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The Feasibility of Managed Clinical Networks in Nigeria: a case of policy transfer to less advanced settings

Tarry Asoka

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**Keele University
Staffordshire, United Kingdom**

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Name of candidate: **Tarry Asoka**

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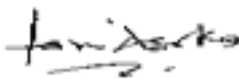
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Abstract

The concept of the ‘managed clinical network’ has provoked significant attention for its promise as a means of improving services for people where their condition requires care across a range of organisations and agencies. The concept suggests a model of service organisation and governance that gives privilege to working relationships among organisations, clinical work groups, and/or individual clinicians and so promotes coordination and integration of scarce care resources, knowledge and practice. Despite repeated calls by the World Health Organisation for the adoption of managed clinical networks in developing countries, the feasibility of the network model of service delivery in this setting has not been demonstrated. Taking the implementation of programme clusters for care and support of HIV/AIDS in Nigeria as a ‘more feasible’ case study, this thesis examines the process of transfer of the idea of the managed clinical network into less advanced settings.

The empirical findings in this dissertation suggest that the two programme clusters, as suggested by the expressed ‘Theory of Change’, altered networks of relationships and produced new forms of collaborative practice within these HIV/AIDS programme clusters in response to understanding of the disease as a ‘wicked problem’, requiring collective action. Though operationally feasible, the findings of this research study also indicate that, because these networks challenge existing institutional arrangements in Nigeria, the ability of collaborating partners to sustain the networks without reform within the institutional context is unclear. Further research is recommended, to explore ‘whether’, ‘how’, and ‘why’ the policy/idea of the managed clinical network, as an alternative means of service integration, might be situated in an institutional context that is characterized by a mix of modes of

governance (hierarchy and markets) typical of Nigeria, and the possibility of ‘sustainable transfer’ into this environment.

KEY WORDS: *Managed clinical network, Policy transfer, HIV/AIDS, Nigeria*

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List of Abbreviations

AIDS – Acquired Immune Deficiency Syndrome
ANC - Ante-Natal Clinic
ART – Anti-retroviral Therapy
ARV - Anti-Retro Viral
BCC - Behaviour Change Communication
CBOs - Community-Based Organisations
DFID – Department for International Development
DoC - Drivers of Change
DOTS - Directly Observed Therapy, Short Course
FBOs - Faith-Based Organisations
FCT - Federal Capital Territory
FGN - Federal Government of Nigeria
FHI - Family Health International
FMoH - Federal Ministry of Health
GON - Government of Nigeria
GOPD - General Out-Patient Department
GP - General Practitioner
HBC - Home-Based Care
HCT- HIV Counseling and Testing
HIV – Human Immunodeficiency Virus
HPCC - Health Partners Coordinating Committee
IHSDNs - Integrated Health Service Delivery Networks
IEC - Information, Education and Communication
ILO - International Labour Organisation
ITNs - Insecticide-Treated Nets
LACAs - LGA Action Committees on AIDS
LGA - Local Government Area
LGSC - Local Government Service Commission
LNG - Liquefied Natural Gas
MAP - Multi-Country HIV/AIDS Program for Africa
MCN - Managed Clinical Network
MDAs - Ministries, Departments and Agencies
M&E - Monitoring and Evaluation
MNCH – Maternal, Newborn and Child Health
MOHs - Ministries of Health
MoU - Memorandum of Understanding
NACA - National Agency for Control of AIDS
NACs - National AIDS Commissions or Councils
NASFs - National AIDS Strategic Frameworks
NGOs - Non-Governmental Organisations
NHS - National Health Service

NPHCDA - National Primary Health Care Development Agency
 NSHDP - National Strategic Health Development Plan
 NSP - National Strategic Plan
 NYSC - National Youth Service Corps
 OVC - Orphan and Vulnerable Children
 PPACA - Patient Protection and Affordable Care Act
 PPP - Public - Private Partnerships
 PEPFAR - President's Emergency Plan for AIDS Relief
 PHC - Primary Health Care
 PHCC - Primary Health Care Centre
 PLWHA - People living with HIV and AIDS
 PLHIV - People Living with HIV
 PMTCT - Prevention of Mother-to-Child Transmission
 PRRINN – Partnership for Revitalizing Routine Immunisation in Nigeria
 QALYs - Quality Adjusted Life Years
 SACAs - State Agencies for Control of AIDS
 SMLG - State Ministry for Local Government
 SMoH - State Ministry of Health
 SOPs - Standard Operating Procedures
 SSHDPs - State Strategic Health Development Plans
 SSA - sub-Saharan Africa
 STIs – Sexually Transmitted Infections
 SWAp - Sector-Wide Approach
 TB - Tuberculosis
 The Global Fund - The Global Fund to fight AIDS, Tuberculosis, and Malaria
 UK – United Kingdom
 UN - United Nations
 UNAIDS - United Nations Programme on HIV/AIDS
 UNDP – United Nations Development Programme
 UNESCO - United National Education and Scientific Organisation
 UNHCR - United Nations Humanitarian Committee for Refugees
 UNFPA - United Nations Fund for Population Activities
 UNICEF - United Nations Children's Fund
 UNODC - United Nations Office for Drug Control
 USA - United States of America
 WFP - World Food Programme
 WHO - World Health Organisation

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Chapter 1 - Introduction

This thesis concerns the ways in which global moves towards health service integration point normatively and are leading, potentially, towards more collaborative service delivery arrangements among health service units, agencies and organisations. It takes, specifically, the case of contemporary health reform in Nigeria as a site in which the pressures for integration and the adoption of collaborative working might be in evidence. The question is how such pressures are carried out and what effects they have. Most specifically, the thesis considers Nigeria's attempt to use the idea of the Managed Clinical Network (MCN) as a 'collaborative service delivery model'. The MCN is a model of integrated care that has been tried in economically advanced nations as a form of governance of health services that might operate alongside or intermingle productively with well-established bureaucratic and market forms of governance (Ahgren & Axelsson, 2007; Miller, 2008; Curry & Ham, 2010).

The thesis considers this first and foremost as a case of 'policy transfer' into a developing country setting. Nigeria's health sector is, in many ways, rather antipathetic to such an innovation. But I take the case of HIV/AIDS services as representing a context that is perhaps receptive to the development of collaborative practice: that is, it is a site that is most amenable to successful adoption. This offers an opportunity to explore how organisational and institutional factors shape forms of practice, and the extent to which organisational 'technologies' might be transferable perhaps despite institutional resistance. In short, I suggest that there is something going on here that needs to be thought through before, or if, notions of 'integrated care' can be taken forward and 'recommended' with confidence.

Thus this thesis aims to make a contribution by: (i) providing empirical data of policy transfer of the idea of the MCN, as a model of integrated care into a developing country setting; and (ii) offering a way to explore the transferability of this policy (the idea of the MCN) into such jurisdictions, that is, the predominant conditions for adoption, ahead of transfer.

1.1 Background

Health service delivery in both advanced economies and developing countries all over the world is constantly being reorganised in response to changing contexts and debates (political and technical). Questions about the appropriate role of the state in relation to the private sector (Mills, Bennett & Russell, 2001; Reich, 2002), how healthcare services are financed and managed (Sen, 2003; Mills, Bennett & Russell, 2001; Hammer & Berman, 1995; OECD, 1996), and the implications of policy choices on access and equity in healthcare for various populations are all central both to the steering of change and assessment of its effects. This research study stemmed from my interest in the global policy community's concern to improve the organisation of healthcare services in low- and middle-income countries.

The publication of the World Development Report: *Investing in Health* by the World Bank (1993) followed the Bank's commitment to market-based policies. The Report advocated the use of the private sector in health care delivery, and user fees as a way of funding health care services. It polarised the global policy community into two ideologically opposed camps, with strong positions that pitched state command and control form of health service delivery against market-based provision (Ridde, 2003; Abassi, 1999a; Ruger, 2005). One group favoured the line of argument taken by the World Bank in promoting more private sector involvement with the role of the state limited to monitoring, quality control and regulation. They argued that this approach leads to an efficient and cost-effective way of applying limited healthcare resources. The other camp, while acknowledging some inefficiencies and ineffectiveness of public sector health service delivery, insisted that the state remains the only entity that could guarantee universal access to the whole population. Citing market failures (information asymmetries, externalities) that occur with financing, consuming, and providing both personal and public health services, critics of the World Bank report argued that a strong

government is necessary to address such negative effects of private sector involvement in the health sector (Turshen, 1999; Ruger, 2003). Responding, the World Bank is said to have admitted that open markets and economic management, while necessary, are insufficient, and that good governance and strong institutions are critical for eradicating poverty in the health sector (Abassi, 1999b). And as Ruger (2005) notes, critics have demanded greater clarity from the Bank on the trade-offs between public and private financing and delivery of health services.

This introductory chapter examines a number of key issues that have, together, been recognised as an agenda of importance in the continuing process of health sector reform.

In particular, it focuses on the charge of organisational failings in health service delivery from proponents of what have become labeled as alternative ‘modes of governance’ (Powell, 1990), namely *hierarchies* (or bureaucracies) on the one hand and *markets* on the other (World Health Organisation (WHO), 2000). The World Health Organisation notes, ‘an organisational failing can result from the wrong arrangements among different parties involved in service delivery’ (WHO, 2000: 49). Each of these ways of organising health services (hierarchies and markets) has notable merits and demerits (Barr, 1994; World Bank, 1996). Hierarchies often exercise monopoly power and can abuse such power (e.g. rent seeking). They are also said to be prone to capture by vested interests: civil servants and/or health professionals and managers. In addition, they exhibit excessive rigidity and inefficient processes that produce low quality care. Though markets could respond more flexibly to the needs of patients or clients, the episodic interactions with care providers could expose patients to financial risk unless adequate arrangements for pooling financial resources and illness risks are put in place. The shortcomings of both governance systems therefore imposes

a responsibility on policy makers globally to experiment with alternative approaches aimed at combining the flexibility and responsiveness of markets, while retaining the benefits of control over achieving strategic national health objectives and financial protection of hierarchies (Lieberman, 2000; Palmer, 1999).

The World Health Organisation (WHO) (2000: 49) cites an example of the complexities of organising service provision.

A poor young woman walks to a rural government health post with her sick baby. There is no doctor at the post, and there are no drugs. But a nurse gives the mother an oral rehydration kit and explains how to use it. She tells the mother to come back in a couple of days if the baby's diarrhoea continues. The nurse sees only half a dozen patients that day. Meanwhile, at the outpatient clinic of a community hospital about an hour's drive away, several hundred patients are waiting to be seen. Some are given cursory examinations by doctors there and are not able to obtain any prescribed drugs at the hospital dispensary. When the outpatient clinic closes, even though it is still early in the day, patients who have not been seen are asked to return the next day, without being given appointments. Some of the doctors then hurry off to work in a private "nursing home" or clinic to supplement their salaries.

Other than absolute lack of resources, most of the 'symptoms and signs' displayed by this illustrative case demonstrate evidence of organisational failings; these failings lead both to loss of *efficiency* in the allocation and utilisation of available resources and loss of *equity* in the distribution of the meager health care resources across the population, and thus, in the quality and effectiveness of care provided and received. Efficiency and equity are two core ideals of any health care system, as well as attributes of high performing health care systems.

This study, which is located in health care setting in a particular country context -Nigeria, is to explore whether it can move beyond the 'tired' dilemma of policy makers, i.e. market or

hierarchy. The global ranking of the health systems by WHO in 2000 that placed the Nigerian health system 187 out of 191 countries, employed measures such as health equality in terms of child survival, responsiveness in level and distribution, and fairness in financial contribution, which are elements of efficiency and equity (WHO, 2000).

The case of Nigeria provides a site for investigation into the way in which ‘policy transfer’ can provide options for new forms of organisational practice. With the principles of market and hierarchy deeply embedded in service organisation and health care practice, and a lack of any clear experience of work to coordinate care resources, it offers an opportunity to explore the feasibility of transfer of ideas and technologies of the network. In particular, the thesis considers the feasibility of transfer of the Managed Clinical Networks (MCNs), an idea and technology that has been the focus of experiments in collaborative/network organising of health services in a number of advanced economies into a less advanced settings. Taking Nigeria as the test case, the thesis considers a fundamental question: *In what terms might the idea of managed clinical networks be considered to be transferable as a mode of governance and organisation of health services or health policy in this environment?*

1.1.1 What makes a good health system?

The WHO (2000) observed that the cardinal objective of the health system is to deliver health services that improve people’s health. Ideally, the WHO (2010a) argues that a well functioning health system will respond in a balanced way to a population’s needs and expectations by: (i) improving the health status of individuals, families and communities; (ii) defending the population against what threatens its health; (iii) protecting people against the financial consequences of ill-health; and (iv) providing equitable access to people-centred care. But there have also been several other responses to ‘what makes a good health care

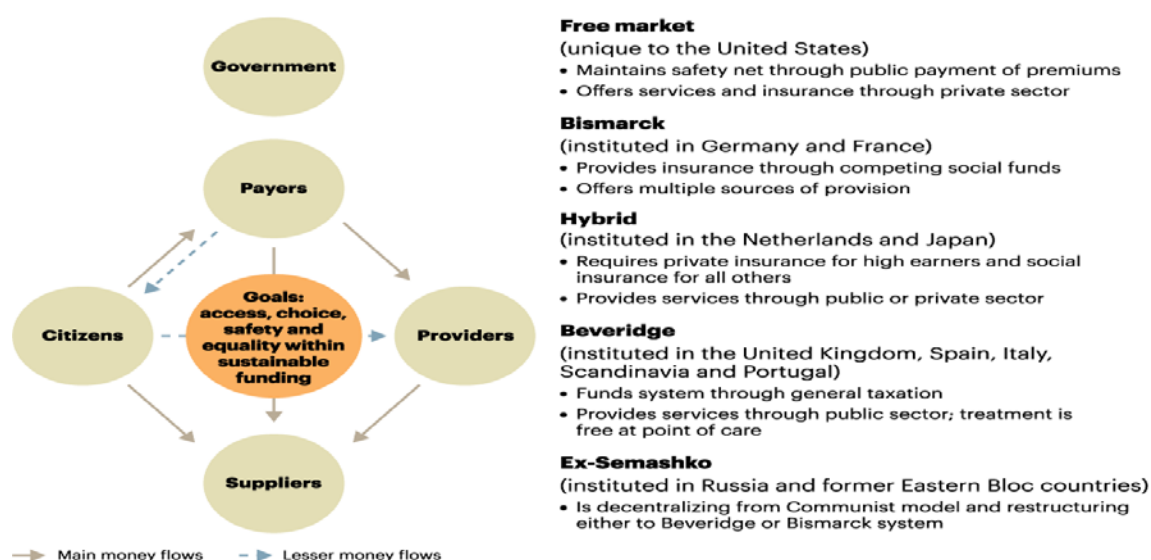
system' (Cooper & Taylor, 1994; Gillies, 2003; Balabanova, Mckee & Mills, 2011; MCE, 2014).

Health care systems are generally described by their modes of financing and provision of health care services. In Lister's (2005) typology (see Figure 1.1) they range from free-market systems at one end to public (government) monopoly at the other end. Though the United States of America (USA) is majority private financing, while that in England is wholly public, yet both healthcare systems are now considered as 'market systems' (Paton, 2013b).

Figure 1. 1 Typology of Healthcare Systems

Figure

Five basic types of healthcare systems



Source: John Lister, Health Policy Reform: Driving the Wrong Way?, (London: Middlesex University Press, 2005)

Cooper & Taylor (1994) considered that delivering high quality care to all citizens for a reasonable cost should be a straight forward matter, but discovered that a host of complex and competing issues are involved including special interests working to preserve the status quo. Comparing the performance of the USA health care system in relation to health care

financing mechanism, with the health financing arrangements in Canada, Japan, Germany and the state of Hawaii in the USA; Cooper & Taylor (1994) concluded that not one of them has a perfect system, nonetheless many seem to operate better than others.

The USA health care system produces high-quality services for those with good health insurance, but has the highest cost of health care among economically advanced countries in the world. With 15% of the population having no health insurance coverage (highest among high-income economies), the USA system also has very high administrative costs (19 – 24% of all health care costs compared to 11% in Canada). At the same time, financial incentives encourage expensive high-tech diagnosis, treatment and specialisation, while there are insufficient primary care arrangements. In contrast, the single payer system in Canada is said to provide access to care for all citizens irrespective of income, age or health status; and coverage is 'portable' - meaning residents retain their health benefits wherever they move to. Nevertheless, access to some high-tech procedures are limited due to shortage of some equipment, while cost over-runs, mainly in physician services are not unusual; and this makes provincial governments to apply cost controls mechanisms resulting in provider and public outrage about 'rationing' of care. In Japan where health care is considered as a 'right', coverage is also universal with patients having the freedom of choice among physicians and hospitals. And though each physician is paid the same fee for a given procedure, medical services are noted to be fragmented, and with lack of control on expenditures - clinics and hospitals suffer from significant duplication of services and excess capacity.

Cooper & Taylor (1994) describes the German's 'sickness fund model' as one that combines decentralised power and decision-making with an effective negotiating system that takes place at federal, state and local levels. Although coverage is also universal (and patients can

move freely among physicians), with health care costs distributed within each fund, from the young and healthy to the elderly and the ill; this is why health care administration in Germany is believed to be complex. And some of the savings in this system are said to have come from paying health professionals (not physicians) much less, as well as employing fewer health workers when compared with the USA or Canada. Moreover, with higher drug prices than in other advanced countries, German doctors are known to prescribe three times more drugs than say in the USA. While not a country, Cooper & Taylor (1994) featured the state of Hawaii's 'employer mandated plans' that provide basic package of health benefits to all residents, as well as support health promotion and prevention. Even as controls on health care expenditure are said to be maintained, this health financing approach is credited with high life expectancy and low infant mortality compared with many other states in the USA. However, it suffers from some of the major challenges that bedevils the USA health care system - increasing health insurance rates, 80% of physicians classified as specialists, and a rising cost escalation due to demand for high-tech care, despite cost controls measures in this state.

For low- and middle-income countries, faced with limited health care resources as the critical driver for making health policy decisions, Balabanova, Mckee & Mills (2011) report that the ultimate goal remains attaining good health for citizens at low cost. Showing how many low-income countries had achieved vast improvements in a number of health measures (often reaching levels comparable to those seen in developed countries); they observed that in these settings, apart from social and economic changes, health policies that gave importance to functioning health systems contributed to improved health status. The health system is seen in this context 'as a social institution working with other institutions to promote well-being rather than just providing treatment' (Balabanova, Mckee & Mills, 2011:17). Gillies (2003)

made a similar observation about health systems in developed countries, where health policy and the manner the health care systems turned out were considered to have been shaped by the values and underlying social and political expectations of health and health care. Gillies (2003) concluded that policy making in every health care system is engaged in a series of trade-offs between social values such as universality and accessibility, and key health system drivers like health financing issues, and organisational challenges. Supporting these views in *The Economist*, MCE (2014) suggested that ‘preferences and values’ tend to override raw data when it comes to judging world health systems. It reported on the rankings of health care systems by the Washington-based Commonwealth Fund (Thomson et al, 2013), which used quality, access, value for money and equity as criteria that saw the United Kingdom (UK) NHS coming tops among other 11 rich countries. Critics of this ranking pointed out that other surveys that gave different weightings and added patient choice produced a different ranking.

There is a sense therefore that, irrespective of their economic status, ethical considerations or values in several countries could dominate technical arguments such as cost-effectiveness and health gain. These may seem like political posturing but within the public domain they represent individuals’ and groups’ ideas of how best to provide health care since ‘arguments about what society *ought* to do always involve ethics’ (Roberts et al, 2004: 40). A case in point is the Healthcare reform debates about the *Patient Protection and Affordable Care Act* (PPACA) (also known as ‘Obamacare’) in the USA initiated by President Barak Obama that sought to provide affordable, quality health care for all Americans and reduce the growth in health care spending (United States Congress, 2010). On the surface, some opponents of the Obamacare claimed that they are not happy with it because ‘the new law moves America’s health care system in the wrong direction, transferring vast powers to Washington bureaucrats who will control the dollars and decisions that should be in the hands of

individual patients and their families’ (Owcharenko, 2010:1); but a close look reveals that their main complaint has to do with a fundamental belief about the American system, insisting that ‘*It Is an Unconstitutional Violation of Personal Liberty and Strikes at the Heart of American Federalism*’ (Moffit, 2011:5). Chait (2014) confirmed that the conservative critique of Obamacare has been shifting from the ‘practical to the philosophical’, as they are opposed to a National Health Insurance, which aligns with socialist ideals. On the other hand some of those in support of the law, point to the fact that the concept of social insurance has been accepted by majority of Americans as a ‘fundamental value’ since Social Security and Medicare indicate that sharing assistance to the poor, sick and the elderly is good for society (Hiltzik, 2014). It is clear that larger ethical concerns lie behind the USA health reform debates and thus has a bearing on how policy makers explain and defend their own positions, as well as understand and respond to the positions of others (Roberts et al, 2004).

In the search for alternative modes of health service delivery as this research study is attempting to do, policy makers will necessarily face these sort of ethical undertones, which heighten and colour the technical arguments. The point here is that because values such as efficiency, fairness, health improvement, individual right, quality, and access conflict with each other, having a better understanding of value-based issues in health reform debates serve as tools for making decisions on how the healthcare delivery system should be organised. As the USA health reform debates illustrated above, there were segments of the American society who valued individual liberty above efforts at improving access to health care and containing costs. At the same time, there were groups that attached high importance to the need for social solidarity than individual choice. It is therefore not about finding a ‘midway policy’ to satisfy the opposing arguments but to find positions where both technical issues and value orientation are in balance. Even in resource constrained environments there is now

the realisation that technical arguments, which are not backed by social preferences and political realities (laden with value-based ideas) are unlikely to be carried through (Omaswa, 2013). Societal values therefore impinge powerfully on the types of governance (markets or hierarchies) that are seen as legitimate.

1.1.2 In search of health service delivery alternatives

Although there are some notable variations, health care services globally have been organised broadly into two categories. These are: as *hierarchies* typified by the traditional UK NHS, which delivers a standardised set of continuous/universal entitlements to health care across the population; and as *markets*, involving short-term interactions between patients and providers as seen in the USA (Williamson, 1991; Watson & Ovseiko, 2005). In several developing countries including Nigeria both organisational forms are represented (WHO, 2000). But in these resource-constrained environments both government and market failures in health service delivery have instigated the search for better organisational forms that can deliver results.

As noted by the WHO (2000), the traditional civil service hierarchical bureaucracy of government health services installed in most developing countries is inefficient and produces low quality care that is unresponsive to the needs and expectations of the populations and individuals being served. There is often fragmentation of service provision manifesting as: lack of coordination between different levels of settings of care, duplication of services and infrastructure, underutilised productive capacity, and inappropriate care locations, especially in hospitals (Montenegro et al, 2011). In such fragmented systems, Montenegro et al (2011) observed that service users experience lack of access to services, loss of continuity of care, and failure of health services to meet their needs and expectations. The alternative most

commonly pursued in health sector reforms involves a largely unregulated private sector that engaged in short-term contractual (market) interactions between patients and providers, which exposes individuals especially the poor, to financial risk of illness simply as a result of their inability to pay for personal healthcare. The private sector incentivised by financial return and not the priorities (interventions and patients) that the public sector is trying to target, may not match this requirement. The private sector then may not produce the public health goods and services that most clearly lead to better health outcomes; nor are its services well integrated into the range of services patients may require.

Health service fragmentation alongside the challenges of conventional bureaucratic health care delivery system, called for service delivery reforms (WHO, 2008a) to reorganise health care services around people's needs and expectations, while producing better health outcomes. Moreover, demographic changes consequent upon a rapidly aging population has modified the epidemiological profile leading to an increase in chronic diseases and co-morbidities, which require integration between levels and settings of care (Montenegro et al, 2011). At country level, while the search for more resources for health care continues, governments are also seeking for new ways to do more with existing resources (WHO, 2007), by optimising the contribution of health care services to health gain and equity. Therefore, though the need to integrate health services could be seen primarily as an effort to tackle the challenges of health service fragmentation; it could also be assumed to be in response to national interest to provide comprehensive, equitable, and continuous health services for populations. As Montenegro et al, (2011) reported, health service integration can contribute to better 'continuity of care', which is referred to as the degree to which a series of discrete health care events is experienced by people as coherent and inter-connected overtime, and consistent with their health needs and preferences.

If ‘service integration’ is the most important issue, which both hierarchies and markets failed to address appropriately, the idea of *networks* as an alternative mode of governance for delivering care that is integrated across time, settings and providers has been supported (Saltman, Rico & Boerma, 2006; WHO, 2000; WHO 2002; WHO, 2008a). There has been work to examine the potential of ‘networks’ as a means to integration, whether in the context of a dominant market form of governance or a hierarchy (Hamilton et al, 2005; Miller, 2008). But what is meant by ‘network’ here? Can the emerging use of ‘managed clinical networks’ as a means of resource sharing and service integration in the UK and elsewhere in the world, be relevant to the conditions of developing countries? If in principle they might be, are managed clinical networks feasible in developing countries given the conditions necessary for them to function properly? Are those conditions present or could they be created?

1.1.3 An Agenda for Reforming the Health Service Delivery System

In the past century, largely influenced by societal values and preferences, health systems across the world have undergone a series of evolutions from the establishment of national health systems, through the expansion of social health insurance schemes, to consumer-driven demand approaches. While this appeared to have been a common pattern, across many regions (McCracken & Philips, 2012), other influences including knowledge about the organisation of health services, and adjustments to economic realities are considered to have been important mediators and ‘trajectory’/ ‘pathway’ (Roberts et al, 2004, Paton, 2013b; 2014). Commenting on ‘market reforms’ in the English NHS over a period of 25 years (1987 – 2012), Paton (2014) suggested that while the NHS attracts substantial consensus around its ethical principles and goals, the initial and ongoing market reforms are derived from ideological hegemony of neo-liberalism in general rather than evidence of ideas related to health policy making. For many developing countries, the advent of the modern health

system and its progression/trajectory is mainly historical relating to a large extent on their colonial experiences and the influence of development policies (Adeniyi-Jones, 1964; Wisner, 1988; World Bank, 1993). However, for both developed and least developed nations there has been intense pressure for their health systems to meet growing expectation from the population in the face of scarce resources. As noted by Roberts et al. (2004:17):

Many countries today face a gap between what they can pay for and what they would like to provide in the health sector. Expectations continue to rise as economies improve, countries become more democratic, and media-based images spread around the globe. In almost all countries, health-care costs are increasing, due to changing demographics, evolving disease patterns, and new technology. The implications of these changes are fought out increasingly diverse, open, and egalitarian political and social processes, in countries with severe budget deficits and limited economic resources for health.

A response to this tension has been to explore how healthcare delivery systems are organised and managed on an ongoing basis. And several countries across the globe embarked on health sector reform: ‘a significant, purposeful effort to improve the performance of the health-care system’ (Roberts et al., 2004: 9) that promised new thinking and innovation to correct inadequacies found in the health system.

However, attempts at improving the equity and efficiency of health service delivery in many developing countries through health sector reform have been very disappointing due to several perceived reasons. First, it was observed that the complexities of organising better service provision in the health sector go beyond technical fixes to include political dimensions that require the proactive management of stakeholder interests (Buse et al, 2008). The lack of success with health sector reform was blamed partly on over-concentration of attention on the *content* of the reforms, while neglecting the *actors* involved in policy reforms, the *processes* contingent on developing and implementing change, and the *context*

within which policy is developed (Walt & Gilson, 1994). But of serious concern was the wholesale transfer of new ideas that were being tried out in advanced health systems to the developing world. Much of the criticism centered on the uncritical promotion of models from the National Health Service reforms of the United Kingdom by international agencies (Collins, Green & Hunter, 1994). The persistent re-organisation of the NHS within a 'market' frame of reference (Paton, 2013b) has not lost its attraction as global interest in market-driven economies keep growing.

With tax-based financing, universal coverage and primary medical care system, Collins, Green & Hunter (2000) traced international interest in the UK NHS from its inception through the adoption of general management in the 1980s, and neo-liberal approach to health sector reforms in the early and mid-1990s; down to the Labour Government's tempering of the use of the internal markets by forms of collaboration and partnership in the late-1990s. Of particular interest in the transfer of policy were features of the NHS internal market, including: the separation of purchaser and provider functions, introduction of managed competition, contracting, General Practitioner (GP) fund holding and hospital autonomy. As noted by Collins, Green & Hunter (2000), while policy makers from other countries closely followed the NHS reforms over these periods, when their countries needed to introduce market-driven health sector reforms into their public sector health systems they also often turned to the UK experience.

Consequently, persuaded (and sometimes coerced) by international donors, many developing countries 'imported' these ideas and translated neo-liberal health policies from the UK NHS into a package of health sector reform programme broadly categorised into six components (Cassels, 1995). These include: (i) improving the performance of the civil service including

improving the functioning of national ministries of health; (ii) decentralisation of the management and/or provision of health care to local government or to agencies within the health sector, including establishing self-governing hospitals or autonomous district health boards; (iii) improving the functioning of ministries of health; (iv) broadening health financing options; (v) introducing managed competition; and (vi) working with the private sector. Key observers (Berman & Bossert, 2000) noted that apart from technical capacity gaps in undertaking health systems reform, the reforms needed in the health sector require several external conditions that are difficult to achieve, especially in the lower income countries. These include a major political opportunity for change, sound leadership, stability in government over an extended period of time to allow for reforms to develop according to a coherent strategy, and significant capacities in human skills, information, and organisations. Cassels' (1995) question about the extent to which the experience of industrialised nations is relevant to the political, economic, social and institutional context prevalent in less developed countries is highly germane.

Some critiques of transfer (Collins, Green & Hunter, 2000; Buse et al, 2008) point to ethnocentrism, where policies being promoted are not backed by evidence or subject to technical consensus. Notable among these was the first wave of privatisation and cost-recovery measures; as the capacity to put reforms from other countries into context, by identifying the conditioning factors in the environment that determines policy appropriateness was lacking. Others (Walt & Gilson, 1994; Cassels, 1995) refer to the lack of fit between new reform policies and the wider health care system of the broader institutional framework that exist in the countries. Cassels (1995) noted that institutional issues now seem to account for the difference between the theoretical efficacy and actual effectiveness of health interventions in the field. And this is dependent on practical rather than research. He argued that one of the

reasons the World Bank's *World Development Report, 2003 – Investing in Health* (World Bank, 2003) gave such limited coverage to institutional issues was because of perceived scarcity of convincing published research in this field. But it could well be the economists' (in the World Bank) lack of appreciation of the specific contextual factors at play. Confirming this assertion, Cassels (1995) observed that many cost-effective interventions may fail to achieve their predicted efficacy because of failure of the delivery systems or the behaviour of people; the most important political and institutional issues (such as the chronic imbalance between salary and operational costs, the powerful professional associations, health service unions and other interest groups, and the lack of robust political leadership) are those that act to limit the health system as a whole from making cost-effective or rational choice of any kind.

These issues are important for donor agencies, whose role in 'standardised transfer of reform ideas' and implementation of global initiatives influences the shaping of policies and programmes despite not being a major source of health finance in most developing countries (Cassels, 1995). Of particular concern is the behaviour of certain agencies to promote specific reform strategies (including user charges, community financing, and use of the private sector) rather than taking a more country-specific view and helping recipient governments to analyse the implications of different options for reforms. Cassels (1995) predicted that this attitude would continue as a combination of factors: ideological conviction, national experience, and the need of some agencies to maintain an identifiable niche in the market for public and donor support, prevails. And fundamentally, as Paton (2008: 222) reflected, '... the decline of tax and spend in the developing as well as developed world means that third-way solutions (meaning neither traditional state or fully public services nor unregulated markets) are also sought in the third world'.

Clearly as outlined above, not much attention was paid to this basis for policy transfer, ‘the process by which actors borrow policies developed in one setting to develop programmes and policies within another setting (Dolowitz & Marsh, 1996: 357); and the role played by ‘knowledge actors’, in this instance, international donors who act as ‘policy entrepreneurs’ that interact with government officials and non-state actors in recipient countries (Stone, 2001).

Drawing on developing literatures in health policy, politics and policy transfer, Freeman (1999) wrote about the fascination with the idea of transfer and the degree of skepticism about whether, in practice, it means very much. Using the development of health policy on AIDS that emerged in the mid-1980s, Freeman (1999) argued that national policies were determined in practice by the international commercial availability of HIV tests, followed by new drug therapies. And these were further shaped by information exchange among networks of medical, epidemiological and health services researchers both in print and at international conferences. Local initiatives, especially some national programmes and early stages of policy making, Freeman (1999) further explained, were led by those most directly affected by the disease (gay men), with a high degree of cross national communication among activists and organisers. He concluded that the actions of each of these actors seemed to matter more than the limited inter-governmental consultations that took place, often after such events. But if ‘policy transfer’ in health care is to be significant, then state actors would be involved, he asserted - as public and parastatal agencies are usually much more powerful than health care commercial and non-profit sectors.

In a related matter, Stone (2001; 2011) and Nay (2012) directed attention to international development as an area rich in the application of policy transfer, where much of the literature

points to the role played by international development agencies as ‘international policy intermediaries’. But in health care, where the WHO for example has struggled to find a role in the European Union, much of its mission has consistently been applied to promoting exchange and transfer of health policy, where the direction of movement has been more or less been exclusively from developed to developing countries (Freeman, 1999). Collins, Green & Hunter (2000) rejected this notion of one-way process in international policy learning. They insisted that while the South can learn from the North, the North could as well learn from the South, especially in the areas of community involvement, political process, and open decision-making. Even as there has been further support for a more global focus in policy transfer (Stone, 2001), the direction of travel has remained the same.

For the purpose of this research study, my interest in the exploration of policy transfer is based on a way of thinking that helps me to see the problem of ‘the feasibility of implementing change’ within the Nigerian health system through a network mode of organising service delivery. What might be the conditions that mean that managed clinical networks are: (a) doable, and (b) sustainable in Nigeria? So far, much of the evidence of policy transfer in the health sector and in international development has served to elaborate hypotheses, rather than confirm them (Freeman, 1999). And there is also the recognition that the field of health policy is notable for the absence of studies which set to investigate the process of transfer or learning in any specific instance (Marmor, Freeman & Okma, 2005). As history tends to repeat itself with the call (WHO, 2000; 2008) for low- and middle-income countries to set up ‘clinical networks’, similar to those that have been subject of experiments in advanced economies; this research study seeks to develop a method to investigate the prevailing conditions, potential for adoption, and therefore the feasibility of networks, prior to transfer of the idea of ‘clinical networks’ into these environments. With the assumption

that different systems may produce different problems and therefore require different solutions, the task is to produce an historical and institutional analysis, which explains, why specific policies on ‘clinical networks’ developed as they did. Equally, the task is to assess why the idea and technology of ‘clinical networks’ may be promising and doable, promising but impossible or doable but not promising (Marmor, Freeman & Okma, 2005) in the Nigerian context. And these would be done with an understanding of the national institutional arrangements and the source of the pressure for policy reforms. So in contrast to generic prescriptions, this research: (a) explores the potential of an idea on the ground; and (b) seeks to link this assessment to, nuanced understanding of the conditions in which practice occurs.

In the UK for example, there has also been a continuing search for new ways of organising health services in the face of particular though different conditions. In England, as a minor part of the process of the never-ending NHS reforms, the search for economies of scale and scope has increasingly looked towards new models of service planning across clinical and geographical boundaries (Addicott, McGivern & Ferlie, 2007). These tended to favour a regulated market, although the *Calman – Hine Report* (Calman & Hine, 1995) on cancer services in England and Wales introduced the idea of systematic network provision. It was the Scottish Executive’s Health Department (Scottish Executive, 2002) that first brought the managed clinical network (MCN) as a way of integrating and sharing scarce distributed resources to improve access, quality and equity into the mainstream of health policy (Cropper, Hopper & Spencer, 2002).

Following the report of Sir David Carter of the Acute Services Review (Scottish Office, 1998), the Scottish Executive (formerly Scottish Office) of the UK National Health Service (NHS) defines a managed clinical network as *‘linked groups of health professionals and*

organisations from primary, secondary, and tertiary care working in a co-ordinated manner, unconstrained by existing professional and [organisational] boundaries to ensure equitable provision of high quality effective services' (Scottish Executive, 2002). As noted by this report, the emphasis shifts from buildings and organisations to services and patients. Consequently, Edwards (2002) observed that clinical networks have been formed using several criteria: function - pathology, emergency medicine, critical care; client group - children; disease - cancer, renal; and specialty - vascular surgery. And depending on one's outlook many of these have achieved variable degrees of success, while lessons on good practices are still being accumulated (Ferlie & Addicot, 2004; Provan & Milward, 1995).

Within the health sector globally, interest in inter-organisational networks stems from its potential benefits over hierarchies and markets in delivering care that is integrated across time, settings and providers (Saltman, Rico & Boerma, 2006; WHO, 2000; WHO 2002). Some of these benefits include: (i) service integration that leads to better health outcomes for patients (Montenegro et al, 2011); (ii) efficient use of health resources, especially scarce human resources for health in low income countries (WHO, 2008a); and increase patient satisfaction with the health services (PAHO/WHO, 2011). And as suggested by the WHO (2002: 52) these benefits can be achieved from re-organising health services around people's needs and expectations, by 'giving primary-care providers the responsibility for the health of a defined population, in its entirety: the sick and the healthy, those who choose to consult the services and those who choose not to do so'; as well as 'strengthening primary-care providers' role as coordinators of inputs of other levels of care'. In addition, the WHO (2008) is specifically advocating for the adoption of networks as an alternative service delivery model in resource poor countries in order to induce better coordination among providers through the redefinition of the power relations, which exist within health systems. As the

proposed primary care providers' coordination role gives them the administrative authority and purchasing power, it calls for situation in which discrete primary and specialist care are transformed into articulated local networks of health care service that incorporate all levels of care. Despite repeated calls by the WHO (2000; 2002, 2008a; 2010b) for the adoption of clinical networks in resource poor countries, the feasibility of the network model of service in this setting is not proven: there is no evidence to show that the concept of such integrated clinical networks could be of value in planning the future development and organisation of healthcare services in resource constrained environments, that also exhibit dominance of market and hierarchy within institutional contexts.

This research attempts to examine feasibility of clinical networks in Nigeria by mapping existing 'naturally- occurring' forms of collaborative practice in a service area in which a team-based collaboration is particularly likely - HIV/AIDS. The features of this service area include: a) a strong identity and therefore clearly bounded, b) high social interaction within the community of professionals, who are c) despite potential organisational barriers, collaborative in attitude. The study employs a case study approach in one of the 36 States in Nigeria - Rivers State, which I argue is typical of any other in the country in terms of its institutional arrangements, service delivery configurations and funding mechanisms for health care. The research study reflects on measures used to understand patterns of collaborative practice, and what difference these revealed of the HIV/AIDS service delivery teams (HIV/AIDS Programme Clusters) that have been incentivised by the Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund) in Nigeria; as compared with successful collaborative efforts in practice among similar organisations in human services, government, and other non-profit organisations. It then tries to explore the 'feasibility of

introducing systematic collaboration' into the Nigerian setting given the prevailing conditions
- as an example of policy transfer.

The prime focus is on collaboration that occurs at the service delivery point, beyond the strategic and governance levels. In this setting, it refers to collaboration among units, agencies, individual health professionals, client-groups, and resource controllers that enables health services to be delivered to a set of patients. However, with the presence of multi-level governance structure in Nigeria, such an assessment will also involve the impact of National and State institutions on how providers deliver services on the frontline. Using HIV/AIDS service provision in Rivers State as an index case of collaboration, a network under study would be viewed as either formal or informal structure that develops from the collaborative activities of the organisations, agencies or units within the network, as well as the micro-politics of individual actors as their roles intersect across organisational, sectoral and geographic boundaries (Sullivan & Skelcher, 2002).

As the aims and objectives below will reveal, this thesis has two strands: one being empirical, the exploration of the implementation of the idea of the MCN in a developing nation; and the other conceptual, comprising the feasibility of the idea of the MCN in low-income country settings and the role of a global non-governmental organisation (NGO) that aided the transfer of this knowledge. Freeman's observations (Freeman, 1999; Marmor, Freeman & Okma, 2005), noted above, are important parts of the rationale for this study. In particular, (i) much of the evidence of policy transfer in the health sector and in international development has served to elaborate hypotheses, rather than confirm them; and (ii) the field of health policy is notable for the absence of studies which set to investigate the process of transfer or learning in any specific instance.

The study will make a contribution to the field along the two strands of the thesis. Given that this research study seeks to examine the process of policy transfer of the idea of the MCN in the circumstances outlined above, it presents an opportunity to provide empirical data on the implementation of this collaborative service delivery model in a developing country setting. The key questions are: (i) whether this model of integrated care is feasible at all; (ii) whether it works and leads to service improvement that enhances health system performance; and (iii) whether it can be sustained in this resource-constrained and otherwise rather hostile environment. Secondly, by undertaking causal analysis to explain why specific policies on ‘clinical networks’ developed as they did, this study also suggests a conceptual approach to assessing the use of relatively tried and tested ideas into new contexts, in this instance, a method to investigate the conditions prevailing for adoption, ahead of transfer of the idea of the MCN into less advanced countries. Other than these two major areas of contribution to the field, multi-stakeholder groups who have to use collaborative mechanisms to deal with complex social issues in similar contexts may also find practical value in the findings of the study.

1.2 Aims and Objectives

The purpose of this study as outlined below is premised on key two assumptions:

1. Collaboration is the central problem (or issue) in any collective undertaking (Thoenig, 1998), irrespective of the nomenclature used in health care - integrated care, health networks, disease programme management; and
2. The facts of collaboration or its absence are good indicators to analyse collective actions among agencies and organisations in the health care delivery system.

Therefore the main aims of this research study are: (a) *to investigate the status (extent, character and effects) of collaborative activities as the basis for the formation and development of inter-organisational clinical networks in Nigeria; and (b) to explore the feasibility of introducing systematic collaboration into the Nigerian setting, as an example of policy transfer.*

And the specific objectives of this study are:

- i. to map and evaluate inter-professional and inter-organisational collaboration among the teams and organisations that work together to provide services for HIV/AIDS patients in ‘programme clusters’ in Rivers State;
- ii. to identify the conditions, which may indicate that the transfer of the idea of the MCN is: (a) doable, and (b) sustainable in Nigeria; and
- iii. to interpret the emerging findings as part of an assessment of the feasibility of implementing clinical health networks to enable change within the Nigerian health system.

Chapter Summary

To summarise, this chapter has highlighted that the idea of integrated care has some history, but that it remains an on-going challenge to introduce and sustain - to institutionalise - the principles and practices of collaborative service provision. I take, specifically, the idea of managed clinical networks as an idea of integration that has had traction in some parts of the world. While this experience of practical implementation of the idea of the MCN serves as a platform of learning that needs to be taken into account when considering what integration or networks might mean in resource-limited environments, there remain questions and uncertainties, not least about the range of convenience and transferability of the idea. This is

the primary rationale for this study which makes a contribution in two areas: first, in providing empirical data on what happened as in-country implementation of the idea of the MCN in Nigeria proceeded; and second, and on the basis of this experience, in offering a conceptual method to consider the feasibility of networks in low income settings and the transfer of knowledge aided by a global NGO.

1.3 Overview and Structure of the Thesis

Other than this introductory chapter, the rest of the thesis is structured into seven other chapters. Chapter 2 - *Framework for Policy and Institutional Analysis* provides a framework for understanding whether and if so, how the idea of the MCN might be transferred. It also sets out briefly the institutional arrangements obtaining in Nigeria, and in the HIV/AIDS context that might facilitate or impede the process of transfer of a health policy. As collaboration is seen as the core of networks, the next chapter, Chapter 3 establishes the *Conceptual Framework* for the study. The Chapter examines generally, theoretical accounts of collaboration as a way of understanding inter-organisational collaborations that occur in clinical networks. But these ideas are then developed and linked within a sketch of *a model of collaboration in Nigeria* (that takes into account the specific character of Nigerian institutional arrangements) and its capacity to provide a coherent analytical framework for studying the feasibility of clinical networks in Nigeria.

Chapter 4 provides a detailed description of the *Methodology*, which explains the research design, the techniques employed and the justification for using them, how the data was analysed, in addition to ethical issues raised by the research and how these were addressed. There are also some comments on: the position of the researcher in the research, and the limitations of the study.

Chapter 5 - *Policy and Institutional Analysis*, the first empirical chapter presents the institutional history analysis of HIV/AIDS programming in Nigeria and the policy reform context, while Chapter 6 presents findings of the *Cases Studies: Collaborative Links of HIV/AIDS Programme Clusters in Rivers State, Nigeria*. This chapter shows the character and traces the formation of collaborative links within the two HIV/AIDS clinical networks studied in Rivers State, Nigeria and discusses the similarities and differences between the two networks. Chapter 7 presents a *Discussion* of the findings in relation to the research question and considers the question posed for the study, whether the policy transfer as suggested by WHO is feasible.

Chapter 8, the *Conclusion*, summarises the key findings from this study and comments on the significance of these findings in relation to the literature on clinical networks. The contributions of this research to public policy and its implications for future research needs are also outlined, and a final section reflects on where this research study has taken me personally, and how this will influence my professional practice in public policy in the future.

Chapter 2 - Framework for Policy and Institutional Analysis

The introduction to the thesis indicated that integrated care, and whatever clinical networks might come to mean in a developing country setting, need to take into account the context in which clinical networks are expected to function and thrive. In this chapter, in addition to presenting an analytic outline of the overall institutional arrangements that prevail in Nigeria and the specific HIV/AIDS disease context, I propose a framework for understanding whether and if so, how the idea of the managed clinical network (MCN) might be transferred. This chapter considers ‘whether’, ‘how’ and ‘why’ a policy may travel - be transferred or borrowed - across jurisdictions, and how the particular institutional arrangements that obtain both in particular jurisdictions, and in the organisational context of a specific disease (or health issue), may facilitate or impede the process of transfer of a health policy.

The fragmentary pattern of care in Nigeria and other developing nations is a consequence of the combination of dominant modes of governance, which emphasise vertical specialisation and control, and the consumer as the integrator of market-based services. For a health problem such as HIV/AIDS, where a reliable and integrated response is required, the World Health Organisation’s concept of the clinical network (WHO, 2008a) and The Global Fund’s (The Global Fund to fight AIDS, Tuberculosis and Malaria) idea of HIV/AIDS programme clusters - networks of care based around a core facility and drugs programme - provided a ‘packaged mechanism’ for service integration (National Agency for the Control of AIDS, 2010a).

