



# **ORGANISATIONAL LEADERSHIP AND QUALITY OF CARE OF NIGERIA'S HIV/AIDS' RESPONSE**

***By***

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March, 2007

### **Declaration**

I declare that this dissertation is an output of my research effort. In carrying out this research, concerted efforts were made to acknowledge all sources of data and information used in the references and bibliography. However, in case of inadvertent omissions and/or incomplete referencing, I nevertheless still express the acknowledgement of such sources. I accept full responsibilities for any shortcomings and errors of judgment, logic or fact of this study.

Godwin Etim Asuquo

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Signed

### **Approval /Certification**

This is to certify that this dissertation entitled: “Organizational Leadership and Quality of Care of Nigeria’s HIV/AIDS Response” was carried out under my supervision and guidance. The dissertation has also been approved for submission to St. Clements University for the award of the Degree of Doctor of Philosophy (PhD) in Health Policy and Management.

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### **Dedication**

This research work is dedicated to my children, Abasifreke and Inimfon. They have been a great source of inspiration and support.

### **Acknowledgements**

I owe immense gratitude to the Almighty God for the knowledge, wisdom and foresight and for the strength bestowed on me to carry out this demanding project at this auspicious time in the history of the national HIV/AIDS' response in Nigeria. I am grateful to my colleagues and the leadership of the POLICY Project/Nigeria, ENHANSE Project/Nigeria, United States Agency for International Development (USAID) and the United Nations System in Nigeria for availing me with various intellectual and material support that made this assignment possible. Specifically, I acknowledge the contributions of Dr. Jerome Mafeni, Chief of Party ENHANSE Project/Nigeria; Dr. Wole Fajimisin, Dr. Dairo, Dr. Benedicta Ogusiobo, Ms. Ogoh, Emem Obong Uko and others too numerous to list here.

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**Godwin Etim Asuquo**

### **Abstract**

## **Organizational Leadership and Quality of Care of Nigeria's HIV/AIDS Response Program**

To address the challenges posed by the HIV/AIDS epidemic in Nigeria and curb its spread, the Federal Government of Nigeria in 2002 commenced a national treatment program as part of a comprehensive response to the epidemic. Treatment centers were designated in 25 tertiary health institutions across the country. After two years of the national intervention, there were persistent complaints about the poor performance of these centers which had become characterized by stock outs; long waiting times for services, inadequate monitoring and adjunct laboratory services and various management bottlenecks. Poor leadership was often cited as a major impediment.

It was against this background that this study was carried out to assess the relationship between organizational leadership and the quality of services provided by the national treatment program. The purpose of the study was to provide necessary data that will assist in addressing leadership and program management issues for the program to succeed. One hundred and thirty-three health care workers (doctors, nurses, social workers, pharmacists and program managers) working in health institutions providing care and treatment to HIV/AIDS patients and 88 patients were enrolled in the study. All respondents (aged 20 years and above) were drawn from 8 public and 7 private health institutions in the FCT and were all actively involved in the national HIV/AIDS program either as health staff or patients. Three hypotheses were tested at 0.05 degree of freedom: to determine the association between management style preference and quality of care; leadership style preference and quality of care in public and private facilities and whether lack of modern leadership style was an impediment to program performance. Data was collected using a questionnaire and 2 focus group discussions, the Chi Square was used for data analysis and facilitated by the SPSS computer package.

The major findings from the study were that there was a relationship between the leadership orientation of program managers and the quality of care for services provided in their institutions i.e. the quality of HIV/AIDS services depended on the leadership orientation of program managers and that lack of modern leadership skills was a major impediment in providing high quality services.

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## **Organisation of Chapters**

This research report is divided into six main chapters as follows:

Chapter one deals mainly with the general introduction, problem statement, objectives, significance of study as well as the scope of the study. Chapter two focuses on the review of related literature with emphasis on the concept of leadership, leadership orientation of Nigeria's HIV/AIDS program, leadership in HIV/AIDS program management in Africa, global perspectives and impediment to effective realization of national and global targets.

Chapter three discusses the methodology where the chi-square and multiple perspective analysis will be employed in order to permit for in-depth investigation into the program leadership and the quality of care of Nigeria's HIV/AIDS program. Methods of data collection will be clearly described here. Chapter four deals with the presentation and analysis of the data and Chapter five provides the opportunity to discuss the results and the extent to which they conform to existing knowledge and views. In the final chapter (i.e chapter six); a summary of the whole study and its conclusions and recommendations for improving leadership efficiency in HIV/AIDS service delivery in Nigeria will be presented.

## **CHAPTER ONE**

### **INTRODUCTION**



### 1.7 **Statement of General Problem**

HIV and AIDS plans in Nigeria have evolved from the short-term plans of the 1980s, through the Medium Term Plans (MTPs) 1993 – 1997, which were health sector-led responses, to the multisectoral HIV and AIDS Emergency Action Plan (HEAP) of 2001- 2004. The HIV and AIDS programme has however remained largely donor-driven and highly fragmented, with uneven distribution of resources and programmes (National Action Committee on AIDS, 2005). Although external resources have increased significantly in the past three years, there remain many states with little or no financial support in the country. The 774 Local Government Areas (LGAs) administrate the community level response in Nigeria. Both capacity and resources at this level are extremely limited with HIV prevalence in rural areas nearly equal to the urban areas, the LGA health systems and the communities they support will be seriously challenged as the epidemic advances. So far, the extended family is carrying the main burden of care and support.

The capacity of the health system to meet the additional demands for services generated by the HIV epidemic has been undermined by years of neglect and inadequate funding of the sector. The poor working environments and lack of investment in human resources have resulted in a demoralized workforce and poor health practices. The majority of the consumers therefore use the private sector, both formal and non-formal, for their health care needs. These providers are unregulated and they do not use the national health information system, so their contributions are unknown. Private sector providers are nevertheless vital partners to the public sector in expanding access to health care (National Action Committee on AIDS, 2005).

The National Action Committee on HIV/AIDS formed by President Obasanjo to design an HIV/AIDS control plan is still plagued with uncoordinated effort and poorly defined strategy. Hargreaves, (2002) indicated that after considerable years of heel-dragging by the Nigerian government, there is now a strategy that outlines how the country will move forward on the issue of HIV by forming

the National Action Committee on HIV/AIDS (NACA). The committee receives widespread political and financial support but their strategy is yet to be fully implemented in a coordinated fashion.

There are fears that the national HIV/AIDS program might go the way of past health programs of the government which were largely unsuccessful considering the usual all too familiar systemic and operational challenges. For a country blessed with an enormous amount of revenue from the oil industry, mismanagement and corruption at all levels of government, federal, state and local government, has affected the provision of adequate public services. The neglect of public health services is evident in the health care system with poor health facilities, inadequate health personnel, inadequate drug supply and poor government funding. Thus the questions are: What is the current status of implementing HIV/AIDS services in Nigeria? What level of service quality is being attained? What are the leadership competencies of HIV/AIDS program managers? What are the leadership issues and problems affecting the implementation of the program in Nigeria? What are the processes and techniques being adopted in both the public and private sector institutions to strengthen the management of HIV/AIDS program in the country? These and other related questions structure the argument of this study.

## **1.8 Background**

In the past decade, great strides have been made in the prevention, diagnosis, and treatment of HIV/AIDS. The HIV and AIDS pandemic over twenty years on, has claimed 20 million lives globally. An estimated 38 million people are living with HIV and AIDS; 25 million of these are in sub-Saharan Africa, of whom 57% are women (UNAIDS Global Report, 2004). Nigeria faces the formidable task of tackling a widespread epidemic which has already claimed an estimated two million lives and left approximately two million orphans in its wake. A growing number of Nigerians (estimated by the National Population Report at between 2.4 -5.4 million are people living with HIV or AIDS

(PLWHA); nearly all Nigerians are affected and having to face the many physical, social, financial and emotional problems that result.

In the year 2001, the government of the Federal Republic of Nigeria flagged off a National treatment program for PLWHAs in Nigeria with a target of providing antiretroviral drugs for 10,000 adults and 5000 children annually. Treatment centres were established in 25 health care facilities across the country. In addition, 11 tertiary health institutions were designated as treatment centres for the Prevention of Mother to Child Transmission (PMTCT) program. The program is implemented on behalf of the government by the National AIDS and STD Control Program (NASCP) of the Federal Ministry of Health with support from international donor agencies and non-governmental organizations. Three years later, the national treatment program has managed to treat only 13,000 patients while the PMTCT program about 3000 women. In a country with an HIV prevalence rate of 4.4 percent and an estimated 3 million people living with the virus, the numbers so far having access to treatment is a far cry from what is expected. A number of private sector health care institutions are also providing various HIV/AIDS services to complement federal government efforts. In spite of this, there has been persistent outcry from persons living with HIV/AIDS (PLWHA), the supposed beneficiaries of the program about inadequate access and poor quality of services in most HIV/AIDS treatment centres across the country. It was on the basis of the above that this study intended to examine the leadership capacity of the national HIV/AIDS program efforts in the public and private sectors to determine the extent to which leadership issues have affected the quality of services in Nigeria under the program.

#### 1.9 **Rationale for the Study**

This study would be invaluable to the government and its agencies, development partners, NGOs and the civil society nationally and internationally in the design, development implementation and evaluation of HIV/AIDS

interventions. The study is especially very relevant and timely as the Federal Government with the support of international agencies is embarking on rapid scaling up of ART/PMTCT services in the country. The country has already commenced activities under President Bush's emergency plan for AIDS Relief in which 350,000 Nigerians will be provided treatment by 2008. The World Health Organization's 3 by 5 initiatives is yet another treatment program that will boost HIV/AIDS services in the country. All these efforts can only succeed when quality and committed leadership is available at all levels to drive the process.

Therefore, a study to assess the strength and weaknesses of the leadership and quality of the current programs will certainly generate necessary data and information that will be helpful in program improvement and in the design and implementation of new HIV/AIDS program initiatives in the country.

The study would also be useful to the organized private sector including both corporate and non-profit organizations as well as the target groups (HIV/AIDS clients) in understanding the dynamics of program leadership and how they can synergize with the public sector to optimize service delivery and to scale up HIV/AIDS services. This research work should also be of great significance to researchers in management, administration and in the dynamic field of public health. Besides contributing to existing knowledge, it would also serve as a basis for further research.

#### **1.10 Objectives of the Study**

The broad objective of this study was to examine program leadership and quality of care of the national HIV/AIDS program in Nigeria. The specific objectives were as follows:

- i. To appraise the leadership skills, knowledge and experiences of program managers in implementing the national HIV/AIDS program in Nigeria.
- ii. To identify the leadership issues and problems affecting the implementation of the program.
- iii. To examine the strengths, weaknesses of the centres and gaps in program management with a view to suggesting remedial measures

#### 1.11 Scope and Limitation of the Study

This study examined the leadership orientation of health care workers working on the national HIV/AIDS program in selected government health care institutions and compare with those in the private sector health care facilities. Only centers providing Antiretroviral Therapy (ART), Prevention of Mother to Child Transmission (PMTCT) and Voluntary Counseling and Testing (VCT) programs will be included in the study. In the same vein, an assessment of service quality in those institutions will also be undertaken to determine the correlation between leadership orientation of health care providers and quality of care as perceived from a survey of patients and staff. Due to financial and logistics constraints, the study will be limited to only the Federal Capital Territory (FCT).

The decision to focus attention on the Federal Capital Territory is to enable the researcher have easy access to data; also a study base on the FCT will permit for a much more detailed research. However in discussing the findings, references would be made and examples drawn freely from other states of the federation and broad government policies as they affect HIV/AIDS will be examined.

**Information bias:** In some instances in the study, information obtained from the respondents may not be accurate. This is possible where there are questions related to self appraisal and comments on the superior or the authority. This is reflected in this study in the following:

**High positive score on attitudes representing self appraisal:** a high positive score on this variable may be linked to the direct nature of the question and the fact that a “NO” answer may be somewhat indicting. It is also important to note that being available and willing to communicate does not necessarily mean that the right type of communication is taking place and the best services are being provided.

**Information withholding about activities of the authority:** People are being careful and not wanting to speak to such sensitive issues as release of funds especially among respondents from public sector institutions.

## 1.12 Definition of Terms

In this section an attempt is made to operationally define the key independent, dependent and sub-variables as are they are used in the study:

1. **Organizational Leadership:** This is defined as the extent to which a program staff or an institution exhibits qualities of sensitivity, teamwork, empowering and participatory approach as measured from the responses to a set of questions on the questionnaire.
2. **Quality of Care:** Client's level of satisfaction with services provided as assessed from the responses on a set of questions on the questionnaire which attempts to measure this.
3. **Sensitivity:** This is an attitude of program staff to demonstrate attitude of consideration, understanding and tolerance with staff and colleagues as demonstrated from the response to some questionnaire items assessing this.

4. Teamwork: A willingness or otherwise of program staff to work together as a team as evidenced from their response to specific questionnaire items
5. Participation: The desire of program staff to create opportunity for the staff and clients to be involved in planning and decision making. This is measured according to their response to specified questions on the questionnaire.
6. Public sector health institutions: These are health care institutions established and run by the government at the national or state level
7. Private Sector health institutions: These are institution established and run by private for profit or not-for-profit institutions.
8. Program Performance: In this study, this refers to both client's level of satisfaction with services plus program staff's self and institutional assessment of output of services.
9. Program Staff in this study is used in reference to all doctors, nurses, social workers, pharmacists and program mangers directly involved in providing services to HIV/AIDS clients in the public or private sector.

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## **CHAPTER TWO**



## **LITERATURE REVIEW**

In this chapter, an attempt is made to review existing literature and studies on leadership that relate to the main variables under focus in the study. The chapter begins with an exploration of the concept of leadership, leadership styles and preferences before delving into various leadership theories and practices. Because of the importance accorded to charismatic and transformational leadership as evidenced by the huge and weighty literature existing on this subject, the researcher painstakingly analysed several studies and some theories on the subject. After examining leadership in health care in Nigeria, the subject of quality of care was exhaustively discussed in general terms and in relation to HIV/AIDS program management. The chapter was concluded with a review of evidence in leadership in the global, Africa perspectives and national HIV/AIDS response.

### **2.1 The Concept of Leadership**

Leadership in any hierarchically organized human groups can be defined as that part of management which deals with direct supervision of subordinates. Leadership is “the art of influencing individual or group activities towards the achievement of organizational objectives” (Bedian, 1986:38). A leader can therefore be described as anybody who can influence others to perform beyond their formal authority. The concept of leadership is relative to followership because there is no leadership without followership.

Leadership emerges because every society is organized. The moment an organization is set up, leaders must emerge since masses cannot lead. However, the ability to lead and direct has been identified with certain personality types and traits. The social psychologist have not been able to establish that there is any single trait or characteristics that identifies a person as a leader in all situations. Practically, every person is a leader of a sort on some occasions and a follower on others. For instance,

the singularly very successful leader in religious prayer congregations may not succeed as the leader of a local sports championship organizing committee.

The nature of every group, community or society requires that there be a leader who acts as facilitator for a particular organization in planning, coordinating, identifying the needs of the organization at different times and translating these needs into task accomplishment by obtaining the commitment of its members to the organization's goal.

Leadership is one of the main factors determining group behaviour. It is leaders in organization who make things happen. Leadership is so important that all kinds of people have shown interest in it – philosophers, psychologist, politicians, business executives, etc. Glueck (1980) defines leadership as “a set of interpersonal behaviour designed to influence employees to cooperate in the achievement of objective”. In the words of Hicks and Gullet, “Leadership is the ability of one person to influence the behaviour of others. One of the key words in the three definitions “influence” refers to the exertion of force on another person to change their attitudes or behaviour.

“Power” is generally defined as potentials influence”. That is, one person has power over another if he or she has a potential to enforce.

Hence, the degree of influence may be determined by the amount of power possessed. A leader is the most influential person in an organization who provides direction, guides group activities and ensures that group objectives are attained. The function of leadership pervades all organizations. A good leader is therefore one who is capable of persuading other to move enthusiastically towards the achievement of group goals. Allan and Robert (1969) define leadership as “a process where one person exerts social influence over the members of a group”. A leader then, is a person with power over others who exercises the power for the purpose of influencing their behaviour. Leaders characteristically “induce or inspire” others to achieve.

Leadership occurs within a specific situation. In the social setting, there is a person, a position and a situation.

The traits often considered desirable for effective leadership usually includes fairness, honesty, loyalty to group goals, reliability, foresight, thoughtfulness, judiciousness, perception, firmness and courage. But experience has shown that there usually are some exceptionally gifted persons who stand out so much in the crowd that the leadership naturally and indisputably falls on them. Moreover that generality of men and women do not want to be burdened by the demands of leadership. They care less about issues which do not directly affect their means of livelihood and also to some extent about those who lead them.

The importance of leadership in any organization cannot be underestimated. As observed by Plato, the Greek philosopher who postulated the philosopher King that "Ruling is a skill to be acquired and that since men differ in their capacities, those who exhibit the greatest capacity for ruling (leadership) should be trained to rule, and that except in a primitive society where the blind leads the blind – with the meritability of both falling into a pit, only the most enlightened, educationally qualified persons or proven integrity, experience, intellectual and moral discipline should be allowed to rule in any decent community (Redhead: 1984:23).

Therefore, the higher the moral character of a leader, the greater is ability for development, the deeper the understanding of the people in terms of their basic aspiration and motivations, the greater the ability for leadership. Leadership comes in many forms, with many styles and diverse qualities. While some find their strength in eloquence, others in judgment and courage. Acts of leadership takes place in a variety of settings and does much to determine in which leader emerge, but the character of the leader in turn have impact on history.

Leaders act in the stream of history. As they labour to bring about result, multiply forces beyond the control, sometimes even beyond their knowledge, are also moving

to hasten or hinder the result. Leaders may suffer from the mistake of their predecessors and leave some of their misjudgments as time bombs for successors.

The term Management and Leadership are at times wrongly assigned the same definition. However, they are not the same. Leadership is the only one important aspect of management functions but certainly not all of it. For example, planning is an important managerial function but does not necessarily involve leadership. Likewise, one can lead without doing any planning, organizing and control. The distinction between managers and leaders can also be clarified in terms of the source of power to influence. Managers are appointed. They have legitimate power to reward and punish. Their ability to influence is thus derived from and dependent upon the formal authority inherent in their position. Leaders, in control may either be appointed or emerged from within a group.

The leadership relationship is not limited to leader behaviour resulting in subordinate behaviour. Leadership is a dynamic process. The leader – follower relationship is reciprocal and effective. Leadership is a two way process which influences both individual and organizational performance.

According to Marcus (1991), “Leadership is vitally important at all levels within the company from board to the shop floor: Leadership is the moral and intellectual ability to visualize and work for what is best for the organization and its employees. The most vital thing the leader does is to create team spirit around him and near him not in school boy sense but in realistic terms of mature adults. Good leadership helps to develop team-work and the integration of individual and group goals. It aids intrinsic motivation by emphasizing the importance of the work that people do.

“Leadership in groups can appear as concentrated or broadly distributed” (Ospina and Schall, 2001). Bluman and Leavitt (1999) point out the “dispersion of leadership” in some successful groups, in which special people who play leadership roles” may be identified by the work they do rather than by their leadership status. The Literature

of leadership teams suggest that leadership is distributed among team members. For example, Barry (1991) identifies self-managed team as settings for leadership that: “(a) Emerges from the groups, (b) consist of a collection of roles exchanged over time among group members, and (c) cannot be ascribed to a single individual while Lipriack and Stamps (2000) believe that virtual teams can only succeed if leadership is distributed over the group”

Bennis (1997) writes that intensely creative groups despite their collaborative nature have strong leaders. Cohen and Prusak (2001) write that successful virtual collaboration seems to require charismatic leadership. Drath (2001) represents the tasks of leadership as three fold – (a) setting direction, (b) creating and maintaining commitment, and (c) facing adaptive challenge. First, leadership sets direction for the group of organization, establishing orientation towards a common vision and purpose. This may take place according to Drath, in distinct ways: (a) through the authority of a single leader, in one-way traffic or meaning from the leader to led; (b) through negotiation and persuasion, in which the leader adopts the orientation that prevails in the group; or (c) in a manner of more collective leadership which enfolds ambiguity and multiple meanings. Secondly, leadership engenders trust, collaboration and engagement of the group's member in the service of its purpose. This may occur through allegiance to the leader, commitment to the result of a process of negotiation following from engagement in the process itself, or the shared creation of an unknown future” (Drath, 2001). Lastly, leadership fosters a response to challenges which the group lacks the resources to handle (Aeifetz and Laurie, 1997). This entails negotiation of new meaning, with some degree of tolerance for ambiguity.

### **2.3. Leadership Styles**

Leadership as a behavioural category has attention to the importance of leadership style. In the work situation, it has become clear that managers can no longer rely solely on the use of their position in the hierarchical structure as a means of exercising the functions of leadership. In order to get best result from subordinates, the manager must also have regards for the need to encourage high morale, a spirit of involvement and co-operation and a willingness to work. This gives rise to consideration of the style of leadership and provides another rubric under which leadership behaviour can be analyzed. By leadership style, we mean the way in which the functions of leadership are carried out, the way in which the manager typically behaves towards members of the group.

Empirical research studies conducted by Lewin, Lippitt and White of the University of Iowa 1962 identified three major leadership styles namely, autocratic, laissez – faire and democratic. The democratic leader gets members involved in decision making by guiding them to determine how the group functions. The autocratic leader provides the direction and determines policy, while the laissez-faire leader allows people in the group to determine their own direction and function without involvement. These styles of leadership are not to be seen as styles to be selected from. They represent a range of behaviour in a continuum.

### **2.2.1 People-Oriented and Production-Oriented Leadership Style**

This grouping examines the leader relationship. Words like “consideration” – the extent to which job relations are characterized by mutual trust and consideration for one another’s feeling; and “initiating structure” which examines how the leader defines activities and attempt to accomplish them. The more popular terminologies for these concepts are “people – centered” and “production – centered” – concern for the people or concern for production. It is known that in real life these terms are not mutually exclusive and the use depends on circumstances of the environment (Gore 2000).

### 2.2.2 Basic Leadership Styles

To throw more light on the leadership style, Likert in 1961 summarized the characteristics of each leadership style as follows:

#### Autocratic Leader and Group

This style is used when the leader tells her employees what he wants done and how he wants it done, without getting the advice of her followers. Some of the appropriate conditions to use it is when you have all the information to solve the problem, you are short on time, and your employees are well motivated.

Many feel that this style does not take into account the potentials of subordinates and encourage the use of threats, demeaning and abusive language and abuse of power. It is about **bossing people around** and makes management of resources very unprofessional. The authoritarian style should normally only be used on rare occasions. For instance when the manager hasn't the time and has to take decisions quickly. In summary the following can be said of authority leader/leadership.

1. He is very conscious of his position;
2. He has little trust and faith in his subordinates;
3. He feels that pay is a just reward for work and is the only reward that will motivate the workers;
4. He gives orders and demands that they be carried out. No questions are allowed and no explanation given;
5. Group members assumes no responsibility for performance and merely do what they are told;
6. Production is good when the leader is present but drops in his absence.

#### **Laissez-Faire and Group**

Lais...sez faire (or *lais...ser faire*) which is the noninterference in the affairs of others. [French : *laissez*, second person pl. imperative of *laisser*, to let, allow + *faire*, to do. In this style, the leader allows the employees to make the decision. However, the leader is still responsible for the decisions that are made. This is used when employees are able to analyze the situation and determine what needs to be done and how to do it. Control and supervision is almost non-existent. This is not a style to use so that you can blame others when things go wrong, rather this is a style to be used when you have the full trust and confidence in the people below you. As risky as this style may seem, managers are encouraged not to be afraid to use it but it must be used with utmost wisdom in combination with other leadership styles. In summary the following can be said of this leader/leadership style:

1. He has no confidence in his leadership ability;
2. He does not get goals for the group;
3. Decision making is performed by whoever in the group is willing to accept it;
4. Production is generally low and work is sloppy;
5. The group has little interest in their work;
6. Morale and team-work are generally low.

### **Democratic Leader and Group**

This type of style involves the leader including one or more employees in on the decision making process (determining what to do and how to do it). However, the leader maintains the final decision making authority. Using this style is not a sign of weakness; rather it is a sign of strength that employees will usually respect.

This is normally used when you have part of the information, and your employees have other parts. Note that a leader is not expected to know everything; this is why you employ *knowledgeable* and *skillful* employees. Using this style is of mutual



benefit; it allows the staff to become part of the team and allows you to make better decisions. This style is summarized as follows:

1. Decision making is shared by the leader and the group;
2. Criticism and praise are objectively given;
3. A feeling of responsibility is developed within the group;
4. Quality and productivity are generally high;
5. New ideas and changes are welcome;
6. When a leader is forced to make a decision, his reasoning is explained to the group.
7. The group generally feels successful under the democratic leadership.

According to Warren and Benis (2000), a good leader uses all three styles, depending on what forces are involved between the followers, the leader, and the situation.

Some examples include:

- Using an authoritarian style on a new employee who is just learning the job. The leader is competent and a good coach. The employee is motivated to learn a new skill. The situation is a new environment for the employee.
- Using a participatory style with a team of workers who know their job. The leader knows the problem, but does not have all the information. The employees know their jobs and want to become part of the team.
- Using a delegative style with a worker who knows more about the job than you. You cannot do everything! The employee needs to take ownership of her job. Also, the situation might call for you to be at other places, doing other things.
- Using all three: Telling your employees that a procedure is not working correctly and a new one must be established (authoritarian). Asking for their ideas and input on creating a new procedure (participatory). Delegating tasks in order to implement the new procedure (delegative).

Darnes (1998) examined the forces that influence the style to be used to include:

- How much time is available.
- Are relationships based on respect and trust or on disrespect?
- Who has the information - you, your employees, or both?
- How well your employees are trained and how well you know the task.
- Internal conflicts.
- Stress levels.
- Type of task. Is it structured, unstructured, complicated, or simple?
- Laws or established procedures of an organization

### **2.2.3 Positive and Negative Approaches to Leadership**

There is a difference in ways leaders approach their employee. Positive leaders use rewards, such as education, independence, etc. to motivate employees while negative leaders emphasize penalties. While the negative approach has a place in a leader's repertoire of tools, it must be used carefully due to its high cost on the human spirit.

Negative leaders act domineering and superior with people. They believe the only way to get things done is through penalties, such as loss of job, days off without pay, reprimand employees in front of others, etc. They believe their authority is increased by freighting everyone into higher lever of productivity. Yet what always happens when this approach is used wrongly is that morale falls; which of course leads to lower productivity. (Darnes, 2000).

It must be noted that most leaders do not strictly use one or another, but are somewhere on a continuum ranging from extremely positive to extremely negative. People who continuously work out of the negative are bosses while those who primarily work out of the positive are considered real leaders

### **2.3 Situational Leadership**

Empirical research findings indicate that the situation in which a leader operates shapes his leadership (Fiedler, 1967). The performance of leaders is to be associated with the situation in which they find themselves. War leaders emerge, USA, Russia or Nigeria have exhibited special leadership qualities that make them the idol of their contemporaries – Churchill, Washington, Hitler, Gowon, to mention but a few. Many Studies in leadership point out that there is a relationship between the leader and outcome which are contingent on some aspect of the situation. Thus, the leader's behaviour and leadership qualities are only a part of the factors affecting leadership in an organization. Factors such as the behaviour of members, structures of organization, task being performed, and members' expectation from the leader are important dependent variables that affect the leadership process. According to Mary Parker Follet (1971), what matter in leadership is , obeying the laws of situation. In what she called "depersonalizing of orders and obeying the law of situation" Follet argues that what matters is to discover the law of the situation and obey it. "One person should not give orders to another person but both should agree and take their orders from the situation.

The limitation of the situational approach is that people who possess the appropriate knowledge and skills appear to be most suitable leaders in a given situation may not emerge as effective leader. Moreover, it is not workable in an organization to allow the situation continually to determine who should act as a leader.

### **2.4 Charismatic and Transformational Leadership**

The most significant trait of leadership is charisma, and the search for charismatic leaders to resolve myriads of problems of organizations continues to be the goal of many recruiters. Charisma may be perceived as a social relationship rather than a trait since it lies in the eye of the beholder and not in the mind of the processor (Performance and Innovation Unit, 2001). Secondly the reliance on charismatic

leadership tends to undermine the ability of followers to participate in and thus achieve the resolution of their collective problems. It negates the well known fact that leadership is a collective process and no single individual has the superhuman qualities to dictate to others how to solve collective problems.

#### **2.4.1 Charismatic Leadership**

Discussions on charismatic leadership would be viewed in the context of transformational leadership within the frame work of developmental theory. The primary objective is to explain how charismatic leaders develop themselves and their followers. Avolio and Gibbons (1988) came up with a few assumptions in an attempt to introduce the idea of development into an analysis of charismatic leadership.

Firstly, the development of charismatic leadership is assumed to be a transformational leadership process. Secondly, transformational leaders are assumed to be charismatic as well as intellectually stimulating, inspirational, and so forth. Thirdly, “pure” charismatic are not concerned with the development of others into leaders. They merely attracted followers’ attention, convinced them of the merits of their vision and established a strong following. At the extreme charismatic leaders may fail to develop themselves and in turn their missions may fail from a lack of sensitivity to environmental demands (Avolio and Bass 1987). Finally the charisma of the transformational leader is viewed as the emotional fuel that energizes and transforms followers into leaders.

#### **2.4.2 Charismatic Leadership: A developmental perspective**

One of the assumptions is that developmental change is a continuous process accumulated for the most part gradually and incrementally over time. Therefore individual development results from smaller and less obvious incremental changes

involving the circumstances of daily events and the individual interpretation of those events. This is in contrast with popular crisis-stage models of development (Levinson, 1978). Brim and Ryff, 1980 and Campbell, 1980 posit that development is not necessarily due to a crisis or abrupt change. Crisis is simply a reaction and the awareness of change or the need for change and not necessarily the driving force behind development.

Development, Avolio and Carbons (1988) explains, entails the accumulation of both minor and major events across one's life resulting in what Whitbourne (1985) refers to as the life span construct. The life span construct is the script of an individual's past and present. It establishes a basic framework for interpreting future events and is the mechanism used to organize an individual's life experiences into an integrated whole (Whitbourne 1985). Explaining development Leadership or otherwise, using the life span construct also assumes that people play an active role in structuring their own development.

Avolio and Gibbons (1988) went further to explain that development can also be seen as a continuous process of change and reaction to life events that occur over time. For example, quoting Campbell (1980) they conclude that most audit do not partition their life span into age-related script or stages but rather see them as a continuous process of change and development without abrupt stager of crisis.

Nevertheless, there are common or universal developmental events or stage that are culturally deter-mined and that occur at standard point in time for most individual if not all however, such constructs underestimate many areas of life span development.

The mode of analysis recommended for studying charismatic transformational leadership focuses on transitions (critical or not) using a longitudinal framework. The unit of analysis is the interaction of the leader with his or her environment over a specific time interval. A similar framework for studying human development was recommended by Murray (1938) and more recently by Stokals (1982) Both

recommended an analysis of life span development that is unique to the individual but does not disregard historical events common to a particular individual or group.

Two key elements for studying change: the structural components (the leader, the follower, and context) and the dynamic components (the interactions of the structural components) proposed by Werner (1926, 1940) are very useful in the analysis of charismatic transformations and leadership. The components of the systems, the relation, among those components and the interaction of the personal system with the environmental system are assumed to have a developmental order (Werner and others 1983; Werner 1957). Over time they become more differentiated. At the upper end of the developmental continuum, optimal development was operationalized by Kaplan (1966) as a differentiated and hierarchically integrated person – in – environment system with capacity for flexibility freedom, self- mastery and ability to shift from one mode of person- in environment relationship to another as required by goals demands of the situation and by the instrumentalities available. Kaplan's definition of optimal development comes close to describing several popular definitions of charismatic / transformational leaders (Avolio and Bass, 1987)

### **2.4.3 Overview of Transformational Leadership.**

Charismatic leadership is central to the transformational process and accounts for the largest percentage of common variance in transformational leadership ratings. Followers want to emulate their charismatic leader, they place a great deal of trust in their leader's judgment, as well as in his or her mission, they support the leader's values and typically adopt them, and they frequently form strong emotional ties to the leader.

There is a marked difference between charismatic / transformational leader and a charismatic leader. Pure charismatic leader may intentionally or unintentionally fail to transform followers. He may find followers desire for autonomy a threat to their own

leadership and hence intentionally keep followers from developing. A charismatic / transformational leader, however, is seen as demonstrating a concern for the individual needs of followers (treating followers on a one to one basis) and encouraging followers to look at old problems in new ways through intellectual stimulation. Pure charismatics may unintentionally fail to recognize followers needs (Bass 1987). And in regard to intellectual stimulation, we see a fundamental difference between the purely charismatic leader who has trained followers to blind obedience or habituated subordination (Graham, 1987) and the transformational leader who encourages followers to think on their own.

Until about 1978 when Burns published a book entitled leadership, not much was known about transformational leadership. From thence the focus on various literatures has been what transformational leadership is, who has it, what it can do and how it differs from other conceptualization of leadership. The justification for a developmental analysis of transformational leadership according to Avolio and Gibbons (1988) comes from the consensus in the field that transformational leaders change and develop followers. Equally important, transformational leaders also change and develop themselves.

Gibbons (1986) summarized and integrated three theories of human development to explain the origin, and development of transformational leadership. They are the psychoanalytical, the humanistic and the constructivist theories. All three theories tend to explain transformational leadership as having its roots in childhood.

**Psychoanalytical theory:** Zalemik (1977) attributed the development of charismatic leadership to early childhood experiences although he assigned greater importance to crisis experiences such as when an individual is separated from his or her parents .According to this theory higher level stages of development are only possible through the resolution of inner conflict(Zalemik,1963) by learning how to deal with and resolve (master) personal conflict and disappointment in childhood, leaders can turn their attention to more supportive and far reaching issues. Bass (1985), referred to the

visionary quotation of charismatic/transformational leaders as a function of the leaders freedom from inner conflict.

**Humanistic theory:** According to Avolio and Gibbon (1988), the humanistic model stems from the work of Allport (1961), Rogers (1961) and Maslow (1970). Maslow for instance focused on the innate potentials of an individual. He believed that the environment merely help to bring out the innate potentials in the individual. Allport believed that behaviors and thoughts were unique to the individual and could be understood by examining the individual's developmental history or what is called life script. Rogers like Maslow and Allport viewed the optimum level of development as the "fully functioning" person. He desired a fully functioning person as having characteristics similar to those in Maslow's stage of self actualization. Human qualities such as personal self regard and inner self were dependent on the approval (or disapproval) received from one's parents in early childhood development (Rogers 1951).

The views of humanistic and psychoanalyst overlap with respect to the relevance of the inner self to an individual's personality and the transformational leadership development. Avolio and Gibbon (1988) therefore concluded that while both views (theories) can contribute to the understanding of charismatic/transformational leadership development, they are seen as weak developmental theories in that each does not adequately explain changes in leadership development across the life span.

**Constructivist theory:** Egan and Lahay (1984) suggest that development is a function of the way people make meaning out of their experiences regardless of their age. People at the same point in their life span may experience events differently based on their interpretations of those events. The interpretation of an event is dependent upon an individual's life construction and his or her level of cognitive development. Taking cognizance of Piaget's theory of cognitive development, Egan and Lahay view leadership development as a function of the qualitative change in the



meaning system which occurs as one's cognitive complexity level increases .(Kegan and Lahay 1984,p.202).

Kegan and Lahay likened peaget's stages of cognitive development and three development phrases of leadership-interpersonal institutional and interindividual.The individual's identity is codetermined based on other people's needs, the situation, and so forth. The interpersonal leader is seen shifting with the wind and often accused of inconsistency. The institutional leader is more dependent on though usually, he or she may develop strong adherence to his identity without any built-in mechanism for alteration or self correction. The leader's identity is inextricably linked to the organizational identity. The interindividual leader on the other hand is more concerned about development of systems and other people than their maintainance.The leader's identity transcends the present demands placed on him or her;thus,he or she is more willing and able to change and develop others as well as him or herself.

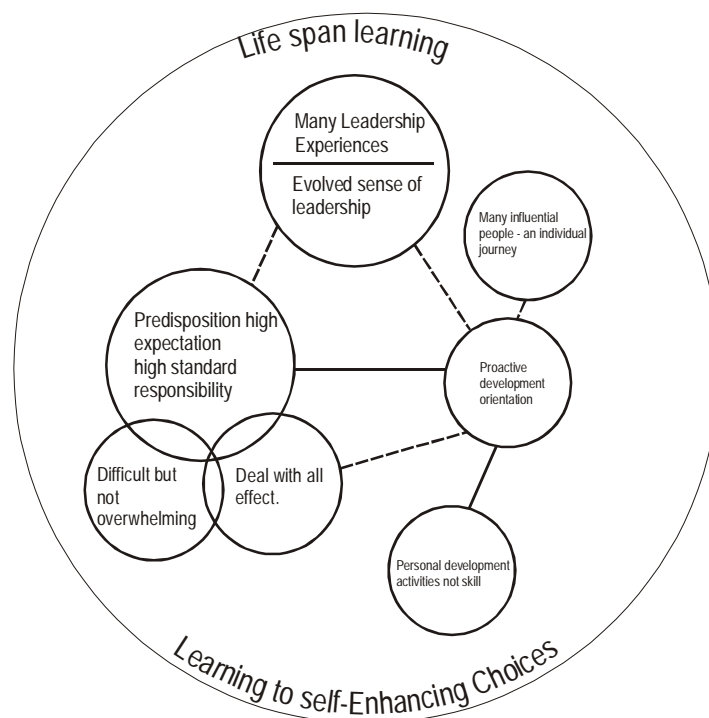
Still on the constructivists view point, Lewis and Kushner (1987 viewed development hierarchically and in stages. They hinged their discussion on four different stages of leadership. While `leaders at the lowest stage (stage 1) are developmentally incapable of transcending their own self –interests and needs, the highest developmental level (stage four), transformational leaders operate our of a personal value system that is beyond immediate transactions, goals and individual loyalties. Leaders at stage four construct or make meaning out of the world through their end values. Stage four leaders have a self-determined sense of identity. As suggested by the psychoanalytical view the leader is more inner-directed and therefore e more able to transcend, the interests of the moment. The sense of inner-direction if translated properly by the leader will attract followers who agree with the leader's end values. How effectively those values are communicated and the degree to which followers identify with the leader's own values both result in what House (1977) described as charismatic leadership (Avolio and Gibbons, 1988).

#### 2.4.4 A retrospective study of the Development life events of transformational leaders

Gibbons (1986) studied life histories in retrospect of sixteen individual using multifactor leadership questionnaire (MLQ). The idea being to different transformational leadership from other type – transactional laissezfaire and management by exception. The analysis resulted in the identification of seven key elements that encompass some of the significant key antecedents to the development of transformational leadership.

The seven factors which when present, appear to result in transformational leadership are shown in the diagram below:

Figure 1



Model of life span events that contribute to leadership

Called from: Jossey - Bass (1988)

Gibbon's findings lend credence to the three models of leadership earlier discussed, and highlighted the importance of using a development lens to study leadership- a lens that focuses on continuous and incremental life span changes. The results like that of Campbell (1980) and Whitbourne (1985) could not reveal any consistent evidence that support a "critical life events" model of leadership development. They confirmed the argument that development of charismatic /transformational leader is best characterized by a life span process of change with early, as well as later, life events affecting the development of leadership potential.

The conclusions (Gibbon's) were based on retrospective analysis and reconstruction of the leader's life history and events and therefore are subject to errors of omission and intrusion. People remember events on the basis of their reconstruction of those events in recall, not necessary the actual events or fact (Cantor and Miscall, 1977).

For example, one may initially classify an experiment as unpleasant but later in his or her span go back and reclassify an experiment as developmental – seeing the experience as having made a positive contribution to development.

Finally, the analysis of the model discussed here presents leadership as a continuous developmental process. Each of the models reviewed has made a significant contribution to the understanding of how charismatic/transformational leader develop. The primary criticism of these models however is that they fall into the category of weak development theories. The strongest theories the constructivist view – still falls short of explaining how developmental change and transitions occur. Nevertheless, Lewis and kuhnert (1987) proposed a clarification system which is useful in keeping us capture leadership development as an orderable process of increasing complexity and differentiation. Its flaw is the idea that leaders need to be at the highest stage of cognitive development in order to be charismatic and transformational. One cannot help but agree with Bass (1988) that charismatic / transformational leadership occurs

relative to the group with which the leader interacts and that transformational leadership can occur even at lower levels of cognitive development.

#### **2.4.5 Emotional and cognitive development of transformational leaders and their followers**

There is no ceiling which an individual must reach before one can be seen as a charismatic/ transformational leader. Transformational leadership can occur at different levels of cognitive and emotional development. The level of individual development required to be transformational is partly related to the developmental level of the individual or group being led. Raising the needs of followers who are at the lowest developmental level to a qualitatively higher level is transformational (Avolio and Bass, 1987).

The other angle to this involves the level within an organization at which charismatic / transformational leadership is observed. Lucent evidence summarized by Avolio and Bass (1987) shows that charismatic / transformational leadership can occur at all organizational levels in varying degrees. The charismatic / transformational leadership qualities commonly associated with top corporate leaders appear to also be present in leaders at lower levels of the organizational hierarchy. In this case, the degree of charismatic / transformational leadership observed is relative to the organizational level.

A leader who operates at a lower developmental level than his or her followers can not transform followers to a level higher than his own. Bennis and Nanus (1985) submitted that what differentiates leaders from now leaders is a commitment to personal development as well as to the development of others. Burns (1978) in his analysis of world – class political leaders, concluded that transformational leaders are characterized by a desire and intrinsic to engage in growth and development of the

self. Bass (1985) similarly described transformational leaders as continually developing to higher level and to developing followers into leaders. Cibbons (1986) concluded that transformational leaders are eager to develop and challenge themselves conscionably throughout their careers.

