

**Ghana's Participation Programme, 1996–2000:
Reproductive Health Advocacy at District, Subdistrict, and
Community Levels in the Eastern Region**

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Foreword

Participation activities in Ghana have been carried out within the context of the government's decentralization policy as expressed in the Local Government Act 462, 1992, which repealed and replaced the Local Government Law, 1988.

As part of the ongoing process, new structures and functions of various national, regional, and district agencies have been indicated in several important documents.

To facilitate programme implementation through institutional integration, central administrative and political authority have been devolved to the district level; government agencies in any given district or region have been placed under the District Assembly or the Regional Coordinating Council, as the case may be.


In all this, the emerging and critical role of NGOs as partners for progress has been fully recognized by the government. Establishment of the National Population Council and its Regional Population Advisory Committees (RPACs) and District Population Advisory Committees (DPACs) has strengthened the decentralization policy, which has, in turn, paved the way for participation of NGOs and civil society in decentralized implementation of population and reproductive health programmes.

Participation activities in the Eastern Region of Ghana have been conducted on a pilot basis, supporting the National Population Council in terms of enhancing visibility of its programmes, particularly at the district level. The guiding principles have been community partnership and ownership of population programmes in which the District Assembly is central.

In my carefully considered view, the participation process should be continued and replicated in selected districts in the other regions of Ghana in order to ensure further strengthening of intersectoral networks among all development partners, be they governmental or nongovernmental. Certainly, this level of partnership should enable us to confront and address, in a better coordinated fashion, the problems that threaten development at the district and community levels, particularly the rising incidence of HIV/AIDS. To ensure sustainability, capacity building in policy analysis and advocacy skills should continue.

I am particularly pleased that the lessons learned on this pilot project have now been documented; the next step, of course, is aggressive marketing in the other regions and districts in the expectation that they will feel inspired enough to generate and allocate their own resources to address their felt needs in the area of reproductive and sexual health.

I have great pleasure in recommending this document to them as well as to any of our development partners who may wish to assist.



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Ghana's Participation Programme, 1996–2000: Reproductive Health Advocacy at District, Subdistrict, and Community Levels in the Eastern Region

Introduction

The government of Ghana has national policies and programmes to address key issues of population, including reproductive health. These are consistent with the International Conference on Population and Development (ICPD) *Programme of Action*. However, the critical level of decision making and responsibility for effective implementation of these policies and programmes is at the district level. This report describes how district-level advocacy makes a difference.

This report tells the story of networking among nongovernmental organizations (NGOs) in five districts of Ghana's Eastern Region. It highlights the potential for community participation in development at the district level. The case for replicating advocacy networks in all districts of the country is unassailable. Community participation can and should be encouraged as an anchor in a state of flux in the political arena, especially if governance is to be subjected to transparency and accountability.

District-level Advocacy in the Context of Ghana and the ICPD

The success of decentralization depends on the extent to which civil society, including NGOs, participates in the policymaking process, especially at the district level. Civil society is the anchor that can stand the continuous change of government and district leadership.

It is not surprising that one of the major political interests in Ghana since the early 1980s has been the government's decentralization process. The government's decentralization policy aims at transferring power functions and financial and human resources from central government ministries and departments to the districts assemblies. District assemblies, as established by the Local Government Act 462 (1992) and in accordance with constitutional requirements, are responsible for translating national policies into implementable programmes and activities. Decentralization in effect encourages communities to participate fully in the management of their own economic, social, and political development.

This is clearly expressed in Ghana's developmental framework, Vision 2020, a blue print for economic transformation to middle-income status by 2020. This framework seeks to promote an integrated approach to sustainable development and recognizes the population factor as central to the transformation process and calls for active population programmes. However, district assemblies seem to be paying more attention to the development of physical structures than to human development programmes. There is, therefore, the need to advocate for effective population and reproductive health policies and developmental programmes. In so doing, civil

society has an important role to play in the policymaking process at district levels where a good share of the nation's resources is now allocated.

Another important aspect of the development process is population. The long-term goals of Ghana's population policy are to

- Achieve a level of population growth consistent with the economic growth of the country;
- Promote sound environmental management; and
- Improve the quality of life.

The government established the National Population Council (NPC) in 1992 as the highest advisory body to government on all population and related issues. Act 485 was passed by Parliament in 1994 in support of NPC's establishment. The NPC, like other government agencies, has its own decentralization programme, which is stipulated in the revised National Population Policy (1994) as follows:

In line with government policy on decentralization, the NPC Secretariat shall work closely with the political administrative units of the country, especially the District Assemblies and various communities to design and implement population programmes and activities.

Since 1997, the NPC has decentralized its institutional framework to all 10 regions of the country. However, NPC's presence at the district level is restricted to only two districts out of 110 because of inadequate finances. Local Government Act 462 makes the districts the action centres for implementing national development policies. Since population is the kingpin of development planning, it is important that population activities do not remain at the national or regional levels, but rather move to the district and the subdistrict levels. Integration of population factors into development processes at the district level is a challenge for the NPC because the district assemblies are still young institutions with little experience in policy formulation and implementation. Thus, they may not give priority to reproductive health and population programmes.

Moreover, Ghana's efforts to address population issues primarily have been executed through government agencies. Therefore, being the government agency responsible for population, the NPC has developed plans to work in the districts through the district assemblies. Evidence of this consists of advocacy committees that have been established in five selected

districts. To complement this effort, there is an urgency to create a permanent advocacy presence of civil societies, including NGOs and community-based organizations (CBOs) in all 110 districts. Civil societies can support and monitor population programmes when changes occur in district assemblies.

“The regional level should be strengthened to effectively coordinate, monitor, and evaluate; and the district level should also be capacitated with manpower capable of local-level planning, implementation, and converting local resources into developmental phenomenon.”