For the purpose of this thesis, The Global Fund’s ‘HIV/AIDS programme clusters’ will be taken as analogous to the idea of the ‘managed clinical network’ (MCN). Such ‘technologies’ have been trailed in practice in a number of countries affording very different institutional

conditions: notably in Australia, the USA and the UK. The Global Fund's programme clusters are usefully considered, I propose, as an instance of policy transfer. In asking whether or not the policy (the idea of the MCN) has proved to be feasible/transferable, and whether it might apply to other services, I will examine experience in Nigeria in light of evidence arising from experiments with such networks in the UK health service.

The idea of the MCN allows for a form of integrated care that is flexible: it allows two forms of integration to occur under its umbrella. First, health centres can provide access to multi-disciplinary teams/varieties of service, which are co-located; and second referral pathways between services can be specified, relevant to different times or phases in the process of care, and linking services that are not co-locatable (e.g. some in hospitals and others in community/primary settings). Marmor, Freeman & Okma (2005: 332) ask, 'how competent learning from one nation to another can take place in health care policy?'

2.1 The Issue of Policy Transfer

Some definitions of the concept of 'policy transfer' that have been offered include:

Policy transfer is concerned with 'process by which knowledge about policies, administrative arrangements, institutions and ideas in one political system (past or present) is used in the development of policies, administrative arrangements, institutions and ideas in another political system' (Dolowitz & Marsh, 2000:5).

Policy transfer tries to 'make sense of the cross-cultural transfer of knowledge about institutions, policies or delivery systems from one sector or level of governance to another level of governance in a different country' (Evans, 2009: 239).

Policy transfer is defined as the ‘transportation of policies and/or practices already in operation in one jurisdiction to another’ (Page, 2000: 2).

Policy transfer is referred to as ‘the spread of a policy – or some aspect of a policy – across units of government that occurs as a result of the adopting unit having at least some knowledge of the existence of policy in other units’ (Wolman, 2009: 1).

Though each of these definitional terms may not be considered to be superior to the other; they show the range of perspectives from which the concept is studied. It also shows the difficulty scholars and practitioners have faced in fully conceptualising the concept. As policy-makers increasingly rely upon ‘policy transfer’ in policy-making, a key question remains: ‘how and why’ policy transfer happens? (Dolowitz & Marsh, 1996: 355).

In seeking to understand the transferability of the idea of the MCNs into Nigeria, as a case of policy transfer, the extant literature on policy transfer, is reviewed to see how and why the travel of the idea of the MCN might lead to similar or different outcomes across jurisdictions. The review starts from four related articles published in *Political Studies Review* between 2011 and 2012, which provide a concerted attempt to assess and elaborate the conceptualisation and theorisation of policy transfer. The first article, ‘What We Have Learned from Policy Transfer Research? Dolowitz and March Revisited’ (Benson & Jordan, 2011) is a stocktake of the concept’s position in the overall tool-kit of policy analysis: it provides an overview on how policy transfer studies have evolved in the past two decades or so; as well as summarises some of the main answers provided in the literature on how and why transfers happen. The next two articles: ‘On the Past and Future of Policy Transfer Research: Benson & Jordan Revisited’ (Dussauge-Laguna, 2012), and ‘Policy Assemblages, Mobilities and Mutations: Toward a Multidisciplinary Conversation’ (McCann & Ward,

2012) are critical responses to the first article by Benson & Jordan (2011) mentioned above. They offer additional and contrary findings and suggestions for refining knowledge on how transfer processes take place. The fourth article, 'The Future of Policy Transfer Research' (Dolowitz & Marsh, 2012), which reprises and responds to the issues raised in the second and third articles also enriched this discourse.

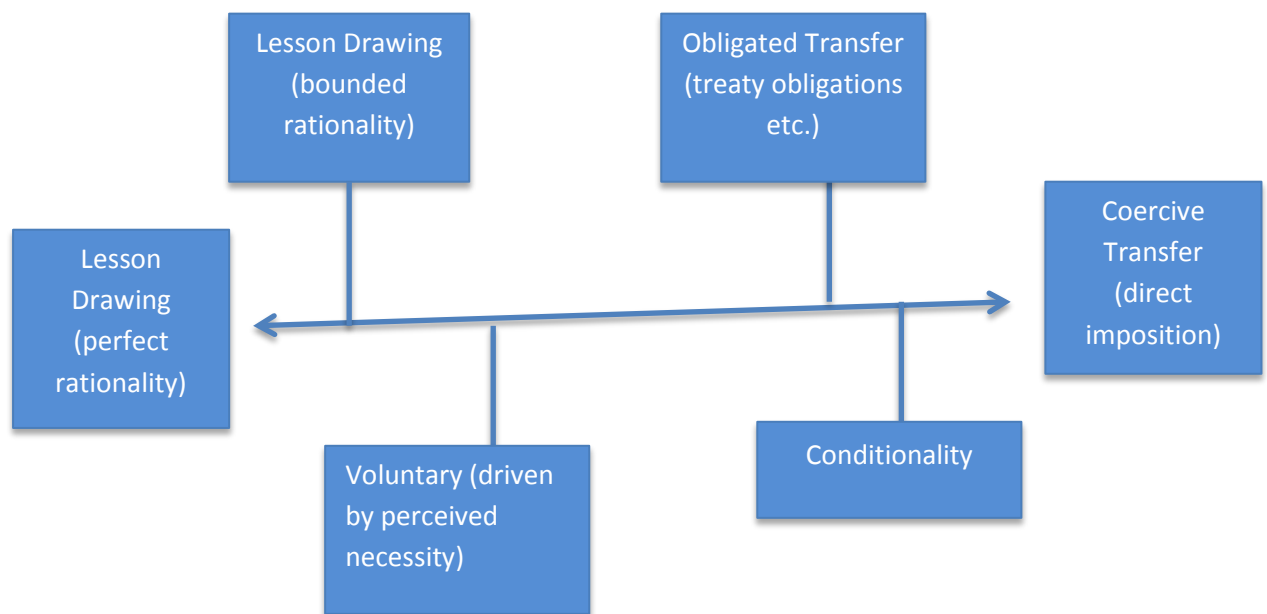
Benson & Jordan's (2011) article, 'What Have We Learned from Policy Transfer Research? Dolowitz and Marsh Revisited' uses Dolowitz & Marsh's (1996) classic review of the policy transfer literature as its starting point, assesses what has been learned by whom and for what purpose. They observe that while Dolowitz & Marsh (1996) originally identified six types of actors that might conceivably engage in transfer activities: (i) elected officials; (ii) political parties; (iii) bureaucrats/ civil servants; (iv) pressure groups; (v) policy entrepreneurs/experts; and (vi) supra-national institutions; researchers have also identified other non-state experts engaged in promoting norm transfers across national boundaries. Citing several sources they noted that these include: transnational advocacy networks, transnational philanthropic institutions, think tanks, and epistemic communities. At the same time they point out that since policy transfer has been shown to occur within horizontal and vertical networks of actors - extending across the governance scales below the state, within and across borders; sub-national institutions such as regional and local governments subject to a number of linked processes including globalisation and devolution are considered as important transfer agents. Similarly, under conditions of globalisation, the influence of transnational corporations, and intergovernmental norm diffusers such as the Organisation for Economic Cooperation and Development (OECD) and global financial institutions - shown to be significant was also noted. The influence of international agencies, especially those with global health mandates such as the WHO, Unicef, and the World Bank in the transfer of health policy ideas into

developing countries such as Nigeria has already been highlighted by this study. And as International health development has had its fair share of fads, fashions and ideologies masquerading as best practices; sooner or later these become norms that are imposed on developing countries.

On why actors engage in transfer, Benson & Jordan (2011) found refinement of Dolowitz & Marsh's (1996) distinction between voluntary and coercive forms of transfer. Reflecting on Dolowitz & Marsh's original conceptualisation, which makes the important distinction between a voluntary act of transfer by rational actors in specific contexts (sometimes labelled 'lesson learning') and transfers when one government or supra-national institution is pushing or even forcing another to adopt a set of policy innovations. They suggest that two sub-types of the coercive form of transfer have become discernable, where the critical distinguishing characteristic was cited as follows: 'direct coercive transfer' denoting the forced transfer of policy; and 'indirect coercive transfer' resulting from transnational policy externalities and mutual inter-connectedness between states.

But given that what constitutes coercive transfer in the context of international organisations may be debatable, for example in the European Union (EU) where the members states (i.e. the importers) must first approve policy innovations in the Council of Ministers, the reviewers, based on empirical data from a notable source cited a continuum of different transfer types: 'semi-coercive', 'conditionality', and 'obligatory'. Dolowitz & Marsh (2000: 13) also recognise and extend this refinement of the forms of transfer by suggesting, 'it is better to conceptualise transfer as lying along a continuum that runs from lesson-drawing to the indirect imposition of a program, policy or institutional arrangement in one political system by another' (See Figure 2.1 below).

Figure 2.1 Dolowitz & Marsh's Policy Transfer Continuum



Source: Dolowitz & Marsh (2000)

Meanwhile, at the global level Benson & Jordan (2011) identified a source that associated coercion with the activities of powerful states and/or international organisations such as the World Bank when they seek to impose their policies on other actors, especially those in the developing world. As many countries in sub-Saharan Africa (SSA) relied significantly on external funding for the control and prevention of HIV/AIDS, with the President's Emergency Plan for AIDS Relief (PEPFAR) from the United States of America, the Global Fund to fight Tuberculosis, AIDS and Malaria (The Global Fund), and the World Bank being the common major donors; their coercive actions that compelled recipient countries to adopt specific institutional arrangements have been well documented (Dickinson et al, 2008; Hongoro, Mturi & Kembo, 2008; Putzel, 2004; England, 2006). Yet for non-state actors, persuasion and voluntary transfer appear to be the main modes of operation, Benson & Jordan (2011)

observed. In any case, they emphasise that more empirical question of why and when certain types of transfer appear in particular settings and not others has still not been fully addressed.

With regards to elements of policy that are transferred, again Dolowitz & Marsh (1996) were seen to have originally listed a number of things that could in theory be transferred: policy goals, structure and content; policy instruments or administrative techniques; institutions; ideology; ideas, attitudes and concepts; and negative lessons. But the reviewers recognise that the direction of travel has moved from ‘hard’ transfer of policy instruments, institutions and programmes between governments, to the ‘softer’ transfer of ideas, ideologies and concepts; as these policy elements tend to circulate freely among non-state actors under conditions of greater globalisation. For the categorisation of the degree of transfer, Benson & Jordan (2011) further observed has moved from terms used to represent forms such as: copying, emulation, hybridisation, synthesis and inspiration; to include categories that denote: photocopying, copying, adaptation, hybrid, synthesis, disciplined inspiration and selective imitation. Several of these transfer elements can be seen exemplified in SSA, right from the start of health sector reforms in the 1980’s and the 1990’s up to the present moment.

In relation to where policies are *transferred from*, Benson & Jordan (2011) saw that growth in the policy transfer concept occurred in other ways than was originally identified by Dolowitz & Marsh (1996), that is, from both endogenous and exogenous sources of learning. Actors seeking to innovate, looked first into their own (i.e. domestic) context and policy repertoire by examining previous policy successes and failures; beyond this, policy makers tend to look at foreign political systems, and in particular those that are established innovators in specific policy area. The reviewers point out that increasing number of learning venues have subsequently been identified by scholars to include: peer-to-peer transfer between national

governments; via epistemic communities; Non Governmental Organisations (NGOs); think tanks, advocacy coalitions; and inter-governmental bodies such as OECD. They also noted that vertical channels of policy transference were also found to extend upwards and downwards from national to various sub-national levels, as well as horizontal learning between levels in different political systems. The implication of these findings, they assert, is that policy transfer activity has shifted away from its original government-centric emphasis to encompass multiple sites and actors. In Nigeria and elsewhere in SSA, the source of health policy ideas have usually come from outside, but once implemented, it is not unusual to find inter-regional transference and cross-country learning. In order to foster broad health sector reforms and specific reforms in immunisation services and HIV/AIDS control and prevention in Nigeria, 'change agents' from the health sector undertook a series of focal 'study tours' to Ghana, South Africa, Cambodia, Egypt, Tanzania, Zambia and Uganda between 2001 and 2006 (Oloriegbe, 2007).

On the issue of what factors enable or constrain transfer, Benson & Jordan (2011) identified several potential constraints relating to the inherent complexity of implementing policy programmes. These included: (a) path dependency arising from past decisions; (b) institutional and structural impediments; (c) lack of ideological compatibility between transferring countries; and (d) insufficient technological, economic, bureaucratic and political resources on the part of the receiving country to implement transferred policies. Though subsequent literature confirmed these constraints to be significant, Benson & Jordan (2011) consider that constraints could be broadly conceptualised in relation to the 'transfer process', with four types becoming apparent. These are: (i) *Demand side* factors - policy makers are often unwilling to move beyond the status quo unless forced to by unexpected shocks such as huge failure in existing policy or global economic crisis. And even where demand is

artificially created through coercive transfer, it may not necessarily be sustained due to subterfuge and even overt ‘policy resistance’ by entrenched interest. (ii) *Programmatic* factors - the specific characteristics of the policy programmes and their wider social and policy context (in the ‘exporter’s jurisdiction’) can reduce their transferability into new settings. (iii) *Contextual* factors - related to the ‘importer’s jurisdiction such as path dependency or policy layering, historical background, the relative density of institutional structures, political context, and ideological or cultural incompatibilities. (iv) *Application* factors - including the high transaction cost of institutional adjustments, the scales of domestic change required and whether policies themselves must undergo modification to ensure successful transfer. The significance of some of these factors in shaping health policy outcomes during the period of health sector reform in SSA has also been noted by this study. But Benson & Jordan (20011) observed that crucially, enough attention has not been given to policy transfer limitations in the literature.

Observing that Benson & Jordan’s (2011) delimitation of the policy transfer literature is problematic, Dussauge-Laguna (2012) asserts that drawing a clear-cut line between policy transfer and other associated fields of inquiry such as policy diffusion, lesson drawing and policy innovation is not straightforward, and thus there is the likelihood of losing more than can be gained along the way. He explains that despite methodological and theoretical differences, there are numerous overlaps between policy transfer and associated literatures - whereby the issue of how and why transfer may happen, crosses institutional isomorphism, policy convergence, and administrative reform debates. Three examples were offered:

First, Dussauge-Laguna (2012) notes that though there is a common understanding that when international organisations become involved in the process of transfer of ideas, it is likely to

result in some form of coercive policy transfer; some diffusion studies concluded something different. He cited a study on how multilateral organisations have influenced social reforms in Latin America - which argued that although the World Bank and the Inter-American Development Bank are important channels for external ideas, their influence on changes in the education and health sectors has been limited by the multiplicity of models, partly competing inputs from other international and bilateral agencies and groups, the political difficulties of reforms in these sectors, and the bank's own institutional limitations and tendencies.

The second example is related to the question of 'rationality' in cross-national policy learning. Citing a study on how Chile's pension privatisation and health sector reform models were diffused across South American countries, a 'bounded rationality' approach based on the 'heuristics' of availability, representativeness, and anchoring - was advanced. This study noted that these 'heuristics' allowed policy makers to: assign disproportionate weight to particularly striking information; overestimate the extent to which a small sample represents true population values; and limit adjustments that policymakers introduce to adapt a foreign import to the specific characteristics of their own country.

Dussauge-Laguna's (2012) final example relates to 'how ideas spread' across jurisdictions. Quoting several sources, he mentioned that what travelled in the diffusion of practices across jurisdictions was not so much a defined goal or a set of goals as a label that accommodated many goals; similarly, ideas are translated by various actors involved in their international circulation. Therefore, he concludes that what travels is not 'an idea or a practice as such, but rather accounts that undergo translation as they spread, resulting in local versions of models

and ideas in different local contexts. The question of what travels is important to this study (the travel of the idea of the MCN), both conceptually and methodologically.

In the same manner, McCann & Ward's (2012) critical response to Benson & Jordan (2011) also argues that it is important to detail and conceptualise further how policies are not merely *transferred* over space, but rather how their form and their effects are *transformed* by these journeys. Along these lines McCann & Ward (2012) offer a nascent approach to policy transfer: policy assemblages, mobilities and mutations. In summary: *Policy assemblages* - policies and territories they govern are neither entirely local constructions nor are they entirely extra-local impositions; they are parts of the near and far, of fixed and mobile pieces of expertise, regulation, institutional practices etc., that are brought together in particular ways, and for particular interests and purposes. *Policy Mobilities* - policy-making is a complex, power-laden, multiply scaled, relational and emergent social process, rather than a straightforward A-to-B movement. *Policy Mutation* - policies morph and mutate as they travel, the spaces and times of travel are not dead or unimportant, but should be taken seriously as playing a role in the shaping policy knowledge.

Both Dussauge-Laguna's (2012) and McCann & Ward's (2012) refinements of the concept of policy transfer are of particular relevance to the transfer of the idea of the integrated care to Nigeria as proposed by the WHO, and the way this is being operationalised through the incentives provided by The Global Fund for integrated HIV/AIDS service delivery in Nigeria. Clearly, the role and influence of these global actors, the actions of actors in translating policy ideas, and the key attributes of the idea itself need to be conceptualised within this broader understanding of policy transfer.

Responding to both critiques of Benson & Jordan's (2011) article, Dolowitz & Marsh (2012) whose initial work 'Who Learns What from Whom? A Review of the Policy Transfer Literature' (Dolowitz & Marsh, 1996) generated the debates as outlined above; make the point that their framework on the state of policy transfer research was intended as an heuristic and not a theory, therefore subject to various uses.

Nevertheless, Dolowitz & Marsh (2012) echoing Benson & Jordan's (2011) earlier concern, also acknowledge that the policy transfer literature raises questions at higher levels of abstraction that have never been considered. Of particular note is 'how policy transfer relates to differing modes of governance'. Reflecting that most of the governance literature distinguishes between three modes of governance - hierarchy, markets and networks, in principle, it has been argued that within late modernity these different modes coexist; though most observers of the industrialised nations see networks as replacing hierarchy as the dominant mode. However, they also make the point that 'the nature and role of policy transfer in a political system with hierarchy as the dominant mode would be very different from one in which networks are the dominant mode' (Dolowitz & Marsh, 2012: 342). This consideration is especially relevant in Nigeria where the idea of the MCN is being transferred into a governance environment that could be considered to be a mix of both the hierarchy and markets. Explaining further (Dolowitz & Marsh, 2012: 342):

If hierarchy is the dominant mode, then one would expect policy transfer to be more of top-down process – one in which it would either be at the coercive end of the Dolowitz & Marsh continuum or if it was voluntary, initiated by an agent acting at the level of the state. In contrast, if networks are the dominant mode, then one would expect the process to be a negotiated one, with other actors, both at the various levels of government and outside government, to be involved in the decision to transfer, the process of transfer and the implementation of the policies once transferred. However, even here, it is vital to consider the

different stages of the policy process, as what might originate as top-down transferred policy can be undermined by local agents involved in the implementation of the policy. Similarly, a policy may be developed in a top-down manner, but be implemented based on data local-level administrators draw from other locations in an approach that more reflects network governance.

So ‘the ‘games’ that transfer agents engage in will shape what is borrowed, where it comes from, how it is understood, how it is sold, where it is used in the policy cycle and how the information is used (reused) as a policy works its way through the development and implementation process’ (Dolowitz & Marsh, 2012: 341). In the same manner, Dolowitz & Marsh (2012) somewhat confirming the positions earlier taken by both Dussauge-Laguna (2012) and McCann & Ward’s (2012) that the use of transferred information will change depending on where an agent who is interested in using it interacts with the policy-making process, and the role the person plays in the policy’s development. They observe that, the type of transferred data necessary to place an item on the broad governing agenda will be much different from the type of information required to generate options to a problem, which will in turn be different from the type of information necessary to develop a programme on the basis of which - expenditures can be made, personnel deployed, and procedures developed to reduce or eliminate the undesirable state of affairs, without undue consequences to related activities. Furthermore, there is the likelihood that the above situation may change once a policy is enacted and enters the implementation stage, as there will be new actors who may be motivated by different needs and information requirements.

The difficulties experienced with the passing of the National Health Bill in Nigeria as part of donor-supported on-going reforms in the health sector, showed how the process faced many obstacles (in relation to strongly held ‘stakeholder positions’ based on their interpretations of

the proposed health bill), as there were many political and other vested interests in opposition. As narrated by Asoka (2013b):

An earlier attempt that got the National Health Bill to the President's table in 2011 failed to convince the President to sign the Bill into law. The current renewed efforts aimed at resolving the concerns of a broad range of stakeholders, and getting the process going again have revealed that some policies the Bill is promoting are still contentious. And despite several rounds of advocacy activities, most of the stakeholders have not shifted their position on these issues.

What all these indicate about the policy transfer process is that the motivations underpinning an agent's use of foreign information is critical to understanding the transfer of ideas into new settings (Dolowitz & Marsh, 2012).

There is also the issue of measuring whether 'transfer' has occurred and assessing the extent of 'non-transfer' (James & Lodge, 2003). This requires treating policy transfer as an independent variable, which is difficult to do as the success of a policy depends on a range of factors associated with policy-making environment and situation that are often beyond the control of those who initiated the transfer (Benson & Jordan, 2011; Dussauge-Laguna (2012; Dolowitz & Marsh, 2012). But there are attempts to validate transfer by evaluating whether it is possible to demonstrate: that peculiar domestic factors are not independently responsible for policy transfer; that similar transfers are not the result of cross-national forces with separate effects in different states; that policy-makers are aware of policies in other areas; and that evidence from elsewhere is utilised within the domestic policy debate (Bennett, 1997). James & Lodge (2003) mention approaches that propose to narrow 'transfer' and 'learning' perspective down to the transposition of 'policies' and 'practices' already in operation in one system to another, rather than 'ideas' or 'knowledge'. They report that the exploration of the extent to which the 'executive agency' model of public service delivery, as developed in the

UK, and emulated in different countries, is believed to be using a similar approach. This research too appears to be attempting to undertake a similar assessment in Nigeria, as it explores the degree to which the MCN model as designed and implemented in the UK can be transferred.

Nevertheless, Dolowitz & Marsh (2012: 340) note that the issue of whether policy transfer results into a ‘successful’ or ‘unsuccessful’ policy should rather be preceded by an obvious question: ‘what do we mean by a ‘successful’ policy?’ And there is an additional issue of ‘success for whom?’ Therefore, if policy transfer has to be treated as an independent variable and its influence on policy outcomes examined, then understanding what is meant by policy ‘success’ or ‘failure’ is critical, they insist. Citing a source that advance a distinction between three dimensions of success: (i) process success, (ii) programmatic success, and (iii) political success; Dolowitz & Marsh (2012) caution that a policy can ‘succeed’ in one dimension, or for one set of people, while ‘failing’ in another dimension, or for other sets of people. As an exploratory study, this research has proposed to undertake feasibility assessment of the idea of the MCN at three levels. First, is *operational feasibility* - whether the MCN can technically exist as a collaborative entity, since MCNs are only viable where there is higher level of relational practice? Second, is *contextual feasibility* - if the ‘conditions’ for clinical networks to function properly as politically and legally permissible bodies are right, since how the overall institutional matrix and texture that obtains in the country may constrain, shape and regulate the formation and development of the idea of the MCN in Nigeria? And third, *interventional feasibility* - how the MCN are realisable based on a defined change hypothesis and action, where the idea of the transfer of the MCN into the Nigerian healthcare setting - as a mode of organising integrated care, is a desirable health policy objective.

Finally, of particular importance and relevance of how the idea of the MCN as a form of service integration in advanced economies is transferred into a developing country setting such as Nigeria; are contextual considerations in policy transfer. As this review has also shown, there is strong recognition in the literature that policy transfer processes and outcomes are shaped by the setting and context in which they take place. ‘Indeed, it is difficult - if not impossible - to find a study dealing with policy transfer that does not recognise that ‘context matters’ in transfer processes’ (Swainson & de Loe, 2011: 59). In reviewing important contextual considerations in the policy transfer literature, Swainson & de Loe pointed out a number of aspects of a policy’s setting that must be considered for effective transfer, including its institutional and structural setting, the national political structure in which it is embedded, relationships to other policies, and the economic structure of the jurisdiction. They observed that ‘arrangements premised on the strong authority of unified central government may not be transferable to a federal state where power is shared among levels of government’ (Swainson & de Loe, 2011: 60). In Nigeria with the 36 States, each with considerable financial and political autonomy, who often contest territory in several areas of public policy making and service delivery, is a well-known fact (Asoka, 2013b).

Swainson & de Loe (2011) also note that contextual fit is also largely dependent on the extent to which institutions are compatible with the socio-cultural norms and values of the jurisdiction. They explain that policy transfer is inhibited when a jurisdiction’s social context or characteristics (such as embeddedness, trust and social capital) and political context (dominant ideology, citizen participation, role of the state) are dependent on particularly distinctive values or institutions. As would be discussed later in this chapter, the peculiar institutional context found in Nigeria imposes significant influence on how policy changes leading to desired policy outcomes can take place in this environment. Successful

implementation of policies and programmes, Swainson & de Loe (2011) further observe, demands varying levels of resources, as well as administrative and organisational capability. They clarify that the capacity of agencies responsible for implementing policies or programmes, as well as their resources - financial, human, technical, and administrative - influences how a given policy will fit in a particular environment. There is evidence to suggest that many healthcare agencies within the Nigeria health system lack 'absorptive capacity' for the financial resources, which are available from domestic sources to implement health policies and programmes (Okorosobo & Asoka, 2013). No doubt such inherent organisational difficulties could constrain successful policy transfer in this environment. Another contextual consideration in relation to policy transfer that is highlighted by Swainson & de Loe (2011) is the issue raised by Dolowitz & Marsh (1996) that even a desirable policy or programme will not be successfully transferred if implementation requires technological abilities beyond a nation's capability. This consideration is particularly relevant in the health sector in Nigeria, where scientific and technical compatibility for effective implementation of most health policy ideas is not guaranteed.

In summary, this review of the policy transfer literature recognises that policy transferability is influenced by a number of factors, ranging from attributes of policy transfer, and the ubiquity of the policy transfer process, to the context surrounding the transfer of a policy. But as indicated above, fit and transferability of a policy apart from taking all these factors (considered above) into account, could be seen to be particularly contingent on understanding the specific jurisdictional institutional context. These are in terms of the interplay between agents, structures and the intuitions that facilitate (or otherwise act as barriers to) the successful transfer of policy ideas. The next section of this chapter provides an analytical framework of the Nigeria institutional environment and discusses how change may happen in

this setting. The focus is on the challenge posed by the transfer of the idea of the MCN as a new form of governance (networks) into already existing institutional arrangements (hierarchy and markets), as framed by the ‘drivers of change’ approach to institutional analysis (World Bank, 2007). It attempts to offer a better appreciation of a country’s political economy process; and draws attention to structural and institutional factors likely to drive ‘change’ in the medium term, as well as the interests and incentives that operate in the environment for reform.

2.2 Institutional Analytical Framework

The institutional analytical framework is an attempt to present a better understanding of the institutional setting for policy transfer, in particular, the political economy of Nigeria, as a federal country, as well as the values within this jurisdiction; and to use this information to identify strategic implications for the transfer of the idea of the MCN. Nevertheless, it may be impossible to fully understand a concept independent of the structures that frame it, since the viability of the idea of the MCN, which corresponds to the HIV/AIDS service delivery teams seen in Nigeria depends on a higher degree of collaboration and other relational practices among participants. This analytical framework also incorporates an approach that sets the acts of collaboration and its emergent form into context. Specifically the context of institutional norms, incentives, and model practices that obtains in Nigeria in general, but also in healthcare, and other public services. Moreover, although the importance of institutional context in policy transfer is well recognised in the policy transfer literature; it privileges the role of agencies and ideas/narratives, while it tends to ‘downplay the importance of structures and institutions’ (Dolowitz & Marsh, 2012: 342).

Consequently Williams (2012: 23) remarks, ‘the role of individual actors is often understated in the course of collaboration work’. But it also raises a fundamental question: to what extent individuals have the ability to create change in social life in the face of enormous constraints (McAnulla, 2002). ‘The balance between structure and agency in collaboration is as contested as it is in other aspects of public governance and management’ (Walshe & Smith, 2011: 548). And as with the classical ‘Structure - Agency Debate’, what is contested is the relative importance between these two phenomena. From Williams & Sullivan’s (2009) summary: there are structuralists who believe that social, political, and economic outcomes can be explained by ‘structure’ - relating to the form, function, context, and setting (enduring features of society), provides the background against how social life is carried out; as opposed to behaviouralists who argue that ‘agency’ - referring to the volitional and purposeful nature of human activity, is the determining factor. However, Giddens (1984) provide an alternative approach by reconciling this theoretical dichotomy in viewing human action and social structures as linked by their ‘inter-dependency’.

Positing a ‘duality of structure’ Giddens (1984) suggests that structures make human actions possible, and at the same time human action creates and recreates those very structures, through time and space. Commenting on this theory, Haralambos & Holborn (2004: 969) observe that Giddens use ‘structuration’ as a single term to describe this process, and emphasised, ‘structure has no existence independent of the knowledge that agents have about what they do in their day-to-day activity’. Furthermore, ‘structural properties of social systems are both medium and outcome of the practices they recursively organise’ (Giddens, 1984: 25). Giddens identifies two aspects of structure: rules and resources. He terms rules to mean written down laws or bureaucratic rules that express the interpretations of human

agents, and through which agents communicate, exercise power, and sanction their own behaviour and that of others (Abou-Zeid, 2007). He notes that such structural rules can either be produced by human actions or they can be changed through the development of new patterns of interaction. In the same manner, Giddens (1984) observes that resources (the second aspect of structure), which take two forms: allocative and authoritative, can only come about through human actions and they can either be changed or sustained by them. Allocative resources are said to include: raw materials, land, technology, instruments of production and goods; while authoritative resources are non-material resources that result from individuals being able to dominate others (Haralambos & Holborn, 2004).

On human action, Giddens (1984) postulates that people (actors) are ‘knowledgeable agents’ with the capacity to transform situations. They are not merely passive or cultural artefacts of institutional or structural arrangements. Accordingly, as knowledgeable agents, actors use interpretive schemes to constitute and communicate meaning and then take action with intentional or unintended consequences. He argues that existence of mutual knowledge and the basic human desire for some degree of predictability; tend to provide regulations in social life. ‘Patterns of behaviour are repeated, and in this way the structure of society, the social system and institutions are all reproduced’ (Haralambos & Holborn, 2004: 970). Giddens (1984) refers to the ‘reflexive monitoring of actions’, whereby humans constantly think about what they are doing and consider whether their goals are being met; and where they are not achieved, Giddens suggests that agents may start to act in new ways that may lead to change in the patterns of interactions and with that the social structure.

In relating Giddens (1984) stand on structure and agency to collaboration, Crosby & Bryson (2010: 227) agree that ‘structuration theory, which provides a useful way of thinking about

how actions and practices create, recreate, and stabilise the structures that then provide rules and resources to draw on guide further action and collaboration'. However, Jessop (1996) taking a strategic relational approach also avoided the structure - agency dualism but expresses a slightly different view by focusing on the interaction between strategic actors and strategic context. He notes that 'structural constraints always operate selectively: they are not absolute and unconditional but always temporally, spatially, agency- and strategy- specific' (Jessop 1996: 124). As there is conceptual ambiguity that surrounds the term collaboration and other related terms associated with working across boundaries, Williams & Sullivan (2009) argue that such a situation creates opportunities for agents to shape what is meant by collaboration in a particular context, giving them considerable power over potential agendas and actions. They refer to a specific group of actors, 'boundary spanners' - who operate as 'frame articulators' helping to 'surface different meanings', and through effective interpersonal skills, networking, communication and negotiation, influence the design and implementation of collaboration. Nevertheless, Williams & Sullivan (2009) took a position that while actors make outcomes; the parameters of their capacity to act (the constraints and opportunities) are set by the structure context within which they operate. Further on, Williams (2012: 26) following Hay (2002) introduced 'ideational' factors such as user-friendly, partnership working and integration that 'combined with those of agency and structure offer a comprehensive framework to explore the interplay, direction, and force of individual factors that constitute collaborative working'.

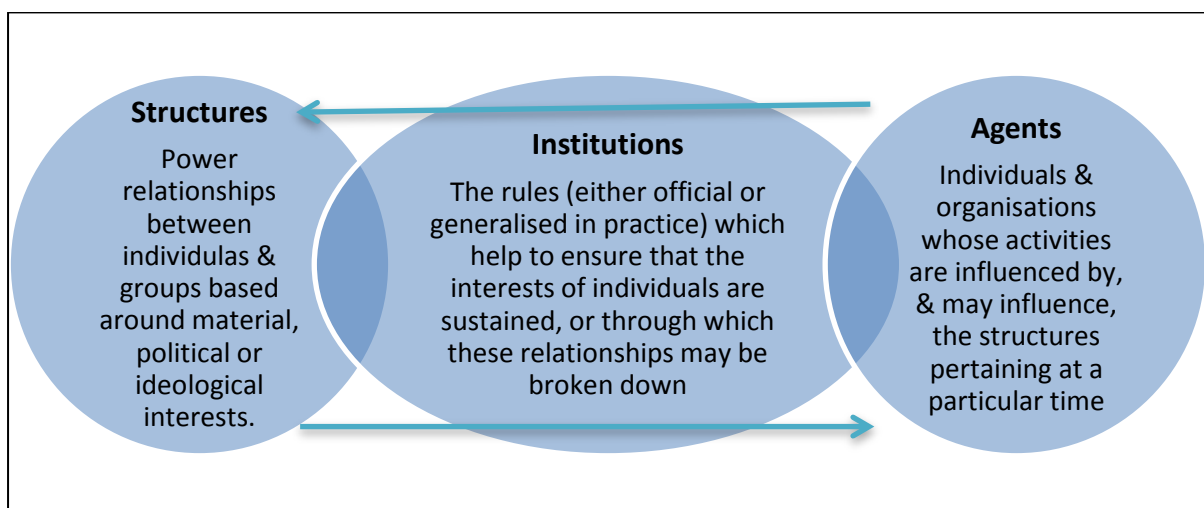
For the purpose of this research study, the concepts of 'structuration theory' offer a powerful way of conceptualising the relationships between the sort of agentive, micro-level dynamics

of relational conduct and the contexts in which such conduct is meaningful, legitimate and potentially effective.

2.2.1 Drivers of Change Analysis of Nigeria

Following the Drivers of Change initiative in Nigeria (Heymans & Pycroft, 2003), Figure 2.2 below presents the basic propositions for making this analysis. On the basis of the broader structure vs. agency debate in shaping human behaviour, as outlined above: structure refers to the recurrent patterned arrangements that influence or limit the choices and opportunities available; while agency is seen as the capacity of individuals to act independently and make their own choices (Baker, 2005). But in relation to the Drivers of Change (DoC) analysis of Nigeria (Heymans & Pycroft, 2003), *structure* is perceived as ‘power relations’, mainly between groups or classes that have access to and strive to sustain their control over power and those that do not have access but may be striving to achieve it.

Figure 2.2 – Relationship between Structures, Institutions and Agents



Source: Anyebe, Bezzano & Foot, 2005

In this instance, away from the conventional view of power as a resource exercised by more powerful actors over less powerful ones; it is the ‘power effects’ which all actors are

subjected to - the prevailing web of power relations that resides in every perception, judgement, and act, and from which the prospects of escape are limited for both dominant and subordinate groups - that is being referred to here (Lotia & Hardy, 2008). And the sources of power relations are mainly three: (i) control over material, capital, financial and human resources; (ii) control over state power; and (iii) control over ideas or ideology. *Agents* on the other hand, are seen as individuals and organisations pursuing particular interests (Heymans & Pycroft, 2003). Although they are able to operate according to individual interests, in general, it is difficult for them to act outside the influence of structural forces. And while structural forces do not determine outcomes, they can influence them heavily since collective interests are subject (sometimes forcibly) to structural forces (Agranoff & McGuire, 2003). Nonetheless, where agents can sufficiently gain access to one of the sources of power, or where certain conditions collude to weaken the position of those who currently hold it, changes in the structural relationships can be achieved.

Finally, *institutions* are considered as frameworks of rules structuring the behaviour of agents (Heymans & Pycroft, 2003). They are variously comprised of 'cultural-cognitive, normative and regulative elements that, together with associated activities and resources, provide stability and meaning to social life' (Scott 2001: 48). Thus, they are the rules or norms within which the interplay between structural constraints and the activities of agents are played out. And sometimes they are more or less represented by the rules and regulations legislated for, in addition to cultural norms that are adhered to. But in some instances the norms can deviate quite significantly from the law. But whatever happens, the institutions tend to reflect the interests of those groups or classes that are currently holding on to power. And they tend to use their influence to try to ensure that the institutions favour the continuation of their positions. While systemic change involves the relationships between these three drivers, there

is no clear-cut connection within these relationships. Heymans & Pycroft (2003) explain that agents often offer entry points for change and structures fundamentally define the scope for change, but institutions mediate between structural features and agents. Therefore, to assess collaboration within the Nigerian setting, it is important to understand how institutions have evolved, how they interact with agents and structures, and how agents contest the territory of institutions.

To illustrate, not just in health care but also in other basic services (water, sanitation, transport etc.); the middle-class in Nigeria often resorts to using private services, due to failure of public services despite paying huge taxes. But as the structural constraints do not just go away, and unable to work through institutions that have acquired structure-like characteristics; the range of influential middle-class interests can only bring about change for their benefit by intervening in the way structural elements and agents relate via existing institutions. And this has come about by working together through an ‘issue-based approach’ that defines an outcome for the common good. Similarly Nigerian film-makers in the face of daunting structural impediments have created a globally acclaimed and profitable home movie industry by altering the way the structures, institutions and agents interact through collective action (Asoka, 2010). So collaboration is about mutual adjustments by partners to and reciprocal commitment to development of one another. But as Scott (1987; 2008) argues, it is also a way of changing ‘institutional context’ that promotes and sustains collaborative practices. As noted by Asoka (2010: 1):

Knowing that fixing all the socioeconomic problems to create an environment conducive for film making – lack of basic infrastructure, bureaucratic incompetence, and high poverty levels – may never happen, a group of people who insisted on making a living from this way of life have to re-think how things are done in this industry. Since no single organisation had the

capacity to pull all the resources required to fund and manage a complex project such as film making, production management was organised as ‘temporary inter-organisational projects’.

Essentially, this involved ‘two or more organisational actors from distinct organisations working jointly to create a tangible product / service in a limited period of time’ (Jones & Lichtenstein, 2008: 234). Key elements of social relationships, such as mutual trust, knowledge of each other’s values and discipline, and a sense of belonging were noted to be critical in holding such project teams together to produce results. But as the exchanges within this ‘community of passion’ evolved from one-off encounters to repeated and durable long-term relationships among many organisations, the understandings that emerged is said to have created a rich project ecology that kept on facilitating coordination and guiding collaborative activities among organisational actors (Grabher, 2002).

Therefore irrespective of the environmental limitations, which influence the choices and opportunities available to people in Nigeria, the capacity of individuals and groups to independently take actions and make their own free choices can lead to significant outcomes. And clearly, there is no need to question if a major health problem can become an issue around which contemporary forces for change can mobilise; since stakeholders in such situations although having different values, worldviews and philosophies usually have a common outcome in mind - reduction in maternal mortality, increased quality of life for people with diabetes, or reduced incidence of malaria. HIV/AIDS as a complex social issue or ‘wicked problem’ (Rittel & Webber 1973) merits such a treatment, which is briefly discussed in the next section.

2.3 HIV/AIDS as a ‘wicked problem’

Despite having a much lower HIV/AIDS prevalence compared to several countries in sub-Saharan Africa, Nigeria has the second highest number of people living with HIV in the world after South Africa (National Agency for the Control of AIDS, 2010a). With a population of approximately 162,265,000, the National Agency for the Control of AIDS (2012) estimated that 3,459,363 people live with HIV, while about 1,449,166 of them require anti-retroviral drug treatment. It further noted that in 2011 alone 388,864 new infections and 217,148 deaths occurred. Women below 49 years are said to have the highest HIV prevalence rates, consequently mother-to-child transmission accounts for 10% of new infections. And with AIDS claiming so many lives, the life expectancy of Nigerians has declined to about 52 years (UNDP, 2011).

Chronological reports indicate that from 1986 when the first cases of HIV were reported, the Government of Nigeria (GON) was slow to respond to the increasing rates of transmission (Adeyi et al, 2006). It was only in 1991 that the Federal Ministry of Health made its first attempt to assess the HIV/AIDS situation. By which time 1.8 % of the population of Nigeria has been infected with HIV. And after a period of increasing prevalence to 5.8 % in 2001, it steadily declined to 5.0 % in 2003, and 4.4 % in 2005; and though a slight spike in the prevalence rate (4.6 %) occurred in 2008, the rate came down to 4.1 % as at 2010 (National Agency for the Control of AIDS, 2012). Nevertheless, the HIV and AIDS epidemic in Nigeria remains a public health problem of enormous magnitude that threatens the well-being of many Nigerians, burdens families, impoverishes communities, weakens institutions, and threatens the social and economic development of the country as a whole.

Thus other than just being a public health problem, HIV/AIDS transcended to become a 'complex social issue' exhibiting attributes and consequences that can be felt at all levels of

the Nigerian society (National Agency for the Control of AIDS, 2009). These have in turn helped to provide a deeper understanding of the nature of the problem at hand as efforts aimed at managing the disease assumed centre stage. And no doubt HIV/AIDS in Nigeria merited to be conceptualised, approached and addressed as a ‘wicked problem’, where the answers are incomplete, contradictory and set against changing requirements (O’Brien et al, 2008).

Following the explanations of Rittel & Webber (1973) that first exposed the concept of ‘wicked problems’, Richey (2007) simplified the nature of ‘wicked problems’ as indicated on Figure 2.3 below. It is important to frame the HIV/AIDS challenge in Nigeria in this way prior to finding solutions; to help interpret the qualities of HIV/AIDS as a complex social issue in Nigeria as outlined above. But as O’Brien et al (2008) also noted; response to wicked problems often lead to indirect adaptations that occur as a by-product of some other measures, which though are necessary but not sufficient to resolve the ‘wicked problem’ itself.

As the wicked problem frame allowed actors to embrace a multi-disciplinary approach by bringing new and often conflicting ideas to the table in search of solutions that would work, HIV/AIDS was also recognised as a cross-cutting issue that needed to be mainstreamed across all sectors of society. Sullivan & Skelcher’s (2002) description of a cross-cutting issue fitted this purpose, since the traditional medical model of disease failed to fully respond to the social and economic impact of the disease. As noted, it was not an issue that could have been successfully tackled by a single agency, nor would disjointed action lead to lasting effect. Even when considered as a medical problem, it was also observed that HIV/AIDS required

concerted action by several actors within the medical establishment, in addition to those outside it from across all sectors - public, private, voluntary and community.

Figure 2.3 The Nature of Wicked Problems

- 1. There is no definite formulation of the problem**
- 2. There is no exit strategy from the problem**
- 3. Answers are not true or false, but better or worse**
- 4. There is no immediate solution and no ultimate test of a solution**
- 5. Any intervention in a 'wicked problem' counts significantly because there is no opportunity to learn by trial and error**
- 6. 'Wicked problems' do not have a well-defined set of potential solutions**
- 7. Every 'wicked problem' is unique**
- 8. Every 'wicked problem' is a symptom of another 'wicked problem'**
- 9. The logic of explanation of a 'wicked problem' determines the solution**
- 10. Planners must be liable for the actions they generate in responding to a 'wicked problem'**

Source: Richey (2007)

Ferlie et al (2011; 2012) who examined the relationship between various public policy networks (that included Genetic Knowledge Parks, Managed Cancer Networks, Sexual Health Networks, Older People's Networks) and 'wicked problems' in the UK National Health Service (NHS) found that wicked problems existed in all cases. They noted that the networks were seen to have often worked on cross-cutting objectives across agencies, which were only realistically achievable over the long term. In addition, they observed that the actors involved comprised organisations from fragmented, multi-sectoral arenas such as the NHS, local government, Universities, voluntary and private sectors agencies, where cooperation cannot be guaranteed. Moreover, they found out that much network activity involved challenging behaviour change objectives that involved both service users and service providers. And there was some evidence of co-production and influence from users

and citizens. Ferlie et al (2011) therefore concluded that the issue of the ‘wicked problem’ was not something that is just imagined but rather a pervasive phenomenon that should be persuasive enough in designing governance modes. They finally asserted that the network is the best way for handling such wicked problems, although they called for more time for them to develop.

Therefore, even within health systems the issue of the ‘wicked problem’ cannot be said to be a UK occurrence and is shown to have wider applicability both in advanced and emerging countries. And it is valid to support the argument that network forms, as opposed to hierarchies are particularly suited to handle ‘wicked problems’ such as the impact of HIV and AIDS in Nigeria. The final section of this chapter makes the case that emerging networks formation practices for HIV/AIDS service provision, provide a suitable model for studying how the idea of the MCN, as a form of service integration can be transferred.

2.4 HIV/AIDS Service Delivery as Network Formation

Infection with the human immunodeficiency virus (HIV) leads to a chronic disease condition - acquired immune deficiency syndrome (AIDS) that requires care over a long period of time and across various settings. Moreover, with considerable impact on the socio-economic circumstances of sufferers, care of AIDS patients involves issues that have to deal with housing, livelihood, education, and human rights among others. And as already established, AIDS by its very nature (a multi-party issue) even as a health problem, cannot effectively be dealt with by a single health care organisation. It requires the delivery of a ‘service package’ in an integrated manner so that the diversity and complexity of the services provided by various agencies do not lead to fragmentation, inefficiency and confusion (Austin, 1983). Thus, People living with HIV or those, whose disease has progressed to become AIDS, often

need a variety of medical and social services ranging from clinic-based primary medical care, on-going home-based care, occasional financial support, and palliative care; throughout the duration of their illness.