There seems to be two dimensions to charismatic / transformational leadership assuming that the analysis above are a function of methodologies the first is that the provision of intellectual challenge for followers can affect their cognitive development as it encourage the development of new information structure or cognitive scripts to address indenting challenge. Secondly, job challenges can – and usually do – result in increased level of emotional stress. The increased stress results in a need to see ways to cope effectively with the challenge. If the challenge is appropriate for the individuals current developmental level (or potential), then the challenge can result in emotional development as well.

Providing intellectual challenge to followers promotes a key fact of individual development- the evolution of meaning – making system to higher level of cognitive complexity (Kohl-berg, 1969; Loevinger, 1966; Merron, Fisher and Torbert, 1986). Merron, Fisher and Torbert (1986) found that managers at higher developmental level see problems as opportunities to observe and learn; managers at lower developmental levels see problems as fires to be put out.

The presentation of challenge to followers provides opportunities for those who are developmentally ready to accept them – to learn and develop from the challenge. Lessons learned from a challenge, whether it was handed successfully or not, can be used as a basis for creating future opportunities in an individual life span. All problems can be viewed as learning experiences, both cognitively and emotionally; to do so is to be seen as a transformational leaders (Cibbons 1986).The challenge, therefore can be developmental as transformational. Except in autocratic leadership where there seems to be no balance between the challenge and the support and other resources available in an organization. The autocratic leader intentional

withholds support and resources and this leads to increased dependence on him and no desire for growth and individual development. Charismatic / transformational leadership thrives in an environment in which some sort of balance is maintained.

In summary, charismatic / transformational leaders provide challenges to both followers and themselves, to move to higher level of development. By addressing those challenges and building some record of successful achievement the leader develops to a higher level of emotional and cognitive development

## **2.5 Self-efficacy, Self-management and Self-development**

According to Bandore (1977) in his social learning theory, behavior is a function of both internal and external events. Self – efficacy could be interpreted as the level of belief that a certain amount of efficacy will result in the achievement of a desired outcome. The internal mechanism to which Bandore refers is represented by feelings of self-efficacy external and the challenges and risk that goes along with that challenges. A significant part of developing or transforming followers is developing their feelings of self – efficacy and it can be done in the following ways;

- (A) Provision for followers tasks that result in experiences of success. Incremental successes encourage followers to pursue more difficult objectives.
- (B) Challenges that results in higher intrinsic motivation and an increase in feeling of self-efficacy should be provided. This gets the followers involved.
- (C) The power of persuasion of a leader about certain goals, values, mission, or even vision, increases the probability that the follower will attempt to accomplish the task assigned him.
- (D) Appropriate strategies for achieving success have to be modeled for the followers.

By developing the follower's self-efficacy levels, the charismatic / transformational leader enables the followers to address more challenging problems. And Sims (1980) using social learning theory as a basis for discussing the development of self management skills, recommended that to transform followers to leaders, we need to concentrate on both environmental planning and behavioral change.

Another primary goal of transformational leadership is to develop in followers a mechanism for self – confidence and self development. The leader transforms followers into leaders who are responsible for their own actions, behaviors, performance and development. Social learning theory is useful for the understanding of how transformational leaders both shape behaviors to desired end states and affect the cognitive scripts or mental road maps followers use to interpret the world around them.

Life span orientation to help examine events that move people to developmental level at which they are able to handle more responsibility for their own behavior and eventually, for some, the behavior of others was an argument advanced in addition to social learning theory. The biggest contributor to understanding how development takes place is understanding how personal history of an individual has contributed to his or her current developmental level (Bandura and Cervone, 1986).

## **2.6 Leadership as Activities**

Hicks and Gulliet (1981) have offered the following as common leadership activities.

**ARBITRATING** - An effective leader will often resolve disagreement between members by arbitrating or making the decision on the course of action to be taken.

**SUGGESTING** – Suggestions are often employed by an adroit leader as this often permits the subordinates to retain dignity and a sense of participation more than if given a direct and a sense of participation more than given a direct order.

**SUPPLYING OBJECTIVES** – A manager must see that the organization is always supplied with suitable objectives. He should define objectives that will allow members to work together.

**CATALYZING**: A leader may provide the force often required to start or to accelerate movement. When doing this the leader is acting as a catalyst, pushing subordinate to action.

**PROVIDING SECURITY** – in organization, personal security is often an important factor. A leader can provide a large measure of security by maintaining a positive, optimistic attitude, even in the face of adversities.

**REPRESENTING** – The leader speaks for the organization stating the organization's position on matters with which it is concerned. In addition, the leader serves as a symbol of the organization. Outsiders are likely to think of the whole organization in terms of their impression of the leader.

**INSPIRING** – When inspired, a member will enthusiastically accept organizational objectives and will work effectively towards their accomplishment. Thus leaders should inspire members by letting them know that the work they are doing is worthwhile and important.

**PRAISING** – Everyone enjoys receiving praise for a job well done. Managers can help to satisfy these needs by sincere praise or sincere pat on the back for good work done as this will probably make a member pleased and help him or her become involved.



## **2.7 Leadership and Organizational Purpose**

Positions of leadership are established in work setting to help organizational sub-units to achieve the purpose for what they exist within the large system. Organizational purpose is operationalized as a direction for collective action. Leadership processes are directed at defining, establishing, identifying, or translating this direction for their followers and facilitating or enabling the organizational process that should result in the achievement of this purpose. Organizational purpose and direction becomes defined in many ways, including through mission, vision, strategy, goals, plans and tasks. The operation of leadership is inextricably tied to the continual development and attainment of these organizational goals states.

This perspective of leadership is a functional one, meaning that leadership is at the service of collective effectiveness (Fleishman et al., 1991). The seven leadership patterns that form the continuum are boss – centered leadership and subordinate centered leadership. The continuum contains varying aspects of leadership: Oppressive, autocracy, benevolent autocracy, consultative and participative.

## **2.8 Determinants of Leadership Style**

Of the several studies on leadership, no one study has been declared as possessing the answer to the leadership question. Each study attempts to make contribution by breaking or refining existing studies. The question of what determines effective leadership is not completely answered. Tannenbaum and Schmidt have attempted this question and come up with the following factors:

**2.8.1 Size of the Organization** - As an organization grows larger and gets more complex, there is a tendency for decision making to be centralized, leading to very limited participation or no participation at all. The manager may only present ideas and invites questions. It is different when the organization is very small and

consultation is very easy. Large organizations have a tendency to follow the line of authority very rigidly, leading to a strict adherence to the principle of unity of command.

**2.8.2 Degree Of Interaction** – The degree of interaction in an organization influences the style of management. Where employees must co-operate in order to accomplish a task, there is bound to be an open channel of communication. Functional specialization tends to promote an open channel of communication since members must interact; but where there is no functional specialization and the manager tends to have the expertise, an autocratic style of leadership is likely to be practiced.

**2.8.3 Personality Of Members** – Some people react to certain styles of leadership than others. Individuals who like to depend on other do not like to participate since their needs for security and direction are assured by rigid organizational structures. Individual who have a clear sense of direction and which to get a head, love to participate in decision-making. A leader in this situation must adapt to the situation by providing opportunity for participation for those who need it and leading those who cannot benefit from participation.

**2.8.4 Goal Conveyance** – Goals conveyance exists as the goals of the individual and the goals of the organization are perceived to be the same. In this situation there is a unity of direction and purpose as everybody works for the attainment of a common goal. Participative decision making is ideal. If the goals are not identical, leadership will tend to be more autocratic and there will be the adherence to rigid organizational structure, rules and regulations governing behaviour.

**2.8.5 Level Of Decision Making** – In a centralized organization, there is little or no provision for decision to be made by people at the lower levels of the organization. Directives are handed down and strict compliance is expected. The style of leadership tends to be directive rather than participative or laissez-faire. Thus, the

location of decision making which is the function of technology of the organization and the functional specialization of the organization determines the style of leadership.

**2.8.6 The State Of the System** – when the productivity of an organization is high and company profit target are being met, there is a tendency for the organization to be more democratic. When the situation is different, the leadership style to be adopted will be such as to encourage high productivity. Leadership becomes authoritative. Unproductive employee will have to be dismissed and some company item may have to be cut in order to improve the profit picture. In many of these issues, the leader makes the decision and announces it. The state of the system plays a very important part in determining the leadership style.

In summary, it must be observed that the success or failure of an organization depends on the leadership. Success demands that a leader adopt a style appropriate to the organization. With employee education and sophistication, unilateral action by leadership is resented and could affect morale and consequently productivity. The leader is responsible for the key function of the organization – planning, organizing, directing and controlling.

### **2.9.1 Theories of Leadership**

Researchers wanted to find out if there was something unique in behaviour of effective leaders. For example, do they tend to be more dictatorial than democratic?

Furthermore, it was hoped that if successful, the behavioural theories would produce critical behavioural determinant which will serve as basis for training people to be leaders. The difference between trait and behavioral theories lies in their underlining assumptions. Traits theories assumed that leaders are born: You either have it or you don't! And so, if the trait theories have been successful it would have provided a basis

for selecting the 'right' person to assume formal positions in organizations requiring leadership.

On the other hand, the behavioural theories assumed that specific behaviour identified leaders. If this was so, then we could teach leader by designing programmes which would impact these behavioural patterns in individuals who desire to be effective leaders.

The failure of the trait theories to provide adequate explanation made scholars to look at the behaviour that specific leaders exhibited.

### **2.9.2 Ohio State University Studies**

One of the earliest studies on leadership behaviour was conducted at the Ohio State University under the leadership of Ralph M. Stogil in the 1940s. The aim of the study was to determine the relationship between effective leadership behaviour and subordinates satisfaction and performance.

The research began with over a thousand dimensions which the eventuality narrowed down to two, namely initiating structure and consideration.

**Initiating Structure:** refer to the extent to which a leader is likely to define and structure his or her role and those of subordinate in the search for goal attainment. It includes behaviour that attempts to organize work, work relationship and goals.

On the other hand, **Consideration** is described as the extent to which a person is likely to have job relationship that were characterized by initial trust, respect for subordinates idea and regard for their feelings. This is a two-way communication as the leadership behaviour was oriented towards developing mutual trust, two-way communication, and respect for subordinate ideas and concern for their feelings.

In consideration, there is a psychological closeness between leaders and followers because leaders listen to the subordinates. He treats subordinate equally and he has advance notice to changes. He looks out for subordinate's welfare. While in initiating structures, the leader has concern for actively directing subordinates towards getting work done. There are scheduled works to be done and the leader maintains standard performance. He encourages use of uniform procedures and decide what is to be done and how to it.

### **2.9.3 University of Michigan Studies**

The university of Michigan survey research center carried out the second leadership behaviour studies. They were aimed at identifying characteristics of leaders that appeared to be measures of performance effectiveness.

The findings of the Michigan studies identified two dimensions of leadership namely employee oriented and production oriented leadership. Leaders who were employee oriented emphasized inter personal relations. They took a personal interest in the needs of their subordinates and accept individual differences among members. On the other hand, the production-oriented leader tends to emphasized on the technical or task aspect of the job – their main concern was in accomplishing their group's task and the group members were a means to an end.

### **2.9.4 The Technical Grid**

Another theory of leadership behaviour in an organization is what is often described as Managerial Grid which is a two dimensional view of leadership developed by Robert R. Blake and Jane S. Mouton. The managerial grid is based on the 'concern for people' and 'concern for production'. The grid has nine (9) positions along each axis, creating eighty one (81) difference portions in which the leader's style may fall. It

does not show result produced but rather than dominating factors in a leader's thinking in regards to getting results.

## **2.10 Leadership and the Provision of Basic Health Services in Nigeria.**

The health sector covers wide range of providers; public sector, including ministries of health at federal and state levels, LGA health department, parastatals, training and research institutions and by extension, the health components of Defence (AFPAC) and Internal Affairs (Prison). The health sector also covers private which accounts for about 60% of the health care needs of the people. The country operates a three-tier system of health care: primary, secondary and tertiary levels. The health system in Nigeria and the health states of Nigeria have been described in the health sector Reform Strategy as 'deplorable' ranking Nigeria in 187<sup>th</sup> position among the 191 World Health Organization (WHO) member states. Health indicators are below average for sub – Sahara Africa. In 2002, infant mortality rates was 100 per 1000 live births; maternal mortality ratio was 948/100,000; and under – five mortality, 201 per 1000 live births (NDHS, 2003).

Various surveys over the years indicate that access to health care varies tremendously by socio-economic status, level of education and employment status of consumers, in addition to geographic location of facilities and whether they are public or private. Though the Northern zone have almost two-third (65%) of all the public sector Primary Health Care (PHC) in the country, this correlates negatively with health status, which is worse in the northern states. This may be explained in part by the cultural norms that restrict woman's mobility in the northern states including access to health care.

Surveys have highlighted the many inadequacies of the public sector health facilities such as the lack of equipment (or where available, not in working condition), lack of medicine and health communities, lack of staff and poor staff attitudes. The list

continues and highlights the persistent lack of funding, management capacity and community engagement and demand that has beset the public sector health services. In a 2002 FMoH Health resources and Services survey of PHC facilities, only a third of the facilities provided treatment for sexually transmitted infections (STIs). The bias towards the private sector for health care, especially STI care, is not surprising.

The declining quality of public sector service has fuelled the growth of private providers in their various forms both formal and non-formal. Thus the health sector as a whole is heterogeneous and complex.

### **2.11. Socio Political Environment**

The poor health statistic that rank Nigeria so low on global table provide a stark reminder of the urgent need to improve access and quality of services. To do so well, require new ways of doing business. The Federal Ministry of Health recognizes that the public sector alone cannot meet the demand for access to quality for the vast and scattered population of Nigeria.

There is now strong political commitment to reform the public sector as enshrined in the Nigerian Economic Empowerment Development Strategy (NEEDS). This Nigeria – led poverty reduction strategy provides an over-arching medium-term framework for reform in restructuring, right sizing, professionalizing and strengthening government and public institutions to deliver effective services to the people. It also aims to eliminate waste and inefficiency, and free up resources for investment in infrastructure and social services by government.

The social charter of NEEDS provides a strategy framework for the sector where HIV and AIDS is considered not only a social problem but also a major threat to productivity and the economy. An effective health care delivery system, especially

aspects directed at contributing HIV&AIDS and other preventable diseases such as malaria and tuberculosis is a key strategy for preserving a health workforce.

The HIV & AIDS epidemic in Nigeria has placed an additional burden on a weak health care system. The government at all levels, has not yet been able to fully re-skill, support and equip its health professionals to provide the specialized services demanded by HIV & AIDS. This lack of support has not only resulted in weak capacity, poor quality of care but also in health professionals lacking motivation and confidence.

Two recent evaluations of health facilities (HMoH/WHO 2003 and USAID 2994) and the state situation analysis found that training and equipment for managing the ARV program were deficient. Guidelines and protocols were either not available or not being followed. Another study (FMoH/WHO 2003a), found that management of STIs and other common problems including malaria, rarely followed the standard protocols. Poor compliance by patients, poor quality drugs and re-infection from untreated partners all compound a formidable situation that has led to drug resistance amongst other things.

Comprehensive prevention, treatment, care and support services are needed at all levels. At each of these levels and in both public and private sectors, a package of services should be defined based on international best practices and national protocols, supported by training and supervision for health providers. Services need to provide a 'continuum' of care that meets the multiple and changing needs of PLWHA and their families.

Ethics is integral to service delivery. Maintaining confidentiality is the norm in any health care environment, and is crucial in VCT but is not always followed with the result that employers have discriminated against employees found to be taken the HIV test, irrespective of the result.



One of the many reasons that consumers are dissatisfied with public sector services is because clinics and hospitals often lack medicines and essentials health supplies. A recent FMOH/WHO study of the pharmaceutical sector (2003) found that more than half of the key medicines were not available in the public health facilities and out of these, 7% were already expired no expired medicine meanwhile were found in private outlets.

## **2.13 Leadership and Quality of Care in HIV/AIDS Programme: A Global, African and Nigeria Perspective.**

### ***2.12.1. Leadership in HIV/AIDS Program Management and The Challenge of Service Quality***

Quality refers to as something done by human beings at a very high level of excellence, often times in the sense of works of performance as being distinctive from inferior mediocre performance (Michael, K 1997). It is therefore inferred that “quality is a continuum from poor to excellent. All stages of the continuum are part of “quality” in that they express some level of quality even in the interior range. Service quality can be consistently poor, above average, excellent, and can also decline or improve. Since service quality can be influence positively or negatively, it matters a great deal whether people are trying to influence it for the better.

One of the most vital and decisive factors influencing quality of service is leadership. Nothing can be achieved in any human endeavour without a measure of leadership being required to ensure that things turn out well. It is important to note that leadership in this context connotes “the capacity of some people to lead” and not necessary a formal role as in the early understanding of leadership.

A number of studies have been carried out to provide an understanding of the dimension of service quality. The work of Kendrick Michael (1997) is relevant here and will thus be reviewed.

a) Service As An Internalized Ethics. According to Kendrick, “quality begins inside people and radiate outwards. This means that quality can only come as a result of personal and institutional commitment to it. we cannot for instance achieve an attitude of respect for our clients by merely talking about it or by putting it subject on the syllabus of continuing education lessons for the staff. The test of genuineness “require that you mean what you say and this is recognized as a tangible part of who you are. For leaders, the task becomes one of both calling for and exemplifying a consistent commitment to quality in one self and others, such that it becomes a part of who people are – that is an ethical foundation in their identity. The task becomes one of getting people to authentically care about quality and then to continuously challenge themselves to do something about it. There must be a will and an intention to do superior things before a quality outcome can be achieved. Whatever one lets one’s commitment to excellence to lapse quality will inevitably decline.

b) Quality, People and Organization

Modern management attributes quality to organization and elucidates that quality is something that comes to client or customer via organizations. Kendrick 1997, Arbor (1999) and Princely (2000) in their respective studies oppose this notion as it ignores the commonly cited observation that organizations are only good as the people in them. They aver that the more fundamental origin of quality is “persons, both in their personal and collective sense. Without good people, good result can hardly come; quality mirrors the strengths and weakness of the people and other structures do profoundly influence people but at the end the raw essence of quality lies in the character of those who are involved.

To buttress the above point, Max Sillain in his analysis of “Nigeria and her leaders” explains how corruption has become institutionalized in Nigeria as a result of the character of it leaders.

According to Him, when Ibrahim Babangida took over the reigns of power in 1985 the President's tactics of using money and corruption to solve every problem destroy the moral fabric of Nigerian society. Yet rather than speak out against the scandalous corruption of Babangida regime, Nigerian and its leadership simply copied him and succeeded in bringing corruption to the door step of every Nigerian and bribery thus become to date the defacto method of survival in Nigeria. It permeated all level of governance and is adjudged as being responsible for the slow pace of development of Nigeria as a nation and poor quality of services at all levels.

The impact of this is that superior quality will only derive from people doing superior job. The challenge for leaders becomes the recruitment of the "right" people and redirection or substitution of those less suited. It means the deployment of people where they can do the most good and providing the ongoing substance to them to meet the demands of achieving quality. It is a forbidable and costly task which must be embraced by all leaders if quality is to be attained.

#### **2.12.2 Achieving Excellence: How Easy?**

Several studies in human resources management and psychology have shown that achieving any thing of quality is not easy (Darne, 2002). Unfortunately, there seem to exist in all of us a wish to make things easier, making the desire for "shot cuts and quick fixes; a common fault among most people which inevitably results in poor quality of services. Quality has a price tag and must be paid through planned and visionary processes. Quality and excellence are usually measured against a standard hence excellence will be increasingly difficult to achieve as one increases the standard. Consequently, fewer and fewer people will reach the standard as the degree of quality increases. Thus in most things, including human services, the average level of quality can be expected to be routinely and ordinary or worse and only infrequently remarkable or out standing. Thus most quality assurance schemes

are minimal standard-oriented since this is much more consistent with “regression to the mean” tendencies that derive from human nature (Kendrick, 1971).

What is said to be quality in human service may not necessarily be centered on the service user, Manor, 1998, Bricks 2000 and Kendrick 1971 examines the concept of quality from the perspective of the service user and concluded that “foolishness, foolibility, and inability to discern quality are ever present in all of us at onetime or another. This leaves us valuable to those who can resent themselves as excellent whether or not there is any evident for their claims. One’s perception of service quality functions for most as their standard.

Consequently, quality can be what ever people want it to be. However, if service is genuinely good, then surely it must be of distinctive benefit to the person served. This assumption, requires that all service is beneficial to the person served, at least in so far that such benefit are realistically feasible. It is this assumption that encourages many people to look at service user outcome as a clue to whether authentic services have been rendered. On the other hand, non service user factors are also considered when analyzing service quality. They include financial control, documentation of policies and practices, adherence to regulations, minimal standards, competitive unit cost, administrative performance etc. Both service outcome measures and units of services received have their pitfalls in measuring service quality nonetheless, leader needs to direct their energies to establishing some manner of service that is focused on the people served. Quality in service must relate to what is good for people. It must be consistent with the values and aspiration of the people. A meritorious service provider must consciously and admittedly chose values that benefits persons served or there will be no benefit. Values do relate to what is good for the people even if this fact gates obscured. Gerald (2000) and Kendrick 1977, emphasized that service quality is simultaneously multidimensional and its sub elements differently ordered given the specific need of each person served. Human beings need a variety of things in quite differing orders of priority. For instance, they might be many things that people share in their personal sense of what constitute a good home life for them

selves but it is very unlikely that the person – by – person order of importance of these is distinguishably in the abstract. More commonly, there is individual variation as to how each person might prioritise the many variables of quality in their home life. The challenge for a leader is to recognize that service quality has many facets that have to be managed simultaneously but also manage with direct relevance to the greater and lesser needs of each unique person served. This argues against “pre-packaged” or standardized service and service outcome. Since by definition outcome must be tailored to the variable needs and priorities of person served. With this in mind it is not hard to see why the very best services are the ones that derive from who the people served actually are, rather than from generalized assumption about them i.e. overly standardized service models and practices (Kendrick 1977).

It is therefore clear that it is not possible to discern whether a service is good for a given person except by delving deeply enough into who that person is and what it is there actually need to enhance their life while some checklist of possible element of quality could be utilized as a starting point for analysis, this, in the end, can only be ordered person. Even the evaluation of services by standardized outcomes may miss the point since there are, at best global and reductionist starting point, since the true worth of a service is directly tied to its relevant address of a given persons need.

Motivated by a genuine desire not to overlook the wishes and needs of each individual most organizations have attempted to operationalise some measure of individualized planning, service delivery and even finding.

In practice however, we have witnessed the standardization of procedures and bureaucratic rituals for even individualization, irrespective of whether or not people want this mechanism. At the end, services are provided in such a way that they no longer matter.

### **2.12.3 Quality, Competing Demands and Vested Interests**

It is common knowledge that many human services are bedecked by vested interest both legitimate and illegitimate. No where else has this been most visible than in the provision of HIV/AIDS services. Most service users are actually poorly positioned to influence services due to the many more powerful interest at work (Kendrick 1977).

Unfortunately, those who most rely in services are often the least able to shape what services are and thus become hostage to the will and priorities of others who hold more influence for service users to benefit from services, a great deal will rest upon the values, commitment and alignment of interest of variance people and groups who are normally more powerful than service users and will likely remain so.

Findings from Mark Angels study of 40 cooperate organizations in Europe indicate that service quality must necessarily compete with other necessities and leaders wade through innumerable other matters and may not be able to give service quality the concentration and attention it requires. He recommended that learning organization need to build service quality into the shared purposes and vision of the many interest at work in services. He also reflected on the often mistaken but widely held assertion that vested interests are usually selfish interest. This need not be the case at all as it is quite possible for groups to alike align themselves with the service users interest. Kendrick buttered this view by observing that it would be unwise to leave the matter to chance given the competing pressure that must be faced. That it is for this reason that the role of committed leaders building momentum towards service quality is so crucial. Without people bringing the focus back on the people served, there is a great risk of their needs being overlooked.

From the forging review, some pertinent correlates of service quality have emerged, that:

- i. Quality is an ethical issue.
- ii. It is people that make quality service possible individually and collectively.

- iii. Achieving quality is not easy, it requires a planned and systematic process devoid of “short cut and quick fixes”.
- iv. Service quality is determined by both the user and non user factors.
- v. The provisions of quality service must take cognizance of the personal needs, and values of the people.
- vi. Service quality is affected by competing demand and vested interest and that vested are not usually vested, hence all interest must be recognized and aligned towards to achievement of optimal service quality.

Based on this understanding, what is service quality in the provision of HIV/AIDS services?

The general consensus on the measurement of quality especially in the provision of HIV/AIDS services is that there are three dimensions to quality:

- 1. Appropriateness of care (i.e. patients should receive a procedure when it benefits them and not if it does not
- 2. The excellence of care (when something is done to patients it should be done in a manner that maximizes the benefit-to-risk ratio and
- 3. The humanness of care(including being consistent with societal norms).

Quality of care is a multidimensional concept. The basic understanding is that more effective and more appropriate processes between the provider and the patient will improve health outcomes, while better facilities, equipment, staffing, and training affects outcomes indirectly by improving processes. In the clinical setting, consideration must be given to efficacy, appropriateness, accessibility and continuity. This means that both technical efficiency and interpersonal relationships must be considered. “The goal of quality assurance is to improve the outcomes of patients. This is accomplished in part by attaining a better understanding of which aspects of structure and process affects outcomes. Ultimately, improving the quality of care can benefit not only individuals, but can improve the health and productivity of

communities (Donabedian). Lessons learned from evaluation of HIV/AIDS programs show that quality of care measured in terms of structure and processes can have an impact on patient satisfaction(Akin 1997, Stoskoph 1996, Croucher 1997, Katz, 1997) and survival(Bennet 1989, Kaitahata, 1996 and Palenick 1997).

A major contribution to research on Quality of care for HIV/AIDS is the work of Albert Wu, Allen Gifford, and Steven Allen for the Foundation for Accountability, Oregon, USA. This study collaborates existing research information on the measurement of the quality of care in HIV/AIDS care by identifying and classifying HIV/AIDS quality of care indicators into five domains:

1. Health outcomes (CD4 number, HIV RNA, degree of progression to AIDS, degree of symptoms, health status measures and health utility).
2. Economic and productivity outcomes(days in hospital, bed days and reduced productivity).
3. Satisfaction (generic satisfaction and HIV targeted measures, communication, interpersonal relationship, coordination of services, availability and continuity of services, technical care, information on side effects and coping strategies, cultural competence).
4. Self-Efficacy (for self-management and adherence to medication).
5. Essential care processes (awareness of and practice of essential care processes)

The indicators developed for quality of HIV/AIDS care in this project builds on the pioneering efforts of this study.

#### **2.12.4 Patient's Attitudes and Satisfaction**

Patient satisfaction with health care is a key outcome measure of quality of care. There have been few studies on the satisfaction of HIV patients in receipt of ambulatory care (Langner & Hutelmyer, 1995). This is an important area given the



recent advance in combining anti-retroviral therapy, that is, using several anti-HIV agents which interfere with viral replication.

Beedham & Wilson-Barnet (1995) gathered information on consumers' view on patients' needs and services provided using interviews with 85 clients. Satisfaction was high but prejudice was experienced. In a cross sectional study of 386 patients selected from hospital, out patients, home-care and long-term care setting, Berk, et al (1995) showed that although there was a variation in patients' health needs between settings, often there was little variation in their psychological and financial needs. The work identified the importance of monitoring individuals to pinpoint the nature of the distress and emphasized that special their special needs will vary overtime.

Catalan et al (1994) showed that there was a discrepancy between staff perception preference for information and the views held by patients themselves. This gives cause for concern as it may lead to patient dissatisfaction with care, uncertainty about progress and treatment and this in turn affect compliance with medical advice. There were large differences between patients and the importance of good communication was expressed. Doctors had a more paternalistic view which opened up the possibility of conflict. Social workers expected a greater desire for choice than patients preferences allowed and did not appreciate patients' expectation regarding information. Patients' expectations about involvement in their own care were observed to vary with age, socio-economic group, culture and previous experience (Sensky & Catalan, 1992). This showed that as patient views are not fixed is important to provide time discussion. This study identified the need to study many difference group of people with HIV/AIDS and their carers in a range of situation.

Attitudes can be defined as the determinants, components and consequences of belief, values and behaviour (Green and Kreuter, 1991). It has been shown that negative attitudes towards people with HIV/AIDS may affect the quality of patient care or may result in refusal to care for patients (Frank, 1986; Gerbert, 1991).

A review of 32 studies between 1981 and 1989 on nurses knowledge, attitudes and practices relating to care of people with HIV/AIDS suggested that work in this field was largely descriptive of health professionals in acute health care settings (Swanson, et al, 1990). These studies lacked a conceptual framework on which to base design and measurement and analysis of data. Thierry (1995), provided a review of research on knowledge, attitudes and education of nurses in relation to HIV/AIDs and identified a lack of training and confidence among nursing teachers. She also pointed out that, although evaluative research had been scarce, some forms of HIV nurse education had been shown to have beneficial effects which had resulted in improvements in nursing knowledge and attitudes. More research is needed in order to offer direct guidance for developing HIV/AIDS education and for monitoring improvements and changes in attitudes (Akinsanya and Ronse, 1991). Similar conclusion were reached by Horsman and Sheeran (1995) who reviewed 164 papers and looked at the impact of HIV/AIDS in health care workers, their knowledge and attitudes. Notable gaps in the literature were identified and some neglected areas included attitudes to women, people from ethnic minorities and organizational and societal factors mediating the impact of HIV. Limitations of the research to date are discussed in more detailed in the conclusion. There is a need to move forward to more advanced qualitative techniques which can then be used to test theory (Preston, et al, 1995).

Unreasonable stigma and prejudicial attitudes associated with AIDS have been identified among practicing physicians and medical undergraduates (Kelly et al, 1987). Work has shown that physicians' positive attitudes to HIV increases with increased clinical experience (Orlander et al, 1994). One national survey shows that counseling and advice HIV transmission were given in fewer than 1% of patients' visits to primary care physician (Fitzpatrick, et al, 1994).

### **2.13. Barriers to Care**

Barrier to care, in other words anything that blocks effective communication, may severely limit the therapeutic potential of any relationship. These barriers are not always explicit and relate to the background, experience, mood and expectation of the individual involved. Once defined and understood barriers can be lessened and sometimes resolved (Quitl, 1989).

Caring is the central focus of nursing (Kyle, 1995). Promoting a caring attitude understanding of HIV/AIDS require a significant knowledge base if quality care is to be achieved. Studies have identified the poor knowledge base some professionals, particularly in terms of primary prevention and infection control in HIV disease (Lewis et al, 1994). This supports the argument that increased knowledge and awareness may improve caring

### **2.14 Global Leadership in HIV/AIDS**

Lessons learned from the implementation of HIV/AIDS programme all over the world have reinforced the fact that programmes can not work without a visionary and bold leadership. Clifton Charles in “Access to All: Qualities of leadership”, an analysis of the lesson learned from the 15<sup>th</sup> international AIDS conference held in Bangkok, Thailand captures the essence of leadership in HIV/AIDS thus:

“We need leaders to break the silence that still hold AIDS as a political, social and economic hostage. We need leaders to denounce the status quo that feed stigma, discrimination and violence against individuals living with HIV and those who want to help them. We need leadership that generates substantial resources for lasting, prevention and care for individuals living with and impacted by HIV/AIDS. We need leadership that brings government, private sectors and communities to the same table – to foster effective listening and

forging even more effective partnership. We need a commitment to provide access to all”

The international community has acknowledge that HIV/AIDS is the biggest development challenge human beings are currently facing and will most likely continue to face in the coming decade. It is in this light that the June, 2001 United Nations General Assembly Special Session (UNGASS) Declaration of Commitment stress that “strong leadership at all levels is essential for an effective response to the epidemic”(UNAIDS 2001). It also opined that “leadership involves personal commitment and concrete action.” In packaging its leadership development programme specific to building a new crop of leaders to confront HIV/AIDS, the United Nations Development Program (UNDP) describes leadership as “not necessarily associated with rank or position, but intrinsically associated with qualities such as spirit, energy, patience, perseverance, vision and innovation. The attitude of this leadership include: the capacity to inspire others to action, speaking and listening in a way that enables individuals participating in the conversation to act and to create future life conditions that were not predictable at the start of the conversation. Chris Argyris postulated that “the new leadership challenge is to perceive and actualize emerging opportunities. Real power or influence cause from the ability to recognize and adaptively respond to the pattern of change of the leader is to recognize these emerging patterns and position herself/himself, personally and organizationally and as part of a larger generative force that will reshape the current landscape in other to achieve the sustainable result desired. The challenge for leaders is to develop “knowledge for action”.

From the forgoing, the question that comes to mind is: Where have we seen bold leadership in global effort to stem the tide of HIV/AIDS? In attempting to answer this question, we will first of all review existing literature and studies on leadership of HIV/AIDS services in Africa before delving into the efforts of the international donor community.

## **2.15 The African Perspective**

There is no doubt that Africa is experiencing the biggest impact of the epidemic and its effects are becoming feasible in nearly all countries of Africa. In 2002, 25.3million people were infected in sub-Saharan Africa, with 3.8 million new infection in 2000 an average HIV/AIDS prevalence of 8.8%. Within sub-Saharan Africa the epidemic has generally moved South and West from Central and Eastern Africa. Eastern and Central African countries now have a mature wide spread level of HIV infection with Southern African countries experiencing high level of infection although AIDS mortality level there are still relatively low compared with those in Eastern Africa. West African countries vary quite widely in their level of infection (UNAIDS 2004).

The epidemic in the southern and eastern part of the region is now generalized, touching virtually every segment of society. Contrary to previous projections, infection levels in many of these countries continue to mount. In West and central Africa, where epidemics are less severe, the rate of new infection appears likely to increase significantly. In eight countries in the West and Central Africa, adult prevalence has now surpassed five percent. Between four and six million people are estimated to be infected in Nigeria, the most populous country in Africa and the U.S. National intelligence report projects that up to 15 million people will be infected by 2010. The council also projects that infection rates in Ethiopia will escalate from official estimate of 2.7 million infectious in 2002 to up to 10 million by the decade's end.

**2.15.1 Primary Modes Of Transmission** – The majority of HIV transmission in the region stems from sexual behaviour. Sub-Sahara Africa is also home of roughly 90% of the 800,000 infants who contract HIV each year before or during birth or as a result of breastfeeding, although this percentage is slowly declining as epidemics grows in other regions. An estimated 2.5% of new infections in Africa stems from unsafe infection practices.

In Sub-Saharan Africa, women account for 58 percent of all HIV/AIDS infection and infection rates among young women age 15 – 24 are approximately twice as high as those among men. The growing disparity between male and female infection rates in Africa reflects the degree to which gender inequalities are now driving the epidemic in Sub-Saharan Africa, as women who lack economic independence, educational opportunities and access to information on health and services have difficulty avoiding exposure to the virus. Gender focused programmes must address the many social, economic and political disadvantages that directly increase women's vulnerability to HIV infection.

Although available interventions and technologies are highly effective in reducing transmission rates, prevention strategies will be optimally successful if they address the social and economic condition that accelerates vulnerability to HIV. Limited educational opportunities for girls, for example, are directly correlated with higher teen pregnancy rates and earlier initiation of sexual activity. Where a woman's economic security depends on a man, she may be less able to negotiate condom use during sex. From society standard, countries that are too poor to support even a minimal health care infrastructure are unlikely to have the wherewithal to provide VCT, STD diagnosis and treatment or PMTCT.

In assessing the leadership of the HIV/AIDS response in Africa, we find ourselves inevitably looking at the political commitment of the leadership in each country. In this regard, political commitment is exemplified by:

- i. Leading Politicians' personal and public identification with the epidemic and
- ii. A willingness on their part to mobilize resource and fast track implementation. These are commonly used indicators of leadership and political commitment in HIV/AIDS programme management and operations research (Adnar, 2002).

To put in its proper context the leadership response to HIV/AIDS in Africa, it is important to understand the pattern of responses to the epidemic. As in other infections and communicable diseases in the past, the pattern of response to the HIV/AIDS epidemic can be divided into three stages:

- i. Denial – that the new epidemic is present within a country reflected by either the absence of any preventative or treatment measure or by any border restrictions.
- ii. Recognition – That the epidemic is present in the country (a country will admit that cases of the epidemic are occurring and will adopt measures to find out how wide spread the epidemic is) and
- iii. Mobilization – A country gets active at the levels of society and government to prevent further spread of the epidemic (Man, J, 1987).

Denial was wide spread in Africa in the early 1980s and middle days of the epidemic and physical evidence of the disease was lacking while some political leaders in Africa are still in denial phase, most are in the process of moving towards recognition as evidence of the impact of the epidemic is becoming increasingly hard to avoid. In Africa to day, countries like Kenya, Zimbabwe, South Africa, Botswana, Nigeria, Namibia and Malawi seemed to have moved away from denial to recognition. Botswana and Nigeria have moved rapidly towards the mobilization phase while Senegal and Uganda are the only countries adjudged to have moved fully into the mobilization phase.

#### **2.15.2 Evidence of Leadership In Senegal**

Senegal is a politically stable, predominantly Muslim country, with one of the lowest rates of HIV/AIDS in sub-Saharan Africa. In 2003, there were an estimated 41,000 people living with HIV/AIDS (0.8% of adults).

The epidemic has disproportionately affected the very poor, particularly those involved in sex work or migrant labour. In Dakar, fewer than 1% of sex workers were

affected in 1986, but this figure had increased to 14% by 2002 – rising to over 20% outside of Dakar during the same period. By 2002, 4% of male sexually transmitted infection clinic patients in Dakar had tested positive for HIV.

The government of Senegal's prevention efforts has successfully kept a larger-scale epidemic at bay. Key to this has been an early, all-encompassing programme involving religious and political leaders as well as the non-governmental organisation sector, which already had a well-developed tradition of community mobilisation.

Right from the early stage of the infection, Senegal proactively confronted the epidemic through a combination of:

1. An effective epidemiological surveillance system.
2. The involvement of all leaders: religious, political, and traditional.
3. Intensive information campaigns and
4. Wide spread provision of preventive measures such as condom.

According to Gow (2002) Senegal's success is attributable to strong political leadership and the country's high level of social cohesion, of governmental ability to work effectively with civil society and religious structures to address HIV/AIDS from the mid-1980s onward. Senegal's response was woven around a long tradition of community involvement in health and development issues. Senegal to date becomes a glaring example of a country that has managed to contain the epidemic to incredibly low level despite high poverty level as a result of organized and committed response of all sectors to the issue.

### **2.15.3 The Uganda Experience**

The Uganda experience is also a testimony of how committed leadership can bring about positive outcome in reducing HIV/AIDS prevalence. In Kampala, HIV prevalence among tested prenatal clinic patients rose from 11% in 1985 to 31% in



1990 and declined to a stable 15% 1996 (Bernard, 2000); this is one of the fastest declines recorded in Africa. Many researchers have agreed that many HIV/AIDS intervention have contributed to stemming the epidemic, not because they were about AIDS but because they were about building civil society, taking responsibility and responsible leadership (Gore 2001, Amil 2002, Arden 2003). Between the late 1980s and mid-1990s, at a time when HIV/AIDS was well on its way toward ravaging Sub-Saharan Africa, Uganda achieved an extraordinary feat: It stopped the spread of HIV/AIDS and recorded an extraordinary reduction in the rates of infection. By now, Uganda's success story has become virtually synonymous with the so-called ABC approach to HIV/AIDS prevention, for *Abstain, Be faithful, use Condoms*. And, indeed, it is clear that some combination of important changes in all three of these sexual behaviors contributed both to Uganda's extraordinary reduction in HIV/AIDS rates and to the country's ability to maintain its reduced rates through the second half of the 1990s. Beyond that, however, the picture becomes considerably less clear.

ABC refers to individual behaviors, but it also refers to the program approach and content designed to lead to those behaviors. Researchers and public health experts continue to study both and to delve into the many and varied complex relationships among them. This information is critical to determining to what extent the Uganda experience really is replicable and what from that experience productively might be exportable to other countries. At the same time, much more research is needed into the relevance of the ABC approach for the prevention of other sexually transmitted diseases (STDs) as well as unintended pregnancy and the abortions or unplanned births that inevitably follow, both in Sub-Saharan Africa and in other parts of the world.

The findings of an analysis released by The Alan Guttmacher Institute in November 2003, **A, B and C in Uganda: The Roles of Abstinence, Monogamy and Condom Use in HIV Decline**, are consistent with the current consensus. Between 1988 and 1995, the time period during which HIV prevalence was declining, key changes in behavior occurred:

- Fewer Ugandans were having sex at young ages. The proportion of young men who had ever had sex decreased substantially and the median age at which young women began having sex rose from 15.9 in 1988 to 16.3 in 1995. Importantly, however, among those people who were having sex, overall levels of sexual activity did not decline.
- Levels of monogamy increased. Sexually active men and women of all ages, particularly the unmarried, were less likely to have more than one sexual partner in a 12-month period in 1995 than in 1989. Other research has found that the proportion of men reporting three or more sexual partners also fell during the period.
- Condom use rose steeply among unmarried sexually active men and women. Among unmarried women who had had sex in the last four weeks, the proportion who used condoms at last intercourse rose from 1% in 1989 to 14% in 1995; among unmarried men, condom use rose from 2% to 22%.

The relationship between individual sexual behavior and HIV risk is further complicated, however, by many other factors that overlay a simple A, B and C analysis. The risk of exposure is greater, for example, in the presence of other STDs and it appears to be lower for circumcised men. The number of a man or woman's sexual partners matters, but so does the duration of relationships, the extent to which relationships might overlap, frequency of sex, specific sexual practices, how consistently and correctly condoms are used with different partners, and the stage of infection of an HIV-positive partner.