—Mr. Kwamena Ahwoi, Minister of Local Government

Courage to Meet the Challenge: Advocating for Reproductive Health at the District Level

In September 1994, delegates from 180 member states of the United Nations reached an unprecedented consensus at the ICPD in Cairo. Although previous population conferences placed emphasis on the numbers of people, the ICPD represented a shift to a holistic approach of responding to the health needs of individuals—from the most personal to the highly public aspects of life. The definition of reproductive health in chapter 7 of the ICPD's *Programme of Action* clearly illustrates this point: that this holistic approach is the most appropriate way of responding to the health needs and development of people. However, the conference went further in affirming that every individual has the right to fulfil his or her human potential. It also addressed sexual health and rights. People should know their rights, how to get access to health service, and what to ask for when using the services. Reproductive health is therefore seen as a constellation of events, which involves information, education, and communication (IEC). Advocacy, policies, standards and the legal framework also play important role in promoting Reproductive health.

The ICPD addressed issues such as gender inequities, poverty, and consumption patterns that influence population growth, distribution, and structure. It also sought the promotion of appropriate policies, including population-related policies, to achieve sustainable development.

The *Programme of Action* also recognized the potential contribution of NGOs and their relevance in population and development. In fact, one of the factors that influenced the process of the ICPD was the impact of NGOs. As stated in the *Programme of Action*, “Explicitly integrating population into economic and development strategies will both speed up the pace of the achievement of population objectives and an improved quality of life of the population.”

The ultimate goal of the ICPD is the achievement of quality of life. Fulfilment of this goal will be determined by the adoption of appropriate programmes and policies by member states of which Ghana is one. People are both initiators and beneficiaries of development.

Before the ICPD, previous governments of Ghana recognized the pivotal role of population in national development. The focus, however, differed from one political period to another. During the first republic, population growth was seen as an important factor in economic development. From 1967 to 1989, there was a noticeable shift in perception of governments regarding the role of population and national development. Governments at that time realized that a high population growth rate could pose a problem to Ghana's socioeconomic development. Several important steps were therefore taken. Beginning in 1968, a manpower board was established to promote the development of human resources in the country. The 1969 population policy, with its ultimate goal of reducing the growth rate, was the outcome. This policy, entitled “Population Planning for National Progress and Prosperity,” identified the nation's population as its most valuable resource. In the introduction, the policy states, “We are now embarked on the most ambitious programme of planning and development aimed at achieving progressively advancing levels of productivity and well-being” (Ghana National Population Policy, 1969).

Ghana was one of the countries in sub-Saharan Africa to sign the world declaration on population and one of the few countries that had a population policy by 1969. This policy, although it is well-written and considered all aspects of economic life, faced problems of implementation because the policy process was not participatory, and there was no legal framework within which it could be operationalized.

In order to address this limitation, the NPC was established in 1992 and given the legal mandate for population activities through Act 485 of 1994. Through a participatory process, the NPC revised the 1969 population policy, taking into account emerging issues such as HIV/AIDS, migration, and the handicapped.

As its reproductive health policy goals, the 1994 revised National Population Policy contained the following:

1. To reduce further the high rates of infant, child, and maternal morbidity and mortality, with emphasis on maternal care, prevention, and control of communicable diseases and reduction in the incidence and prevalence of all types of nutritional disorders in order to promote reproductive and sexual health for all, including adolescents.
2. To promote safe and effective fertility management measures among individuals, couples, and communities and to regulate their reproduction on a voluntary basis.
3. To promote reproductive and sexual health for all including adolescents.

The Ministry of Health (MOH) sets the direction for delivery of health services in Ghana. Prior to ICPD, the MOH's Medium Term Health Plan was geared toward the provision of universal access to primary health services and the improvement of the quality of health services. However, the shift from family planning to reproductive health, as defined by the ICPD, supported the MOH's policy of expanding maternal and child health (MCH) to include sexual health, an integrated approach, and client-centred services in order that quality of care is tailored to meet individual needs. The MOH's basic goal, therefore, is to provide universal access to basic reproductive health services; and secondly, to improve the quality of services. Achieving these goals will improve the quality of life of the people of Ghana.

Research has also shown that in the developing world, antenatal, perinatal, and postnatal problems, including urinary tract infections and sexually transmitted infections (STIs), are responsible for two-thirds of diseases that affect women of reproductive age (15–49). Results from Ghana's Demographic and Health Survey (DHS) for both 1993 and 1998 point to the challenge facing the MOH. Infant mortality, as an indicator of health services in the country, stands at 57 per 1,000 live births (1998 DHS) and the maternal mortality rate was 214 per 100,000 (1993 DHS). Knowledge of HIV/AIDS is very high, but the use of condoms to prevent the disease is comparatively low.

Dr. Taylor, Medical Superintendent of the Koforidua Regional Hospital, provides a vivid scenario of reproductive health status in Ghana:

Too many women are dying who need not die. For every one death, 45 women suffer disability and most of these [disabilities] are preventable. One woman dies each day. It is like 450 women

crashing every four hours or like a tatta bus with 60 women crashing every hour with 50 percent chance of dying. Maternal mortality is a matter of human rights.

Although there have been slight improvements in these indicators overall, they indicate that it will be an uphill challenge if other strategies are not put in place to act as a catalyst to spur efforts to achieve programme targets as contained in the Medium Term Health Plan.

An overview of the reproductive health situation in Ghana demonstrates improvement in the policy environment. With the implementation of the National Reproductive Health Policy, a draft HIV/AIDS policy is having an effect on the HIV/AIDS situation in Ghana. Apart from its population policy, the MOH has also developed the Ghana Reproductive Health Policy, Standards, and Protocols. In addition, there is a draft Adolescent Reproductive Health Policy. However, more must be done if Ghana is to get to the middle-income level by 2020.

The ICPD also brought adolescent reproductive health needs to the fore. The *Programme of Action* called on governments and NGOs to “establish appropriate programmes to respond to those needs.” It further stated that countries, where appropriate, should remove legal, regulatory, and social barriers to reproductive health information and care for adolescents. Ghana is in the process of responding to this, having come out with a draft policy on adolescent reproductive health.