Brief historical accounts of the evolution of HIV/AIDS services (Kwait, et al; 2001; Grant et al, 2004) noted that as the HIV/AIDS epidemic overwhelmed healthcare systems everywhere, especially in sub-Saharan Africa (SSA), medical and social services organisations that traditionally cared for ordinary people failed to respond to the needs of this special group of patients. In reaction to this lack of formal services for HIV/AIDS patients several organisations (local, national and foreign-based) responded by creating HIV and AIDS-specific programmes and agencies to address the diverse medical and social needs of this population of patients. As the epidemic continued to grow and with the help of global initiatives, existing organisations that were part of the traditional healthcare system also began to develop HIV/AIDS services. Eventually at the community level, an HIV/AIDS service delivery system emerged that comprised a broad range of organisations that included Hospitals, Primary Health Care Centres, Local Government Health Departments, Community-Based Organisations (CBOs), and voluntary local Non-Governmental Organisations (NGOs).

In such a differentiated service delivery environment, HIV positive clients and AIDS patients often seek care from several organisations and agencies to obtain much needed services. Consequently, Organisations and agencies that define themselves as providing care for HIV/AIDS clients/patients have a need to work collaboratively to ensure that their clients or patients receive the full range of care and no one falls through the gaps between organisations and agencies in the HIV/AIDS service delivery system that has been created. Nevertheless, clients and providers are often challenged by the fragmentation and duplication of services

that have emerged through the sudden appearance of these separate and autonomous HIV/AIDS-related organisations, agencies and programmes at the community-level. As a result, 'coordination of care' and 'development of inter-organisational relationships' have become important issues in the HIV/AIDS service delivery arena.

Kwait, et al (2001) reported a practice in Baltimore, Maryland, USA where most of the inter-organisational collaboration among HIV/AIDS agencies occurred on a rather ad hoc basis; driven by the need to meet the more immediate needs presented by clients. Though highly structured coordination, involving substantial investments in resources and relationships were also observed, these were found to be less common. Furthermore, they noted that HIV/AIDS service providers in Baltimore were inclined to work directly with others as client needs arise, rather than negotiating through 'clearing house' types of organisations. Another common practice also in the USA, is the formation of 'coalitions or consortia' of HIV/AIDS organisations, with a view to providing coordinated care for HIV/AIDS clients at the community level. Zapka et al (1992) in their case study of the Worcester (Massachusetts) AIDS consortium indicated that membership included all services and organisations in the Worcester area that has contact with high-risk individuals. However, while member activities were coordinated, member agencies still retained their autonomy. Penner (1995: 233) also acknowledged, 'mandated consortia are a popular and powerful policy instrument in responding to the HIV epidemic'. She added that such HIV consortia appeared to increase organisational interdependence and service and/or system efficiency.

In the UK, the *national strategy for sexual health and HIV* states that all HIV practitioners will be expected to work within managed service networks (Department of Health, 2001). Observing that networks provide a means of meeting the wide range of needs of people with

HIV in a coordinated way, the strategy advocated for structured collaborative working between the different services involved in their care. A charity supported by the British Medical Association - the Medical Foundation for AIDS and Sexual Health, suggested that this way of working will be necessary to enable services to implement the recommended standards for HIV services in the UK (Medical Foundation for AIDS and Sexual Health, 2003).

Thus HIV/AIDS service provision presents a good case in defining the key features of a network and for studying how a service delivery network may function.

But this study assumes that *collaboration* is the organising logic and central problem in such a service delivery network. Two main forms of collaboration required for HIV/AIDS care are described below. The first is co-production of necessary services: HIV counseling and testing, anti-retroviral therapy, treatment of opportunistic and HIV-related infections, and the chronic management of the disease in people living with HIV/AIDS (PLWHA); by a team of medical, nursing, pharmacy and laboratory professionals at any single point in time. Such a collaborative arrangement may result in centralisation (National AIDS Control Programme of Pakistan, 2006), or services configured around a lead provider (NHS England, 2013). But in either case, there should be documented ‘care pathways’ that makes it clear to patients and care givers how the pathways operate (British HIV Association, 2012). As care pathways for comprehensive management of HIV/AIDS patients go beyond the scope of specialised clinical services, the second form of collaboration required for HIV/AIDS care is inter-agency linkage of autonomous or semiautonomous service providers (NHS England, 2013). This is usually between core clinical services for HIV/AIDS care (as outlined above) and other health care services such as mental health care, ante-natal care, substance misuse care;

in addition to community services provided by community-based organisations (CBOs) and non-governmental organisations (NGOs), as well as the Association of people living with HIV/AIDS - to enhance access to other forms of care such as palliative, and other support services that are nutritional, financial and social in nature. This range of services provide support on management of a long-term condition, adherence to treatment, management of side effects of medications, counseling for other risk factors, and strengthening the capacity of people living with HIV/AIDS to undertake advocacy to reduce stigma and discrimination. Though not specifying the exact model of care delivery for HIV/AIDS in the UK, the *British HIV Association's standards for HIV care 2013*, recommended that 'collaborative working arrangements within and between HIV service providers are essential for equitable delivery of care and for maximising efficiency' (British HIV Association, 2012: 6).

Accordingly, the fact of collaboration or its absence should be good indicators for analysing how such a clinical network functions. The main task is to report on agency, structural, and institutional factors that facilitate or otherwise act as barriers against collaborative working among autonomous service providers for HIV and AIDS patients.

Chapter Summary

This chapter set out a framework outlining some aspects of the Nigerian health sector and the institutional forms that are prominent in that context, and highlighted the key elements that may facilitate or otherwise impede the process of transfer of knowledge of the idea of the MCN into the Nigerian health system. It also explained the particular setting of HIV/AIDS as a chronic disease that 'demands' strong collaborative working relationships among care providers. Together with a review of the extant literature on policy transfer, the chapter has provided a sense and analysis of the policy and institutional framework in Nigeria as a

necessary basis on which to examine whether or not the policy (the idea of the MCN) is feasible/transferable.

Chapter 3 - Conceptual Framework

The last chapter sought to establish a sufficient sense of the policy and institutional framework to provide a basis on which to examine the context into which the idea of the managed clinical network (MCN) into the Nigerian environment was to be transferred. This chapter asks: (i) what we know about the idea of the MCN, in terms of its essence; (ii) how we might think about this idea conceptually; and (iii) how this will help us to generate the empirical evidence to determine whether the idea of the MCN is transferable or not into the Nigeria setting. In this chapter, I also note attempts by countries that are implementing the idea of the MCN, in particular the UK, to learn about the validity of this idea. This knowledge is used together with the analysis of the policy and institutional framework, to propose a conceptual model through which to assess the transferability of the idea of the MCN from an advanced country setting into a developing one and to ask whether there are other dimensions of institutional context that are central to the likelihood of feasible transfer/adoption.

3.1 Concept of Networks

The notion of networks itself may mean many things to different people (Provan, Fish & Sydow, 2007). Several academic disciplines can lay claim to the use of the term ‘network’. And this has no doubt created problems in its definition. In the earliest version of networks, systematically treated in theoretical and empirical (social science) terms, a (social) network has been described as an abstract concept that refers to a set of nodes (individuals or organisations) and relationships (friendships or sharing of resources), which link them

together (Mitchell, 1969; Boissevain, 1968; Laumann, Galaskiewicz & Marsden, 1978; Fombrun, 1982). Since then various perspectives on networks have emerged, influenced by the use to which the term may be applied as well as one's conceptual framework.

In applying the idea of networks to policy-making and implementation, three distinct forms of networks have been identified (Klijn, 2008: 122). *Policy networks* are those that utilise the network approach for decision-making and consensus building among various interest groups. The focus here is on the actors that participate in decisions and those that have access to power and decision-making. This is in contrast to *inter-organisational service delivery and implementation networks*, which use networks as vehicles for service delivery and implementation of policies. The main objective is to foster collaboration as the basis for joint service production and delivery of outcomes. Finally, *governance networks* employ the network concept as a mechanism for resolving 'value conflicts that are at stake when actors try to achieve workable solutions for policy problems'. The attention in this case is directed at the process of deliberations, when several actors with different value systems need to undertake joint actions that provide solutions for difficult societal problems.

In terms of conceptual thinking there has been heavy reliance on insights from research into social network insights, with the development of relationships and the structural forms (patterns and positions) of such relationships as central themes. Thus *intra-organisational networks* refer to the sort of relationships that exist between individuals inside organisations (Raider & Krackhardt, 2002), while *egocentric networks* relate to the 'focal organisation's pattern of relationships with other organisations in the same network' (Gulati, Daldin & Wand, 2002: 281). This form of network (or organisation set) consists of the focal organisation (known as ego), a set of organisations (known as alters) that have ties with the

ego, the ties between the ego and alters and the ties between the alters (Wasserman & Faust, 1994). But rather than focus on different parts of the organisation's network, an *inter-organisational network* is seen as an organisational form whereby the entire set of relationships are integrated into a 'whole' that necessarily has to perform as a unit (Baker & Faulkner, 2002). Although conceptually, Baker & Faulkner (2002) describe these three network phenomena as Chinese boxes, one fitting into the other, there is now considerable interest on the last category - the 'network of form organisation' or 'whole network' as the unit of analysis in understanding inter-organisational relations (Provan, Fish & Sydow, 2007).

Related to the above forms are also social and professional networks, which are relationships among individuals in inter-organisational networks, whereby the interactions carry the mandate or recognition of the organisations involved (Sheaff et al, 2011). While *social networks* refer to communities of individuals, who share common interests and / or activities, or who are interested in exploring the interests and activities of others; *professional networks* in contrast focus on interactions and relationships of a business or professional nature (Bernard et al, 1990; Degenne & Forse, 1999; Dawson, 2003; Arthur & Rosseau, 1996). These are easily represented by the online versions of *Facebook* and *LinkedIn*, respectively.

In terms of set up, networks could also be said to be voluntary or mandated (Guthrie et al, 2010). The term *voluntary* refers to networks, which are found to have emerged when combinations of individuals, groups and sometimes organisations identify issues of mutual interest or mutual problems that require to be addressed, or about which they feel some degree of collaboration would be useful. In contrast, the term *mandated* refers to networks, which are created by organisations or individuals from the outset and deciding the potential

membership, as a way of seeking to counter fragmentation and co-ordinate disconnected groups to achieve an externally-identified aim.

Alter & Hage (1993) term networks as constituting the basic social form that allow inter-organisational interactions for the purpose of exchange, taking concerted action and joint production among member organisations. Networks are thus described as non-hierarchical collectives of legally separate units or clusters of organisations that may or may not be formally linked together. As an attribute, networks could be perceived as exchange systems whereby the linkages serve as conduits for the flow of information and resources (Trevillion, 1999). In this instance, functionally then, network forms of organisation with reciprocal patterns of communication and exchange are presented as attractive alternatives to hierarchies and market-based governance structures; and they are said to be suitable where organisations are involved with one another in an elaborate web of collaborative work (Powell, 1990). 'Markets' are a remarkable device for fast, simple communication, Powell noted; and they are a form of coordinating, non-coercive organisation, but they lack integrative effects. Powell (1990) also observed that hierarchies (whereby tasks are often quite specialised, and work activities are highly interdependent) are suitable in situations where: reliability - the capacity for producing large number of goods or services of a given quality repeatedly; and accountability - ability to document how resources have been used, are required. However, hierarchical forms are known to be easily destabilised when they are confronted by sharp fluctuations in demand and unanticipated changes. On the other hand, networks, Powell (1990) stressed neither involve the explicit criteria of markets, nor the familiar paternalism of hierarchies. Networks are said to exhibit mutual orientation, whereby the parties involved establish knowledge about each other and upon which they communicate and jointly solve problems.

So despite the plethora of network meanings, there are still limitations to our capacity to describe networks precisely, as well as our ability to create boundaries around them. But a way out of this dilemma and to assist inter-organisational researchers and practitioners to better understand the sort of networks they are dealing with have been offered by Knight & Pye (2006). Building on existing reviews of network research and illustrating with an empirical study of network learning, they proposed that the meaning of 'network' can be: a logic of organising; an analytic perspective; and an organisational entity (See Table 3.1 below). Combining these multiple meanings of the network, Knight & Pye (2006) further suggested an organising framework comprising these three elements to serve as a 'heuristic' approach to inform inter-organisational research theory and practice.

Elaborating, Knight & Pye (2006) explained that the 'logic of organising' meaning portrays networks as a form of governance situated between markets and hierarchies, the other two types of 'organising logic'. Following Thorelli (1986), Knight & Pye (2006) suggest a way of thinking whereby the three organising logics are seen as a continuum of institutional arrangements: from loose to tight, from arms-length bargaining to total integration, from spot transactions via standing relations to the internalisation of markets. In commercial terms, at one extreme of the spectrum is the open market of firms, while the other end represents the self-sufficient firm that is vertically or functionally integrated. In between, and in response to other significant occurrences such as globalisation and the information society, networks (distinct from markets and hierarchies) are groups of legally autonomous organisations with high levels of inter-dependence and co-operative working.

A common view of the underlying 'organising logic' (Mayntz, 1993) is outlined as follows: the logic of markets is competition; that of hierarchies is authority and obedience, while the

logic of networks is negotiation. Powell (1990) also made an attempt at summarising some of the key difference among markets, hierarchies, and networks. He noted that the basis of exchange in markets is prices, which are supported by legal sanctions through contracts or property rights. Powell (1990) observed that the value of goods to be exchanged in market situations is much more important than the relationships, and even when these matter, they are treated as commodities. However, in hierarchies where communication takes place within the context of the employment contract, relationships matter, and previous interactions tend to shape current ones. But the pattern and context of these exchanges are said to be strongly shaped by individuals' position within the formal hierarchical structure of authority. On the other hand, the network forms of exchange 'entail indefinite, sequential transactions within the context of a general pattern of interactions' (Powell, 1990: 300). Powell (1990) further noted that where sanctions apply in networks; they are considered to be normative, rather than legal. And these exchanges are considered to be guided by a philosophy of indebtedness and reliance over the long haul. In the public sector, the equivalent situations is said to be represented by partnerships and networks set up to formulate specific policies (e.g. policy networks), deliver local services or resolve difficult problems; as against the use of traditional public bureaucracies or the state leaving public management entirely to market forces. In this respect, following Mayntz's (1993) observation, Knight & Pye (2006) noted that the emergence of 'policy networks' for example, is seen as a response to the complexity of governing modern democratic societies that increasingly need consensus on a number of issues. They concluded that the network is thus regarded as a form of governance, which is characterised by negotiation and collaboration - a purposeful co-operation over time.

In this context, collaboration rather than being perceived as an organisational form is seen as the 'mode of organising in networks' different from hierarchies and markets (Williams &

Sullivan, 2007). Lawrence, Phillips & Hardy (1999: 481) define it as: 'cooperative, interorganisational relationship that relies on neither market nor hierarchical mechanisms of control but is instead negotiated in an on-going communicative process'. Lawrence, Phillips & Hardy (1999) made the point that collaboration is not mediated through market mechanisms but cooperative relationships that are alternative to the price structure. In the same manner, while members within a hierarchy are willing to submit to authority, collaboration involves the negotiation of roles and responsibility in a context where no single authority has the legitimacy to manage the situation. In essence, it could be taken that the network on its own has no intrinsic value, except what it is meant to do - collaborating, by way of interacting with the system. It is therefore not surprising that several of the network studies in the UK health care sector (Currie et al, 2010; Guthrie et al, 2010; Ferlie et al, 2010) have taken this view of the network, as they tend to consider collaboration within networks as the key relational quality. Nevertheless, while emphasising the importance of cultivating inter-personal relationships; good communication, political and negotiation skills, an appreciation of the problem structure, and identification of the potential solutions among network participants are seen as critical collaborating skills (Lawrence, Phillips & Hardy, 1999). At the same time, Williams & Sullivan (2007) also noted that the fragility of personal relationships, the creation of cliques and the tensions of multiple accountabilities are problems within networks.

On the other hand, the meaning of network as an analytical perspective as explained Knight & Pye (2006), relates to the position of network actors who face constraints and opportunities that are the sum total of all the relationships they are engaged in. They drew attention to the rich and structured context that tends to define the organisation within its institutional environment. Drawing from the literature on inter-organisational network studies, Knight &

Pye (2006) used three examples to explain this network perspective. These are: (1) an organisation may be embedded in one or more networks - for example, a firm supplying its products to several distinct industrial sectors could belong to a network in each of the sectors, and anyone of these networks could be regarded as the organisation's focal network; (2) a focal network can itself be embedded in other networks - for instance, the network of organisations providing health services for renal patients being embedded in the wider National Health Service network of England; and (3) considering individuals not just as employees of particular organisations, but also belonging to other institutions such as professional associations. Thus, network as an analytical perspective, sees networks as 'purposive social actions' taken by actors, alongside the relational and structural aspects of on-going social systems that are constantly being reproduced through interactions between situated actors (Granovetter, 1992; Araujo & Easton 1996)

In contrast, the meaning of network as an organisational entity as explained by Knight & Pye (2006), is either socially constructed or objectively seen as such. Although it can be argued that describing networks in such manners are ways of cutting the network into an understandable phenomenon either, in response to certain relational patterns or forms of identity. Using various sources from inter-organisational network studies, they noted that the definition of such a network could be based on several criteria. These include: location - based in the same geographical region (e.g. regional networks or clusters); sharing resources - technologies, suppliers or customers; specific purposes - to implement policy, to innovate, to learn, to exploit commercial opportunity etc.; as well as belonging to the same industrial or business sector. Knight & Pye (2006) further observed that this category of networks can be differentiated into whether the organisations within the network are: (a) closely and formally linked and engaged in co-operative activities to achieve a common purpose; or (b) more

loosely-linked with divergent objectives and where co-operative activities are confined to sub-set of network participants. And with the network as an organisational entity, the network ‘boundary’ although may not be obvious is important, as different criteria that identify network actors could significantly affect the composition of the network. This view therefore defines a network as ‘a group of organisations (however it is defined and bounded) that can be regarded as a unit within organisational domain’ (Knight & Pye, 2006: 5). It is considered as ‘an entity’ at system level above the three other levels of individuals, groups, and organisations.

Table 3.1: Three Meanings of Networks

View of Network	Key Features
<i>Logic of Organising</i>	<ul style="list-style-type: none"> ▪ Network as a form of governance, distinct from hierarchies and market ▪ Organising logic as criteria for differentiation: <ul style="list-style-type: none"> ○ hierarchies - authority and obedience; ○ markets - competition; ○ networks - negotiation and collaboration
<i>Analytic Perspective</i>	<ul style="list-style-type: none"> ▪ View actors and events as relationally and structurally embedded in wider social contexts ▪ Focus on particular actors and events; and assumptions about agency or cause and effect ▪ Difficult to demarcate boundaries between actors or events and their contexts
<i>Entity in organisational domain</i>	<ul style="list-style-type: none"> ▪ The inter-organisational network as a unit of analysis <ul style="list-style-type: none"> ○ What types of organisations are in the network? ○ What types of link exist between them (by purpose, by governance type and formality, by frequency and quality of interaction etc.)? ○ How is it determined whether an actor is in the network or excluded from the

	network?
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Source: Adapted from Knight & Pye (2006)

Although this research study is interested in that notion of the network that is related to its use as a means of organising health care services through inter-agency collaboration; my unit of analysis is the network as an organisational entity, with definite attributes such as goals, processes and structure, as well as linked to the external environment.

Other than understanding the nature and structure of relations between network actors, focusing on inter-organisational network as the unit of analysis provides additional insight into network processes and outcomes. For the purpose of this study, a clinical network would be seen as a service delivery inter-organisational entity, formal or informal, ad hoc or enduring, whereby participating agencies collaborate across organisational boundaries to provide quality health care services to a given set of patients. But at the same time, the rich and structured context of the clinical network could offer one the ability to see how the actions of particular network actors and significant events affect network behaviour. Therefore, in as much as this study assumes the view of the network as an entity, the logic of organising and analytic perspective views of the network are also relevant (Knight & Pye, 2006).

Meanwhile, clinical networks do not exist in isolation. As organisational forms, they operate within an institutional environment, in which they seek to establish and maintain legitimacy by re-aligning organisational behaviour in consonance with relevant rules or laws (Scott, 1995) through institutional mechanisms. Three institutional mechanisms are noted by Scott: (a) Regulatory - formal and codified approaches such as legal and regulatory frameworks, and professional standards or occupational codes; (b) Normative - broadly accepted informal

norms or values; and (c) Cognitive-cultural - culture-specific beliefs about socially appropriate behaviour and taken-for-granted practices. Slightly different from Scott's institutional pillars, DiMaggio & Powell (1983) had also identified 3 such institutional mechanisms, which forces one unit in a population to resemble other units that face the same set of environmental conditions. They include: (i) Coercive mechanisms - resulting from both formal and informal pressure exerted on organisations by other organisations upon which they are dependent or by cultural expectations in the society within which organisations function; (ii) Mimetic processes - whereby organisations pattern themselves on other organisations under conditions of uncertainty that may be symbolic or real; and (iii) Normative pressure - brought on by professionalisation, whereby members of an occupation define the conditions and methods of their work, and even control the admission of new members. Bossevain (1974; 1979) argued in his work on social networks, that network analysis had to be informed by a related understanding of institutional context. And the previous chapter has extensively dealt with the specific institutional context that obtains in Nigeria, in relation to the transfer of the idea of the MCN.

In the meantime, the related concepts of 'health service integration' and 'collaborative service delivery' have to be further elaborated and their inter-relationships understood, since the attraction to the managed clinical network as a model of service organisation and governance stems from its potential for service integration through inter-agency (or inter-organisational) collaboration.

3.2 Notion of Health Service Integration

Like any concept, the Pan American Health Organisation/ World Health Organisation (PAHO/WHO) (2011) reasoned that the idea of health service integration stand the risk of

multiple interpretations and uses. Simplistically one could divide integration mechanisms in health care, which are relational in nature into two broad categories - *structural* and *functional* integration. Structural integration is taken to mean a situation in which health care organisations, agencies, and units irrespective of the level of care, or focus of care are linked to each other to produce better health outcomes for patients because they have a common source of funding and/or administration. Examples include: (i) the Veterans Health Administration (VHA) in the USA that employs doctors, owns and runs hospitals and medical offices, and manages the full range of care within a budget allocated by the federal government; and (ii) Kaiser Permanente - the largest non-profit health maintenance organisation serving 8.7 million people in eight regions also in the USA, in which the health plans, hospitals and medical groups in each region are distinct organisations that are linked through exclusive and interdependent contracts (Curry & Ham, 2011).

By contrast, functional integration is effected in arrangements, which configure the relationships between health care organisations, agencies and units so as to achieve a special activity, purpose or task, irrespective of the level of care, funding mechanism or administrative control. Though a functionally integrated care arrangement may take a particular form, it is designed to be practical and useful, rather than attractive. Notable examples are: (a) 'chains of care' in Sweden, and (b) 'managed clinical networks' in Scotland (Ahgren & Axelsson, 2007; Curry & Ham, 2010). These are ways in which attempts are made to co-ordinate or integrate care for patients and populations with specific conditions (Curry & Ham, 2010). Chains of care seek to meet the needs of patients with a particular condition by linking primary care; hospital care and community care through care pathways based on local agreements between providers. Typically this might include a screening element in a primary care centre, treatment plans developed at a specialist centre at the local

hospital and rehabilitation provided in the community. Managed clinical networks that have been established in the Scotland to strengthen coordination between organisations and clinicians, Curry and Ham (2010) observed, are similar to chains of care in many ways. The objective of networks, they explained, was to create a working relationship among organisations and individuals to improve the treatment of people with certain conditions who require care across a range of organisations and agencies. So managed clinical networks have been conceived on a number of scales - local, regional and national; with a range of scopes, for people with a particular disease condition - diabetes, cancer; across various specialties - neurology, cardiology; and for particular functions - emergency care, pathology (Cropper, Hopper & Spencer, 2002; Miller, 2008; Curry & Ham, 2010).

Kodner (2009) who undertook a review of the concept of integrated care elaborates this basic distinction between structural and functional forms of integration. He proposed a conceptual scheme that sees integration as a 'nested concept' with 5 different dimensions: (i) foci of integration, (ii) types of integration, (iii) levels of integration, (iv) breadth of integration, and (v) degree of integration; to differentiate integrated care archetypes.

Kodner (2009) noted that integration efforts can focus on: (1) entire communities or enrolled/rostered populations irrespective of health status, (2) vulnerable client sub-groups (e.g., the frail elderly and persons with disabilities), or (3) patients with complex illnesses (e.g., chronic conditions, some cancers).

Kodner (2009) distinguished six types of integration: (1) functional integration (different from the usage above) - the degree to which back-office and support functions are coordinated across all units, (2) organisational integration - relationships between healthcare

organisations, (3) professional integration - provider relationships within and between organisations, (4) service or clinical integration - coordination of services and integration of care in a single process across time, place and discipline), (5) normative integration - shared mission, work values and organisational/ professional culture, and (6) systemic integration - alignment of policies and incentives at the organisational level.

Related to the above dimension, integrated care also operates on five different levels, Kodner (2009) noted: (1) funding - Pooling of funds (at various levels), Prepaid capitation (at various levels); (2) administrative - Consolidation of responsibilities / functions, Inter-sectoral planning, Needs assessment / allocation chain, Joint purchasing and commissioning; (3) organisational - Co-location of services, Discharge and transfer agreements, Interagency planning and/or budgeting, Service affiliation or contracting, Jointly managed programmes / services, Strategic alliances or care networks, Consolidation, common ownership or merger; (4) service delivery - Joint training, Centralised information, intake and referral, Case management, Disease management, interdisciplinary team work, Around-the-clock (on call) coverage, Integrated information systems; and (5) clinical - Shared diagnostic criteria, Uniform, comprehensive assessment procedures, Joint care planning, Shared clinical records, Continuous patient monitoring, Common decision support tools (i.e. practice guidelines and protocols), Regular patient / family contact and on-going support.

In addition, Kodner (2009) saw that organisations link up to provide a range of clinical and functional services in two ways: (1) horizontal integration, wherein similar organisations/units at the same level join together (e.g., two hospitals), and (2) vertical integration, which involves the combination of different organisations / units at different levels (e.g., hospital, community health centre, home care agency and nursing home). But

both horizontal and vertical integration may be real or virtual (Curry & Ham 2010): (i) real integration - refers to integration through control and direct ownership of all the parts of the system (unified ownership of assets); while (ii) virtual integration - takes the form of alliances, partnerships and networks, refers to integration through relationships, not asset ownership, as a means of collaboration among system components. These concepts of integration: horizontal, vertical real and virtual are presented on Table 3.2 below.

And finally, Kodner (2009) discerned that as suggested by Leutz (1999), there are three different configurations of health-related service integration: (1) linkage - the least-change approach whereby providers work together on an ad hoc basis within major system constraints, (2) coordination - in which there is a structured, inter-organisational response involving defined mechanisms to facilitate communication, information-sharing and collaboration while retaining separate eligibility criteria, service responsibilities and funding, and (3) full integration - the most transformative combination, and refers to a 'new' entity that consolidates responsibilities, resources and financing in a single organisation or system in order to deliver and pay for the entire continuum of care.

Irrespective of the nomenclature (Integrated Health Service Delivery Network, Clinically Integrated System, Integrated Health Organisation), PAHO/WHO (2011) describes an *inter-organisational delivery system* as: 'a network of organisations that provides or makes arrangements to provide equitable, comprehensive, integrated and continuous health services to a defined population and is willing to be held accountable for its clinical and economic outcomes and the health status of the population served' (PAHO/WHO, 2011: 31).

Table 3.2 Some Concepts of Integration - Horizontal, Vertical, Real and Virtual

Concept	Definition	Observation
Horizontal Integration	The coordination of activities across operating units, which are in the same stage in the process of delivering services - when two or more organisations or services delivering care at a similar level come together.	Examples - consolidation, mergers, and shared services within a single level of care...such as mergers of acute care hospitals; formation of organisations like Care Trusts that bring together health and social care
Vertical integration	The coordination of services among operating units that are at different stages of the process of service delivery - when two or more organisations or services delivering care at different levels come together.	Examples of this type of integration are the linkages between hospitals and medical groups, outpatient surgery centres and home based care agencies. There is forward vertical integration, which is towards the patient or user, and backward vertical integration, which is towards the supply side, such as medical equipment and supply companies. Furthermore, there is the possibility of vertical integration with health insurers.
Real Integration	Integration through control and direct ownership of all of the parts of the system (unified ownership of assets)	Examples may include mergers between organisations, but a notable example is the Veteran Health Administration in the US that employs doctors, owns hospitals and manages the full range of care within a budget allocated by the federal government.
Virtual Integration	Integration through relationships, not asset ownership, as a means for collaboration among system components	Modalities that uses contracts, agreements, strategic partnerships, affiliations or franchises, which stimulate the benefits of asset ownership. This type of integration can coexist with asset ownership.

Adapted from PAHO/WHO (2011) *Integrated Health Service Delivery Networks: Concepts, Policy Options and a Road Map for Implementation in the Americas* Washington, D.C.: PAHO/WHO

And a wide range of such network service delivery models are also available, which can be arranged under three general categories: (a) systems that integrate only health workers; (b) systems that integrate workers and health facilities; and (c) systems that integrate health workers, health facilities and health insurers (PAHO/WHO, 2011).

In the USA, Australia and the UK that have been early champions of the network form of health service delivery, integration pressures are believed to have been brought on by attempts to reconcile increasing demands for health care with limited resources, in order to reduce cost and improve quality of care (Woods, 2001; Miller, 2008). As noted earlier, in the UK in particular, ‘the intention is to ensure appropriate access to the range and level of specialist knowledge and practice required to ensure consistent quality of care’ (Cropper, Hopper & Spencer, 2002: 2). Accordingly, networks are seen to have been formed focusing on: (a) a specific disease - cancer, peripheral vascular disease; (b) a specialty - cardiology, vascular surgery, neurology; and (c) a specific function - pathology, medical receiving. Cropper, Hopper & Spencer (2002) further noted that the term is seen as permitting a variety of arrangements operating at different possible scale: within a primary care trust, across primary, community, and acute care within a health district, across a number of health districts, or larger geographical area. And the key priority has been to balance resources throughout the care route, by ensuring that ‘patients do not experience delay as a result of a shortage of resource at one point in the pathway’ (Cropper, Hopper & Spencer, 2002: 2). They further suggested that networks are fundamentally a means of enabling services to be formed, or linked, across organisational boundaries, where those boundaries would otherwise have restricted the coordination of resources. However, Cropper, Hopper & Spencer (2002) point to their apparent lack of productiveness as noted by key observers; secondly, they

cautioned that since networks require time to develop and thrive, there is a need to manage the expectations of their value propositions.

The UK Department of Health (2000) recognised four types of networks in a hierarchy, from informal to the more mature formalised types. These are: (i) Clinical Association - an informal group that corresponds or meets to consider clinical topics, best practices, and other areas of interest; (ii) Clinical Forum - a more formal group that meets regularly and has an agenda that focuses on clinical topics, and possibly share, audit and formulate jointly agreed clinical protocols; (iii) Development Networks - a clinical forum that has started to develop a broader focus other than purely clinical topics, with an emphasis on service improvement; and (iv) Managed Clinical Networks - which include the function of a clinical forum, has a formal management structure with defined governance arrangements and specific objectives linked to a published strategy. There is a possibility that UK health policy-makers made this categorisation as a sort of an evolutionary process of associated network participants towards integrated service delivery (Goodwin et al, 2004; Guthrie et al, 2010; Currie et al, 2010; Ferlie et al, 2010; Sheaff et al, 2011). But what do we know about the managed clinical network as it has been implemented within the NHS in the UK? The next section provides a summary of how the idea of the MCN is seen to have worked in this environment.

3.3 Managed Clinical Networks in the UK

The suite of research studies commissioned by the National Institute for Health Research's (NIHR) Service Delivery and Organisation (SDO) programme of the National Health Service (NHS) in England provides some insight into the key principles underpinning the organisation of these entities. Three of these studies: (i) the management and effectiveness of professional and clinical networks (Sheaff et al, 2011); (ii) delivering health care through

managed clinical networks (MCNs): lessons from the North (Guthrie et al, 2010); and (iii) comparative evaluation of children's services networks: analysing professional, organisational and sector boundaries in Paediatric Nephrology, Children's Safeguarding, and Cleft Lip and Palate networks (Currie et al, 2010) - are of particular relevance to understanding how the idea of the MCN as a form of integrated care has worked.

Sheaff et al (2011) using social networks analysis and comparative case studies compared seven health networks to understand factors that promote the effectiveness of professional and clinical networks. They observed that there are two modes of network creation. Thus: 'voluntary networks' that emerged 'from below' as groupings of individuals and organisations interested in performing common tasks, which might include producing relatively intangible artefacts such as information or guidance, or more tangible tasks such as changing service provision; and 'mandated networks' that were created 'from above' by NHS management, typically by taking control of pre-existing emergent networks and then, in some cases, restructuring them. They further noted that in mandated networks, the objectives of the networks were determined by national guidance and this tends to alter network activities accordingly. While they found no evidence that network connectedness stimulated innovation-related activity; member organisations used the networks mainly to link with each other directly (in pursuit of specific tasks) and not just communicating through the network's coordinating body. Furthermore, financial incentives were seen to have played little part within the networks, as the main incentives for network members to cooperate were the expectation of practical help-in-kind and the legitimacy of evidence-based practice in knowledge management. And though there was some evidence that the more highly-connected organisations within the networks demonstrated better outcomes in terms of reductions in referrals following improved primary-secondary care co-ordination; network

outputs were predominantly intangibles - guidance, policies, etc., apart from one network (a user-controlled network) that produced tangible service changes.

The research by Guthrie et al (2010) on delivering health care through managed clinical networks in Scotland observed that while each MCN is situated within single Health Board areas, they encompass a variety of existing organisations both within and sometimes outside that area. In addition, the MCNs also incorporated people from a variety of professional backgrounds, as well as different aspects of single professions such as different medical or nursing specialties and/or roles concerned with a single medical condition or disease. On the origin of networks, they found that distinction between formal mandated networks and more informal voluntary networks was not clear-cut, since the nature of clinical work involved for participants in all MCNs demanded that at least some ties between some individuals involved in the networks were likely, prior to any formal identification of these groupings as clinical, or even Managed Clinical networks. Nevertheless, the researchers reason that since the concept of the MCN came from *policy*, the study distinguished MCNs formally established before the policy as ‘voluntary’ (since there was no requirement for them to be created); and those established after the policy as ‘mandated’ (as the policy required them to be created in every Health Board area). Based on their observations, the researchers reported that the focus of voluntary MCNs tended to be related to things they were trying to do through informal networking prior to their establishment. However, the continuation of many of the same aims and with the same participants allowed the MCNs of voluntary origins to make a smoother transition (from being informal, enclave or individualistic networks to becoming established as a MCN) than the MCNs of mandated origins. As per mandated MCNs, their creation was the predominant mutual aim of members until significant relationships among network participants were formed to allow the network to tackle other issues. But in both cases, the

establishment of relationships (which requires time) among network participants was seen to be a crucial aspect of creating an effective MCN. Again, the mandated MCNs, which presumably arrived suddenly, seem to fare worse than voluntary MCNs that had the opportunity to adapt to their MCN status over time.

Furthermore, Guthrie et al (2010) also reported that in the MCNs studied, participants were clear that the role of MCN management/leadership processes was to achieve participation and integration within the MCN in relation to the clinical topic of interest. And this was seen to be more effective when clinical and organisational aims were aligned, given that the MCNs are inter-organisational in nature, therefore lacked the direct employing and decision-making of organisations. They note that the dominant management/leadership process in MCNs, regardless of origin was 'distributed leadership' characterised by informal, negotiated style rather than one that is more directive. Although occasionally a more direct style was employed when those placed in MCN management and leadership positions sought to meet the governance obligations placed upon them through the organisational aims set out in policy documents. But this tended to have a detrimental effect on relationships and perceptions within the MCNs, though the network objectives are delivered; as participants feel there was conflict between the MCN and their employing organisations that have managerial authority over their actions. Overall, the researchers believe that 'a consensual, motivational, inclusive, facilitative, negotiated style was likely to be most successful in terms of organising, management and leadership processes in MCNs, regardless of origin' (Guthrie et al, 2010: 90).

In terms of MCN structure, Guthrie et al (2010) reported that all the MCNs studied other than minor different governance structures in relation to accountability through their host health

boards, were similar in structures with regards to activities undertaken within the MCNs. They observed that each had an MCN 'board', through which a wide variety of stakeholders were represented, and through which decisions relating to MCN activities took place. In addition, each MCN has a form of 'core group' alongside a range of 'working groups' that meet to discuss operational issues related to MCN 'board' level decisions. Nevertheless, the researchers point out that although similar on the surface, the way these MCN structures worked in practice demonstrated differences regarding MCN origins, local context and areas of clinical interest. They found that getting the right structure can help in situations where clinicians, patient representatives and managers wished to participate because the established MCN structures helped them to do things related to their areas of mutual interest. For example, the creation of working groups through which issues discussed at MCN 'board' level were progressed, allowed network participants to identify with key aspects of the MCN that is of interest to them. On the other hand, the wrong structures can undermine network participation. Unless people feel that they are doing something useful through their attendance, or they feel that a particular group they belong to has legitimacy within the MCN; they are unlikely to be actively engaged. Guthrie et al (2010) reflected on a case where this happened when structures were imported and imposed on a mandated MCN, without regard to the particular MCN's clinical area of interest, resulting to participant disengagement from the MCN. They summarise that whilst MCNs may be mandated, engagement cannot be enforced by structural means. On the involvement of patients in network structure, Guthrie et al (2010) observed that although involving patient in network structures was most developed in one of the voluntary MCNs with the creation of a 'patient council'; each of the four MCNs studied had at least one patient member of the overall MCN 'board' and one MCN (a voluntary MCN) included a national group representative. In addition, the MCNs were seen to also have included both national and local patient representatives on 'working groups'

particularly in relation to patient education. The researchers note that patient role within the MCN structures varied, including being the Chair of the overall MCN 'board'.

With respect to network resources, Guthrie et al (2010) recognise that MCNs need resources of various sorts to carry out their governance role in terms of promoting integration and coordination. They also note that other than resources associated with leadership in the form of lead clinician and manager roles; there are resource implications for other participants who attend meetings and participate on MCN 'boards' and working groups. In some instances, clinicians in particular primary care are required to fund replacement clinicians to deal with clinical duties while they are away carrying out MCN activities. They reason that where MCN funding has not kept pace with MCN development, it could lead to situations that are unlikely to be sustainable in the longer-term.

And on local learning with the MCN experiment in Scotland, Guthrie et al (2010) observed that local context was influential for all issues outlined above in relation to MCN origins and processes. They note that while one of the policy aims for MCNs was the ability to standardise access to consistently high quality services, regardless of where patients were located; their findings proved this policy objective to be impractical. They highlight some of the tensions related to context. One of which is the ways in which the requirement for MCNs to base discussions about service development on evidence-based care were incorporated in different areas. They observed that though these local issues were presented in different ways within urban and rural settings, they were more obvious within the rural Health Board areas, where the 'gold standard' might suggest doing something in a specific way but would not always deliver the best service for local people. As such MCNs processes need to be flexible in order for locally-tailored services to be delivered. Similarly, different localities

were found to have their own distinct cultural characteristics resulting to simultaneous tensions as both MCNs and locality struggled to balance the need for local services and planning to ensure equity and access to services. Guthrie et al (2010) conclude that contextual issues: overlapping aspects of geography, cultural norms, and existing organisational arrangements; combined to produce specific challenges for MCNs and this is believed to illustrate the complexities of implementing MCNs.

On the impact of MCNs, Guthrie et al (2010) found some evidence of professional perceptions of MCN impact that ranged from the relatively intangible relating to inter-professional and inter-organisational working (achieving inclusion, shared vision, and improved collaboration) to the much more tangible that concern clinical practice and patient care (changing professional practice, enhancing influence and ability to mobilise resources, and examples of service improvement). They explain that MCN participants perceived the intangible impacts (which were typically more strongly attributed to the MCNs) to be necessary but not sufficient conditions for service improvement. The researchers state that attribution of tangible changes was weaker because it was often seen either at least driven partly by other agencies or partly reliant on existing NHS organisations. They note however, that MCN participants were typically clear that MCNs facilitated and often improved implementation.

In their comparative evaluation of children's services networks, Currie et al (2010) used mixed methods (social network analysis (SNA) and qualitative field-work) to assess how the potential for leadership agency and knowledge management transcended institutional hurdles and so ensure that networks are networked. They found varied patterns of leadership across networks, encompassing a mix of more concentrated and distributed dimensions. Some

networks were seen to have showed leadership as dispersed into uni-disciplinary silos, rather than the type of distributed leadership considered more suitable for complex organisational settings such as MCNs. Though there was temporal dimension to the development of distributed leadership as a network matures. They further note that the concentration of leadership was seen to align with the need for accountability requirements, as effective leadership aligns to a large extent with professional hierarchy. At the same time, leadership influence was less about charismatic individuals and more about the status of the formal leader in the eyes of other health and social care professionals. Currie et al (2010) reason that concentrated leadership or network brokerage is necessary in the face of accountability regimes in public services but at the same time leadership needs to be distributed for high quality outcomes to be attained since the latter requires commitment and decision-making participation from those nearer the frontline of service delivery. On patterns of knowledge exchange, they found that it also reflected professional hierarchy to a large extent, where certain knowledge is privileged, in particular clinical, and even more narrowly medical knowledge. In addition, professional work arrangements prior to the implementation of networks while not ideal for co-ordination and integration purposes, provided a starting point that helped to bring disparate component knowledge together. Furthermore, co-location of network staff and local level relationships between network staff accounted for better situated-learning. Currie et al (2010) conclude that their research confirmed previous NIHR SDO research that networks seem vulnerable to institutional influences: first, due to the pattern of interactions between stakeholders that link to professional hierarchy; and second, where networks are administratively managed with emphasis on meeting centrally set targets, collaboration between stakeholders may be stymied, resulting to network fragmentation as stakeholders orientate towards the interests of their employing organisations. In such instances, policy aspirations that networks behave in a networked manner may not be met.

Overall, what these SDO studies are saying about the feasibility of implementation of MCN is that there is no one-size-fits-all model of MCNs for policy makers to follow to create these entities, because local context, including the nature of the condition (clinical interest) on which the network focuses, will influence what is best. Similarly, there is no template for the introduction of the policy of MCNs in the health sector, as the proper functioning of MCNs as network forms of organisation is contingent upon institutional influences. Another valuable insight from these studies with relevance to implementation is about the significance of the relational nature of MCNs. In summary, the studies note that MCNs are about relationships between people in different professions and organisational settings. But as with most relationships, time is needed to establish the features that make them worthwhile ventures. As Guthrie et al (2010: 81) observed: 'Relationships underpinned by mutual respect, trust and legitimacy, were only formed over time through sometimes bruising exposure to one another through MCN activities'.

Since the MCN has no inherent value except the development and maintenance of quality relationships among network participants to achieve a common aim, the next section of this chapter sets to examine the sort of relational practices expected to be relevant for the idea of the MCN to be viable.

3. 4 The issue of Collaboration

Network formation in the health sector is based on the assumption that strengthening inter-organisational (or inter-agency) collaboration will lead to improved service coordination and this in turn, will produce better health outcomes. Outcomes that are commonly suggested include: service availability; population coverage; continuity of care; client satisfaction; and

improved quality of life (Fleishman, 1990). The literature on service integration in health care particularly views the formation of networks as a means to improved coordination of inputs and to more effective achievement of desirable outcomes through service collaboration (Montenegro et al, 2011; Shortell, et al, 1996; Reynolds & Sutherland, 2013; Woods, 2001; Kodner, 2009; Huerta, Casebear & Vanderplaat, 2006; Goodwin et al, 2004; Goodwin, 2008). Alternative arguments might emphasise individual professionals repairing poor 'agency relationships' (Figueras, Robinshon & Jakubowski, 2005; Neuman & Neuman, 2007); or giving service users their own budget (personal health budget) as in the UK, so that they can integrate service provision from their consumer position (Department of Health, 2009). Nevertheless, it has been shown that in most situations where improved coordination of inputs and of outcomes is desired; inter-agency collaboration needs to be established to ensure that services can be coordinated (Gadsby, 2013; Gulliford, Naitiani & Morgan, 2006; Larkin & Dickinson, 2011; Dickinson & Glasby, 2010; Forder et al, 2012). But, what in essence is collaboration?

Collaboration like many other ill-understood concepts has come to mean many things to different persons (Schrage, 1995; Rosen, 2007). Huxham & Vangen (2005: 4) see collaboration as 'any situation in which people are working *across organisational boundaries* towards some positive end'. However, Thomson, Perry & Miller (2009: 25) emphasised that collaboration is a multidimensional variable construct, and offered a definition of collaboration based on the growing body of research:

Collaboration is a process in which autonomous or semi-autonomous actors interact through formal or informal negotiations, jointly creating rules and structures governing their relationships and ways to act or decide on the issues that brought them together; it is a process involving shared norms and mutually beneficial interaction.

At the same time, different accounts of the concept have structured it based on several dimensions. Some of these include: (i) *ad hoc* versus *continuing*; (ii) *policy making* versus *service delivery*; (iii) *response to conflict* versus *pursue mutual interest*; (iv) *formal* versus *informal*; and (v) *age (or stage)* versus *maturity (or lifecycle)*.

Defining ‘collaboration as any joint activity by two or more agencies that is intended to increase public value by their working together rather than separately’; Bardach (1998: 8) argued that the concept covered many of these different collaborative dimensions. Elaborating, Bardach (1998) contends that: (a) the nature of work is immaterial, as long as some new value is created that is of benefit to the public from the joint activity; and (b) the work can be *ad hoc* or enduring, involving intense contact among agencies or occasional meetings, has little or a lot of support, and may be undertaken unconsciously or with deliberate effort or skill. For example, ‘*ad hoc* collaborative initiatives’ are said to respond to specific needs and often dissolve when the problem is solved (Chrislip & Larson, 1994). Set against this collaborative form is ‘*continuing collaborative working*’ that is also termed *inter-organisational* or *inter-agency collaboration* (Chrislip, 2002), which usually limit participation to representatives of affected organisations. In addition, Chrislip (2002) finds *ad hoc* initiatives to be focused on policy making, whereas *inter-agency collaborations* pay attention to implementing decisions already made.

