultation with civil society organisations

Table 13: Consultation with civil society actors

Ho						Obuasi						Sunyani							Techiman							New Juaben						
1	2	3	4	C1	P1	1	2	3	C2	P2	P3	1	2	3	4	5	C3	P4	1	2	3	4	5	C4	P5	1	2	3	4	C5	P6	P7
-	-	+	-	+	+	+	+	+	-	-	+	+	-	-	+	-	+	+	-	-	-	-	-	+	+	+	+	+	-	+	+	+
50.00%						**66.66%**						**57.14%**							**28.57%**							**85.71%**						

Key:

Ho	Obuasi	Sunyani	Techiman	New Juaben
1-AFRIWEB	1-SSF	1-BV	1-FO	1-4-H Ghana
2-FUGI	2-PACAI	2-CSD	2-ACF	2-M25H
3-CLF	3-KWADA	3-6th MWF	3-IFFN	3-FHF
4-LDF	C2-Chief2	4-MH	4-LPA	4-RW
C1-Chief1	P2-Pastor2	5-WASA	5-BCSF	C5-Chief5
P1-Pastor1	P3-Pastor3	C3-Chief3	C4-Chief4	P6-Pastor6
		P4-Pastor4	P5-Pastor5	P7-Pastor7

Notes:

I maintain the pastors and chiefs with their identification numbers from Table 4.

Table 13 shows the number of leaders of the selected CSOs that were consulted by health staff. Consultation is represented by "+" whilst non-consultation is represented by "-" For each case, all the sum of all "+" were expressed as a percentage of total number of CSOs. The results are interpreted using the same scale: ***high*** (if ≥ 70%), ***medium*** (40%-69.5%), and ***low*** (≤ 39.5%). In the analysis of causal relations, high level of consultation (scores of 70 percent or more) were expected to lead to development of shared interest around management of HIV and AIDS between health staff and leaders of the CSOs. Low level of consultation (scores of up to 39.5 percent) are unlikely to facilitate the development of shared interests between health officers and CSO leaders.

Appendix L: Overall performance: consultation with elected Assembly members and CSOs

Table 14: Overall performance: consultation with elected Assembly members and CSOs

Case	Performance Indicators	
	Consultation with elected assembly member	Consultation with Civil Society actors
Ho	30%	50.00%
Obuasi	60%	66.66%
Sunyani	30%	57.14%
Techiman	30%	29.28%
New Juaben	60%	85.71%

Note: Performance is ***high*** if (≥ 70%), ***medium*** (40%-69.5%), and ***low*** (39.5%)

Table 14 only presents a summary of the overall performance in terms of consultation with elected Assembly members and leaders of the selected groups within civil society that were interviewed. The figures in the second column show the number of elected Assembly members that were consulted as a percentage of the total number interviewed (10 in each case). The figures in the third column are the averages taken from Tables 7 and 8 in Chapter 7. They are also the same figures in the 14th row in Table 3 in Chapter 3 which show the number of selected CSO leaders interviewed expressed as a percentage.

Appendix M: Hon. Alhaji Alhassan with his citations

Appendix N: Fighting HIV/AIDS by Obuasi Municipal Assembly

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Appendix O: Per capita amount received from central government

Table 15: Per capita amount received from central government by each Health Department (2000 – 2008)