District-level Advocacy

The period from September 1, 1996 to August 31, 2000 was a period of silent revolution: the role of NGOs underwent a fundamental change. NGOs went from being mere service implementers to becoming active advocates in the policy process, engineering a bottom-up approach in decision making by encouraging community participation. The setting was the Eastern Region of Ghana with its 15 districts, five of which were to become organizational instruments for Reproductive Health Advocacy Networks under the aegis of the POLICY Project. In six days, Reproductive Health Advocacy Networks were formed in five districts, each expressing the same idea: district-level participation can and should be encouraged as an anchor during a state of flux in the political arena. Several statements below capture this sentiment.

“I have always known teenage pregnancy is a problem, but I never knew it was so serious. We [the Assembly] should do something about it.”

—Assembly member after a presentation on the reproductive health status of Suhum to the Executive Committee Members of the District Assembly by Suhum Reproductive Health Advocacy Network

“Why have you kept this information to yourself all this time? You should have shared it with us earlier so we know how to protect our people.”

—an Imam after an AIDS Impact Model (AIM) presentation to an Moslem Youth group

“Parents are poor and cannot care for their children and once the children get the knack of caring for themselves, the parents have no control over them anymore, so I call on the Assembly to organize mass programme for the parents to educate them on the girl child.”

—teacher at another seminar in Suhum/Kraboa/Coaltar

Sample of Network Advocacy Activities in the Eastern Region

1. The Akwapim South network had as a goal the reduction of the incidence of teenage pregnancy in the district. To achieve this, the network solicited the support of programmes on adolescent reproductive health to help reduce the incidence of the spread of HIV/AIDS by 2 percent within two years. In their advocacy activities, the network members had meetings with the District Chief Executive to win his support. The network invited him to their meeting where they had a presentation made on the reproductive health status of the district. The members also had a meeting with some of the imams and leaders of Sabon Zongo Community. The assemblyman of the area who participated in the meeting thanked the network and added, “There must be behavioural change.” Network members also advocated to Moslem elders by using the Ghana AIDS Impact Model (AIM) an advocacy tool to raise awareness of the devastating impacts of the disease on the population. At the end of the session, one Moslem leader said, “I thought AIDS was not real, now I know it is real.” The outcome was that the network established close collaboration with the District Director of Health Services who donated office space for the network. The network also established a close relationship with assemblymen and the District Chief Executive.
2. The Akwapim North Reproductive Health Advocacy Network advocated on the issue of adolescent reproductive health and organized focus group discussions with adults and adolescents to find out their views on the issue. The District Chief Executive himself participated in these activities. The network also made a presentation to the entire district assembly. One of the outcomes was that the District Chief Executive worked in close collaboration with the network and spoke on behalf of the network. He pledged 5 million *Cedis* to implement HIV/AIDS sensitisation campaigns.
3. The Kwaebibirem Reproductive Health Advocacy Network organized community meetings, focus group discussions to raise awareness on the effect of teenage pregnancy and build support for the network’s issue of improving adolescent reproductive health status in the district. These efforts reached over 8,300 people in 17 towns and villages in the district during the period from 1998 to 2000. In the course of its work, the network reported to the District Director of Health Services that chemical sellers were administering injections in their stores—a serious risk for HIV transmission. As a result, MOH took immediate action to clamp down on the offenders.

What Are These Reproductive Health Advocacy Networks and Who Is Involved?

Currently, six Reproductive Health Advocacy Networks are operating in five districts in the Eastern Region: New Juaben, Suhum/Kraboah/Coaltar, Akwapim South, and Akuapem North. Two other networks are in the early stages. In Kwaebibirem, the Akwatia and Kade networks cater to the peculiar economic activities of the mining and agricultural communities. They operate separately but link up for some activities. Except for Akwapim North, no networks existed in the districts before POLICY Project participation support.

The Reproductive Health Advocacy Networks are made up of NGOs, government agencies, and individuals. They are organizations with diverse interests but with similar missions of improving the quality of life and status of young people. To date (1996–2000), the networks consist of 145 NGOs and CBOs, with the latter in the majority. Numerous international organizations are involved, such as the Red Cross, YMCA, and YWCA, as well as national associations (e.g., GNAT, PPAG, GRMA, CYO, and GUNSA). Other organizations that are not focused on health are also members, such as GPRTU and trade organizations (tailors, dressmakers, hair dressers, and market traders' associations). These trade associations are particularly concerned with adolescent reproductive health issues because they have young people in their care as apprentices and employees. Such organizations make it easy for the network to reach the young through IEC and get their concerns across. They can also reach these youths with information on HIV/AIDS. In addition, the networks have members who work with or are members of their prime target group, the district assemblies.

The networks are endowed with rich human resources, which allow them to respond quickly and effectively to various situations. This phenomenon was demonstrated in the case of New Juaben: when the network conducted its baseline survey and needed someone with statistical background to analyse the data, a demographer and two statisticians who are members of the network were ready to use their expertise in the analysis and writing of the report. Another New Juaben member is a journalist and has helped the network access the media and increase press coverage of activities.

How Do the Networks Function?

The networks have a very simple and flexible structure. They are nonbureaucratic and have operating procedures that encourage meeting on a regular basis. They also have communication plans that share population activities with other members. Members are encouraged to participate whenever possible. Almost all the networks developed mission statements, identified policy issues, and formulated strategies and action plans during their first advocacy workshop.

The structure of the networks is simple and flexible. They have only two standing bodies—the Executive Committee and function subcommittees. Working groups are formed on an ad hoc basis.

- The Executive Committee is composed of a chairman/coordinator, a secretary, a financial secretary (not in all networks), and a treasurer. Committee members are elected by the general membership to function as the decision-making body of the network.
- Subcommittees address specific functional issues. The number and focus of subcommittees vary among the networks and may include IEC; research; planning; data gathering; and/or monitoring and evaluation. One network has zonal representatives who provide a linkage between the network and community leaders.

Leadership is elected and coordinates the work of the network and convenes network meetings. The networks are based on democratic principles and group consensus. Lively debate and persuasions are encouraged. According to one member, “Minority views are respected.”

Scope of Activities

Network activities were all directed towards the different stages of advocacy campaigns, finally reaching the decision makers in the district assemblies and the communities (e.g., religious leaders, traditional leaders, teachers, parents, and youth leaders).