Collaborative policy making results from ‘interactions among a plurality of separate actors with separate interest, goals, and strategies’ (Scharpf, 1978: 346), aimed at achieving a collective outcome. And what emerges from such ‘collaborative dialogue can be genuine innovation – not just creative ideas, but ideas that get turned into new practices and institutions’ (Innes & Booher, 2003: 49). In support, Gray (1989: 5) sees collaboration as ‘a

process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own limitations'. Gray (1989) uses the expression 'stakeholders' to refer to those parties with an interest in the problem, while the term 'problem domain' (Trist, 1983) is used to mean the way a problem is conceptualised and bounded by the different stakeholders. Trist's (1983) definition, which Thomson, Perry & Miller (2009) followed, emphasises collaboration as a process rather than focusing on the function or goal is more specific about the means of collaboration. As noted by McCann (1983) a *problem domain* (simply looking at only the topics of individual's interest, and excluding everything else) is independent of traditional organisations and hierarchical relations and so transcends established boundaries. It therefore leads to a view of collaboration as a means of creating a richer and more comprehensive appreciation of the problem among the stakeholders than any one of them could construct alone. That is, collaboration can be seen as way of building a common understanding of a problem domain from the different perspectives of stakeholders.

Gray (1996) noted that, as well as providing a response to conflict situations, parties may also be interested in collaborating in order to address a shared vision, which provides a collective good. On this basis, Gray (1996) suggested a typology of collaborative design (See Figure 3.1 below - more like a portfolio of mechanisms that produce collaboration), which set the motivating factors for collaboration (advancing a shared vision or resolving conflicts) against the expected outcomes (exchange of information or joint agreement) from such collaborative efforts. As shown in this diagram, though 'collaborative service delivery' may demand that new programmes and/or partnerships are formed to address specific needs (Chrislip, 2002), depending on the issue of interest and how it is perceived by stakeholders, a combination of any of the collaborative mechanisms may suffice. In this instance, both the process of doing

collaborative service delivery and the collaboration (the partnership) itself that ensued from the collaborative process of joint service provision are considered as important outcomes (Sandfort & Milward, 2008) of managerial, social and political actions.

Figure 3.1: Types of Collaborative Designs

		EXPECTED OUTCOMES	
		Exchange of Information	Joint Agreements
MOTIVATING FACTORS	Advancing a shared vision	APPRECIATIVE PLANNING <ul style="list-style-type: none"> - exchange of information about visions and understanding - understanding of others' vision and expectation - fuller comprehension of problem by stakeholders - agreement on problem direction 	COLLECTIVE STRATEGIES <ul style="list-style-type: none"> - agreement reached - agreement implemented - survival of alliance - partners' goals achieved - problem alleviated
	Resolving Conflicts	DIALOGUES <ul style="list-style-type: none"> - development of trust - recognition of legitimacy of others' interests - generation of integrative ideas - on-going interaction - recommendation for action 	NEGOTIATED SETTLEMENTS <ul style="list-style-type: none"> - integrative agreement reached - agreement6 implanted - reduction in negative reactions from consultants - extent of compliance with the agreement

Source: Gray (1996)

In a later development, Gray & Wood (1991: 146) refined the aspect of collaboration related to 'pursuit of mutual interest', by further specifying the methods used in collaborating. 'Collaboration occurs when a group of autonomous stakeholders of a problem domain engage in an interactive process, using shared rules, norms, and structure, to act or decide on issues related to that domain'. Chrislip & Larson (1994) echoed this sense of collaborative action as a form of shared governance. 'It is a mutually beneficial relationship between two or more

parties to achieve common goals by sharing responsibility, authority and accountability for achieving results' (Chrislip & Larson, 1994: 5). Chrislip, (2002) also indicated that another category of collaborative initiatives other than seek consensus building, as Gray (1996) had earlier mentioned is to support mutual learning.

Also related to Gray's (1996) argument of seeing collaboration as a process rather than an organisational form; neither is collaboration a structural element as in relationships, refers to the dimension of stage of collaboration as against maturity. Suggesting that collaboration is an evolving process, at any point in time, a collaborative arrangement can only be seen at a given stage of development. And that particular stage may therefore not necessarily be described as collaboration as such. But it could be regarded as part of the process of collaborating, progressing from 'unorganised systems in which individual stakeholders act independently, if at all, with respect to the problem (Brown, 1980) to more tightly organised relationships characterised by concerted decision making among stakeholders' (Gray, 1989: 15).

Distinctions

One way of specifying the meaning of collaboration has been to distinguish collaboration from other 'prescribed states' or forms of relational practice. Mulford & Rogers (1982) differentiate collaboration from 'cooperation' and 'coordination'. They refer to 'cooperation' as interorganisational relationships characterised by *informal* trade-offs and by attempts to establish reciprocity in the absence of rules; while 'coordination' is referred to as *formal* institutional relationships among exiting networks of organisations. The idea that collaboration goes beyond (is more significant/intense than) communication, cooperation and coordination is also corroborated by Chrislip & Larson (1994). 'It is more than simply

sharing knowledge and information (communication) and more than a relationship that helps each party achieve its own goals (cooperation and coordination)’ (Chrislip & Larson, 1994: 5). In addition, Huxham (1996) emphasises that collaboration is about helping each party achieve their own objectives, and also promoting some type of jointly produced and valued outcome. But Himmelman (1996; 2001; 2002) provides perhaps the clearest, most coherent and, hence, most compelling distinction between the key forms of organisational relational practices: networking, coordinating, cooperating, and collaborating.

In Himmelman’s (1996) framework, these four forms of practices are more like a step-wise or progressive ladder in which forms of positive relational behaviour build on each other along a spectrum of complexity and commitment. Thus starting with *networking*, which is defined as ‘exchanging information for mutual benefit’; *coordinating*, in addition requires ‘altering activities and to achieve a common purpose’; while *cooperating* adds ‘sharing resources’ to the above dimension. And finally, *collaborating* sums it all together as ‘exchanging information, altering activities, sharing resources and enhancing the capacity of another for mutual benefit and to achieve a common purpose’ (Himmelman, 1996: 28). Collaboration therefore could be regarded as the end-point of progression of dynamic network formation and development, and ties well with Gray’s (1989) earlier assertion that collaboration is a process in evolution. Though with regards to collaborative service delivery, Sandfort & Milward (2008: 154) observed that formalised *service integration*, ‘in which two or more organisations work together to provide new services to their mutual clients’, could be a further step beyond this most intense form of relationship. In examining how the idea of the MCN could transfer in Nigeria as a collaborative undertaking, this model could serve as a useful frame of reference for assessing inter-professional and inter-organisational collaboration.

The discussion of definitions above, may have added to our understanding of collaboration, by mapping it in relation to other related constructs. However, in relation to exploring how the idea of the MCN may be feasible; additional (theoretical) perspectives that help to provide a deeper appreciation of the concept have also been considered. The next section presents a summary of three of such perspectives.

3.4.1 Collaboration as means of gaining ‘collaborative advantage’

According to Huxham (1996), ‘collaborative advantage’ is achieved when something unusually creative is produced that no organisation could have achieved on its own; and when each organisation, through the collaboration, is able to achieve its own objectives better than it could on its own. Organisations enter into collaborative arrangements in order to capture the collaborative advantage of working together, since they are no longer constrained by their own resources or expertise (Huxham & Vangen, 2005). Though this was the central idea from which Huxham & Vangen (2005) developed an insightful framework for understanding collaboration, they also noted that collaborative inertia (i.e. failure of collaboration) and not just the lack of collaboration often results when multi-party actors try to work together.

In any case, drawing from a wide range of cases of collaboration from several sectors, the authors started by identifying some common basis for collaborative advantage, which they listed to include the following: to have access to resources such as financial, human, and technology; to share the risk of venturing with other organisations; to achieve efficiency through economies of scale; outsourcing; for government tapping into efficient operations of commercial organisations to deliver public services; to better coordinate services for the same client group; to learn from each other; and to resolve complex societal issues that cannot be resolved by any organisation acting alone. Apart from government mandates and incentives

that encourage organisation to go into collaboration, they also gave two other reasons why organisations collaborate. Getting into one form of collaborative arrangement such as strategic alliances, joints ventures or network is said to be *part of the core strategy* of many organisations. ‘Others find themselves drawn into collaboration *somewhat less intentionally*, for example in response to an invitation from those seeking partners or because of a need to protect territory against encroachment by others’ (Huxham & Vangen, 2005: 7). Oliver (1990) who reviewed evidence that determine inter-organisational relationships suggested that the distinction between mandated and voluntary collaboration ‘is important because the explanations and consequences of relationship formation associated with each other are fundamentally different’ (Oliver, 1990: 243).

As noted earlier, the focus of voluntary MCNs are observed to be related to things the collaborative groups were trying to do through informal networking prior to their establishment (Guthrie et al, 2010). While in mandated networks, their objectives were determined by national guidance that tends to alter network activities accordingly (Sheaff et al, 2011). Furthermore, the creation of the mandated MCNs appears to be the predominant mutual aim of participants until they develop significant relationships among themselves to tackle other issues. (Guthrie et al, 2010). And as the establishment of relationships (which requires time) among network participants is crucial, voluntary MCNs that had the opportunity to adapt to their MCN status over time performed better than mandated MCNs, which presumably arrived suddenly. Though networks with voluntary origin were seen to be more effective than those which have been mandated by external agencies such as government (Goodwin et al, 2004; Human & Provan 2000; Scharpf, 1978); mandating clinical networks is noted have created space within which new forms of collaboration flourished (Guthrie et al, 2010).

As acknowledged by the Huxham & Vangen (2005), these issues have thrown some light on the rationale for collaborating, but fail to explain what collaboration is, and how it takes place in practical terms. Although they also suggested a meaning for collaboration (as presented above) they did not dwell much on it. Their main concern was directed at exposing a theory of collaborative advantage underpinned by various ‘themes in collaborative practice’. As the aim was to explore the ‘nature of collaboration in practice’, they set out to address a central question derived from two inter-related concepts. The authors’ asks why collaborative inertia is so often the outcome, if collaborative advantage was the initial intention. *Collaborative advantage*, which is the main goal for those who enter into collaborative arrangements, is to gain joint and separate advantage from collaboration; while *collaborative inertia* refers the negligible output frequently seen in collaborative arrangements, along with the extremely slow rate of progress, and hard work that accompany success.

3.4.2 Collaboration as mechanism for solving complex problems

In a bid to solve the complex problems of society - ranging from acid rain, decaying of urban infrastructure, to racial tensions and illiteracy, collaboration has been seen as an alternative strategy for addressing public concerns in relation to current political realities (Gray, 1989; Chrislip, 2002). As solutions are not forthcoming because decision makers are polarised, deadlocked in political battles, or stuck in legal wrangling - Huxham’s (1996) idea of collaborative inertia; collaboration helps to create a shared vision and joint strategies to address concerns that go beyond the purview of any particular party (Chrislip & Larson, 1994; Gray 1989).

Consequently, two main opportunities for collaborating were identified by Gray (1989): resolving conflicts and advancing shared visions. In resolving conflicts, the collaborative turn

suggests that stakeholders can transform adversarial interaction into a mutual search for information and solutions that nevertheless guarantees that their interests are well represented. On the other hand, parties who are attracted by a shared vision, enter into collaboration in order to advance the collective good of the stakeholders involved.

Using detailed case studies, Gray (1989) attempted to illustrate how collaboration was used to address issues arising from key problem domains. In a case of turning conflict into collaboration, which involved the preservation of a potentially deteriorating community, the step-by-step process by which collaboration takes place among multiple parties was illustrated. It showed that although time consuming, it followed the ‘collaborative process’ that entailed three phases as suggested by Gray (1989). They include: (i) problem setting - concerned with getting to the table so that face-to-face dialogue can begin, and during which time the situation takes an explicit form or identity that allows stakeholders to communicate about it and eventually act upon it; (ii) direction setting - where stakeholders articulate the values that guide their individual pursuits and begin to identify and appreciate a sense of common purpose or direction; and (iii) implementation - in which carefully forged agreements are implemented with particular attention to specific issues such as dealing with constituencies, building external support, structuring and monitoring the agreement and ensuring compliance. Gray (1989) also noted that other than illustrating the gradual stepwise process by which collaboration unfolds the case indicated that the process of collaborating itself impacted on the outcome, which in this case was the realisation of the community’s ‘desire to remain a well-preserved, economically sound, integrated community’ (Gray, 1989: 111).

For advancing a shared vision, Gray's (1989) illustrative examples of collaboration showed that apart from providing avenues, which could lead to increased awareness about a problem domain among stakeholders, the collaborative processes created a common value basis for future planning. Emerging from these activities may be specific agreements, in the form of partnerships, joint ventures, and coalitions to solve a shared problem or carry out the vision.

3.4.3 Collaboration as a means of building social capital

Health professionals are socialised throughout their education towards a strong discipline-based view of their clients and the services they provide, such that professional jurisdictions are often rigidly circumscribed (D'Amour et al, 2005). No doubt this outlook has contributed to an organisational culture that does not strongly support team-based work within health care. As observed by D'Amour et al (2008), while health professionals involved in collaborative activities want to work together to achieve better team outcome, they have their own interests and want to retain a degree of autonomy and independence at the same time. The recognition of institutional limits to collaboration has earlier been made by Boissevain (1968); who argued that the so called 'structural-functional' view of the world does not provide an adequate account or explanation of social life and that attention should shift (at least to some extent) from the analysis of formal institutions and corporate groups to individuals, networks and informal organisations. Boissevain (1968) modelled how the analysis of social networks among individuals together with an understanding of the prevailing institutional norms provided a powerful insight into Maltese society. Building on social network perspectives, the concept of social capital provides a useful way of examining the process by which individuals, embedded within informal, emergent relational orders, can mitigate the power of formal structures. For example, it highlights the use of brokerage skills

that enable information and practical assistance to flow across potentially closed boundaries (Trevillion, 1999).

While there is no universally accepted definition of social capital, on-going debates between different schools of thought have strengthened the theoretical base of the concept. Although several explanations of the notion tend to differentiate facets of social capital, key definitions provided by Bourdieu & Wacquant (1992); Nahapiet & Ghoshal (1998); Putnam (1993); and Coleman (1990) see social capital as a multidimensional concept.

Bourdieu & Wacquant (1992: 119) defined social capital as ‘the sum of the resources, actual or virtual, that accrue to an individual or group by virtue of possessing a durable network of more or less institutionalised relationships of mutual acquaintance and recognition’. They referred to certain features of social relationships such as interpersonal trust, norms of reciprocity, and membership of civic organisations that act as resources for individuals and facilitate collective action for mutual benefit. Coleman (1990), who identified social capital as a resource that accrues to individuals by virtue of their access to contacts, connections and linkages also noted several forms of social capital, namely: levels of trust within a social structure, ‘appropriable’ social organisations, norms and sanctions, and information channels. Social capital is therefore integral to the structure as well as the relational dimension of collaboration. And Nahapiet & Ghoshal (1998: 243) whose definition: ‘the sum of the actual and potential resources embedded within, available through and derived from the network of relationships possessed by an individual or social unit’, also confirms the multidimensional nature of social capital, insist that social capital comprises both the network and the assets that may be mobilised through that network.

The multi-dimensional nature of the concept has been subject of ‘tidying’ and ‘sorting’ among researchers. For example, Nahapiet’s (2008) review of the role of social capital in inter-organisational relationships noted and explained three dimensions of social capital: structural, relational, and cognitive - initially identified by Nahapiet & Ghoshal (1998). The *structural* dimension of social capital points to the overall pattern, and configuration of connections between actors. This dimension focuses on the advantages derived from the configuration of an actor's, individual or collective ties within the network, and the ability of an individual to make weak and strong ties to others within a system. Bridging ties and the role of brokers who fill structural holes or gaps in the network are highly emphasised (Burt, 1992; Coleman, 1990). As an example, Burt (1992) stressed that actors on either side of a structural hole circulate in different flows of information. *Relational* social capital, by contrast, looks at particular qualities (or contents) of the relationships between actors that influence behaviour, such as trusts, friendship, shared norms and mutual obligation, and identification. For example, ‘two actors can occupy a similar position in a network, however if their emotional and personal attributes differ, their actions will be different in many aspects’ (Macke & Dilly, 2010: 126). Thirdly, *cognitive* social capital refers to the representations, interpretations and systems of meanings shared between actors and, which enable or restrict their social exchange. It focuses on the shared meaning and understanding that individuals or groups have with one another. It has been argued (Abou-Zeid, 2007) that at the group level for example, ‘communities of practice’ - collections of individuals bound by informal relationships that share similar work roles and common context (Lesser & Prusak, 1999), form the basis of an organisation’s ability to create and share tacit knowledge and learn from experience.

Other than the three dimensions of social capital as outlined above, (Woolcock, 2001) also categorised social capital into three types. These are: (i) *bonding* - ties between people in similar situations or based on a sense of common identity, such as immediate family, close friends, neighbours, and people who share our culture or ethnicity ('people like us'); (ii) *bridging* - distant ties of like persons that stretch beyond a sense of shared identity, such as distant friends, work colleagues and associates; (iii) *linking* - links to people in dissimilar situations or individuals and groups entirely outside of the community, especially those further up or down the social ladder. Putnam (2000) suggested that the bonding social capital may be more inward looking and have a tendency to reinforce exclusive identities and homogeneous groups; while bridging social capital may be more outward-looking and encompass people across different social divides. Again these are seen as dimensions along which different forms of social capital can be compared, rather than a way of neatly assigning the phenomena into either-or categories, as different combinations of the three types of social capital may produce different outcomes (Field, 2003).

Drawing from inter-professional collaborative case studies D'Amour et al (2008) explained that health professionals must be mutually acquainted with each other personally and professionally if they are to develop a sense of belonging to a group and succeed in setting common objectives. Mutual acquaintance professionally in this sense means knowing each other's disciplinary frame of reference, approach to care and scope of practice. Relating this to cognitive social capital as both an enabler and impediment to the performance of inter-organisational relationships, Nahapiet (2008: 593) reported on a study of the UK health care sector (Ferlie et al, 2005), where both social and cognitive factors were responsible for differential spread of evidence-based medical innovations in multi-professional organisations:

In those cases where innovations spread effectively, professionals had a foundation of shared identity and values that encouraged and enabled their take-up of new treatments. By contrast, the cases in which innovations failed to spread were characterised by both social and cognitive or epistemological boundaries between professional groups. The former frequently involved disputes concerning social and role boundaries between doctors and nurses, the latter different assumptions about what constitutes appropriate evidence held by different professional groups.

And as noted by D'Amour et al (2008), this familiarisation process is said to occur at social occasions, training activities and formal and informal information-exchange events. But beyond knowledge of other professionals, Putnam's (1993) asserts that social capital in the sense of 'norms of generalised reciprocity' - the expectation that exchanges between two or more parties will be mutual (Nahpiet, 2008) - creates opportunities that are more open to collaboration. He argued that network of such exchanges will not only facilitate coordination and communication, as well as amplify information about the trustworthiness of other individuals; but also embody past success at collaboration, which can serve as a cultural template for future collaboration. Similarly, D'Amour et al (2008) also noted that among health professionals, collaboration is only possible when they have trust in each other's competences and ability to assume responsibilities. As observed, in situations where health professionals do not know each other well, they must constantly gauge risks and allow themselves to be placed in a vulnerable position. But as trust reduces uncertainty, in its absence, health professionals hold on to responsibility for their clients as much as possible and avoid collaborating. While such actions are not supportive of the goal of network formation, health professionals are said to use the results of collaboration to assess each other and build trust.

Related to this is the issue of power dimension as a significant contextual variable in collaboration. In this instance, power refers to the way some stakeholders are able to influence the behaviour of others partly as a result of exercising their legal rights in their official roles or their ability to control resources necessary for action. McCann & Gray (1986) commenting on power and collaboration in human service domains noted that collaboration can threaten the existing distribution of power among organisations or groups involved in collaborative ventures. Based on field experience, McCann & Gray (1986) observed that stakeholders with power gain legitimacy quickly. Others that are less powerful have to build their own capacity and power base to enable them gain access to collaborative efforts. Such countervailing efforts may result in a redistribution of power, which increases the diversity of perspectives and preventing unilateral control. These findings are supported by Fung (2002), who suggests that ‘countervailing power’ (not necessarily in adversarial terms) produced, to support less organised, more diffuse and non-professional interests are essential in collaborative arenas. As Fung (2002) noted, apart from helping to develop capacities necessary to engage effectively in collaborative governance, it is also vital in planning and implementation. In addition, countervailing power is also said to provide adversarial pressure that induces collaboration. Therefore, as power is developed and shared during collaboration, understanding the power relationships present in collaboration is imperative.

Clearly, these three collaborative perspectives provide a valuable way to characterise the complete set of organisational relationships that may occur in the MCN, including those that cross institutional boundaries; as well as deepen understanding of the mechanisms and incentives that allow multi-party actors within the MCN to collaborate. The issue of how a successful collaboration is measured, to provide a basis for assessing the transfer of the idea

of the MCN remains. What follows is an attempt at suggesting a framework to appraise collaboration.

3.4.4 Framework for Appraising Collaboration

No doubt, there could be several ways of assessing whether collaborative practices can be seen in a collaborative venture that represents the idea of the MCN. But three approaches for measuring collaborative practices that seem relevant to this research study have been considered. These are (see Appendix I – A to C): Mattessich, Murray-Close & Monsey's (2001) 'Factors Influencing Successful Collaboration'; Thomson, Perry & Miller's (2014) 'Five-Dimension, Seventeen-Indicator Collaboration Scale'; and D'Amour et al's (2008) 'Structuration Model of Collaboration'.

First, Mattessich, Murray-Close & Monsey (2001) following a review of the research literature on factors influencing successful collaboration, considered 19 factors critical to the success of collaborations formed by human service, government or non-profit agencies. These factors, which are grouped into six categories covered: (i) *environmental characteristics* - geographical location and social context within which a collaboration group exists; (ii) *membership characteristics* - skills, attitude, and opinions of individuals in a collaborative group, as well as the culture and capacity of organisations which form collaborative groups; (iii) *process /structure* - management and decision-making, and operational system of a collaborative effort; (iv) *communication* - channels used by collaborative partners to send and receive information, keep one another informed, and convey opinions to influence the group's actions; (v) *purpose* - the reasons for the development of a collaborative effort, the result or vision the collaborative group seeks, and the specific tasks or projects the collaborative group defines as necessary to accomplish; and

(vi) *resources* - financial and human ‘input’ necessary to develop and sustain a collaborative group.

On environmental characteristics, Mattessich, Murray-Close & Monsey (2001) found that other things being equal, collaborative efforts will most likely succeed where: cooperative or collaborative activity has a history or is encouraged; political and social climate acts as positive external motivator to collaboration; and the collaborative entity is seen (at least by the agencies that make up the group) as the leader within the community in relation to the goals and activities the collaborative group intends to accomplish. For membership characteristics, collaboration is seen when: members of the collaborative group share an understanding, respect each other and appreciate the qualities of organisations that make up the group – how they operate, their cultural norms and values, limitations and expectations. It is also expected that: members are drawn from representatives from each segment of the community who will be affected by the activities of the group; collaborative partners believe that the cost of membership (such as loss of autonomy and ‘turf’) will be offset by the benefits of collaboration; and collaborative partners are able to compromise – as many decisions within the collaborative effort cannot possibly fit the preferences of every member perfectly.

With respect to factors related to process/structure, Mattessich, Murray-Close & Monsey (2001) note that collaboration manifests when: members of the group feel ‘ownership’ of both the way the group works and the result or product of its work; every level (upper management, middle management, operations) within each organisation in the collaborative group participates in decision-making; the collaborative group remains open to varied ways of organising itself and accomplishing its work; the collaborative partners clearly understand

their roles, rights and responsibilities, and how to carry out those responsibilities; and the group has the ability to sustain itself in the midst of major changes – even changes of major goals or members – in order to deal with changing conditions. On communication, collaborative group members need to interact more often, update one another, discuss issues openly, convey all necessary information to one another, and to people outside the group. Channels of communication need to exist on paper to allow free flow of information; in addition, members are able to establish personal connections to produce a better, more informed, cohesive group that is working on a common project.

Mattessich, Murray-Close & Monsey (2001) indicated that in relation to purpose of the collaborative group: goals and objectives are clear to all partners and that they can be realistically attained; members share the same vision (developed at the outset or as the group work together), with clearly agreed upon mission, objectives and strategies; mission and goals of the collaborative group creates a ‘sphere of activity’ that may overlap but not identical to the sphere of any member organisation. Finally, Mattessich, Murray-Close & Monsey (2001) recognise that resources (financial and human) are critical to sustain and develop a collaborative group. They note that apart from consistent financial base to support its operations, a skilled convener – an individual with organisational and interpersonal skills – that is granted ‘respect and legitimacy’ is also necessary to get the group going.

Suggesting that their research provides a useful framework to guide managers and staff in public and non-profit agencies whose works draws them into collaborative situations, Mattessich, Murray-Close & Monsey (2001) caution users on the need to decide on how to apply this knowledge. Citing an example from their research, Mattessich, Murray-Close & Monsey (2001) observe that while mutual respect, understanding, and trust are essential

ingredients for collaborators in order for their project to succeed; there are a variety of ways collaborators can go about developing and maintaining respect, understanding and trust.

The second framework for assessing collaboration that is considered is Thomson, Perry & Miller's (2014) 'Five-Dimension, Seventeen-Indicator Collaboration Scale'. Based on their 'multi-dimensional model of collaboration, 17 indicators under five key dimensions that involve process-related activities have been seen to be useful, as a means to study collaboration processes and outcomes. Accordingly, the dimensions include: (i) *governance* - making joint decisions about rules to govern the collaborative effort; (ii) *administration* - getting things done through effective operating system that supports clarity of roles and effective communication channels; (iii) *organisational autonomy* - addressing the implicit tension exhibited in collaborations between organisational self-interest and the collective interests of the group; (iv) *mutuality* - working through differences to arrive at mutually beneficial relationships; and (v) *norms* - developing trust and modes and reciprocity. Thomson & Perry (2006: 24) state that of the five dimensions, 'two are structural dimensions (governing and administering), two are dimensions of social capital (mutuality and norms), and one is an agency dimension (organisational autonomy)'.

Thomson, Perry & Miller (2014) explain that in the governance dimension, collaboration is seen when joint decision-making happens through the more informal negotiation mechanisms of brainstorming and appreciation of each other's opinions rather than the formal mechanisms of standard operating procedures formal agreements. With respect to the administration dimension, rather than formal mechanism of the reliance on a manager, formal communication channels, and monitoring, useful indicators for successful collaboration include: clarity of roles and responsibility, effective collaboration meetings, goal clarity and

well coordinated tasks. In relation to mutuality, collaboration is present where partner organisations combine and use each other's resources to the benefit of all, share information to strengthen each other's operations and programmes, feel respected by each other, able to achieve their own goals better working with each other than alone, and work at differences to arrive at win-win solutions. On norms, 'collaboration involves a process characterised by the beliefs that people who represent organisations in collaborations are trustworthy, that partner organisations can count on each other to keep their obligations, and it is more worthwhile to stay in the collaboration than to leave' (Thomson, Perry & Miller, 2014: 99). For organisational autonomy, Thomson, Perry & Miller (2014) note that collaboration is affected by: the extent to which organisations perceive that the collaboration is hindering them from attaining their own mission; if organisations believe that their independence is affected by collaborating; and whether organisations' representatives feel pulled between trying to meet the expectations of their own organisations and those of the collaboration. Thomson, Perry & Miller (2014) believe that public managers will benefit from using this sort of systematic and careful analysis to understand how collaborative partners interact as these five key dimensions together indicate collaborative action.

The D'Amour et al's (2008) 'structuration model of collaboration' is the third framework, which can also be used to assess inter-professional and inter-organisation collaboration in clinical networks. D'Amour et al's (2008) model suggests that collaborative actions can be analysed in terms of four inter-related dimensions that influence each other. These include: (i) *shared goals and vision* - the existence of common goals and their ownership by the team; (ii) *internalisation* - professionals being aware of their interdependence and the need to manage such relationships; (iii) *formalisation* - the existence and use of documented procedures that communicate expected outcomes and behaviour; and *governance* - the leadership functions

that support collaboration. On this basis D'Amour et al's (2008) model uses 10 indicators to evaluate collaboration, to recognise three types of collaboration: collaboration in action, collaboration in construction, and collaboration in inertia.

D'Amour's et al's (2008) model is premised on the fact that health professionals are socialised throughout their education towards a discipline-based view of their clients and the services they provide, such that each discipline develops strong theoretical and discipline-based framework that give access to professional jurisdictions, which are often rigidly circumscribed (D'Amour, et al, 2005). And this outlook no doubt has contributed largely to an organisational culture that does not encourage team-based work within health care. Consequently, for health professionals to collaborate, this paradigm has to change to give way to one that allows for joint-working. But as observed by D'Amour, et al, (2008), while health professionals involved in collaborative activities want to work together to achieve better team outcome, they have their own interests and want to retain a degree of autonomy and independence at the same time.

D'Amour et al (2008) propose these four dimensions and the interactions between them capture the processes inherent in collaboration. However, external and structural factors such as resources, financial constraints and policy also influence collaborative processes. And these too have to be taken into consideration when collaborative activities in health networks are being considered.

All three models - Mattessich, Murray-Close & Monsey (2001), Thomson, Perry & Miller (2014), and D'Amour et al (2008) although using slightly different methods in approaching the issue of evaluating collaborative practice in networks, in principle, they share many

common features. For example, Mattessich, Murray-Close & Monsey's (2001) process/structure and membership characteristics categories appear to correspond to the governance and mutuality dimensions of Thomson, Perry & Miller (2014), and D'Amour et al's (2008) governance and internalisation dimensions respectively. However, while Thomson, Perry & Miller (2014) emphasise that mutuality and trust are the two big issues in collaboration, Mattessich, Murray-Close & Monsey (2001) (even as they recognise the significance of these two attributes of successful collaboration) highlight the various ways collaborative partners can use to achieve mutuality and trust. In addition, D'Amour et al (2008) who treated their collaborative case as an independent variable, recognise that contextual factors (as Mattessich, Murray-Close & Monsey (2001) also did) imposes significant impact on how a collaboration functions. As this research study seeks to investigate whether collaboration might be taking place (or not) in the HIV/AIDS Programme Clusters within its institutional context, all three models of assessing collaborative activities in networks are applicable.

The final section of this chapter suggests one way through which collaborators (employing the idea of the MCN) within the health sector in Nigeria, and on the basis of finding a common solution to the 'wicked problem' of HIV/AIDS could collaborate to achieve better health outcomes for HIV/AIDS patients, as well as improve the performance of the delivery system.

3.5 A Conceptual Model for Collaboration in the Managed Clinical Network

The rationale for the transfer of the idea of the MCN to Nigeria is that poor access to the full range of care and support services required by patients suffering from chronic illnesses such as HIV/AIDS, which leads to poor health outcome for this patient group, is due to the lack of

integration among different health and psychosocial service providers. As proposed by this research study, to get health professionals and care givers better able to improve patient outcomes with enhanced efficiency both for the client and healthcare system, service integration at the point of care is critical. The Himmelman, (2001; 2002) collaborative continuum is used to frame the strategies or processes by which multi-organisational actors could use to attempt to approach the ‘wicked problem’ of HIV/AIDS in Nigeria, and in integrating services for HIV and AIDS patients through collaborative service delivery.

3.5.1 Collaboration Continuum

The collaboration continuum is a framework that tries to explain the kind of exchanges that take place between multi-party actors when they tend to work together, irrespective of the context and level at which those interactions occur. These exchanges: contact (networking, communication), coordination, cooperation and collaboration, though sometimes used interchangeably have different meanings, strengths and limitations, in relation to their capacity for bringing about change in inter-organisational relationships (Himmelman, 2001; 2002; Wolff, 2005; Denise, 2007; and Waibel, 2010). They are essentially noted to be descriptors of what people do or have to do to work effectively together. But they could also be termed as multi-organisational strategies or processes for achieving collaborative solutions.

As one progresses along the continuum from networking to collaboration, the logic of the collaboration continuum presents a situation where the amount of risk, commitment, investment required for the exchange increases (See Figure 3.2 below). This is also seen to be positively correlated with the capacity to produce major change and benefits to both participants and target beneficiaries. Collaboration, the end-point of this progression is

considered as the most powerful tool for change in multi-party relations since the first three types of exchanges all provide foundation work for collaboration (Wolff, 2005). Accordingly, collaboration takes time to develop if services are to be jointly produced rather than independently; turf issues arise when partners do not see each other as equally benefiting from the collaboration; and lack of trust becomes a barrier when prior or current troubled working relationships occur. But Himmelman (2002: 1) cautions: 'It is important to emphasise that each of the four strategies can be appropriate for particular circumstances depending on the degree to which the three most common barriers to working together - time, turf and trust - can be overcome'.

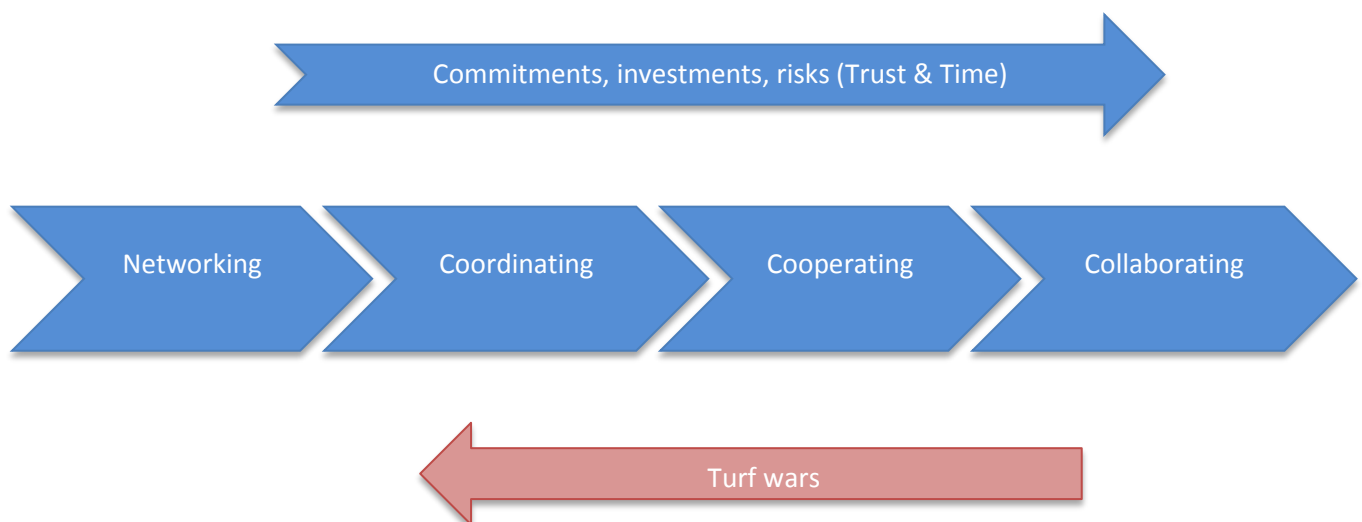
Relating trust to Giddens' (1984) Structuration Theory, Bachmann & Zaheer (2008) observed that institutional arrangements gain their legitimacy, meaning, power and trustworthiness because they guide social actors who acknowledge their value by letting their behaviour continuously reproduce them. They suggest that trust 'is embedded in the social practices that govern the relationships among individuals and businesses as well as other types of organisations' (Bachmann & Zaheer, 2008: 545). In practical terms, Child (2001) points out that trust encourages openness in exchanging ideas and information, which is a necessary condition for problem solving; in addition, it generates a willingness to overcome cultural differences and to work through other difficulties that arise in collaborations.

The importance of mutual trust and recognising the professional frame of reference, as core ingredients for collaboration within the health sector have earlier been highlighted (D'Amour et al, 2008; Ferlie et al, 2005). Seeing that Thomson, Perry & Miller (2014), also emphasise that mutuality and trust are the main issues in determining whether a collaborative entity will be successful or not, such insights help to confirm the usefulness of Himmelman's (2002)

scheme - for whom the extent and intensity of mutual trust are key; and thus, captures the essence of collaborative practice. In a sense, Himmelman (2002) helps us to distinguish the quality and intensity of collaboration, from simple information exchange through co-production to capacity building for mutual advantage.

Considering Himmelman's (2002: 2) continuum of collaboration in turn, *Networking* is defined as 'exchanging information for mutual benefit'; when there is communication about the scope of service or normal practice in a service, or about certain organisation activities such as staffing changes, programme development, clinic hours and so on.

Figure 3.2 – Himmelman's Collaboration Continuum



Source: Adapted from Waibel (2010), and Torres & Margolin (2003)

Wolff (2005) observed that many coalitions and partnerships begin their meetings with a go-round of information exchange about what is new in their organisations, in order to facilitate networking. The key element here is communication, which may be formal or informal among participating organisations; and may include transfer of information, not just facts, but

also policies, plans, predictions, rumours, feelings and other human experiences. In the healthcare arena in Nigeria, providers are usually limited in their ability to connect clients with resources, because they often do not have up-to-date information on what happens in related organisations. Those who are able to do so, achieve that because they have colleagues or good friends that happen to work in associated provider organisations. Therefore, networking is an essential building block for collaboration. The question is how to make sense of and differentiate between all the possible information provided and the specific information required by individual organisational entities to participate in collaboration. Although considered vital to collaborating, reflecting an initial level of trust, limited time availability and reluctance to share turf, networking is not collaboration.

Following on, *coordination* builds on networking to mean ‘exchanging information and altering activities for mutual benefit and to achieve a common purpose’ (Himmelman, 2002: 2). It is said to introduce a behaviour change, modifying activities and a focus of attention in achieving a common purpose. It starts with an assumption that different individual professionals, different units of the same organisation or different organisations within the same organisational field create overlap, redundancy and separation that lead to wastage of resources and loss of opportunities. And coordination creates a framework to ensure that these separate entities will all tie together and that everything will be streamlined and fall into balance. Therefore, coordination is about efficiency or the ability to effectively meet the needs of the collaboration. Wolff (2005) notes that whenever people agree to announce each other’s activities in their newsletter, recruit for each other’s events, or modify their practices in light of each other’s activities, coordination could be said to be taking place for the mutual benefit of providing better service to a client group. Coordination presupposes that individual professionals or organisational units in collaboration know their respective core activities and

when to do them; and that they also understand and see the relationship between what they do and what the collaboration (the coordinated whole) intends to achieve. Thus depending on context, there could be weak correlation between coordination and results (Denise, 2007). These are essentially situations, where there could be a lot of motion (coordinating for efficiency) without movement (the consequences of the coordination efforts). When compared to networking, coordination involves more time, higher levels of trust, but little or limited access to each other's turf. One would consider that to create the step change, which leads to value creation (e.g. productiveness) more investment in capacity for behavioural change among networking partners would be needed (Alexander et al, 2003).

Building on the exchanges of networking and coordination, *cooperation* is considered to be 'exchanging information, altering activities, and sharing resources for mutual benefit and to achieve a common purpose' (Himmelman, 2002: 2). The additional element here is 'sharing resources' that actually gets work done. As Himmelman (2002) noted it requires greater organisational commitments than the previous types of exchanges and may involve written (perhaps, even legal) agreements or memorandum of understanding. And shared resources may embrace a variety of human, financial, and technical contributions, including knowledge, staffing, physical property, access to people, money, and others. Wolff (2005) observed that cooperation can take a simple form, for example when a number of health service providers share space to reach the same client group - a case of simple pooling of resources to meet a huge cost of an individual budget item. But it could take a more complex form when these agencies contribute funds to create a shared staff position that would require the management of individual organisation's expectations (as to the value derived from that staff against each organisation's contribution). Therefore, in a cooperative relationship, the risk and involvement increases as each participant increases demand on

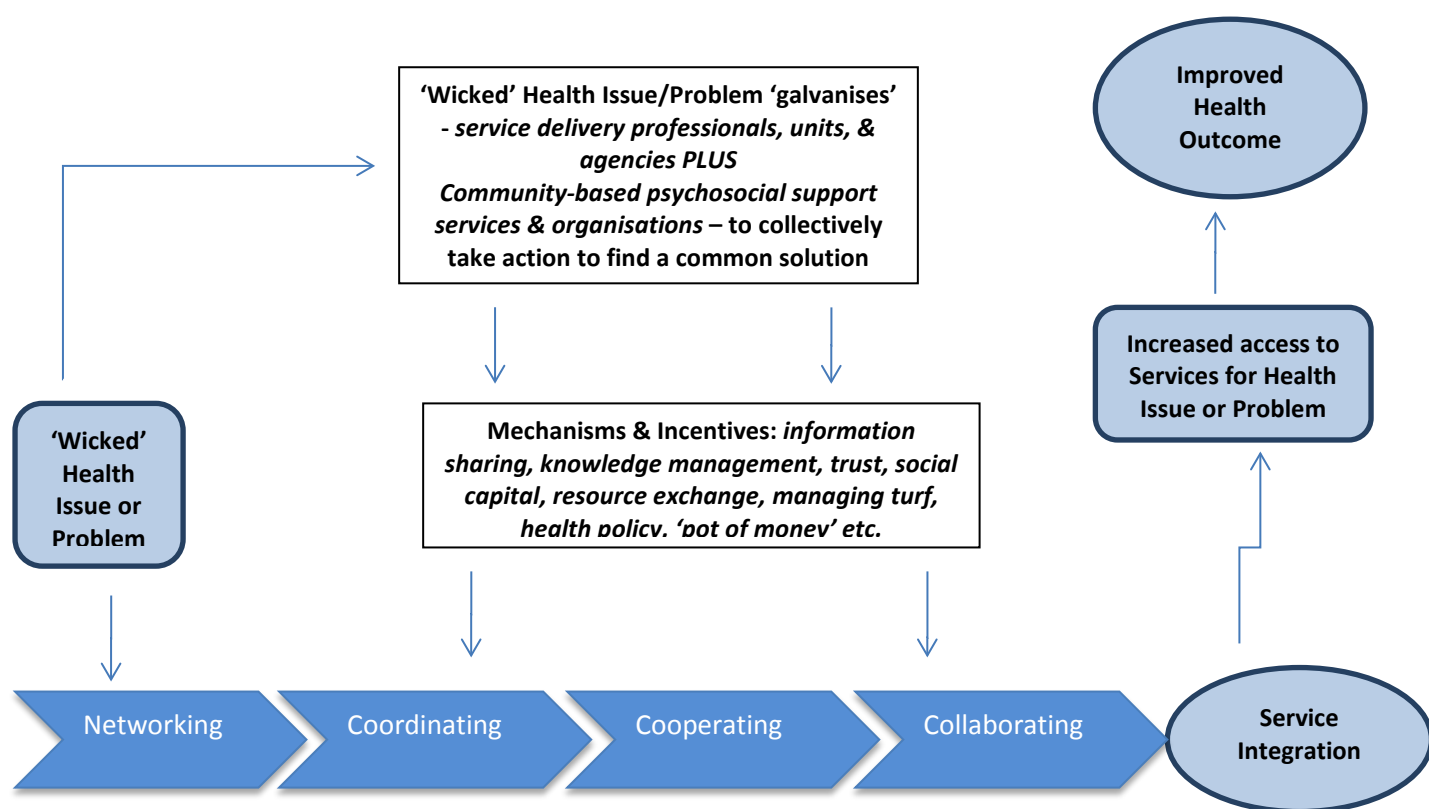
shared resources. Acknowledging that serious questions arise in any cooperative effort, 'Will all the participants get their money's worth? Who supervises? Who gets credit?' Wolff (2010: 48) observed that finding a 'common purpose' helps with the decision process in cooperative exchanges, though this has to be linked with greater levels of trust. Consequently, participants need to engage in discussions to clarify and articulate a common purpose that helps them to appreciate where they want to go as separate entities, as well as help them to understand what parts of their purpose are held in common. The capacity of the cooperative partnership to undertake such tasks is the step change that is required here. But the main limitation of this type of exchange is that cooperation in many cases is a call for increased socialisation to a 'group culture', rather than a prompt for high performance (Denise, 2007). In relation to networking and coordination, cooperation requires a substantial amount of time, high levels of trust, and significant access to each other's turf.

Finally, *collaboration* that builds on networking, coordination and cooperation is defined as 'exchanging information, altering activities, sharing resources, and enabling the capacity of another for mutual benefit and to achieve a common purpose' (Himmelman, 2002: 3). The additional element in this type of exchange is that each organisation in the collaboration is willing to assist its partners become the best at what they do, while carrying out their core activity. It also assumes that when organisations collaborate they share risks, responsibilities and rewards, each of which contributes to enhancing the other's capacity to achieve a common purpose. Collaboration is therefore said to be usually characterised by substantial time commitments, very high levels of trust, and extensive areas of common turf. Putting it all together, Himmelman (2002: 3) summarises collaboration as *a process in which organisations exchange information, alter activities, share resources, and enhance each other's capacity for mutual benefit and a common purpose by sharing risks, responsibilities*

and rewards. While accepting this step-wise logic, collaborations should indeed bring about something that was not there before (Huxham, 1996).

Denise (2007) argues that collaboration should not be anchored on the process of relationship but in the pursuit of specific result, but ‘stability of collaboration’ is fundamental in the long-term as outcomes fluctuate (Gust, Altfeld, & Kreutzfeldt, 2012). Reflecting on the advocacy activities of the coalition of civil society organisations (Health Sector Reform Coalition of Nigeria) that was credited with getting the National Health Bill signed in Nigeria, there was good evidence to suggest that the fundamental feature of this network was its ‘stability’ over the period (more than 10 years) it took from the conception of the bill to the time it became a law. Although focused on its outcome of getting the health bill signed, the strength or weakness of the ties among members; based on intensity, intimacy, mutual confidence and the duration of the relationships (Ahuja, 2000) played a crucial role in keeping the coalition intact as it has to deal with several occasions of near misses to its target. While acknowledging that the stability of collaborations is a function of their sustainability, I wish to establish that collaborations exist mainly in an outcome framework that has been instigated by an issue. Accordingly, collaborations are created to solve problems, develop new understandings, design new products or develop a new service. In this sense, there is nothing routine about collaboration (Schrage, 1990). Applying this rigor to the conceptualisation of the collaboration continuum, I would resist the attempt to define the three building blocks of collaboration: networking, coordination and cooperation in ‘process terms’. And as commitment among collaborating partners changes as one moves along the continuum, mutual accountability for outcomes increases as the joint production tightens (Himmelmann, 1996; Waibel, 2010).

Figure 3.3: A Model for Collaboration within the Managed Clinical Network



Source: Author's Diagram

As the conceptual model proposes (see Figure 3.3 above), Rather than exchanging information as in networking, it would be using information to create something new. Rather than trying to achieve structural harmony as in coordination, it would be seeking divergent insight and spontaneity for shared creation. And rather than promoting a group culture as in cooperation, it would be thriving on differences and sparks of dissent for co-creation. So that in the end, collaborations achieve some common grounds, that are interpersonally determined, rather than structurally constructed.