In high-prevalence settings, ascertaining exactly which behavior change or combinations of changes can have the most impact in reducing HIV infection among the population as a whole is the focus of more recent studies. Indeed, based on the Uganda experience and drawing on an understanding of the epidemiology of STDs more generally, scientists are now concluding that other things being equal, even if absolute monogamy is not attained, having fewer sexual partners, especially

concurrently, may be the most significant behavior change for a population overall. (Whether this is always the most significant protective factor at the *individual* level may be another matter.)

*Creating behavior change.* It is not possible to make a direct and simple link between the changes that took place in Uganda and the policies or programs that may have caused them to happen. The widely held view among Ugandans and outside analysts, though, is that increases in all three of the ABC behaviors led to reduced HIV rates following a comprehensive national message that HIV prevention was of the utmost importance to the country and the responsibility of all of its citizens. The message was delivered in different ways through a multiplicity of approaches, programs and types of organizations and was buttressed by a level of political commitment to forthrightly addressing the AIDS crisis that was unique among African governments.

It is important to note that these changes would not have occurred without the able and unfettered leadership and commitment of President Yoweri Museveni. President Yoweri Museveni himself exhorted Ugandans, and still does, to practice A, B and C. Further, as Harvard medical anthropologist Edward Green observed recently, "ABC is far from all that Uganda has done." Uganda, he noted, "pioneered approaches towards reducing stigma, bringing discussion of sexual behavior out into the open, involving HIV-infected people in public education, persuading individuals and couples to be tested and counseled, improving the status of women, involving religious organizations, enlisting traditional healers, and much more."

The evidence, therefore, points to the existence of a range of complementary messages and services delivered by the government and a wide diversity of nongovernmental organizations. To be sure, those messages included the importance of both young people delaying sexual initiation and "zero grazing" (monogamy). But contrary to the assertions of social conservatives that the case of Uganda proves that an undiluted "abstinence-only" message is what makes the

difference, there is no evidence that abstinence-only educational programs were even a significant factor in Uganda between 1988 and 1995.

Encouraging signs also are beginning to emerge from other countries where HIV/AIDS had become a generalized epidemic. In Zambia, for example, HIV rates appear to be declining, at least among urban youth. The U.S. Agency for International Development (USAID) notes that "clear, positive changes in all three ABC behaviors" have taken place. Indeed, it would seem that the HEART (Helping Each Other Act Responsibly) program, a major USAID-funded media campaign there, may deserve much of the credit. This program, which was designed for and by youth, promotes both abstinence and condom use. One year after the campaign's initiation, indications are that young people exposed to its comprehensive messages are 46% more likely to be delaying or stopping having sex and 67% more likely to have used a condom the last time they had sex, compared with those who were not exposed.

In Jamaica, where HIV rates are still relatively low but sexual activity at early ages is prevalent, a similar media campaign is beginning to show results. According to a recent summary from the USAID-sponsored YouthNet project, "More than half of the youth who recalled the ads said the ads had influenced how they handle boy/girl relationships through abstaining from sex, not giving into sexual pressure, and always using a condom/contraceptive when having sex."

HIV/AIDS rates also are declining in Cambodia, Thailand and the Dominican Republic, three other countries where various combinations of ABC behavioral changes appear to have played an important role. In Cambodia and Thailand, the epidemic spread mainly through prostitution. Both countries are adopting a "100% condom use" policy in brothels, and it is yielding positive results. In the Dominican Republic, meanwhile, the infection rate has slowed mainly due to men having fewer sexual partners as well as to increased condom use.

Finally, Brazil has so successfully stemmed the tide of HIV/AIDS that only half the number of Brazilians is infected today as the World Bank had predicted only a few years ago. Brazil's case may be atypical in one sense because of the government's decision to make free antiretroviral drugs available to anyone who qualifies for AIDS therapy. But it is equally atypical within Latin America because of the government's decision to promote frank talk about sex as well as condom distribution programs. Indeed, the Brazilian Health Ministry announced plans in August 2003 to distribute condoms to sexually active high school students in five Brazilian cities to prevent not only HIV/AIDS but also teenage pregnancy. Officials are particularly concerned about preventing HIV-positive teenage girls from becoming pregnant and then transmitting HIV/AIDS to their newborn infants.

In concluding this section on the Ugandan experience as compared to the HIV response in Cambodia, Thailand, Dominican Republic and Brazil, leadership remains to key issue affecting how the programs were structured and implemented and the level of achievements recorded.

#### **2.15.4 Assessing Leadership and Political Commitment to HIV/AIDS**

The national HIV/AIDS control program of Thailand, the Brazilian government's provision of universal access to antiretroviral (ARV) drugs, the early establishment of comprehensive harm reduction program in Australia, the formation of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and the US President's Emergency Plan for AIDS relief-each of these initiative was brought about, in large part, because of political commitment and leadership at local, national, and international levels. Elizabeth Glaser's determination to use her struggle to put the issue of pediatric AIDS on the national agenda in United States, Zackie Achmet's refusal to take ARVs until they become more widely available to other South African living with HIV/AIDS, Mechai Viradvaity's visit to Thailand's red light district to hand out condoms, and Nelson Mandela's public disclosure of his son's cause of death all

remind us of personal dedication and courage needed to ensure that HIV/AIDS remains a priority for national policymakers and program planners.

Inadequate leadership and political commitment is seen when a country turns its back to the tide of rising HIV prevalence, when the government denies the urgency of the epidemic or fail to appropriate adequate human and material resources to meet the challenge. But for many reason, isolating, defining, and measuring what “political commitment” really is has been difficult.

Defining political commitment can be highly subjective. Not only do different people have different ideas about what constitutes strong political commitment its definition can also vary significantly from one person to another, or from one country to another. One universal list of attributes and activity will not likely sufficiently cover the role responsibilities of each sector in galvanizing and sustaining a country’s HIV/AIDS response. “Additionally, while high-level acts of political commitment are many “instance or acts” of political commitment are likely to happen away from public view. And the gradual changes in the political climate may be hard to pinpoint, track, and measure over time. Nor does the mere existence of policy or budget reveal much about how it is implemented and how it impact programs in the practical sense” (Policy Project, 2005)

Political commitment is intrinsically linked, to some degree, to each facet of a successful HIV/AIDS programs. When national AIDS control staff are well trained, strategies offer the appropriate balance among prevention, treatment, and support, and resources are mobilized and used in an efficient manner. We might assume that strong political commitment helps to facilitate these outcomes. However, it might not always be clear what the role was of national political commitment versus, says, international donor support or community-based advocacy or other factors. This raises several questions: was political commitment the factor that made the difference? Was it necessary pre-requisite? Could it have happened in the absence of strong political commitment?

These questions are not merely of academic interest, they are of importance for HIV/AIDS advocates and policymakers. Encouraging political commitment, and a personal willingness of individuals at all level to take up the fight, is of particular relevance for HIV/AIDS because epidemic often start by affecting vulnerable groups who might otherwise be ignore by the society; silence and stigma drives the disease underground; and substantial resources and long-term vision are required to address the epidemic.

This section considers how organizations have defined and measure political commitment and leadership for confronting HIV/AIDS. It also explores the role and significance of political commitment in national HIV/AIDS response.

#### **2.15.5 What is Political Commitment?**

Recognizing that political commitment can be a force that helps to catalyze and sustain successful HIV/AIDS programs, various organizations have sought to more clearly define and articulate keys characteristics of political commitment. For UNAIDS, political will 'expresses national commitment and overall leadership to the nation in response of AIDS. Effective responses are characterized by political commitment from community leaders up to a country's highest political level. Such commitment leads to high-profile advocacy and help bring in all sector and players, along with the necessary human and financial resources. It is also critical for making the right choices often involve in adopting intervention method that really worked' (UNAIDS, 2000).

Policy Project defined political commitment as "the decision of leaders to use their power, influence, and personal involvement to ensure that HIV/AIDS programs received the visibility, leadership, resources and ongoing political support that is required to support effective action to limit the spread of HIV and mitigate the impacts of the epidemic (POLICY Project, 2000).

These definitions emphasized that political commitment should come from various level and sectors of society (not just government policymaker) and that it involves not only raising awareness or visibility of HIV/AIDS, but also support for effective implementation of policies and programs. Therefore a multi-sectoral approach and one that includes prevention, treatment and care and supports are also underlying themes in these definitions. Political commitment is a combination of personal quality or attribute (e.g. personal involvement an ability to make hard choices) and specific action (e.g. mobilization of resources and support for an effective response).

The term political commitment, however, can have its limitations when we begin to think about all of the various players, activities, and the intervention needed for an effective national HIV/AIDS response. It should not be confined to the government or “political” world, rather, PLWHAs, NGOs, faith-based groups, business, the media, and other sectors have roles to play not only as advocate who hold government accountable, but also as leaders within their own communities. It follows then that “political commitment in the broadest sense means leadership commitment” (POLICY Project, 2000)

The use of the word “political” may also give the impression that the issue is primarily one concerned with the policy development and legislation. Laws and policies provide the necessary guidelines and framework on which to base programs; they also detail how resources will allocated and mobilized. However, political commitment has roles to play throughout the entire policy and program development process-for examples, placing and keeping HIV/AIDS on the national agenda, reducing the gaps between policies and implementation, insuring widespread participation, and collecting, analyzing, and disseminating data and information that lead to the improvement of future policies and programs.



### **2.15.6 How important is political commitment and leadership?**

As HIV/AIDS has evolved from been viewed as a public health issue-to be dealt with primarily by doctors and scientific researchers-to being recognized as an epidemic that affect every aspect of country's national and socioeconomic development, the need for strong commitment and leadership has become more apparent. For more than a decade, the need to strengthen political commitment and leadership has been a cornerstone of international meeting, declarations, and summits on HIV/AIDS

In 2000, more than 1,500 government and civil society representatives convened at the African Development Forum under the theme "AIDS: the greatest need for leadership challenges." The Forum emphasized leadership commitment at all levels, from personal involvement to international partnerships. Also in 2000, in its update on the global HIV/AIDS epidemic, UNAIDS identified nine common features of effective national response; political will and leadership" was the first item on the list but what attest to the importance of national political commitment is the fact that it plays a critical role in promoting the other eight features of effective responses. For example, strong political commitment from the country's top leaders can help mobilized resources, facilitate by-in across sector, encourage community- based involvement, ensure wherewithal to support a sustained response, and promotes openness in terms of addressing HIV/AIDS and caring for those affected by the disease. Recognizing the need for improving commitment and national leadership for addressing HIV/AIDS, the XV International AIDS Conferences (held in 2004), for the first time, devoted an entire track to leadership to complement the scientific and community-based program of the conference.

The response needed to confront the HIV/AIDS epidemic, including significant human capacity and infrastructural development and changes in societal and behavioral norms, will not come about through a "business as usual" approach or through regular bureaucratic processes-it therefore needs individuals and groups who demonstrate leadership and continually, thoughtful advocate to move the process forward.

### 2.15.7 How can we measure political commitment and leadership?

Measuring and tracking political commitment and leadership is important to success of HIV/AIDS programs because it helps us determine if current commitment is adequate, if there are certain areas of strength and weakness, and if changes in commitment impact programs and outcomes. Because it is intangible, individualistic, and difficult to isolate, finding direct measure of political commitment among national leaders has been a challenge. Researchers have often had to rely on proxies or indirect measure and data from various sources to get a complete picture of a country's political commitment.

Three primary approaches for measuring political commitment, to date, have been to: 1) analyze public statements made by leaders; 2) track quantifiable actions that can be seen as resulting from political commitment(e.g., HIV/AIDS budget level); and 3) using the judgments of key informants to develop a composite indicator of national effort (POLICY Project, 2000). Each approach can offer useful information, but also has own limitations.

- **Public Statements of national leaders.** Especially in low HIV prevalence countries, where few PLWHAs may be able to safely disclose their status, national and community leaders can help raise the veil of silence and stigma that surrounds HIV/AIDS and provide a voice for affected group. Speaking out about HIV/AIDS when an epidemic is in its infancy is a critical first step for HIV/AIDS on the nation agenda and for encouraging community dialogue. This is a time when commitment and national leadership is even more critical because emerging epidemics often impact vulnerable communities (e.g., injection drug user [IDUs], sex workers, and men who have sex with men [MSM] that are outside the mainstream of society and may lack their advocates and policy champions. While national leaders public statements about HIV/AIDS, in general, are important, going a step further and vocalizing the needs of PLWHAs vulnerable groups is a particularly powerful demonstration

of political commitment. The limitations of using public statements as an indication of commitment and leadership, however, is that such statement may be tied to particular event (e.g., World AIDS Day) and once the event ends, commitment for action wanes.

- **Quantifiable program action and result.** If political commitment is effective, we can assume that it will result in the adoption of appropriate policies and operational guidelines, the establishment of implementation mechanism, and the mobilization of the resources. The 2001 declaration of commitment on HIV/AIDS outline the number of targets (e.g., adoption of a national HIV/AIDS policy, reduction in HIV prevalence among key subgroups) that can be used to track progress toward a commitment for a comprehensive national HIV/AIDS response. In case where financial resources are scarce, a significant contribution of the national budget to HIV/AIDS can be an indication of the country's priorities. Similarly, if laws and policies protect the human right of PLWHAs and prohibits discrimination on the basis of HIV status or perceive status, this too is key indicator of the country's commitment. However, as noted above, the existence of a policy does not necessarily say much about how it is implemented; and the level of spending does not tell how funds are disbursed or whether they are used efficiently or not.
- **Composite indication of national effort.** As part of an effort to improve monitoring and evolution of national HIV/AIDS programs, the POLICY Project collaborated with UNAIDS and USAID to develop the AID program Effort index (API) (UNAIDS, USAID, AND POLICY Project, 2001). The API produces a composite index, based on the assessment of 15-25 experts in each country, which measures high-level inputs of national programs and international organization into the country's HIV/AIDS response. Program effort inputs include political support, participation by civil society, and resource levels. The API does not measure outputs. The revised API questionnaire, used in 54 countries in 2003, covers 10 component of national program efforts using both

“yes/No” items and summary ratings (interviewees answer on a scale of 0-10) (USAID, UNAIDS, World Health Organization, and POLICY Project, 2003). This approach provides useful information on various aspects of the national program, including prevention program and treatment and care services. While the revised format of the API reduces subjectivity in the findings, particularly on the summary ratings. This makes it hard to track changes overtime or to make comparison with other countries. As the API produces a numerical score, it also may be difficult to interpret what the findings mean. For example, why did the respondent give “political support” a summary rating of 7 as opposed to 6 or 8 or 10?

Another approach to understanding political commitment as proposed by the Patterson (2000), which calls for improving governance as a way of enhancing the national HIV/AIDS response and increasing commitment and accountability from the country’s national leaders. According to this argument, sustained political commitment is uncommon and fragile; it is also difficult to measure political commitment and to identify its determinants. At the time experience shows that governments are more likely to be responsive to societal needs when “government leaders must face the consequences of non-action” (Patterson, 2000). Here accountability and strong leadership are inextricably linked. It follows, then, that strategies such as promoting respect for civil and political rights, increasing civil society participation, and encouraging of the development of free, independent media can mobilize pressure on the government from the ground up. In this case, rather than measuring speeches made by politician as a sign of commitment, for example, there should be a focus on “concrete and measurable programming option to increase government effectiveness in the response to AIDS, and which may also increase visible government commitment as well” (Patterson, 2000).

The POLICY Project emphasizes an approach to measuring and building political commitment that includes working with local and national government leaders, as well as civil society and private sector groups. POLICY’s approach involves four key

component: building political and popular support; improving planning and financing of HIV/AIDS programs, ensuring that accurate up-to-date information informed evidenced-based decision making; and enhancing in-country and regional capacity to participate in the policy process.

The political commitment assessment questionnaire presented in the next section focus more specifically on political commitment and expressed by a country's national leading experts in the HIV/AIDS field to help advocate and policymakers identify areas of strength and weakness in the national response to the epidemic.

Given the scope and magnitude of the HIV/AIDS epidemic, a strong and unwavering dedication of individuals and communities is the catalyst needed for mobilizing the huge amount of resources to make a difference. Collective will of the people will help in overcoming the stigma, so that it is dealt with in an open and non-judgmental manner. Political commitment and effective leadership are essential for creating an enabling environment that promotes the development and growth of appropriate, sustainable HIV/AIDS policies and programs. The need for strong leadership is acutely felt in low prevalence countries where there is still an opportunity to contain the spread of the epidemic. International efforts such as the 2001 Declaration of Commitment on HIV/AIDS (signed by all 189 members of the United Nations) have repeatedly called on political, religious and community leaders to answer the challenges posed by the epidemic. However, "political commitment" is a term that is often used without a clear sense of what it means, how it affects programs, when it can be most effective, and how it can be strengthened by advocates and policymakers (Policy Project, 2005).

#### **2.15.8 Leadership and Political Commitment: The Asian Study**

To address this, the United States Agency for International Development's (USAID) Asia and Near East (ANE) Bureau commissioned a study of national political commitment for confronting HIV/AIDS in low prevalence countries across Asia. It asked one of its projects to carry out a study to assess leadership and political

commitment to HIV/AIDS in four countries namely, Bangladesh, India, Nepal, and Viet Nam-resulting in individual reports for those countries. According to the Policy Project, “these diverse countries were selected because they represent a “window of opportunity,” where strong political commitment and leadership for confronting HIV/AIDS can make a difference in terms of heading epidemic before it reaches the magnitude witnessed in other parts of the world. Political commitment and leadership are likely to have the greatest impact on the epidemic while HIV prevalence is still low. Unfortunately, this may be the time when local and national leaders are least likely to act because the potential impact of the epidemic is not yet fully recognized. Paradox of the national leaders may be tempted to wait until “crisis mode” before they mobilize a comprehensive response. In addition, early in an epidemic, national leader may unwilling to make hard unpopular decision needed to prevent what is perceived as a distance threat”

Being one of the foremost studies undertaken to assess leadership, political commitment and HIV/AIDS, this study and its findings will be reviewed in details because of its similarities in approach and the findings of this research study. The study began with a review of what was known as at then about political commitment today, why it matters, what its characteristics are, how it has been measured to date, and how it can be strengthened. It also reviewed the multi-country pilot assessment study in Asia, reviewing common themes from the country studies, analyzing lesson learned, and providing concluding thoughts and recommendations for future study and action.

Isolating and analyzing the role of political commitment and leadership may be a challenging endeavour. However, a thoughtful look at a level of commitment for addressing HIV/AIDS demonstrated by key players in the national response can help countries diagnose areas of strength and weakness, hereby pinpointing gaps and challenges and providing directions for future advocacy efforts.

### **2.15.9 Leadership and Political Commitment Variables in the Asian Study**

POLICY Project researchers conducted a review of the literature on political commitment for addressing HIV/AIDS and other relevant health issues, such as family planning and reproductive health. This review, coupled with the Project's own experiences in assessing and building political commitment, informed the development of qualitative research guide for assessing 13 aspect of national political commitment. The questionnaire begins by asking respondent about their own definition of political commitment. It then proceeds to an assessment of 12 program areas (e.g. leadership policy, and resources) that have been shown to be critical to an effective national HIV/AIDS response. However, rather than been a standardized questionnaire, the question presented under each topic in the assessment tool were intended more as a guide and starting point for researchers to explore their country's response. The questionnaire also captured the roles of government and civil society as both contribute to country's response to the epidemic. In summary the variables captured are as in the table below:

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#### **CATEGORIES OF LEADERSHIP AND POLITICAL COMMITMENT VARIABLES IN THE ASIAN STUDY**

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- Understanding of Political Commitment
- Foreign Technical Assistance and Foreign Experience
- Top Leadership
- Public information/Education/Use of Media Policy Formulation
- Legal and Regulatory Environment
- Resources
- Monitoring and Evaluation
- Organizational Structure
- Program Components
- Multi-ministry Involvement

- Stigma and Discrimination
  - Role of NGO's and Civil Society in the National Response
- 

The questionnaires also sought to explore societal issues, such as stigma and discrimination which can influence the policy environment. The assessment served as a diagnostic tool for identifying areas for future advocacy and action. Given the somewhat objective nature of political commitment, open-ended format was used to allow for greater exploration into the country's unique experience. For example, if HIV/AIDS policy is an area that was deemed weak by respondents, the researcher followed up with additional questions: why is "policy" a weak area? Have policy been adopted? Do they have any major gaps? Do they protect PLWHAs against discrimination? Are policy strong on paper and yet weak in implementation? Have policy been determinate? Are program staffs trained in application? Are there mechanism for monitoring progress made toward achieving policy goals and objects?

The assessment questionnaire was pilot-tested in four diverse countries with low national HIV prevalence in Asia: Bangladesh, India, Nepal, and Viet Nam. Local staff and in-country consultants reviewed relevant literature pertaining to each country's national HIV/AIDS response, including policies and plans, proposal to GFATM, UNAIDS reports, declarations, and other documents. They conducted in-depth interviews with about 12-16 informants from each country. These informants were selected because of their expertise in the HIV/AIDS field were drawn from the range of sector and groups, including the government (e.g., Ministry of health, Parliaments, and national AIDS control program), NGO's, PLWHAs groups, faith-based organizations the international donor community, international NGOs, and other (e.g., the media, academia, and human right organization). Sixty two respondents were interviewed each country from the government and NGO sector, international donor agencies, PLWHAs, human rights groups, faith-based organizations, the media and the academia.



#### 2.15.10 Major Findings from the Country Studies

The following common themes emerged across the countries of study:

- **Commitment for addressing HIV/AIDS tended to be sporadic, yet increasing.** Respondents across countries noted that the political commitment was sporadic and, too often limited to specific events, such as World AIDS Day or an appearance at an international conference. In many cases, sustained political commitment was demonstrated only by a small group of national leaders. Viet Nam was an exception, where respondent felt that the influence of the communist Party allow for broad-based support to flow from the highest level of the party and government down through the provinces and state organized mass organizations. India has also demonstrated increasing commitment in recent years, with the lunch of the Parliamentary Forum for HIV/AIDS in 2002 and a national convention on HIV/AIDS that brought together more than 1,000 elected officials from the level of government in 2003.
- **A gap existed between policy and implementation.** All countries have drafted national HIV/AIDS policies or ordinances and to varying degrees developed strategic plans, adopted human rights guidelines, and established an organizational framework to coordinate and implement the HIV/AIDS programs. A common concern among the respondents from all countries was the gap between political commitment as expressed in statements and policies, and political commitment as demonstrated by support for implementation – as evidence by financial resources mobilization and allocation, support for training, enforcement of policies and guidelines, and a development of non-stigmatizing public education campaigns. Some of the other keys of challenges in implementing programs were limited civil society and PLHA collaboration in the national program; lack of accurate data regarding vulnerable groups; and bureaucratic structural and budget processes that lack flexibility.

- **Achieving the appropriate balance of program approaches and group targeted was a challenge.** National leaders were in need of assistance in terms of identifying priority activities, advocating for program approaches that may entail hard or unpopular choices, and allocating resources to achieve maximum impact. In some countries, respondent felt that national program focused on prevention effort rather than recognizing the need to also provides treatment and care services. Respondent from Nepal urged that while the national HIV/AIDS operational plan covers voluntary counseling and testing (VCT), prevention of mother-to-child transmission (PMTCT), and highly active antiretroviral treatment (HAART), the government should do more to establish prevention and care programs especially for vulnerable groups. In Bangladesh, respondent felt that policies were unclear or lacking with regard to vulnerable groups, such as sex worker, IDU, and MSM.
- **National leaders should take charge of efforts to reduce stigma and discrimination.** Whether discussing enforcement of policies or human rights guidelines, the appropriate balance of program component and resource allocation, the role of NGOs and civil society, roll-out of public education campaign, or need for accurate data and evidence-based decision making, respondents frequently came back to the issue of stigma and discrimination against PLHAs and vulnerable groups. Respondent generally felt that top national leaders had not done enough to address stigma and discrimination. In Vietnam, for examples, HIV/AIDS activities were linked to programs to address so-called “social-evils” such as the sex industry and injections drug use. Respondents in India stated that HIV/AIDS is treated as a “foreign” or, “Western” disease. In some instances, even when intentions may have been good, national leaders’ statements and actions tended to exacerbate the situation (e.g. encouraging fear rather awareness).

- **NGOs are leading the way.** In general, respondents credited NGOs and civil society organizations for doing groundbreaking work with communities most affected by HIV/AIDS, even though the NGO and civil society sector in the four countries are in various stage of development. In Viet Nam, which has a strong centralized government and state-organized mass organizations, respondents stated that the NGO sector was just beginning to emerge and was in need of support for capacity development. At the same time, HIV/AIDS was an area in which Vietnamese NGOs were very active. Respondents in Bangladesh reported that NGOs have had to fill in the program gaps that were not addressed by the government. In India, NGOs have played a leading role in implementing targeted intervention for vulnerable populations. In each country, respondents noted that PLHAs and other vulnerable population have begun to organize themselves into advocacy and peer support groups. Growing commitment was also seen in the faith-based communities and business sector. In addition, efforts were underway to better coordinate NGO activities. For example, a task force of Vietnamese and international NGOs met every three months to discuss coordination and collaboration, including HIV/AIDS prevention activities. Bangladesh has established a National HIV/AIDS and STD Network, while Nepal has a National NGO Network Against AIDS. Respondents across counties urged government to do more to build NGOs capacity and encourage civil society and meaningful PLHA participation in national policymaking and program implementation.

#### **2.15.11 Lessons learned from the Asian Study that can benefit current and future research efforts.**

After a review of this study considering its methodology and findings, the following observations were made which helped this research effort and will be helpful to future researchers interested in exploring this vast area of research into leadership and political commitment:

- **The view of the respondent validated the inclusion of the topics explored in the open-ended political commitment assessment questionnaire.** As a starting point, respondents were first to define what they meant by “political commitment”. Characteristic of political commitment that respondents frequently mentioned include dedication, perseverance, personal involvement, a vision for the future, a willingness to learn, a strong follow through. In terms of identifying ways in which national leaders demonstrate their political commitment, respondents listed: formulating and adopting policies, strategic plans, and legislation; delivering speeches and public statements; participating directly in public education campaigns; encouraging multisectoral engagement and civil society participation in planning and program implementation; establishing special committees, institutions, or agencies to address HIV/AIDS; reducing stigma and discrimination; recognizing the HIV/AIDS as a development issue and that there was the need to address other factors; such as poverty and education, and allocating adequate human and financial resources to HIV/AIDS programs. The action and activities highlighted by the respondents themselves as aspect of political commitment matched up well with the 12 program component evaluated by the assessment questionnaire.
- **Finding knowledgeable key informant for each top area critical and may be a challenge in low prevalence countries.** Human capacity, technical expertise, and widespread participation in addressing HIV/AIDS are only beginning to emerge and should be nurture in low prevalence countries, making it a challenge to identifying key informant who can speak to all of the topic covered in the assessment guide. The political commitment assessment studies were designed to provide a range of representatives regarding each country’s national political commitment for confronting HIV/AIDS. As such, key informants were drawn from a

variety of sectors, including government, NGOs. International NGOs, and donor, PLHA groups, human organizations, and others. In some cases, researchers found that government respondents were unwilling or unable to participate in the interviews. In other cases, respondents were not familiar with the inter-workings of the government and did not feel comfortable evaluating topics such as the degree of multi-ministry collaboration or the allocation of the HIV/AIDS budget. Some respondents were experts in their own field (e.g., HIV/AIDS service organizations, the media), but were less able to commit on the levels of commitment in other sectors (e.g. faith-based organizations, or women's groups). Researchers planning to use the political commitment assessment guide will need to take care in identifying informants who are both representative and knowledgeable of the HIV/AIDS situation and response in the country. Particular, where possible and appropriate, researchers should consider expanding the pool of informants (e.g. to include more women's group and business representatives).

- **The questionnaire was designed to be tailored to the specific country context.** Given the experiences and expertise of the respondents who did participate in the four countries studies (e.g., senior government leaders, pioneering NGOs' representatives), and the open-ended nature of the questionnaire, researchers had the opportunity to explore the special circumstances of each country. While the pilot studies were designed to test the questionnaire in its current form, future researchers should remember that it is intended as a guide and is not something that must necessarily be standardized in each case. Researchers should feel comfortable pursuing relevant topics as they come up and deciding which questions best meet their assessment's needs. Additionally, some sections of the questionnaire may not be relevant for all countries. For example, Nepal's Parliament has been dissolved so the section on the "national legislature" was not relevant. In

such case, interviewers instead explored how the dissolution of the parliament affects the policymaking and national accountability. As another example, Viet Nam has a number of mass organizations that, functions in many ways, like NGOs in other countries, yet they organized by the Communist Party that also rules the government. In such an instance, instead of asking all the questions in the section on the role of civil society and government. For example, are mass organizations more involve in policymaking and program implementation because of their ties to the party? Or, conversely, are they less able to hold government accountable because they are organized by and dependent, to some degree on the party? Do the mass organization facilitate link between government and civil society? Can they serve as an empowering voice for different groups (e.g. women's youth, etc)?

- **There is a need to expand the assessment of NGOs , civil society, and private sector and highlight their roles as leaders in the national HIV/AIDS program.** The political commitment assessment guide, in the current forum, focuses mainly on the country's top political leaders and national government's response (e.g., budget, monitoring and evaluation, program components, and policy formulation). In particular, the "Top Leadership" ask a number of question about Country's President or Prime Minister and, such, may have skewed the respondents perception of who the country leaders were and a limiting effect on responses to certain question (e.g., Does the top leadership contribute toward the reduction of stigma? If so, in what ways?). In many cases, respondents answered questions about the national response only in terms of what government was doing or not doing. While the current questionnaire does include item relating to the role of civil society and NGOs, these items are included in the separate section. .

It was observed that leadership and political assessment studies can serve as a useful tool for helping HIV/AIDS advocates and policymaker analyze a country's national political commitment and leadership for confronting HIV/AIDS. In-country researchers can use this method to tailor question to their country's unique context. Such researchers can lay the foundation for identifying areas of strength and weakness in the country's HIV/AIDS program and highlighting areas for future advocacy and policy change efforts. For the country involved in the four pilot studies, developing human and health system capacity, reducing stigma and meeting the needs of the most vulnerable groups, and encouraging collaboration, participation, and coordination emerged as priority action areas for national leaders.

Experience has shown, in countries such as Brazil, Senegal, Thailand, and Uganda, the strong commitment early can have dramatic impact on the course of an epidemic. Political commitment and leadership are not likely to have the greatest impact-in terms heading off an epidemic and averting its worst consequences-if countries act when HIV prevalence is still low. Unfortunately, for more many reasons, this is the time when local and national leaders may be least likely to act.

- The need may not yet seem readily apparent;
- Countries may face other competing priorities;
- The issues to be tackle (e.g., reducing gender inequality, improving health system capacity) may seem too great;
- Needed interventions may be considered too political unpopular; and
- Reticent to reach out to the most vulnerable, and stigmatized, groups.

Strong political commitment and leadership for address HIV/AIDS are, to some extent, intangible qualities. Attempts to measure and assess political commitment have tried to triangulate information and data from various sources. Researchers have considered:

- Individual acts (such as a politician making a speech);

- Inputs into the national response (such as adoption of an HIV/AIDS policy or increases in the HIV/AIDS budget);
- Inputs from program efforts (such as the number of people accessing VCT services);
- Environment factors (such as the level of stigma and discrimination); and
- Long-term impacts (such as rise or decline in HIV prevalence).

This measure can say a lot about a country's national HIV/AIDS response-its strengths, weakness, and gaps-and they do allow us to make educated assumptions about the nature of leadership and political commitment within a country. But this still are not direct measures of political commitment and leadership. With political commitment, we know that it is necessarily tied to action because political commitment involved more than word or believe and must move on to implementation and action. At the same time, the essence of political commitment cannot be reduced to action alone. A person may be highly committed to fighting HIV/AIDS, yet still face obstacles that prevent or hinder effective action. Conversely, people may make statements, adopt laws, and allocate budgets without demonstrating strong, genuine leadership or commitment for the issue. We know intuitively that successful, multisectoral HIV/AIDS programs required political commitment and are examples of political commitment but we are still left with questions about the relationship between political commitment and leadership and program response and outcomes.

Some questions for further researcher and reflection are:

- What are the various factors that compel people to commit to addressing HIV/AIDS? Especially in low prevalence countries, what motivate people to come forward to confront HIV/AIDS? What are the characteristic and values of these "first responder"



- What are the barriers to effective leadership for HIV/AIDS? Under what condition is strong leadership most likely to occur? Under what condition can leadership and political commitment have the greatest impact?
- When is the “critical mass” reached and does commitment becomes widespread enough to affect positive change.
- What are the “best practices” for strengthening leadership and commitment in different sector (e.g., government, NGOs, faith-based groups, business, PLHAs)? What are “best practices” for insuring commitment at different stages or components in the national response (e.g., policy formulation, implementation, monitoring)?
- What social, institutional, or environmental factors facilitate effective leadership? Conversely, how does strong leadership influence sectoral, institutional, and environmental factors?
- How can we distinguish the appearance of political commitment (e.g., just paying “lip services” to HIV/AIDS) from genuine commitment and leadership?

These are some questions for further consideration. While isolating the contribution of political commitment and leadership to effective national responses remains a challenge, the importance of these factors is far too great to give up the chase. We must continue to strive for ways to define, measure, and strengthen political commitment and leadership for confronting HIV/AIDS. Those that recognize the need for increased attention for care and support. Respondents raised this point in regard to the appropriate balance among program components and to messages in public education and information campaigns.

- Bangladesh established a National AIDS Committee (NAC) in 1985. It is headed by the Health Minister and bring together members from 17

ministries, with the President of Bangladesh as Chief Patron. Along with the NAC's Technical Committee, it seek to promote multicultural engagement. Respondents, however, felt that both the NAC and Technical Committee need to meet more frequently, improve collaborative links across ministries, and encourage greater NGO participation, especially given the NGOs are well suited to reach out to vulnerable populations.

- Public education and information campaigns, according to respondents, need to be improved as they often are based on inaccurate information or tend to generate fear instead of understanding. Several respondents mentioned faith-based organizations as possible avenue for raising sensitive issues. They stated that religious leaders can help show that HIV/AIDS is not punishment for sin and that people instead focus on care and support for those affected by the disease. In some places, imams are already discussing HIV/AIDS issues during Friday prayer sessions.

### **NGO and civil society involvement in the national response**

- All respondents agreed that NGOs are critical to the success of the HIV/AIDS program and NGOs have been leading the way in Bangladesh. Activities undertaken by NGOs include advocacy and awareness raising, care giving, drop-in and clinical services, referrals, counseling, prevention activities, support and self-help groups. And meeting the need of PLHAs and affected communities.
- According to respondents, some of the sector that have not yet demonstrated a strong commitment to addressing HIV/AIDS in Bangladesh are the media, academia, human rights groups, women's right organizations, lawyers, teachers, and others.

- Many respondents believed that government needs to do more to encourage, strengthen and coordinate NGOs activities. In particular, government need to help build NGO capacity, identifying program gaps and avoid duplication, and confront the stigma surrounding HIV/AIDS, which hinder NGO work and prevent other NGOs from taking up HIV/AIDS issues.

## **Research, Monitoring, and Evaluation**

- In general, respondents felt in Bangladesh's HIV surveillance and behavioral studies provide accurate data on the state of the epidemic. Family Health International has complete and release the findings of the fourth round of second-generation surveillance.
- Respondents noted a need for better information regarding topics such as vulnerable populations. An additional area in need of improvement, according to respondents, is monitoring and evaluation to measure program impact and provide direction for future strategies.

### **2.16 Stigma and Discrimination**

- Most respondents believed that HIV/AIDS related stigma and discrimination are pervasive in Bangladesh. PLHAs have been denial treatment in the hospital as well as social support and therefore, are fearful about disclosing their status-thus preventing people from seeking testing and treatment. Stigma can persist even after death; for example, the custom of rituals, bathing of the dead is often withheld from those who die from AIDS-related illness while their immediate survivors are often denied family property.
- National leaders, according to respondents, tend to be silent on HIV/AIDS issues or have added to stigmatizations by, for example, misinterpreting

surveillance data. They have also been said to ignore key issues, such as women's vulnerability, while contributing to the perception that certain groups are "guilty" for the spread of the epidemic.

- Respondents recommended empowering those affected by the disease, providing greater social support and protection from discrimination (e.g., in the workplace), and sensitizing communities and leaders to help remove the stigma surrounding HIV/AIDS.

## **2.17 India Country Summary**

### **Top Leadership:**

- India's national political leaders have recently taken steps indicating a growing political commitment to addressing HIV/AIDS. For example, for the first time ever, a Prime Minister mentioned HIV/AIDS in an Independent Day address; the leader of the Congress Party wrote to state Party committee to encourage their support for HIV/AIDS programs; and the Parliament established a Parliamentary Forum on HIV/AIDS. In addition, a large-scale national convention of elected officials from a level of government highlighting HIV/AIDS was held in July 2003.
- According to respondents, political commitment for confronting HIV/AIDS has been sporadic and has been led mainly by a few individuals, such as the National AIDS Control Organization's (NACO) former project director. Too often, a public statement of support is made at special events and fails to translate into long-term, consistent support.
- A central concern raised by respondents was that the words and actions of top political leaders sometimes contribute to the stigma and discrimination

faced by the people affected by the diseases. HIV/AIDS is often treated as a “foreign” or “western” disease that is not part of India society or culture.

### **2.17.1 Government Response**

- India adopted a National HIV/AIDS Policy in 2002. respondents representing NGOs, PLHAs, human right groups, international NGOs, donors, and other sector agreed that the government of India have well-documented, comprehensive policy that covers all the basic components of the nation's HIV/AIDS programs. The policy takes a human right-based approach, and mentioned a commitment to GIPA. Some civil society groups were involve in the policy formulation through technical working groups. At the time of the study, respondents reported that while article 14 of India's constitution guaranteed the equality of citizens, no specific law prohibiting discrimination on the bases of HIV status (or perceived status) had been passed. In April 2005, India announced plans to introduce anti-discrimination legislation.
- Many respondents believed that the government of India does not contribute enough of it own resources to HIV/AIDS programs and services. The nation is largely depends on external sources of finding. The government does seek resources to fill gaps in program finding- for example, for provision of ARVs- through GFATM. While respondent agreed that India's budget is transparent, finding is centralized and state have little input into how fund should be used. In mid-2004, the newly elected United Progressive Alliance government pledge to increase spending on health by 2 to 3 percent of the domestic product over the next five years.
- India has developed clear-out structure for addressing HIV/AIDS. The National AIDS Control Program (NACP) is managed by NACO, under which the State

AIDS Control Society operates. Respondents believe that the NACP structure will support program coordination and provide program direction. However, they felt that NACO, could do more to strengthen multiministry collaboration, promote meaningful civil society and PLHAs involvement, and allow for greater fusibility at the state level given that different states are different stage of the epidemic. Development in 2004 includes pledge by Groups of Ministries on HIV/AIDS. THE India Network for People Living with HIV/AIDS also prepared a strategy document for increasing PLHAs involvement in the national response.

- The major components of the HIV/AIDS programs are VCT and prevention of parent-to-child transmission. As of April 2004, the government also launched a ARV program that covered about 2,500 people by the end of the year. According to the respondents, the NACP, especially right after its formation, largely focus on prevention. Targeted intervention are increasingly been developed for groups that practice high-risk behaviors. Implementations of various component of the program have been a challenge, however. According to respondents, many ministries does not have budget earmarked for HIV/AIDS programs, and NACO and NACP lack sufficient personnel with technical expertise in HIV/AIDS issues.

#### **2.17.2 NGO and Civil Society Involvement in the National Response**

- Many respondents credited NGOs with taking a lead in the country's response to HIV/AIDS. In particular, NGOs have been involved in providing care and support, addressing stigma, and implementing targeted intervention programs among vulnerable populations.
- Though many international funding mechanism require NGO involvement (e.g., the country's coordinating mechanism of GFATM), respondents reported the government effort to work with NGOs often take forms of token gestures. The

government, according to the respondents, tends to select for involvement those NGOs whose philosophy supports the government's ideas and approached; when NGOs provide criticism or feedback, it is not clear to what degree the government incorporates suggested changes into final policies, plans, and proposals.

### **2.17.3 Research, Monitoring and Evaluation**

- India operates an HIV/AIDS surveillance system that dates back to 1985, although sentinel surveillance did not begin until 1994. the government issues behavioral surveillance surveys and other studies to provide periodic information on relevant trends, behavioral and program impact. The government has established specific goals and benchmarks for component of the HIV/AIDS program.
- Respondents raised the concern that current HIV sentinel surveillance methods fail to cover the entire country. With surveillance limited to public sector site, much of the population is excluded, leading to underestimates on prevalence and incidence.
- Respondents felt that India must do a better job in terms strategic planning and priority setting. While the government does try to use whatever information that is available, it often carries out priority setting in an ad hoc, reactive manner.

### **2.17.4 Stigma and Discrimination**

- All respondent noted that stigma surrounding HIV/AIDS remains high in India. Factors that contribute to stigma are the nature of the disease (e.g., that is eventually life-threatening, that there is no cure) an attitude

regarding how HIV is transmitted (e.g., some believe that HIV is a punishment for what society deems immoral behavior).

- Throughout the interviews, respondents noted examples of message and actions taken by government, courts, or political leaders that contribute to stigma and discrimination.
- Respondents reported that the level of political commitment for addressing stigma is particularly low. Efforts to address stigma have been sporadic-political leaders and policymakers rarely conduct campaigns, make speech, or visit people affected by the disease.

## **2.18 NEPAL COUNTRY SUMMARY**

### **2.18.1 Top Leadership**

- Political commitment to address HIV/AIDS in Nepal is somewhat limited primarily to public statements made by certain key individuals-including the late king, the Prime Minister, and the former Minister of Health.
- Some respondents felt that, while commitment among the national leadership is low, they nonetheless noted growing concern regarding HIV/AIDS issues. For example, even though the council has met infrequently since its inception, respondents note that Nepal was the first member of the south Asia Association for Regional Cooperation to have its Prime Minister chair a national AIDS council.