Data collection is the one of the first activities in an advocacy campaign, and all the networks undertook this step to help in deciding their policy issue, their aim, and objectives. Data were collected from the MOH, health services directors, from doctors in hospitals, and from the district health management teams. Three district networks conducted baseline surveys in their respective districts. Although demanding a lot of time, it proved to be an effective advocacy tool. The data collected helped the networks bring the message home to their communities; as advocates, they were convinced of the issue’s relevance, thus enabling them to use data gathered within their own locality and not nationally. As Professor John Nabila of Population Impact Project (PIP) said, “We used data specific to the district so the audience could better relate to the data. It becomes a strong advocacy tool.” Armed with the data, they could speak convincingly to identified groups, especially the district assemblies. They also had outreach programmes to reach the remotest of areas.

Building a constituency. The network needed the community’s support in their advocacy campaign; therefore, they planned and executed group discussions with various identified groups in the community. They had awareness-raising encounters with the communities that were being served. They met the teachers, church and Moslem leaders, chiefs and elders, women’s groups, artisans, traders, youth groups, and finally the district assemblies. The baseline surveys and data collected helped them decide what issues to address, with the data to back the topics addressed (mainly teenage pregnancy and HIV/AIDS). The networks formulated questions to help them get the groups talking about reproductive health, what they could do to solve the problem, and who could help (see Appendix III for list of questions).

Lobbying. Network leaders also lobbied key individuals in the district assemblies. The District Chief Executive (DCE) was never left out of inaugural meetings. He was always briefed about the network before the inaugural meeting and then invited to open it. There were frequent

visits to the assembly to inform the DCE of any important activity. In almost all the networks, there were members who were either assemblymen or worked for the district assembly. They were the link between the assemblies and networks.

Message development and delivery. The networks collected enough information about issues through the surveys, data collection, and focus-group discussions they carried out. The next step was to tailor messages for various audiences. Because they needed the skills to do this, a workshop was organized in message and material development. They developed fact sheets and looked for appropriate materials developed by others (e.g., the MOH, Johns Hopkins) to support their messages. They learned how to give effective presentations and made presentations to district assemblies on topics such as teenage pregnancy and HIV/AIDS. The AIM was used with district-specific data for the HIV/AIDS presentations. Fact sheets were also distributed to members of the assemblies. Members supported the work of the networks in educating people about AIDS. At the Akwapim North District Assembly, one member believed that it was the sustained education that had brought the down the prevalence rate in the Greater Accra Region, and therefore said, “The assembly should support the network as well as the FM stations to spread the education on HIV/AIDS to reach everybody.”

The Parliament member for the area also appealed to the DCE to “Use [his] position as chairman of the DCEs Association to mobilize colleagues to spread the message.”

On AIDS day, the networks were asked to participate in activities of the *Day One to One Education*. As the community got to know some of the members of the network, they came to them for further information on AIDS. The flipchart model produced by POLICY for the use of the network became useful in small group discussion events conducted in various communities and in small work places (e.g., at the barber shop).

Advocacy presentation to the chiefs and elders. Those series of seminars and presentations often followed a given sequence. After presentations to the district assembly, chiefs would invite the networks to address their communities. The Kwaebibirem District had a good record of such invitations, which took them to all corners of the district. As one chief heard of the happenings in the neighbouring community, he would also invite the network to his community. The networks seized any opportunity to get their messages across (i.e., at *durbars* and even at the anniversary celebrations of some of their own member organizations).

Youth. Some heads of schools also invited the network to address the students on teenage pregnancy and HIV/AIDS. The networks also organized awareness seminars for the out-of-school youth. New Juaben District went further and developed a comic on teenage pregnancy for youth. Such seminars helped the network to get information on what youth think about the issues discussed.

Fundraising. The networks had to raise funds for their activities. They wrote proposals and applied for POLICY minigrants for their activities. They appealed to members in the community for help. They received some small amounts of money as well as services in kind (e.g., use of equipment, vehicle, and communication expenses). Although some district assemblies promised monetary support, the networks are yet to receive it.

Linkages with district assemblies and RPACs. The networks did not work in isolation but rather had linkages with some institutions. The NPC is the main partner to POLICY, but the Regional Population Officer in Koforidua played a key role in the networks: he worked closely with them and gave them his expertise in their surveys and advocacy presentation to the district assemblies. The networks in turn helped the NPC to achieve its aim of reaching the district with population activities.

The networks also worked closely with the MCH section of the MOH and the District Director of Health Services. Personnel from the MOH often served on some of the committees and were also resource persons on a team of presenters. They also obtained some of their visual aids from the ministry. The ministry also saw them as partners and encouraged them in their advocacy work. The networks had access to district data as they complemented each other in their work.

Partnership with PIP existed not only because they shared common objectives of informing policymakers on key reproductive health issues, but also because they worked closely with the networks in providing district-specific data that benefited both partners. They also trained network members in conducting surveys.

District Education Offices also collaborated with the networks in allowing time for the networks to speak to the students on teenage pregnancy and HIV/AIDS. One laudable example worth mentioning is the special partnership that developed between the Akwatia Network and the Primary Care Unit of the St. Dominic Catholic Hospital. The unit provided the network with a cinema van and one staff member to travel to all corners of the district with the message to help reduce HIV/AIDS/STIs.

Such partnerships were invaluable. The NPC Executive Director said at the close of a capacity-building workshop, “Let us increase our collaboration in this direction, all of us—NPC, PIP, POLICY, UNFPA, and all other key partners—we should work together.”

Initiating the Participation Programme in Ghana

Participation activities in Ghana began in 1995 with the visit to Ghana of POLICY Project staff to participate in the annual GHANAPA Project cooperating agencies meeting. At that time, POLICY staff held preliminary discussions with local NGOs, CEDPA partners, the NPC, and USAID officials about the Participation component of the project. As a result of the discussions, a three-person POLICY team returned to Ghana in April 1996 to assess the environment for population issues, especially in FP/RH. The visit was to

- Determine the level of support for and interest in the Participation component of the project; and
- Identify appropriate activities for NGO involvement to support NPC's decentralization efforts.