As illustrated in the diagram, for the idea of the MCN to work in Nigeria, there must be collaboration or similar relational practices as outlined above; and as the Drivers of Change Analysis of Nigeria indicated, this may happen where there is an *issue* that describes an

outcome around which concerned interests can come together to jointly produce something (Anyebe, Bezzano & Foot, 2005). Not just a coalition to authorise the production by one organisation; rather an outcome that indicates joint work and which has around it incentives and mechanisms that mobilise or encourage collaborative behaviour towards that outcome. The Himmelman's (2002) 'collaboration continuum' - relational qualities that represent both stages along a process of development, as well as a set of distinct points on a continuum - for finding collaborative solutions; is proposed as a useful model for assessing the degree and extent of collaborative activities within the HIV/AIDS programme clusters in Nigeria, incentivised to function as MCNs.

But the idea of the MCN as a model for service integration cannot be implemented in a vacuum. In Nigeria, and with respect to this research study, the idea of the MCN as an alternative means of organising health care is being introduced into a peculiar institutional environment that seemed to have produced (as shown by the Drivers of Change Analysis of Nigeria) a mix between the hierarchy and markets modes of governance, where it is difficult to draw the boundaries and also decide where accountability lies. This is in addition to the disease specific context of HIV/AIDS as a 'wicked problem' that calls for a network mode of governance in tackling it. Therefore, an additional framework using the HIV/AIDS case study approach suggests a *Theory of Change* of how the idea of the MCN can implement change within the Nigeria health system.

This theory, although a combination of the two approaches: the collaboration continuum, and the drivers of change analysis of Nigeria, draws heavily from international development perspective of 'theory of change' (Weiss, 1995; Mason & Barnes, 2007; White, 2009; Vogel,

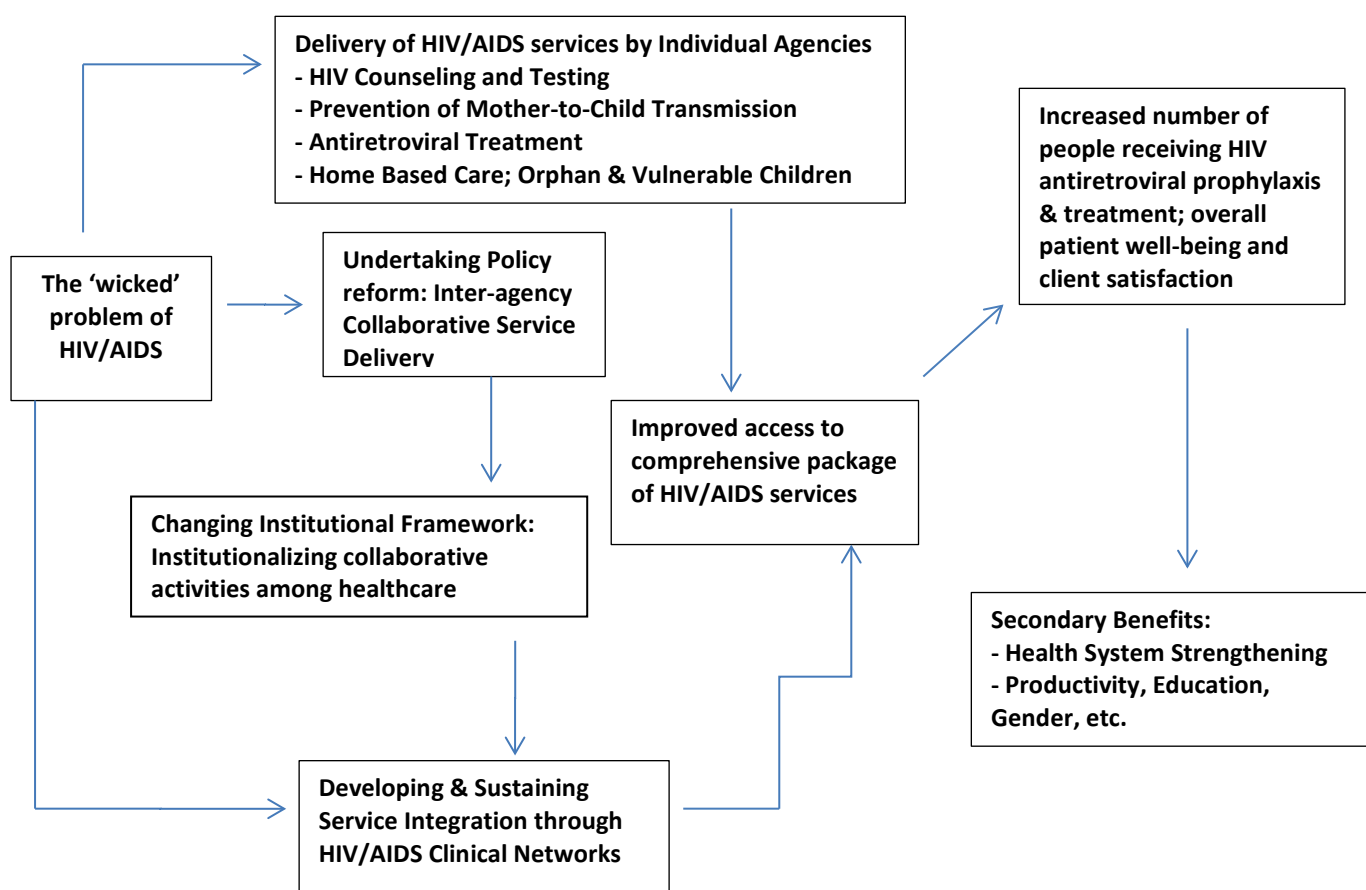
2012), which gives privilege to concepts such as context, actors and a sequence of logically-linked events leading to long-term change or outcome. As Vogel (2012) found out, people work with theory of change flexibly, according to their needs. In my case, the key adaptation is the identification of an issue with a definite outcome for which the process of change is determined by the type of exchange (based on the collaboration continuum) that takes place between actors. And the assumptions on how this might happen in a particular context are what a 'drivers of change' analysis provides.

Using theory of change evaluation approach, an outcome pathway, which presents the conditions that must be in place to reach the goal, is mapped out below on Figure 3. 4. The main components are: (i) developing and sustaining inter-agency collaboration for HIV/AIDS (the collaborative process); and (ii) policy reform that fosters collaborative service delivery (the challenge to existing institutional arrangements), as previously explained. The additional features are the inter-relationships among the various parts and the point at which an issue triggers the whole system to respond to the challenge; and of course how the desired outcome emerges from this interaction.

Though the diagram has essentially displayed line relationships, in reality, there could be feedback loops at several sections with changes in the relative positions of the issue concerned and the outcome it evokes from the change process. For example, it is assumed that service integration which is shown, as the output of the inter-organisational interactions would result into improved access to health services that would eventually lead to improved health outcomes. As presented below, because of the 'wicked problem' of the disease, a programmatic approach to HIV/AIDS service delivery is required to convert programme

inputs (on the left) into the outputs and outcome (on the right). And this describes the theory of change.

Figure 3. 4 - Theory of Change for HIV/AIDS clinical networks in Nigeria



Source: Author's Diagram

Apart from direct interventions such as HIV Counseling and Testing, Antiretroviral treatment, Prevention of Mother-to-Child Transmission (PMTCT) and Home-Based Care for which evidence of effectiveness are well established; other elements are required to achieve greater impact. These include (i) service delivery policy reform to foster inter-agency collaboration and (ii) service integration by individual agencies working together. There are several assumptions about how the effectiveness of these inputs (direct interventions, policy on inter-agency collaboration, and actual service integration) would be transformed into the

outcomes, which is increased number of people receiving antiretroviral prophylaxis and treatment. But as studies (Dowling, 1999; Wan, Lin & Ma, 2002; Lee, Alexander & Bazzoli, 2003) have shown that Integrated Health Service Delivery Networks (IHSDNs) can: improve access, reduce fragmentation, improve system efficiency, prevent duplication of infrastructure and services, reduce production costs, and respond effectively to people's needs and expectations; it is assumed that these combined approaches would result to a change in service delivery expressed in terms of improved access to a comprehensive package of HIV/AIDS services.

The basis for this 'theory of change' derives from the network literature, which suggests that: (i) HIV/AIDS is a 'cross-cutting issue', having 'a fundamental effect on well being yet continue to defy actions of governments to address them...they cannot be tackled successfully by a single agency, nor will disjointed action have any real effect' (Sullivan & Skelcher, 2002: 56), and shares many features with 'wicked problems' (Rittel & Webber, 1973); (ii) many complex policy areas facing 'wicked problems', such as poverty, anti-crime, mass housing, and anti-drug policies require work across conventional organisational boundaries (Clarke & Stewart, 1997; Australian Public Service Commission, 2007); and (iii) network forms may be particularly effective in tackling 'wicked problems' (Ferlie et al, 2011).

As noted previously, the concept of 'wicked problems' as Rittel & Webber (1973) explained refers to problematic social situations where: there are no obvious solutions; several stakeholders (individuals and organisations) are involved; there is disagreement among stakeholders; and certain behavioural changes are desired. Public policy problems are considered to be 'wicked', where they go beyond the scope of any one agency - as the

HIV/AIDS disease presents, and intervention by one actor, where not aligned with other actors fails to produce expected outcomes - as in delivery of care for HIV/AIDS patients (Clarke & Stewart, 1997). Such a wicked problem, as depicted by HIV/AIDS requires broad response, working across organisational boundaries and engaging stakeholders and citizens in policy-making and implementation (Australian Public Service Commission, 2007). But in such an arrangement, 'collaboration' replaces competition as the guiding principle in the relationships among stakeholders (Sullivan & Skelcher, 2002).

The basic assumptions of the 'theory of change' (how inputs are converted into outputs and outcomes) draw heavily from the National Institute for Health Research (NIHR) Service Delivery Organisation (SDO) Programme studies of Clinical Networks in the UK (that have earlier been examined) and related clumps of work in the USA. And this justifies the choice of case study research design that gave rise to the data collection and analysis methods.

Just to recap: Currie et al's, (2010) study that built on previous NIHR SDO research (Ferlie & McGivern, 2003) confirmed that networks seem vulnerable to institutional influences that may represent constraints on the possibilities for collaborative actions. This report notes that first; the affiliation of network participants is oriented towards their accountability within their employing organisations rather than the network. Moreover, since the networks are made up of many organisations, some may compete for resources to deliver health and social care services, as others are positioned in commissioner-provider relationships. Second, 'professional jurisdictions and socialisation means professionals orientate towards their own silos, rather than collaborate' (Currie et al, 2010: 12). They noted that divisions between primary and hospital doctors in particular, and more broadly, between health and social care professionals tend to hinder integration. Currie et al (2010) reflected on these findings and

concluded that policy aspirations that expect ‘networks to behave in a networked way’ may not be met, unless network processes accompany structural reforms towards network forms of organisation.

Guthrie et al’s (2010) research that sought to explore and learn from Managed Clinical Networks (MCNs) in Scotland reported that MCNs were established through policy mandate with the intention of promoting access to, and consistency of quality of, healthcare services by fostering collaboration and / or integration across geographical, organisational and professional boundaries. They observed that, while there is no one-size-fits all model for creating and initiating clinical networks, local context, and the nature of the condition, which the network focuses, are important considerations. Supporting the suggestion that networks with voluntary origin are more effective than those which have been mandated by external agencies such as government (Goodwin et al, 2004; Human & Provan 2000; Scharpf, 1978); the researchers also noted that ‘mandating clinical networks created a space within which new forms of collaboration flourished’ (Guthrie et al, 2010: 206). Though they cautioned that problems with service integration and coordination across complex organisational and professional boundaries cannot be definitely solved; they agreed that clinical networks are a means to flexibly address and improve on these issues.

As most of the empirical work from which this particular theory of change relied on, predominantly asked ‘how and ‘why’ questions, the dominant research design was case studies of purposely selected health care networks. This sets a precedent for this research study (an exploratory study of the same phenomena, though in a different setting), as such a case study design seemed well adapted to explore organisational processes through time and the meaning that organisational actors attach to their actions. Therefore, I have adopted a

similar narrative approach to the cases that sought to tell the story of the networks as a whole over time. And as the case study design requires multiple methods to be holistic, I have employed multiple data sources: documentary reviews, semi-structured interviews and direct observation. Furthermore, since study of the organisations in a case study is embedded in complex contexts, I have also placed my cases within their several contexts - the disease (HIV/AIDS), which is the focus of the networks; the national policy - broadly and health specific; and local organisational context. To understand how the multi-organisational collaboration interacts with these contexts, I have employed policy analysis as a research method to help with investigating the inherited and evolving mix of political, economic and social variables that influence policy agendas and change.

Notwithstanding the rationale and evidence for this ‘theory of change’, I am aware that similar policies may have very different consequences in different environments. As noted earlier, organisational reform of the health sector in developing countries are influenced by a number of factors. Kutzin, (1995) observed that while decisions of government health authorities are said to affect some factors immediately, others were noted to have an effect only over the medium- and long-terms. ‘Moreover, certain contextual factors that affect the consequences of reform, such as macroeconomic performance, infrastructural development, educational levels, and cultural norms, are beyond the influence of the Ministry of Health’ (Kutzin, 1995: 41). Therefore, the processes by which the HIV/AIDS programme components are expected to be translated into the desired impact and outcomes in Nigeria (as demonstrated in the theory of change) are further assessed based on the contextual factors that are observed from the findings of this case study.

In summary, what both the ‘conceptual model for collaboration’ and the ‘theory of change’ say about collaboration is that it does not just happen. An issue or a problem within a setting, when acted upon through collective action leads to a desired outcome, drives it. However, there is also a larger political economy environment, as well as specific health sector context that could facilitate or create barriers to collective actions that may be undertaken by actors. Within the change domain in the health sector, policy reforms and /or institutional change are seen as essential tools that multi-party actors can use to produce emerging inter-organisational relationships. Therefore, these instruments could be seen as processes associated with collaboration, apart from the relational practices demanded by the nature of the MCN. Similarly, since collaborative mechanisms are modulated by the whole system of structures, institutions and agents, which in the first place set the ‘rules of engagement’; it may not be possible to undertake inter-agency collaboration that leads to service integration without subtly or fundamentally changing the rule and norms that pattern the practices and structures of collaborating organisations. It is essential to state at this point that there is a possibility that the degree of inter-organisational joint working that seeks to attain a definite outcome for a defined problem, may be directly related to how effective policies and the institutions have been altered to favour joint action - joint production or coordination of tasks.

This is the way I see collaboration that results into service integration leading to enhanced health outcomes taking place in Nigeria, and therefore informs the way I intend to investigate the feasibility of implementing the idea of the MCN in Nigeria. This is also reflected in the selection of the appropriate research methods, the presentation of my findings and analysis, as well as the validity of my conclusions.

Chapter Summary

This chapter has considered how we might think about the idea of the managed clinical network (MCN), what we know about the MCN from implementation attempts in the English NHS and Scottish NHS, and how the process of transfer of the idea to resource-limited environments might appropriately be framed. The managed clinical network ‘bundles’ a variety of concepts into its frame. The chapter has therefore defined and explained the integral concepts of network, integration and collaboration, and has offered an understanding of their inter-relationships. As relational practices underlie the idea of the MCN, the final section of the chapter provided a conceptual model by which to evaluate the quality of relationships among participants within the HIV/AIDS service delivery clusters in Nigeria; as a way of assessing how the country can borrow the idea of the MCN, considered to be analogous to these service delivery networks.

Chapter 4 - Methodology

Chapter 3 proposed a conceptual model through which to explore and assess the development of forms of service integration within HIV/AIDS care and to account for the policy and institutional framework in such an assessment. That model provides a set of questions about practice that are amenable to research. The thesis therefore proceeds to examine whether there is evidence of an emergence of networking practice in HIV/AIDS services, these providing the most likely context in which to find such evidence in health care practice in Nigeria. This chapter focuses on the research approach used to elicit the necessary evidence. It begins by describing the research strategy and data collection methods, and explains the reasons why the study took this particular approach. It then considers the way the data was analysed; including the method used to make an assessment of the feasibility of implementing managed clinical networks (MCN) in Nigeria. The chapter concludes with a discussion of other issues of method: the position of the researcher, ethical considerations, personal reflections on the role of the researcher, and limitations of the study.

4.1 Research Strategy

This research study is an initial exploration of the feasibility / applicability of the concept of the managed clinical network within a context (a developing country) that has not been previously considered. And the fundamental question is: *whether 'the idea of the managed clinical network' could be an effective means of service integration in a developing country setting, and if so how and why?* The basic line of inquiry therefore is to see if there is evidence of the emergence of networking practice or collaborative working in the most likely context.

The prime focus of this research study is to examine existing ‘naturally-occurring’ forms of collaborative practice in a service area for which a team-based collaboration is particularly likely. Conventionally, a study of this nature would be undertaken either in the most likely / favourable circumstances or in a specifically challenging set of circumstances. In this instance, I elected to examine networking practice or collaborative activity in HIV/AIDS service delivery in Nigeria, as a case study.

HIV/AIDS service (prevention and treatment) is chosen because: (i) this is a service area which has high identity and therefore is relatively clearly bounded, and (ii) presumably with high social interaction within the community of professionals. In addition, the exchanges between professionals are said to be collaborative in nature (NHS England, 2013), where professionals involved in this undertaking are expected to coordinate their activities in order to meet the wide range of needs of people with HIV in a coordinated way (Department of Health, 2001).

The distinctive purpose of the case study method, Yin (1994) has argued is to examine the way in which a phenomenon evolves in its context, collaborative working in the Nigeria context, as in this case. Moreover, Yin (1994) elaborated that the case study is the preferred strategy for an exploratory study, when ‘how’ or ‘why’ questions are posed. As in this research, the critical research question is: *‘how’ and ‘why’ the ‘clinical network’ might be an effective means of service integration in Nigeria.* But as noted by Hwang & Powell (2005) collaborative working, by the very nature of how agents relate with each other and with structures, tends to re-make institutions, even when they are relatively stable and settled. Thus another set of questions, which help to provide information to describe the relational strategies used by individuals and groups to approach the ‘wicked problem’ of HIV/AIDS,

and the collaborative process or networking practice among agencies providing services for HIV/AIDS are also required to understand the pattern of collaborative actions that emerged in the Nigerian context. These include: (i) how did each team come about?; (ii) is there a formal instrument that serves as a mandate?; (iii) how are members chosen?; (iv) are they co-located in one or more health care facilities?; (v) is there a management structure?; and (vi) what in addition to the disease focus serves to unify the team?

Following from the need to look for relevant evidence to address these questions, and given that the demarcation between phenomenon and context may not always be clearly evident (Yin, 1994); the case study's unique strength lies in its ability to deal with a full variety of evidence: documentary, artefacts, interviews, and observations, to cover the array of research questions that have ensued from an exploratory research of this nature. Case studies are amenable to such a variety of types of data collection methods, with techniques chosen to provide data that could converge in a triangulating fashion. In this instance, I employed direct observation, semi-structured interviews and review of documentary material, in addition to policy analysis, to attain an in-depth understanding of the 'case' as an integrated whole (Crowe et al, 2011). Therefore, this research study benefits from the case study strategy; by helping to identify the measures used to understand patterns of collaborative practice, and what difference these revealed of the HIV/AIDS programme teams in Nigeria. Action research was considered as an alternative research strategy, but the research question did not arise from a situated problem that is best understood by the researcher working in partnership with participants. The focus here is not on helping the HIV/AIDS programme teams in addressing issues of collaboration or solving particular problems through collaboration. Rather, it is aimed at understanding collaborative practices, how individual entities that make up the HIV/AIDS programme teams collaboratively work together.

Consequently, I decided to assess collaborative actions in HIV/AIDS service delivery within the Nigerian Health System in one of the 36 States - Rivers State (estimated population, 5.2 million in 2006 census) at two sites: Ahoada and Bori - providing HIV/AIDS services targeting populations of two out of the three senatorial districts of the State. The choice of Rivers State was primarily for convenience; but also, this State is typical of any other in the country in terms of the *collaborative context* - institutional arrangements, service delivery configurations and funding mechanisms for health care.

Although as a State within a Federal system of government, Rivers State like the others, has considerable leverage to make health policies on its own that take into account local peculiarities. And this is sometimes the case given that parts of the Niger Delta which fall within the boundaries of this State make up at least 60 per cent of a terrain that is difficult to reach. However, all of the States have poorly developed and under resourced health systems with an historical legacy of organisational complexity, which means even health interventions that are relatively technically straight forward, such as immunisation - are difficult to programme as an integral part of the routine, publicly funded health services. Similarly, all the States have some form of health reform programs to make their health systems more efficient and effective, and with an improved resource base that each State could sustain. Over the years, States have progressed at different rates with their reforms, in part reflecting varying levels of external technical and financial assistance, but with a shared pattern to the reforms. This implies that a standardised programme approach for HIV/AIDS with minor modifications in all the States is equally appropriate.

Moreover, as States do not have the resources and capacity to deal with the complex issues around service delivery for HIV/AIDS, they are quite happy to follow the lead of the federal government. Consequently, to assist the States with managing the scourge of HIV and AIDS, as well as achieve the national goal of controlling the epidemic within Nigeria; the federal government has to put in place a similar institutional framework for HIV/AIDS service delivery at the State level that has been adopted by all States. This means the *context*, which matters so much in finding optimal solutions among the States, is essentially the same since several aspects of inter-organisational relationship among HIV/AIDS service agencies in all the States are meant to be similar. And there is therefore the possibility of applying the findings from this study to the others. But I am also mindful that even within the same context and although aiming towards similar outcomes; different *approaches or mechanisms* may apply as national health policies and plans are translated at local levels. In a large and complex society such as Nigeria, significant diversity in practice is not unexpected due to culture, historical legacies and micro-political preferences of its people. The selection of two sites within Rivers State is aimed at exploring if different mechanisms for collaborative activities apply at different locations within the same State and also at understanding why institutional policy on HIV and AIDS may become different at the frontline of service delivery in Nigeria. Though ‘collaborative service delivery’, may specify that new programmes and/or partnerships are formed to address specific needs (Chrislip, 2002), Gray’s (1996) collaborative typology suggests that depending on the issue and how it is perceived by stakeholders, a combination of any of the collaborative mechanisms may be used by collaborative partners to find a common solution. At the same time, the policy transfer literature indicates that transferred information may change depending on where an agent is located in the policy-making process, and the role the person plays in the policy’s development (Dussauge-Laguna, 2012; McCann & Ward, 2012; Dolowitz & Marsh, 2012).

With respect to the choice of the two study sites in Ahoada and Bori, these were purposively selected through peer recommendations. These were also two out of three Local Government Areas in Rivers State, where active HIV/AIDS intervention programmes with external support were operating effectively. And my unit of analysis was the ‘HIV/AIDS Service Cluster’ based at the General Hospitals in each of these locations at Ahoada and Bori, where distinct types of linkages among service providers and agencies/organisations were said to exist. These included: patient/client referral to other agencies/organisations; patient/client referral from other agencies/organisations; exchange of information about shared patients/clients; formal written linkage agreements or memorandum of understanding (MoU) for patient/client referrals; and joint programme implementation. Thus each of these linkages represented an element of health or social service that service provider agencies/organisations must share in order to meet the needs of their patient/clients populations better. While patient/client referral and exchange of information suggest direct service delivery ties; formal linkage agreements (or memorandum of understanding) and joint programme implementation may mean administrative linkages.

This research study seeks to describe the overall inter-organisational network structures that emerged from the HIV/AIDS Programme Clusters in Rivers State; the positions of specific agencies/organisations within the different networks; and the correlations between the networks. By comparing network structure across the different types of ties, it aims to provide an insight into how the HIV/AIDS service delivery system in Rivers State functions, especially with external donor support. At the same time, by comparing the structural and functional attributes of the two networks under study, it may be possible to find out why the *outcome* of an institutional policy may become different at the local level despite a similar

institutional context. And whether, the networks that have emerged have been designed to trigger different mechanisms, which could be responsible for the different outcomes. A final component is to determine if the observed direct service delivery or administrative inter-organisational linkages are useful mechanisms for implementing change that leads to impact, which is the improvement of overall health service delivery in terms of *increased access to quality care that leads to better health outcomes* in Rivers State, Nigeria.

4.2 Data Collection Methods

The study was undertaken in Rivers State (estimated population, 5.2 million in 2006 census) at two (2) out of six (6) anti-retroviral treatment (ART) sites in the State providing anti-retroviral drugs, treatment for opportunistic infections, as well as Sexually Transmitted Infections (STIs). Other than peer recommendation, these (Ahoada and Bori) were the only sites where a cluster of secondary and primary health facilities that provide comprehensive HIV/AIDS prevention (testing and counselling), treatment (PMTCT and ART), care and support services within a geographical sphere were seen to be functional in the State. And thus the interactions and inter-dependencies among actors providing services for patients suffering from this disease were most likely to exhibit network behaviour.

At each study site, the elements within the HIV/AIDS service delivery system include: HIV Counseling and Testing (HCT) centres, an Anti-Retro Viral (ARV) Treatment centre, Prevention of Mother-to-Child Transmission (PMTCT) centres, Home-based care units, and a support group of those living with HIV. The unit of analysis was this ‘whole system’ - the *HIV/AIDS Programme Clusters* whereby the inter-organisational relationships that enable or otherwise prevent the system’s elements from collaborating were examined. This was the service delivery frontline and task integration, which was the object of focus. But the

HIV/AIDS service delivery system in Nigeria also includes the administrative (resource and policy) coordinators. At the national level is the National Agency for Control of AIDS (NACA), while the State counterparts are the State Agencies for Control of AIDS (SACAs). These bodies are composed of representatives of various stakeholder groups including the bureaucracy, professionals, academia, business, and client groups. So there is also administrative coordination above the service delivery level that could influence the outcome of the collaborative activities of frontline actors in delivering integrated care. Therefore a rich account of the institutional arrangements as well as the motivating factors for collaboration was also provided.

On the basis of the above scenario and recognising the fact that social interactions are the raw materials of collaborative work within networks, multiple data sources was used to obtain an in-depth analysis of each site under study. The study employed semi-structured interviews, information from documents and reports, detailed observations, as well as institutional analysis of the collaborative context to gain access to areas requiring deeper understanding such as individual meanings, views and personal experiences that are not reachable through quantitative methods. The selection of data collection tools was intended to enable different perspectives and understandings of the various stakeholders to emerge but also to enable triangulation of findings to increase the robustness of the analysis. And by being pragmatic this approach took into consideration resource availability, including that of the time of key informants.

Interviews were conducted with key informants, representing each of the constituent elements within the inter-agency collaborating networks studied. Prior to undertaking the key informant interviews, a ‘framework of questions’ that guided the interviews was developed

(Appendix IV). It covered three main areas: (i) collaborative formation, structuring and activities; (ii) collaborative processes and maintenance; and (iii) collaborative outcome. This guide to the key informant interviews was pilot tested at a third active HIV/AIDS service delivery site in Rivers State, based at the Braithwaite Memorial Specialist Hospital in Port Harcourt. This informed the relevance and adequacy of this tool and led to some minor modifications especially with respect to questions meant for stakeholders at policy coordination organisations and agencies. Apart from some minor modifications all key informants followed the same lines of inquiry in order to obtain different perspectives and experiences on each of the subject areas. It is important to note that not all of the areas were specific to the different stakeholder organisations and agencies but there was a measure of the likelihood of a common knowledge base of the key informants at different levels and positions in the system. And as soon as feasible following key informant interviews the summary of the discussions was prepared.

In order to give maximal attention to each study site, data was collected on each site in sequence over a period of 18 months, first at Bori and then Ahoada. This took place between January 2011 and June 2012. As a final step in the data collection process, follow-up discussions were undertaken a few months after the end of the data gathering period with some key members of each cluster, to ensure that updates on the activities of the networks in the interval between the two discussions were captured; in addition, discussions were held on the findings from the initial analysis, focusing on issues that may need to be examined further. But the researcher also maintained telephone contact afterwards that was useful in further clarifying some issues where necessary. Each of the interviews lasted between 30 to 45 minutes and took place at the organisations where the individuals worked or at suitably agreed locations. A total of 38 persons were interviewed (Appendix V): 15 persons from

Ahoada site, 16 from Bori site, 3 persons at the State level: State Ministry of Health, and State Agency for the Control of AIDS, and two persons at the national level: Federal Ministry of Health and National Agency for AIDS Control; as well as one programme officer or coordinator of the Global Fund Programme Managers at each study site. This was to ensure that as an exploratory research, a broad spectrum of opinion about the workings of the HIV/AIDS Programme Clusters and the application of the Integrated Cluster Model itself was obtained from a broad-range of stakeholders. The identification and recruitment of those to be interviewed was also informed by purposefully selecting participants for their ability to confirm or challenge emerging findings as the data gathering process progressed. All those interviewed agreed to take part after the purpose of the research was explained, supported by official letters in some cases and consent to participate obtained.

Documents (Appendix VI) such as programme or project memorandum, strategic plans, terms of reference, minutes of meetings and annual reports were reviewed to provide specific information and to help fill in information gaps. In addition, pertinent information about contextual data such as the political, economic, social and institutional appraisals of Nigeria in general and the health system in particular were also reviewed and linked to the network study, using forms of institutional analysis. Each document was purposefully reviewed for content related to the areas under investigation.

In addition, the researcher was permitted to observe two meetings at each site, as well as participate in a meeting at the State coordination level to understand policy harmonisation. The limited number of observation of meetings was due to unpredictability of the cluster meetings (meetings failing to hold on scheduled dates due to one reason or the other) after traveling to the venues, which is over 50 kilometres in each direction on bad roads. As a way

around this, minutes of cluster meetings covering a period of over one year in each site were provided to the researcher even after the site visits. Furthermore, one also tried to understand the management of network resources by observing a patient-journey through the referral pathway at each of the study sites. This process of data gathering was adopted in order to ensure that despite the limitations in the data gathering stage of the research, the sort of evidence required to answer the research questions is as robust as possible given the nature of inquiry - an exploration of a complex social issue with a multi-dimensional nature.

Furthermore, acknowledging that collaborative service delivery instigates a reform agenda that does not happen in a vacuum but takes place in a particular context; this study emphasises the significance of political economy and the reform context. Policy analysis was undertaken to understand the political economy of reform by assessing the impact on, and the influence of, institutions and stakeholders in relation to the policy of collaborative service delivery (World Bank, 2007). It presented a useful means of investigating the inherited and evolving mix of political, economic, and social variables that influence policy agendas and change. And by applying a social analytical lens to examining stakeholder interests and incentives, as well as understanding the influence on the policy process of formal and informal institutions; it offered a means to identify political economy risks that needed to be effectively managed, so as to prevent their likelihood of impeding the policy reform process. But most importantly, analysis of the policy process allowed the exploration of how, why, and under what conditions the policy of collaborative service delivery might work, or fail to work, through a greater understanding of the contextual factors, mechanisms, and processes underlying the implementation of this policy (World Bank, 2007). It was basically an attempt to test the assumptions about the interests of social actors (stakeholders), and the social rules (institutions) governing the implementation of the policy.

Adopting a narrative approach, policy analysis was conducted using secondary literature, including broad national policy documents and those specific to health and HIV/AIDS, as well as *analytical reports* such as the DFID's Drivers of Change (DOC) Analysis of Nigeria (Heymans & Pycroft, 2003), NORAD's (Norwegian Agency for Development Cooperation) Good Governance in Nigeria (Amundsen, 2010), Overseas Development Institute (ODI)/UNICEF Nigeria's Social Protection in Nigeria (Holmes et al, 2012), the Nigeria Academy of Science's Strengthening Health Systems in Nigeria (Odubanjo, Badejo & Sofola, 2009), Nigeria Health Sector Political Economy Report (Anyebe, Bezzano & Foot, 2005) etc. In particular, the DOC Analysis directed attention to structural and institutional factors likely to 'drive' change in the medium term, and to the underlying interests and incentives that affect the environment of reforms in Nigeria. In undertaking this policy review, the systematic analysis of secondary data was enriched by my position of a 'reflective researcher' that is embedded within this policy environment.

4.3. Data Analysis

The data collected from the two sites was analysed in two stages. An initial case analysis of each site was followed by a comparative case analysis (Miles & Huberman, 1994). The key approach to data analysis was constant comparison, using some principles of 'grounded theory' - developing analytical constructs that were then used in an iterative manner across the findings from the various research methods employed - to allow the researcher confirm, reject, or modify concepts during the analysis (Green, 1998; Lingard, Albert & Levinson, 2008).

Based on the interviews, my observation at the meetings of each HIV/AIDS Programme Cluster along with review of the minutes of the meetings, process tracing of the care pathway, and the review of relevant documents; an analysis of the findings from each site was made, following which comparison of the similarities and differences of the two clusters were carried out. But these were preceded by institutional analysis of the HIV/AIDS programing context that was informed by the policy analysis of the reform context for collaborative service delivery. Specific themes for analysis such as: emergence of collaborating entities; membership; management structure; core agenda; and integration with routine clinical services, were identified and used based on expected collaborative parameters from the data. This information was compared to the theoretical perspectives of networks relevant to this study: theoretical concepts of collaboration, and the setting within which collaborative activities were said to have happened. Patterns of agreement or disagreement between the data and these frames of reference in addition to previous research findings were used to determine the character and formation of clinical networks in Rivers State, Nigeria.

Following this, each case was compared to the other using matrices of various data sets (Appendix VII). Based on the topic areas, sets of variables from the data were created and used to compare across each case. The above findings were specifically reviewed to focus on the quality of existing collaborative relations and to identify barriers that have led to the failure of such relationships or where they have not been formed in the first place. By noting regularities, patterns (differences/similarities), explanations, possible configurations, causal flow, and propositions; the findings were verified against theoretical perspectives and evidence-based practice on inter-organisational health networks. But the conclusions on the feasibility of the clinical network in Nigeria are drawn based on its ability to effect change within the health sector in this environment.

The feasibility of implementing clinical networks in Nigeria should have been based on two major criteria: (i) the *cost* of adopting this concept, and (ii) its *value* - in relation to other alternatives (Young, 1970). But for this research study, I assume that the cost of implementation is the same for all available options, while the value is considered equivalent to the ability of each of the available options to be maintained at a certain rate or level. In this instance, the ‘sustainability of the idea of clinical networks’ within the exiting institutional arrangements found within the health system in Nigeria. That is, *whether the idea of the MCN as a form of health service integration will work in Nigeria, if it arrives.*

4.3.1 Approach to the Feasibility Assessment

Though policy transfer literature recognises the significance of contextual considerations with respect to ‘whether’, ‘how’ or ‘why’ a policy may travel; Dolowitz & Marsh (2012: 340) suggest that to understand the process of transfer of a policy and ‘examine its influence on policy outcomes’, policy transfer needs to be treated as an ‘independent variable’. James & Lodge (2003: 190) cited an example that adopted this approach to explore ‘the extent to which the ‘executive agency’ model of public service delivery, as developed in the UK, was emulated in different countries’. This research study follows this precedent.

A key objective of this research study is to test the emerging findings against the feasibility of implementing change within the Nigerian health system through *clinical networks*. But given that this is an exploratory study, the feasibility of clinical networks in Nigeria is assessed from three different aspects based on the findings and analysis of the two HIV/AIDS Programme Clusters in Rivers State evaluated by this research, and the institutional and HIV/AIDS contexts that were seen to have existed. As collaboration is considered by this

study as the essence of networks, the first level of feasibility assessment looks at *operational feasibility* of the clinical network approach as a ‘collaborative enterprise’ using a set of criteria that are designed to assess whether (and how well) the clinical networks under review exhibited (or did not exhibit) key features of successful collaborative endeavours. These are based on empirical evidence from collaborative efforts among similar organisations in human services, government and other non-profit organisations. And the domains in which the criteria are specified include: motivation, process, outcomes and other features. Next is *contextual feasibility*, which examines how viable (survives and thrives) the clinical network form is within its specific institutional environment in relation to the existing political economy. It is an assessment of the practicability of the assessed clinical networks against certain institutional dimensions such as political and regulatory framework, administrative capacity, health service processes and procedures, funding (or financial flows), stakeholder actions and organisational logistics arrangements that exist in Nigeria. And finally, *interventional feasibility* whereby the clinical network model is purported to be designed to achieve desired outcomes following a particular ‘theory of change’ that takes into account both its operational features and environmental factors. In this instance, ideas about how best to implement the clinical networks in Nigeria are tested based on an expressed hypothesis and assumptions - i.e. positing a theory of change and action.

The usefulness of this method is that depending on one’s needs, it tends to answer the fundamental question posed by this research: ‘Is the network a feasible form of healthcare delivery in Nigeria?’ More so, when all the three dimensions of feasibility as outlined above are taken together, it increases the degree of confidence to make a definitive judgment to determine whether clinical networks can function in this setting. Furthermore, for practical purposes this approach may also be useful in terms of responding to the extended concern of

how feasible - i.e. what health policy makers should be watching out for; and changes needed to be made as implementation proceeds.

4.4 The Position of the Researcher

Fine (1994) described the relationship between the researcher and the researched in social research as a complex encounter, with 'self and other knottily entangled'. A recognition and acceptance of this statement could help researchers to come to a deeper understanding of not only the research that is being undertaking, but also of themselves, both as researchers and as individuals. Within the text of this thesis, reference is made to specific situations in which I have been involved first at my personal level as a 'citizen-actor' of Nigeria that interacts with the structural features through the formal and informal institutions to create change within the sphere of my influence; and secondly at a professional level in the Nigerian health sector - initially as *Health Advisor* (2001 to 2006) for the United Kingdom Department for International Development and later as an *Independent Consultant* (2006 onwards) to different levels of governments (Federal, States and Local Governments), voluntary and private organisations, in addition to international development agencies, in order to effect change within the health system.

Even as I recognise that in some instances 'I the researcher' may also be involved 'in the world of those researched' (Smith, 2002), I maintained the position of an outsider looking inside (O'Leary, 2012). It was natural for me to adopt this location as it correlated very well with my professional role as an independent consultant or adviser within each project, which has been that of an outsider entering a setting in order to facilitate change within the setting, by engaging with a group of insiders. Therefore, these experiences and observations have not largely influenced my objectivity with respect to the interpretation of the accounts and the

final written work. But significantly, I have somewhat used them as historical data where necessary to support my argument. And though ethical considerations do not allow me to use original documentation in many cases, as much as possible the authenticity of these personal and professional experiences has been preserved.

Nevertheless, as others (Ekins & Stone, 2012) have also found out, the central significance of my ‘self’ upon my ‘research’ has been its impact on the research process right from the decision to embark on this doctoral research through identification of the research focus, the choice of methods and the development of the analytical framework to the ultimate presentation of the thesis.

Therefore, the justification of using personal and professional experiences in this study is because they provide opportunities for testing models of collaborative activities both in the broader ecosystem of the Nigerian nation and its specific health service context. And while process of testing models cannot be undertaken experimentally with materials of this nature, it is possible to explore the materials in a critical manner to see if what is being described fits the general theoretical position of collaboration and networks.

4.4.1 Personal reflections on my role in the research process

The qualitative research methodology adopted in this research meant that much rested on my own capacity to ‘see’ how the policy of network development for HIV/AIDS services had landed in the two study sites. I follow Cunliffe (2003) and Mauthner & Doucet, (2003) in recognising the influence that the researcher will, inevitably, exert on the accounts of social and organizational phenomena. As Cunliffe (2003: 985) argues, ‘we need to go further than questioning the truth claims of others, to question how we as researchers (and practitioners)

also make truth claims and construct meaning.’ In all the aspects of design and conduct of the research, an understanding of the way in which my choices - declared and implicit - have been based on presumptions about knowledge, and the way my reading of events and my invitation and interpretation of others’ accounts of the network experience have formed a particular story of policy transfer is crucial to a reading of this thesis. It starts, in many ways from my interest in the topic and in the theoretical lenses I have adopted. But it also starts with my position - my social position - as both ‘insider’ and ‘outsider’, which was taken by me as the researcher. My insider position derives from my sharing professional features, notably my status as a qualified medical practitioner, with some of the research participants, and with the language and knowledge of the field of HIV/AIDS that I was able to deploy, as someone with medical training and experience. I could speak the doctors’ language; I could understand and anticipate the medics’ requirements for effective practice; I could understand the uncertainties and politics of the networked services from the medical point of view. Much that was shared could also, then, be taken for granted and, in interviews, we could move quickly over some of these matters, and, whilst recognising their experience, move straight to others that I considered perhaps more central to my concerns. For example, issues around the care protocols and the clinical pathway taken by HIV/AIDS patients at the Anti-Retroviral Treatment sites. My outsider status has to do with being an independent agent. I was not a member of staff of the River State Ministry of Health and related agencies, nor was I directly implementing any health project on its behalf or for a third party. My participants’ experience of outsiders might not always be rewarding, and to secure access in the case study settings required a certain authority on which straightforward interest in the HIV/AIDS services and a willingness to discuss issues they raised would build a degree of trust (or tolerance of the intrusion). The insider and outsider statuses, thus, directly clashed and required fine balance in the field. For example, there was a perception among several

participants that being a medical doctor meant that I understand the issues that were raised, but coming from outside the State Ministry of Health allowed me to be objective about their real nature.

The effects of this dual position were likely to reverberate in the account that I give. I set out in as far as possible to guard against potential bias by simply being aware of my personal beliefs, experiences and values and where these might or did influence the study methodology, design and/or results (DeLyser, 2001; Greene, 2014). I sought then to mitigate this, for example by employing a number of practices (Greene, 2014; Glesne & Peshkin, 1992; Lincoln & Guba, 1985).

The process of gaining and maintaining access to the study sites is an instructive example. I established authority, at least enough to gain outsider access to the sites, by ensuring that as well as carrying formal ethical approval from my Research Institute (Keele University), I also requested access from the Rivers State Agency for the Control of AIDS, and the Rivers State Ministry of Health. This process apart from helping to lay down the ground rules for the conduct of the research, also explicitly communicated the practical value of the research, which helped individuals and organisations associated with the research to decide whether to participate or not. Not all did, and the difficulty I had in maintaining access as the dates of meetings changed suggests that official access does not mean effective access. I was not always able to get adequate accounts of the meetings I missed. And not all participants agreed to participate. This will have led to biases, and some may have been systematic reactions to my insider and/or outsider status.

Reflexivity also demands attention to the researcher's 'command' of truth' - that is, the capacity to offer a plausible account, recognizable to those involved as a description and explanation of their experience (Guba & Lincoln, 1998). Throughout the data collection and analysis period, I kept copious field notes alongside a log of my daily activities and a diary summarising my personal reflection. In my interviews with key informants and analysis of the data, I was very cautious of not projecting my own views onto the research participants and the data that was being analysed. Moreover, by way of 'triangulation' in order to ensure the validity of the research data, I used multiple sources of information and research methods to generate the research evidence. I also discussed the research findings from the initial analysis of the data with some key members of each cluster (towards the end of the data gathering period) to ensure that the research has been critically thought through, and to identify any feelings that might have affected my judgement.

Finally, throughout the research process I actively engaged myself in questioning perceptions, as well as exposing their contextualised and power driven nature (Bourdieu & Wacquant, 1992). This was done through prolonged engagement well beyond the data collection period. These approaches allowed me to ensure that by keeping the focus on those being researched, I was able to understand that this research is not only about what cluster members tell me about what is going on within these groups, but also what I can ascertain from my interactions with them. For instance, the minutes of the cluster meetings often report the outcomes of member interactions, which can be different from the communicated intentions of participants.

4.5 Ethical Considerations

While many health professionals in Nigerian who work on the frontline are frustrated by the fragmented delivery system, they feel powerless in doing something about it. Therefore, any proposed activity that can help in finding ways of providing an alternative could be a welcome development.

Nonetheless, qualitative interviews on a sensitive topic such as this that could result in re-configuring the health system may evoke emotional responses. In order to protect participants from any form of harm, a process of engagement to win their trust was undertaken prior to obtaining formal consent to participate. Information on the research study was presented in a comprehensive manner to include: a full disclosure of the purpose of the research, its main features, and the potential risks (if any) and benefits of participation. The concern for confidentiality was addressed, as well as the right of withdrawal from the study. An information sheet that contained all these issues was provided in order to obtain verbal rather than signed consents - to reinforce anonymity. Towards the end of the data gathering process (during the follow-up) interviews, participants were made to preview my analysis of their network - to validate the data and to be sure they are happy with the use of their data.

4.6 Limitations of the Study

In this section, a number of limitations of the research are acknowledged, related to the methods used, work undertaken and lines of inquiry that were left unexplored.

A first, and perhaps the main, limitation of this study is associated with ‘the most frequently discussed reservation about qualitative research’, the generalisability of the research findings (Fulop et al, 2001: 51). While this research offers the reader a communicated experience of

an individual case of transfer of the idea of the Managed Clinical Network to a less advanced setting - Nigeria; in 'statistical' terms, the ratio of settings studied relative to the population to which the findings could be generalised (across Nigeria and/or other developing countries) is exceedingly low. It is also the case that the study rests on a methodological and theoretical principle of contextual privilege. That is, the specific configuration of the context is crucial to understanding the likelihood that an idea will translate and become assimilated. The thesis deals at some length with the particular character of the Nigerian health system and no claim can be made that it is 'like enough' to other national contexts, or even that Rivers State is sufficiently similar to other States in Nigeria, that an equivalent experience of translation could be assumed were networking to be introduced or studied elsewhere. But, as this study has provided 'detailed descriptions', Scale (1999) suggests that this can provide a basis on which to decide about the applicability of the research findings to other contexts.

Whilst the thesis does present the cases studies in some detail, I also report a situation that a constraint was encountered during the data collection period, which resulted in a relatively limited number of direct observations of the meetings of the HIV/AIDS Programme clusters in each of the sites. Four to six meeting observations per site were planned, but attendance at only two meetings in each case was achieved. This was due to unpredictability of the cluster meetings (meetings failing to hold on scheduled dates due to one reason or the other) after traveling to the venues that were over 50 kilometres in each direction on bad roads. This was somewhat compensated for, by securing minutes of cluster meetings covering a period of over one year in each site, including after the site visits which allowed an assessment of the validity and completeness of the minutes against the experience of the meeting discussions themselves.