### 2.18.2 Government Response

- Nepal has established the National AIDS Council, headed by the Prime Minister, as well as the National Center for AIDS and STD Control (NCASC), whose director is highly placed in the Department of Health Services.
- While Nepal does not have a specific law regarding HIV/AIDS, the Constitution guarantees equal opportunities and right. To all citizen and should apply to those affected by HIV/AIDS. The NCASC commissioned legal experts to analyze the country's existing laws that relevant in the context of HIV/AIDS and to determine if any steps need to be taken to bring laws in accord with international human right guidelines.
- Nepal has adopted national HIV/AIDS policy, national strategic plans and national operational plans. While some felt that the government used a participatory approach to develop the policies and plans, other suggested that the PLHAs and NGOs involvement was limited
- Some respondents raise concerns that the country policies and plans focus on prevention activities rather than a balance approach that promotes care. Support, treatment, and mitigation efforts and program for vulnerable populations.
- While a variety of ministries participate in the National AIDS Council, many do not have their own budget and personnel dedicated to HIV/AIDS activities. Nepal does received external financial assistance, including the award of fund from GFATM. Some respondent said that the country's budget and resource allocation process lack transparency, which they felt is a critical component of political commitment.

- Nepal's National Operational Plans for HIV/AIDS Control includes provisions for VCT, PMTCT, and HAART as well as independent review of the HIV/AIDS program by an external evaluation team. Some respondent, however, expressed the need for government to develop prevention and care program specially for vulnerable populations.
- The government has endeavored to learn from the experience of other countries in the region. However, reported the need to ensure that the information gain from study tours is used effectively and disseminated to all levels.
- The government has sought to improve public awareness on HIV/AIDS issues and prevention methods through public education campaigns, social marketing program, and life skills curricula in schools. Respondents suggested that any educational message may be pretested and evaluated to ensure accuracy, appropriateness, and impact as well as account for Nepal's cultural and logistics diversity.

### **2.18.3 NGO and Civil Society Involvement in the National Response**

- NGOs, though working mainly in urban areas, have made significant contributions to the country's HIV/AIDS response, with a few involved in national policy making process.
- Vulnerable groups (e.g., MSM and sex workers) and those already affected by the disease have begun to organize themselves into advocacy, support, and peer education groups.

- Commitment and addressing HIV/AIDS is limited though growing in faith-based communities, the business sector, political parties, and women's groups.
- Groups in the NGO and civil society sector have mainly focused on prevention and awareness-raising activities. Some groups are addressing stigma and discrimination, but few seem to be working in the areas of care, support, and treatment access.

#### **2.18.4 Research, Monitoring and Evaluation**

- Nepal initiated an HIV sentinel surveillance system in 1993. base on the best available information, benchmark and goals have established for each component of the operational plan.
- While the NCASC send out monthly reports, some respondents expressed concern that surveillance data do not reach the local level. In addition, some respondents questioned the validity of the data, which pertain on the individuals who visit hospitals or clinics for testing.

#### **2.18.5 Stigma and Discrimination**

- Most participants believed that the stigma surrounding HIV/AIDS in Nepal is high. Some of the cause of stigma are social exclusion, fear and denial, and lack of knowledge regarding HIV/AIDS and transmission of HIV. Respondents also stated that the people do not realize that PLHAs can continue to lead productive lives and contribute to society.
- Many respondents said that stigma and fear of ostracism prevent people from using VCT services as well as disclosing their HIV status.

- While some respondents could provide example of policymakers' effort to reduce stigma, nearly all respondents said that government had done nothing or not enough to address issues surrounding stigma.

## **2.19 VIET NAM COUNTRY SUMMARY**

### **2.19.1 Top Leadership**

- Respondents reported the Viet Nam has demonstrated increasing political commitment for addressing HIV/AIDS and individual leaders have played a key role in fostering that commitment. A broad-based census throughout the government and the Communist Party underscores the need to respond to HIV/AIDS.
- According to respondents, Viet Nam's greatest successes in responding to the epidemic lie in the ordinance that outlines the legal framework for HIV/AIDS interventions, awareness-raising programs, and establishment of association for PLHAs and other community-based activities
- One concern noted by the respondents was that, while perceptions are changing, the government approach too closely associates HIV/AIDS with so-called "social evil" programs that target sex work and injection drug use, thereby increasing stigma and discrimination among vulnerable groups.

### **2.19.2 Government Response**

- Although Viet Nam has no law on HIV/AIDS, it has developed several key documents (e.g., decrees, ordinances, and Party Instructions) that establish the legal and institutional framework for addressing the epidemic and provide guidelines on national collective efforts for responding to HIV/AIDS. In terms of policy gaps, NGOs, the private sector and multisectoral actors

lack clearly define roles. In addition, at the time of study, respondents reported that Viet Nam had not demonstrated strong commitment to the GIPA principle and did not guarantee some rights of PLHAs. Voluntary testing has not taken root-as many tests are moderated-and pre-and post-counseling needs to be improved. In April 2005, Viet Nam passed a decree that prohibits discrimination against PLHAs.

- At the time of the study, respondents felt that the budget for HIV/AIDS was sufficient to meet current needs and that existing resources were used inefficiently. For example, programs may try to focus on wide cover rather than on achieving high impact, often targeting the general population as opposed to groups most in need of prevention, care, and support. In 2004, Viet Nam increased its budget allocation for HIV/AIDS from 60 to 80 billion VND and, in addition, it was named by 15<sup>th</sup> focus country of the U.S President's Emergency Plan for AIDS Relief.
- Viet Nam has developed an organizational structure that seek to promote multiministry involvement at the national level and that establishes provincial and local mechanisms for implementing HIV/AIDS programs. However, more need to be done to foster collaboration and build capacity.

### **2.19.3 NGO and Civil Society Involvement in the National Response**

- Viet Nam's NGOs and civil society, in general, are still emerging ; however, HIV/AIDS has been one area where NGOs have been active-particularly at the local level. Their roles in national policymaking has been more limited.
- Vulnerable groups are those already affected by the diseases have begun to organize themselves into advocacy, support, and peer-education groups.

- Commitment to addressing HIV/AIDS is limited, though growing, in faith-based communities and among businesses. To date, women's groups have been active in awareness-raising activities and social support.
- Commitment is considered strong among the state-organized mass organization. mass organization such as Women's Union, Youth Union, Fatherland Front, and others, are represented in the National Committee for Prevention and control of AIDS, drugs, and Prostitutions. The government has asked the Women's Union to work at both the national and community levels, mainly in community development and IEC, including HIV prevention.

#### **2.19.4 Research, Monitoring, and Evaluation**

- Viet Nam has instituted the use of both HIV sentinel surveillance survey and behavioral surveillance surveys to provide some information on both the general population and groups at the risk of HIV infection.
- Respondents note gaps in the measurement of key indicators and expressed the need for improved data collection methods; dissemination and use.

#### **2.19.5 Stigma and Discrimination**

- While Vietnamese laws guarantees equality fro all citizens and protect their rights to access health care services, respondents noted that levels of stigma and discrimination remain high.
- The prevailing perception in Viet Nam seems to that HIV/AIDS is linked to "social evils" or "bad lifestyle"- which contributes to stigma and discrimination against PLHAs and affected communities.

- At the time of the study, respondents felt that government did not have an action plan for combating stigma and discrimination. Respondent were able to identify some examples of step taken by national leaders to help reduce stigma-though this seem to be sporadic. In April 2005, as noted above, Viet Nam passed a decree to punish anyone discriminating against PLHAs.

## **2. 20. Leadership in the National HIV/AIDS Response**

### ***2.20.1 An Overview of the National HIV/AIDS Program: Demonstration of Bold Leadership, Achievements and Leadership Challenges***

Historically the health sector was given leadership in the fight against HIV/AIDS the world over. Indeed the first committee established by the late professor Ransome Kuti was in the ministry of Health when the first case of the disease was reported in 1986. At the global level the world Health organization was also vigorous in its response by the establishment of the Global AIDS program which provided assistance to countries to put in place strategic plans and their implementation.

However in recent times it has become evident the pandemic has become a development issue rather than the original health only paradigm. Thus, there has been a reconstruction of the response at both the global and national levels to ensure the inclusiveness of all relevant stakeholders in the fight against the pandemic. Significant among these constituencies are the other actors in the public sector (education, defence, agriculture, labour, justice, e.t.c.), the private sectors, the civil Society- NGOs and CBOs, faith based organization but most importantly, the community of people living with the virus who have given the pandemic a human face. With this shift in emphasis planning and provision of support for programming has also taken cognizance of this although the health sectors still has a very significant portion of the response.

The Nigeria response has followed the pattern outlined above; there currently exists a vibrant multi sectoral response which is coordinated by the National Action committee on AIDS (NACA) which is situated in the presidency for political leadership and visibility and a very strong health sector response that oversees the different aspects of the health sectors activities all over Nigeria. The multi-sectoral response when it was established President Obasanjo in 2000 – 2001 quickly put in place a strategic plan referred to as the HIV/AIDS Emergency Action Plan which had a life span of three years and expired in 2004. More recently this has been replaced or succeeded by a new Plan which is widely referred to as National Strategic Frame Work (NSF) which is expected to provide strategic direction from 2005 – 2009.

It is within this context and given the uniqueness and the importance of the health sector that the health sector was developed and the plan is that it will fit into the overall strategic frame work for Nigeria.

#### **2.20.2. Policies and Plans**

Programs no matter how well-intentioned, hardly succeed where policies and plans do not exist to guide their implementation. The Federal Government of Nigeria seemed to have realized this early in National response when in 1997 it adopted a national policy on HIV/AIDS and STIs. As at that time, the magnitude and impact of the disease were not well understood hence some essential areas were not addressed (NACA, 2005). Thus in 2001, the Federal Government began the review of the 1997 policy. The review was undertaken with technical assistance from POLICY Project of USAID in conjunction with an array of stakeholders. The main areas addressed in the policy included the upholding and protecting the right of PLWHA, women and children. The Federal Government under the policy committed itself to implementing a multisectoral and multidisciplinary response to the epidemic and the establishment of an appropriate legal and institutional framework for its coordination, identifying sectoral roles and assigning responsibilities for programs implementation based on cooperative advantage and core competences and increase awareness among the general population. The policy main objectives were:



- Promote a national multisectoral and multidisciplinary response to the epidemic in addition to the establishment of an appropriate legal and institutional framework for its coordination;
- Identify sectoral roles and assign responsibilities for the implementation of programmes based on sectors' comparative advantages and core competencies;
- Increase awareness and sensitisation among the general population about HIV/AIDS;
- Foster behaviour change as the main means of controlling the epidemic;
- Improve national understanding and acceptance of the principle that all persons must accept responsibility for prevention of HIV transmission and the provision of care and support for those infected and affected;
- Provide access to cost-effective care and support for those infected, including anti-retroviral drugs;
- Protect the rights of those infected and affected by HIV/AIDS as guaranteed under the constitution and laws of the Republic;
- Remove all possible barriers to HIV/AIDS prevention and control.
- Empower people infected and affected by HIV/AIDS through training, counselling, and education to cope with their circumstances.
- Develop standards and guidelines that lead to the institutionalisation of best practices to mitigate the impact of AIDS.
- Stimulate research, monitoring and evaluation of programs, relevant documentation of activities related to the epidemic and the dissemination of information generated to stakeholders and the general population.
- Ensure that prevention programmes are developed and targeted at vulnerable groups such as women and children, adolescents and young adults, sex

workers, long distance commercial vehicle drivers, prison inmates, migrant labour etc<sup>1</sup>.

The revised policy was launched by the President of Nigerian on the 4<sup>th</sup> of August 2003. As earlier discussed, the HIV/AIDS Emergency Action Plan (HEAP) was a significant achievement for the government at a time when there was nothing on the ground to guide the HIV/AIDS program planning and implementation. Developed in 2001 as a three year action plan, it was built around 2 strategic components:

Creation of an “enabling environment and specific HIV/AIDS intervention. NACA was to play a coordination role while the relevant sectors implemented the activities. A major flaw in the document was the lack of a functional monitoring and evaluation plan making it difficult to monitor activities implemented and to make categorical statements on what intervention were working and what did not (POLICY Project 2003). Thus the development of the National Strategic Framework (NSF) 2005 was based on lesson learned from implementing the HEAP.

The National Strategic Framework (2005 – 2009) is the successor to HEAP. NSF resulted from months of intensive consultations involving a wide range of stakeholders in the private and public sectors. The process began after a comprehensive situation analysis of the National HIV/AIDS response. The thematic areas covered by the document includes:

- Prevention of New Infection and Universal Precaution.
- Expansion of equitable access to ART and reduction of laboratory cost.
- Effective coordination, resource mobilization and capacity building.
- Initiation, care and support of OVC
- Psychosocial support and economic empowerment of OVC, PLWAA, and PABA
- Research and New Technologies.

- Monitoring and evaluation
- Enabling environment

Based on this, the NSF recommended 16 priority interventions which included among others: Behavioural Change Communication and Education, Condom Social marketing, PMTCT, Strengthening monitoring and evaluation system. A logical framework for the NSF has clear goals, priorities and objectives and the strategies by which these will be achieved (NACA 2005). The NSF represents Nigeria's truly comprehensive strategy for fighting "AIDS to finish" or at least for reducing its incidence and prevalence by 25% by 2009 (NACA, 2005). To feed into the NSF, is the Federal Ministry of Health's Health sector strategic plan. The Health Sector Strategic Plan (HSP) clearly marks out the areas of focus, the priorities objectives and strategies of the health sector response to HIV/AIDS. The development of the Health Sector Plan commenced with a situation analysis at the National, State and Local Government levels during which data was collected on the implementation of HIV/AIDS activities nationally. The major finding from the situation analysis included: inability of the state and LGAs to provide appropriate leadership at the state and LGAs respectively, lack of funds, managerial, limited technical capacity and inadequate information. Based on this, the HSP was developed taking cognizance of the Health Sector Reform agenda. The HSP will guide the planning and implementation of HIV/AIDS interventions in both public and private sectors in order to achieve the goals of the National HIV/AIDS Policy and the HIV/AIDS millennium development goal. A costed implementation plan has also been developed to ensure a smooth and orderly implementation of the HSP.

The Federal Government also demonstrated leadership in seeing to the development of the National HIV and AIDS Behaviour Change Communication Strategy 2004 – 2008. This care about as a result of extensive participatory process and consultation among key stakeholders – Federal Government line ministries, parastatals, development partners, behavioural change experts, donor agencies, civil society organization, non-governmental organizations and network of people living with HIV

or AIDS. The BCC strategy highlights the key issues related to BBC over a period of 5 years; the most effective strategies to ensure verifiable impact, the various goals and indicators. It also identifies priority audience, relevant strategies and priority intervention. The goal of the five years strategy is to attend a coordinated national response from BBC programming addressing HIV and AIDS issues which will produce verifiable result within the shortest possible time (NACA, 2005). The highest priority is on halting heterosexual transmission of HIV/AIDS and mother to child transmission, but also deals with other modes of transmission. The priority audience for BBC include the “youth: high risk behavioural change or most risk people (MARPS), PLWHAS, health care provider, men and women of reproductive age 26 – 49 year old. The key strategies are: Abstinence, Be Faithful and Condom Use, Stringe reduction and Gender – measures to improve the status of women.

To ensure that some form of guidance exist on how to deal with HIV/AIDS issues at the workplace, the Federal Ministry of Labour in collaboration with NACA, social and development partners NGOs and PLWHA developed a national policy of HIV/AIDS in the workplace. Launched in March 2005, the policy provides guidance on the prevention of HIV/AIDS, the response to its spread and the management of it impact in the work place. The policy has an overall goal providing guidance to government, employers, and workers and identifies strategies for promoting the rights and dignity of workers infected and affected by HIV/AIDS. The policy will guide the negotiation of terms and employment condition about HIV/AIDS issues with workers and their representatives and abhor all form of discrimination against PLWHA at the workplace. Employers are expected by the provisions of the policy to initiate programs to inform, educate and train workers on HIV/AIDS matters and to provide access to voluntary counseling and testing and appropriate treatment to PLWHA. Employers will strive to protect the right of its workers especially PLWHA; for example, an employee is under no obligation to reveal his or her status to the employer, and health insurance coverage must be available to all employees regardless of their HIV status and HIV testing shall not be imposed as a condition to access any health insurance scheme. Further more, the policy prescribes that the only criteria for employment is fitness to

work A deliberate exclusion of PLWHAs from workplace activities and decision making shall receive appropriate sanction according to law. The policy also provides for enabling laws at the states and national level to protect PLWHAs in the workplace.

Besides the workplace policy, a host of guidelines for implementation of HIV/AIDS program now exist. The ART Guidelines, PMTCT Guidelines, Young Child and Infant Feeding Guidelines, Counseling and Testing Guides are examples of some of the guidelines already in place while work going on a number of others.

It is important to note that the Federal Government of Nigeria recognizes that for it to effectively implement HIV/AIDS programs in a harmonized and result oriented fashion, it must be guided by the principle of the “Three Ones”. This principle was adopted at the international conference on AIDS and STIs in Africa (ICASA) in September 2003. The “three ones” is used in reference to One Central coordinating body, One national plan and One national M&E framework. The “three ones” allows for strong leadership and coordination. UNAIDS in a recent assessment of the implementation of the three ones identified four areas for improvement:

- Empowerment of national leadership and ownership, alignment and harmonization, reform for a more effective multilateral response and accountability and over sight (UNAIDS 2005).

### **2.20.3 Political and Popular Support**

Since the inception of the Obasanjo government, there is certainly a high level of political support for the control of HIV/AIDS at the federal level. This is reflected in the President’s public statements and continental leadership for HIV/AIDS global advocacy. The current government has also budgeted more funds for HIV/AIDS control than any of their predecessors. The President has also led by personal example in allowing his picture and his utterances be used in public awareness campaigns against HIV/AIDS. Ministers in his cabinet have also from time to time

openly expressed the country's determination to overcome the epidemic in support of the Presidents' vision and efforts.

The amount of support seen at state levels are however not as high as that seen at the federal. State governors are less visible in their campaign against HIV/AIDS. Some states have left the leadership of the response to the epidemic to wives of the state governors who use the medium of non governmental organisations (NGOs) in which they have personal interests to mobilize resources for their activities in their capacity as heads of the newly created State Action Committees on AIDS (SACA). The conflicts of interest that arise from this strategy create wrong perceptions of the true intent of all those involved and often cannot be sustained beyond the terms of the elected governors (POLICY Project, 2003).

Though all states except one have created State Action committees on AIDS which have membership from a wide range of organisations such as seen at the federal level, most do not understand their roles and several are still led by the health sector or health professionals. Consequently, the other sectors have not been able to accept ownership of the response and contribute little to funding these new structures. Where non-health professionals have headed these SACAs, they have also tended to have similar conflicts with the health ministries as was experienced at the federal level. The desire to control the agenda and HIV/AIDS resources has been a crux of the problem in transforming from a health sector response to a multi sector one.

The question as to who should head the SACA has been raised. Though the general consensus is that it should be run from the Governor's office, in practice this is not case.. Some have placed it under the Office of Secretary to the State Governments and others under the Ministry of Health. Positioning it such usually limits the effectiveness and visibility of the SACA and affects the funding.

In considering the sustainability of the present increasing level of commitment to the HIV/AIDS response it is important to gauge the level of commitment of political parties

to the HIV/AIDS national response. Unfortunately this is very low. No party made the HIV/AIDS epidemic an issue for political discourse or debate. A study of political commitment of political parties to HIV/AIDS issues carried out by the POLICY Project in 1999 found out that the manifestoes of parties neither included nor articulated HIV/AIDS as a problem that needed urgent attention. When Nigerians were asked to gauge the level of support political parties gave to HIV/AIDS issues, they scored lowest of all social institutions. When persons considered knowledgeable about the national response were asked a similar question they also rated their commitment low (FMOH 2001).

Though the country has taken a proactive stance in its program against HIV/AIDS, the funding of activities is not a very reflective index of commitment. Most of the funding for HIV initiatives is provided by donor organisations, bilateral and multilateral development partners. The President had directed that all federal ministries should include HIV activities as line items in their budgetary submissions. Without such approval, most sectoral ministries have great difficulty committing resources for HIV/AIDS activities. NACA has held sensitization and advocacy activities with the top hierarchy of the public sector including members of the National Council of State (that has all the state governors as members) as well as with the national assembly that it is hoped that some of these problems may be overcome in the 2004 budgets. While this is a step in the right direction, one should also note that there can be major differences between budgetary allocation and the actual release of funds for expenditure.

Ad Hoc committees on HIV/AIDS have been set up in both arms of the National Assembly but are yet to pass any bills in support of the Response. In addition, confusion still exists as to whether these committees are better considered as sub-committees of the statutory health committees or stand-alone committees. A bill for the establishment of a statutory body to coordinate the nation's response to the HIV epidemic and replace NACA is still undergoing review in the National Assembly. Efforts to get it passed earlier were delayed due to the multiplicity of bills submitted for the same purpose by different actors with different interests from NACA, the Federal

Ministry of Health and independents in the national assembly. These have all been harmonized and have gone through preliminary readings and one public hearing. In spite of this, the bill is yet to be passed. Existing and developing political parties have also shown very little interest in the HIV/AIDS response.

In determining political support, it may be misleading to gauge support by the words of government officials only. It may be more appropriate to use other indices such as amount of resources dedicated to activities and the evidence of programmes being implemented. If one were to use the AIDS program effort index to measure the perceived level of commitment as judged by persons working in the area of HIV/AIDS in the country. The API for the country has been as high as seen in most other African countries. There however is a major difference in the amount of political commitment and the resources made available for HIV/AIDS with the latter rated poorly though improving.

## **2. 21. 1 Popular Support for HIV/AIDS Programs**

Nigeria is a large and heterogeneous country with numerous ethnic groups and languages. Public knowledge and opinions towards the HIV/AIDS epidemic and the current interventions being used vary with location. Attitudes towards present HIV/AIDS initiatives are more positive in the urban areas and southern zones of the country. Religious groups are essentially opposed to condom promotion and the introduction of sexuality education curricula in primary and secondary schools(Ado, 2000). Talking about sexual issues is not the norm in most ethnic groups. Condom advertisements are considered by many as likely to increase promiscuity and the sexual activities among youth by negating moral teachings of society and the two major religions of Christianity and Islam. Though NACA and her developmental partners and NGOs have tried to provide evidence from studies to indicate that in the era of globalisation, empowering youth with information and options is more effective than concentrating only on moral weapons for instituting behaviour changes that have a lasting protective impact on the epidemic, the conservatives remain unconvinced. In the National HIV/AIDS & Reproductive Health Survey only 59.9% of persons believed



that Christian organisations were in support of HIV/AIDS activities; figures for Islamic groups and traditional leaders was even worse which was 49.6 % and 57.1% respectively(FMOH 2003).

NGO leaders have shown the highest support for HIV/AIDS and are the major implementers of activities. They have been in the fore-front of the battle against this epidemic from inception even when there was little or no government support or understanding. Unfortunately many though well intentioned, lack the financial or human technical capacity to make the desired impact. Fund raising skills and financial accountability have also been problems, as many find it difficult to raise funds or account for them well after they have been disbursed. A lack of knowledge of what works and what doesn't remains problematic as very few evaluate their programmes. There was until recently no structure or system to coordinate their output as to ensure maximal effect from their activities. NACA is articulating plans to ensure their input is factored in as part of the Nigerian response but this could be a long time in coming.

### **2.21.2 Funding and International Donors Support**

According to the Federal Government sources, funding from external sources has increased tremendously over the past five years. United Nations (UN) agencies, the World Bank, United States Agency for International Development (USAID), British Department for International Development (DFID), Canadian International Development Agency (CIDA), Japanese International Cooperation Agency (JICA), European Union (EU), the Italian Cooperation, including Foundations such as the Bill and Melinda Gates Foundation, Mac-Arthur Foundation, Ford Foundation, Packard Foundation, Gede Foundation etc have all increased their financial and programmatic support for Nigeria's HIV/AIDS efforts. The POLICY Project in 2003 however observed that 'a matter of concern is that the amount received per capita is much smaller than most sub-Saharan African countries with the same state of the epidemic. This is because "Nigeria has always had the problem of being one of the poorest

countries per capita but one of the highest gross national product on the African continent. This has led to misrepresentation and misinterpretation of the country's needs. Donor assistance though much is only able to achieve little in the face of the high population, the high population growth rate, and the present high debt burden and the relative economic stagnancy. Though the funding is rising and the donor base continues to expand, the large population and the fast growth rate is begging for more and faster (POLICY Project, 2003).

Nigeria is also a beneficiary of the World Bank Multi-country HIV/AIDS Program for Africa (MAP). The plan makes available an initial amount of US\$1billion in International Development assistance (IDA) credits to scale up national HIV/AIDS efforts and support sub regional HIV/AIDS initiatives. The overall goal of MAP is to dramatically increase access to HIV/AIDS prevention, care, and treatment programs, with emphasis on vulnerable groups like youth and women of child-bearing age. So far more than \$ 487 million has been approved for projects in Benin, Burkina Faso, Cameroon, Cape Verde, Ethiopia, Kenya, Uganda and Nigeria. Funds from this project supported Nigeria's HIV/AIDS Emergency Action plan and other HIV/AIDS activities from 2001 – 2005 to the tune of US\$90 million.

Under the United State President's Emergency Plan for AIDS Relief(PEPFAR), funding will be provided to put 350,000 Nigerian PLWHAs on antiretroviral drugs, and to implement care and support interventions for 1.75 million people and prevent 1.15 million new infections. On the other hand, the Global Fund has committed US\$ 4.4 billion to fight AIDS, Tuberculosis and Malaria in 128 countries of which Nigeria is also a beneficiary. Nigeria has financed the following projects under the scheme:

- Expansion of antiretroviral program in Nigeria(US\$41 million) with NACA as principal recipient
- Prevention of Mother to Child Transmission and Centres of Excellence)US \$27 million with NACA as principal recipient
- Assess and promote effective participation of civil society in the national response to HIV/AIDS, a one year grant of about US\$ 1.6 million with the

Yakubu Gowon Centre for National Unity and International Cooperation as principal recipient.

With a 4 billion pounds annual budget, DFID has also made a significant contribution to the fight against HIV/AIDS in Africa. In Nigeria, its efforts has contribute directly to improve human development in areas such as health education and HIV/AIDS. In this regards it is supporting Nigerian government's efforts at implementing supporting the NEEDS. Nigeria will be benefiting from the over 70 – 100 million grant money that DFID will be committing to development efforts in 2005-2006. In the same vein the Canadian International Development Agency(CIDA) in 2000 appriopraited \$90 million through bilateral programs alone to fight HIV/AIDS in Africa. In Nigeria, Canada has committed \$4.8 million over five years to fund Nigeria's AIDS Response Fund and another \$10 million dollars for the UNICEF HIV/AIDS Prevention Project in Nigeria to deal with PMTCT and National Youth Corps Volunteers in HIV/AIDS prevention.

As already observed, the international donor community has been very benevolent to Nigeria. The financial commitment of the federal government is a far cry from the expected. Until recently, government spending on HIV/AIDS was very insignificant but it is heart-warming though the note that government funding has been steadily improving as the federal government committed US\$13.2 million to the fight in 2005. Table 1 below shows contributions of some donors and the government to HIV/AIDS program in Nigeria

Table 2.1 Contribution of some donors and government to HIV/AIDS Program in Nigeria

Funding Source	Amount	Year
	in US\$ (million)	
PEPFAR	81	2004-5

Global Fund	28	2004-5
World Bank credit (IDA)	93	2002-6
DFID	130	2002-8
CIDA	4.8	n/a
APIN(Bill and Melinda Gates Foundation	25	2001- 2005
UN SYSTEM	20	2005
Federal Government of Nigeria	13.2	2005

Source: NACA: Nigeria HIV/AIDS Country Report Preview 2005

## **2.22 1. Monitoring and Evaluation**

As already noted elsewhere in this report, the main defect of early efforts at implementing the national response under the HEAP was the absence of a monitoring and evaluation (M&E) plan. Without a workable M&E plan, programs cannot be audited, priorities can not be set and outcomes of interventions and programs cannot be improved. One significant achievement of the national HIV/AIDS response is that it now has an evaluation plan known as the Nigerian National Response Information Management System (NNRIMS). NNRIMS was developed to monitor control activities in the country as well as assess the impact of the various strategies on the outcome indicators. It will facilitate the collection and dissemination of information on programs including impact assessments. This will ensure the progress towards achieving the national HIV/AIDS policy objectives, UNGASS declaration and UNAIDS Country Response were being monitored.

To complement the NNRIMS in collecting program data to inform program planning, the Federal Government carried out the following surveys and studies in 2005:

- ANC sero-prevalence survey
- National AIDS and Reproductive AIDS Survey 2005
- UNGASS Country report on 17 indicators

- Institutional and technical capacity assessment of World Bank effective states. The national M&E technical Working group was inaugurated in 2004 to coordinate M&E activities of the national response. This has also been replicated in the states.

### **2.23.1 Private Sector Participation**

#### ***Organised Private sector***

Private sector leaders have only recently seen the need to get actively involved in the HIV/AIDS national response outside their workplaces. In July 2003 the President of the Federal Republic of Nigeria held a business forum on HIV/AIDS during which a private sector HIV/AIDS business initiative was launched which in turn led to the establishment of a Nigerian HIV/AIDS Business Council. The process of articulating the structure and the agenda is presently still being worked out.

The acceptance of their role notwithstanding many of the organisations would prefer to provide money for HIV initiatives anonymously believing that the stigma around HIV/AIDS could taint the names of their companies leading to decreased sales and profit. This perception is however progressively changing and increasing large multinational corporations like Coca-Cola and MTN are now openly associating their brands and products with the National HIV/AIDS response.

The factors driving the Business Forum initiative are the presidential commitment to control HIV/AIDS epidemic and perhaps the social responsibility of the business community to the country. There is yet to be enticements such as tax relief for monies spent on HIV/AIDS. Pharmaceutical companies also do not receive any relief for the importation of ARV which could have resulted in price reductions for the end user.

Several organised private sector organizations have been involved in the control of HIV/AIDS within their workplaces through various initiatives; some not well thought out and with potential for stigma and discrimination and others supportive of the national response.

The statutory pre-employment medical test utilized by many employers of labour as part of criteria for recruiting new employees was updated to include HIV screening by several of these organizations. This and the routine annual medical evaluation have been used by several of these companies to determine employability and career enhancement. This clearly constitutes an invasion of the privacy of job applicants and is a definite violation of the rights of both prospective employees and staff being evaluated for promotion or other benefits. Confidentiality and privacy have been overlooked. Ethical issues around pre-test counselling and privacy of the affected individuals has been ignored by the medical retainers or health establishments of these companies. Commendably, a few large corporations have recognized the harm created and have abolished such practices. Unfortunately though, such practices still persist in several other organisations.

In addition, some of the larger international companies now have prevention, care and support programs, including workplace policies that provide for temporary reassignment to other tasks during illness episodes and the provision of anti-retroviral therapy. They have also recognized their social responsibilities to their host communities and opened their doors for partnership with NGOs more familiar with working on communities' prevention programs. These however are a minority, most are still in denial of HIV/AIDS and refuse to address the situation.

### **2.23.2 Faith Based Organisations**

Many faith based organisations have been actively involved in HIV/AIDS initiatives, predating NACA. However their responses were isolated and not coordinated with the national response. Occasionally they worked in manners that were not complimentary to the national goals and objectives e.g. promoting faith and miracle healing that interfered with care seeking for those infected. A few of these faith based organisations (FBOs), especially the Catholic Church developed successful initiatives that the other faiths and organisations could benefit from, but these were not shared.

In April 2003, NACA invited the major faith based organisations in Nigeria to a consultative forum for experience sharing among themselves, understanding of the national response, their potential contributions and to learn from what their peers in other countries with more mature responses had been able to achieve. As a result of this meeting, an Interfaith HIV/AIDS Council evolved through which faith based organisations could contribute to the national response. Such contributions could include initiatives to maximize on their potential to reach large segments of the population through the preaching, and the provision of spiritual counselling and care and support services for which most religious institutions have known comparative advantage. Such messages and activities are also expected to contribute significantly in reducing stigma and discrimination within their membership.

Due to the large number of groups within Christian and Muslim faiths in Nigeria, it is difficult to critically assess the effect of religions on the national HIV/AIDS response. It must however be stated that while many good influences are gradually being manifested, especially in the “care and support” initiatives, a lot of obstacles have been imposed by the moral creeds. The banning of prostitution in states that have adopted the Sharia Law has led to prostitution going underground. This makes it even more difficult to reach this high risk group.

The constant attempts by major religious groups to “put down” the use of condoms as a means of protection also impacts negatively on the national response. Earlier in the epidemic many churches adopted a compulsory HIV/AIDS test before marriage. This violated the rights of their members and exposed those found positive to stigma and discrimination. Some of them even stated that those found positive could not marry in the church, a factor that even increased the stigma and discrimination and violated their rights to marry and right to spiritual support. Though most of the leadership at the highest levels have recanted this decision, it is still practised in many of their parishes. It is also important to note that the Anglican Communion, Catholic Church and the Interfaith Coalition were among the first FBO groups to become fully involved and make noticeable contributions to the HIV/AIDS response.

## **2. 24.1 Health Sector Intervention Programmes: Technical Areas And Cross Cutting Issues**

### ***Voluntary Counseling and Testing (VCT)***

States have reported that VCT services are only available in large clinical settings and mainly as part of PMTCT services rather than as integrated VCT centre. Though efforts are being made to meet the demand for VCT from a range of providers, those outside the public sectors are unregulated and many do not conform to standard protocols. There is also evidence that shortfalls in supply of HIV diagnostic reagents has resulted in use of unregulated reagents from the open market and consequently false result. There is a need to institutionalise VCT because of its overwhelming benefits in both prevention and care. Voluntary counselling and testing services in Nigeria exist on a small scale. According to the FMOH, most VCT services are stand-alone sites operated by NGOs in a few states in the country. Institutionalising VCT services will include building the capacity of NGOs already involved in VCT and linking them up with institutions to provide continuum of care. The Federal Government of Nigeria and a few developmental partners are now addressing this and it is hoped that in the next couple of months several of these linked to the PMTCT and ARV sites as well as stand-alone sites will become widely available. Following the needs assessment study conducted by the FMOH and partners, initial projections are for the establishment of a minimum of 112 sites spread evenly across the country.

Screening methodologies are not uniform. WHO has provided technical assistance in the development of appropriate screening methodologies but these are yet to be universally implemented. The Federal Ministry of Health, on a cost reimbursable basis to health institutions, has provided most screening kits. The kits until 2001 were mainly procured by DFID, though the US Centres for Disease Control (CDC) provided kits used during the 2001 and 2003 sentinel surveys and will likely be providing more under the new US Presidential Initiative on PMTCT and the rapid expansion of the



ARV program. Family Health International (FHI) also has plans to introduce an additional 20 VCT centres up from the current 2 they established in Lagos and Kano.

The cost of testing in public health facilities is much smaller than what obtains in private settings. Though HIV testing does occur in governmental institutions this is usually done on the doctor's recommendation. No protocols exist within most government health institutions for persons just voluntarily opting to know their status. Such persons use the services offered by NGOs or private laboratories. Unfortunately, most individuals are also unable to meet the cost of HIV screening in the private unsubsidised facilities that exist. Another problem with these laboratories is that most of them test without appropriate counselling.

The number of trained counsellors, screening and counselling centres continues to improve but still requires massive scaling up. The Federal Ministry of Health has written guidelines for counselling services but these are yet to be widely disseminated. FHI, Pathfinder and Engender Health (USAID) have been in the forefront for training counsellors. However activities are limited to very few States. Several smaller NGOs also claim to train counsellors. The content of these courses is not known. Major challenges are the disseminating the guidelines and ensuring their adherence in both private and public institutions; determining the skills required by trained counsellors, developing a curriculum to meet these needs and ensuring conformity in training institutions.

Quality control of testing procedures is expected to be undertaken by the research laboratories. The Nigerian Institute for Medical Research (NIMR) has commenced operation of their HIV/AIDS research and testing laboratory supported by a Ford Foundation grant. This now supplements facilities present at the Nigerian Institute for Pharmaceutical Research and Development (NIPRD) and one being developed at the Jos University Teaching Hospital with funds from the AIDS Prevention Initiative in Nigeria (APIN). These institutions however only offer quality control for public institutions and only those offering ARV or PMTCT services. There is very little control for private institutions and NGOs.

### ***Prevention of Mother-To-Child Transmission (PMTCT)***

NASCP reports that PMTCT services have been provided to over 13,000 women from the 21 selected sites. Access remains restricted to women within proximity of the sites. Though treatment is currently to protect the child, a strategy for continue treatment of the mother (PMTCT +) is anticipated. A PMTCT monitoring information system (MIS) has recently been deployed with the support of partners. The PMTCT guidelines were developed in 2002 but were not been well disseminated. The document was recently reviewed and efforts are being made to ensure a wider dissemination.

The PMTCT programme started off with pilot schemes in some of the federal health institutions with the support of UNICEF. Through the six initial sites, practical lessons were to be learnt which were to inform future programme expansion. The expected lessons were to be in the area of logistics, human resource requirements, and service guidelines. An additional five sites were added to the scheme with the support of developmental partners including the Bill Gates Foundation and the Centre of Disease Control, Atlanta, USA. Under the direction of the PMTCT Task Team, the eleven pilot sites were advised to scale up services to nearby General Hospitals within its area of operation and by the end of 2004 the number of PMTCT sites in the country had risen to 21. With technical and logistics support from the POLICY Project and other partners, a national scaling up plan for PMTCT was developed. In line with the policy, all states of the federation would have a functional PMTCT program by 2005. To ensure that services provided are in tandem with current developments in the dynamic field of HIV/AIDS care, the national PMTCT Guidelines were reviewed while a PMTCT operational plan was also adopted. It is expected that with inflow of funds from PEPFAR, Global Fund and WHO's 3 by 5 initiative, and the lessons learned from the implementation of the pilot program, there is going to be rapid

scaling up of PMTCT services thus increasing access to services which is currently put at about 3000 since the commencement of the program. .

The program is however facing some challenges, foremost of which is coordination. Until recently, the different sites had varying procedures of implementation with disparities in services being offered at different sites. These differences were based on the varied focus of the developmental partners. Most persons, especially the health workers on the field, saw the initiatives as projects of the developmental partners involved. The FMOH (NASCP) has been having difficulty with coordinating all the players due to a limitation of government funds, inadequate human capacity and lack of basic working tools, including necessary communications facilities and equipment which forces them to rely on partners to fund their supervisory visits and program reviews.

Some lessons are already evident. They include the fact that HIV/AIDS education among health workers at the sites should have commenced long before the commencement of the programs to reduce or eliminate stigma and discrimination expressed by health workers. This should have included adequate education of health workers on the practice of universal precautions and the adequate provision of hospital supplies to practice it. Another lesson from hindsight is that the VCT services should also have pre-dated the PMTCT services – as things now stands, it seems as if the main function of VCT services is to screen pregnant women. Other factors that are noted to be affecting the program include the poor remuneration for public sector health workers involved in the project; logistics issues around ARV, testing kits, and breast milk substitutes, and the upgrading of facilities at project sites including laboratory facilities

In spite of the challenges the program shows a lot of promise. There is a steady increase in enrolment in all the centres, an HMIS has been put in place to ensure an efficient M&E and site coordinators and other relevant personnel have been trained not only on HMIS but also in program management .An operational research agenda has been developed after a proposal writing training supported by the Global Fund. It

is expected that PMTCT Task Team might be able to access funding for the OR research proposals developed at the Proposal Writing Workshop held in December, 2004. Following this and the likelihood that a comprehensive evaluation of the national PMTCT Program might be undertaken this year with support from the ENHANSE Project, it is hoped that the challenges the program is experience will be resolved to allow for sustainability.

On the whole the PMTCT TASK Team which manages the program and the Core Partners Forum which is an advisory body were set up to ensure harmony and leverage of resources in implementing the program has performed creditably well in providing policy direction, improving coordination and redefining PMTCT goals for Nigeria. They have also helped to improve quality control, monitoring and evaluation, and in mobilising resources for the program. It is hoped that with the recent improvement in the staffing of NASCP, it will assume full control and assume the drivers' seat role to provide better coordination for the program. If this happens, and the government also heeds the call for decentralization of authority, a zonal arrangement for NASCP and to build the capacity of the states to operate and run their services with minimum supervision from the FMOH, the future of the program will be assured.

### ***Blood Safety***

The availability and quantity of safe blood for transfusion in Nigeria is very uneven and remains a route of HIV transmission. Nearly all states in the survey cited blood safety as a priority to be addressed. Blood, usually donated by relative or professional donors, is not routinely screened in many centres owing to lack of reagents. The quality of reagents available in the open market is unreliable. There is currently a plan for the creation of a National Blood Transmission Service (NBTS). Its implementation at state level is vital to improve access to safe blood for all Nigerians.

### ***Universal Precaution (Up) Including Injection Safety***

UP is vitally important both for the safety of the health worker and of the client. Surveys have shown that adherence to universal precaution including injection safety in health service delivery setting is poor. Training of health workers must give emphasis to universal precaution including injection safety and safe disposal of all clinical waste.

### ***Post Exposure Prophylaxis (PEP)***

The situation analysis in the state shows that there appears to be no current policy followed on PEP at health facility levels. A 2004 FMOH survey found that 50% of health workers surveyed had experienced a needle stick injury during the period 12 month but only 6% of these people were offered PEP. Used sharps were found outside 65% of facilities surveyed.

PEP is included in the revised Anti Retroviral. Therapy (ART) guidelines and must now be given priority as a measure to safe guard the health of providers and patients. PEP should also be available to rape victims, and the policy on use of PEP should be applied in all health care delivery settings.