The POLICY Project strives to create a supportive environment for family planning and reproductive health (FP/RH) programmes through the promotion of a participatory policy process and population policies that respond to client needs.

Participation is one of the four elements of the POLICY Project. It is defined as the process by which stakeholders at all levels are empowered to shape the formulation and implementation of public policy.

Thus, Participation does three major things:

- It helps to develop and implement RH/FP policies that are responsive and accountable to beneficiaries.
- It bridges the gap between policymakers and grassroots needs.
- It broadens the focus of population issues to include reproductive health, gender, and women's status.

Based on the findings and recommendations of the Participation assessment, the POLICY Project decided to work in partnership with the NPC to implement district- and the subdistrict-level advocacy on population issues through NGOs. This was to occur in one region in order to develop a process for promoting community involvement in population activities at the regional, district, and subdistrict levels that could serve as a model for other regions. The pilot regional, district, and subdistrict planning and advocacy activities were therefore designed to achieve the following three long-term objectives:

1. Ensure greater representation of population and FP/RH programmes in district development planning;
2. Increase the level of funding allocated for population and FP/RH activities in the pilot districts; and
3. Promote full community participation in these activities.

In support of these objectives, the POLICY Project developed the following two related short-term objectives:

1. Assist in developing a regional, district, and subdistrict-level Reproductive Health Advocacy Network in the pilot area; and

2. Inform local decision makers about the reproductive health concerns and needs of the local communities.

POLICY's first assignment was to appoint a Participation Coordinator to be responsible for coordinating and monitoring all participation activities in Ghana. Specific responsibilities included

- Selecting a pilot region using criteria given;
- Assisting in the formation of FP/RH networks;
- Designing and conducting advocacy training;
- Providing technical assistance and facilitating issues identification and advocacy meetings at the district and community levels;
- Assisting the Regional Population Officer in identifying areas for collaboration with NGOs; and
- Documenting participation/advocacy activities, lessons learned, and recommendations for improvement.

The Participation Coordinator first contacted the NPC to discuss how she could work with the organisation at the regional level. She also visited the offices of international organizations, such as UNFPA, UNDP, UNESCO, UNICEF, and the national NGOs, to brief them on the project and find out their interest in population issues and the types of programme activities they were engaged in. Other institutions visited were the ministries of Health and Local Government, the ministries of Youth and Sports and Education, the National Council on Women and Development (NCWD), and some religious institutions, such as the Christian Council (CCG), the Catholic Secretariat, and the Muslim Family Counseling Services (MFCS). The Participation Coordinator also called on directors of programmes, such as the Population Impact Project (PIP) and Family and Development Programme in Ghana (FADEP).

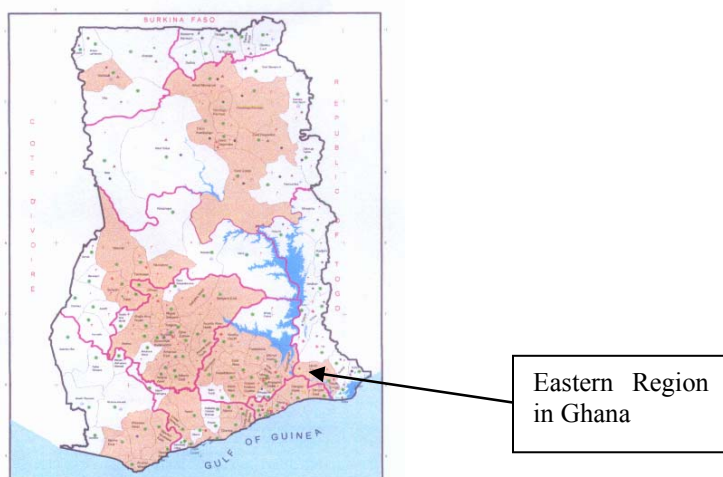
Selecting the Pilot Region

The first activity was to select the pilot region. The criteria for selecting the pilot region were based on the following indicators:

- Presence of NPC, its interest, and support;
- Presence of NGOs; and
- Proximity to Accra.

Three regions near to Accra were selected: the Central Region, Eastern Region, and Volta Region. In assessing the number of NGOs in each region, the Participation Coordinator designed a form for 15 national NGOs to indicate the number of projects and programmes, including offices they have in the three regions. The analysis showed that the Central Region had the greatest number of projects/programmes, followed by the Eastern Region. However, at that time the Central Region did not have an NPC office, whereas the Eastern Region did. The regional

capital, Koforidua, was nearer to Accra than Cape Coast in the Central Region. Thus, the Eastern Region was chosen as the pilot region.



Target audiences were the decision makers, such as members of Parliament, the DCE, assemblymen, influential people (religious leaders, chiefs, and directors of departments), NGOs, and CBOs. The coordinator visited the region in September 1996, going to the Regional Population Office and meeting the Population Officer who showed an interest in the project. The coordinator's first call was to the Regional Minister to brief her on the project. She made other similar calls to heads of government agencies and ministries, such as the Regional Director of Health Services, Ghana Education Services, Community Development, and the NCWD. Their support was also solicited. At the region's Economic Development and Planning Office, the Participation Coordinator checked whether one could get access to the development plans of the districts in the region so that she could study the district health development plans. During subsequent visits, she called on the chairman of the Local Council of Churches. There was good rapport with all the people the coordinator met.

Advocates. NGOs are known to be potential advocates because they know the problems in the communities; however, more often than not their first action is to try to find solutions to the problems rather than to advocate to change or amend policies that will bring about a lasting solution. Thus, the Participation Coordinator followed up on the contact names that she received at the National Headquarters of NGOs in Accra. These people were slated to become the implementers of advocacy activities. She visited 10 organizations and collected names of local organizations that might be interested in the project. The main NGO the coordinator worked with was the Planned Parenthood Association of Ghana (PPAG), one of the oldest family planning organizations. The MCH section of the MOH was the first sector agency to collaborate with the project. The Participation Coordinator began working with representatives from the MCH, the Regional Officer of Planned Parenthood, and the Population Officer to plan a one-day inaugural meeting of stakeholders.