In terms of the coverage of possible lines of inquiry, the thesis stayed close to the process of translation on the ground for the primary data collection, at least. Another study might have given greater privilege to the earlier stages and processes of policy adoption, discussed in this thesis using only secondary sources and in providing the context to the process of implementation. Even in the main study site - the two cases - the primary data collected did not allow a particularly nuanced account of the dynamics of change, or the struggles and forms of power at play in the processes that led to the different forms the two networks took. These remain projects for future inquiry.

Chapter Summary

Other than describing the research design, the research methods used (and the justification for using them) to answer the research question; the way the data was analysed was also explained in this chapter. In addition, the chapter also clarified: ethical issues that were raised and how these were addressed; the limitations of the study; and my role in the research process as an insider with medical training, but an outsider who was not part of the work setting in Rivers State, Nigeria.

Chapter 5 - Findings I: Policy and Institutional Analysis

In this chapter, the first set of findings are presented. These concern the ‘policy analysis’ of the Nigerian implementation context carried out using the policy and institutional analysis framework developed in chapter 2. As this study has already established, context matters. This chapter provides a summary of the observations of the policy, institutional, and disease-specific contexts in Nigeria, into which the transfer of the idea of the managed clinical network (MCN) as a form of service integration was contemplated. The chapter starts by outlining the role of Global Multilateral Action that provoked the ‘policy transfer’ agenda in the control and prevention of HIV/AIDS; and how this influenced national HIV/AIDS policies and programmes in developing countries. It then goes on to present the key features of the national ‘policy reform context’ for collaborative service delivery for HIV/AIDS in Nigeria. These include: the overall political economy of Nigeria; the health service structure and organisation in Nigeria; the institutional arrangements for the HIV/AIDS control programme in Nigeria; and the implementation of the HIV/AIDS control programme in Rivers State, where this research study was undertaken.

5.1 The Role of Global Multilateral Action in HIV/AIDS Policy Transfer

Looking at things from an organisational perspective, the idea that a ‘wicked problem’ such as HIV/AIDS demand a move away from traditional ‘command-and-control’ style of management as exhibited by hierarchies; to one that is more inclusive, collaborative and dynamic that networks promise was seen to have been embraced by the global community through ‘institutional entrepreneurship’ (Hwang & Powell, 2005); where the resulting institutional changes were mainly due to the actions taken by the Joint United Nations (UN) Programme on HIV/AIDS (better known as UNAIDS) that acted as a ‘policy entrepreneur’ within the UN system (Nay, 2012).

Hwang & Powell (2005) showed how creating change in existing institutional arrangements could be considered as a form of entrepreneurship. They listed professional knowledge both in terms of professionals expanding their jurisdiction, and creating standards of practice, in addition to rule making or the creation of formal laws that define the playing field; as the three main processes that could facilitate institutional change. As noted by Nay (2012), the UNAIDS demonstrated all three elements by capitalising on its convening role on HIV/AIDS within the UN system to influence the transfer of policy ideas in this domain. And this entrepreneurial activity of UNAIDS was seen to have been critical to the emergence of national HIV/AIDS policies and programmes that had in turn created new institutions for HIV/AIDs, as new models of service delivery within the health system.

Records (UNAIDS, 2005) showed that as the HIV/AIDS situation created a global emergency bordering on panic, the response to the HIV/AIDS pandemic was subject to very sharp controversies about the most appropriate choices to be operated effectively, against the disease. Central to this was in setting the global HIV/AIDS agenda, where a competitive process ensued in which all policy actors and stakeholders seek to frame ‘policy problems’ and to influence the identification of appropriate ‘solutions’ to these problems (Nay, 2012). And this competitive circulation of ideas on how to craft ‘policy solutions’ for HIV/AIDS mobilised various state and non-state actors although seen to have come from the same public policy networks.

Notable among these were United Nations (UN) agencies - World Health Organisation (WHO), United Nations Children’s Fund (UNICEF), United Nations Fund for Population Activities (UNFPA), United National Education and Scientific Organisation (UNESCO), United Nations Office for Drug Control (UNDOC), World Food Programme (WFP), United

Nations Humanitarian Committee for Refugees (UNHCR), International Labour Organisation (ILO); other multilateral agencies - World Bank; Bi-lateral donors, especially United States of America (USA), United Kingdom (UK), Canada, Australia, Japan and the Scandinavian states; Recipient countries of international Aid in Asia, Africa, Latin America and the Caribbean; Academia, Think-Tanks, and Research Institutes; the Private Sector, Civil Society Organisations (CSOs), Advocacy and Coalition Groups, and Non-Governmental Organisations (NGOs) both international and national. But these large numbers of actors were said to have different interests, and do not support the same policy priorities neither do they share the same norms and beliefs with regards to 'policy solutions' for HIV/AIDS.

In the meantime, financing for prevention, care and support, and treatment activities in developing countries increased by an order of magnitude, in particular through the advent of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund); in addition to on-going funding from the World Bank's Multi-Country HIV/AIDS Africa Programme (MAP) and the US President's Emergency Plan for AIDS Relief (PEPFAR). At the same time, Governments across the world committed themselves to accelerating their responses to the epidemic in their respective countries; while antiretroviral therapy has been shown to work in resource-poor settings, even as consensus was emerging that the international community should commit to working towards achieving universal access to treatment and prevention services.

Nevertheless, many organisations especially the UN agencies continued to undertake HIV/AIDS interventions along their areas of expertise, consolidate data and disseminate policy ideas to their different constituencies (Nay, 2012). Thus among others, WHO focused on access to HIV treatment, UNICEF on orphans and vulnerable children and mother-to-child

transmission, UNFPA on condom programming, UNODC on injecting drug users, UNESCO on HIV educational settings, UNHCR on refugees, WFP on AIDS and malnutrition, and ILO on work place policies. Naturally, a situation of this nature requires some sort of policy coordination that goes beyond the capacity of one agency to undertake. The failure of WHO in the early 1990s, to lead a global partnership programme to respond to the HIV and AIDS epidemic in association with other UN agencies could not have come therefore as a surprise (Lisk, 2010).

Based on an empirical analysis of the Joint United Nations (UN) Programme on HIV/AIDS; Nay (2012) argued that following a ‘policy transfer’ approach, the UNAIDS Programme created a coordination platform for transferring policy ideas on HIV and AIDS globally. Its key objective was on policy-making activities and partnerships for HIV/AIDS globally - bringing together efforts and resources of the UNAIDS Secretariat and the ten multilateral organisations that are members of UNAIDS (UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO and the World Bank). Nay (2012) observed that while many terms might describe what the UNAIDS Secretariat does in line with its mandate: facilitating, brokering, liaising, networking, coordinating, intermediating, conveying ideas, building bridges, disseminating, diffusing, relaying, integrating, merging and mainstreaming; each term refers to a specific type of work, but they all relate to two broad sets of activities: first, it establishes agreements among policy actors driven by self-interest (interest brokering); and second, it shapes common understandings and shared perceptions regarding policy issues (idea brokering).

Nay (2012) further explained that one of the core aspects of the UN mandate is to elaborate and disseminate policy guidance in order to encourage national governments to go beyond

their self-interest and build international consensus on key development issues. As such the involvement of the UN in the production of policy ideas about AIDS through the UNAIDS Programme is in keeping with that mandate. But it was also noted that many actors involved in the global governance of HIV/AIDS (including coalitions of activists and NGOs) exerted great pressure on UNAIDS to create the conditions for international and national partners to converge towards a common understanding of policy priorities; while governments of the North long accused of not mobilising the level of resources needed to respond to the massive expansion of the epidemic in poor countries were looking for a ‘common pot’ to put their resources. Moreover, the specificity of the epidemic, which requires paying special attention to information, education and communication (IEC) strategies to prevent the epidemic also required a coordinated approach to avoid mixed messages. At the same time, ‘advocacy campaigns’ bringing together UN agencies, scientific communities and advocacy groups who have been strategic for involving national political elites and development partners who may have been reluctant to scale up the response to AIDS, or who have even been promoting ideological campaigns that hamper international efforts, also needed a common global platform to engage with. Therefore, Nay (2012) argued that the policy coordination role undertaken by the UNAIDS Programme was legitimate; its fragile institutional legitimacy compared to well-established UN agencies or national institutions working on HIV and AIDS, notwithstanding.

Drawing on the public policy literature on policy transfer to clarify the role of UNAIDS in relation to articulating and disseminating relevant HIV and AIDS policies to support country-level implementation of interventions; Nay (2102) argued that policy transfer is a useful social construct for understanding the involvement of state and non-state actors who actively participate in the elaboration of policy-oriented information and knowledge. And depending

on the context, these actors who may be professionals, experts, and decision-makers within a wide variety of stakeholders; borrow, adapt, and put forward policy approaches and opinions, often with a view to promote the interests of their organisations and constituencies. He focused on three complimentary approaches: (i) transfer of policy goals (policy diffusion); (ii) transfer of institutions (new institutionalist perspective); and (iii) transfer of ideas as the basis for his analysis. But he cautions that they should not be confused with each other. As outlined below, all three approaches are seen to apply to this research study.

Nay (2012) referred to ‘policy diffusion’ perspectives that stress the usefulness of cross-national processes through which policy goals, procedures and instruments can be conveyed beyond national borders. But as illustrated in this case study and also supported by Clark (2009) who looked at policy adoption in dynamic international environments with evidence from National AIDS Programmes; the coordination role being undertaken by UNAIDS goes beyond transfer of policy across national boundaries. In as much as policy makers tend to take shortcuts to solve complex problems, it has been observed that policy diffusion, which is characterised by uncoordinated interdependence, is distinct from multilateral action that is an explicit effort to coordinate action (Elkins & Simmons, 2005). Nevertheless, ‘the broader policy diffusion literature would suggest that as more neighbouring countries adopt policies, a country would have an increasing opportunity to adopt legislation to combat the HIV/AIDS epidemic’ (Clark, 2012: 2).

From new institutionalist perspective, Nay (2012) identified policy transfer processes that focused on organisational processes, which ensure the dominance of some institutional models (values, policy-oriented beliefs, routines, standard procedures, roles and patterns of behaviour, among others) that may result in ‘isomorphic processes’ among organisations.

This research study demonstrates that while the transfer of institutions by creating similar structures such as the adoption of multi-sectoral coordinating national agencies for HIV and AIDS appeared intuitive; as predicted by Peters (1997) it underestimated the role of actors and the dynamics of power involved in transfer processes. Although its merit of identifying ‘patterns’ of policy transfer through holistic approaches, concentrating primarily on structural factors and on macro-social processes associated with the diffusion of policy standards and ideas is well recognised (Nay, 2012).

Of particular interest to this study is UNAIDS’s (2004) role in promoting the ‘Three Ones’ key principles for coordination of national responses to HIV/AIDS, aimed at bringing together self-coordinating entities, partnerships and funding mechanisms to take concerted action against HIV/AIDS. This was premised on the assumption that the increased but yet limited resources available to respond to the needs of people living with HIV and AIDS and those at risk of infection will be utilised more efficiently if there is maximum coordination within the international community. Moreover, the perspectives that frame the debates on HIV and AIDS noted that policy problems associated with the epidemic are multidimensional; therefore, policy solutions should be multi-sectoral. The significant output from this initiative was the establishment of National AIDS Commissions or Councils (NACs), as one National AIDS Coordinating Authority with a broad based multi-sector mandate. As observed by this case study, the success of NACs was depended on constant adaptation of this institutional model to better suit local circumstances. But most importantly, the study noted that the power, authority and credibility of NACs appeared not to be based on their location in the wider country-system, but was partly depended on the personalities and relationships between key individuals in the NAC and broader areas of government and other sector.

Finally, Nay (2012) commented on the transfer of norms and ideas that could occur through interests, rational behaviours and power distribution among actors involved in public organisations and policy networks. These cover voluntary processes and rational behaviours, which are sometimes associated with different types of inducements and opportunities, as well as forms of coercion. And as cautioned by Wolman & Page (2002), it is important to examine the intentions and motivations of the various actors involved in the production and dissemination of ideas. In this instance and in relation to this research study, the role played by UNAIDS within the multi-lateral system that played out at the country level is very instructive. Once more Nay's (2012) policy transfer analytical work of UNAIDS supports the findings in this case study that multi-lateral agencies working in HIV/AIDS in Nigeria gained influence by engaging in the sphere of ideas. And Nay's (2012) chronicle of UNAIDS activities in disseminating expert knowledge and scientific information proves this point.

In Nay's (2012) account, the UNAIDS Secretariat has one of the most sophisticated data banks on the HIV and AIDS epidemic, and its annual report on the global AIDS epidemic provides data and projections that are used by most actors and stakeholders working on AIDS. It also publishes various reports, policy guidelines, abstracts and documents. It has been particularly active in developing partnerships with scientific networks and advocacy coalitions (AIDS activists' organisations, networks of people living with HIV, community leaders and associations representing vulnerable populations), which are pressing on the UN system to develop innovative responses to AIDS. In addition, it worked hard to bring out some policy issues that could reduce cognitive dissonance among UN programmes, and subsequently could be endorsed and shared among its co-sponsors.

Nay (2012) noted that through these activities, the UNAIDS Secretariat accumulated policy inputs emerging from experiences and actors in the field, with the goal of building up a corpus of evidence-based, innovative knowledge to serve as general guidance for all stakeholders, including its co-sponsors. It thus acquired greater intellectual influence on two levels: socio-demographic and economic projections on the evolution of the epidemic worldwide, and qualitative analysis of key policy results drawn from national programmes and grass-roots projects on prevention, treatment, care and support. In particular, the incorporation of civil society inputs was said to have contributed to the introduction of ideas about grass-roots experiences into the UNAIDS programme, such as the issue of HIV/AIDS-related stigma and discrimination and the need for more inclusiveness of people living with HIV.

Consequently, Nay (2012) concluded that UNAIDS's capacity to influence policy dialogue and to frame the perception of social, economic and political problems related to AIDS, was critical to the development of HIV and AIDS policy at country level. And this was said to have been achieved by the UNAIDS experts through the emphasis given to the 'multidimensional' nature of HIV and AIDS. Their argument it was noted came from evidence-based observations that scattered and sectoral projects on HIV and AIDS usually lead to ineffective and costly solutions at country level. Whereas comprehensive and coordinated programmes that articulate the various aspects of the response to the epidemic (epidemiological, medical, economic, financial, political, social and cultural) were likely to lead to more coherent and more effective HIV and AIDS policies (Poku, Whiteside & Sandkjaer, 2007). Similarly, prevention of HIV, treatment, in addition to care and support seen as mutually reinforcing elements, should be integrated at all levels, from community-based projects to international policies.

Thus one can say with certainty that this was the source of importation by the Global Fund in Nigeria, of the idea of the 'Integrated Cluster Model' for developing a network or clusters of secondary and primary facilities that provide comprehensive HIV/AIDS care - encompassing prevention, treatment and community outreach services. Alternatively, as the Global Fund was brought under the UNAIDS multi-lateral coordination framework, this policy of integrated care approach for HIV/AIDS services was a given, for which the Global Fund was expected to adopt. As illustrated by the findings of this research study, the adoption of the Integrated Cluster Model upon which the Global Fund Round 5 Grant was awarded to Nigeria, provided the very basis for the formation and operation of the clinical networks - the HIV/AIDS Programme Clusters that were studied. Although one could say that the argument for a multi-sectoral approach that led to the adoption of the Integrated Cluster Model was very compelling; the funding from the Global Fund appeared to have been a very strong inducement as shown by this research study, as it facilitated the strengthening of the links between general hospitals, primary health care facilities and community based efforts to ensure a continuum of care for people living with HIV/AIDS.

This position is confirmed by Clark (2009; 2012), who noted that Development Aid can influence HIV/AIDS policy, since HIV/AIDS funding is often restricted. And these restrictions frequently necessitate the adoption of policies favoured by the donor, even where these restrictions are not always in line with the priorities of the country receiving the Aid. He illustrated this assertion with the US government, President's Emergency Plan for AIDS Relief (PEPFAR) that directed funding to be spent on specific activities, in particular on abstinence programme. He went on to show that coercion is not always direct, and can be implemented through an international Non-Governmental Organisation (NGO) or Multi-

lateral Agency; paradoxically these organisations could also be used by donors for the transmission of good practice from one country to the other.

In as much as Nay's (2012) empirical analysis of UNAIDS claimed to have focused primarily on its influence within the organisational environment of the UN system, it provided enough evidence that gave an insight into its influence in broader HIV/AIDS-related policy networks, which join various state and non-state actors. There is a strong recognition that international development is an area of much application of policy transfer ideas (Stone, 2011); where multi-lateral organisations are shown to be positive catalysts in advancing policy innovation in the diffusion of public policy (Altman, 1999; Tews, 2005; Clark, 2009; 2012). Others point to the successes of international coordination and consensus building but also to the governance challenges of implementation at national and local levels (Ngoasong, 2011). Nevertheless, the influence of multilateral action at the country level, working through UNAIDS that disseminated expert knowledge and scientific information on HIV/AIDS globally could be considered to have been critical in Nigeria to the formulation of national HIV/AIDS policies and programmes that in turn influenced the way the clinical networks under study emerged.

5.2 Nigeria Political Economy contexts

Nigeria is a federal country whereby the Federal Government of Nigeria (FGN), the 36 States and the Federal Capital Territory (FCT), as well as the 774 Local Government Areas (LGAs) derive their power from the national constitution (Federal Republic of Nigeria, 2004). And as a political system patterned after the American model of democracy, public policy decisions at all levels are products of bargaining and compromise among conflicting interests; inherent in a federal system of checks and balances (Knoke & Chen, 2008). With huge oil wealth

accounting for over 95% of government revenues, there is intense struggle between competing elite groups on one hand, and between regional groups that struggle to control these resources at the central level, on the other hand (Anyebe, Bezzano & Foot, 2005).

Overall, public governance systems including financial management systems tend to be weak, but these are sometimes influenced by the values and behaviour of those outside governments (World Bank, 2009). This is because; a large proportion of social, economic, and political transactions take place outside the formal system, even where a formal system exists. Therefore, it would not be sufficient for collective actions to engage with the formal system alone, as the strength of informal arrangements: patronage politics, traditional authority, extra-legal arrangements and activities, often circumvent or replace the formal system.

The 36 State Governments along with the 774 Local Government Councils exercise considerable political and fiscal autonomy, and consequently control over 50% of the national government resources (World Bank, 2009). Although these lower levels of governments have direct responsibility for providing public services: education, healthcare, water and sanitation etc., most of them have serious capacity constraints to effectively deliver these mandates (Anyebe, 2005). They are neither responsive, nor accountable to the Federal government. And Federal – States relationships tends to be conflictive. Nonetheless, some attention is being given to building consensus and coordination through the statutory forum of the National Council of States, which has the State Governors sitting alongside the Heads of the National Assembly (the two chambers of parliament), the incumbent President and his deputy and past Presidents or Heads of State. In addition, the Federal Government has put in place some incentives and rewards to challenge States to improve their performance.

These institutional features have been shown to have significant impact on the governance systems for healthcare in Nigeria. Thus the Nigeria healthcare system exhibits certain characteristics that could create the urge for or otherwise restrain collaboration among service providers. These include: organisational confusion among various actors on their respective roles; economic constraints on the capacity of government to deliver a basic package of care to all citizens; widespread corruption in the public sector that permeates into the health sector; and inappropriate interference by international donors as they try to implement their global mandates. But it is vested interest and a tendency to maintain the status quo that has mainly caused the present disjuncture in policy and strategy development, which in turn has led to fragmentation of care.

On the surface, this institutional context may represent ‘the existing arrangement of territories, functions and practices, and the ways in which these are organisationally, professionally and politically demarcated and defended’ (Cropper, 1996: 92). In reality, the institutional environment of healthcare is a reflection of the wider political economy and social milieu that exist in Nigeria. Reflectively, the key driver is the federal system, which although has contributed to the survival of Nigeria as a somewhat cohesive nation, it has also maintained the potential cleavages resulting from the complexity of holding together over 300 ethnic groups with 500 indigenous languages and adopting two major foreign religions, Islam and Christianity (Amundsen, 2010).

While tensions between Federal and State governments that particularly play out in health policy and strategy development disjuncture is partly technical, the officials on both sides fail to understand the importance of dealing with this problem; it also relates to persistent vested interests being displayed by both Federal and States health authorities (DFID, 2007). State

Ministries of Health are protective of their independence in decision-making, and tend to favour large, visible, capital-intensive physical projects. Whereas, the behaviour of the Federal Ministry of Health and its agencies is influenced by a desire to retain existing channels of expenditure and the political and financial opportunities that these provide. Dealing with this issue requires agents both within and outside the system who are able to act differently to progress a reform agenda.

In the meantime, healthcare service agents are brought into this picture with respect to their role as part of the public service, or in the private and voluntary sectors (Anyebe, Bezzano & Foot, 2005). Nevertheless, in as much as these agents are identified by their place in the health sector, they have been swept along by events and forces at play elsewhere in the economy. At the same time, some aspects of Nigeria's institutional make-up have come to assume structure-like characteristics (Heymans & Pycoft, 2003). In particular, the dominance of the political elite has become self-perpetuating and this is rooted in structural realities and institutional patterns like oil wealth, ethnic and other cleavages and traditional systems of patronage. This has in turn weakened other aspects of the institutional framework related to democracy, free markets and accountable service delivery.

5.3 Health Service Structure and Organisation in Nigeria

The public health system in Nigeria is simple in design but complex in operation. Essentially, it is in three tiers: Federal, State and Local Government Areas (LGAs) but in practice it is highly fragmented with many different agents responsible for aspects of the same service. This could be attributed to the differentiated polity (Rhodes, 1994; 1997; Rhodes et al, 2003), characterised by: political devolution into 36 States; institutional fragmentation and inter-dependencies, where state level public sector Ministries, Departments and Agencies (MDAs)

have no direct line relationship with the federal counterparts, but rely on them to give national policy direction; as well as functional decentralisation with parastatal agencies having health programme implementation mandates.

The Federal government through the Federal Ministry of Health (FMOH), sets overall policy goals, co-ordinates activities, ensures quality, training and implements health sector programmes. Over the years, the Federal Government has attempted to fulfill its health care mandate by retaining considerable control of programme implementation through its agencies. The National Primary Health Care Development Agency (NPHCDA) for instance, was set up primarily to ensure the institutionalisation and sustainability of primary health care (PHC). It provides technical direction to States and Local Governments in the implementation, supervision and monitoring of PHC. But the Agency has no formal or institutionalised relationship with other departments or agencies of the FMOH that also provide significant technical support to the States and LGAs. Therefore, although these federal institutions are working towards the same goal of improving the health and well being of Nigerians, collaboration and the co-ordination of activities among them is poor (Johnson, 2000).

A similar situation exists at the State level, particularly in relation to oversight of PHC delivery. At present, with minor variations among States, PHC implementation is supported, supervised, monitored and evaluated by the State Government through the State Ministry of Health (SMoH), State Ministry for Local Government (SMLG) and the Local Government Service Commission (LGSC). But despite the interrelationships of their functions, linkages among these key players in the management and delivery of PHC are neither sufficiently firm nor clearly defined. There is also no setting for generating the synergy required for effective

health care delivery at this level (Anyebe, 2005). Although there is now an attempt to streamline the delivery of PHC at the State level by bringing the financing and administration of PHC services under one health authority - the State Primary Health Care Development Agency or Board.

In addition to the challenges that exist in the power relationships *within* the Federal and State levels, relationships *between* the 3 tiers of government in their collective responsibility for the delivery of health care in Nigeria are poorly defined and their respective roles are not very clear. Some observers (DFID, 2007; Asoka, 2013b) believe that this uncertainty arises from constitutional omissions and/or commissions, as the Constitution of Nigeria is largely silent on health services (Federal Government of Nigeria, 2004). Even the National Health Act (Federal Republic of Nigeria, 2014) - the overarching national health law that was promulgated towards the end of 2014, failed to compensate for this lack of legal mandate. For instance, constitutionally the State Commissioners for Health are accountable to State Governors and not to the Federal Minister of Health. State Governors and Chairman of Local Governments often follow their own agendas rather than health sector strategic direction set by the FMOH. Meanwhile, the Federal Minister of Health is responsible for the health of the nation, but (even with the new health law) does not have the authority or means to exercise the necessary managerial accountability.

Given the lack of coordination that exists within the public sector itself, it is not very surprising to note that government stewardship of the health system pays little attention to working with private providers to ensure that what goes on in this sector is in line with national health objectives. But since 2004, there has been a health reform programme led by the FMOH (Federal Ministry of Health, 2004a), aimed at resolving the conflicts of roles and

responsibilities among the tiers of government, as well as advancing a shared vision for a national health service with all actors. Following from this is the National Strategic Health Development Plan (NSHDP), 2010 - 2015 that incorporated State Strategic Health Development Plans (SSHDPs) from each of the 36 States; where one of the eight priority areas is 'partnership for health' that seeks to enhance harmonised implementation of essential health services across the country. The strategic focus here is to ensure that collaborative mechanisms are put in place for involving all partners (public, private, voluntary, community and external donors) in the development and sustenance of the health sector. And the core activities selected for achieving this include: public-private partnerships (PPP); coordination of international development partners' activities; and engaging professional groups to work together across organisational limitations (Federal Ministry of Health, 2010a).

The basis for undertaking a public-private partnership (PPP) policy within this framework is to leverage additional resources and managerial approaches from the private sector with the social orientation of the public sector in order to improve the delivery of health services. Although no one definition has been agreed upon, the essential feature is that there is collaboration between the public and private sectors to achieve specific goals with the public sector having a degree of supervision. In this context, PPPs are clearly not perceived as the same as privatisation, which involves complete transfer of public assets to private owners. And in line with the national policy on PPP, notable PPP initiatives that are undertaken at all levels (Federal, State and LGA) include: contracting or out-sourcing, leases, concessions, social marketing, and franchising. Two of such examples (Federal Ministry of Health, 2012) are: (1) In Ebonyi State, where Mission Hospitals are encouraged to set up in rural and underserved areas to expand coverage for maternal and child health services; as the public sector (government) provided complementary resources such as money, commodities and

staff, as incentives. (2) In several States, the public sector provides training in specific areas such as immunisation, family planning and handling of clinic wastes to the private sector at no cost, in return for spreading good practice, as well as undertaking these specific health service activities.

For the coordination of international development partners' activities, the National Health Policy (Federal Ministry of Health, 2004b) calls for the institutionalisation of mechanisms for the harmonisation and alignment of development partners' support to national health programmes. One key approach especially at the State level has been the Health Partners Coordinating Committee (HPCC). Chaired by the respective State Ministries of Health, and functioning at variable degrees; these committees are experimenting with modalities for joint working using national systems. A few models (briefly explained below) have been given serious consideration, and these include: Joint Funding Agreement, Sector Wide Approach, and sectoral multi-donor budget support.

Working via the State Partners Coordination Forum, Zamfara State reported (Federal Ministry of Health, 2012; PRRINN-MNCH, 2011) a significant improvement in immunisation coverage in 2010 through a 'Basket Fund' arrangement between the State and Local Governments, in addition to international development partners that financed a whole range of immunisation-related activities. This was made possible through negotiation among the parties involved to reach an agreement that increased their confidence to pool ear-marked funds for immunisation from the organisations together; in order to achieve a common purpose. Similarly, there is work-in-progress in Jigawa State, where a Sector-Wide Approach (SWAp) is bringing together the State and Local Governments, International Development Partners and a range of other Stakeholders within the health sector to agree on a 'set of

operating principles' to effectively streamline the activities of about 28 individual health programmes and projects; to work towards more coordinated management of the State's health development plans (Asoka, 2013a). A SWAp therefore calls for the development and sustenance of relationships, as well as more interaction among government, development partners and other stakeholders including the private sector, in the formulation of ideas and plans for making decisions in the health sector of a given State, and less on the implementation of these plans.

In engaging professional groups to work together across organisational limitations, the Nigeria health policy reforms (Federal Ministry of Health, 2004a) were aiming at strengthening the referral system between care levels that are administered by the different tiers of government through greater collaboration among health professionals; as well as implement treatment protocols and care pathways, which could begin to re-orientate health professionals away from provider-initiated care to client-centred care. Moreover, attempts at coordinating primary and secondary care at State level in Enugu and Jigawa States through the integration of the administrative structures respectively residing with Local and State Governments encountered serious implementation challenges (Uzochukwu et al, 2009; Odubanjo, Badejo, & Sofola, 2009). These have to do with how the new agencies (e.g. the District Health Boards in Enugu State) were to be jointly funded by the State and Local Governments; staff movements and concerns with career development; and some tensions between these new agencies and the State Ministry of Health in relation to certain administrative functions.

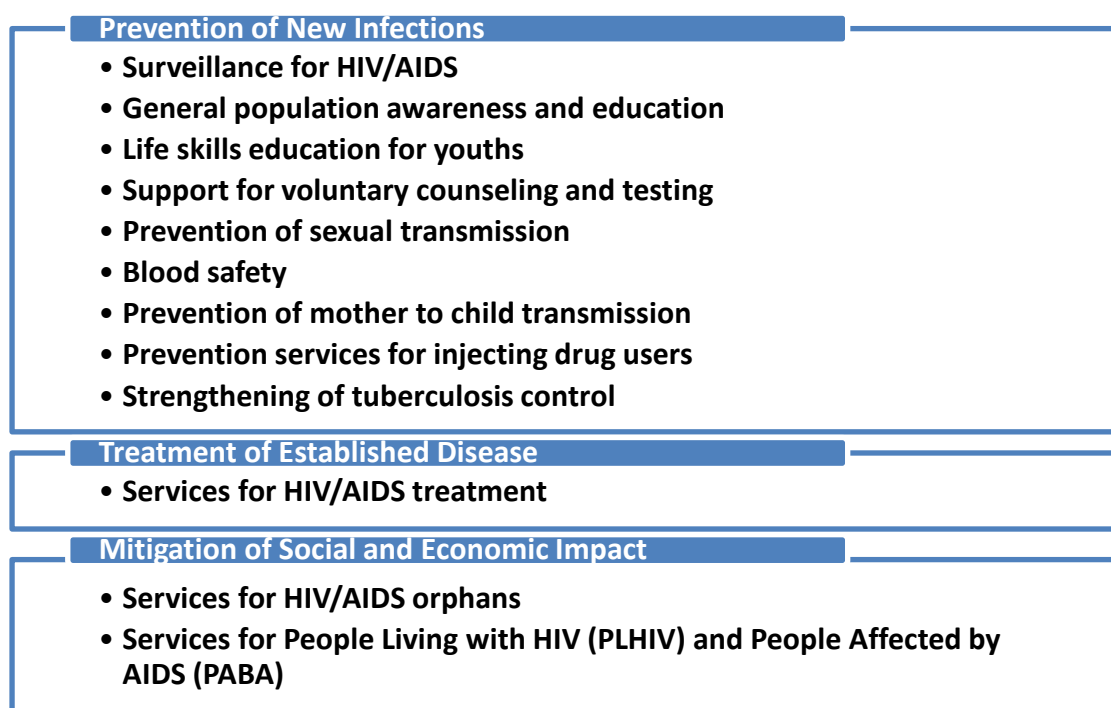
As demonstrated in this example, while the structural constraints that have led to the fragmentation of care remain dominant; changes to organisational structures, which are

reflected in legislation (rules) and financial allocation (resources); will face technical, organisational and possibly legal challenges. This thinking is now supporting the assumption that ‘functional integration’ may be easier to achieve than formal changes to the institutional structures. And such an expectation using the ‘clinical network’ to deliver better services is now opening up the possibilities for integrated care through collective action at the Local Government level. But based on empirical case study research from Wales, which drew on different types of examples of integration in health and social care; Williams & Sullivan (2009) noted that while actors make outcomes possible, their capacity to act is ultimately set by the structural context which they find themselves. In this regard, acts of collaboration will have to pay careful attention to incentives that address vested interests and a tendency to maintain the status quo. Understanding the different motivations that induce individuals and organisations to undertake cooperative strategies is said to be critical to managing this process (Williams & Sullivan, 2007).

5.4 Institutional Arrangements for HIV/AIDS Programming in Nigeria

Like in most parts of sub-Saharan Africa (SSA), as the HIV/AIDS epidemic overwhelmed the healthcare system, the response to the disease following global initiatives in Nigeria (at country level and sub-national levels) was seen to have been undertaken using a programme methodology. And due to its persistent nature as a chronic disease and the consequent socio-economic impact on economies and healthcare systems; a comprehensive strategy was noted to have been adopted along three main approaches. These include: (i) prevention of new infections, (ii) treatment of established disease, and (iii) the mitigation of impact on individuals and society. Furthermore, this strategy was observed to translate roughly into 12 service elements ordered under the three approaches as shown below on Figure 5.1.

Figure 5.1 Comprehensive HIV/AIDS Programme Strategy in Nigeria



Source: Grant, 2004

In addition, in fulfilment of the requirement for national governments' commitment as demonstrated by the formation, staffing and funding of a National HIV/AIDS Control Programme; Nigeria was seen to have established one national AIDS coordinating authority with a broad-based multi-sectoral mandate for HIV and AIDS, to guide the country's national response. However, as a federal country with a Federal Government, 36 States and a Federal Capital Territory, as well as 774 Local Government Areas (LGAs), the national response was noted to have been coordinated through this three-tier system of administration.

Consequently, apart from the National Agency for the Control of AIDS (NACA) - established by an Act of the National Assembly (Parliament) in 2006 and assigned with the task of overall coordination of the national response; State Agencies for the Control of AIDS (SACAs) and LGA Action Committees on AIDS (LACAs), which are also multi-sectoral

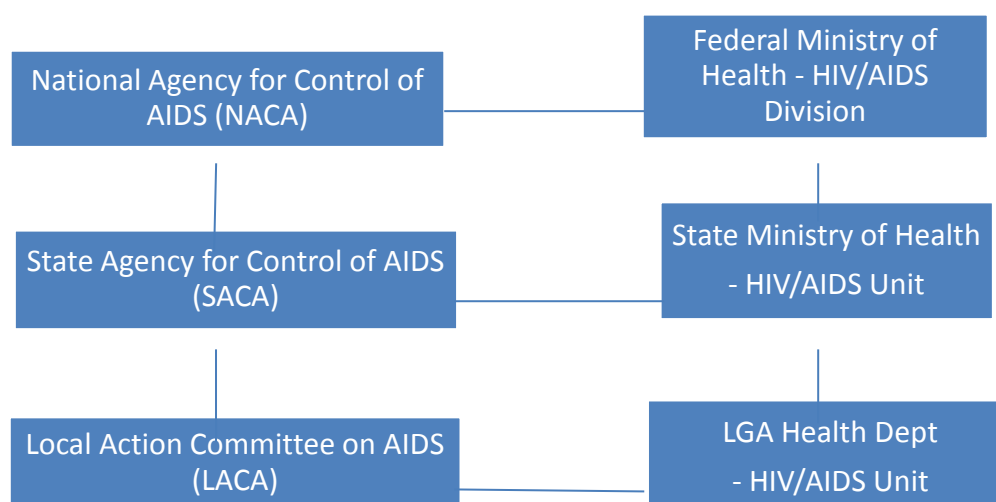
entities were found to have been given similar roles at the State and Local Government levels respectively. Both SACAs and LACAs were also understood to have appropriate legislative backing. Prior to this time, the Federal Ministry of Health seen as a federal coordinating body (rather than a national body) was said not to have been able to exercise full control in coordinating State and Local level HIV and AIDS activities due to the semi-autonomous status of States in Nigeria, and lack of legal backing. The new legislation was believed to have provided NACA with the authority and mandate to work with these levels, as well as with Federal line Ministries and Departments. And as NACA is held to be situated under the Presidency, supervised by the Office of the Secretary to the Government of the Federation; SACAs and LACAs are also thought to be positioned under the Offices of the Governors and LGA Chairmen respectively. This arrangement was said to be predicated on the assumption that coordinating institutions irrespective of the tier of government are likely to be successful if given political authority to coordinate the multi-sectoral response.

But actual implementation of HIV and AIDS programme activities takes place at the State and LGA levels led by line Ministries, Departments and Agencies (MDAs), in addition to several other stakeholders: Non-Governmental Organisations (NGOs), Community-Based Organisations (CBOs), Faith-Based Organisations (FBOs), the private sector and communities, working at these levels. Figure 5.2 below shows the structural relationship between coordinating agencies at each level, and the health sector implementing agencies, spearheading the execution of a package of services known as ‘health sector response’ to the population, at same level also. The core components include: HIV/AIDS prevention and health promotion; treatment, care and support; influencing positive changes in health systems and health standards; informed policy and strategic development; and strengthened health information system.

Accordingly, the HIV/AIDS Division of the Federal Ministry of Health leads the health sector response at the Federal level, while at the State level the programme is led by the HIV/AIDS Unit of the State Ministry of Health. And finally, at the LGA level, the HIV/AIDS Unit of the LGA Health Department drives the health sector response. And directly related to these institutions at all levels are health facilities: hospitals, clinics and health centers that render HIV/AIDS services to clients. Therefore as depicted in Figure 5.2, HIV/AIDS service coordination in Nigeria that eventually benefits individual clients is presumed to be undertaken at four levels: policy, organisational, programme and client, where the focus of collaboration is different at each level but ultimately aimed at either improving systems or services (Sandfort & Milward, 2008).

At the policy level, the National Policy on HIV/AIDS in Nigeria (National Agency for the Control of AIDS, 2009) sets the policy framework for service coordination through provisions that permit the mobilisation of resources including the development of public-private partnerships to leverage funding from local and international sources; as well as coordinate the allocation of equitable finance for programme activities across the country. The policy also allows the development of programmes for appropriate care of persons with HIV related conditions and AIDS, in addition to agreeing to sharing information among major stakeholders for policy making and programming.

Figure 5.2: Framework showing the linkage between public sector organisations for HIV/AIDS control in Nigeria



Source: National Agency for the Control of AIDs (2009)

At the organisational level, there was said to have been a re-organisation of HIV/AIDS coordination, which was initially led by the Ministry of Health within government, to the creation of NACA, SACAs and LACAs as multi-sectoral entities, where public sector ministries, departments and agencies; private sector, donors, NGOs, CBOs, FBOs and client groups, share coordination functions. At programme level, various components of the HIV/AIDS programme were observed to be co-located within existing health facilities, and as much as possible health facility personnel who are already engaged in dealing with other conditions have been trained to take on the extra task of managing HIV/AIDS clients. And at client level, HIV/AIDS programme teams that constitute individual professionals, units, and facilities looking after the same population of clients were seen to have started to put efforts in coordinating services for individual clients based on the care process.

While the Federal Government of Nigeria and to a lesser extent some State Governments, as well as large private sector organisations provided some funding for HIV/AIDS prevention

and service; by far a significant proportion of HIV and AIDS investment in Nigeria is noted to have come from external sources, mainly international donors (National Agency for the Control of AIDS, 2011a; 2011b).

Table 5.1: HIV/AIDS Expenditure in Nigeria

Financing Sources	Amount in USD							
	<i>2007</i>	<i>%</i>	<i>2008</i>	<i>%</i>	<i>2009</i>	<i>%</i>	<i>2010</i>	<i>%</i>
Public Sources	43,854,033	14.65	30,082,450	7.6	97,790,519	23.55	125,139,587	25.18
Private Sources	0	0	300,000	0.1	278,303	0.07	850,547	0.17
International Funds	255,392,257	83.35	364,581,432	92.3	317,218,608	76.39	370,927,337	74.65
TOTAL	299,246,295		394,963,881		415,287,430		496,917,471	

Sources: National Agency for the Control of AIDs (2011a; 2011b)

As shown in Table 5.1 above, between 2007 and 2010, only about 7.6 to 25 percent of the total HIV/AIDS spending came from domestic public sources. Majority of the funding was provided by external development partners. The main donors included: the US Government through the President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund and the World Bank. By August 2012, the Global Fund seen to have approved US\$360,454,493, and disbursed US\$275,586,635 in funds for Nigeria to expand HIV/AIDS treatment, prevention, and care programmes (The Global Fund, 2012). And most of these funding commitments have been targeted at expanding antiretroviral treatment access across secondary health facilities; decentralising HIV prevention, support and care to make it more available in primary care facilities and at a community level; as well as to increasing gender sensitive prevention interventions.

5.5 Rivers State HIV/AIDS Programme

At the frontline of service delivery in Rivers State, the core HIV/AIDS prevention and service elements noted earlier were observed to have been constituted into ‘an HIV/AIDS Programme’ delivered at several sites for defined populations. At each site, the members of the HIV/AIDS Programme Team were well defined. They comprise hospital units, or health centres, Non Government Organisations (NGOs), including Community-based Organisations (CBOs) and private agencies, undertaking the following prevention and service components, which are also called interventions:

- HIV Counselling and Testing (HCT) - this service, which involves letting people know their HIV status in order to take appropriate measures is available at stand alone primary health care facilities as well as at hospitals that also house other HIV/AIDS care services. In addition, there are NGOs that also provide HCT services either on an ad hoc or on-going basis.
- Prevention of Mother-To-Child Transmission (PMTCT) - this service is usually linked to antenatal clinics for pregnant women and uses a drug regimen to lower the risk of HIV transmission from mother to child.
- Paediatric HIV - this is a specialised service for the management of clinical HIV disease in children.
- Antiretroviral Therapy (ART) - this entails the use of antiretroviral drugs, which inhibit the replication of HIV, with the aim to reduce disease and prolong survival among HIV-infected people.
- Care and support - as cure for HIV infection remain elusive; the final outcome for the vast majority of HIV-infected is death. This service provides palliative care that makes the life, as comfortable and as meaningful as possible for the patient and his/her family. This is an out-reach service where care takes place at home.

- Tuberculosis co-infection - as tuberculosis is the most frequent opportunistic infection, this service coordinates with tuberculosis treatment programme using the DOTS (directly observed therapy, short course) treatment strategy.
- Behaviour Change Communication (BCC) - this is aimed at preventing HIV infection in the general population, as well as promoting rational and appropriate attitude to HIV infection and persons living with HIV.
- Monitoring and Evaluation (M&E) - systematic collection of data concerning disease frequency and distribution, the analysis of those data and their dissemination to relevant parties to act. Also enables the determination of progress with respect to the effectiveness of interventions being undertaken.

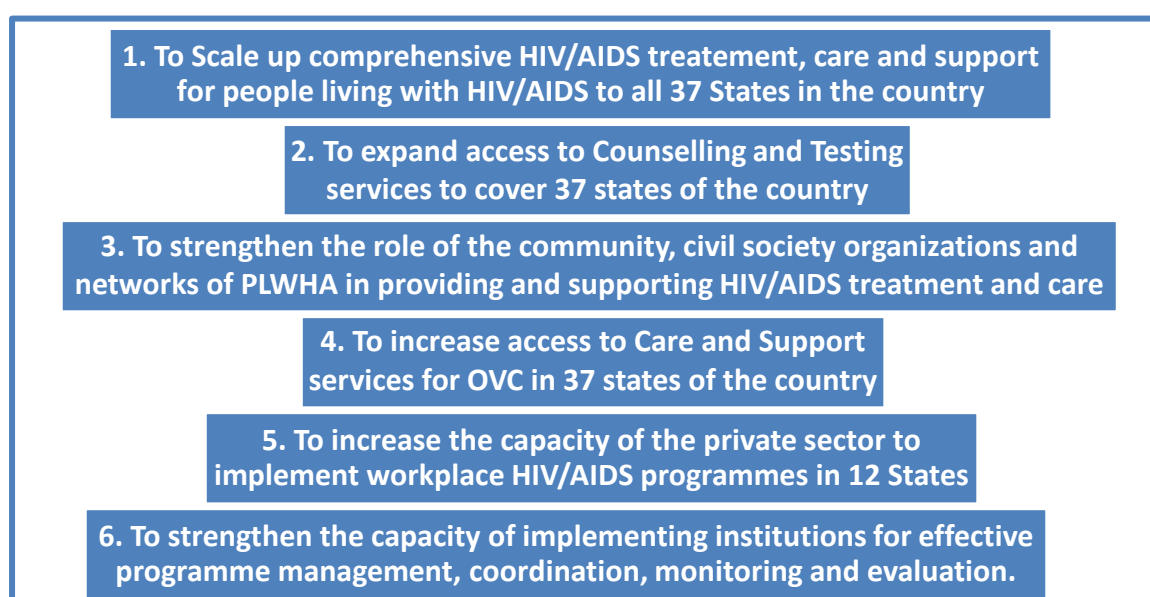
This ‘package of interventions’ formed the core of the health sector response that was seen to be spearheaded by the Ministry of Health. A Strategic Plan and a Programme Memorandum at the State level set out the direction and framework for implementing these interventions at the periphery - with strategic goals, specific objectives, planned activities, targets and performance indicators for a given period (Rivers State Agency for the Control of AIDS, 2009; and Rivers State Ministry of Health, 2009). But apart from a list of intentions there was no prioritisation of what can be feasibly achieved in the set period. There was also no indication of how the various interventions would be integrated at the point of care. It was taken for granted that since these sub-sets of health professionals looked after the same patient population, they would necessarily work together through referral pathways or through other mechanisms.

In reality such an assumption was unfounded. Progress towards service integration was seen to be only possible where deliberate efforts at coordinating the actions of those looking after each of the interventions were made. And the observed mechanism that had somewhat

enabled and regulated the linkages among key players towards patient-centred care seemed to have been the formation and sustenance of ‘collections of care providers’ around the drug treatment of HIV infection and related health conditions. Nevertheless, this need to collaborate, appeared to have been fostered on the collaborating bodies by an external donor agency - the Global Fund to fight AIDS, Tuberculosis, and Malaria (Global Fund) - who through a grant of \$180,448,985 over 5 years to the country was noted to have compelled them to work in ‘clusters’ (National Agency for the Control of AIDS, 2008). Moreover as indicated below, this sort of collaborative service provision was not seen to have emerged around the anti-retroviral treatment sites funded by either the Federal Government of Nigeria or by the Government of Rivers State; as they were known not to have tied such conditions to funding the ART centres.

And while the overall goal of the Global Fund grant is to reduce HIV/AIDS-related morbidity and mortality through six objectives, stated as outlined on Figure 5.3 below; it demanded that the grant recipients jointly adopt the ‘Integrated Cluster Model’ of service delivery for HIV and AIDS. On reviewing the project objectives, there is a sense that the integrated cluster model as demanded by the Global Fund may not deliver all the expected results. But since the individual objectives of the partners expected to be involved in the service integration model are aligned with the project objectives, it is possible that the funding agency aims to achieve a strategic goal through this organisational reform.