### **Condom Use**

Knowledge about the role of the condom in preventing STIs is widespread; yet the use of condoms for prevention of STIs remains low. The National Demographic & Health survey (NDHS), reported 78% of men aged 15-24 years reported high risks sex in the previous 12 months. Yet some FBOs strongly discourage the use of condoms, even for HIV serodiscordant couples. It is widely acknowledged that unprotected sex is the main transmission route of HIV and the National HIV & AID policy given priority to the use of condom in addition to other prevention strategies. Social marketing provides 80% of condom in Nigeria, but discrete access to free condoms from health sectors facilities need to be improved.

### ***Antiretroviral Treatment (ART)***

The national ART programme started from 25 tertiary hospital sites and from an unknown number of private sector clinics and hospital. The choice of drugs to the patient from these different settings varies widely. Even though the cost of ARV drugs is subsidized in the public sector, the cost of treatment at \$1,000 per month and the cost of the required tests to the patients is high. Yet there are numerous patients on waiting lists giving an indication of the unmet need.

The ART programme has only recently been scaled-up from 13,888 PLWHA on drugs provided from 25 centres in 17 states to approximately 35,000 PLWHA supported through the government programme and those of both international and national NGOs. More recently, the president gave a directive to FMOH and NACA to scale up access to ART to 250,000 people. In December 2005 the federal government announced that antiretroviral drugs will now be free to all PLWHA enrolled on the national program. This is cherry news as this approach will considerably improve access to ARV treatment in the country.

Increased access to ART is urgently needed, but such rapid and extensive scale up in a weak health system raises serious concerns about the capacity of the health system to deliver the services and sustain the drug supply. The stock out crisis of ARVs in 2003 that lasted about 4 months became a life threatening problem for PLWHAs (DFID, 2005).

### ***Opportunistic Infections (OIs), Including STIs And TB***

States have reported that OIs, especially tuberculosis, constitute a serious national health problem because many TB patients are co-infected with HIV. The Directly Observed Treatment Strategy (DOTs) for treatment of TB appears to be working well and could provide an effective entry point for ART at community level. Machines for

OLs are generally not available in public sector facilities and are expensive. There is demand to have OI medicines included in the essential medicines lists.

The presence of STIs increase under availability to HIV infection significantly, yet management of STIs is generally poor in both public and private facilities. Access to OI medicine is limited owing to the lack of availability of the key mediums in the public sectors. The cost of medicines in the private sectors is unregulated and usually expensive for the patient. There have been demands on the federal Government to waive tariffs for essential medicines and health commodities related to HIV & AID prevention and care.

### ***Care and Support/Home Based Care (HBC) For PLWHAs***

The extended family is carrying the main burden of care and support, and coping with the consequences of illness and death, NGOs and FBOs have so far provided most of the HBC support, including spiritual support. Improvement of nutrition, by hygienic practices and access to treatment for opportunistic infections can prolong the life and productivity of a PLWHA. Medical and nutritional advice is most important at HBC level.

One of the strategies being adopted in the national response is the provision of home based care to PLWHA. Because this infers care at the community level, the strategy is being led by the National Primary Health Care Development Agency (NPHCDA), a parastatal of the Federal Ministry of Health. While strategies have been developed very little has occurred. Budgetary support for these activities is extremely limited, thus the bulk of the work is still being carried out by NGOs and FBOs who in turn, depend largely on funding from international donor agencies. Key funders of NGOs in this area include the Ford Foundation, McArthur Foundation, DFID, USAID, UNICEF, International Labour Organization (ILO), and United Nations Organization for Women activities (UNIFEM).

The Federal Government is developing a national guideline on palliative care with a section on home based care through the support of ENHANSE Project, USAID and other development partners. A framework to this effect has already been developed. This is major step at implementing an organized and standardised palliative program in the country.

The challenges of stigma and discrimination have limited the amount of work done in this strategy. Obtaining volunteers is also hard.

### ***Care for Orphans and Vulnerable Children (OVCs)***

It is thought that Nigeria has the largest number of HIV orphan in Africa. As more people die from AIDS, the problem of Orphans vulnerable children will continue to increase. While the ministry of Women Affairs has the mandate to lead on OVC, the health sector, in particular PHC, has responsibility to provide support for basic health services and nutrition of community level. The government has done very little work in meeting the needs of this OVCs. The country has just completed a plan of action with multi stakeholder participation assisted by UNICEF and Policy Project. This plan charts a way to move the OVC agenda forward and commence with a situation analysis funded by the World Bank which is now to be followed by a national conference to increase visibility for this program. The lead organisation for the government is the Federal Ministry of Women's Affairs and Youth Development.

Some organisations including CEDPA, Africare and Hope Worldwide have carried out localised activities which have provided valuable lessons that could inform future programs and activities. Many Faith based organisations have actually been in the forefront of providing the needed care but due to a lack of documentation, a lot of the knowledge acquired is not available for future programming. Hopefully current increased linkages by the public sector and development partners with faith based organisations should improve upon this lapse. Some organisations have started micro credit schemes for persons living with HIV/AIDS, and persons affected by it, to overcome the poverty associated with the condition. These activities are still in their infancy and are yet to show evidence of their effectiveness.



## **2.25 Coordination and Linkages within the Sector**

The National Situation Analysis revealed that there is weak coordination in the health sector between the national, states and local government levels, for both the ministries and the multi- sectoral coordinating bodies – NACA, SACA and LACA. This has led to a lack of coherence of policies, strategies and protocols, in addition, clear out delineation of roles and responsibilities between Federal and state ministries of health and NACA/SACA is yet to be achieved. This gap was a recurring theme in the state situation analyses.

Furthermore, within the federal and state ministries of Health there are no institutional or functional linkages between the HIV & AIDS programmed as well as relevant programmed and and division s, such as well as relevant programmes and divisions such as TB, Nutrition, Reproductive Health, Epidemiology, planning and research, Essential Drugs, etc. These also apply to relationships with agencies within the sector, such as the National primary Health Care Development Agency ( NPHCDA ) and National Agency for food and Drug Administration and control ( NAFDAC ).

The combination of strong leadership and coordination on the part of federal and state governments and clear operational plans will help target resources more efficiently and approximately. It is important that NASCP/FMoH takes on its co-ordination and leadership roles in all matters related to HIV & AIDS in the health sectors, and that it has confidence and support of its partners and many stake holders as well as the willingness to harmonize their activities(Bernard, 2005). For this to happen it is important to understand how the policy process works and the interplay of policy analysis, leadership and decision making at NACA.

### **2.25.2 Policy Analysis, Leadership and Decision Making at NACA**

Leadership, policies and decision making have a lot in common. Good policies are a product of good leadership and a painstaking and all-inclusive decision-making process. It is now expedient to explore the process of policy formation, policy analysis and decision making within the context of the Nigeria health care delivery system and highlight the rigours involved in weighing alternative policy choices and subsequently arising at a decision. The concept of policy analysis and decision making will be examined in details and using the experience of the National Action Committee on AIDS (NACA) with the review of the foremost Nigeria's HIV/AIDS Policy and Strategic plan, the HIV/AIDS Emergency Action Plan (HEAP), a demonstration will be made on the application of the policy analysis and decision making steps in a Nigerian health care institution. An appraisal of the lessons learned and how the policy analysis impacted on the development of the new strategic plan (2005- 2009) will also be undertaken. An understanding of the dynamics of policy formulation, analysis and implementation at NACA provides an understanding of the inherent challenges in providing quality HIV/AIDS services.

#### **Policy Concepts and Characteristics**

Policy as a concept simply defines action taken or to be taken and actions not taken or not to be taken by government or private organizations. It is a statement of what an organization wants to do, what it is doing, what it is not doing and what would not be done. It can also be regarded as general rules, regulations, guiding practices on actions in a particular activity or problem area (Ikelegbe, 1996). Institutional pursuit of goals must be guided by policy to guard against ineffectiveness and inefficiency in order to accomplish overall organizational objective(s). It specifies the line of action or proposed line of action in relation to certain activity areas. Areas affected by policy include health care, housing, education, productivity, transportation, foreign affair etc. It appears as government or corporate statements, legislative enactments, executive and administrative orders, budgetary actions and organizational directives.

From the aforementioned, one comes to understand that our lives are in fact affected and influenced by policies made by governments and communities, social organizations, churches, labour groups, educational business and service organizations. The result of policies is also all around us. The provision of social services, the cost of fuel, the availability or non availability of imported goods, the scope of our economic activities, the availability of agricultural loans and how much tax we pay or are to pay including the provision of health services are all determined by or are the results of policies.

From these concepts arise key characteristics which enhance our recognition of a policy. A policy is a course of action and a programme of actions, which is chosen from among several alternatives by certain actors in response to certain problems. Once taken, it guides behaviour, activities and practices and provides a frame for present and future decisions (Ikelegbe, 1996). The chosen course may actually be just a statement of intentions or a projected programme of actions or it could be concrete actions or set of decisions.

However, a policy need not be a decision or concrete action. It could be what is not being done or the absence of action. Inaction in a particular problem area by an organization could be regarded as her policy response. As Dye (1978) puts it in relation to government, "a policy is whatever government chooses to do or not to do".

Policy has some key characteristics; first, it involves a choice. It is an important choice or a critical or major decision taken by individuals, groups or organizations. Policy alternatives must be completely analyzed to determine their positive and negative effects as to inform a decision among them. Depending on the available funds, personnel, environmental effects of available policy alternatives, the social benefits and overall effects on the target population, a decision could then be reached on the most beneficial alternative to be chosen for implementation.

This means that there has to be several policy alternatives. Policy formation must involve the development of several policy alternatives and the choice of an alternative. Second, policies are decisions. Policies are prospective or are statements of future actions. Policies state what is going to be done or would be done. It outlines a course of contemplated or desired action in relation to certain desired objects or events in the real world.

Thirdly, a policy is goal oriented. It is directed at the attainment of certain end states or more simply objectives. A policy has certain purpose or intentions. Fourth, policies have to do with particular problems or problem areas; they are not abstracts, but rather related to and are actually responses to the challenges and pressures arising from an environment. In fact, often times, policies are designed and targeted at relieving existing or future problems or satisfying certain needs.

Finally, a policy is a course setting action. It provides the direction, the guide and the way to the achievement of certain goals. It provides the frame within which present and future actions are undertaken. Dror (1973) wisely conceptualizes policy as a “major guideline for action”

Policy analysis and decision making play prominent role in Nigeria's health care delivery system through government enactments and guided principles of actions and inactions affecting the consumption and delivery of health care. The health care industry including public and private organizations must align their activities in the area of health care delivery to existing government policy guidelines. This is in effect to achieve maximum possible benefit for the Nigeria citizenry health wise.

## **The Concept of Policy Analysis and decision-making**

Public discourse today is saturated with the advocacy or criticism of various policies. It is common to hear of foreign policy, defense policy, economic policy, educational policy and policies in almost every area of government and private activity. We also hear of policy statements, enactment of policies, and declarations of policy intentions and the commitments of millions of Naira to the implementation of certain policies. But what exactly is policy? Policy may be defined as “a definite course or method of action selected from among alternatives and in the light of given conditions to guide and usually determine present and future decisions” (Presthus 1979). Jacob and Flink (2003) also define policy as an integrated programme of actions which an actor (or group of actors) is accustomed to or intends to undertake in response to given problems or situation with which he is confronted.

### **What Is Policy Analysis?**

Policy analysis is the process through which we identify and evaluate alternative policies or programme that are intended to lessen or resolve social, economic, or physical problems” (Patton, 19??). Theodore (1978) defines policy analysis in terms of the focus of analysis. To him policy analysis refers to the “analysis of the determinants, characteristics, and implications of public policies and programmes and the substantive consequences and outcomes they produce. To this list of analytical focus could be added the nature, causes, and effects of alternative policies, the political and other context of policymaking, the policy process, the analysis of policy implementation and performance. “Policy analysis is essentially the generation of information and analysis directed at better policy making and performance. The goal is prescription. That is proffering policy options or alternatives, solutions and strategies based on analyzed data. The analyzed data could emanate from the social and policy problems, social indicators, evaluation of existing or past programme and projections (Ikelegbe, 1996).

Based on the ideas and approach followed by Carl V. Patton, there exists a very simple pattern of ideas and points to be considered in doing an actual policy analysis. It is important to point out here that the number of steps identified in process analysis often tends to depend on the details of the analyst. However these steps or stages are grouped into three basic stages identified as follows:

1. Policy formation
2. Policy implementation and
3. Policy outcome.

It's also worthy to know that these stages are further divided into sub-stages. However for simplicity we shall follow the six steps as professed by Patton in our further discussions.

### **1. Verify, define, and detail the problem.**

This is the most relevant and important of them all because many times the objectives are not clear or in some cases even contradictory. Policy analysis requires clearly identifying the problem to be resolved. This is the foundation for an efficient and effective outcome of the whole process. The researcher must question both the interested parties involved as well as their agendas of the outcome. Locating the problem in such a way that eliminates ambiguity for future references. Care must be taken here not to be involved in identifying the symptoms of the problems rather than the problems it self. When problems are not well defined, proffering solutions or alternative policies becomes pretty difficult. For instance the problems of HIV/AIDS in Nigeria cannot be effectively resolved by simply proffering solutions to the symptomatic manifestation of the disease.

Furthermore, a poor understanding of the nature of the HIV/AIDS problems had led to wrong interventions, wasteful and unsustainable interventions in the past until recently when improvement in our understanding of the disease and its challenges has led to a multisectoral response and more proactive approaches.

## **2. Establish evaluation criteria.**

In order to compare, measure and select among alternatives; relevant evaluation criteria must be established. Cost, net benefit, effectiveness, efficiency, equity, administrative ease, legality, political acceptability and economic benefits must be considered in evaluating the policy. How the policy will harm or benefit a particular group or group will depend on a number of options viable. Options more difficult than others must be considered but ultimately decided through analyzing the parties involved with policy.

Political and other variables go hand in hand with the evaluation criteria to be followed. Most of time the client, or persons or group interested in the policy analysis will dictate the direction of the evaluation criteria to follow.

## **3. Identify Alternative Policies.**

In order to reach this third step the other two must have been successfully reached and completed. As it can be seen, the policy analysis involves an incrementalist approach; reaching one-step in order to go on to next. In this third step, understanding what is sought is very important. In order to generate alternatives, it becomes important to have a clear understanding of the problem and how to go about it. Possible alternatives include the “do nothing approach” (status quo), and any other that can benefit the outcome. Combining alternatives generates better solutions not thought of before. Relying on past experiences from

other groups or policy analysis helps to create a more thorough analysis and understanding. It is important to avoid settling prematurely on a certain number of options in this step; many options must be considered before settling into a reduced number of alternatives.

#### **4. Evaluate Alternative Policies**

Packaging of alternatives into strategies is the next step in accomplishing a thorough policy analysis. It becomes necessary to evaluate how each possible alternative benefits the criteria previously established. Additional data needs to be collected in analyzing the different levels of influence: the economical, political and social dimensions of the problem. These dimensions are analyzed through quantitative and qualitative analysis that is the benefits and costs per alternative. Political questions in attaining the goals are analyzed as to see whether they satisfy the interested parties of the policy analysis. In doing this more concise analysis the problem may not exist as originally identified; the actual problem statement from the first step may suffer a transformation, which is explained after evaluating the alternatives in greater detail. New aspects of the problem may be found to be transient and even different from the original problem statement.

This modification process allows this method of policy analysis to allow for a “recycling” of information in all the steps. Several fast interactions through the policy analysis may well be more efficient and effective than a single detailed one. What this means is that the efficiency is greatly increased when several projects are analyzed and evaluated rather than just one in great detail, allowing for a wider scope of possible solutions, Patton further suggests to avoid the tool box approach: attacking options with a favorite analysis method; it is important to have a heterogeneous approach in analyzing the different possible alternatives. It becomes inefficient to view each alternative under a single perspective; there is



need to evaluate each alternative following diverse evaluating approaches singled out according to the uniqueness of each of them.

## **5. Displays and Distinguish Among Alternative Policies**

The results of the evaluation of possible alternatives list the degree to which criteria are met in each of them. Numerical results don't speak for themselves but are of great help in reaching a satisfying solution in the decision. Comparison schemes used to summaries virtue are of great help in distinguishing among several options; scenarios with quantitative methods, qualitative analysis, and complex political considerations can be melded into general alternatives containing many more from the original ones. In making the comparison and distinction of each alternative it is necessary to play out the economic, political, legal and administrative ramification of each option. Political analysis is a major factor of decision of distinction among the choices; display the positive effects and negative effects interested in implementing the policy. This political approach will ultimately analyze how the number of participants will improve or diminish the implementation. It will also criticize on how the internal cooperation of the interested units or parties will play an important role in the outcome of the policy analysis. Mixing two or more alternatives is a very common and practiced approached in attaining a very reasonably justified policy analysis.

## **6. Monitoring the Implemented Policy**

This assures continuity, and determines whether they are having impact. "Even after a policy has been implemented, there may be some doubt whether the problem was resolved appropriately and even whether the selected policy is being implemented properly. This concerns require that policies and programme be maintained and monitored during implementation to assure that they do not change for unintentionally, to measure the impact that they are having, to

determine whether they are having the impact intended, and to decide whether they should be continued, modified or terminated.

Mainly, we are talking about internal validity; whether our programme makes a difference, if there are no other alternate explanations. This step is very important because of the special characteristic that programmes evaluation and research design presents in this particular step.

### **Steps in Policy Decision Making**

Decisions in policymaking involving alternative programmes are never made in a vacuum. Apart from the theories and models of policy analysis, there are several techniques or tools, which are used in the planning, analysis, evaluation and management of policies and programme.

These same tools are also used in the decision process to aid programme managers in making decision involving alternative policies. Some of these techniques are system analysis, cost benefit analysis, cost effectiveness, efficiency, programme effectiveness, management by objective planning, programming-budgeting system, zero base budgeting, decision tree, critical path method, programme evaluation review technique and the Delphi method. Depending on the researcher or programme manager, a decision is usually made on which technique or tool is most favourable to produce the most desired result. For simplicity and space, the system analysis technique shall be examined to gain insights in the policy decision-making process.

### **Systems Analysis**

System analysis technique involves the application of explicit, systematic comprehensive and quantitative analysis to decision problems. It comprises a

reasoned and deductive approach to problems requiring decisions particularly governmental problems and programme. It involves systematic collection of relevant data and comprehensive analysis, using sophisticated, quantitative, and rigorous methods, models and techniques and rational criteria to aid policy makers and programme managers in arriving at rational, efficient alternatives.

The emphasis is therefore quantitative methods and analysis. The goal is efficient policies. In respect of programme, the goal is the most favourable ratio between the value of resources expended and benefits obtained.

Specifically, systems analysis involves:

1. Clear determination of goals and objectives.
2. Determination of alternative means or systems for attaining goals and objectives.
3. Estimation in quantitative terms, the cost and resources required and benefits of each alternative
4. A description (i.e. a model) of the relationships between the objectives, alternatives costs, benefits and problem environment.
5. A criterion for choosing, the preferred alternative based on objectives, costs and benefits.
6. Determination of the most cost beneficial, cost effective approach in relation to problem environment and objectives.
7. Advise of public officials or appropriate officers on most favourable alternative or combination of alternatives based on above model and criteria (Ikelegbe, 1996).

## **Application of Policy Analysis and Decision making process at National Action Committee on AIDS (NACA)**

### **Brief Historical Perspective:**

The first case of acquired immune deficiency syndrome (AIDS) was reported in 1986 and since then there has been a rapid increase in the total number of people living with HIV/AIDS. It is now being estimated that about 3.5 million Nigerian live with the disease. According to FMOH, HIV/AIDS control was neglected and fragmented under previous governments. Since 1999, the federal government has placed high priority on prevention, treatment, care and support activities. AIDS prevention and control activities have received a high level of political commitment and donor support. In recognition of the need to scale up a multisectoral response from all sectors of government and civil society, the Federal Government established key institutions including the President's Committee on AIDS (PCA) and the National Action Committee on AIDS (NACA). One of NACA's primary responsibilities is the execution and implementation of activities under the HIV/AIDS Emergency Action Plan (HEAP), introduced in 1996 as a bridge to a long-term strategic plan.

Under the financial and organizational leadership of NACA, the HEAP focused on two main components: (a) creating an enabling environment through the removal of socio-cultural, informational and strategic barriers and catalyzing community-based responses; (b) HIV/AIDS-specific interventions such as preventive interventions for the general population and targeted to high-risk populations and care and support for persons infected by HIV/AIDS. With rising HIV prevalence rates and AIDS-related deaths, the lessons learned from the implementation of HEAP suggested that a review of the National Policy on HIV/AIDS was seen as a necessary step forward. Therefore, to help limit the spread of HIV/AIDS in the country, in 1997 the Government of the Federal Republic of Nigeria developed the National Policy on HIV/AIDS and STI, which represented a new approach based on the involvement of

all sectors of society in the planning, implementation and evaluation of the country's response.

Following the expiration of the HEAP, the federal government considered a review of the implementation of the policy and strategic plan as a step towards the development of a new strategic framework covering the period 2005 - 2009

Based on our understanding of the policy analysis and decision processes already examined, we shall now explore the extent to which NACA conformed to these processes in the review of the HEAP. For the purpose of guidance and proper understanding, the Patton policy analysis steps will be followed.

### **Policy Analysis Application Steps As Applied**

#### **1. Verify, define, and detail the problem:**

In analyzing the HEAP policy, NACA assembled representatives of all line ministries and relevant government agencies: Education, Health, Agriculture, Women Affairs, Youth Development, National planning and a host of non-governmental organizations, religious, civil society groups and development partners. A landmark stakeholders' meeting lasting a week was held at NICON Hilton, Abuja for members to review the nationwide implementation of HEAP and identify issues, challenges and opportunities according to thematic areas.

Problems and challenges identified were categorized as follows:

- a. Institutional and coordinating structures
- b. Resource mobilization and management.
- c. Prevention
- d. Care and support.
- e. Socio- economic impact and impact mitigation.
- f. Uniformed services, Regional Programme and new technologies.
- g. Monitoring and evaluation, Surveillance and Research

- h. Policy Advocacy, legal and human rights.

Several problems were identified in the broad areas enumerated above some of which are summarized below:

- a. While NACA has a strong multi-sectoral representation and participation in HIV and AIDS planning and activities, this approach is not reflected effectively at the States and Local government levels. The capacity of most of the coordinating entities still needs to be strengthened to ensure an effective management and coordination of all activities to stem the epidemic in Nigeria.
- b. The expiration of the HEAP coincided with the Launch of the United States Presidential Emergency plan for Aids Relief (PEPFAR), from which the country expects to attract about US \$ 1 billion between 2004 and 2009 into the National Response. However, during the period under review, over-dependence on donor funding has restrained the responsiveness of indigenous resource mobilization. The private sector is currently not adequately involved. Religious bodies and communities are yet to be sufficiently motivated to contribute to the national response.
- c. While the guidelines and program for the Syndromic Management of STIs was initiated, male support and involvement in reproductive health programmes remain a major challenge. A wide range of traditional, religious and socio-cultural factors continue to put young women and girls at risk of HIV infection.
- d. In 2002, the government initiated an anti-retroviral (ARV) program that targeted 10,000 adults and 5,000 children. Most of the treatment centers were public institution and have exceeded their quotas with about 17,000 people receiving ARVS by the end of 2004.

- e. Gender inequalities and poverty, worsens the socio-economic impact of HIV and AIDS on the Nigerian Society. Orphans and vulnerable children's (OVCs) present a major development challenge, particularly in education, health, and food security and employment opportunities. Lack of comprehensive sector studies on the impact of the epidemic prevent a more focused and informed approach to mainstreaming HIV and AIDS including gender in the key development sectors.
- f. There is significant program in HIV and AIDS programme targeted at armed forces, police, and immigration personnel. But there still exist a strong need to develop and disseminate gender sensitive. Behavioral change communication (BCC) materials for different target groups of the uniformed services (HIV/AIDS).
- g. The review revealed that Nigeria had accomplished some of the HEAP-set goals for Monitoring and Evaluation which included periodic update of data through HIV/AIDS syphilis Sero-prevalence, conducting a situational analysis of OVCs and establishing the Nigeria National Response Information Management System (NNRIMS). The major challenges in this area included: lack of gender sensitivity in the system, failure of NNRIMS to address programme evaluation. NNRIMS is still in its early stages of implementation NNRIMS was based on the HEAP, which had a narrow focus on HIV/AIDS responses and thus needs to be reviewed to be in harmony with the thematic areas in the new NSF.
- h. There is need for advocacy for the development of relevant legal instruments to give strategic policies (workplace, insurance coverage and more) a legal backing in cases of violation of human rights. The response review reported violation of individual's human rights in settings and women particularly those

testing positive in ante-natal clinics (ANC) settings continue to experience stigma and discrimination.

As can be observed from the foregoing, NACA actually satisfied the first step in the policy analysis process by determining, verifying and detailing problems and challenges.

## **2. Establish Evaluation Criteria:**

One major challenge in the HEAP policy review process was the lack of baseline data and evaluation criteria to assess progress. The HEAP was developed at a time when there was very little knowledge about programming for HIV/AIDS. The activities in the document were not costed and neither were there benchmarks to assess overall progress. So the decision as to what was working and what was not working were left to the imagination of members of the various technical working groups. Therefore a determination on alternative courses of action for the new policy document was done theoretically and subjectively.

Policies where properly assigned criteria of evaluation makes it possible to select among them as to which policy (ies) may have the most plausible impact on the intended population. It's not good enough to state expectant performance percentages among the various policies as to their impact on the target population without comparing and quantifying policies on given criteria. When this is done we are able to channel our limited resource to policies that are not only plausible but will have the greatest impact on the intended population.

## **3. Identify Alternative Policies:**

This third stage of policy analysis calls for the generation of alternatives or policies to resolve the stated problems. It must be stated that performing excellently in this



stage demand a clear understanding of the problem and how to go about it. It was evident that the lack of evaluation criteria to assess performance levels, efficiency and impacts was a major handicap militating against the proper identification of alternative policy thrusts. However, to deal with this problem; NACA recruited about 20 international consultants with the assistance of international donor agencies to work with technical working group members to analyze the problem identified and make recommendations for policy change.

#### **4. Evaluate Alternative Policies:**

Packaging of alternatives into strategies is the next step in accomplishing thorough policy analysis. It becomes necessary to evaluate how each possible alternative benefits the criteria previously established. Evaluating alternative policies based on established criteria could not be performed here since NACA had no established criteria to evaluate alternative policies. As already stated, NACA understood that this could constitute a major impediment to process and assigned the consultants to bridge this gap. There is evidence that some progress was made considering the changes in policy direction in favour of one national strategic plan, one national policy and one national monitoring and evaluation plan.

#### **5. Display and Distinguish Among Alternative Policies:**

The result of the evaluation of possible alternatives lists the degree to which criteria are met in each of them. Here policies cannot be numerically weighted due to the absence of evaluation criteria. NACA was unable to establish such evaluation criteria.

## **6. Monitoring the Implemented Policy:**

At the time the HEAP document was developed, no monitoring and evaluation plan or performance monitoring plan was in place. This explains the difficulty with measuring program effectiveness and efficiency. However, the Nigeria National Response information Management system (NNRIMS) was developed with a set of key national indicators. As the monitoring and evaluation plan was being piloted, it became possible to capture some data that has been utilized to assess the implementation of HEAP. This combined with the report from the national situation analysis survey provided some information upon which future policy will be based.

### **Decision Making**

It is observed that there was some attempt by NACA to follow some scientific policy analysis and decision making approach in its policy review process. This process was however neither systematically followed nor pursued with enthusiasm by NACA. This is not surprising. At the time NACA came into being, as already observed there was a dearth of information on what constituted good management of HIV/AIDS program, secondly the ambivalence on the part of government and widespread denial of the HIV/AIDS problem meant poor political will and commitment exemplified by lack of investment in planning for the national HIV/AIDS program. Hence initial efforts were prescriptive and medical in orientation. The introduction of the HEAP was the first major breakthrough arising from sustained pressure from NGOs and civil society groups. So the document was hurriedly put together with inadequate involvement of all interest group groups. The goals of the project were laudable but not well targeted, activities were not evidence-based, work plan was not costed, there was no clearly defined model and public officers lacked the technical knowledge to give informed advice.

The review of the document last year provided an opportunity to learn from the mistakes of the past and ensure that the perceived inadequacies of the previous document were corrected. In summary therefore, as observed in the appraisal of the conformity of the review process using Paton's framework, it could be easily adduced that the review process did not fully align with the steps in scientific decision making.

### **Implications of NACA's Experiences on Policy Analysis and Decision Making on National Health Care Planning**

Notwithstanding the imperfections in the NACA's policy review process, it is however commendable that it is one of the few public institutions in the country that employed the process of policy analysis in trying to understand the workability of its policy to determine priorities in the development of a new policy. As we have already observed the process yielded tonnes of new information on various programmatic areas. This means that NACA goes into the development of its new strategic plan armed with current information on its progress, challenges and lessons learned. There are no doubts that this experience will inform the policy thrusts and options for repositioning. A lesson to be learned from this is that national health care service delivery system will achieve more where national health care policies are subjected to periodic analysis to determine their focus and direction. The national health care system has witnessed a number of health care policies since pre-independent period; from the period of national development plans to the implementation of the national primary health policy. These policies have not translated into better, affordable and accessible health care for the people. It behooved that the Federal Ministry of Health should follow NACA's example in policy analysis especially at this time that it is embarking on the health care reforms.

So far, we have examined the meaning of policy, the intricacies and steps in the policy making, analysis and decision making and experience of NACA in policy analysis and decision making regarding the review of the National HIV/AIDS

Emergency Action Plan. It was observed that policy analysis is vital and necessary process to be undertaken periodically by public and private sector institutions if efficiency and effectiveness must be maximized. Policy analysis calls for the consideration of alternatives policies through established criteria to inform our choice as to which policy (ies) or combination of which will yield the utmost result for the betterment of health for our citizenry.

It is highly recommendable that policy analysis and scientific decision-making processes must be an integral part of management of public and private institutions in Nigeria. Apart from the benefits in leveraging resources, it ensures that policies reflect the desires and expressed needs of the people and ensures community ownership of programs so that policies become implemented and impact on the lives of the people. This is one way of overcoming the leadership challenges in our health care system.

## **2.26 Challenges and Barriers: Factors affecting the delivery of HIV/AIDS services**

A major weakness in the education of health care professional in the field of HIV /AIDS is that patients expressed needs are often not taken into account, only the providers perceptions of their need are often considered ( Schietinger & Daniels, 1996). Yet there is a dearth of literature about the consumers' perspective regarding health care providers' attitudes and skills (Beedham & Wilson – Barnett 1995). Much of the work that has been carried out has been in the area of audit. Further research is needed in the area of consumers' satisfaction with care, the consumers and the health care providers' relationship, impacting providers' attitudes and the willingness and ability of consumers to access care.

There may be several reasons why the consumers' perspective is very important in assessing HIV training needs of health care providers but these required testing through further research. First, one of the greatest barriers to care for people with HIV

/ AIDS has been the unwillingness of many health care workers to provide care for people known to be infected (Dwoken et al., 1991).

Second, many people with HIV have been marginalized and stigmatized by society and are at a greater risk of being misunderstood by health care providers due to homophobia (Fitzpatrick et al 1994).

Third, some people are at risk for HIV (Taylor & Robertson, 1994) and some people with HIV have poor access to health care because of social and economic factors. Health Care provider may not be necessarily aware of the patient's social and psychological needs (Schietinger & Daniel 1996).

Fourth, a key outcome of provider training should be the provision of better care to consumers (Horsman & Sheeran, 1995). The consumers' perspective serves as a sensitive tool for monitoring and evaluating quality of care

From the foregoing and the lesson learned from implementing HIV/AIDS programme in Africa, successful responses have the following characteristics:

- i. Wide spread community support was mobilized by leadership
- ii. Leadership efforts were geared towards stigma reduction and overcoming silence, denial and changing sexual behaviours to embrace safer sex.
- iii. Examples of sustained actions at the national level were showcased.
- iv. Committed leadership were developed at all levels.
- v. Partnership were developed at different levels.
- vi. Resources were mobilized, priorities set and initiatives adequately financed.
- vii. Local institution, communities and the public and private were effectively used.

In all this it is clearly seen from the literature review so far that without top level political commitment and the mobilization of resources and leadership at all levels, HIV prevalence will not decline. Strong political leadership in the fight against HIV/AIDS is a fundamental prerequisite to setting up a national strategy response to HIV/AIDS which includes multi sectional participation and action at the community level. The action and inaction of political leaders through government is the glue, which brings together an interpreted and effective response. If political leaders do not display commitment and government do not check the leading role in committing to ameliorative action then failure is almost guaranteed (Gore 2000). Studies have shown that the reaction time of most African leaders to address HIV/AIDS epidemic has been very slow, countries with wide spread epidemic such as South Africa and Zimbabwe are just beginning to overcome the denial phase. Generally in Africa inadequate public dialogue, resources and capacity have been posed serious challenges. Denial, stigma and discrimination and the consequences of inability to be open and frank about the HIV/AIDS scourge African leaders are also confronted with innumerable political problems and socio-economic challenges, particularly poverty especially in the rural areas. According to Cohen (2000), this scenario has led to outcomes that expose the poor to increase probabilities of HIV infection. Besides physical and human resources to improved countries education, welfare and general population are lacking so also are the infrastructure and human capacity need for increase level of illness.

## **2.27 Resource Allocation and Mobilization**

An indicator of effective and proactive leadership in HIV/AIDS programme management is the allocation of resources, human and material to fight the epidemic. This is one area in which African leaders have not fared well. Health care budget in Africa do not at all reflect the enormity of the HIV/AIDS problem. Gore (2000) compared HIV/AIDS spending with military spending across 14 African countries and concluded that spending on wars, civil violence, or preventive security measures vastly outweigh spending on health generally, and HIV/AIDS specifically. Table 2.2

below provides an overview of the relative commitment of sub Saharan African countries to HIV/Military spending in 1996 showing relatively low HIV spending as compared to military spending. Zimbabwe stands out with a rate of military spending of 6,782 times larger than the HIV/AIDS. At this time, the actual HIV prevalence was 25% with more than 1.5 million Zimbabwean citizens infected. It is generally observed that the trends in military spending in Africa has been running dramatically, with an increase in real terms of 37% between 1998 and 2000 – from 86.5 billion to 89.8 billion in constant 1998 prices (Stockholm International Research Institute (2001). One fact stands out clearly from this analysis i.e. that the issue of resources to fight the HIV epidemic in many African countries is not one of the availability but one of priorities.

Unfortunately, conflict and wars are correlated with a higher probability of HIV transmission. The conflicts in Burundi, Sudan, DRC, Sieria Leone and Liberia have increased HIV/AIDS prevalence in these countries. In fact all countries in Eastern and Southern Africa that engaged in or experienced wars and violence between 1970s - 1980s are the countries now experiencing the most severe epidemics. This is mainly due to breakdown of social order leading to rapes and other forms of sexual abuse and STIs. Table 2 below shows HIV/AIDS military spending in some selected African countries as compared to HIV/AIDS spending.

Table: 2.2

HIV/AIDS and Military Spending in Selected Sub-Sahara African Countries, in Constant 1996 U.S. Dollars (millions)

HIV/AIDS Spending				
Country	National Government	International Donors	National Government Military	Ratio of Military to National HIV/AIDS Response

Spending <sup>b</sup>				
Angola	\$0	\$0.4	\$975.0	-d
Bostwana	2.7	0	195.8	72
Cote d'voire	0.7	6.5	10.9	15
Dem. Rep. of Congo	0	3.6	214.3	-d
Lesotho	-e	0	35.5	-d
Malawi	1.1	5.2	15.5	13
Mozambique	0	2.9	65.4	-d
Namibia	0.4	0.7	98.3	225
South Africa	-e	0	2,696.5	-d
Swaziland	-e	0	27.9	-d
Tanzania	0.1	2.3	-e	-d
Uganda	2.5	35.0	127.3	50
Zambia	0.2	6.0	38.3	200
Zimbabwe	0.2	13.9	297.1	6,782

Source: UNAIDS 2002

People living with HIV/AIDS (PLWHA) face many forms of stigma and discrimination. This is the case in whichever country they may live, as has been shown a number of previous research studies. In addition to experiencing unfair treatment in their families, communities and places of work, PLWHA may encounter discrimination from health care professionals. This can interfere with effective prevention and treatment. Discriminatory practice in the health care sector may also appear to legitimize other forms of discrimination against PLWHA. Vincent Lacopino and colleagues from the organization Physicians for Human Right, in collaboration with researchers from Policy Project – Nigeria and the Center for the Right to Health (also in Nigeria) investigated the problems in Nigeria.



## **2.28 The Global Perspective**

The care of people with HIV/AIDS is challenging due to its multidisciplinary nature, its medical complexity, the physical manifestation, the need for infection control procedures and the associated system. Despite gains in knowledge, several problems affect the care of patients such as: the fears of becoming infected (Peate, 1994), homophobia (Taylor & Robertson 1994), bournout (Nesttt, et al, 1996), religious attitudes (Dyer, 1993), unwillingness to care and the absence of touch (Butts & James, 1995).

Research on caring has been mainly descriptive and has used a variety of research tools such as: Liket Scales that measure agreement and disagreement between items (Stienborg, 1992), open ended questions, questionnaire (Sheeram & Obell, 1996), taped interview, focus groups (van Wissen & Woodman, 1994), attitudes theory measurement (Preston, et al, 1995), inventors, self report instrument and visual analogue scales

(Harrison, et al, 1994). In depth, qualitative studies have been few (Burmard & Morrison, 1996). Many of the methods used have not been employed at the expense of interview based, observational or quasi experimental studies and many of the survey have used single item measures and have lacked scientific rigor (Horsman & Sheeran, 1995). Nearly all the studies are cross sectional and it is therefore responsible to distinguish causes from effect. In addition, the sample used have usually been selected convenience samples which limits the generalizability of the research. Few studies have attempted to follow up non-responders in order to determine the representativeness of the samples.

Hospital doctors, nurses and dentist have been the major frequently studied groups and few studies have been looked at other health care workers such as laboratory technicians, social workers, community workers and paramedical staff. Most studies ignore groups of staff such as porters and domestic workers. Only three references

could be found in which both patients' and carers' attitudes to each other were considered and none looked at negative feelings and their impact.

There have been various review articles on the literature on professional attitudes to caring for people with HIV/AIDS. One of the recent comprehensive reviews carried out by Horsman & Sheeran (1995), identified the extensive literature in the impacting HIV/AIDS on health care workers. Themes identified included: the fear of infection, beliefs about the right to refuse care, the stresses associated with caring for HIV positive people and educational intervention which attempts to alter the beliefs of health care workers.

### **2.28.2 International Donor Support and Leadership**

#### ***The United States Example***

The United States of America has to date become the largest contributor to international HIV/AIDS care, treatment and mitigation efforts. Many public health and development experts however depose that this did not result from an act of benevolence or a genuine concern for the plight of the suffering people of Africa but because it became apparent that US interest was affected by the burgeoning epidemic in many parts of the world. Until the 1990s, the African epidemic received little direct attention from the United States' Government. The perception of HIV/AIDS as primarily a health care problem at that time was one of the reasons adduced for the slow response of the US Government and lack of a comprehensive program to address the epidemic. As the scale of the epidemic and its effects in the society became more apparent, the US Intelligence began to have a clearer picture of the risk and the threat posed to America and its interests. For example, HIV/AIDS knows no borders and with increasing international travel and migration, migrants escaping the harsh economic climate of many developing countries have migrated into US with not only HIV/AIDS but also other communicable diseases. For example, US death rate from communicable diseases has doubled since 1980 and treatment of diseases cost

\$120 billion annually, or 15 % of the total US health spending (Kassalo, 2001). These diseases were brought into the United States by both foreign immigrants and traveling citizens. HIV/AIDS epidemic has destabilized societies, economies and governments and has the potential to cause instability, civil unrests and reduced quality of lives. According to Andrew Smith, declining health status with a decline in state capacity, leading to instability and unrest through reduced prosperity, increased inequality and reduced human capital.

Studies into the risks and strategic implications of the epidemic to US interest were commissioned in the late 1990s and by the year 2000, the National Intelligence Council and the Congressional Research Service both produced public reports that examined in details the threats of the growing epidemic and the implications to the United States (National Intelligence Council, 2000). The National Intelligence Council concludes that:

New and re-emerging infectious diseases will pose a rising global health threat and will complicate US and global security over the next 20 years. These diseases will endanger US citizens at home and abroad, threaten US armed forces deployed overseas, and exacerbate social and political instability in key countries and regions in which US has significant interest (National Intelligence Council, 2000).

The findings of the National Intelligence study have been collaborated by projections from the United Nation and research by other competent authorities. For example, UNAIDS projections are that by 2010, the number of absolute infections in Asia alone(mainly India and China) will be likely to outstrip that number in Sub-Saharan Africa; at the end of 2000, twenty five million Africans were estimated to be living with HIV. This means that if the epidemic goes unchecked the risk to US interest will continue to grow over the next 20 years.

In response to this, the American government has moved away from a domestic orientation towards an international focus on the disease. The US Government has

been the largest international donor to African countries throughout the 1990s. From 1986 to 2001, USAID has spent \$1.6 billion on programs to address the epidemic in developing world(UNAIDS, 2001). A large percentage of these funds went to Africa. During 1996-1999, an average of \$135 million per year was committed to HIV/AIDS spending, \$80 million per year in Africa (USAID 2001). In July 1999, Vice President Al Gore proposed \$100,000 million in additional funding for the Global LIFE (Leadership and Investment in Fighting an Epidemic) AIDS initiative for African countries which commenced in 2000. In July 2000, the US Export Import Bank made available a total of \$ 1 billion in loans to African countries to purchase HIV/AIDS medications and infrastructure from US firms (Copson 2001).

A new legislation enacted during the 106<sup>th</sup> Congress increased HIV/AIDS funding worldwide and initiated several African AIDS programs. In June 2001 the Global Access to HIV/AIDS Prevention, Awareness, Education and Treatment Act (HR 2069) passed the House International Relations Committee, authorizing large increases for international HIV/AIDS programs. It authorized \$560 million in both fiscal years 2002 and 2003 for USAID activities and a further \$750 million in 2002 for contributions to the global fund and other multilateral efforts (Copson 2001). Total direct US spending on HIV/AIDS in Africa increased to \$168 million and \$234 million in 2001 – 2002.