Inaugural Meeting with Stakeholders

The organization of an inaugural meeting of all stakeholders became a necessary step after sensitisation of decision makers, NGOs, and CBOs, and other advocates in the participation process. The purpose of the meeting was to introduce the POLICY Project and its proposed activities for creating a supportive environment for FP/RH through a participatory process, a process that would enable all stakeholders to have the right to be heard in policy formulation and decision making

The meeting was designed to

- Explain how the POLICY Project fits into the strategic framework of USAID;
- Explain what the Participation component of the project seeks to do;
- Explain the functions of the NPC;
- Identify potential areas of collaboration among government agencies and the community leaders;
- Solicit input from stakeholders on reproductive health issues, what needs to be done, who is doing it, and who else could help to address these issues; and
- Discuss networking and the guidelines for such a network.

The official opening brought together decision makers, religious leaders, traditional chiefs and elders, and NGOs, paving a way for closer collaboration. A total of 40 participants representing 16 NGOs, 10 government agencies, and four community leaders were present at that meeting.

To better understand reproductive health, participants were given handouts on the ICPD reproductive health commitments to reproductive health and rights. Other handouts were on participation and the definition of network. Those handouts were provided to facilitate the group discussions. The meeting also allowed participants to discuss FP/RH issues from within their own region. They also discussed contributory factors, how those concerns were being addressed, and what NGOs could do to help. Participants moved further to identify areas of collaboration that, in turn, led them to look at the advantages of networking and the formation of networks.

The meeting was very participatory. At the end of the day, the decision to form a network was made. Participants also realized that they had no data to support the issues raised and that there was need to form a small working group to follow up on the meeting.

The coordinator facilitated subsequent meetings. The outcome was the establishment of the New Juaben and Suhum/Kraboah/Coaltar networks. Each network chose its own coordinator, drew up operating procedures, and decided on their times of meetings. However, both networks agreed to conduct a baseline survey in their respective districts. They planned to make population issues visible to the people in their communities in order that they could build support from their communities to lobby policymakers as well as to support population issues. The networks were well endowed with people with the appropriate skills to write a proposal for a

small grant and to survey questionnaires. The entire membership was involved in administering the questionnaires, and a small group was given the task to analyse the data and write a report.

Community Interactions to Build Support

The network had interaction with identifiable groups in the community. They organized group discussions with Moslem leaders, church groups, women, youth (both in school and out of school), professional groups, and artisan groups. They met some traditional leaders and organized a symposium for the general public. Apart from building support for the networks, group interactions also informed the community about reproductive health issues. This facilitated the networks to access qualitative data during the baseline survey.

The six networks can be classified into three categories.

1. *Catalysts*. The first two networks acted as catalysts to bring together NGOs to discuss reproductive health as it affected their region. Cosmos Ohene Adjei, the Network Coordinator for New Juaben Reproductive Health Advocacy Network, commented,

We discussed as a group how to form a network to advance the objectives of the POLICY Project. We thought it was a good idea, a workable idea. Population and health issues are relegated to the background, and you need a group voice to get policymakers to understand the link between population and development.

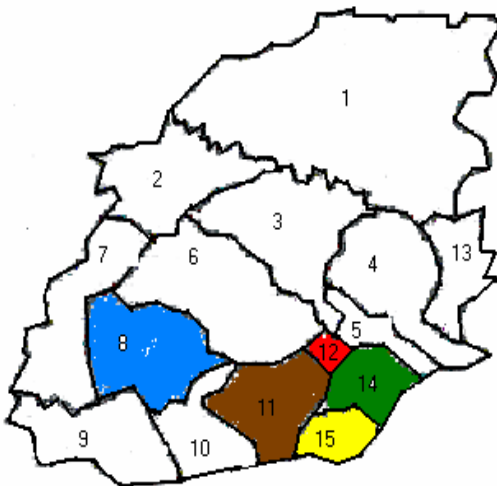
2. *Expansion—Applying Lessons Learned from the First Networks*. In 1998, the POLICY Project sponsored an inaugural meeting in the Kwaebibirem District in order to attempt to replicate the success of the first two districts. Kwaebibirem is a newly created district; it is underdeveloped yet has natural resources, including diamonds. According to its five-year development plan, one of the reasons for its underdevelopment is “her inability to plan and implement programmes and projects with adequate involvement of the local people.” What a challenge for a network to help local people get involved in their own development. This opportunity was not missed by the Kwaebibirem Reproductive Health Advocacy Network. In August, the Participation Coordinator inaugurated another network in Akwapim South. The previous network members were instrumental in the choice of this district because they were aware of similar adolescent problems there. They gave names of people to contact. There was significant government interest.

Lessons learned from the first inaugural meeting made the Participation Coordinator include a doctor among the speakers at the official opening of the inaugural meetings to explain reproductive health and also provide the overview of reproductive health in the respective districts. PIP gave a presentation on reproductive health using local statistics obtained from the MOH. The POLICY Project introduced gender perspective to teenage pregnancy, and the programme was well accepted by the members of the networks.

After the inaugural meeting at Kwaebibirem, the network decided to divide into subdistricts, namely Akwatia Reproductive Health Advocacy Network for the mining area and Kade Reproductive Health Advocacy Network for commercial and farming areas. The separation

became necessary because of their peculiar challenges. Thus, the Akwatia Network had HIV/AIDS as its priority issue, while the Kade Network had teenage pregnancy as its priority issue. Thus, three new networks emerged in 1998. It took a relatively shorter time for the three networks to get their messages to their respective district assemblies. They also adopted strategies that got them to communities that were further afield within a reasonable time.

3. *Unanticipated—An Approach from ANNGONET.* ANNGONET is a network made up of NGOs and CBOs in the Akwapim North District that have agreed to work together to promote development in the district. Membership is compulsory for all NGOs, but voluntary for CBOs. ANNGONET, unlike the other networks, was formed without any assistance from POLICY. A member had heard of the activities of networks formed by POLICY and wanted technical assistance in building the capacity of its members so that they could also advocate for reproductive health issues in their district. The POLICY Project, therefore, extended invitations to four members of ANNGONET to attend the next scheduled training that was organized for the other networks on reproductive health, in order that they could interact and share experiences with members of other networks. They were so impressed that they requested an advocacy workshop for their own network, which was granted in June 1999. At that workshop, they chose HIV/AIDS as their issue and developed a goal and objectives as well as a strategy for their advocacy campaign. They never stopped educating their communities about HIV/AIDS. It did not take them long to get their message to the district assembly to solicit its help. One could say that the later networks benefited from the experience of the first two and managed to reach the decision makers quicker than the others.