Year	Ho			Obuasi			Sunyani			Techiman			New Juaben		
	Amt. (GH¢)	Pop.	Per capita	Amt. (GH¢)	Pop.	Per capita	Amt. (GH¢)	Pop.	Per capita	Amt. (GH¢)	Pop.	Per capita	Amt. (GH¢)	Pop.	Per capita
2000	15,294	200,000	0.08	18,823	115,564	0.16	16,302	179,165	0.09	13,659	174,600	0.07	9,727	136,768	0.07
2001	23,100	202,000	0.11	16,491	120,187	0.14	19,561	186,332	1.10	18,760	179,838	0.10	18,727	139,503	0.13
2002	6,087	204,020	0.03	19,284	124,994	0.15	14,867	193,785	0.07	3,074	185,233	0.01	17,933	142,293	0.12
2003	16,976	206,060	0.08	25,936	129,994	0.20	24,198	201,536	0.12	17,017	190,789	0.08	26,740	145,138	0.18
2004	28,248	208,121	0.14	30,739	135,194	0.23	18,372	209,597	0.08	11,552	196,512	0.05	52,176	148,040	0.35
2005	40,375	210,202	0.19	37,295	140,601	0.27	41,479	217,981	0.19	23,596	202,407	0.11	46,824	151,000	0.31
2006	37,283	212,304	0.18	51,739	146,225	0.35	22,375	226,700	0.09	46,635	208,479	0.22	17,220	154,020	0.11
2007	26,510	214,427	0.12	24,582	152,074	0.16	31,810	235,768	0.13	35,445	214,733	0.16	20,534	157,100	0.13
2008	64,296	216,571	0.30	73,176	190,907	0.38	69,863	245,199	0.28	71,399	221,174	0.32	86,312	160,242	0.53

Source: Author's construct, July 2010

Notes:

(i) Sources of figures for the construction of the table include: HMA (2007), TMA (2006); NJMA (2006), OMA (2006a), OMHD (2008), SMA (2006a), and various interviews

(ii) These are central government transfers under ITEM 3 (e.g. HIV/AIDS, malaria, immunisation). Even though Ghana's currency was changed in 2004, I have converted all amounts to the new Ghana Cedi (GH ¢).

(iii) Population figures are based on 2000 Population and Housing Census which estimates that from 2000, the growth rate for the municipalities are: Techiman (3.0%), NJMA (2.6%),

(iv) Population for Ho: http://www.ghanadistricts.com/districts/?r=7&_=116&sa=4260 (accessed on 18th July 2010)

(v) Population of Obuasi: http://en.wikipedia.org/wiki/Obuasi (accessed on 18th July 2010). Obuasi's population growth rate was 4 percent (OMA 2006a; OMHD 2008).

Appendix P: Mode of seeking election to the Assembly

Section 7 of Local Government Act, Act 462 of 1993

(1) A candidate seeking election to a District Assembly or to any lower local government unit shall present himself to the electorate as an individual, and shall not use any symbol associated with a political party.
(2) A political party shall not endorse, sponsor, and offer a platform to or in any way campaign for or against a candidate seeking election to a District Assembly or any lower local government unit.
(3) A candidate who contravenes subsection (1) of this section commits an offence and on conviction shall have his nomination cancelled by the Electoral Commission.
(4) A political party which contravenes subsection (2) of this section commits an offence and is liable on conviction to a fine not exceeding five million cedis