US leadership in the global fight against HIV/AIDS is now consistent and exemplary as the President is now able to march word with action. Its contribution to the Global Fund still remains the most outstanding and the largest contribution from any government. On May 11, 2001, President George Bush pledged a donation of \$200 million. As at March 2002, the total commitment from all sources topped \$ 1.9 million. The Bill and Melinda Gates Foundation contributed \$100 million.

#### ***US President's Emergency Plan for AIDS Relief (PEPFAR):***

The most outstanding contribution of the US Government to international HIV/AIDS efforts the Presidents Emergency Plan for AIDS Relief (PEPFAR). This initiative was

announced by U.S. President George W. Bush during his 'State of the Union' address in January 2003. In May, President Bush signed the U.S. Leadership against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 into law. The plan calls for \$15 billion over the next five years, with nearly \$10 billion being new funding. About \$9 billion will be directed to 14 heavily-affected target countries, \$1 billion is pledged to the Global Fund, and the remaining \$5 billion will be used to support current HIV/AIDS, tuberculosis, and malaria programs. About \$2 billion is planned for 2004.

To coordinate the implementation of the program, the Office of the Global AIDS Coordinator, located in the State Department, is charged with overseeing the emergency plan. Though institutional structures and relationships are still being developed, the Office of the Global AIDS Coordinator works closely with other agencies working in the HIV/AIDS arena and will not be limited to coordinating efforts only in the 14 target countries.

Randall Tobias, who has the rank of Ambassador and whose official title is State Global AIDS Coordinator (S/GAC), heads the Office. PEPFAR aims to enhance the HIV/AIDS response in the most affected countries. It currently targets 15 countries in Africa and the Caribbean. They are: Botswana, Côte d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, and Zambia and Vietnam. (These countries are also the focus of the President's previously announced \$500 million Mother-and-Child HIV Prevention Initiative.)

These 15 countries account for nearly 20 million people living with HIV/AIDS—almost 70 percent of the total in all of Africa and the Caribbean and 50 percent of global HIV infections.

PEPFAR's three long-term objectives are to:

- Avert 7 million new HIV infections;
- Provide antiretroviral (ARV) treatment to 2 million people; and

- Provide a range of care and support to 10 million people living with HIV/AIDS and AIDS orphans.

The White House website explains that:

Implementation of the President's Emergency Plan for AIDS Relief will be based on a "network model" being employed in countries such as Uganda. This involves a layered network of central medical centers (CMCs) that support satellite centers and mobile units, with varying levels of medical expertise as treatment moves from urban to rural communities. The model will employ uniform prevention, care, and treatment protocols and prepared medication packs for ease of drug administration. It will build directly on clinics, sites, and programs established through the U.S. Agency for International Development, the Department of Health and Human Services, non-governmental organizations, faith-based groups, and willing host governments. The initiative will be implemented through:

- **Central Medical Centers (CMCs)**, which will be existing hospitals staffed by physicians with expertise in HIV and infectious diseases, doctors-in-training, nurses, nurse practitioners, and laboratory technicians. The centers will provide the highest level of care and will be capable of managing the more complicated medical issues.
- **Primary Satellites**, which will be independent medical centers with doctors, nurses, pharmacists, counselors and medical technicians, who will provide basic medical care, including the prescription of ARV treatment. Primary Satellites could have doctors on staff or doctors rotating through from the CMCs. Many private and public clinics run by faith-based groups and non-governmental organizations will be in this category.

- **Secondary Satellites**, which will be staffed by nurses and nurse practitioners, medical technicians and counselors, who will perform tests to diagnose HIV and other infectious diseases. Patients with the disease will be referred to Primary Satellites or CMCs for evaluation and initiation of ARV treatment. However, routine evaluation and care, including filling prescriptions, will occur at the secondary sites through standard protocols and prepared medication packs.
- **Rural Satellites and Mobile Units**, which will be remote sites staffed by lay technicians, possibly rotating nurses, and local healers, who will be trained in standard clinical evaluations and distribution of medication pack refills.

The initial funding mechanisms focus on five areas: orphans and vulnerable children, abstinence and behavior change for youth, rapid expansion of ARVs, PMTCT, and blood safety and other medical precautions. The U.S. State Department website explains:

A variety of mechanisms are being used to address several critical activities as appropriate for different activities. USAID will manage new Annual Program Statements for **orphans and vulnerable children** and **behavior change through abstinence and being faithful [targeted to youth]**. The U.S. Department of Health and Human Services (HHS) will manage new Requests for Application for providing care and **antiretroviral therapy for HIV-infected persons** and **prevention activities through safe blood programs**. Funds for a Cooperative Agreement for the **establishment of a Twinning Center to support twinning and volunteer activities as part of the implementation of the President's International Mother and Child HIV Prevention Initiative** will be awarded jointly through HHS/Health Resources and Services Administration and USAID.

U.S. Ambassadors are currently being tasked with leading efforts to develop both a 12-month interagency coordination plan for each country and a 5-year strategic plan that outlines how each country program will work toward PEPFAR's objectives.



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## CHAPTER THREE

### RESEARCH METHODOLOGY

#### 3.1 Research Methods and Approaches:

This is a non-experimental study design adopting both quantitative and qualitative methods to compare the leadership orientation of health care workers in public and private health care institutions and quality of care as perceived from a patient satisfaction survey. The methodology employed in this study was the use of multiple perspective analysis to enable an in-depth inquiry into HIV/AIDS program with a view to examining the quality of care vis-à-vis the leadership skill and orientation of the programme officers charged with the responsibility of actualizing the objectives of the program. Data for this study was obtained through primary and secondary sources. The primary data were derived through the use of opinion survey involving the use of both interview and questionnaire. An in-depth interview was undertaken of two key private sector and two public sector program managers in the FCT, structured questionnaire consisting of three sections was administered to program officers at the FCT health care institutions. Section A of the questionnaire sought to obtain information about their health care institutions and the bio data of respondents, while section B inquired about leadership style preferences. In section C respondents answered questions relating to leadership within their organizations while section D focused on quality of care issues. It must be noted that all program officers were required to respond to all sections of the questionnaire while the patients addressed questions on section D of the instrument. Two Focus Group Discussions (FGDs) were held, one among people living with HIV/AIDS and the second for service providers. The main variables upon which data collection was based are:

- i. Communication: these are addresses by questions 1-8.



- ii. Teambuilding and Facilitation was determined using variables in Q 9-19
- iii. Win-Win Negotiation: Q 20 – 22
- iv. Flexibility and Innovation: Q 23-24
- v. Risk taking: Q 25- 27
- vi. Seeing the Big Picture: Q 28-30

Data was also collected on some key quality of care indicators which include, interpersonal relationship, availability of services, waiting times, availability of relevant information, involvement of consumers in decision making, stigma and discrimination as well as technical competence of service providers.

All healthcare institutions providing HIV/AIDS services in the Federal Capital Territory (FCT) participated. Simple random sampling was employed to give every member of the population equal chance of being chosen as a respondent. However, to qualify to participate in the study, you must be directly involved in HIV/AIDS service delivery either as a health worker, program manger or as a patient.

### **3.2 Justification for Methodology:**

From analysis of several studies carried out to assess health care outcomes, a cross sectional non experimental study design with a combination of qualitative and quantitative approaches to data collection has often proven very effective in generating rich and valuable data. Notable examples are the USAID ART Assessment Study, the World Health Organization's Situation analysis of HIV/AIDS services in Nigeria and UK DFID HIV and Gender Studies (Alma 2002). While the Likert-type structured questionnaire used allowed the researcher to obtain specific quantitative data which could permit easy comparison across the board, the focus group and in-depth interview guides enable us to gather rich qualitative data that allowed an in-depth understanding of all the issues.

### **3.3 Instruments/Tools Used and Reliability Assessment:**

The draft questionnaire was pre-tested in a pilot survey of fifty respondents in five healthcare institutions other than the ones included in the field. The field workers were required to report on their experiences with administering the questionnaire and necessary adjustments were made on the instrument to provide a valid and reliable measurement.

Most importantly, the supervisors recruited were those that were familiar with this type of study having conducted similar fieldwork during the national reproductive health survey. Further training was provided to equip them for the task ahead and to ensure that the fieldwork was successful. The field enumerators were equally trained in a methodology workshop to adequately prepare them for the field.

Data collection instruments were circulated to some of the program officers in institutions not participating in the study for their comments and input. All the comments received were utilized to fine tune the final questionnaires. After the incorporation of all observations and inputs from all stakeholders, the final instrument was mass produced and hand- carried by data collectors to institution participating in the study. Writing materials and other essential stationeries were provided to the various locations so as to facilitate prompt commencement of the survey as stipulated in the work plan. As the principal investigator, I coordinated the fieldwork and also prepared dummy tables for input of data from the field and prepared for data treatment that would make it amenable to the computer package to be used for analysis.

### **3.4 Research Population, Sample Size and Sampling Procedures:**

The population of the study consists of all nurses, doctors, pharmacists, social workers, national program managers and people living with HIV/AIDS in the ART,

PMTCT and VCT centers in the Federal Capital Territory Abuja. There were a total of 133 staff involved in provision of HIV / AIDS services. The facilities where the HIV services were located included: National Hospital Abuja, Garki District Hospital Abuja, Asokoro General Hospital, State House Clinic, General Hospital, Nyanya, Garki Hospital, Gwagwalada Specialist Hospital, Gwagwalada Township Clinic, SSS Clinic, Kwali General Hospital . Private HIV service providers include Central Bank Clinic, NNPC Clinic, Abuja Hospital, Zankli Hospital, Ferroprod Hospital, St. Mary's Hospital, Gede Foundation

### **Sample size Determination**

Sample sizes are determined for study for various reasons among which are the non feasibility of involvement of all possible participants, cost of the conduct of the study which becomes exorbitant when all participants are involved, reasons of practicality and scientific accuracy. All the factors enumerated above were taken into account in determining the sample size.

Two sample sizes needed to be determined in the conduct of this study. These were the sample size for the health care providers and the sample size for the clients. The sample size for the health care providers was easily determined given the practicality of involvement of all possible health care providers in the study locations. However for the clients it is not practicable to involve all of those who could possibly use the facilities since these are not known until the visit the centers, neither is it scientifically accurate. Therefore a scientifically determined sample size is calculated.

**Sample size for the health care providers:** All the 133 health care providers were involved in the study as mentioned earlier.

### **Sample size for the clients**

The Leslie-Kish formula for determination of sample size was used. This is given below.

$$N = \frac{z^2 pq}{d^2}$$

Where Z= 1.96 (a constant at 95%)

P = 97% = proportion of clients satisfied with HIV/AIDS services in previous study (Roach , Kilaru, Hunte, Sippy , Adomakoh , Adomakoh, 2004)

This brings the total number of respondents to 200.

$$P = 1-p$$

$$d = 0.05$$

Substituting the values above,

$$N = \frac{1.96^2 \times 0.97 \times (1-0.97)}{0.05}$$

This gives a value of N= 37.44, which approximately is 38.

Thus a minimum of thirty eight patients were required to determine client satisfaction in each group. An attrition of ten percent is expected. Thus a total of 42 patients are required for each group in the study.

### **Sampling Procedure:**

All patients attending the facilities for retroviral therapy were included in the study as they make the figure required. From this number attending the facilities, patients were recruited into the study until the sample size of 42 was obtained. Additionally to increase the power of the study, more patients in each facility group were recruited.

### **1.13 Statement of the Hypothesis**

Three hypotheses were tested each at 0.05 level of significance. The hypotheses were as follows:

## **HYPOTHESIS 1:**

**The Null Hypothesis (H<sub>0</sub>):** Program sites managed by program managers whose management style aligns with transformational leadership orientation will not provide services of better quality than centres managed by those leaders with traditional management orientation.

**Alternate Hypothesis (H<sub>a</sub>):** Program sites managed by program managers with transformational leadership orientation will provide services of better quality than those managed by program managers with traditional orientation.

## **HYPOTHESIS 2:**

**The Null Hypothesis (H<sub>0</sub>):** Consumers of HIV/AIDS services in public and private sector health program sites will not consider leadership style as a serious impediment to program performance.

**Alternate Hypothesis (H<sub>a</sub>):** Consumers of HIV/AIDS services in the public and private sites will consider leadership style as a serious impediment to program performance.

## **HYPOTHESIS 3:**

**The Null Hypothesis (H<sub>0</sub>):** Private sector HIV/AIDS program managers will not align more to transformational leadership model than HIV/AIDS program managers in the public sector treatment sites

**Alternate Hypothesis (H<sub>a</sub>):** Private sector HIV/AIDS Program managers will align more to transformational leadership than their counterparts in the public sector sites.

### 3.2 Statistical Techniques for Data Analysis

The instrument used in data analysis was the SPSS computer package data, frequencies were obtained, chi-square test was used to compare data across groups according to scale of measurement.

The independent variables in the tests of the hypothesis were the leadership orientation and the type of facility in which the program officers works. Of particular importance in this study were the following variables which were key indicators used to determine leadership orientation:

- Sensitivity to others
- Teamwork
- Adoption of participatory leadership

**Sensitivity:** a leader was regarded as sensitive if he answered agree or strongly agree to question 16. Other responses (disagree, strongly disagree and undecided) indicated that the leader is not sensitive.

**Teamwork:** a leader was regarded as practicing teamwork if he answered agree or strongly agree to question 20. Other responses (disagree, strongly disagree and undecided) indicates that the leader was not a team person.

**Participatory approach:** This was determined by responses to question 25. Those who responded strongly agree and agree were categorized as adopting participatory while other responses (strongly disagree, disagree and undecided) indicates that the leaders did not adopt participatory approach.

The dependent variables in this study were:

- Programme performance
- Quality of care.

Programme performance is determined using client reported quality of care as a proxy for its measurement. Quality of care on the other hand was determined by the clients reported satisfaction level or reported perception of technical competence of the staff.

**Client satisfaction:** A respondent was regarded as satisfied if he responded “good or fair to Question 68. Other responses (Bad or None) indicate that he was not satisfied.

**Technical competence:** This is based on the response to Question 69. Responses such as excellent, very good and just fair indicates that the respondent assesses the staff as competent while responses such as poor and no response indicates that the assessment is incompetent.

### **3. 4. Data Processing**

Prior to the administration of the questionnaire, a data processing plan was developed. This involved three main steps: allocating codes to the answers to each question (or variable, allocating computer columns to each question, producing a code book and checking codes. The essence of coding is to give distinctive number to each question. Each answer to question was given a distinctive code. This code is fed into a computer and the number thereafter represents a particular response to a given question. In order to ensure that a valid analysis, consideration was given to the following:

1. The need to ensure that the levels of measurement and type of variables were ascertained and delineated as nominal, ordinal or interval.
2. The need to ascertain the format in which the data will be entered into the SPSS software to be used for the analysis
3. The need to ensure that to check data entry and other errors including missing data.

To enter codes on to the computer, the codes were put on a record. The codes for respondents were put on a number of records. The records for each respondent were then put together so that the first set of records represent the first respondent, the next record the next respondent in that order. In other words, this put together is called a data file so a data file was developed. Each record could only hold 80 characters i.e. 80 columns. When putting codes from each questionnaire on to the computer, care was taken to put the code which represents the response to a particular question in the same position on the data record for each case.

After taking the decision was taken on the codification method, a systematic record of all decision made was compiled (code book) and the following points were included:

1. All questions asked were listed
2. The name given to all variables were listed
3. The column in which each variable was located was specified
4. The valid code for each question was identified.
5. the codes for missing data were identified
6. Coding instructions were provided

Notwithstanding the fact that the SPSS used for data analysis is a sophisticated package that minimizes errors with data entry, some checks still had to be put in place to avoid data entry errors:

1. Valid range checks which ensured that only certain codes were legitimate. For example, where a question was denoted by a five-range code and six was made as an entry that wouldn't count. So a table of frequencies was developed before data analysis to address this.
2. Filter Checks. The questionnaire was set up such that some people should answer specific questions, for example, there were questions to be answered by program officers and some by their patients. If for example, it was indicated



at the introductory part that you were a program officer and you later answered questions meant for patients, this could be detected.

3. Logical Checks: I tried to proactively address illogical responses, for example where a respondent had earlier on stated that he was a team player, a win-win and person and very sensitive to the feelings of his staff and turned to also have strong scores on attributes of autocratic leadership, it was also possible to pick this up and determine the validity of the response and whether the questionnaire was actually completed by the right person.

To ensure that the data processing was done in a manner devoid of errors, data entry operators engaged were highly experience people who have handled complicated data entry procedures in the past.

One other step taken at the data processing stage as the preparation of dummy tables that enabled data to be categorized and summarized prior to data analysis. These dummy tables form the basis for all the tables and charts in the next chapter.

For the qualitative data obtained from the focus group discussion and in-depth interview. The data was manually processed. Themes upon which the responses will be processed was pre-selected to include: understanding of leadership, leadership style preferences, organizational leadership preference, leadership issues and challenges in the national response, leadership and its impacts on quality of care and suggestions for improving HIV/AIDS leadership and management. The responses from the focus group discussions were transcribed and threads of opinion and information collected were then arranged under the themes. The most commonly occurring responses were also grouped together and so also were the most commonly occurring themes. The qualitative data collected was now used to validate and corroborate findings from the quantitative analysis.

## References

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- Roach, Kilaru, Hunte, Sippy, Adomakoh, Adomakoh, (2004) Sampling Methods in Health Services Research. *Health Care Research* 3, pgs 12-13
- Vaus D. A, (1994). *Surveys in Social Research* 3<sup>rd</sup> Edn. London: UCL Press Ltd, University College, London, pg 36

## CHAPTER FOUR

### DATA PRESENTATION AND ANALYSIS

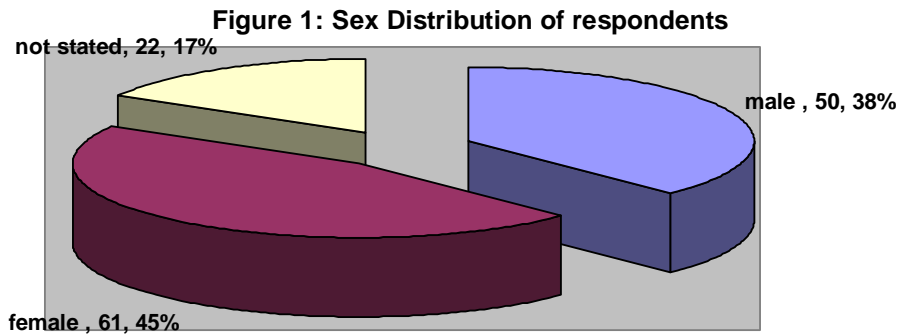
This chapter dwells on the presentation and analysis of data from the fieldwork. For ease of interpretation, data from the field was summarized by cross tabulation between variables. It is important to stress here that, of the 151 questionnaires administered to both public and private sector health institutions in the Federal Capital Territory (Abuja) Nigeria, 133 questionnaires were duly filled and returned. **This gives a response rate of 88.1%.** The analysis of data will therefore be based on the 133 retrieved questionnaires.

#### 4.1 Characteristics of Respondents

Table 4.1 Age Distribution of Respondents

Age	Frequency	Percent
<b>20-29</b>	34	26,3
<b>30-39</b>	65	48,9
<b>40-49</b>	28	21,1
<b>50 &amp; above</b>	1	0,8
<b>Not stated</b>	4	3,0
<b>Total</b>	133	100,0

Table 4.1 above showed the age distribution of the respondents. Majority of the respondents fall within 30-39 years of age (48.9%) This is followed by respondents within 20-29 years (26.3%) and then 40-49 years age group (21.1%). Only one respondent was in the 50 **years** and above age category (8%).



As can be seen from Figure 1 above, the study sample consisted of a fair representation of men (38%) and women (45%). Surprisingly, as many as 22 (17%) respondents did not indicate their sexes. This distribution is typical of what obtains in the public health arena in Nigeria with more women than men dominating the health care system. As would be seen subsequently, majority of the subjects were nurses (see figure 2) who are predominantly women.

**Figure 2: Designation of Respondents**

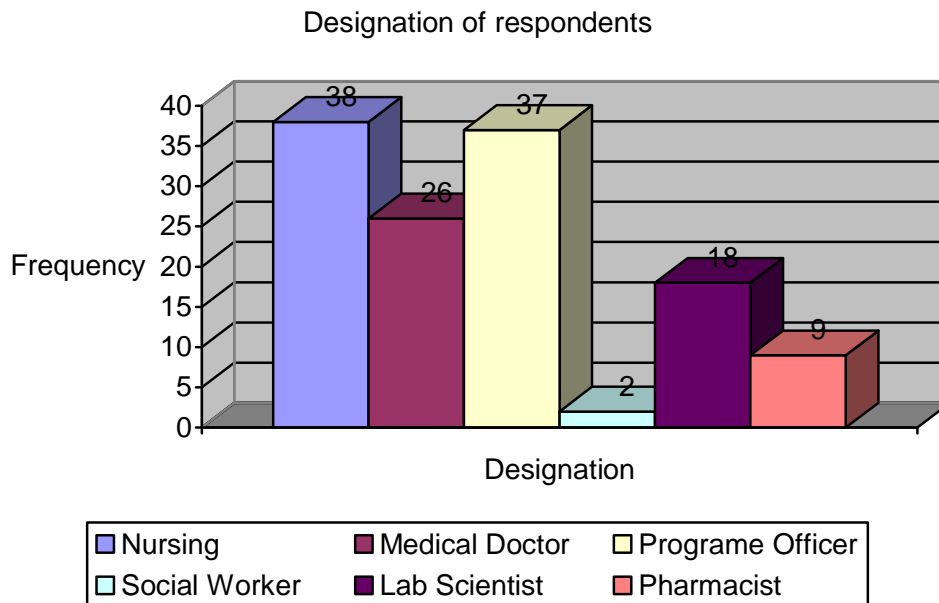


Figure 2 above indicated that Nursing officers formed the highest number of respondents with 28.6 percent, this is followed by program officers amounting of 27.8 percent, medical doctors 19.5 percent then followed by laboratory scientists standing at 13.5 percent. Pharmacists had 6.8 percent and the lowest number of respondents being the social workers standing at merely 1.5 percent.

**Table 4.2: Experience in Management Position**

<i>Years of Experience</i>	<b>Frequency</b>	<b>Percent</b>
<b>Not-stated</b>	7	5,3
<b>None</b>	9	6,8
<b>1-2 years</b>	37	27,8
<b>3-5 years</b>	61	45,9
<b>6-10 years</b>	18	13,5
<b>10 years &amp; above</b>	1	0,8
<b>Total</b>	133	100,0

Table 4.4 above showed the level of experience of respondents in management position. Forty-five percent of the respondents had 3-5 years of experience in a management position while respondents with 1-2 years of experience in a management position constituted 27.8 percent of the sample. This is then followed by respondents with 6-10 years of experience (18.5 percent). Those without any experience in management position were 9 in number (6.8 percent). No experience here means not having any management training and not really working as a substantive program manger for up to a year.

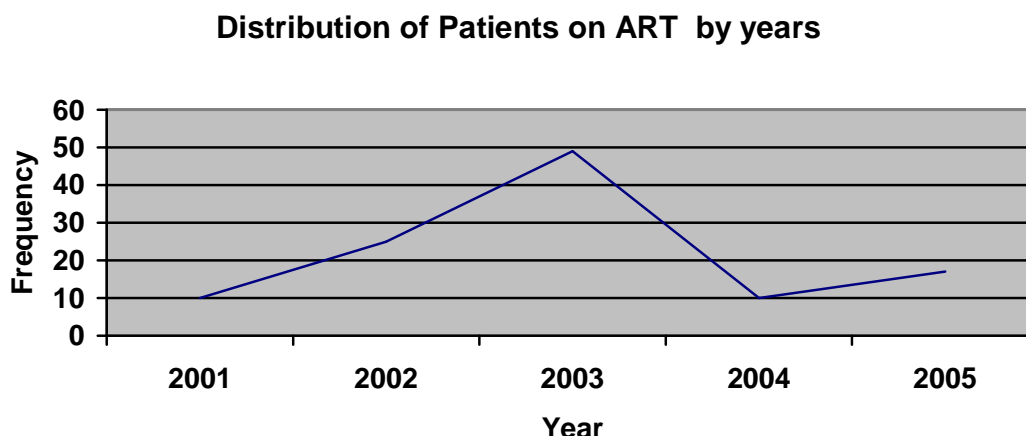
**Table 4.3: Working experience of respondents**

<i>Years of experience</i>	<b>Frequency</b>	<b>Percent</b>
<b>Not-stated</b>	7	5,3
<b>Less than 1 year</b>	23	17,3
<b>2-4 year</b>	81	60,9
<b>5 years &amp; above</b>	22	16,5
<b>Total</b>	133	100,0

Based on the table 4.5 above, majority of the respondent had working experience of between 2-4 years (60.2 percent). Following them in working experience were respondents with less than a year's working experience (17.3 percent). Respondents with 5 years and above working experience had 16.5 percent. This showed that by virtue of the respondents working experiences, some level of efficiency and effectiveness in providing quality services should be expected from them.

**Table 4.4: Date of commencement of HIV/AIDS services in the facility**

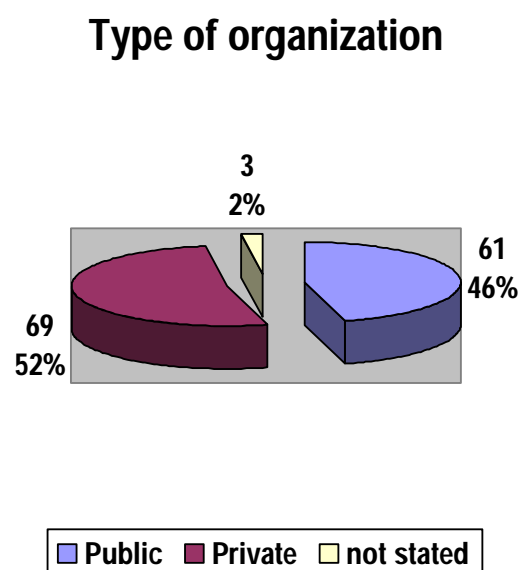
<i>Date of commencement of HIV/AIDS Services</i>	<b>Frequency</b>	<b>Percent</b>
<b>2001</b>	10	7,5
<b>2002</b>	25	18,8
<b>2003</b>	49	36,8
<b>2004</b>	10	7,5
<b>2005</b>	17	12,8
<b>Not-stated</b>	22	16,5
<b>Total</b>	133	100,0



**Figure 4.3 Distribution of patients on ART by years**

The above table and graph clearly indicated the date of commencement HIV/AIDS services and the distribution of patients in the various health centers of both the public and private sector facilities. Collecting this information provides an understanding of HIV/AIDS- related management experience and how this experience shapes the provision of quality services at the different centre. Majority of the respondents (36.8%) indicate that HIV/AIDS services commenced in their centres in 2003. About 18.8% started services in 2005, 7.5% in 2001 and 2004 respectively. About 22 respondent (16.5 percent) however failed to indicate the date of commencement of HIV/AIDS in their facility. From the foregoing, it is observed that most health facilities in the FCT commenced HIV/ AIDS services in 2003. The fact that so many centres have already started implementation of services is a plus considering that the national policy on HIV/AIDS was formulated only in 2001 and with the usual bureaucratic bottlenecks and inadequate linkages between the public and private sectors, its implementation has been on a slow pace.

**Figure 4.4 Type of organization**



The private sector provides about 60 % of health services in Nigeria but inadequate coordination, collaboration and linkages among private and public facilities have continued to be the bane of the health sector. Table 4.7 above showed that, majority of the respondent belong to the private sector health facilities which amount to 51.9 percent, while public sector institutions had 45.9 percent. Three respondents standing at 2.3 percent did not indicate the type of their facility.

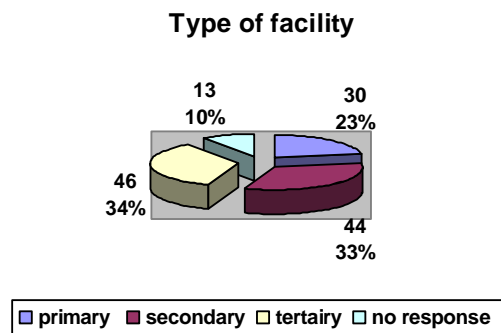
**Table 4.5: Type of private sector facilities**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>NGO</b>	15	11,3
<b>CSO</b>	15	11,3
<b>CORPORATE</b>	24	18,0
<b>FAITH- BASED</b>	18	13,5
<b>Not stated</b>	61	45,9
<b>TOTAL</b>	133	100,0



Table 4.8 dealt only with private sector institutions majority of whom were corporate organizations standing at 18 percent, followed by faith – based organizations which had 18 respondents standing at 11.3 percent. In Nigeria, it is generally agreed that while, non-governmental organizations, especially faith-based organizations are less profit inclined, corporate organization place profit motive above quality concerns and considerations. Collecting data on type of private facility provides an understanding of facility type and quality of care.

**Figure 5: Type of Facility (levels of care)**



Nigeria's operates a three-tier health care system from primary which is a the lowest level consisting of health centres catering for basic health care to secondary level with general hospitals taking care of services that are too complex for the primary level to handle. Tertiary level provides more specialized care backed more sophisticated technology and personnel. To provide and understanding of what is going at all levels, sample included respondents from all levels. As shown on Table 4.9, majority of respondents were in tertiary facilities (34.6%). This is followed by secondary facility with 33.1 percent and primary facility; 22.5%. Thirteen respondents (7.9 %) did not respond to this item.

**Table 4.6: Location of the Facility**

<i>Location</i>	<b>Frequency</b>	<b>Percent</b>
<b>Municipal</b>	96	72,2
<b>Gwagwalada</b>	26	19,5
<b>Kwali</b>	8	6,0
<b>No response</b>	3	2,3
<b>TOTAL</b>	133	100,0

Location of facility whether urban or rural can affect the quality and quantum of services provided by health care institutions. Table 4.10 showed the location of the health facilities of respondents in the Federal Capital Territory. There are six area councils in the FCT but not all area councils provide HIV/AIDS Services. As a result, the table above only indicated the area councils providing HIV/AIDS Services where the various respondents belong. Based on the data in table 4.10, Abuja Municipal Area Council (AMAC) had the highest number of facilities providing HIV/AIDS Services with 72.2 percent. This may not be unconnected with the urban nature and business opportunities available in the area as compared to other area councils. Gwagwalada Area Council follows this with 19.5 percent and then Kwali Area Council having a mere 6.0 percent. This distribution is explained by the fact that generally in Nigeria there is an over concentration of health facilities more in the urban than rural areas. This also plays out with the distribution of HIV/AIDS services as can be seen in the above table where Abuja municipal has the largest share of facilities while the five semi-urban to rural area councils have a few centres.

**Table 4.7: HIV/AIDS Services Provided by Organization**

<i>Type of HIV/AIDS Services Provided</i>	<b>Frequency</b>	<b>Percent</b>
<b>PMTCT</b>	10	7,5
<b>ART</b>	14	10,5
<b>VCT</b>	16	12,0
<b>All of the Above</b>	90	67,7
<b>None of the above</b>	3	2,3
<b>TOTAL</b>	133	100,0

From Table 4.11 it is clearly shown that a large number of facilities provide services across all different categories of HIV/AIDS Services. The different services are Prevention of Mother to Child Transmission (PMTCT); Antiretroviral Therapy (ART); Voluntary Counseling and Testing (VCT). Ninety respondents indicated that their facility provides all the above-mentioned HIV/AIDS Services, which stand at 67.7 percent. Following this is VCT, which had 16 respondents amounting to 12.0 percent. ART had 10.5 percent and the lowest being PMTCT with 7.5 percent of respondents.

## **2. LEADERSHIP ORIENTATION**

### **Leadership Variables:**

In this section, analyses of all the leadership variables are presented. As would be seen in the next chapter the objective of this analysis is to segregate between leaders and organizations with transformational and traditional leadership qualities and in turn analyse and examine quality of care indicators for possible correlations with styles of leadership.

**Table 4.8: Accessibility of Respondents at work**

<i>Accessibility</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	9	6,8
<b>Disagreed</b>	6	4,5
<b>Undecided</b>	4	3,0
<b>Agreed</b>	75	56,4
<b>Strongly Agreed</b>	36	27,1
<b>No response</b>	3	2,3
<b>Total</b>	133	100,0

In table 4.12 Majority of respondents 56.4 percent agreed that they were accessible and available for communication. Following this are respondents who strongly agreed that they were accessible. Those who strongly disagreed of their accessibility amount to 6.8 percent of the respondents and those who simply disagreed stand at 4.5 percent. Based on the above table, it is inferred that officers providing HIV/AIDS Services in the FCT are generally accessible and available for communication. However, on a more careful appraisal, one might be tempted to link the high positive score on this variable to the direct nature of the question and the fact that a “NO” answer may be somewhat indicting. It is also important to note that being available and willing to communicate does not necessarily mean that the right type of communication is taking place and the best services are being provided.

**Table 4.9: Sensitivity to Patients and Audiences**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	4	3,0
<b>Disagreed</b>	10	7,5
<b>Undecided</b>	9	6,8
<b>Agreed</b>	90	67,7
<b>Strongly Agreed</b>	18	13,5
<b>Non</b>	2	1,5
<b>Total</b>	133	100,0

Table 4.13 above indicated that a greater percentage of respondent amounting to 67.7 percent agreed that they show sensitivity to patients/audience in need of HIV/AIDS Services. This is followed by those who strongly agreed standing at 13.5 percent. Those who disagreed on whether or not they show sensitivity to their patients /audience stand at a mere 7.5 percent. Nine respondents at 6.8 percent were undecided as far showing sensitivity to patients. From the foregoing analysis, one can safely say that program officers of HIV/AIDS in the Federal Capital Territory (FCT) are sensitive to their clients and larger audience.

**Table 4.10: Sharing of Information Timely and Concisely**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	10	7.5
<b>Disagreed</b>	20	15
<b>Undecided</b>	30	22.5
<b>Agreed</b>	48	36.09

<b>Strongly Agreed</b>	22	16.5
<b>No response</b>	3	2,3
<b>Total</b>	133	100,0

Information flow at all levels is an important pre-requisite for effective management functions. The researcher tried to find out the extent to which information was shared among health care personnel and with the patients. Table 4.14 above showed that there is some level of open and timely information sharing. Thirty six percent agreed that this was the case while 22 % disagreed and 7.5% of respondents strongly disagreed. Curiously though, 22% were undecided. This gives the impression that there might have been an attempt by some respondents to withhold information on this item. This is not surprising considering the fact that we are in a country where open and concise information sharing in public and private institutions is still a major issue even in the era of democracy. A number of studies have shown that information sharing in the management of HIV/AIDS has continued to be challenge and to some extent table 4.14 above speaks to this.

### **Effective Communication through Good Listening**

A major complaint of patients has been the inability of health care providers to listen in a therapeutic way. Therapeutic listening involves not only allowing enough time for patients to for the patient to verbalize about his illness, fears and concerns but to work the patient through his care regimen and possible options in an empathetic manner.

**Table 4.11**

<i>Effective Listening</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	12	9

<b>Disagreed</b>	30	22.5
<b>Undecided</b>	4	3,0
<b>Agreed</b>	61	45.86
<b>Strongly Agreed</b>	22	16.5
<b>No response</b>	4	3,0
<b>Total</b>	133	100,0

Table 4.15 above showed that majority of respondents indicated that they actively listen and ask questions open-mindedly. The number that agreed to this was put at 45.8%. Those who strongly agreed on this stood at 16.5 percent while 22.55% of the sample disagreed citing lack of time and work pressure as barriers to effective listening and 12% sample strongly disagreed. Good listening is one of the pre-requisites of effective communication. The person receiving information must understand the sender for him to decode the information and act in the desired direction. Based on the data above it is observed that notwithstanding that majority of respondents saw that effective listening was important and was being put into practice, the percentage that agreed to not having the time to listen effectively was put at about 30% (i.e. both agreed and strongly agreed). This is significant and reflective of the totality of the situation in the country's health care system where therapeutic listening is not possible owing to inadequate health personnel and large numbers of patients to be attended to on a daily basis.

### **Sensitivity towards others:**

Sensitivity towards the feeling of clients is an important consideration in the caring professions in particular and all professions in general. The researcher sought to know the extent to which health care providers were sensitive to feelings of clients while providing care.

**Table 4.12: Sensitivity towards others**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	1	0,8
<b>Disagreed</b>	7	5,3
<b>Undecided</b>	7	5,3
<b>Agreed</b>	95	71,4
<b>Strongly Agreed</b>	22	16,5
<b>No response</b>	1	0,8
<b>Total</b>	133	100,0

Table 4.16 above showed that respondents exhibit high sense of belonging by showing sensitivity towards others by seeking to understand them. In this regard, 71.4 percent of the respondents agreed and 16.5 percent strongly agreed. The number of respondents that disagreed is at 5.3 percent and strongly disagreed stand at 0.8 percent. Undecided respondents constituted 5.3 percent.

Effective communication in implementing HIV/AIDS Services in Nigeria is facilitated through showing sensitivity towards others by seeking to understand them in order to make oneself being understood by others. It is interesting to note that findings from the patient satisfaction survey also undertaken as part of this study did not seem to corroborate the fact that health workers were sensitive to clients' situation. Majority of the patients felt the opposite instead that health workers were not very sensitive to their plight.



**Table 4.13: Checking assumptions before taking action**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	4	3,0
<b>Disagreed</b>	6	4,5
<b>Undecided</b>	11	8,3
<b>Agreed</b>	82	61,7
<b>Strongly Agreed</b>	29	2,18
<b>No response</b>	1	0,8
<b>Total</b>	133	100,0

In table 4.13 above, majority of the respondents, about 61.7 percent agreed that they check assumptions before taking any action and 21.1 percent even strongly agreed to this criterion. This of course is one of the requirements for transformational leadership which is necessary in achieving quality care in the national HIV/AIDS Program in Nigeria. A leader must take action after having clarified values and the situation lest he takes an action that will be detrimental to the success of his organization. Only a negligible percentage disagreed on whether or not they check assumption before taking action, a mere 4.5 percent and strongly disagreed stands at 3.0 percent while 8.3 percent indicated undecided.

### **Feed back and Criticisms**

Transformational leaders base policy and decision making on adequate and appropriate feedback and criticisms received from within the organization and without. Successful organizations encourage this and put place systems and structures which support and operationalize this assertion. One of the questionnaire items sought to know the extent to which this was acknowledged and put into practice.

**Table 4.14: Offering and Receiving Feedback and Criticisms in the interest of the organization**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	15	11.27
<b>Disagreed</b>	30	22.5
<b>Undecided</b>	11	8.3
<b>Agreed</b>	54	40.6
<b>Strongly Agreed</b>	20	15
<b>No response</b>	3	2.3
<b>Total</b>	133	100,0

In table 4.14 above, greater percentage of the respondents(40.6%) showed that they offered and received feedback, constructive criticism that help them accomplish organizational objectives and individual effectiveness while 15% of the respondents strongly. About eleven percent strongly disagreed and while 22.5% disagreed that this fundamental principle of efficient and effective communication and management was practiced in their organization. The total number of respondents in the strongly disagree/agree category put at 37.5% was quite high and speaks volumes about our health care system where adequate provision is not made for feedback and constructive criticisms. In most cases, especially among government institutions constructive criticisms and feedbacks from staff are often misconstrued as acts of disloyalty and insubordination which do not go unpunished.

### **Fun at Work**

Modern business environment are set up to provide an organization atmosphere where work and fun go together to facilitate “teaming,” collegiality and relief of stress. When asked whether program managers provided the opportunity for fun and other

recreational activities, 30.7% felt that wasn't the case while 16% felt that it wasn't happening at all. About 32% of the respondents agreed to having some forms of recreational activities in place in their organizations with 9.7% being in strong agreement (see table 4.19 below). It could be inferred from the statistics above that not enough attention was being given to having fun at work. This is typical of most work settings in Nigeria where no opportunities exist at the office for unwinding, refreshments and fun.

**Table 4.15 Relieving Stress by Having Fun at work**

<i>Fun at Work</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	22	16.5
<b>Disagreed</b>	40	30.7
<b>Undecided</b>	13	9.8
<b>Agreed</b>	43	32.3
<b>Strongly Agreed</b>	13	9.7
<b>No response</b>	2	1,5
<b>Total</b>	133	100,0

Stress management is one of the requirements of good leadership orientation in all organization including health institutions and individual managers must device ways of managing stress in their work place through appropriate recreational activities and working in an atmosphere where jokes, laughs and funs among staff are allowable to the extent that the work is not jeopardized.

**Table 4.16 Team work to strengthen internal and external networks**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	4	3,0
<b>Disagreed</b>	3	2,3
<b>Undecided</b>	6	4,5
<b>Agreed</b>	81	60,9
<b>Strongly Agreed</b>	35	26,3
<b>No response</b>	4	3,0
<b>Total</b>	133	100,0

Table 4.20 above showed that 60.9 percent of the respondents agreed that they encourage teamwork in order to strengthen internal organizational dynamics, units and sections as well as external networks of customers and clients. This point cut across individual leadership requirement but organizational nature, individual leadership orientation however influences organizational leadership. Comments on the questionnaire point to the fact that though managers generally area aware of the need for team work, administrative work, administrative structures on ground and current work culture are not overly supportive of team approach. ‘Silo” managers have continued to be the bane of the national HIV/AIDS program where managers hold tenaciously to their job pot-folios and not allowing adequate information flow and collaboration for fear of losing their territories.