MAP OF EASTERN REGION SHOWING DISTRICTS WITH RH NETWORKS

REFERENCE

1. AFRAM PLAINS DIST.
2. KWAHU SOUTH DIST.
3. FANTEAKWA DIST.
4. MANYA KROBO DIST.
5. YILO KROBO DIST.
6. EAST AKIM DIST.
7. BIRIM NORTH DIST.
8. KWAEBIBIREM DIST.
9. BIRIM SOUTH DIST.
10. WEST AKIM DIST.
11. SUHUM/KRABOA COALTAR DIST.
12. NEW JUABEN DIST.
13. ASUOGYAMAN DIST.
14. AKWAPIM NORTH DIST
15. AKWAPIM SOUTH DIST.

Building Capacity within the Reproductive Health Advocacy Networks

A workshop on advocacy was organized in order that its members would acquire appropriate skills to become effective advocates for FP/RH and population issues. The first workshop was on reproductive health advocacy skills. The workshop was hands-on training. Results of their baseline survey were used to determine their advocacy goal and objectives at the workshop. They developed their advocacy strategy. At the end of the workshop, each network had a draft of their advocacy strategy that they were to finalize with the rest of the members. By the end of the workshop, there was a need for a reproductive health workshop in order that members of the network would gain sound knowledge and information not only of reproductive health in general, but also specifically of the Ghana population situation.

Technical assistance given to the networks was in the area of capacity building to help them advocate for population related issues in their districts. They have been given skills through workshops on advocacy, reproductive health, and gender; basic skills in conducting baseline surveys; use advocacy tools such as the AIM; and other IEC tools.

Lessons Learned

The networks have committed serious time and effort into preparing their advocacy events. With each encounter with community members, officials, politicians, or the media, network members have proven extremely knowledgeable about issues and, more importantly, have supported their messages with local, accurate, and up-to-date data. Throughout their evolution, the networks have learned important lessons that have implications for their further development and future work.

- *Establishing a good relationship with district assemblies has helped the networks convey their messages.* Over the course of numerous advocacy activities and presentations, the networks have established a reputation among local leaders for providing objective and accurate data and analyses. Several of the groups have become indispensable to local policymakers and established partnerships at the policymaking level.
- *Accumulated experience of the six networks has revealed the importance of understanding the specific nuances of the decision-making structure within the district assemblies.* They have discovered that the finance committee wields considerable power because it submits budgets and plans to the general district assembly for approval and is often responsible for pushing certain legislation through the process. Additionally, most assembly members do not have training in planning and budgets and look to the finance committee for guidance. The DCE is also in a position to influence the district assembly.
- *It is necessary to distinguish between IEC and policy advocacy.* IEC activities play a crucial role in advocacy campaigns by generating grassroots commitment to policy change and by building a large and well-informed popular base of support. However, some members see the work of the networks primarily as a tool for community education and view IEC as an

end in itself. While some confusion and tension still exists, most of the network members acknowledge the differences and recognize the role of IEC in promoting policy change.

- *It is important to clarify network members' roles as advocates.* The networks and district assemblies are both relatively new institutions that are still defining their own internal priorities, processes, and policies within the context of decentralization. Frequently, tensions arise within the networks because many members come from implementing organizations that have approached their district assemblies for funds for program implementation. When the same network members address the assembly as network advocates, it causes confusion. The networks' main function is to advocate for policy change, not to implement programs, and members must be clear in what capacity they are acting when they meet with district assemblies.
- *Sharing the expertise and knowledge between well-established and more recently formed networks has hastened the latter's success.* The first phase of network building was a learning process for everyone involved—the network members and POLICY, most certainly, as well as for USAID/Accra, the NPC, and the district assemblies. The subsequent four networks enjoyed a jumpstart and avoided many pitfalls because of the lessons learned from the first two networks. The challenge to the Eastern Region FP/RH advocacy networks is to turn these lessons into tangible results, surpassing the difficult hurdles posed by financial constraints, changing policymakers, and competing priorities.

The Way Forward

Participatory strategies that mobilized members of the communities at the district and subdistrict levels to become advocacy champions and part of the decision-making process should be encouraged to strengthen civil society to have an impact on decisions and policies that affect their lives. The Reproductive Health Advocacy Networks proved that their activities increased awareness of reproductive health issues in the communities. Their activities also increased communities' interest in the work of the district assemblies—small beginnings of ensuring democratic governance.

The networks' activities brought to the fore population programmes at the district level, and therefore promoted the NPC' objective of decentralizing population activities. Replication or adaptation of these networks is not only necessary, but essential for decentralizing population activities at the district, subdistrict, and community levels.

The Participation Programme has certainly shown the way of galvanizing the strengths and energies of civil societies and NGOs in working together as reproductive health advocacy champions at the district and subdistrict levels, and in influencing district-level decision making in population activities, including reproductive health and HIV/AIDS.

The urgent need to expand and adapt the Eastern Region experience cannot be overemphasized. Future generations will judge us on the adequacy of our response.