Figure 5.3: Objectives of the Global Fund Round 5 Grant for HIV/AIDS to Nigeria



Source: National Agency for the Control of AIDs (2008)

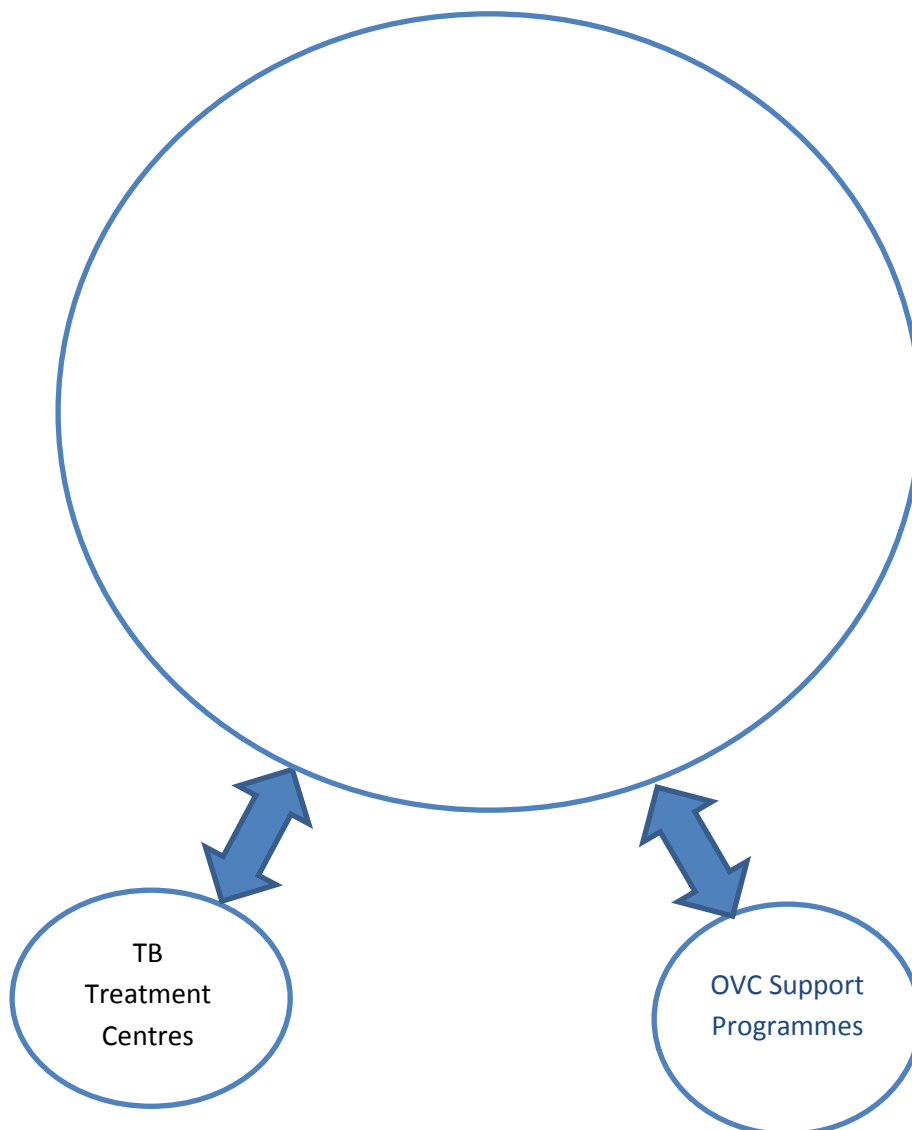
Therefore, it may be reasonable to assume that in as much as fund receipts were mandated to coordinate service provision for HIV/AIDS patients through task integration; the integrated cluster approach appeared to be just a means of achieving a higher goal (scaling up of anti-retroviral drug treatment services) than an end in itself.

The rationale for this model is assumed to be based on evidence of the significant role the use of anti-retroviral drugs in reversing the impact of HIV/AIDS epidemic has become. Thus making, anti-retroviral treatment programmes the ‘fulcrum’ around which efforts at coordinating ‘seamless care’ for HIV/AIDS were designed. Treatment for HIV/AIDS covered drug treatment for adults and children; prophylaxis for pregnant mothers; management of opportunistic infections; as well as treatment for co-infection with tuberculosis. But drug treatment on its own was not sufficient to produce the sort of outcome required for people living with HIV or those suffering from AIDS to live quality lives. To be successful, anti-retroviral treatment programmes required comprehensive counseling that

promotes compliance and adherence to the drug regimen; in addition to management of complications at the home level, improving the quality of life of persons living with HIV and modifying the public perception of the disease through better patient outcome. Additional services were therefore, necessary to both help relieve the suffering of those infected by the virus, as well as those socially and economically affected by the disease. Programme managers were said to have been in search of an arrangement whereby treatment interventions were integrated with those that provide care and support; in a way that a 'comprehensive package of HIV and AIDS services' was provided for a given population clients/patients.

Meanwhile, with different autonomous (or semi - autonomous) organisations, agencies, units, and departments within and outside the health sector responsible for various aspects of HIV and AIDS interventions as outlined above; the problem of coordinating the activities of these different actors to produce the desired patient/client benefits became obvious. Moreover, each service provider although aware of the complementarity of the services provided by others had no formal contacts with those that can add value to the services they were providing. And as each service provider had its own separate source of funding, every one of them was protective of their territory both organisationally and professionally. It may be fair to also assume that the 'common purse' provided by the Global Fund grant was a strong incentive in getting these individual entities to begin to work together.

Figure 5.4: Integrated Cluster Model – showing the cluster of comprehensive HIV and AIDS treatment, care and support interventions in one location



Key:

1 x Treatment Centre; 3 x Counseling and Testing (C&T) Sites; 1 x PMTCT Site; 2 x Home Based Care (HBC) Projects; 1 x People Living With HIV and AIDS (PLWHA) Support Group; Tuberculosis (TB) Treatment Centres; and Orphan and Vulnerable Children (OVC) Support Programmes

Source: National Agency for the Control of AIDS (2008)

Figure 5.4 above, is a schematic representation of the Integrated Cluster Model as mandated by the Global Fund. Accordingly, in every locality (Local Government Area) a ‘cluster’ of related HIV and AIDS services, which would include: antiretroviral drug treatment and treatment for opportunistic and related infections; Prevention of Mother to Child Transmission (PMTCT); HIV Counselling and Testing (HCT); Home-Based Care (HBC); People living with HIV and AIDS (PLWHA) support groups; Tuberculosis (TB) treatment; and Orphan and Vulnerable Children (OVC) support programmes, were meant to exist.

As presented, the model did not depict any service provider as the central organisation; neither did it show the expected relationships among individual organisations for collaborative service delivery. Rather the model was more concerned on the logic behind the approach expected to be adopted by the inter-organisational service delivery entity. Nevertheless, it identified a core group, assumed to be the integrated cluster proper that would develop relationships with organisations and others located elsewhere but providing supportive services.

In Rivers State, anti-retroviral treatment (ART) services were meant to be operating at six (6) sites with funding from three main sources - Federal Government, State Government and the Global Fund. Table 5.2 below shows these sites along with their corresponding funding sources. At least more than half of the ART sites were seen to be functioning, however it was noted that among the 6 sites, the cluster model was operational in only 2 sites - Bori and Ahoada. And as indicated above, funding for these two ART sites were from the Global Fund. While this may imply that in the other sites, individual service providers have not yet developed the capacity for joint working among themselves, it further confirms the Global Fund’s influence in fostering the cluster model for integrating HIV and AIDS interventions in

Rivers State. The other site with Global Fund funding but where the cluster model was not seen to be in operation - the Health of the Sick, Nkpogu, Port Harcourt, was noted to be owned by a faith-based organisation as opposed to the others that were owned by the State government. There was also an impression that although this facility agreed to host an ART site, the proprietor did not feel highly incentivised by the State Government to be running a public health programme, despite the support from the Global Fund.

Table 5.2: Anti-retroviral treatment (ART) sites in Rivers State, Nigeria

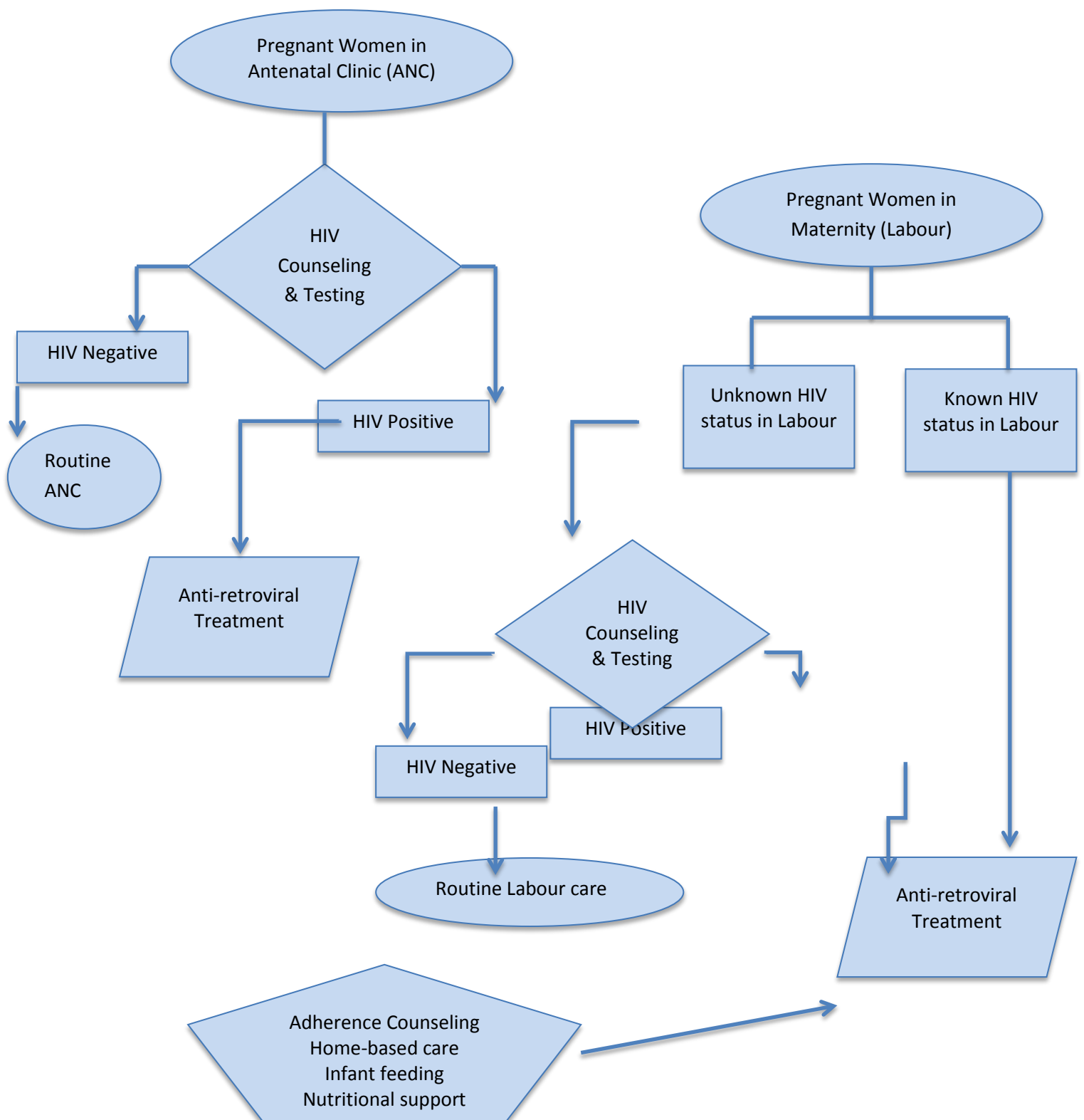
<i>S/No.</i>	<i>Anti-retroviral treatment (ART) sites</i>	<i>Funding Source</i>
1.	University of Port Harcourt Teaching Hospital	Federal Government
2.	Braithwaite Memorial Specialist Hospital, Port Harcourt	State Government
3.	Health of the Sick Hospital, Nkpogu, Port Harcourt	Global Fund
4.	General Hospital, Bori	Global Fund
5.	General Hospital, Ahoada	Global Fund
6.	Military Hospital, Port Harcourt	Federal Government

In as much as the Integrated Cluster Model specified the membership composition of each cluster and the expected relationships between members, the operational modality was based on the operational guidelines for anti-retroviral treatment as provided in the Standard Operational Procedures (SOPs) following National Guidelines for HIV and AIDS Treatment and Care in Nigeria (Federal Ministry of Health, 2010b). The SOPs were seen to have several objectives (Stuart et al, 2009). First, they provide individual HIV/AIDS service providers with operational information on organising services for specific HIV/AIDS intervention, and how these services relate with one another in providing patient care. Second, they describe

the process for linking with community-based HIV services, such as home-based care and support group for people living with HIV, which are essential components in the delivery and sustainability of comprehensive HIV care. In addition, SOPs provide instructions and describe the steps to be followed in performing specific clinical tasks or practices, for standardisation, correctness, and effectiveness of performance. At individual service provider level, they are also used to prepare new staff for HIV service delivery and in reinforcing standards and processes for existing staff that may need on-going on-the-job training.

Figure 5.5 below is an example of a typical care pathway for Prevention of Mother-To-Child-Transmission of HIV that is adopted by each of the Integrated HIV/AIDS programme clusters. Even for what seemed like a single service where every pregnant woman is offered Counselling and Testing for HIV, there appears to be two pathways in the care process that meet at the same key decision and action points - 'HIV Counseling and Testing' and 'Anti-retroviral Treatment'. But at each of these critical points there are multiple professionals Midwives, Laboratory Scientists, Trained Counsellors, Doctors, Pharmacists etc. that undertake on-going exchanges to improve the well-being of each patient.

Figure 5.5 – Care pathway for Prevention of Mother-To-Child Transmission of HIV



Source: Integrated National Guidelines for HIV Prevention, Treatment and Care (FMOH, 2014)

Chapter Summary

In this first empirical chapter, the institutional history of HIV/AIDS programming in Nigeria, and an account of the policy reform context for collaborative service delivery for HIV/AIDS in Nigeria were presented. The chapter provides contextual data which permits, first an evaluation of the likely impact of the policy of service integration for HIV/AIDS, as a reform agenda in Nigeria; and second, evidence, which will be combined with the findings of the networking activities of the HIV/AIDS programmes clusters presented in the next chapter to address the question of whether the idea of the MCN is both doable and sustainable in Nigeria.

Chapter 6 - Findings II: Case Studies - Collaborative links of HIV/AIDS Programme Clusters in Rivers State, Nigeria

This second chapter of findings presents two cases studies of network implementation in Rivers State, Nigeria: the Ahoada and Bori HIV/AIDS Programme Clusters, respectively. The chapter proceeds by describing and analysing the formation, structure and character of the inter-organisational networks that emerged from the collaborative linkages within the two HIV/AIDS service delivery clusters. Following examination of the HIV/AIDS Programme Cluster networking activities in each of the study sites, key similarities and differences in terms of the core network characteristics between the two clinical networks are also discussed.

6.1 HIV/AIDS Programme Cluster in Ahoada

6.1.1 Background

Among those providing HIV/AIDS services in Ahoada East LGA, it is believed that the need to work with each other more closely was publicly recognised as soon as the Ahoada General Hospital was designated as an Anti-Retroviral Treatment (ART) site in 2007. And some sort of forum to address issues related to coordination of these services was supposed to have been attempted. But it was not until two years later, when the referral pathway for patients suffering from this condition within this geographical area became certain, when a definite move to establish this coordinating body was noted to have been made. The main purpose as remarked by the Chairperson is *‘on our roles in referral services and the need for interaction among members in order to strengthen HIV service delivery’*. Thus members were assumed to have been drawn from service delivery points along the route travelled by persons infected by HIV, as they sort relief through services delivered by different providers.

Two factors other than the willingness of participants to work together to achieve a common goal were said to have largely contributed to the formation of this HIV/AIDS coordinating cluster. First, was the availability of funding from the Global Fund to fight Tuberculosis, AIDS and Malaria, which provided anti-retroviral drugs and sundry equipment for the management of persons infected with the virus. *'Putting the ART site at this hospital was the main reason for the cluster condition meetings'*, reflected an NGO member. And second, was the presence of an external programme manager - an international NGO, Family Health International (FHI) - contracted by the Global Fund to guide the implementation of the ART programme at this site. Other than facilitating the formation and sustenance of the collaborative cluster, the programme manager also tended to hold the group together by force of purpose, as laid out by programme design of the Global Fund Round 5 Grant. A member of the support group for people living with HIV acknowledged this, and noted that *'the FHI people are the ones who make it possible for us to meet...they provide some snacks and give us money for transport... it would have been difficult without them'*. Another key member of the collaborative cluster from the NGO sector also stated: *'although we are aware of what to do to come together and work for these patients, it would not have been possible but for the Global Fund...and with the support of FHI who help to finance our meetings, we are able to work as a team'*. Although the role of the Global Fund programme manager in making sure that the cluster meetings took place as planned, was observed to be more of 'a facilitator' rather than being directly involved with the activities of the group. This emphasis was made in the cluster meetings as recorded in one of the minutes: *'...henceforth, the body will be relatively autonomous while facilitators will only act as observers'*; this situation was confirmed during the observation of the conduct of the cluster meetings.

6.1.2 Clinical Pathway and Care Process

In an attempt to understand the care process for HIV/AIDS patients in this locality, the clinical pathway taken by patients was traced. The focus of activities is centered on the ART centre located at the Ahoada General Hospital, which was chosen as the comprehensive treatment site for HIV/AIDS in Ahoada East and adjoining LGAs - Ahoada West, Abua-Odual, and Ogba-Egbema-Ndoni. This was an attempt to see how the various HIV/AIDS care protocols such as the one shown in Figure 5.5 in the previous chapter, is translated by the Ahoada HIV/AIDS Programme Cluster, to create a clinical pathway for patients from within the catchment area of the Ahoada General Hospital, ART centre.

There are several routes through which patients could access the services of this ART centre:

1. Referrals from other General Hospitals mainly at Erema (Ahoada West LGA), Abua (Abua-Odual LGA), and Omoku (Ogba-Egbema-Ndoni LGA); as well as from health centers located within Ahoada East LGA - Ahoada, Edeoha, Ihugbogo, Ochigba, Ogbele etc.;
2. Self - referral by persons irrespective of location who intend to know their HIV status;
3. Patients with other medical problems such as malaria who visit the out-patients department of Ahoada General Hospital - the base hospital, but with a high index of suspicion for HIV/AIDS;
4. All patients who are admitted into the base hospital;
5. Pregnant mothers attending ante-natal clinic at the base hospital; and
6. Spouses and children of clients receiving treatment for HIV/AIDS.

Irrespective of the source of referral, all clients who arrive at the ART centre are sent to the HIV Counseling and Testing (HCT) unit of this centre for re-screening and confirmation of their HIV status. Those found to be negative are discharged but with discussion around

maintaining a healthy lifestyle. While those found to be positive are enrolled into the anti-retroviral (ARV) treatment programme. A patient management monitoring (PMM) record is opened for the client and sent to the medical staff (doctors with specialised training in HIV/AIDS) for staging of the disease, which also includes laboratory assessment of the viral load in the patient. At this stage counseling for drug adherence is also undertaken, after which anti-viral drugs are dispensed by the pharmacy.

This is as far as hospital or health facility-based care for HIV/AIDS at this site could go. Additional care or treatment support, which is usually ongoing over several years, was seen to be provided by local Non-Government Organisations (NGOs), Faith-Based Organisations (FBOs) and Community-Based Organisations (CBOs) including clients support groups. The main treatment support services include: health promotion on positive living with HIV, home-based care of symptoms of the disease and side-effects of drugs, management of disease progression and palliative care.

6.1.3 Cluster Formation, Structuring and Activities

Membership of the HIV/AIDS Cluster in Ahoada was based on service delivery points visited by patients along the clinical pathway taken by them. These are either whole organisations such as hospitals and primary health care (PHC) centres or units, and even individual health professionals within the base hospital. They include: the medical staff with specialised training on HIV/AIDS, HIV Counseling and Testing (HCT) unit, Pharmacy, Medical Records, Laboratory, and Nursing staff managing the Prevention of Mother-To-Child Transmission (PMTCT) programme based at the Ante-Natal Clinic and Maternity. These units or professionals are co-located within the base hospital in Ahoada. But there are also units within this base hospital that have links with the ART programme but are not members

of the HIV/AIDS coordinating cluster. They are the General Out-Patient Department (GOPD), and the In-Patient Wards. The reason given for their non-inclusion was as a result of the episodic nature of their encounter with the HIV/AIDS programme. Moreover, they were not specifically mentioned in the Integrated Cluster Model as depicted in Figure 5.4 in the preceding chapter. More so, these units were in a way perceived as part of the ART centre as they were located within the same health facility as the ART site. The ART Coordinator, also mentioned that *'this is not an issue since we...Medical Officers working in the out-patient department see every patient...irrespective of the medical condition'*, because no doctor is designated as 'HIV doctor' in the hospital.

Members of the cluster outside the base hospital can be categorised into two groups - those with clinical roles and those providing supportive services. The group with clinical roles is made up of health facilities whose main function was to carry out initial HIV counseling and testing and refer positive cases to the ART centre at the base hospital. Some also undertake Prevention of Mother-To-Child Transmission services, whereby they are able to administer prophylactic anti-retroviral drugs to pregnant mothers. These include: Erema General Hospital, Ahoada Primary Health Care Center (PHCC), Edeoha PHCC, Ihugbogo PHCC, Ochigba PHCC, and Ogbele PHCC.

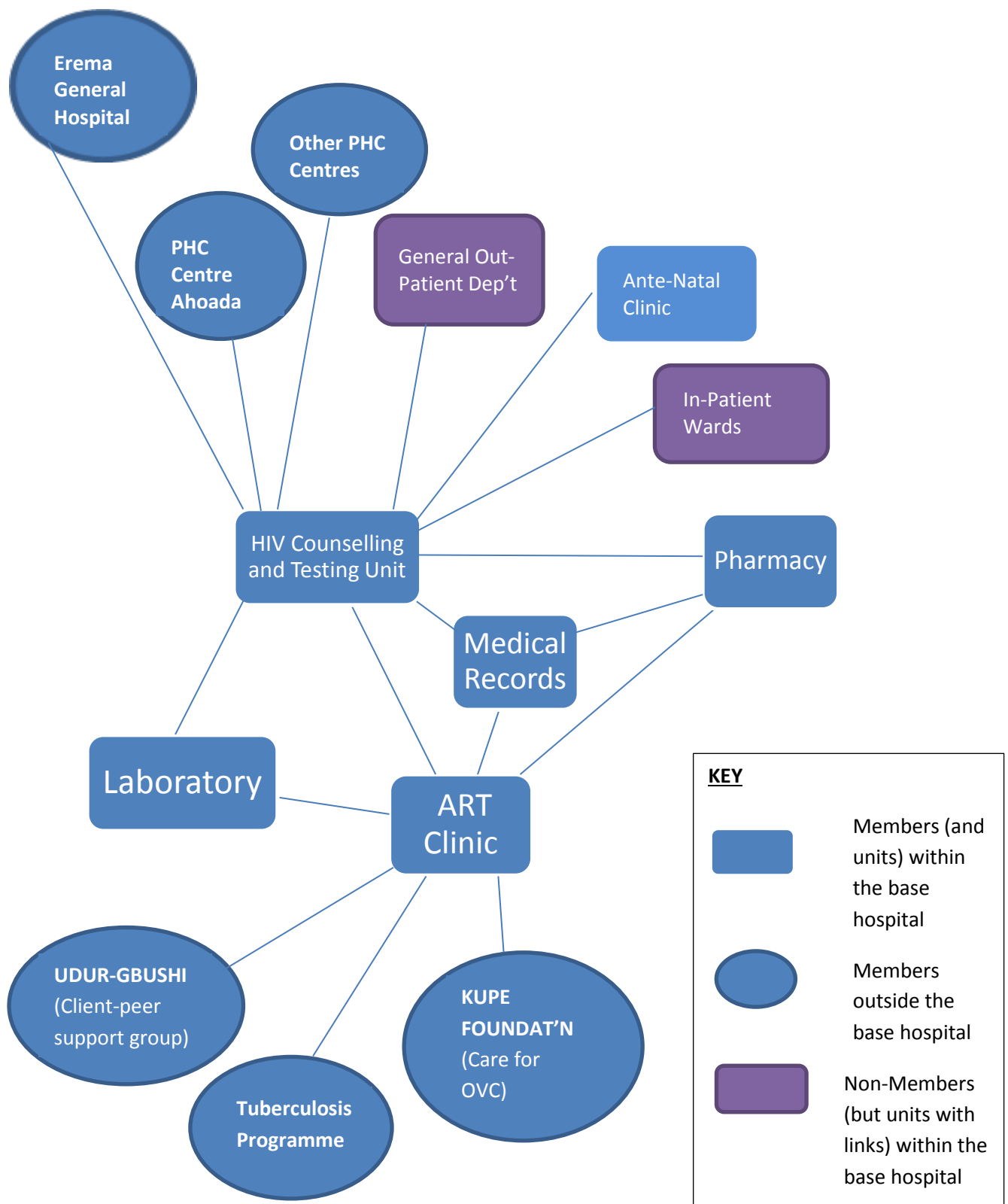
However, members of the group outside the base hospital without clinical roles mainly provide ongoing care and support services directly to persons infected by HIV virus or those impacted by the disease such as orphan and vulnerable children (OVC). Others provide education on HIV/AIDS to populations at risk. They include: Udur-Gbushi (peer-client support group), Rivers of Hope Initiative (CBO), First Baptist Church (FBO), Seventh Day

Adventist Church (FBO), Kupe Foundations - Abua-Odual Orphan and Vulnerable Children Care (OVC) and Status for Youth Development (CBO).

Apart from these core members of the cluster, there are also other members (units and programmes) who although do not have direct HIV patient care or supportive roles, but are still considered important in the overall care of these patients. They are: the Tuberculosis control programme and Roll Back Malaria (RBM) programme that treat co-infection with tuberculosis and malaria. While another member - Local Action Committee on AIDS (LACA) is considered significant due to the member's coordination role at the LGA level (and linkage to the overall institutional coordinating framework - see Figure 5.2 in the earlier chapter). The representative of this member occasionally presides over the cluster meetings in the absence of the chairperson - the ART site coordinator - '*...the chairman had hitherto directed that the LACA Manager of AELGA act on his behalf*', the minutes of the Cluster Coordinating Meetings of February 16th, 2012 reported.

Figure 6.1 below shows the core members of the cluster, how they are linked to each other, and with those outside the cluster but have responsibility for HIV/AIDS care or support. As depicted, the objects in the diagram are in three categories: (i) Units of the base hospital in Ahoada that are members of the HIV/AIDS Programme Cluster; (ii) Organisations/Agencies that are members of the Ahoada cluster, but not part of the base hospital; and (iii) Units within the base hospital that are non members of the Ahoada HIV/AIDS Programme Cluster. The lines between these objects in the diagram signify linkages (relationships) between these units, organisations, or agencies irrespective of their location and/or institutional affiliation, with respect to the care for the population of HIV/AIDS patients within the assigned 'geographical area' of the Ahoada HIV/AIDS Programme Cluster.

Figure 6.1 – Structure of Ahoada HIV/AIDS Programme Cluster



Source: Author's Diagram

As outlined in the care pathway above, the linkages between core members of the HIV/AIDS service cluster in Ahoada could be seen either as ‘referral links’ between peripheral services and specialised units or as ‘shared-care responsibilities’ between units or organisations. While the relationship with those outside the core membership could be regarded as ‘sharing of information’.

The main reason why these organisations have been working together is ‘service integration’ for HIV and AIDS patients in this geographical area. The relationships, which are meant to be continuous, were observed to have been formalised through ‘clinical protocols’ set out by the National HIV and AIDS Control Programme of the Federal Ministry of Health (Federal Ministry of Health, 2010a; 2010b). Each member of the HIV/AIDS programme team is trained on the specific tasks they are meant to perform and are aware of other organisations that perform similar or related services within their locality. Based on the Terms of Reference that set up the Integrated Cluster Model, the funding agency - The Global Fund, also appeared to have enforced an externally recognised purpose of joint working among these organisations (National Agency for Control of AIDS, 2010a).

The contracted Programme Manager of the Global Fund - an international NGO, Family Health International (FHI) - other than facilitating programme implementation, was more inclined to hold the service cluster together by force of purpose to deliver results. The national monitoring and evaluation (M&E) system that forms one leg of the ‘three ones’ tripod could also be regarded as another formalising mechanism for the HIV/AIDS service cluster. The pattern of data flow at the Local Government Area (LGA) level although has a bottom-up approach from service delivery points to the LGA Action Committee on AIDS, also has an in-built feedback mechanism that made it necessary for this ‘information system’

to be formalised among data providers who are also data users within this cluster of HIV and AIDS service providers.

While the national HIV/AIDS clinical protocol was noted to have guided the decision on membership of this group; the Global Fund programme manager (FHI) that was particularly instrumental to the formation of the HIV/AIDS Programme Cluster following the guidance of the Global Fund Round 5 Grant, continued to facilitate the process. Therefore, there was strong evidence to suggest that external bodies - the Federal Ministry of Health, National Agency for the Control of AIDS, and its core funder, the Global Fund to fight AIDS, Tuberculosis and Malaria - dictated the membership structure of the HIV/AIDS Programme Cluster in Ahoada. Overall, most organisations got involved due to their positions along the clinical pathway, but the main reason given for their participation is on their individual roles in the referral process and the need to be better equipped through training to undertake such roles effectively. *'You know the importance of TB...for them to invite me is for a purpose...first purpose is for referral and second to do HIV/TB collaboration'*, remarked one cluster participant. Another cluster member from a Faith-based organisation also reflected, *'our role is to sensitise the people in all ramifications, we now streamline it in every aspect of our programme ...telling people the need to test...I have been more informed about HIV through this meeting'*. Others gave information sharing and networking as their motives for engaging with the HIV/AIDS Programme Cluster. As one member informed the researcher, *'so many of them did not know me but with the meeting we are able to introduce ourselves and contact each other if there are any problems'*. A member from one of the associated Primary Health Care (PHC) facility also added, *'we get to know each other...we try and make sure that those we refer to the comprehensive centre actually go there, and we give this report in the meeting...if we do not meet, we can't know what is happening in the system'*.

6.1.4 Cluster Processes and Maintenance

The main forum for discussing joint programme operations was the ‘cluster meetings’, which were held monthly at the premises of the base hospital at Ahoada. Each service delivery point included in the HIV/AIDS Programme Cluster is usually represented by a member who also acts as the focal person or coordinator for that aspect of the service. Responsibility for coordination and setting up meetings rests with the ART site coordinator, a medical doctor with further training in the management of HIV and AIDS patients, based at the Ahoada General Hospital; although there is a Secretary, a representative from one of the Faith-based Organisations who sends out meeting invitations and reminders. Nonetheless, a staff of the Global Fund programme manager (Family Health International) usually provides further facilitation to ensure that these meetings take place. Such facilitation include, providing additional resources such as stationaries for the secretariat, stipends for participants to cover transport cost, and light refreshment during meetings.

An examination of the minutes of the meetings showed that the key agenda items were discussions on service delivery issues such as: the non-functioning of the CD4 count machine¹ - a major laboratory equipment in the management of HIV/AIDS patients under treatment located at the base hospital; inadequate logistics for outreach services; stock-out of essential drugs and consumables; and training and re-training of health personnel to maintain service quality. Others were presentation and review of data from various service delivery points; and jointly finding solutions to the numerous service delivery issues raised at the meetings by members. A member recalled that, *‘when General refer patients to this place, so*

¹ The machine that monitors CD4, a type of white blood cell that fights infection and their count indicates the stage of HIV or AIDs in a patient, which helps doctors to know the stage of the disease in their patients before subjecting them to medication.

many of them will not come...during the meeting we discuss this problem and try and find how to solve it'. Another member also observed that, *'during the meeting we share our challenges...and through the meeting we can also discuss how to motivate the people*'. The support group members in particular found the cluster coordination meetings very useful, *'because some challenges we are experiencing ...we take it to them...such as defaulters, and they are able to help us*', remarked the focal person. Meeting records were well kept mainly in hard copies (and sometimes hand written), and minutes of a previous meeting were normally read in the subsequent meeting, where matters arising from the past meeting were addressed. As the ART Coordinator pointed out, *'in every meeting report, progress and challenges encountered by members in the preceding month are discussed in order to effect necessary improvements*'. Other than the general monthly cluster meetings, two committee meetings are held to resolve critical care management issues. And these are: the Contact Tracking Committee, and the Pharmacovigilance Committee. The Contact Tracking Committee is led by the referral focal person based at the Comprehensive ART Centre within the base hospital and includes the Data Clerk, and a representative of the Clients-Support Group. Their main task is to trace defaulters who have missed their clinic appointments, find out why they defaulted and report back to the Cluster General Meeting that will then jointly look for ways of getting the defaulters back on track and help them maintain their clinic appointments. The Pharmacovigilance Committee, which is headed by the Pharmacist, includes the ART site coordinator, and another representative of the Clients-Support Group. The key task of this committee is to review drug reactions, dosages, prescriptions and the dispensing of anti-retroviral drugs - taking into account the specific situations of individual clients.

Other than being members of the HIV/AIDS Programme Cluster, some health professionals and support care-givers in participating organisations seem to know each other personally and professionally. The same government health authority - the Rivers State Ministry of Health, where professional roles and responsibilities are well established, employs those working at the public hospitals and health centres. Individuals from specific professions ascribe to the same professional bodies, where they can meet and interact locally or at the State level. As membership of this collaborative cluster is defined by geographical location - Ahoada East Local Government Area, members are found to be working and living within this defined area. They therefore tend to interact in other social settings in the community. Some belong to the same ethnic cultural group and also speak the same dialect, while others are members of the same church, or a friend of an acquaintance. One member representing an NGO noted that, *'many people are new to me...but I know some before coming to this meeting...through church and where I live'*. Consequently, there were ample avenues for exchange of information among professionals irrespective of the setting they find themselves. But the predominant means of information exchange are the formal channels of communication through professional relationships as defined by their respective roles in relation to the care for HIV/AIDS patients in this locality. Informal approaches such as coming to the aid of a member appear to become useful where relationship bottlenecks tend to stand against the achievement of desired objectives. The Support group was noted to have used its relationship with other cluster participants outside the cluster coordination meeting setting to ensure that members of the group (who are also direct beneficiaries of the cluster activities) are not denied access to care due to disagreements with health care professionals in the associated health facilities or hospital units.

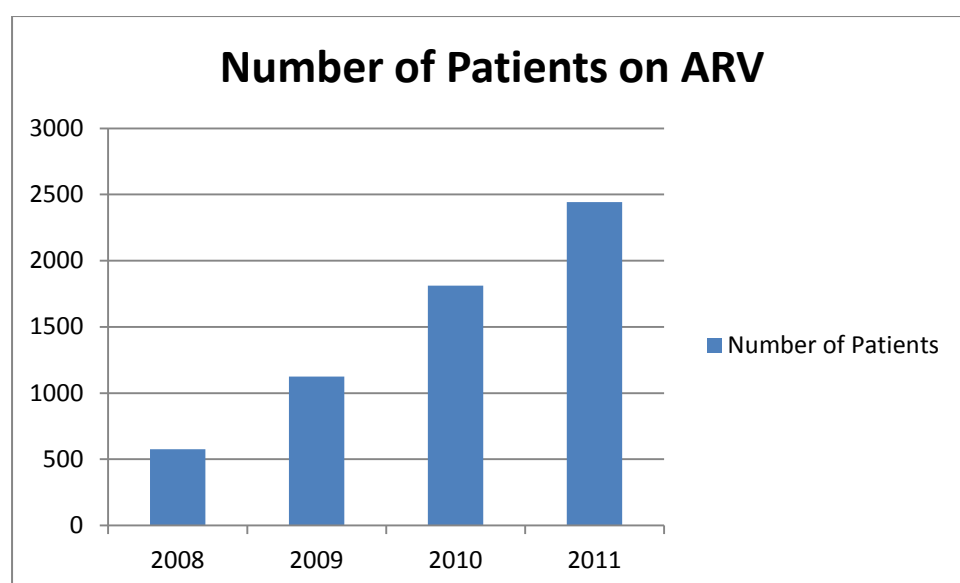
There were no particular issues that have been a source of tension for participating organisations or individual professionals in this collaborative cluster. But membership of the cluster, which was streamlined at some point (due to lop-sided representation of constituent health facilities) to make the group more representative created some difficulties whereby those excluded, refused to cooperate in providing data. This was resolved by ensuring that individual health professionals in all participating health facilities, units and organisations were actively engaged in training activities. Notwithstanding, a good number of members interviewed cited ‘the need for mutual support for the common good of their patients’ as the most important factor that tend to bring and /or keep participating individuals and organisations to be more committed to the HIV/AIDS cluster activities. *‘The cluster coordinates everybody including State-based organisations and FBOs and NGOs... to ensure that at home and everywhere people living with HIV get better care’*, said one FBO representative interviewed. Other factors include: access to programme resources such as clinic inputs, and information; additional incentives for undertaking this specialised work; and capacity building of professional staff.

6.1.5 Cluster Outcome

A good number of members interviewed refer to the ‘linkages’ that exist among the members as the most important consequence of their involvement in the HIV/AIDS Programme Cluster; although many of them, at least over half mentioned ‘learning’ as another significant result of participating in the collaboration. *‘We learn new things all the time...the cluster is now the focus of attention for training on HIV matters in this area’*, remarked a member from one of the hospital units. But in addition, those who lead certain constituencies such as: the manager of the Local Action Committee on AIDS (LACA); the focal person of the clients support group - People Living with HIV (PLHIV); and the representative of the Community-

based Organisation looking after Orphan and Vulnerable Children (OVC) - see the 'recognition' accorded to the HIV/AIDS Programme Cluster in Ahoada as a useful indicator of the achievement of the group. In terms of group performance, the number of People Living with HIV on Anti-retroviral Therapy (ART) increased from 1124 in 2009 when the HIV/AIDS Programme Cluster meetings became more effective to 2442 in 2011 when they were more established.

Figure 6.2: Utilisation of ARV Services at Ahoada ART Site



Source: Family Health International – Programme Managers of the Global Fund ART Programme at Ahoada

As shown in Figure 6.2 above, this is more than a two-fold increase over a three-year period, but also a massive increase in numbers - more than four times when there was just regular referral in 2008. There is therefore the possibility that this increase in utilisation of anti-retroviral treatment services was due to the collaborative activities of the HIV/AIDS Programme Cluster in Ahoada, as against the absence of a collaborative group. As observed by the LACA Manager, because the cluster coordination meetings have strengthened the linkage between community-based primary health care facilities where HIV counseling and

testing take place and the comprehensive HIV treatment centre, *'we are able to know how people have been referred and how many people have reported at the General Hospital...from there we say that number of persons receiving ART has increased'*.

There was a sense of shared ownership of the results of the Ahoada HIV/AIDS programme Cluster as majority of those interviewed were able to point out in practical terms how critical their individual organisational activities were to the achievement of the group's results. Most of them suggested that since activity report (for the previous month) from each individual partner is taken at the meeting, the whole group is able to know if they are contributing to the aim of the cluster, as well as achieving their individual organisation's objectives. Again, the LACA Manager mentioned – *'at the meeting we share experience, lessons learnt and challenges...there are some challenges that can be solved without looking for partners'* - a sort of group self-reliance. Moreover, as data on progress (or lack of it) was regularly shared among members in these meetings, many claimed to have been aware of the need for joint responsibility in delivering expected results. And apart from some concerns on representation and membership of the HIV/AIDS Programme Cluster, none of the participating health centres and Community-based Organisations indicated that some organisations are benefiting more than others.

6.2 HIV/AIDS Programme Cluster in Bori

6.2.1 Background

As Bori is one of the main centres of commercial and political activities right from colonial times in Rivers State, the General Hospital in the town was said to have been designated as an Anti-retroviral Treatment (ART) centre in 2007 to serve mainly the population of Khana Local Government Area, and also the LGAs in close proximity - Gokhana, Tai, and Andoni-

Opobo. And the expectation was to link other HIV and AIDS service providers within these Local Government Areas with the ART centre at Bori General Hospital to access anti-retroviral drugs for patients who have been initially screened by these service providers. Consequently, a referral linkage was established between this centre and other hospitals, health centres, and Community-based Organisations offering HIV counseling and testing service, as well as those providing care and support services for people living with HIV and children orphaned by the disease.

But even as contact between each peripheral health facility or organisation and the ART centre at Bori General Hospital was made through patient referral, there was no feedback on patient outcome. There was also no mechanism for these outlying service providers to obtain information and other resources to deal with difficulties encountered by their patients in accessing anti-retroviral (ARV) drugs at the ART centre. *'Before now we just refer the patients to Bori...we are not sure if they get here or not'*, recalled a cluster member from one of the peripheral health facilities. Similarly, the ART centre at Bori General Hospital was finding it difficult to manage noncompliance by patients on ARV drugs, as well as tracing those who have defaulted from treatment. A Medical Officer attached to the ART centre remarked: *'we did not have the means to locate those who have defaulted from treatment...and what made them not to return for their drugs'*. Furthermore, despite the location of the ART centre at the Bori General Hospital, the clinical staff did not see the activities of the centre as part of the services provided by the hospital. As the Medical Officer at the ART centre further commented: *'although there is still some resistance with the nurses...but things have changed a bit'*.

It was this situation that instigated individual health professionals who find themselves responsible for aspects of HIV and AIDS services, to come together in order take deliberate efforts at resolving the issues confronting the care they were providing to their patients. And since several of those interviewed referred to the 'patient flow-chart' (clearly visible at some service delivery points); another important factor that encouraged these health professionals to consider working together appeared to be the realisation of their respective positions on the clinical protocol for managing HIV and AIDS as prescribed by National HIV/AIDS Control Programme. But the major impetus for gathering this group seems to have come from the mandate from the Global Fund Round 5 Grant, directing HIV/AIDS service providers to work together in integrated clusters. *'This cluster meeting is organised by NACA and draw together workers from Terabor General Hospital in Gokana...also Pope John Paul Hospital Eeken...this treatment centre in Bori General Hospital, ...and our support group'*, reported the cluster Secretary who is also a peer educator. He also noted that the cluster meeting also includes the LACA Manager of Khana Local Government Area, where the comprehensive ARV treatment centre is located and volunteers from NGOs and CBOs from within the area. The aim of the meeting he further noted is to *'review activities of previous month...and also receiving reports for sending to higher authorities'*. *'The chairman is ART Focal Person'*, he concluded. This is in addition to the facilitation provided by the programme manager of the Global Fund at this ART site - Hygeia Foundation, a national NGO - contracted to oversee the implementation of the anti-retroviral treatment programme. Apart from the physical presence of a Programme Officer who was inclined to hold the group together by force of purpose, the programme manager provided logistics support to ensure that the meetings of this cluster took place on a regular basis. In addition, the programme manager ensured that decisions taken at the meetings are followed through.

6.2.2 Clinical Pathway and Care Process

The hub of activities of the HIV/AIDS Programme Cluster in Bori is the ART Centre or HIV Clinic located at the General Hospital, Bori; where people infected with the Human Immunodeficiency Virus (HIV) and patients with established Acquired Immune Deficiency Syndrome (AIDS) receive anti-retroviral drugs to reduce the viral load, and other medications aimed at treating opportunistic infections. The routes taken by patients to access the ARV treatment services at this centre are outlined as follows:

1. Self-referral by patients, who based on public enlightenment information intend to find out their HIV status;
2. Patients who visit the General Out Patient Department (GOPD) of Bori General Hospital for common medical problems such as fever, cough and diarrhea, but are suspected of showing signs and symptoms of HIV infection;
3. Patients referred from other Hospitals - mainly the government General Hospital in Terabor; Pope John Paul Hospital, Eekan run by the Catholic Church; and other private hospitals in the area; in addition to the other numerous health centres located in the Local Government Area.
4. Others are patients on admission at the Bori General Hospital, pregnant mothers attending ante-natal clinic (ANC), as well as spouse and children of patients who are already receiving treatment at the centre.

All those who pass through the GOPD at the base hospital in Bori from whatever source - self referral or referred from other hospitals and health centres, in addition to those on hospital admission, pregnant mothers attending ANC, including spouses and children of patients are sent to the Counseling Unit co-located within the HIV Clinic for HIV counseling and testing (HCT). And from there, positive cases are sent to the HIV Clinic for assessment and commencement of treatment. However, some patients who have already been counseled and

tested at the General Hospital, Terabor and Pope John Paul Hospital, Ekean proceed directly to the HIV Clinic as these hospitals have certified counselors who can make referrals using official programme documents. But a confirmation laboratory test is also undertaken before treatment is started for this category of patients.

At the HIV Clinic an assessment of each patient is done based on clinical symptoms and signs along with the CD4 count obtained from the laboratory. This is to ascertain the stage of the disease in each patient, as it helps clinicians determine the specific drug regimen to be administered to that particular patient. Before drug treatment is commenced patient-record files are opened and drug adherence counseling is provided to each patient to ensure that compliance to ARV treatment is kept when the patient leaves the clinic. Follow-up visits are planned for every month, and based on the patient's residential address, a support group close to the patient's location is identified to help the patient manage notable difficulties the patient may encounter in the course of the treatment, which goes on for many years.

Additional support services other than clinical care at the community level, including mitigating the social impact of the disease on the individual, families and communities are also provided on a case by case basis. These include: health education on living positively with HIV; home-based care of symptoms of disease; identifying side effects of the drugs and how to cope with them; and looking after Orphan and Vulnerable Children (OVC) whose parents have died from the disease or unable to look after them due to incapacitation from the disease. These support services are usually organised by peers who are also living with HIV or by community-based organisations (CBOs), as well as other non-governmental

organisations (NGOs). The members of the National Youth Service Corps (NYSC)² posted to these areas were also seen to be particularly active in offering care and support services for HIV and AIDS patients.

6.2.3 Cluster Formation, Structuring and Activities

On the basis of the care process for people living with HIV and AIDS patients, the membership of the HIV/AIDS Programme Cluster in Bori was said to have been chosen mainly from service providers along the clinical pathway taken by these clients. They include organisations such as hospitals, health centres, and client support groups; departments or units within the base hospital in Bori; in addition to individual professionals, for example Medical Doctors and Nurses with further training in the management of HIV and AIDS.