**Table 4.17: Putting team Goal first over the Individual Goal**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Disagreed</b>	4	3,0
<b>Undecided</b>	12	9,0

<b>Agreed</b>	84	63,2
<b>Strongly Agreed</b>	32	24,1
<b>No response</b>	1	0,8
<b>Total</b>	133	100,0

Table 4.21 above showed that majority of respondents (60.9%) agreed and 26.3% strongly agreed to putting team goal first over their personal goals. The number that disagreed on this is only 3.0 percent of the total respondent and 9.0 percent indicated undecided. If this is anything to go by then it could be said that at least for the FCT, HIV/AIDS Program managers are self-less and committed people working to achieve the goals of the program for Nigeria. However when some of them were probed further they alluded to the fact that putting organizational goals first was important but in practice, this does not entirely hold true and people are reluctant to say the truth on such subjects. Many program managers have deposed that internal and external pressures and the personal goals of others have often led to a compromise of positions and the beclouding of objectives and focus.

**Table 4.18: Managing strain relationships among workers through persuasion**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	1	0,8
<b>Disagreed</b>	4	3,0
<b>Undecided</b>	16	12,0
<b>Agreed</b>	82	61,7
<b>Strongly Agreed</b>	29	21,8
<b>No response</b>	1	0,8
<b>Total</b>	133	100,0

In the above table the highest number of respondents standing at 61.7 percent agreed and 21.8 percent strongly agreed that they recognize and manage difficult relationships by encouraging people to value others' viewpoints and focus on issues rather than persons. This being the case, HIV/AIDS Service providers in Nigeria as a whole and FCT in particular promote teamwork and cooperation, which is an essential ingredient for achieving organizational goals. 3.0 percent of the respondents however disagreed and 0.8 percent strongly disagreed to that assertion.

**Table 4.19: Welcoming Ideas and Skills**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Disagreed</b>	2	1,5
<b>Undecided</b>	15	11,3
<b>Agreed</b>	71	53,4
<b>Strongly Agreed</b>	44	33,1
<b>No response</b>	1	,8
<b>Total</b>	133	100,0

Table 4.19 above showed that 53.4 percent of the respondents agreed that they welcome ideas and skills as leaders and use it to facilitate organizational goals and 33.1 percent even strongly agreed to that fact. The number that disagreed on this stand at merely 1.5 percent, and 11.3 percent were undecided in terms of welcoming ideas and skills.

**Table 4.20: Treating all Team Members with Equity and Fairness**

<i>Equity</i>	<i>Frequency</i>	<b>Percent</b>
<b>Strongly Disagree</b>	18	13.5
<b>Disagreed</b>	32	24
<b>Undecided</b>	11	8,3
<b>Agreed</b>	49	36.8
<b>Strongly Agreed</b>	22	16.5
<b>No response</b>	1	0,8
<b>Total</b>	133	100,0

Equity and justice are essential ingredients of good leadership. Table 4.20 indicated that 36.8 percent of the respondents agreed and 16.5 percent strongly agreed on treating people with justice and equity by creating a nurturing climate through valuing all team members and supporting their development equitably. Twenty four percent felt that though they understood the need for equality, fairness and social justice, the system made it difficult for this to be realizable. Eighteen percent of the respondents felt very strongly that they were unable to treat everyone fairly and equitably as the system made it difficult for this to happen.

### **Participatory approach**

Participatory approach is sine qua non to effective program management. Hence many successful businesses boosted of the participatory nature of their work force. On this questionnaire item, respondents bared their minds on the degree to which they encouraged participatory leadership. Forty two percent agreed and 13.5% strongly that they used participatory approach in management. Of the 21% percent who accepted that their approach was not wholly participatory, most of them cited

administrative and other systemic issues as being responsible for their inability to adopt participatory approach.

**Table 4.21: Sharing of Leadership by Facilitating Participation and Group interaction**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	10	7.5
<b>Disagreed</b>	28	21
<b>Undecided</b>	19	14.3
<b>Agreed</b>	56	42
<b>Strongly Agreed</b>	18	13.5
<b>Non</b>	2	1.5
<b>Total</b>	133	100.0

As much as 14.3 percent however were undecided. Based on the above, it is inferred that HIV/AIDS Service centers in the FCT encourage some level participatory leadership where each member of a group is important and can contribute towards achieving organizational objectives. However given the high percentage of those who felt participatory leadership was not being practiced, there would be need for improvement in this area.

**Table 4.22: Demonstrating Enthusiasm for people and projects by sharing accountability**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	2	1.5
<b>Disagreed</b>	6	4.5



<b>Undecided</b>	14	10.6
<b>Agreed</b>	81	60.9
<b>Strongly Agreed</b>	26	19.5
<b>No Response</b>	4	3.0
<b>Total</b>	133	100.0

Table 4.22 above showed that 60.9 percent of the respondents agreed and 18.8 percent strongly agreed that they show enthusiasm and recognition towards people and projects by sharing accountability. 4.5 percent disagreed and 1.5 percent strongly disagreed on sharing accountability. 10.6 percent however indicated undecided. By this statistics the greater number of respondents opined that they agreed on showing enthusiasm and sharing accountability in such a way that every member will be rewarded for success and accomplishment and hold responsible for failure to meet up with the expectation. This therefore means that all members of the team will commit themselves towards the success of HIV/AIDS Services in their facility.

**Table 4.23 Empowering the Team to deal with Real Problems**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	1	0.8
<b>Disagreed</b>	4	3.0
<b>Undecided</b>	17	12.8
<b>Agreed</b>	80	60.2
<b>Strongly Agreed</b>	30	22.6
<b>No response</b>	1	0.8
<b>Total</b>	133	100.0

Table 4.23 showed that 60.2 percent of the respondents agreed and 22.6 percent strongly agreed that they as leaders empower the team and trust them to deal with real problems of finding solutions to HIV/AIDS pandemic in Nigeria. This is done by allowing time for consensus to develop. A mere 3.0 percent disagreed and 0.8 percent strongly disagreed on that. While 12.8 percent indicated undecided.

**Table 4.24: Demonstrating Win-Win Philosophy**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	4	3.0
<b>Disagreed</b>	6	4.5
<b>Undecided</b>	16	12.0
<b>Agreed</b>	81	60.9
<b>Strongly Agreed</b>	24	18.0
<b>No response</b>	2	1.5
<b>Total</b>	133	100.0

Win-win Philosophy and negotiation should be the watchword of every manager and organizational leader if organizational goals and objectives have to be accomplished. Table 4.28 above showed that the largest number of respondents, 60.9 percent and 18.0 percent agreed and strongly agreed on facilitating win-win philosophy in and out of the organization. This will in turn make all workers and clients know that success will be achieved in the cause of implementing HIV/AIDS Programs in the country as a whole. However only 4.5 percent and 3.0 percent disagreed and strongly disagreed to that fact, 12.0 percent indicated undecided.

**Table 4.25: Setting aside personal agenda to achieve results that are acceptable to all**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Disagreed</b>	5	3,8
<b>Undecided</b>	23	17,3
<b>Agreed</b>	77	57,9
<b>Strongly Agreed</b>	27	20,3

<b>Non</b>	1	0,8
<b>Total</b>	133	100,0

Personal agenda of most of the Nigerian leaders is one of the impediments to achieving organizational success. If leaders in both the public and the private sector institutions in different walks of life will do away with their personal agenda for overall organizational results a lot of success will be achieved, particularly in HIV/AIDS Program which is of course one of the most pressing endemic in Nigeria that is taking away the children and youth as well as the working population.

Table 4.25 above showed that the highest number of respondents, 57.9 percent and 20.3 percent agreed and strongly agreed that they set aside personal agenda for results that will be acceptable to all members of the organization. Only a mere 3.8 percent disagreed and 17.3 indicated undecided.

**Table 4.26 Recognizing the Importance and Dignity of people in Negotiation**

<i>Variables</i>	<i>Frequency</i>	<b>Percent</b>
<b>Strongly Disagree</b>	4	3,0
<b>Disagreed</b>	3	2,3
<b>Undecided</b>	15	11,3
<b>Agreed</b>	80	60,2
<b>Strongly Agreed</b>	30	22,6
<b>Non</b>	1	0,8
<b>Total</b>	133	100,0

Many people particularly those at the echelon of authority in Nigeria do show authoritative power and do not take others as important and do not treat them with dignity. This is a great obstacle to achieving organizational objectives by workers it

will lead to apprehension by workers and lack of respect for leaders and of course organizational goals. Majority of the respondents in table 4.30 amounting to 60.2 percent and 22.6 percent agreed and strongly agreed respectively that they regard others as important as they are and that they treat them with fairness and dignity. This leadership quality is quite central to effective implementation of HIV/AIDS Program in Nigeria. How many leaders and program managers is it that show stigma to HIV/AIDS patients and do not treat them with dignity? Only about 2.3 and 3.0 disagreed and strongly disagreed respectively on taking others as important. 11.3 percent were undecided on that.

**Table 4.27: Keeping to promises and fulfilling commitments**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	3	2,3
<b>Disagreed</b>	2	1,5
<b>Undecided</b>	10	7,5
<b>Agreed</b>	80	60,2
<b>Strongly Agreed</b>	37	27,8
<b>No Response</b>	1	0,8
<b>Total</b>	133	100,0

Table 4.27 indicated that majority of the respondents keep to their promises and fulfill their commitments. The highest number of 60.2 percent and 27.8 percent agrees and strongly agreed respectively to that fact. However, only a negligible number of 1.5 percent and 2.3 percent disagreed and strongly disagreed to that assertion. 7.5 percent indicated undecided. HIV/AIDS Program officers and specialists will achieve a great success if they keep to their promises and fulfill their commitments. Based on the above statistics in table 4.31, health care centers will achieve a lot in combating HIV/AIDS endemic in the country.

**Table 4.28: Challenging the Status Quo by Facilitating Change**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	2	1.6
<b>Disagreed</b>	9	6,8
<b>Undecided</b>	13	9,8
<b>Agreed</b>	89	67,4
<b>Strongly Agreed</b>	19	14,4
<b>Non</b>	1	0,8
<b>Total</b>	133	100,0

Change is an inevitable phenomenon in any organizational dynamics. Organizations devoid of change are indeed static and apathetic and cannot response to new situations. Leaders and Managers have to challenge the old-age traditional management of adhering to rules and regulation and insist on change that will foster the development of all members of the organization.

Table 4.28 showed that 66.9 percent and 14.3 strongly agreed respectively that they would challenge the status quo by exploring new ideas and encourage others to do the same. HIV/AIDS Service providers must device ways on how they will introduce new ways of dealing with HIV/AIDS pandemic if they had to combat the disease. 6.8 percent and 0.8 percent disagreed and strongly disagreed on facilitating change, 9.8 percent indicated undecided.

**Table 4.29 Continuous Improvement by acknowledging Mistakes and Learning from them**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Disagreed</b>	2	1,5
<b>Undecided</b>	13	9,8
<b>Agreed</b>	80	6,2
<b>Strongly Agreed</b>	37	27,8
<b>Non</b>	1	0,8
<b>Total</b>	133	100,0

Managers and leaders in organizations particularly HIV/AIDS centers must not be too arrogant as to know everything. Even as a leader, one must commit himself to continuous improvement by questioning himself and others and by acknowledging his mistakes and learning from them. Majority of respondents in table 4.33 opined this. 60.2 percent and 27.8 percent agreed and strongly agreed respectively to the above assertion. Only a mere 1.5 percent disagreed and 9.8 percent indicated undecided.

**Table 4.30 Seeking Opportunities and Building Partnerships and Collaboration with other Organization**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	1	0,8
<b>Disagreed</b>	4	3,0
<b>Undecided</b>	18	13,5
<b>Agreed</b>	83	62,4
<b>Strongly Agreed</b>	26	19,5
<b>Non</b>	1	0,8
<b>Total</b>	133	100,0

Modern organizational trend shows that no organization can be in an island of itself. In other words, organizations cannot live in a vacuum; they must widen up their horizon to seek for opportunities, build partnerships and collaborate with other organizations in order to combat HIV/AIDS endemic globally. This is because HIV/AIDS is a global phenomenon and needs global approach if it has to be eliminated or minimized, for Nigeria to pursue its objectives of combating the disease it must adopt multi-sectoral approach. Health care institutions must therefore collaborate with others for them to achieve the success of the program. Table 4.34 indicated that 62.4 percent and 19.5 percent agreed and strongly agreed respectively on collaboration with other organizations. 3.0 percent and 0.8 percent however disagreed and strongly disagreed respectively on collaboration and partnership, while 13.5 percent stated undecided.

**Table 4.31: Taking Reasoned Risk to achieve Organizational Goals**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	12	9
<b>Disagreed</b>	36	27
<b>Undecided</b>	11	8,3
<b>Agreed</b>	52	39
<b>Strongly Agreed</b>	21	15
<b>No response</b>	1	0,8
<b>Total</b>	133	100,0

A manager must be a risk taker if he has to accomplish organizational goals. Table 4.35 above showed 39 percent and 15 percent of the respondent agreed and strongly agreed respectively that they as leaders and managers do take reasoned risks in order to accomplish organizational goals.



As much as 27 percent disagreed and 9 percent strongly disagreed that they would like to take risks given the Nigerian context where risking taking can be really costly. About 8.3 percent of the respondents were undecided probably willing to sit on the fence because this was a sensitive issue.

**Table 4.32: Streamlining Reporting Requirement and Eliminating “Red tapism”**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly disagree</b>	19	14.5
<b>Disagreed</b>	50	37.5
<b>Undecided</b>	0	0
<b>Agreed</b>	38	28.5
<b>Strongly Agreed</b>	20	15
<b>No response</b>	6	4.5
<b>Total</b>	133	100,0

A major challenge in the Nigerian health care system has been the lack of the mechanism for reporting progress, challenges and results. “Red-tapism” has impeded the timely execution of health care programs with attendant effects on patient care. It was therefore important to gauge the opinion of the respondents on this issue. As observed on the table below, collectively 52 % indicated that red tapism was an issue. Of the 28.5% who agreed that red-tapism was’nt a major issue, most of them deposed in their comments on the questionnaire that there were deliberate attempts at overcoming “red-tapism” in the past year. Reducing bureaucratic bottlenecks and putting in place mechanisms for timely reporting will facilitate the achievement of the goals of the program as decision making and policy formulation will be informed by relevant information and adequate data.

**Table 4.33: Empowering others to take Risks and encouraging them to learn from setbacks and failures**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	12	9
<b>Disagreed</b>	35	26
<b>Undecided</b>	15	11,3
<b>Agreed</b>	53	41.3
<b>Strongly Agreed</b>	13	9.7
<b>No response</b>	3	2,3
<b>Total</b>	133	100,0

A leader always leads by examples. After having learnt to take risks necessary for achieving organizational goals, a leader empowers others to take risks, support them when things go wrong and encourage them to learn from setbacks, mistakes and failures. Table 4.37 showed that 41.3 percent and 9.7 percent agreed and strongly agreed respectively that they empower others to take risks and help them in difficult situations. Effective leadership that empowers the subordinate for implementing HIV/AIDS Program is required if meaningful and positive development has to be achieved. Twenty six percent of the respondents disagreed and 9% strongly that it was worth the trouble empowering others to take risk. When some of them were probed further, they alluded their position to the peculiar situation in Nigeria where risk taking can be a passport to loss of job and at the extreme, loss of lives. One respondent posited that rather than encourage people to take risks, individuals should themselves decide when, where and whether it is feasible to take risks in the performance of their duties.

**Table 4.34 Understanding the Implications of Today's Work in Tomorrow's Context**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	1	0,8
<b>Disagreed</b>	5	3,8
<b>Undecided</b>	9	6,8
<b>Agreed</b>	76	57,1
<b>Strongly Agreed</b>	41	30,8
<b>No response</b>	1	0,8
<b>Total</b>	133	100,0

A leader is always conscious of today's work for the future challenge and prospects. Table 4.38 showed that majority of the respondents amounting to 57.1 percent and 30.8 percent agreed and strongly agreed that they as leaders they understand the implications of today's management which has direct impact of tomorrow challenge. From table 4.38 it is clear that only a mere 3.8 percent and 0.8 percent disagreed and strongly disagreed respectively on understanding the implications of today's work in tomorrow's context, while a mere 11.3 percent indicated undecided. It is important to stress here that HIV/AIDS Program in Nigeria needs to take into cognizance tomorrow's challenge and not only concerned with now and today.

**Table 4.35 Adapting to Peculiar Circumstances of Regions, People and Cultures**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	3	2,3
<b>Disagreed</b>	3	2,3
<b>Undecided</b>	17	12,8
<b>Agreed</b>	76	57,1

<b>Strongly Agreed</b>	33	24,8
<b>No response</b>	1	0,8
<b>Total</b>	133	100,0

One of the requirement of good leadership for implementing HIV/AIDS Programs is for leader to recognize and adapt to certain circumstances like regional, cultural and sectoral differences by putting specific priorities, initiatives, actions and decisions into a broader context. This will a long way foster achieving meaningful impact in combating HIV/AIDS in the FCT and Nigeria in general. Table 4.39 showed that 57.1 percent and 24.8 percent agreed and strongly agreed respectively that they adapt to peculiar circumstances while implementing HIV/AIDS Programs. However only 2.3 percent disagreed and strongly disagreed to that fact. 12.8 percent indicated undecided.

**Table 4.36 Avoiding duplication of work by encouraging others to share resources**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	1	0,8
<b>Disagreed</b>	3	2,3
<b>Undecided</b>	12	9,0
<b>Agreed</b>	74	55,6
<b>Strongly Agreed</b>	41	30,8
<b>No response</b>	2	1,5
<b>Total</b>	133	100,0

Table 4.36 showed that majority of the respondents indicated they manage scarce resources and avoid duplication by encouraging their subordinates to share resources and processes meaningfully, 55.6 percent and 30.8 percent agreed and strongly

agreed to the above assertion. This figure is quite encouraging and it shows that HIV/AIDS service providers in Nigeria manage their scarce resources meaningfully. Only a mere 2.3 percent and 0.8 percent of the respondents disagreed and strongly disagreed to that assertion while 9.0 percent indicated undecided.

**Table 4.37: Willingness of the leadership to appropriately direct and help the staff to work as a team**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	6	4,5
<b>Disagreed</b>	6	4,5
<b>Undecided</b>	16	12,0
<b>Agreed</b>	59	44,4
<b>Strongly Agreed</b>	46	34,6
<b>Total</b>	133	100,0

Leadership of an institution must be willing to appropriately need and help the staff to work as a team. Table 4.41 showed that majority of the respondents amounting to 44.4 percent and 34.6 percent agreed and strongly agreed respectively that willingness of the leadership to appropriately direct and help the staff to work as a team in an institution is imperative. However, while 4.5 percent each strongly disagree and disagree respectively, a total of 12 percent of the respondents were undecided on the issue.

For the above analysis, we can convincingly conclude that there is willingness of the leadership to appropriately direct and help the staff of HIV/AIDS Service providers to work as a team.

**Table 4.38 Leadership in Organization emphasizes delegation of tasks to subordinates**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	<b>2</b>	1,5
<b>Disagreed</b>	12	9,0
<b>Undecided</b>	19	14,3
<b>Agreed</b>	80	60,2
<b>Strongly Agreed</b>	20	15 0
<b>Total</b>	133	100,0

One of the basic ingredients for effective leadership in an organization is the emphasis on delegation of tasks to subordinates. Table 4.42 indicated that 14.3 percent of the respondents were undecided, 1.5 percent and 9.0 percent strongly disagree and disagree respectively while as much as 60.2 percent and 15.0 percent agreed and strongly agreed to the assertion that leadership in an organization emphasizes delegation of tasks to subordinates. Here, it is important that HIV/AIDS Programs in Nigeria emphasizes delegation of tasks to subordinates.

#### **Organizational Atmosphere:**

**Table 4.39: Motivation of Members as a Key to Maximizing Productivity**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	20	15
<b>Disagreed</b>	40	30
<b>Undecided</b>	21	15.8
<b>Agreed</b>	36	27
<b>Strongly Agreed</b>	16	12
<b>Total</b>	133	100,0

Inadequate motivation of health workers has remained a sore point in the Nigeria health care system over the years. It has been the cause of large scale brain-drain and migration of our very best to foreign countries for greener pastures. From the table above, about 60% of the respondents (disagree/strongly disagree/undecided) accepted that their organizations did not see the motivation of its workforce as important to maximizing productivity. Only 27% agreed and 12% strongly agreed that that their organizations were motivating their staff for better productivity. The response to this questionnaire item may not be entirely unique as it is a reflection of the general feelings of health workers nationwide that most establishments especially government institutions do not really see motivation of the workforce as an integral and sustainable aspect of staff development.

**Table 4.40 Inclusion of Employees as part of decision-making process**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	4	3,0
<b>Disagreed</b>	10	7,5
<b>Undecided</b>	20	15,0
<b>Agreed</b>	72	54,1
<b>Strongly Agreed</b>	27	20,3
<b>Total</b>	233	100,0

Table 4.44 showed that minority of the total respondents amounting to 3.0 percent, 7.5 percent and 15.0 percent strongly agreed, disagreed and undecided respectively. Nevertheless a very reasonable figure amounting to 58.6 percent and 17.3 percent agreed and strongly agreed that the institution encourages the inclusion of employees to be part of the decision making process while at the same time having control of the group. This shows that HIV/AIDS Service providers in Nigeria encourage the inclusion of employees to be part of the decision making process and at the same time having control of the group.

**Table 4.41 Leadership approach emphasizes unlocking potentials and empowering people**

<i>Variables</i>	<i>Frequency</i>	<b>Percent</b>
<b>Strongly Disagree</b>	24	18
<b>Disagreed</b>	11	8,3
<b>Undecided</b>	78	58.6
<b>Agreed</b>	7	5.3
<b>Strongly Agreed</b>	4	3
<b>Total</b>	133	100,0

An institution where transformational leadership is practiced is populated by managers who constantly seek to discover and harness new talents and unlock potentials. The researcher was interested in understanding the extent to which this was happening in institutions where the respondents work. Table 4.41 above indicated that 18% percent (strongly agreed) and 58.6% (agreed) that that their work environment was not such that “unlocked” the potentials of the staff. In other words, management was not keen about the potentials and talents of staff and took no particular interest in developing and retaining high quality personnel. While 15.0 percent of the respondents were undecided, 58.6 percent and 17.3 percent of the respondents agreed and strongly agreed respectively that their organizations were unlocking potentials, whether individual potential, group potential, company/organization potential and empowering people.

**Table 4.42 Presence of High Sense of Work /Job Completion**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	4	3,0
<b>Disagreed</b>	7	5,3



<b>Undecided</b>	20	15,0
<b>Agreed</b>	78	58,6
<b>Strongly Agreed</b>	24	18,0
<b>Total</b>	133	100,0

From table 4.42 above, 58.6 percent and 17.3 percent agreed and strongly agreed to the fact that there is high sense of work / job completion in their institutions. In contrary, 3.0 percent and 5.3 percent of the respondents strongly disagreed and disagreed respectively while 15.0 percent of the populations were undecided. With the large number of the respondents who agreed, it has shown that there is high sense of wok/job completion in the HIV/AIDS service providers in Nigeria. That is, when there is a job to do, unnecessary delay is never encouraged and this is as a result of the quality of leadership.

**Table 4.43 Institutional Leadership Expects Change**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	9	6,8
<b>Disagreed</b>	9	6,8
<b>Undecided</b>	13	9,7
<b>Agreed</b>	81	60,9
<b>Strongly Agreed</b>	20	15,0
<b>Non</b>	1	0,8
<b>Total</b>	133	100,0

Table 4.47 above showed that equal number of respondents, nine each (6.8 percent) accepted that change was slow to come; 9.8% of respondents were undecided while 60.9 percent and 15.0 percent agreed and strongly agreed that change was inevitable and the management systems should be set up in such a way as to make them responsive to change. The world of HIV/AIDS has been a very dynamic one. In the

course of the last decade, so much revolution has occurred from when very little was known about the disease to when the ailment has now been termed and transformed to a chronic illness thanks to the discovery of antiretroviral therapy. This revolution has brought with it the need for management approaches and leadership to be revolutionized to cope with changes in technology and knowledge.

**Table 4.44 Knowledge, Skills and Proven Performance as Criteria for hiring new staff**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	17	12.8
<b>Disagreed</b>	81	60
<b>Undecided</b>	20	15,0
<b>Agreed</b>	14	10.5
<b>Strongly Agreed</b>	1	0.8
<b>Total</b>	133	100,0

The degree of competence to be achieved in an organization depends on the caliber of staff hired. From table 4.48 above, it is observed that knowledge, skills and proven performance were not were not accorded the premium it deserved in hiring staff in most institutions. For example 60% of the respondents alluded to this and 12.8% very strongly. The question that comes to mind is “What then should the criteria for hiring staff be if these essentials were not accorded priority?” Only 10.5% agreed that knowledge, skills and proven performance were key considerations for employment in their institutions. The import of this might be misleading; what is being communicated here may not be the fact that knowledge, skills and proven competence do not collectively constitute an important criterion for employment. Rather what this means is that various other considerations ranging from political connections to tribal factors and alliances may eventually be the determining factors for employment. This corroborates popularly held view that because HIV/AIDS programming has become a

“gold mine” in view of the large influx of funds into it from the donor community and the government; probity is gradually being thrown overboard and political expediency and selfish interest now characterize appointment into key positions.

**Table 4.45: Conducive Working Environment and Availability of Working Tools for Meaningful Output**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	4	3,0
<b>Disagreed</b>	52	39
<b>Undecided</b>	24	18,0
<b>Agreed</b>	35	26
<b>Strongly Agreed</b>	18	13,5
<b>Total</b>	133	100,0

The issue of lack of conducive work environment including basic working tools are basic characteristics of a employment situation in Nigeria. No where else is this most frustrating and consequential than in the health care industry where adequate provision is not made for the comfort of the staff and clients. One of the key questions in the questionnaire was to find out how this played out in institutions providing HIV/AIDS services. Table 4.45 above showed that 39 percent and 3.0 percent of our respondents strongly disagreed and disagreed that there were basic working tools and conducive environment to maximize productivity. Twenty six percent and 13.5 percent agreed and strongly agreed respectively to the fact that they had conducive working environment and basic working tools. It is instructive to note that as much as 18% of the respondents declined to answer this question thus indicating that this was a sensitive question. Many of the respondents might have been unwilling to voice an opinion of this issue to avoid possible reprisals if their employers go to know that they spoke negatively about their instsitution.

**Table 4.46: Institutional Motivation through availability of incentives**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	13	9.7
<b>Disagreed</b>	50	37.5
<b>Undecided</b>	21	15,8
<b>Agreed</b>	35	26.3
<b>Strongly Agreed</b>	10	7.5
<b>Total</b>	133	100

From Table 4.50 above, 37.5 percent disagreed and 9.7 percent of our respondents totally disagree that there were incentives to motivate staff while 15.8 percent of the respondents were undecided. However, 26.3 percent and 7.5 percent of the respondents agreed and strongly agreed respectively that incentives were provided by their institutions. HIV/AIDS Program managers work longer ways implementing HIV/AIDS activities often in collaboration with donor agencies and development partners. Some have to do this as ad hoc in addition to performing a substantive role as say, a medical doctor in a hospital. The outcry for incentives to reward this long schedule has been persistent and coming from almost all program managers. This explains the distribution of response on table 4.50 above. One hopes that relevant authorities get to see this as important and implements an incentive package that will help maximize productivity.

**Table 4.47 Written job description and schedule for every staff**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	20	15
<b>Disagreed</b>	48	36
<b>Undecided</b>	17	12,8

<b>Agreed</b>	34	25.5
<b>Strongly Agreed</b>	12	9
<b>No response</b>	2	1,5
<b>Total</b>	133	100,0

Clearly written job description enhances efficient performance of job roles and schedules for every staff in any organization. Table 4.51 above indicated that 15% and 36% of our respondents strongly disagreed and disagreed respectively to the above assertion that written job schedules were given to staff in their organizations. Only 25.5% and 9% agreed and strongly agreed that their organizations gave out written job description and schedules to staff. However, 12.8 percent of the respondents were undecided and probably unsure about the issue in focus. This data confirms the situation in most organizations in the country where authorities of institution presume that because you are a professional in a particular professional area you ought to know what to do. It is important to note however that every job situation and institution is different thus underscoring the need for well articulated and written-out job description and role for everyone.

**Table 4.48 Availability and Release of Funds in a timely fashion**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	25	18.8
<b>Disagreed</b>	66	49.6
<b>Undecided</b>	29	21,8
<b>Agreed</b>	10	7.5
<b>Strongly Agreed</b>	3	2.2
<b>Total</b>	133	100,0

Table 4.52 showed that 18.8 percent and 49.6 percent of our respondent strongly disagreed and agreed respectively that funds were available and released in a timely

manner; conversely, only 7.5 % 2.2 percent agreed and strongly agreed to the fact that funds for activities in the HIV/AIDS Programmes were always available and released in a timely fashion. It is interesting to note that as many of 29 respondents (21.8 percent) however, were undecided about this matter at hand. Again, this was another clear case of people being careful and not wanting to speak to such sensitive issues as release of funds especially among respondents from public sector institutions.

**Table 4.49 Recognition of Performance as a Major Factor in Employee Motivation**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	18	13.5
<b>Disagreed</b>	47	35.3
<b>Undecided</b>	14	10.5
<b>Agreed</b>	39	29.3
<b>Strongly Agreed</b>	11	8.2
<b>Non</b>	4	3,0
<b>Total</b>	133	100,0

Recognition of the worth and contribution of people in organizations is vital to maximize productivity and efficiency. Many studies have shown that people work better where they command respect and acknowledgement from their superiors and peers. This is an important aspect of motivation which is sometimes more highly priced than monetary compensations. Workers whose performance is recognized exact greater effort to perform them than those who are not motivated. From table 4.53 above, it is observed that 47 percent disagreed and 18% strongly disagreed that their organizations placed emphasis on the recognition of performance as panacea for progressing on the job. Only 29% agreed and 8.2 strongly agreed that their organizations recognized perform as the basis for motivating staff. This seems to be a

reflection of the situation in the country where considerations other than performance play a more important role in the hiring, progress and advancement of workers.

**Table 4.50 Retaining quality staff and prevention of brain drain.**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	74	55.6
<b>Disagreed</b>	26	19.5
<b>Undecided</b>	4	3.0
<b>Agreed</b>	20	15
<b>Strongly Agreed</b>	8	6.0
<b>No response</b>	1	0.75
<b>Total</b>	133	

In Table 4.54 above, majority of the respondents (75%) felt that there wasn't any staff retention plan or policy in their organization hence no deliberate efforts to retain quality professionals in their organizations. Though 15% percent agreed and 6.0 percent strongly agreed they had policies they attract and retain quality staff, they also accepted that they were not being implemented. The health care system has continued to be faced by massive brain drain at a worrisome scale.

**Table 4.51 Favouritism as a major criterion in hiring and firing staff**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Strongly Disagree</b>	19	14,3
<b>Disagreed</b>	13	9,8
<b>Undecided</b>	14	10,5
<b>Agreed</b>	66	49,6
<b>Strongly Agreed</b>	20	15,0

<b>Non</b>	1	0,8
<b>Total</b>	133	100,0

The table above indicated that 49.6 percent and 15.0 percent of our target population agreed and strongly agreed that favouritism does constitute a major criterion in hiring and firing health personnel. When compared to 14.3% and 9.8% who strongly disagreed/disagree, it is obvious that favouritism has continued to be a major determinant in the hiring and firing of employees. About 10.5% of respondents were undecided probably indicating their unwillingness to voice an opinion on a seemingly sensitive question. Be it as it may, the data above seem to buttress what obtains at the larger society in Nigeria.

### **Client's Satisfaction**

**Table 4.52 Distribution of clients according to years of affiliation to facility**

<i>Year</i>	<b>Frequency</b>	<b>Percent</b>
<b>Less than 1Yr</b>	9	11,3
<b>1-2 Yrs</b>	22	26,3
<b>3-5 Yrs</b>	11	12,8
<b>&gt;5 Yrs</b>	4	4,5
<b>Not stated</b>	39	45,1
<b>Total</b>	84	100,0

Table 4.52 indicated that 11.3 percent of our respondents have spent less than 1 year as a client in the facility. About twenty-six and 12.8 percent have spent between 1-2 years and 3-5 years respectively as clients in the facility while 4.5 percent have spent above five years in their various facilities.



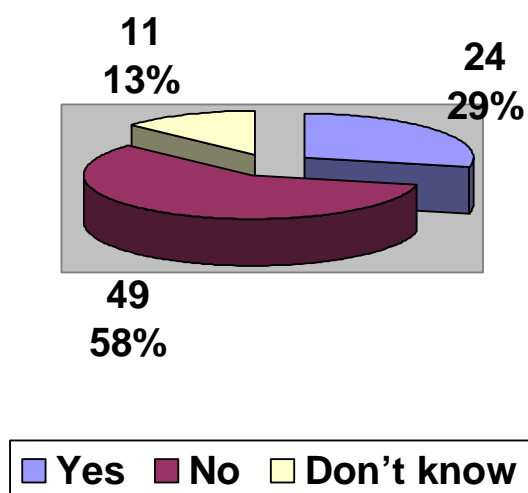
**Table 4.53 Assessment of Interpersonal Relationship Between Service Providers and clients**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Very poor</b>	13	15.0
<b>Poor</b>	19	22.6
<b>Undecided</b>	2	2.3
<b>Good</b>	26	30.1
<b>Very good</b>	22	26.3
<b>No response</b>	2	3.8
<b>Total</b>	84	100.0

Health workers in Nigeria have persistently been criticized by the media for not having good interpersonal relationship with their clients. It was therefore important to find out about interpersonal relationship issues. From table at least 30% of the respondents agreed that client-service provider relationship was good, 26% adjudged the relationship very good. Comparing this with 22.5 % who said that the relationship was poor and 15% who rated the relationship very poor, the margin between good and poor does not seem to be very wide. It could be inferred from the above that interpersonal relationship between client and service providers is on the average. This implies the need to work towards constantly strengthening and improving interpersonal relationships.

**Figure 4.6: “Stock out” of Drugs.**

## **Equipment and drug stock outs**



At the commencement of the national treatment program for PLWHAS, stock-out of drug was a recurring phenomenon. In many centres, the registration of patients was restricted, each centre was instructed not to register for more that 100 patients; and registered patients were sometimes turned away because drugs weren't available. To assess the current situation, respondents were asked whether or not they were experiencing drug stock outs. From the table above, 28.6 percent of our respondents have experienced stock outs of drugs in their facility while 57.9 percent of our respondents were not currently experiencing stock outs. This development is not surprising as the federal government through its antiretroviral program has imported and distributed several tones of drugs in the past year. Development agencies and donor partners under the US President's Emergency Plan and the World Health Organization's Three by Five" program has considerably improved access to antiretroviral drugs on a very large scale.

**Table 4.54 Drug and Equipment Stock outs**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Non</b>	52	61,7
<b>Once</b>	13	15,0
<b>Twice</b>	6	6,8
<b>More than twice</b>	14	16,5
<b>Total</b>	84	100,0

From our table, it showed that 15.0 percent of our respondents have experienced stock outs in their facilities once 6.8 percent of our respondents have encountered stock outs twice while 16.5 percent have experienced stock out from their HIV/AIDS Service providers more than twice.

**Table 4.55 Average time clients have to wait before services are provided**

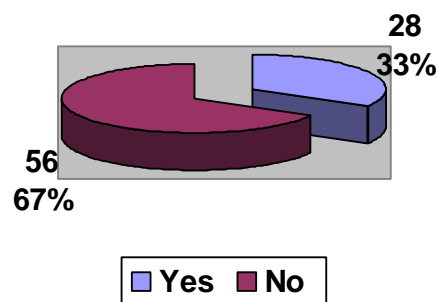
<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Less than 30 min</b>	11	13.5
<b>30 min. to 1 hr</b>	25	30
<b>1-2 hrs</b>	37	36
<b>3hrs &amp; above</b>	11	12.7
<b>Total</b>	84	100,0

Consumers of health care services nationwide have to contend with long waiting time for services. For many, one is not supposed to plan for any other activity during the day you are visiting the hospital. Clients in HIV/AIDS Care centres were asked to know what the situation was like in their facilities. Thirty six percent of respondents accepted that waiting time ranges from one to two hours before services were provided while 12.7% of the respondents deposed that it was possible to wait for 3

hours and above. Only 13.5% alluded to waiting less than 30 minutes while 30% agreed to 1 – 2 hours' waiting time. From the above it could be inferred that the average waiting time is 1 – 2 hours before service. However waiting time could depend on a number of factors: the services to be provided: for e.g. does it involve laboratory tests before prescriptions, the procedures to be undertaken and availability and work load of health personnel.

**Figure 4.7: Provision of information about their treatment and follow up promptly and efficiently.**

**Provision of information about their treatment and follow up promptly and efficiently.**



It is important that clients are fully informed about their condition, treatment options and where to get them, adherence to treatment and management of side effects. The figure above showed that 33.8% of our respondents are of the opinion that clients are provided with sufficient information about their treatment and follow up in a prompt and efficient manner while 66 percent believed that there is inadequate information flow.

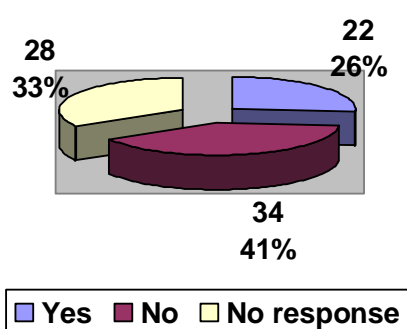
**Table 4.56 Programs where adequate information and enlightenment were not provided**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Home based care</b>	13	
<b>PMTCT</b>	10	
<b>Antiretroviral Program</b>	32	
<b>VCT</b>	17	
<b>During Referral</b>	13	
<b>Total</b>	84	100,0

In view of the importance of adequate information flow, the researcher was also interested in situations and programs where adequate information was not provided. The table above indicates that information is least available in the antiretroviral program and moderately available in VCT, home-based care and during referral; surprisingly,

**Figure 4.8: Involvement of Client in the planning and decision making regarding their care**

### **involvement of client in planning and decision making**



From the figure above 26.3 percent of our respondents one of the believe that when it comes to decision making and planning, the clients are involved but this contradicted the opinion of 40.6 percent of our respondents who were of the belief that clients are were not involved in planning and decision making regarding the care in our HIV/AIDS facilities.

### **Arrangement for Accommodating Indigent People and others who could not pay for services**

Quality service is evidenced by its coverage of all segments of the population in accordance with the principles of equitable and social justice. This means that people cannot be denied services on account of their inability to pay. Before the introduction of the free treatment policy for HIV/AIDS patients last January, services were generally unavailable to a large number of patients who couldn't afford the fees. In trying to find out the extent to which indigent people were accommodated in the treatment programs of institutions participating the studies, the following observations were made:

**Figure 4.9: Provision for the indigent who cannot pay for services**

#### **Provision for the indigent patients**

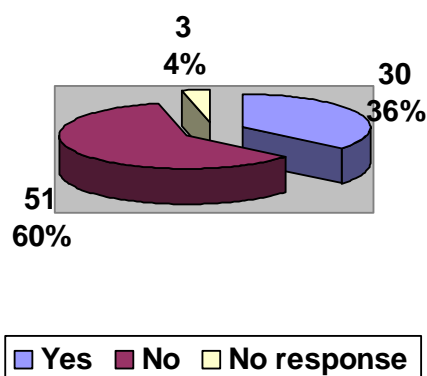


Table 4.66 showed that only 36% of the facilities had some arrangements to accommodate indigent people while 60% of the respondents had no such provisions. The implication of this is that a number of patients may well be turned away due to their inability to pay for one service or the other. This is an indication that much still needs to be done to ensure equity in the provision of services.

**Table 4.57: Stigmatization and Discrimination to Patients at the Facility.**

<i>Variables</i>	<b>Frequency</b>	<b>Percent</b>
<b>Very High</b>	8	9,0
<b>High</b>	15	18,0
<b>Somewhat High</b>	47	55.6%
<b>Not High at all</b>	13	15
<b>No response</b>	2	2,3
<b>Total</b>	84	100,0

From table above, it was shown that 9.0 percent of the respondents believed that stigma and discrimination to patients was indeed very high, 18% said it was high while as much as 55.6% was of the opinion that it was somewhat high while only 15% said that it wasn't high at all. From this analysis, it was clear that stigma and discrimination was still a problem



Figure 4.10: **Level of Satisfaction with the Services Provided**

Level of Satisfaction with the Services Provided

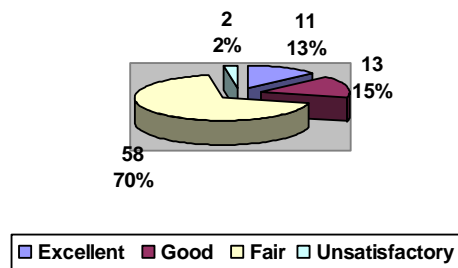
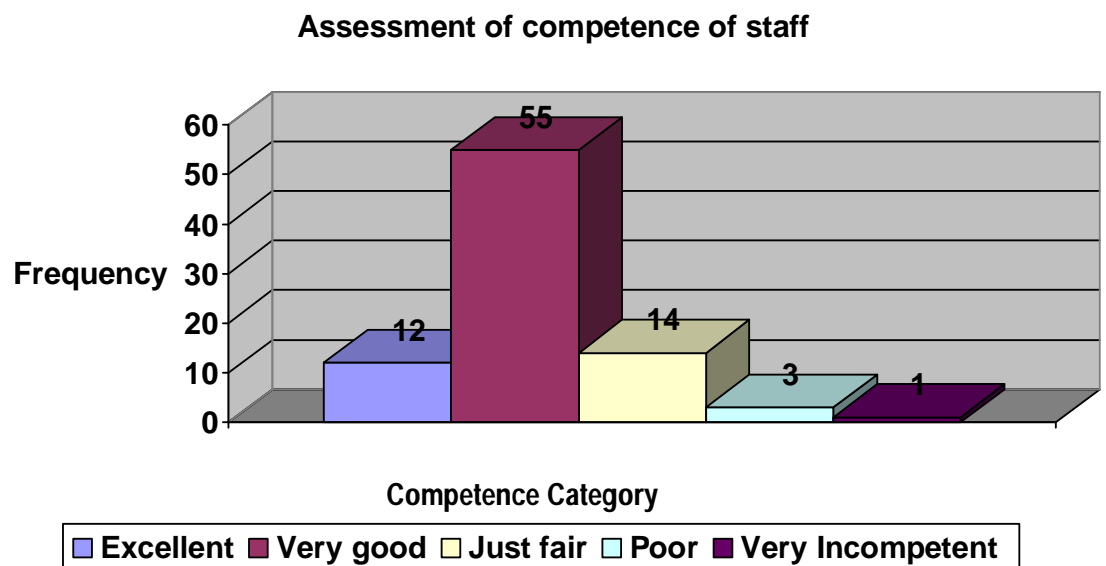


Figure 9 above showed that 13.5 percent of our respondents were of the opinion that the level of satisfaction of clients with the services provided by the HIV/AIDS Services provided was excellent, 15% felt it was good while 69.2 percent thought it was just fair. This finding is instructive given the fact that one would have expected a higher level of satisfaction given the enormous resources sunk into HIV/AIDS services by the government over the past three years.