Appendix Q: Main interviewees and date of interviews

Ho Municipal Area		Obuasi Municipal Area		Sunyani Municipal Area		Techiman Municipal Area		New Juaben Municipal Area	
Municipal Health Directorate		**Municipal Health Directorate**		**Municipal Health Directorate**		**Municipal Health Directorate**		**Municipal Health Directorate**	
Position	Date of interview	Position	Date of interview	Position	Date of interview	Position	Date of interview	Position	Date of interview
MHD	09/10/2009	MHD	14/08/2009	MHD	14/05/2009	MHD	25/11/2008 26/11/2008 21/08/2009	MHD	21/10/2008 23/10/2008 24/10/2008
DDNS/PHN	06/10/2009	DDNS/PHN	17/08/2009			DDNS	24/11/2008 21/08/2009	DDNS	22/10/2008 27/10/2008
DCO	09/10/2009	DCO	17/08/2009			DCO	17/11/2008 21/08/2009	DCO	24/10/2008
Municipal Assembly		**Municipal Assembly**		**Municipal Assembly**		**Municipal Assembly**		**Municipal Assembly**	
MCD	30/10/2009	MCD	24/08/2009	MCD	20/06/2009	MCD	20/11/2008	MCD	18/10/2008 20/10/2008
MPO	30/10/2009	MPO	25/08/2009	MPO	13/05/2009	MPO	18/11/2008	MPO	17/10/2008 18/10/2008
HIV/AIDS F/P	30/10/2009	HIV/AIDS F/P	25/08/2009	HIV/AIDS F/P	14/05/2009	HIV/AIDS F/P	27/11/2008	HIV/AIDS F/P	21/10/2008
Elected Assembly Members		**Elected Assembly Members**		**Elected Assembly Members**		**Elected Assembly Members**		**Elected Assembly Members**	
HAS1	07/10/2009	OAS1	14/08/2009	SAS1	06/05/2009	TAS1	26/10/2009	NAS1	14/10/2009
HAS2	07/10/2009	OAS2	14/08/2009	SAS2	19/05/2009 09/06/2009	TAS2	26/10/2009	NAS2	16/10/2009
HAS3	07/10/2009	OAS3	14/08/2009	SAS3	21/06/2009	TAS3	26/10/2009	NAS3	16/10/2009
HAS4	07/10/2009	OAS4	21/08/2009	SAS4	13/05/2009 19/05/2009	TAS4	27/10/2009	NAS4	16/10/2009
HAS5	09/10/2009	OAS5	21/08/2008	SAS5	06/05/2009	TAS5	27/10/2009	NAS5	16/10/2009
HAS6	09/10/2009	OAS6		SAS6	05/05/2009 06/05/2009	TAS6	27/10/2009	NAS6	17/10/2009
HAS7	12/10/2009	OAS7		SAS7	08/05/2009	TAS7	28/10/2009	NAS7	17/10/2009
HAS8	12/10/2009	OAS8		SAS8	08/05/2009	TAS8	28/10/2009	NAS8	17/10/2009
HAS9	10/10/2009	OAS9		SAS9	13/05/2009	TAS9	28/10/2009	NAS9	17/10/2009
HAS10	10/10/2009	OAS10		SAS10	13/05/2009	TAS10	28/10/2009	NAS10	18/10/2009
NGOs		**NGOs**		**NGOs**		**NGOs**		**NGOs**	
AFRIWEB	08/10/2009	SSF	17/06/2009	BV	27/11/2008 06/05/2009	FO	26/11/08	4-H Ghana	22/10/08
FUGI	08/10/2009	PACA	18/06/2009	CSD	06/05/2009	ACF	27/11/08	Mathew 25	6/11/08
CLF	08/10/2009	KWADA	20/08/2009	6th MWF	18/05/2009	IFFN	27/11/08	FHF	24/10/08

LDF	07/10/2009			MH WASA	18/05/2009 08/05/2009	LPA BCSF	 26/11/08	RW	
Religious Groups		**Religious Groups**		**Religious Groups**		**Religious Groups**		**Religious Groups**	
HRG1	09/10/2009	ORG1 ORG2		SRG1	10/06/2009	TRG1	12/11/08	NRG1 NRG2	24/11/08 24/11/08
Traditional Authority		**Traditional Authority**		**Traditional Authority**		**Traditional Authority**		**Traditional Authority**	
HTA	10/10/2009	OTA		STA	07/05/2009 20/05/2009	TTA	11/11/08	NTA	22/10/08
Radio Stations		**Radio Stations**		Radio Stations		**Radio Stations**		**Radio Stations**	
-	-	-	-	SRS1	17/11/2008	TRS1	17/11/2008	NRS1	24/10/2008
-	-	-	-	-	-	TRS2	17/11/2008	-	-
-	-	-	-	-	-	TRS3	17/11/2008	-	-
-	-	-	-	-	-				
-	-	-	-	-	-	Health officer	05/05/2012	Health officer	02/05/2012

Source: Compiled by Author, October 2009