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Appendix I

Workshops Organized for Networks by the Participation Programme from 1996–2000

Workshop	Coverage	Policymakers Involved & Facilitators	Venue & Date	# Participants
RH Advocacy Workshop for Multisectoral Networks	ICPD <i>Programme of Action</i> ; RH advocacy techniques; hands-on advocacy plans	Regional Minister, Ms. Patience Adow; Municipal Chief Executive, Mr. Adu Boateng; Mrs. Sue Richiede, Kate Parkes	Hotel Eredec Feb 25-March 1997	44
PowerPoint presentation of survey results	PowerPoint presentation of survey results from the Suhum/Krabo/Coaltar & New Juaben networks on analysis of baseline survey	Mrs. Esther Apewokin and Mr. Amartey, both directors from NPC; UNICEF; WHO; Save the Children Fund; CHRISTIAN Council of Churches; Ed Abel, Country Manager, TFGI	Nov. 7, 1997	41
RH Workshop for Advocacy Networks	Overview of RH programmes in Ghana; ICPD <i>Programme of Action</i> ; rationale of FP; overview of HIV/AIDS in Ghana; adolescent sexuality in Ghana; adolescent reproductive health policy; policy process in health and existing policies that affect RH; decentralization & how it works	Dr. Taylor (MOH), Dr. S. B. Ofori. MOH, NACP; Municipal Chief Executive representing the Regional Minister, Ms. Patience Adow; Dr. V. Ankrah MOH; Mr. Kwame Ampomah & Kofi Abinah, Regional Population Officer, NPC; Dr. Benedicta Ababio, POLICY; Mrs. Susan Sagoe, GSMF; Mr. Emmanuel Nuworzoh, PPAG; Mr. K. Ohemeng Agyei, Planning Officer, Akwapim North District Assembly	Hotel Eredec May 24-28, May 31-June 4 1998.	44
RH Advocacy Skills Workshop for Akwapim South and Kwaebibirem advocacy networks	Advocacy steps; policy audience; effective communication; development of message; policy analysis; budget; application for mini-grant; ICPD & RH; monitoring & evaluation; hands-on advocacy plans for networks	DCEs of Akwapim South & Kwaebibirem; Dr. Tinkorang, District Director of Health Services; Dr. Benedicta Ababio, Danielle Grant, and Kate Parkes	Catholic Conference Centre, Nsawam Sept 27-October 1998	28
Community Mobilization, Gender, and IEC Workshop	Community mobilization; gender; IEC	Kofi Wellington Esther Offei-Aboagye Kate Parkes	Hotel Eredec June 16-20	48

Regional capacity building for Ashanti/ Brong Ahafo	Policy Analysis Advocacy Social Marketing; overview of RH in Ghana SPECTRUM	Dr. Turkson, Executive Director, NPC; DCE of Sogakope; District Director of Health Services; Mr. Amartey, Director of Field Operations, NPC; Mr. Cann, Minister of Local Government, Prof. Nabila, PIP; David Logan, Dr. Ababio, and Kate Parkes, POLICY	Hotel Ciscenero, Sogakope June 20-26 1998	24
Also for Western and Volta Regions	Same as above	Same as above	1999	24
RH Advocacy Skills Workshop for Akwapim North & Krobo District	ICPD & RH Policy Process Advocacy Steps Networking Audience Analysis Message Development Monitoring & Evaluation	Mr. Anthony Bampoe, DCE; Mrs. Gifty Alema-Mensah, CEDPA; Mr. Ohemeng Agyei, District Planning Officer; David Logan, Dr. Ababio, and Kate Parkes	Akrofi Christaller Memorial Centre (ACMC)	35
Training of Trainers (TOT) on Networking & Advocacy for RPACT and RH Advocacy Networks in the Eastern Region	TOT skills; evaluation Use of Advocacy Manual Networking for Impact Assessing the Policy Environment Data Collection Designing Training Sessions Hands-on conducting training	Regional Population Officer, Mr. Kofi Abinah; Mr. David Logan; Dr. Benedicta Ababio; Kate Parkes	Abetifi Ramseyer Centre October 24-29, 1999	28
One-day meeting of Advocacy Team	Design Agenda for New Districts using Manual	Participants of TOT workshop	November 2, 1999	
Three series of workshops: Capacity Building for Advocacy and HIV/AIDS for Six Networks	AIM			60
Strategic workshop for sustainability	Project Proposal & Impact Assessment; Effective Communication; Structure/Functions of D/A and Role of Civil Society; Social Mobilization; Consensus Building; Conflict Resolution; Leadership in Management; Fund Raising; Advocacy Strategy; Participatory Technique	Mr. Quarshie, Ministry of Local Government; DCE Akwapim North; Rev. Ayeh Hanson, Chairman of Presbyterian Council		30

Appendix II

Glossary

AIM	AIDS Impact Model
ARH	Adolescent Reproductive Health
CBO	Community-based Organization
CCG	Christian Council of Ghana
CEDPA	Centre for Development and Population Activities
CYO	Catholic Youth Organization
DCE	District Chief Executive
DHS	Demographic Health Survey
FADEP	Family and Development Programme in Ghana
FP	Family Planning
GHANAPA	Ghana Population AIDS Programme
GNAT	Ghana National Association of Teachers
GPRTU	Ghana Private Road Transport Union
GRMA	Ghana Registered Midwives Association
GUNSA	Ghana United Nation Students Association
ICPD	International Conference on Population and Development
IEC	Information Education and Communication
MCH	Maternal Child Health
MFCS	Moslem Family Counseling Services
MOH	Ministry of Health
NCWD	National Council on Women and Development
NGO	Nongovernmental Organization
NPC	National Population Council
PIP	Population Impact Project
PPAG	Planned Parenthood Association of Ghana
RH	Reproductive Health
RPAC	Regional Population Advisory Committee
RPAT	Regional Population Advisory Team
STI	Sexual Transmission Infection
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific & Cultural Organization
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children's Fund
USAID	U.S. Agency for International Development
YMCA	Young Men's Christian Association
YWCA	Young Women's Christian Association

Appendix III

Questions to Aid Group Discussion on Reproductive Health

What, in your opinion, are the problems relating to family planning, childbearing, teenage pregnancy, abortion, and STIs/HIV/AIDS?

What are the causes of these problems?

What do you think about contraceptives? Have you ever used any before?

How was contraception done in the past?

What traditions/customs teach us about the above issues?

Must girls go to school? Give reasons.

What custom related to reproductive health is outmoded?

What skills do parents need to cope with problems of adolescents?

What information on reproductive health do you think appropriate for adolescents?

What age must this information be provided?

Which people in the community can help solve some of these problems?

Which institutions in the community can help solve some of these problems?

Which suggestions would you like to give to your district assembly with respect to any of the problems (e.g., teenage pregnancy)?