Figure 4. 11: Assessment of the Technical Competence of the Staff



Regarding the assessment of the technical competence of the staff of the facility, 14.3 percent and 65.4 percent of our respondents are of the opinion that it is excellent and very good respectively. However, 16.5 percent and 3.0 percent are of the opinion that the technical competence of the staff is just fair and poor respectively. This shows a positive response concerning the technical competence of our HIV/AIDS service providers.

## **HYPOTHESES TESTING**

### **HYPOTHESIS 1:**

**The Null Hypothesis (H<sub>0</sub>):** Program sites managed by program managers whose management style aligns with transformational leadership orientation will not provide services of better quality than centres managed by those leaders with traditional management orientation.

**Alternate Hypothesis (H<sub>a</sub>):** Program sites managed by program managers with transformational leadership orientation will provide services of better quality than those managed by program managers with traditional orientation.

**Table 4.58: Association between leadership orientation (measured by sensitivity towards others) and quality of services (measured by client satisfaction)**

<b>Sensitivity towards others</b>	<b>Client satisfaction</b>		
	<b>Satisfied</b>	<b>Not satisfied</b>	<b>Total</b>
<b>Sensitive</b>	<b>66</b>	<b>9</b>	<b>75</b>
<b>Insensitive</b>	<b>6</b>	<b>3</b>	<b>9</b>

<b>Total</b>	<b>72</b>	<b>12</b>	<b>84</b>
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In this analysis leaders who agreed that they were sensitive towards others were regarded as having a transformational orientation while those who did not were regarded as having traditional leadership orientation.

Based on the chi- square ( $\chi^2$ ) computation derived from table 4.71 the calculated value =0.095

The critical or table value = $\chi^2$  at 1df at 0.05 level of significance which is = 3.84.

Since the calculated value is less than the critical or table value, we accept the null hypothesis and conclude that the quality of HIV/AIDS services depend on the leadership orientation of program managers.

## Hypothesis 2

Table 4.59 below shows the cross tabulation indicating the relationship between leadership orientation (as measured by teamwork) and quality of care (technical competence)

**Table 4.59: Association between leadership orientation (measured by teamwork) and quality of care (technical competence)**

Teamwork	Technical Competence		
	Competent	Incompetent	Total
<b>Practiced</b>	<b>74</b>	<b>2</b>	<b>76</b>
<b>Not Practiced</b>	<b>8</b>	<b>0</b>	<b>8</b>
<b>Total</b>	<b>82</b>	<b>2</b>	<b>84</b>

From the table, the following conclusion was reached that the calculated chi-square value ( $\chi^2$ ) = 0.56776. The table value = 25df at 0.05 level of significance = 3.84.

Since the calculated value is less than the critical or table value, we accept the null hypothesis and conclude that there is a relationship between the leadership orientation of program managers and the quality of service provided in the private sector health institution in terms of HIV/AIDS services.

### **HYPOTHESIS 3**

**The Null Hypothesis (Ho):** Consumers of HIV/AIDS services in public and private sector health program sites will not consider leadership style as a serious impediment to program performance.

**Alternate Hypothesis (H<sub>a</sub>):** Consumers of HIV/AIDS services in the public and private sites will consider leadership style as a serious impediment to program performance.

This hypothesis aimed at examining whether lack of modern skill is an impediment is to providing high quality HIV/AIDS services in both the private and public sector health institution in Nigeria. Question 20 and question 68 are hereby examined using the chi-square statistics derived in table 4.73.

**Table 4.60: Association between leadership orientation (measured by teamwork) and quality of services (measured by Client Satisfaction)**

<b>Teamwork</b>	<b>Client Satisfaction</b>
-----------------	----------------------------

	<b>Satisfied</b>	<b>Not Satisfied</b>	<b>Total</b>
<b>Practiced</b>	<b>65</b>	<b>10</b>	<b>75</b>
<b>Not Practiced</b>	<b>8</b>	<b>1</b>	<b>9</b>
<b>Total</b>	<b>73</b>	<b>11</b>	<b>84</b>

From the table above, the following conclusion was reached: that the calculated chi-square value ( $\chi^2$ ) = 0.833

The table value =  $\chi^2$  at 1 df at 0.05 level of significance = 3.84.

Based on this, it is clear that the calculated value is less than the table value we therefore accept the null hypothesis and conclude that lack of modern leadership skills is an impediment to providing high quality service in HIV/AIDS treatment centers. In other words high quality HIVAIDS services in public and private sector health centers in the FCT is a function of leadership skill of the program managers.

### **HYPOTHESIS 3**

**The Null Hypothesis (Ho):** Private sector HIV/AIDS program managers will not align more to transformational leadership model than HIV/AIDS program managers in the public sector treatment sites

**Alternate Hypothesis (H<sub>a</sub>):** Private sector HIV/AIDS Program managers will align more to transformational leadership than their counterparts in the public sector sites.

### **Hypothesis 4**

Hypothesis 4 aimed at examining whether there is a significance difference in leadership orientation and quality of service between the private and public sector

treatment centers. Table 4.74 was used to derive the chi-square ( $\chi^2$ ) distribution as follows:

**Table 4.61: Association between leadership orientation (measured by teamwork) and quality of services (measured by Client Satisfaction)**

Participatory approach	Client Satisfaction		Total
	Satisfied	Not Satisfied	
Adopted	58	9	67
Not Adopted	16	1	17
Total	74	10	84

The computed value of the chi-square ( $\chi^2$ ) = 0.346 The table value is  $\chi^2$  at 1 df at 0.05 level of significance = 3.84

Since the computed value (0.346) was less than the table/ critical value (3.84) we then accept the null hypothesis and concluded that there was no significant difference between the public and private sector HIV/AIDS treatment centers in terms of leadership orientation of program managers and quality of services provided. In other words the two frequencies fit each other and that in as much as there is good leadership orientation and quality of services in the public sector HIV/AIDS treatment centers, the same is said to be true as regard the private sector and vice versa.

The above assertion can be ascertained by further looking at table 4.75 which derives yet another chi-square ( $\chi^2$ ) distribution as regard the quality of service in the public and private sector HIV/AIDS treatment centers.

**Table 4.62: Association between leadership orientation (measured by teamwork) and quality of services (measured by Client Satisfaction)**

Health Facility	Client Satisfaction		
	Satisfied	Not satisfied	Total
Public	31	7	38
Private	41	5	46
Total	72	12	84

The computed  $\chi^2 = 0.156$

The table/critical value is chi-square @ 1 df @ 0.05 level of significance = 3.84

Since the computed value (0.156) was less than the table value we accept the null hypothesis and conclude that there was significant difference between the quality of services between the public and private sector HIV/AIDS treatment centers.

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## **CHAPTER FIVE**

### **DISCUSSION OF RESULTS**

In this chapter the major findings of the study will be highlighted and the researcher will attempt to appraise and contextualize these findings in line with existing knowledge gleaned from research in the dynamic field of HIV/AIDS program management.

#### **5.1 Highlights of major findings:**

##### **1. Leadership Orientation and Client Satisfaction**

1. Higher levels of clients satisfaction with services provided was reported more in facilities where the program managers' leadership orientation was transformational than in facilities where managers' orientation was traditional.
2. There was no significant difference in leadership orientation (whether transformational or traditional) between managers in private and public sectors. However, more private sector program managers preferred transformational leadership to traditional models than their counterparts in the public sector
3. Among the consumers of HIV/AIDS services, it was evidently clear that they considered leadership issues as a major impediment to providing optimum and quality HIV/AIDS services in Nigeria.
4. While program managers accepted that they were making serious efforts to ensure better information flow among colleagues at the patient, the patient satisfaction survey showed that most patients were not receiving adequate treatment related information.

5. The study also showed that there was inadequate involvement of PLWHAS in decision making
6. Stigma and discrimination was still very high and reported by about 70% of the clients in the survey
7. The level of client satisfaction with services with 69% of clients reporting that it was just fair raises some questions considering the amount of resources invested in the program so far by the government and aid agencies.
8. The program officers involved in HIV/AIDS service delivery were always, accessible and available for communication and sensitive to their patients and audience dispositions.

## **5. 2. Organizational Atmosphere:**

1. It was evident that the organizational atmosphere was improving with most program managers alluding to team work, therapeutic listening, win-win approach, cultural sensitivity and sharing resources as effective ingredients for success which they were putting into practice. However, the research showed that the system was bedecked by a number of organizational challenges some of which included inequity in resource allocation, non-release of funds, conflicting interests, inadequate motivation, lack of basic working tools and lack of staff retention strategy. Other challenges include excessive red tapism, no clear and written job description and inadequate involvement in decision making and a work atmosphere which does not favor having fun at work, innovativeness and taking of reasonable risk

A number of studies carried out on the status of HIV/AIDS services over the past few years has come up with findings which corroborate the findings of this study. For example in 2004, the United States Agency for International development committed a study on the status of HIV/AIDS services in Nigeria. This study which was carried out by the POLICY Project, PHR+ and Deliver Projects of USA and the Nigerian Institute of Medical Research (NIMR) was to gain an understanding of the current status, challenges by assessing the policies, service capacity,

logistics capacity (including laboratory services), and cost of providing services. The assessment focused on the 8 states: Anambra, Bauchi, Edo, FCT, Kano, Lagos, Nassarawa and Rivers. The key findings from the study which was to provide information to chart a new direction for implementation of HIV/AIDS services in Nigeria were very similar to the findings of this study. It highlighted the challenges to include low leadership and program management capacity at all levels, inadequate involvement of PLWHA and the communities, stigma and discriminations and lack of basic working tools, logistics capabilities and staff retention strategy. This study was preceded by a World Health Organisation's situation analysis of Nigeria's HIV/AIDS response in 2003 whose findings were very similar to the USAID study. The Federal Government of Nigeria also committed consultants to carry out a National Response Review (NRR) in 2005 as a preparatory step to developing the National Strategic Framework for HIV/AIDS, 2005-2009. Findings from this review pointed to a huge leadership and coordinating problem affecting the three tiers of government: "NACA has succeeded in raising awareness of HIV/AIDS among the leaders in various sectors and the general population that has stimulated responses to the epidemic. Despite some impressive responses in some states, not all states have effective SACAs and LACAs. While NACA is a federal coordinating body, it is not able to have full control of coordinating SACA and LACA HIV and AIDS activities, because States in Nigeria are semi-autonomous. SACA and their respective LACAs have some degree of autonomy which does not bind them to follow through on all NACA coordination requirements. While NACA has a strong multi-sectoral representation and participation in HIV and AIDS planning and activities, this approach is not reflected effectively at the SACA and LACA levels. The (leadership) capacity of most of the coordinating entities still needs to be strengthened to ensure an effective management and coordination of all activities to stem the epidemic in Nigeria" Among the key recommendations in the report was the "need to provide technical support to SACAs and LACAs in order to strengthen their ability to coordinate stakeholders within the State/Local government response and a "sustained high-level advocacy to the States and

Federal Government to secure commitment of political office holders and Administrative institutions.”

Corroborating a key finding of this study on inadequate allocation of resources and release of funds; the NRR also found out that inadequate allocation of resources and especially non-release of funds was a major issue in the national response and recommended among others “the development and implementation of a nation-wide fund raising campaign aimed at the general public as well as the private sector with the support of development partners to contribute to annual targeted HIV / AIDS theme – based fund.”

A study of the national health sector response to HIV/AIDS in 2005 also brought to the fore a number of issues similar to the findings of this study. According to the research report “In the absence of strong Federal and State Government leadership, the HIV & AIDS programme has remained largely donor-driven and highly fragmented, with uneven distribution of resources and programmes. Although external resources have increased significantly in the past three years, there remain many states with little or no financial support. The 774 Local Government Areas (LGAs) administrate the community level response in Nigeria. Both capacity and resources at this level are extremely limited”

On organization environment and quality of care, the report had this to say:

“The capacity of the health system to meet the additional demands for services generated by the HIV epidemic has been undermined by years of neglect and inadequate funding of the sector. The poor working environments and lack of investment in human resources have resulted in a demoralised workforce and poor health practices. The majority of consumers therefore use the private sector, both formal and non-formal, for their health care needs. These providers are unregulated and they do not use the national health information system, so their contributions are

unknown. Private sector providers are nevertheless vital partners to the public sector in expanding access to health care.”

Leadership issues have been at the epicenter of problems plaguing the response to HIV/AIDS across the globe. Various studies and assessments of national HIV/AIDS response in a number of countries have revealed leadership and quality of care issues similar to what obtains in this study. Southern Africa region has the highest prevalence of HIV/AIDS in the world with Swaziland HIV/AIDS prevalence rates as high as 42%. Meck, Andy and Mkorone, 2004 have demonstrated how visionless leadership and lack of political will and commitment by national leaders have helped to fuel the epidemic in the countries of the region and also countered international development efforts at combating the disease. In an “Analysis of the HIV/AIDS Impacts across the world” these authors identified; culture, lack of leadership and program management capacity, stigma and discrimination and lack of involvement of PLWHAS as key factors shaping the current status and the future of the epidemic in most countries.

Various reports from International donor agencies have highlighted the issues relevant to the findings from these studies in its numerous reports and research. For example the Global Fund to fight AIDS, Tuberculosis, and Malaria in its 2006 Mid-year report “ Investing in Impact” synthesized findings from various assessments and came to the conclusion that the only way to exterminate HIV/AIDS from the world is for all stakeholders to invest in changing the leadership orientation of the peoples of the world. The Government of Canada seemed to have recognized early enough that resolving leadership issues was central to the efforts at stemming the tide of HIV/AIDS hence has built this into its aid package on HIV/AIDS for developing countries. The Canadian International Development Agency coordinating Canada’s AIDS response in its program document opines that focusing on prevention, care and treatment only will be missing the point. “----- if we were to leave it at that we would not necessarily have helped developing countries to build capacity in their own health systems to effectively prevent and manage HIV/AIDS on their own”(CIDA, 2004). It is

for this reason that the Canadian government emphasizes health systems strengthening as the cornerstone of its HIV/AIDS support to developing countries.

To provide a better understanding of the key findings in this study, it is important to also understand the relevant Nigeria context. Decades of military rule had bequeath on the nation a culture of military dictatorship characterized by taking orders without questions and lack of accountability at all levels of government. The health care infrastructure had completely broken down and health system prostrate. The primary health care system had almost virtually collapsed. It is known fact that programming for HIV/AIDS cannot be successful in the absence of a virile health care system with modern infrastructure and equipment and skilled personnel to man them. Under the new democratic dispensation, the government has been working hard to revamp the health care system but the task is daunting and the results might take some time to come. It is against this background that the current challenges as revealed in this study can be understood.

However, a window of opportunity has been created through the increasing interest of donor agencies and development partners in Nigeria's cause to stem the HIV/AIDS epidemic. Rather than depend wholly on international assistance for aid which can only last for sometime, it is hoped that the government would draw up a sustainability plan so that services would continue to be available and accessible when international assistance ceases to be available.

Inadequate involvement of PLWHAS in decision making and stigma and discrimination has also come up as key findings of this study. The two are interrelated and it is important to understand both concepts and their inter-relationships if programs are to be result-based and better articulated.

### **5.3 Corroboration of findings from Focus Group Discussion**

The findings from the analysis of focus group discussion held for eleven national HIV/AIDS program managers in Kaduna corroborates the findings gleaned from the questionnaire. The group members understanding of leadership was that leadership is “for every body” meaning that “everybody can be a leader.” Participants agreed that the “prevailing leadership style is the traditional style where one person tends to do every things and claims to know everything.” “Leadership in modern terms means try to lead, motivate people and then try to act, said a participant. This the participants opined should also apply to managing HIV/AIDS programs. Another participant observed that HIV/AIDS program management should involve everyone and structures should be well developed at all levels (national, state and local government) to facilitate this and that the government’s role should be that of facilitation and coordination.

Participants were concerned about improper role definition for program officers leading to conflict and various other bureaucratic bottlenecks. A participant said: “Leadership is defined by who takes charge of what, that is planning and implementing activities. Who monitors the impact of these programs on the targeted audience. There should be clearly defined roles in whatever sector. Leadership is a process of coordinating and working with other people in other to achieve organizational goals. It is also carrying people along in whatever one is doing and this is the type of leadership required for managing HIV/AIDS programs for success in Nigeria”

In response to a question on whether there is glaring evidence of leadership in the national HIV/AIDS programs, most participants were positive but regretted that so much needed to be done to improve upon the leadership of the program. A participant said “we are seeing some leadership on the part of the government but it is far from the ideal.”

Another said: "There is evidence of good leadership. This can be seen through the establishments of structures to coordinate HIV/AIDS programs." A program manager from the University of Benin Teaching Hospital was concerned about inadequate clarification of control "we must clarify control of HIV/AIDS projects management." who is controlling the direction of HIV/AIDS programs, is it international NGO's or the Government that is giving policy direction? Leadership is also about coordinating all activities going on. In terms of effective coordination, establishment of NACA is a long step forward for the Government. There has to be political will of Government or the interest has to be there or things will not work."

On whether there were glaring evidence of bad leadership, participants pointed at the states and local government areas. "There is improvement in leadership at national level but most states and local government areas are really lagging behind." "The states and LGAs are simply waiting for the federal government and are not doing well. We need to standardize." Another participant argued that that the problem was from the top: "The Federal Government should do more to carry everyone along from the onset, even at states level. If there is failure, it is from the top." A participant countered "there is really nobody coordinating the NGO's they are all doing their own things. In some organizations, the managers are well paid and incentives provided while in others compensation is very poor though they are doing virtually the same thing. It was also observed that "there was no clear plan for distribution of treatment centers with areas with low HIV prevalence having ARV sites at expense of areas with high prevalence." The ARV program is seen as a Federal Government project and not really the people's project. The project is all donor-driven. The Federal Government should redouble efforts to ensure that access to services is drastically improved."

Regarding the leadership skills and competency level of program managers, a participant indicated that most development partners and NGOs have skilled personnel but same cannot be said of government partners and the FBO community. Most program managers lack modern management skills of working as a team and



delegation of tasks. Most of them still want to do everything by themselves and do not delegate. They want to be lone champions hence it's common place hearing about their names and their accomplishments everywhere while little is heard about the group they represent. A participant traced the problem to the recruitment process where emphasis is not placed on leadership skills but on other sinister considerations. "Some people are employed based on who they know and not what they can do." There was a consensus among participants that a lot was expected from the managers in the national HIV/AIDS program and that "people should learn to work as a team; they should know how to delegate appropriately. Learn to plan. Leadership should identify among the team, who can do what and delegate appropriately. No leader succeeds by doing everything by himself."

Participants also tried to identify program sites where there was excellent leadership. For instance most participants pointed to the Jos Teaching Hospital HIV/AIDS program site where there was good team work and team spirit adequate information flow among personnel with everyone understanding the vision and mission of the program and how to get there. Other attributes of the Jos program include: client and community involvement, accountability and adequate record keeping, monitoring and evaluation.

One of the program managers blamed poor leadership on lack of funds. He said that the concept of HIV/AIDS program leadership was faulty from the beginning. It started without any planning or costing of either interventions nor allocation of funds. He noted that morale was low at the beginning but with the injection of PEPFAR funds, program leadership has also improved tremendously. According to him, a lot of things have to do with availability of funding. Sometimes, the drugs are there at the sites, and the facility does not just have the money to get them."

The issue of transparency also came up for discussion. The people at the top lack openness said a participant. He cited the failure of public utilities in the country:

electricity, water supply, and health care services generally indicating that the national HIV/AIDS program might go the same way if there is no transparency.

A federal program officer was concerned about the ambivalence of the states. Why do we have 25 ARV sites when they are 36 states in the Federation? The states Governors are not doing enough.” Most states are also depending on donors and waiting for the Federal Government should bear all the burdens; it can’t work like that.” There was extreme pressure on the Federal Government by PLWHA groups while the states are not under any pressure from these groups to contribute to the response. Everyone is looking up to the Federal Government.” The Federal Government alone can not satisfy everyone, it is a matter of vision and priority. The states have the resources and if they are determined to act decisively, things will change for the better.” A participant agreed with: “the UN secretary general statement of World AIDS day, that Africa does not lack the resources to take care of HIV/AIDS.”

Another participant was concerned about bureaucracy: “there is no free hand for workers in the Government establishments; people are not allowed to express themselves and be creative.” Because “HIV/AIDS is not just a health issue, there must be a change in the way government business is run to allow for more openness”

Participants were also asked to assess the quality of care for PLWHAS. A participant felt that the issue of “quality of care was a real challenge at all levels (primary, secondary or tertiary level). Many participants agreed that there was some improvement in quality of care but not yet at an acceptable level. It was observed that patients were not involved in their care and neither was there any provision for patients and their relatives to work with the authorities to set minimum standards of care. Participant suggested the use of suggestion boxes, questionnaire and other ways of creating avenues for patients and their relatives to verbalize their fears and concerns. Clients should be assured to comment on the efficacy of drugs, cost and accessibility. Participants expressed concern that the technical competence of care

providers was at a low level but were happy that stigma was reducing especially because ARV is now free and widely available. On the whole, participants summed up that there was a remarkable improvement in patient satisfaction but could only rate the level of patient satisfaction at 30% on a hundred point scale. They recommended greater and meaningful involvement of PLHWAS in the planning and implementation of services and capacity building across the board and adequate funding as ways to address gaps in patient satisfaction. According to one of the participants “PLWHA involvement is crucial to get their perspective. But the problem is that the Nigerian factor is creeping into the support groups. Some people are living big, and driving big cars at the expense of others and forgetting their mandate and focus.”

#### **5.4 Stigma/Discrimination and Inadequate Involvement of PLWHAs**

HIV-related stigma may well be the greatest obstacle to action against the epidemic, for individuals and communities as well as political, business and religious leaders. An all-out effort against stigma will not only improve the quality of life of people living with HIV and those who are most vulnerable to infection, but meet one of the necessary conditions of a full-scale response to the epidemic.

Defeating HIV-related discrimination requires health and social services to be sensitive to it and act against it. A key area of action has been within the health sector. For example, in India, the Lawyers Collective in Mumbai has been not only been raising awareness among people with HIV of their legal rights as citizens and as patients, but sensitizing doctors and other health care workers to HIV-related legal and ethical issues.

Voluntary counselling and testing (VCT) services are central to tackling stigma because they constitute the entry point for care and treatment, and it is at this point that potential patients are at their most vulnerable to stigma. Guidelines published by UNAIDS and WHO on beneficial HIV disclosure and partner counseling have helped to establish a coherent and ethical framework for this highly sensitive procedure. Across the world, VCT services are being expanded, and at the same time becoming

more sensitive to discrimination. India's National AIDS Control Organisation is promoting VCT centres; the Chris Hani-Baragwanath Hospital in Soweto is pioneering community outreach and the expansion of VCT services; UNAIDS, particularly with its WHO component, is integrating HIV education and counselling into primary health care in Rwanda. A particular concern in Rwanda is to gear these services to the psychosocial needs of young women who have been the victims of rape.

Protection from discrimination extends well beyond the health and related sectors. For example, the International Labour Organization has recently brought out a new code of practice on HIV and the world of work . HIV discrimination at the workplace has been a focus in many countries, including South Africa, where the Employment Equity Act has made it illegal for the majority of Government departments to carry out pre-employment HIV testing. Micro-finance is another area in which great care is needed to combat discrimination rather than perpetuate it: the International Labour Organization is strengthening micro-finance and entrepreneurial skills among women in Malawi, Mozambique, the United Republic of Tanzania and Zimbabwe, integrating AIDS education into the programme.

In addition to the existing agenda for tackling HIV-related vulnerability and the immediate impact of the epidemic, there is a long-term agenda that has as yet barely begun. A very large cohort of orphaned children will cause political as well as social instability in the worst-affected countries. The impact of AIDS on human resources in public and private sector work is considerable. Development capacity, already overstretched, is being stretched even further as AIDS kills gifted, skilled and educated personnel. Depleted human resource capacity in the most affected countries is only now being placed on the development agenda as a significant issue. Programmes and interventions for dealing with it are urgently needed.

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## **CHAPTER SIX**

### **SUMMARY, CONCLUSION AND RECOMMENDATIONS**

#### **6.1 Summary**

A research on organizational leadership and quality of care of the HIV/AIDS response in Nigeria was conducted. The study sought to establish if there was any relationship between the preferred leadership style of program managers and perception of service quality and satisfaction as perceived by the consumers of HIV/AIDS services in Nigeria's Federal Capital territory. For this purpose, alignment to either the traditional or transformational leadership was the basis for comparison. Study participants were drawn from public and private sector health care institutions providing HIV/AIDS services in the FCT. In the course of the study extensive literature review of the subjects of leadership and quality of care and some relevant research in this area was carried out. At the end of the study the following emerged as key findings from the study:

1. Facilities where program managers preferred transformational leadership orientation also reported higher levels of clients satisfaction with services provided than facilities where its program managers preferred traditional orientation.
2. There was no significant difference in leadership orientation (whether transformational or traditional) between managers in private and public sectors. However, more private sector program managers preferred transformational leadership to traditional models than their counterparts in the public sector
3. Among the consumers of HIV/AIDS services, it was evidently clear that they considered leadership issues as a major impediment to providing optimum and quality HIV/AIDS services in Nigeria.

4. While program managers accepted that they were making serious efforts to ensure better information flow among colleagues at the patient, the patient satisfaction survey showed that most patients were not receiving adequate treatment related information.
5. The study also showed that there was inadequate involvement of PLWHAS in decision making
6. Stigma and discrimination was still very high and reported by about 70% of the clients in the survey
7. The level of client satisfaction with services with 69% of clients reporting that it was just fair was raises some questions considering the amount of resources invested in the program so far by the government and aid agencies.
8. The program officers involved in HIV/AIDS service delivery were always, accessible and available for communication and sensitive to their patients and audience dispositions.
9. It was evident that the organizational atmosphere was improving with most program managers alluding to team work, therapeutic listening, win-win approach, cultural sensitivity and sharing resources as effective ingredients for success which they were putting into practice.
10. The research also showed that the system was bedecked by a number of organizations challenges some of which include inequity in resource allocation, non-release of funds, conflicting interests, inadequate motivation, lack of basic working tools and staff retention strategy. Other challenges include excessive red tapes, no clear and written job description and inadequate involvement in decision making and a work atmosphere which does not favor having fun at work, innovativeness and taking of reasonable risk.

## **6.2 Conclusions**

This study provided an invaluable opportunity to understand the subject of leadership and quality of care issues as it affects the management and delivery of HIV/AIDS services in Nigeria. Findings from this study have been very revealing and consistent

with the findings of past investigators of the subject. A note of caution must be sounded however, that the aim of this investigator was not to determine which leadership style was the best as no such thing as the best leadership style exist. A good leader is one who understands self, the disposition of his staff and the environment and varies his leadership style as may be appropriate. The study proposed that a good leader is one who uses all the three styles, depending on what forces are involved between the followers, the leader and the situation. It could take the example of using an authoritarian style on a new employee who is just learning the job. The leader is competent and a good coach. The employee is motivated to learn a new skill particularly HIV/AIDS services which is complex and wide-ranging. The situation is a new environment for the employee. It is important to note that leadership styles not with standing, participative styles, team approach, delegation, value and vision sharing and empowerment of others should be the key words. The leader knows the problem well, but he wants to create a team where the employees take ownership of the project. The employees know their jobs and want to become part of the team. The situation allows time. It is of grievous concern that lack of the right type of leadership has continued to be a sore point in Nigeria. It permeates all sectors and HIV/AIDS cannot be an exception. It is hoped that key institutions in Nigeria will begin to look at how they can implement new strategies and how to do things differently for the general good of our county and its people.

Ineffective leadership translates to no services or poor quality of services where services exist. It was therefore not surprising that the findings from the service quality survey were not outstanding in spite of the huge investment by all stakeholders. It is an in controvertible fact that health personnel that are not adequately motivated cannot provide high quality services.

The situation and response analysis of HIV/AIDS services in the FCT in particular and Nigeria as a whole has revealed several challenges and many opportunities. Although there is effective coordination of the HIV/AIDS response in both public and private sectors as shown in this study, strong leadership with an appropriate level of



delegated authority is required at all levels, guided by sound policy and strategy based on global best practices and the national evidence base. Despite the fact that majority of the respondents indicated that they had sound leadership orientation skills, empirical evidence on the ground showed that a lot need to be done to improve the capacity of the health sector institutions, systems and personnel to plan and manage a well coordinated, and adequate resourced response to HIV/AIDS in the health sector.

The issues of stock-outs of drugs and lack of basic equipment as discovered in this study are quite an obstacle. International practice showed that appropriate financial, logistic and human resources management systems have to be developed and resources used effectively for HIV/AIDS programs in line with agreed budgets.

Another implication of the research findings is that most of the treatment centers even in the Federal Capital Territory which is the area under study did not enjoy wide coverage. Most of the facilities were located in the urban centers like Abuja Municipal which takes the majority percentage of the respondents, then Gwagawlada and to a lesser extent Kwali Area Council. Increase coverage and improve access to comprehensive prevention, treatment, care and support services for HIV/AIDS and related problems is still lacking as far as HIV/AIDS service delivery in Nigeria is concerned.

The supply of ARVs in Nigeria has been very inconsistent, creating serious short falls in the government centers. This is however being corrected by donor support to scale up treatment, care and support. Anecdotal evidence suggests that there is already wide spread resistance to the available drugs (NACA, 2005).

Equally the supply of diagnostic kits for HIV testing has been sporadic and some transfused blood are still not screened.

### **6.3 RECOMMENDATIONS**

It is evident that there is an increasing level of political will and commitment at all levels to implement the national framework for HIV/AIDS in Nigeria. However, much still needs to be done if effective and qualitative care has to be attained. The following are recommended in order to strengthen the leadership orientation and capacity of program managers necessary to enhance the quality of care:

1. Effective coordination of national efforts within the framework of the three-ones(one national coordinating body, one national plan and one monitoring and evaluation systems) must not only be put it place but the states and local government councils must to supported to replicate this at their levels of authority.
2. Federal Government should ensure that appropriate linkages are developed between the public and private sectors so that resources can be leveraged and experiences shared.
3. All stakeholders in the national response must intensify efforts in building the capacity of health workers on contemporary HIV/AIDS issues. This will be based on a nation wide capacity assessment to ensure that a critical mass of health workers who are not only conversant with clinical issues but also on sound leadership and management practices is developed.
4. Working in concert with development partners and other stakeholders the Federal Government should organize a stakeholders' meetings to develop a strategy on how PLWHAs can be meaningfully involved in decision making and in implementing care and support activities that affect them.
5. To ensure that appropriate standards of services are maintained, national guidelines for services must be developed where they do not exist. Existing guidelines should be adequately disseminated to ensure that they are available and used by service.
6. Governments at the national and state levels should review upwards their budgetary allocation to HIV/AIDS.

7. To adequately motivate health personnel especially those caring for HIV/AIDS patients, the government should work with stakeholders to agree on a new compensation package for health workers.
8. Appropriate legislations should be put in place and enforced by the federal and state authorities to guard against stigma and discrimination for PLWHAS.

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## Appendices

### Appendix 1:

#### QUESTIONNAIRE

This questionnaire is designed to collect data on a study assessing the leadership capacity of the national HIV/AIDS response; a study conducted in partial fulfillment for a Doctorate Degree in Health Policy and Management. I will appreciate if you would assist by taking time out to complete the questionnaire. Please note that every attempt is made to ensure confidentiality of responses; your name is not required and the researcher will not make reference to your name and identity in the research. Please try and complete the questionnaire as fully as possible and note the instructions in each section and any directions that may follow some of the questions.

#### SECTION A

##### **SECTION A BACKGROUND INFORMATION**

Age:    20 – 29    ☐  
          30 – 39    ☐  
          40 – 49    ☐  
          50 and above    ☐

Sex:    Male    ☐    Female    ☐

Designation or Job title \_\_\_\_\_

Experience in management position

None    ☐

1 – 2 years

☐

3 – 5 years

☐

6 – 10 years

☐

10 years and above

☐

How long have you been working in your present position?

Less than 1 year

☐

2 – 4 years

☐

5 and above

☐

Date of commencement of HIV/AIDS Services in your facility:

Month

Year

Type of Organization:

Public (Government)

☐

Private

☐

If private, state whether NGO

☐

CSO

☐

Corporate

☐

Faith based

☐

Type of Facility:

Primary

☐

Secondary

☐

tertiary

☐

Location of facility:

Lagos

☐

Abuja

☐

HIV/AIDS Services Provided by Organization:

Prevention of Mother to Child Transmission (PMTCT)

☐

Antiretroviral Therapy (ART)

☐

Voluntary Counseling and testing (VCT)

☐

OTHERS

☐

please specify: -----

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## SECTION B

In this section, you are required to tick the appropriate cell corresponding to your level of agreement with the following statements as it applies to you. I will appreciate an honest assessment of your self. There is no right or wrong answers. Assessment scale: 1: Strongly Disagree (SD), 2: Disagree (D), 3: Undecided (UD), 4 : Agree (AG), 5 : Strongly Agree (Undecided) to 5 (Strongly Agree).

SN	Questionnaire item	SD	D	UD	AG	SA
1.	I am accessible and available for communication					
2.	I show sensitivity to various audiences by engaging their attention and adapting messages to suit them					
3.	I share relevant information and expectations openly, honestly, clearly, concisely and in a timely fashion					
4.	I listen actively and ask questions with open mind					
5.	I show sensitivity towards others by seeking to understand them before to make myself understood					
6.	I check assumptions before taking action					
7.	I offer and receive feedback and constructive criticism in the interest of improving my own effectiveness					
8.	I help to relieve stress by finding ways to laugh and have fun at work					

9.	I encourage teamwork in order to strengthen internal and external networks					
10.	I put team goals first by understanding and clearly					
11.	I recognize and manage difficult relationships by encouraging people to value other viewpoints and focus on issues					
12.	I seek out to welcome diverse ideas, skills and interests and use them to achieve team goals					
14.	I help to create a nurturing climate by valuing all team members, treating each fairly and by supporting their development equitably.					
15.	I share leadership and help the team become interdependent by facilitating participation and group interaction					
16.	I demonstrate enthusiasm and recognition for people and projects by sharing accountability.					
17	I empower the team and trust them to deal with real problems by allowing time for consensus to develop.					
18	I demonstrate a win-win philosophy when I interact with people inside and outside my department					
19	I set aside personal agendas in order to achieve results that are acceptable to everyone					
20	When negotiating I recognize the importance of people by trusting them and treating them with fairness and dignity					
21	I keep my promises and fulfill my commitments					



22	I challenge the status quo by exploring new ways to do business and I encourage others to do the same.					
23	I commit to continuous improvement by questioning myself and others and by acknowledging mistakes and learning from them					
24	I seek out opportunities to build partnerships and collaboration with other organizations that can help with my work					
25	I take reasoned risks in order to achieve organizational goals					
26	I streamline reporting requirements and eliminate unnecessary red tape.					
27	I empower others to take risks, support them when things go wrong, and encourage them to learn from setbacks and failures					
28	I understand the implications of today's work in tomorrows context					
29	I recognize and adapt to regional, cultural and sectoral differences by putting specific priorities, initiatives, actions and decisions into the broader context.					
30	I avoid duplicating work by encouraging others to share resources and processes.					

## SECTION C

*In this section review each statement and indicate the extent to which it applies to your institution with 5 points being the highest and 1 the least.*

SN	Question	1	2	3	4	5
31	There is a willingness of the leadership of my institution to appropriately direct and help the staff to work as a team.					
32	Leadership in this organization emphasizes delegation of tasks to subordinates.					
33	In our institution, one of the keys holding the team together is motivation of members to maximize their productivity					
34	Our institution encourages the inclusion of employees to be part of the decision making process while at the same time having control of the group.					
35	Leadership approach in our institution emphasizes unlocking potential, whether individual potential, group potential, company/organization potential and empowering people					
36	There is high sense of work/job completion in this institution. When work comes in, due to our leadership quality, it is considered done, no unnecessarily delays.					
37	Our institutional leadership expects change,					

	and when they do come we respond appropriately to strengthen our competitive advantage.					
38	Emphasis is placed on knowledge, skills and proven performance of applicants as the criteria for hiring new staff.					
39	Our working environment is conducive through the availability of working tools necessary for meaningful output e.g. skilled professionals and equipment					
40	Institutional motivation through the availability of incentives engendered on merit is in place in our organization					
41	In my institution there is a written job description and schedule for every staff hence everyone is clear about his/her job roles and expectations					
42	Funds for our activities are available and released in a timely fashion _____					
43	Recognition of performance constitutes a major factor in employee motivation by the way of bonuses, certificate of appreciation					
44	In my organization there is a deliberate policy or plan to retain quality staff and prevent brain drain					
45	Favoritism does not constitute a major					

	criterion in hiring and firing staffs. Some staffs feel advantaged over others due to their connections.					
--	--	--	--	--	--	--

## SECTION D

*This section would be administered to both the program staff and their clients.*

*Tick whether respondent is*

46A Program Staff ☐

(If program staff go to 47)

Client ☐

(If Client also answer next question

below)

46B How long have you been a client in this facility?

Less than 1 year ☐

1 – 2 years ☐

3 – 5 years ☐

More than 5 years ☐

*In this section please tick as appropriate and provide additional information where requested.*

47. How would you assess interpersonal relationship between service providers and clients in this facility:

Very Poor ☐ Poor ☐ Not Sure ☐ Undecided ☐ Good ☐ Very Good ☐

48. Have you ever experienced “stock outs” of drugs in this facility?

Yes ☐ No ☐ (If No, go to Question 50)

49. How many times have you experience stock outs of the following

Drugs: once ☐ twice ☐ More than two times ☐

Laboratory supplies: once ☐ twice ☐ more than twice ☐

50. On the average how long do clients have to wait between arrival time at the facility and when services are provided?

Less than 30 minutes ☐ 30 minutes to One hour ☐ 1-2 hours ☐

3 hours and above ☐

51. Are clients provided with sufficient information about their treatment and follow up in a prompt and efficient manner?

Yes ☐ No ☐ (If No, go to Quest -53)

52. Can you cite examples of situations where adequate information and enlightenment were not provided?

-----  
-----  
-----

53. Does the program involve clients in the planning and decision making regarding the care? Yes ☐ No ☐

If yes, describe -----  
-----  
-----

54. Does the program have an arrangement for accommodating indigent people and others who have difficulty paying for services?

Yes ☐ No ☐

55. To what extent do health workers show stigma and discrimination to patients at this facility?

Very High ☐

High ☐

Somewhat high ☐

Not high at all ☐

56. Generally what is your level of satisfaction with the services provided here?

Excellent ☐

Good ☐

Fair ☐

Bad ☐

Very Bad ☐

57. What is your assessment of the technical competence of all the staff in this facility?

Excellent ☐

Very Good ☐

Just Fair ☐

Poor ☐

58. Comment freely on the leadership challenges that are affecting the delivery of quality services at this facility-----

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## Appendix ii: Focus Group Discussion Guide

### INTRODUCTION

I am pleased to welcome you to this focus group discussion session. My name is Godwin Asuquo and I am carrying out a study to assess the leadership capacity of the national HIV/AIDS response in partial fulfillment for the award of a Doctorate Degree in Health Policy and Management. This meeting provides an opportunity for you to make input into this study. I will be asking a couple of questions which we will discuss together in an orderly manner with one person speaking at a time. Let me assure you that your responses will be treated as confidential and your name will not be mentioned or attributed to any response in the research report. The tape recorder used at this session is to ensure that we don't miss any of the valuable information that will be generated from this meeting and to ensure that the transcription of data will be done effectively. At this I will like to know if any one has any questions. It is important to note at this point that any one that doesn't feel comfortable participating can be excused.

SN	Question/Topic	Remarks
1.	MAIN QUESTION: Within the context of the national HIV/AIDS response, what do you understand by leadership? PROPMT: Are there any examples of good/purposeful and bad leadership?	
2	MAIN QUESTION: What are the most preferred leadership styles of HIV/AIDS program managers? PROMPT: Do they align more to autocratic, democratic and transformational or laissez-faire styles?	
3.	MAIN QUESTION; Based on your experience as program managers, how would you assess your organization and HIV/AIDS response in general with	

regards to leadership style preference?

PROMPT: Is the system autocratic, democratic and transformational or laissez-faire?

4 What are the leadership issues and challenges in the national HIV/AIDS response?

5 How does leadership affect the quality of services available to people living with HIV in our country?

PROMPTS: What are the positive and negative things we can cite as examples

6 What suggestions do you have on how to address the leadership challenges we have discussed and on how to improve leadership generally?

## **CONCLUSION**

I cannot thank you enough for participation and for contributing to the success of this study. I will make efforts to share with you the final report of this study in due course. I wish all of you a safe trip home. Please remember that light refreshment is available at the corner there.

Thank you