Figure 6.3 below demonstrates how the core members of the Bori HIV/AIDS Programme Cluster are linked to each other, and with those who are not members but have responsibility for HIV/AIDS care or support in the geographical area covered by the cluster. Again, the objects in the diagram are in three categories: (i) Units of the Bori General Hospital (the base hospital) that are members of the HIV/AIDS Programme Cluster; (ii) Organisations/Agencies that are members of the Bori cluster, but not part of the base hospital; and (iii) Units within the base hospital that are non members of the Bori HIV/AIDS Programme Cluster. Similarly, the lines between these objects in the diagram signify linkages (relationships) between these units, organisations, or agencies irrespective of their location and/or institutional affiliation, with respect to the care for the population of HIV/AIDS patients within the ‘geographical area’ assigned to the Bori HIV/AIDS Programme Cluster. As the care pathway at this site has

² All fresh graduates from Universities and Polytechnics whether trained at home or abroad (if they return) have to undertake a one-year compulsory National Youth Service in States other than their home States. Apart from working in a primary place of assignment, these corps members also carry out community development projects.

shown, the linkages between core members of the Bori HIV/AIDS service cluster could be seen either as 'referral links' between peripheral services and specialised units or as 'shared-care responsibilities' between units or organisations. Whereas 'sharing of information' could be considered as the relationship with those outside the core membership groups. As shown in the diagram, several of the service providers are co-located within the Bori General Hospital that was designated as an anti-retroviral treatment site. These are: the HIV Clinic incorporating the HIV Counseling and Testing (HCT) Unit and anti-retroviral (ARV) drug treatment centre; the Pharmacy, Medical Records and Laboratory of the base hospital; and the Prevention of Mother-To-Child Transmission (PMTCT) programme based at the Ante-Natal Clinic and Maternity. Within this setting, the HIV Clinic had a unique identity and appeared to be an agency (or organisation) of its own within the base hospital.

There were other units of this base hospital that although had significant contact with the HIV Clinic, were not included in the membership of the programme cluster. The General Out-Patient Department, and the In-patients Wards are the main ones. And despite an official institutional linkage between the HIV Clinic and the Management of the Bori General Hospital, the latter was not part of the coordinating cluster. It was suggested that frequent changes of medical and nursing personnel and the lack of commitment on the part of core clinical staff was the reason for non-inclusion. Consequently, the Medical Staff who run the HIV Clinic were additional staff posted from the State Ministry of Health specifically for that purpose. On certain occasions doctors on national service assigned to the hospital were also drafted to undertake medical duties at the HIV Clinic. But such medical personnel were usually not actively involved in the HIV and AIDS programme cluster activities.

There were two categories/groups of members of the HIV/AIDS Programme Cluster that were located outside the base hospital in Bori. The first group was made up of those that had clinical responsibilities such as the General Hospital, Terabor, the Pope John Paul Hospital, Eekan and the Primary Health Care (PHC) centres within and around Bori town (usually represented by the Manager of the Local Action Committee on AIDS - LACA). The other group comprised those providing supportive services including the Bori people living with HIV Support Group, and volunteers looking after orphan and vulnerable children. Although located outside, the latter group seemed to have a much stronger tie with the ART centre as they were working more closely in managing the continuum of care, and were usually present on clinic days. Whereas, the relationship with the former group could be said to be more like referral linkages that link clients to the ART centre to access ARV drugs.

Although there was a strong recognition among members that they were working on increasing access to ARV drugs for the same patients living with HIV or suffering from AIDS disease in Khana Local Government Area and beyond, their relationship appeared to have been formalised through a Terms of Reference drawn up by the Global Fund Round 5 Grant that financed the procurement of the ARV drugs. And these were meant to be ongoing relationships since the National HIV/AIDS Control Programme had adopted the Integrated Cluster Model as mandated by the Global Fund in providing comprehensive care for HIV/AIDS patients living within a given geographical location. Virtually all those interviewed volunteered that the most important goal on working together on the ART programme was the establishment of a continuum of care for those living with HIV/AIDS. And they recognised the formal linkage of the ART centre based at Bori General Hospital with peripheral Primary Health Care centres and community-based efforts at care and support for HIV/AIDS patients, as a means of achieving this goal.

Membership of the HIV/AIDS Programme Cluster was said to have been decided based on the Integrated Cluster Model as dictated by the tenets of the Global Fund Round 5 Grant and handed down by the National Agency for the Control of AIDS. Accordingly, the stipulated 11 member organisations: ART centre at Bori General Hospital; the PMTCT site, TB programme and one HCT site also at this hospital; one HCT site each at General Hospital, Terabor and Pope John Paul Hospital, Eekan; the Bori Support Group and Volunteers looking after home-based care, and Orphan and Vulnerable Children, could be identified. But this membership seemed to have been expanded to include the hospital Pharmacy, Laboratory and Medical Records. The reason given was that these units were directly involved in patient care and their exclusion would have created major impediments in integrating the tasks of these units in patient care. A notable case was the non-inclusion of clinical staff of the base hospital, which has created problems with admitting clients who need in-patient care into the hospital. Meanwhile, volunteers who were working with the support group to undertake contact tracing and home-based care, were there as individuals rather than representing specific NGOs and CBOs.

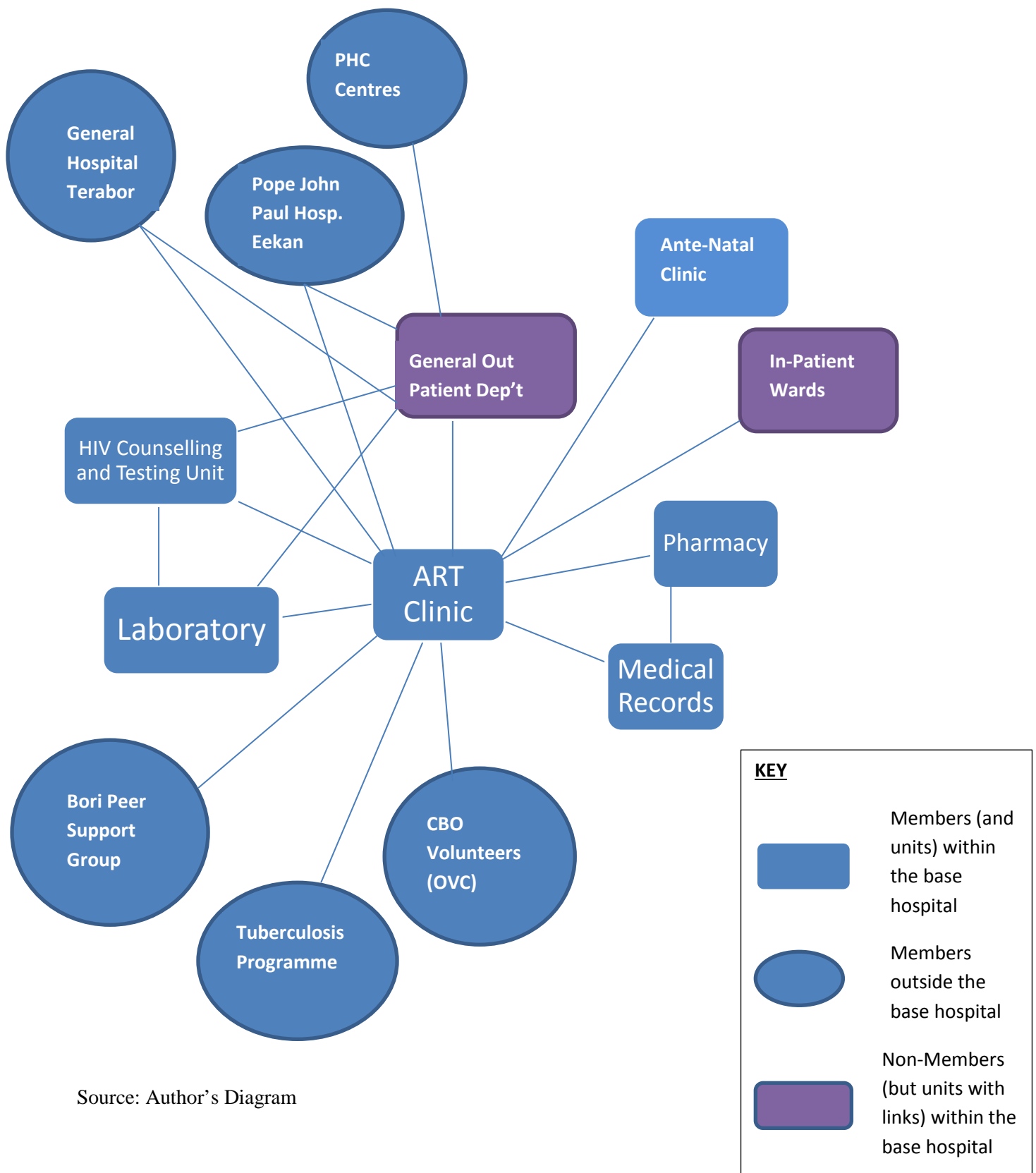
Although there was no one organisation or individual who was instrumental to the formation of this programme group, as the formation and structure of the HIV/AIDS Programme Cluster was more or less mandated by the Global Fund Round 5 Grant; it was noted that the Programme Manager of the Global Fund at this site was actively involved in the set up. *'We had a lot of support from the Programme Coordinator....who came to help us start the cluster meetings in Bori here'*, recalled the chairperson and ART site coordinator. However, at close observation of both the activities of the ART centre and meetings of the HIV and AIDS programme cluster; it was quite obvious that the Global Fund Programme Manager

continued to drive the process, whereby the Programme Officer is sometimes referred to as the Chief Executive of the ART programme.

All the organisations, agencies and units indicated that they got involved in the HIV/AIDS Programme Cluster in Bori because of their respective roles in the patient care process. A member from one peripheral health facility noted: *'we are part of this cluster because we are one of the people who refer HIV patients to Bori for treatment'*. A representative from one of the hospital units also observed: *'all those who have one thing or the other to do with HIV are in this meeting'*. But also because members were funded by the same Global Fund Round 5 Grant to undertake their respective functions in relation to that of other members of the programme cluster. And being located within the catchment area of the Bori ART centre was also noted as another factor responsible for their engagement with the programme cluster.

The Support Group of People Living with HIV/AIDS, the Volunteers carrying out home-based care, and the organisation looking after Orphan and Vulnerable Children were of the view that they stand to gain recognition and have access to resources (financial and information) by participating in the HIV/AIDS Programme Cluster. *'The cluster affords us the opportunity to do what we are meant to do as support group members...we meet here and discuss our problems...including our personal needs'*, the representative of the support group, commented. On the other hand, most of the units (health professionals) within the base hospital saw relevance and opportunity for training and improving the competencies of individual professionals, as what they may lose from not participating. *'If there are innovations, the people supporting us...this is where they come and train us'*, observed one health professional. Moreover, their involvement in this group was a given since their roles in HIV/AIDS care were statutory.

Figure 6.3 – Structure of Bori HIV/AIDS Programme Cluster



Source: Author's Diagram

6.2.4 Cluster Processes and Maintenance

The monthly Cluster Coordinating Meetings were the main avenue for discussing joint programme operations. While these meetings were planned to take place on the first Wednesday of every month, they were noted to have been occasionally shifted to the second or third Wednesday of the month. Nonetheless, as observed from the minutes of the meetings in 2010 and 2011, they were regularly held every month. And as recorded in the minutes of one of the meetings (Bori HIV/AIDS Programme Cluster, 2010: 3) - they were *'aimed at reviewing the activities of the HIV/AIDS Programme Cluster for the previous month including receiving and examining reports from programme components'*. The appointed Chairperson for these meetings was the ART Focal Person at the ART site who was a Laboratory Scientist at the Bori General Hospital. The Secretary, who was responsible for sending out meeting notices and recording the minutes of the meetings, was also a Peer Counselor. In addition, there was a Treasurer who kept the accounts of funds appropriated specifically for the running of the cluster activities including the coordinating meetings. Attendance at the meetings was based on representation from each of the HIV/AIDS interventions identified by the Integrated Cluster Model, in addition to hospital units critical to patient care as outlined above. And while the Programme Officer representing the Programme Manager of the Global Fund was part of these meetings, this person was meant to maintain a facilitator's position. But from my observation at two meetings and based on review of the records of minutes of the cluster meetings, this person was quite actively engaged in the discussions and seemed to have presided over some meetings when the chairman was not present. As reported in the minutes of 20th January, 2010: *'In the absence of the chairman, the Programme Coordinator....called the meeting to order at 3.00pm'*; and the minutes of June 8th, 2011: *'At 15:17 hours the meeting was called to order by the Programme Boss and payers were offered by...'*.

A close examination of the minutes of the cluster coordinating meetings also revealed that the key agenda items were issues related to core patient care activities, such as: inadequacy of clinical staff; the non-functioning of the CD Machine at some point; shortage of vital consumables, the physical work conditions in the health facilities, especially at the base hospital; and the attitude of staff towards their work. Others include: clients failing to comply with the drug regimen and defaults from the ARV treatment programme, as well as other important sundry matters including staff welfare. All agenda items were seen to be usually discussed in a frank and open manner with enough information provided by those responsible for such matters. And decision making was usually consensual although in certain cases members were made to take their cue from Standard Operating Procedures (SOPs) as laid out by the National HIV/AIDS Control Programme. In between meetings, the usual form of communication was noted to be usually through mobile telephone, where urgent matters needed to be resolved were dealt with. Moreover, individual professionals participating in the HIV/AIDS Programme Cluster also tend to know each other personally with several contact opportunities either at church, parties and other social engagements; these informal settings were also said to serve as avenues for discussing cluster coordinating matters in a more relaxed environment. One health worker observed: *'we are quite familiar with each other ...even as we are co-workers in this facility'*.

There was not much sub-committee level work except in occasions where a particular task such as the case of the non-functional CD4 machine, where a task force was set up by the cluster to engage with relevant persons to resolve the matter. But two particular issues were noted as sources of tension for some participating organisations and individual professionals. The first was admission of clients into the base hospital for those who needed in-patient care. As observed by some members interviewed, the non-involvement of the hospital management

of the host hospital - Bori General Hospital, in the programme was responsible for the difficulties the programme was having in getting clients admitted into the hospital wards. On the question of whether having a Laboratory Scientist as the chairperson of the cluster as opposed to a Medical Doctor could have been responsible for some of the problems the cluster was facing, the ART Focal Person said: *'there is no problem with the cluster...we are being directed by the programme coordinator...the problem...our doctors do not want to near the patients, every patient we admit, there is no review'*. But a Medical Officer on National Youth Service posted to the hospital, who was also helping with the ART programme at the HIV clinic expressed a different opinion. *'A lab scientist does not have anything to do with managing HIV patient...they can do lab test but not treatment'*. *'The best way is to have a doctor from within the hospital work with the HIV clinic...that doctor should be the head of the ART programme'*, he suggested. The matter of getting HIV patients admitted into the in-patient wards however, was said to being resolved through constructive engagement with the management of the hospital, by getting them included into the cluster membership.

The other issue has to do with delays in attending to clients already screened and referred from peripheral hospitals that are members of the HIV/AIDS Programme Cluster. This latter issue was resolved by ensuring a better understanding of the clinical pathway and care process among participating health facilities. Meanwhile, over half of those interviewed suggested that the key factor that tend to keep participating health facilities and individual professionals to be committed to the HIV/AIDS Programme Cluster activities was the need to keep up to date with HIV/AIDS programme activities through better information sharing and improved professional capacity to do their work. *'Where we have some challenges...we air it out and solutions will be given'*, said a member who is a nursing staff at the base hospital.

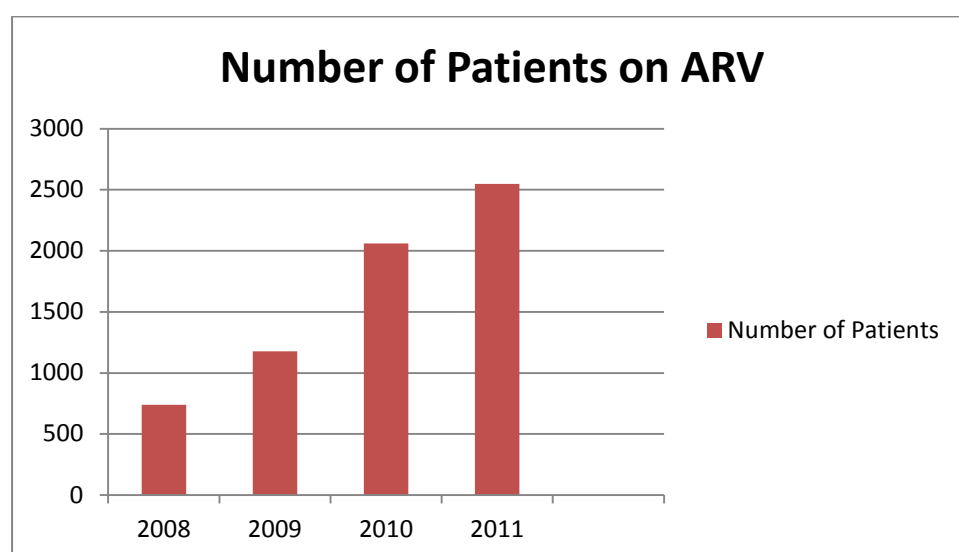
6.2.5 Cluster Outcome

Nearly everyone interviewed especially members who do not have direct clinical functions consider the ability to share information and ideas and then jointly taking decisions that affect the entire programme as the main achievement of the HIV/AIDS Programme Cluster. *'In the interest of our clients...we usually agree together on issues concerning the cluster'*, noted the LACA Manager. *'There is much achievement'*, said another member, *'...it is not one man's job and without these persons no one can succeed'*, he emphasised. Cluster members also mentioned the fact that since each one of them now has a better understanding of how their roles complement each other; the relationships that now exist are also very important. As reflected by a focal person from one of the peripheral health facilities, *'we have focal persons from TB, RBM, M&E, pharmacy, nurses and midwives...PMTCT...all these groups coming together to discuss, to give reports...in fact we are working as a team, and everybody is serious'*. This is as opposed to when each one tried to work on their own despite the inter-relatedness of their functions. Another thing the HIV/AIDS Programme Cluster has been able to achieve was noted as its capacity to disseminate knowledge. And a good number of members mentioned that they looked forward to receiving new information and indeed sometimes learn new things whenever they attend the programme cluster meetings. In their opinion, this has helped not only in the way they perform their individual tasks but also made them to be more open to learning about updated methods in relation to the aspect of HIV/AIDS service that they provide. *'It gives me the privilege to be better informed about HIV...and how to go about helping people with this problem'*, remarked a CBO volunteer.

Group members also felt that on the basis of the setup of the HIV/AIDS Programme Cluster and the recognition accorded to it, members acting through the programme cluster have been able to negotiate with other parties as a legitimate entity, including attracting resources to

support cluster activities. *‘We wrote a letter to the Ministry to have a meeting with us...and they came...this can’t be possible if it is just the support group’*, reflected the Secretary who is also the support group member. But by and large the most significant indicator (based on the Global Fund grant’s objective) by which the HIV/AIDS Programme Cluster is judged is the number of people living with HIV and AIDS that are placed on antiretroviral drugs. In Bori, the number of people receiving antiretroviral drugs at this site as shown in Figure 6.4 increased from 1176 in 2009 to 2547 in 2011. There was no way to know if this increase was mainly due to the presence of the HIV/AIDS Programme Cluster or to some other factors. Nevertheless, there was enough circumstantial evidence (as claimed by those interviewed) to suggest that number of people living with HIV/AIDS accessing antiretroviral drugs in this area markedly increased for a period of three years largely due to the coordinating efforts of programme cluster members. It was argued that as the responsibility on clients to navigate the care process was reduced through the active management of the clinical pathway by cluster members, there was high tendency for more clients to use the services of the antiretroviral treatment centre.

Figure 6.4: Utilisation of ARV Services at Bori ART Site



Source: Hygeia Foundation – Programme Managers of the Global Fund ART Programme at Bori

An attempt was made to obtain data from another centre with a functional ART programme in Rivers State - the Braithwaite Memorial Specialist Hospital in Port Harcourt - where the Integrated Cluster Model was not mandated, in order to be compared with data from the site in Bori, as well as with the other study site at Ahoada. The data generated from this ART site that did not operate the cluster model were perceived either to be incomplete and / or of dubious quality. Therefore, the capacity for data management itself could be considered as another indicator for measuring the performance of the HIV/AIDS integrated cluster model. And one can assume that as the Rivers State Government funded this ART site (at the Braithwaite Memorial Specialist Hospital in Port Harcourt), it did not impose the conditions for joint working among HIV/AIDS service providers as required by the Global Fund. Therefore, the system for information sharing and collective accountability for data management failed to be established in this place.

One could perceive a sense of joint ownership of the results achieved by the HIV/AIDS Programme Cluster in Bori, since group members were aware that they were jointly accountable to the success (or otherwise failure) of the cluster. Moreover, there was general knowledge among members that the efforts of each member towards the care received by every client determined whether new clients are recruited; those already on treatment are supported to follow through with their treatment; and those who default are traced and brought back to resume treatment. One main area of concern for members therefore was the sustainability of this 'Cluster Model' once funding from the Global Fund that broadly supported HIV/AIDS care and support services at this site lapses.

6.3 Notable Similarities and Differences between HIV/AIDS Programme Clusters in Ahoada and Bori

While the HIV/AIDS Programme Clusters in Ahoada and Bori using the same prescribed 'Integrated Cluster Model' for integrating the tasks of autonomous and semi-autonomous HIV/AIDS service providers achieved comparable results (in terms of increase in the number of patients accessing ARV services); they also exhibited certain similar features. What they share in common include:

- a membership structure that was expanded to include key units or departments of the base hospitals that were vital to patient care, other than the 11 core members as stipulated by the Global Fund Round 5 Grant directive;
- the institution of monthly Cluster Coordination Meetings with clear modalities and terms of reference as the main cluster activity;
- the presence of a facilitating agency – a Programme Manager of the Global Fund Round 5 Grant, with its Programme Officer acting as a facilitator; and
- the capacity to maintain well-defined relationships among specific HIV/AIDS programme interventions undertaken by several PHC facilities, hospital units at the base hospital, and community-based organisations; in addition to being able to deliver comprehensive services for HIV and AIDS patients in their respective locations without repeated registration, procedures, waiting periods and other administrative barriers.

Nevertheless, there were also some notable differences, including the implementation of the anti-retroviral treatment programme itself, which was undertaken somewhat differently at the

two sites. Table 6.1 below shows some of the key differences between the two HIV clusters - based on my findings - despite adopting the same policy of collaborative service delivery.

Although the table below summarised the main structural and functional differences, the most significant elements with regards to collaborative service delivery was the capacity to integrate the HIV/AIDS services (the cluster activities) with routine clinical services of the base hospitals. At Bori ART site, a set of clinical staff including doctors, pharmacist and other ancillary staff seconded from the State Ministry of Health were the focal persons that administered the drug treatment programme. The core clinical staff at this hospital only engaged with the ART centre through referrals from either the out-patient clinics or from the hospital wards. At this site, the ART centre although physically linked to the main hospital buildings through corridors was located in a separate structure nick-named the ‘White House’ - said to be so named due to the colour of the outside paint coating and not because it houses the HIV/AIDS clinic.

Whereas at Ahoada ART site, the same clinical staff comprising the medical officers, in-house pharmacists and nurses that attended to every other patient that visited the Ahoada General Hospital, also managed HIV/AIDS patients, from the same care delivery points. In this instance, the Ahoada General Hospital was seen not just as host to the ART centre, but in practice was noted to have demonstrated that HIV and AIDS are like any other health condition that can be treated. Therefore, this approach apart from allowing the HIV/AIDS programme to be more integrated with the routine clinical services at this hospital was said to have greatly reduced the stigmatisation of HIV and AIDS patients, also seen as an additional benefit of the HIV/AIDS control efforts. The inability of the ART centre at the Bori site to achieve this level of clinical integration, could explain some of the difficulties encountered by

the HIV/AIDS Programme Cluster, such as problems with admitting their patients into Bori General Hospital for stabilisation prior to enrolling them on the programme.

Table 6.1 – Key differences between Ahoada and Bori HIV Programme Clusters

S/No	Themes	Ahoada HIV/AIDS Programme Cluster	Bori HIV/AIDS Programme Cluster
1.	Cluster Leadership – ART Focal Person	Medical Doctor	Laboratory Scientist
2.	Frequency of Meetings	Less frequent – there were no meetings in some months of the year	More frequent – meetings took place nearly every month in the year
3.	Report of Partner Activities in the Minutes of the Meetings	More systematic – with space allocated for each and every member in the cluster	Less systematic – though tend to cover issues from all partners in the cluster
4.	Membership Representation	More than the prescribed number of HCT Units, and OVC, HBC, support groups are represented	Support Group and individual volunteers tend to cover the work of OVC, and HBC groups, as none was available.
5.	Physically identifiable HIV clinic at base hospital	None – HIV patients are seen in regular clinics	Yes – HIV Clinic located in a building called the ‘White House’
6.	Integration with routine clinical services at base hospital	A lot more integrated – HIV patients are seen by the same set of clinical staff as others with other medical conditions	Supernumerary clinical staff mainly Medical Doctors, Pharmacists and counsellors are brought in to run the HIV Clinic
7.	Social activities other than core cluster business	None	Celebration and gifts for special occasions - Send Off (Send-Forth), Weddings etc.
8.	Level of engagement with Global Fund Managers	Less hands on – maintained a facilitator role	More engaged – more of supervisory than facilitation

The minutes of this cluster’s meetings repeatedly recorded (17th March, 2010; 19th May, 2010; 5th September, 2010; 27th October, 2010; 20th November, 2010; and 15th December, 2010) the frustration members were having in not been to have clinical access for their patients at the host hospital. In the search for solutions to this problem, the minutes of the

cluster coordination meeting of 19th May 2010 in particular indicated, ‘...*a special invitation letter should be served to the hospital reps to attend our next meeting*’. As observed earlier, this may or may not have anything to do with the headship of the cluster, who is a Laboratory Scientist (a staff of the hospital) rather than being a Medical Doctor as in the Ahoada. It might have been a pre-existing culture when the HIV programme was introduced into the two medical establishments. At Bori, the Chief Medical Officer in-charge informed the researcher: ‘*the HIV programme runs on its own...you will find them at the White House...at the back of the hospital*’; while his counterpart in Ahoada emphasising his interest in the programme stated: ‘*I do attend their meetings sometimes...just to encourage them*’. This was confirmed in the record of Ahoada cluster meeting of 29th March 2012 that stated: ‘...*and introduced the CMD³ & CNO⁴ of the hospital, who walked in while the meeting was in progress*’. Moreover, the identity given to the ART centre was the ‘HIV Clinic’ in Bori General Hospital, more like a separate agency or organisation, located in a distinct building (‘White House’) but only being hosted by the hospital; seemed to have also created some barriers with the routine clinical services at this hospital. In addition, it was also observed that during the course of the research when there was leadership succession at both sites due to routine movement of staff within the same service (Hospitals Management Board), another Medical Officer from within the hospital replaced the ART coordinator at Ahoada. But in Bori, rather than use this window of opportunity to get a Medical Officer at the hospital to lead the cluster, the supernumerary Medical Officer from the State Ministry of Health that was supervising the HIV Clinic took charge of the cluster, thereby perpetuating the dichotomy between the hospital and the HIV/AIDS programme at this location.

³ CMD – Chief Medical Director

⁴ CNO – Chief Nursing Officer

As there were two different Programme Managers for the Global Fund at each of the ART sites, there was an attempt to find out during the follow-up discussions if the differences in approach in the two sites were due to the influence of the particular Programme Managers. It turned out that while both Programme Managers focused on the results that they are being contracted for and directly linked to the objectives of the Global Fund Round 5 Grant Award (as outlined on Figure 5.3 in the last chapter), there was a sense of expediency on their part in implementing the integrated cluster model. For example, giving the difficulties being experienced at the Bori site with access to clinical facilities and the lack of direct linkage with Medical Officers at the base hospital, there was a tendency for Global Fund programme managers to extend their role beyond facilitation to even supervising the conduct of the cluster meetings. Thus in managing the ART programme in each of the sites, they were said to have adopted the most practical means of achieving the set objectives in the face of the difficulties they encountered, including facilitating the activities of the networks. For example, the minutes of two meetings of one of the HIV/AIDS clusters reported how much pressure the programme manager facilitating the cluster, put on members to provide timely and accurate data. It was also clear that none of them anticipated the way the networks turned out as described above, and so the character and formation of the networks could be attributed mainly to the disposition of the membership in the different locations.

Despite these major differences between the two HIV and AIDS Clinical Networks in Rivers State, both sites were seen to be achieving the objectives of the Global Fund Grant Five Award as specified on Figure 5.3 in chapter 5. Notwithstanding, during the follow-up discussions with members of the Bori HIV/AIDS Cluster, the failure to integrate the ART centre with the routine hospital services as it was obtained at the Ahoada site was noted as a major weakness that could prevent programme sustainability at this site, as this requires more

managerial input. On the other, its higher level of social cohesion and identity as demonstrated by its engagement in social activities outside the core business of the cluster could be a source of stability for the cluster. Also, having the ability to improvise by extending the role of the Support group (strengthened with individual volunteers) to cover the work meant to be undertaken by OVC and HBC groups, as well as been able to attract supernumerary clinical staff (paid by the State Ministry of Health); the Bori cluster seem to have developed capacity for mitigating unintended programme implementation risks. Although holding regular meetings is partly a function of the availability to resources for light refreshment and transport re-imbursement of participants, the ability to hold regular meetings could be another way of holding the cluster together in the face of some difficulties in organising collaborative service delivery for its clients.

These are the ways in which collaborative practices were seen to have taken place within HIV/AIDS Programme Clusters in Rivers State - Nigeria, and as demonstrated, they were not just routine activities of working together among multi-stakeholders. The next chapter attempts to make an assessment of the feasibility of transferring the policy of managed clinical networks as a means of collaborative service delivery in Nigeria, using the character and formations of HIV/AIDS Programme Clusters as illustrated above, and the institutional matrix within which they are meant to operate, presented in the previous chapter.

Chapter Summary

This second empirical chapter provided a comparative account of the structure and character, and the formation of collaborative links within the two HIV/AIDS clinical networks studied in Rivers State, Nigeria. Having provided a rich account of the ways in which these clusters formed, it drew out similarities and differences between the two HIV/AIDS clinical networks.

Along with the policy and institutional analysis data from the previous chapter, it provides the basis for the discussion that follows in Chapter 7, which examines the feasibility of the transfer of the idea of the MCN in Nigeria.

Chapter 7: Discussion

In light of the findings of the networking activities of the HIV/AIDS Programme Clusters in Rivers State, and the observations from the analyses of the institutional and HIV/AIDS contexts in Nigeria, this chapter discusses the empirical evidence in relation to the original research question - whether the idea of the managed clinical network (MCN) could be a feasible and effective means of service integration in Nigeria, and how this may happen if this is the case. The chapter examines the feasibility issue from three different aspects: operational, contextual, and interventional feasibilities. A final section in the chapter links these empirical discussions to the theoretical perspectives in the earlier chapters, and offers reflections on the transfer of the idea of networks and collaborations into new settings.

The HIV/AIDS Programme Clusters in Rivers State, Nigeria, arrived through incentives provided by The Global Fund's (Global Fund to fight AIDS, Malaria and Tuberculosis) to adopt an 'Integrated Cluster Model' for service provision. This involves developing a network or clusters of secondary and primary health facilities that provide comprehensive HIV/AIDS prevention (testing and counselling), treatment (PMTCT and ART), care and support services within a geographical sphere or radius of 30 minutes walking distance of a particular community (National Agency for the Control of AIDS, 2010b). Each of the two clusters in Rivers State, basically works as a cluster of:

1. A comprehensive site (a General Hospital) providing anti-retroviral treatment (ART) for HIV positive persons, treatment for opportunistic infection, and Sexually Transmitted Infections (STI);
2. One Prevention of Mother-to-Child Transmission (PMTCT) site (part of the comprehensive site), where pregnant mothers are screened and referred to the comprehensive site for treatment if positive;

3. Three HIV Counseling and Testing (HCT) sites (one in the hospital and two in other Health facilities), where people are screened for HIV and referred to the comprehensive site for treatment if positive;
4. A support group of People living with HIV/AIDS (PLWHA) that liaises with the comprehensive site to enrol PLWHA into the support group meeting; this is a forum for PLWHAs to interact and provide support to one another within their environment. The group also provides other community based services to members e.g. Home Based Care (HBC), Vocational training for PLWHAs, etc.;
5. Two Home-based care community projects;
6. A Tuberculosis (TB) treatment centre providing 'directly observed treatment, short-course' (DOTS) for tuberculosis. The DOTS clinic is where people with tuberculosis are screened for HIV and referred to the comprehensive centre for treatment if positive.
7. An Orphan and Vulnerable Children (OVC) support program: Support is provided for OVCs (Nutritional, Education, and Vocational). This support group interacts with the other HIV/AIDS services within the Cluster.

The 'primary objective' of each cluster is to ensure that this 'cluster of HIV/AIDS-related services' jointly work together to increase the number of people receiving anti-retroviral treatment in the respective locality, as a measure towards the control of HIV/AIDS in Nigeria. Funding for each cluster that holds monthly meetings, as the main forum for taking decisions for service integration comes in two ways: drugs and some money for cluster coordination/management come from The Global Fund, while other activities are funded through normal budgets. A cluster coordinator, a cluster secretary, and cluster treasurer are selected from amongst these providers - who ensure that 'cluster meetings' are held monthly,

reports are submitted, and funding support for the monthly cluster meetings received from the National Agency for the Control of AIDS (NACA).

Therefore, the ‘landing’ and ‘development’ of the HIV/AIDS Programme Clusters within this healthcare setting represent an example of exogenous intervention to secure coordination and integration between otherwise disconnected organisations involved in mutual tasks (Guthrie, et al, 2010). As MCNs allow for the continuous working relationship between organisations and individuals to improve the treatment of patients who require care across a range of different institutions - for example: improving access to care, making more efficient use of staff, reducing professional and organisational boundaries, sharing good practice, and putting the patient at the centre of care (Goodwin et al, 2005); the HIV/AIDS Programme Clusters, which have been given a mandate to integrate HIV/AIDS services, having an identity with central authority, and resources made available for collective use that benefits all - are considered to be ‘equivalent’ to the idea of the MCN.

As indicated in the methodology, this research study follows precedents that treated policy transfer as an ‘independent variable’ in exploring the extent to which a particular policy as developed in one country, was emulated in different countries (Dolowitz & Marsh, 2012; James & Lodge, 2003). In addition, it recognises the significance accorded to contextual factors in the policy transfer literature (Swainson & de Loe, 2011), with respect to ‘whether’, ‘how’ or ‘why’ a policy may travel, as a policy or an idea being transferred is subjected to institutional influences that may facilitate or inhibit its viability. Dolowitz and Marsh (2012: 340) also make the point that, ‘if we are to treat policy transfer as an independent variable and examine its influence on policy outcomes, then some understanding of what we mean by policy ‘success’, or ‘failure’, is crucial.’

As such, the feasibility assessment of the idea of the MCN as a means of service integration in Nigeria was undertaken at three levels: (i) operational feasibility - technical possibility of each of the HIV/AIDS Programme Clusters functioning as a 'collaborative enterprise'; (ii) contextual feasibility - whether the conditions for HIV/AIDS Programme Clusters were conducive and how the clusters survive and thrive within the specific institutional environment of Nigeria; and (iii) interventional feasibility - if HIV/AIDS Programme Clusters are desirable as a means of service integration in Nigeria, similar to the idea of the MCN, then they are designed to achieve pre-determined outcomes following a particular 'theory of change' that takes into account both its operational features and contextual factors. Is the theory of change coherent and plausible/compelling? Each of these aspects of feasibility with respect to the patterns of collaborative practice seen in the HIV/AIDS Programme Clusters in Rivers State, Nigeria is considered as outlined below.

7.1 Operational Feasibility

In relation to the 'mechanisms and incentives' that may influence Himmelman's (2002) cumulative collaborative scheme, and treating each HIV/AIDS Programme Cluster as an 'independent variable', sixteen (16) critical factors have been used in the assessment of the operational feasibility of the HIV/AIDS clinical networks in Nigeria - see Table 7.1 below. While these are researcher imposed, they were largely selected and adapted from three sources: (i) empirical work undertaken by Mattessich, Murray-Close & Monsey (2001) which combined findings from several case studies to identify common key factors that influenced the success of collaboration; (ii) Thomson, Perry & Miller's (2014) 'Five-Dimension, and Seventeen-Indicator Collaboration Scale' derived from empirical data; and (iii) research carried out by D'Amour et al (2008), which used multiple case studies to identify key indicators for collaboration. This research study does not pretend that the chosen critical

factors present a model list, or that all the factors that may influence collaboration have been captured. The list takes into account most of the structural, relational and process factors of collaboration that are commonly stressed both in theory and practice (Schmitt, 2001; D'Amour et al, 2005). But most importantly, it serves as a pragmatic recourse to giving a comprehensive perspective of the phenomenon as it relates to this research study. Its main utility is to assist the researcher determine if the fact of collaboration, or its absence can be established. In either case it helps to assess whether clinical networks can be operated as collaborative ventures in Nigeria.

And following Mattessich, Murray-Close & Monsey's (2001), Thomson, Perry & Miller's (2014), and D'Amour et al's (2008) approaches; these critical factors are organised under five themes. These include: (i) *purpose* - refers to the reason for the development of the collaborative efforts, the result or vision the collaborative group seeks, and the specific tasks or projects of the collaborative group; (ii) *membership structure and characteristics* - consisting of skills, attitude and opinions of the individuals in a collaborative group, as well as the culture and capacity of the organisations that form collaborative groups; (iii) *process and outcome* - which refers to the management, decision-making, operational systems and results of a collaborative effort; (iv) *communication* - referring to the channels used by collaborative partners to send and receive information, keep one another informed, and convey opinions to influence the group's actions; and (v) *resources* - include financial and human 'input' necessary to develop and sustain a collaborative group. The 'sampling method' for this research that included only HIV/AIDS Programme Clusters that are supported by The Global Fund, means that certain factors - such as the ART centres in each hospital being the lynchpin/referent organisation, the idea of pathway, and that providers with resources around the pathway would be members - are held constant. As shown on Table 7.1, the factors under

each theme are set against the observed features of the HIV/AIDS Programme Clusters in each of the study sites; and some remarks are made in the final column to indicate the researcher's inference as demonstrated by the features of the clinical networks under review.

Table 7.1 – Assessment of HIV/AIDS Clusters as collaborative endeavours

Critical criteria for collaboration success	Ahoada HIV/AIDS Cluster	Bori HIV/AIDS Cluster	Remarks
A. Purpose – refers to the reason for the development of the collaborative efforts, the result or vision the collaborative group seeks, and the specific tasks or projects the collaborative group defines as necessary to accomplish			
(A1) Shared vision <i>Collaborating partners have the same vision, with clearly agreed upon mission, objectives and strategy.</i>	The idea of providing a comprehensive package of HIV/AIDs services for a given population was wide spread among members; and they seemed to be dedicated to the belief that it can work.	Members appeared to share the idea of providing a comprehensive package of HIV/AIDS services; and seen to be committed to integration of HIV/AIDS interventions.	There is knowledge that the practice bases of the organisations involved in collaboration are compatible in terms of client type and issues. And they are aware that it would be difficult for a single organisation to achieve by itself, what a collaborative group is trying to accomplish.
(A2) Unique purpose and identity with clear goals and objectives <i>The collaborative group identifies itself with mission or purpose that is specific and differs from that of its member organisation; and the goals and objectives are clear to all partners</i>	Members know themselves as the HIV/AIDS Programme Cluster in Ahoada, and they were aware that the group has been working towards increasing access for anti-retroviral drugs for HIV/AIDS patients in Ahoada East Local Government Area.	Strong recognition among members referred to as the HIV/AIDS Programme Cluster in Bori that they were working on increasing access to anti-retroviral drugs for the same population of patients with HIV/AIDS in Khana Local Government Area.	There is a sense among members of the collaborations of a unique purpose and identity – whereby no other entity in the area is trying to do exactly what each collaborative group is trying to achieve; increasing access to anti-retroviral drugs being the chief goal in each case.
B. Membership Structure and Characteristics – skills, attitude and opinions of the individuals in collaborative groups, as well as culture and capacity of organisations that form collaborative groups			
(B1) Centrality	The Anti-Retroviral Treatment (ART) Centre in Ahoada	The body around which the collaborative process and	In both cases the designation of an ART centre in each of the

<i>The existence of a central agency or organisation with a clearly defined strategic role</i>	General Hospital was central to implementing the collaborative process and structure.	structure was centred was the Anti-Retroviral Treatment (ART) Centre in Bori General Hospital.	base hospitals at Ahoada and Bori was the central authority that provided strategic role and guided collaborative action
(B2) Appropriate cross-section of members <i>The collaborative group has representative from each segment of the community of practice</i>	Membership of the HIV/AIDS Programme Cluster in Ahoada was drawn from service delivery organisations and agencies visited by patients along the clinical pathway taken by them; as well as organisations that provide management support.	Membership of the HIV/AIDS Programme Cluster in Bori was mainly from service providers along the clinical pathway taken by these clients; in addition to agencies with management and supportive roles.	The organisations involved in the collaborations are essentially those who have a stake in what each of the collaborative groups is trying to achieve, and includes both core clinical and supportive agencies.
(B3) Mutual respect, understanding and trust <i>Members of the collaborative group share a common understanding and respect each other, as well as their respective organisations.</i>	The linkages between core members seen either as ‘referral links’ between peripheral services and specialised units or as ‘shared-care responsibilities’ between units or organisations based on the care protocol.	The relationships between members were observed to have been formalised through clinical protocols but are based on their respective roles in the care of HIV/AIDS patients within the local geographical area.	Each of the agencies and organisations in the collaborative arrangements were able to maintain their particular approach to HIV/AIDS care but worked to complement each other. Knowledge of each other’s role was seen as the basis of trust.
(B4) Members see the act of collaboration as being in their self-interest <i>Collaborating partners believe the benefits of collaboration offset costs such as loss of autonomy and ‘turf’</i>	Access to programme resources such as clinic inputs, and information; additional incentives for undertaking this specialised work; and capacity building of professional staff cited as reasons for being involved by organisations.	The need to keep up to date with HIV/AIDS programme activities through better training, information and improved capacity to do their work was noted as the main reasons for participating.	Individual participant organisations that take part in a collaborative group believe that their organisations stand to benefit from the collaboration. The ability to maintain organisational competencies through training appeared to be the key motivation.

(B5) Ability to compromise <i>Collaborating partners are able to compromise since the many decisions within a collaborative effort cannot possibly fit the preferences of every member perfectly.</i>	Restriction of membership caused some dissatisfaction whereby those excluded, refused to cooperate in providing data. This was resolved by ensuring that individual health professionals in all participating health facilities, units and organisations were actively engaged in training activities.	Displeasure about delays in attending to clients already screened and referred from peripheral hospitals that are members of the HIV/AIDS Programme Cluster. This issue was resolved by ensuring that the agreed care process among participating health facilities were adhered to; in addition to using uniform client records.	Though retaining their individual professional and organisational interests; convergence of partners' interests around the HIV/AIDS client seemed to have been the basis for compromise. Goodwill and procedures proved very useful to working through conflicts in the collaborative groups.
C. Process and Outcome – which refers to the management, decision-making, operational systems and results of a collaborative effort			
(C1) Formalisation tools - development of clear roles and policy guidelines <i>The collaborating partners clearly understand their roles, rights, and responsibilities; and how to carry out those responsibilities.</i>	Based on Standard Operational Guidelines (SOPs) each member of the HIV/AIDS Programme Cluster was trained on the specific tasks they are meant to perform and are aware of other organisations that performed similar or related services within their locality.	All the organisations, agencies and units seemed to know their relative position in the HIV/AIDS Programme Cluster with respect to their individual roles in the patient care process based on Standard Operational Guidelines (SOPs).	Formalisation of roles and responsibilities probably helped the agencies and organisations involved in the collaborative groups to develop internal systems and procedures to accommodate the multi-disciplinary approach to HIV/AIDS care.
(C2) Leadership - decentralised decision making <i>Every organisation in the collaborative group participates in decision-making.</i>	Main forum for discussing joint programme operations was the 'cluster meetings', held monthly. Each service delivery point included in the HIV/AIDS Programme Cluster is usually represented by a	Monthly Cluster Coordinating Meetings were the main avenue for discussing joint programme operations. Attendance at the meetings was based on representation from each of the HIV/AIDS interventions.	Each participant in the collaborative groups speaks for their organisations. And there was evidence of ample time to take information back to their organisations to confer with colleagues when decisions are

	member.		made.
(C3) Flexibility <i>The collaborative groups remain open to varied ways of organising itself and accomplishing its work.</i>	Based on operational realities, mandated membership was expanded to include others that were critical to HIV/AIDS care within the locality	Membership expanded to include key units or departments of the base hospitals that were vital to the care of HIV/AIDS patients	Even when collaborative parameters are defined, the collaborations were willing to consider different ways of working.
(C4) Members share a stake in both process and outcome <i>Members of the collaborative group feel 'ownership' of both the way the group works and the results or product of its work</i>	There was a sense of shared ownership of the results of the Ahoada HIV/AIDS Programme Cluster as everyone interviewed was able to point out in practical terms how critical their individual organisational activities were to the achievement of the group's results.	There was general knowledge among members that the efforts of each member towards the care received by every client determined whether new clients were recruited; those already on treatment are supported to follow through with their treatment; and those who default are traced and brought back to resume treatment.	With a sense of shared ownership, members in the collaborations were probably motivated and enthused about the partnerships as they tend to develop 'collaborative capacity' that fostered and promoted partnerships (links between pairs and small groups of members), including the need for joint responsibility in delivering expected results.
(C5) Adaptability <i>The group has the ability to sustain itself in the midst of major changes, even if it needs to change some major goals, members, etc. in order to deal with changing conditions</i>	The cluster was seen to have carried on despite frequent changes of medical and nursing personnel, including its leadership.	Constrained access to clinical resources did not deter the cluster from reaching its goals.	Some indications that the survival of the respective collaborative groups despite operational risks could be attributed to their individual abilities to adapt to changing conditions.
D. Communication – refers to the channels used by collaborative partners to send and receive information, keep one another informed, and convey opinions to influence the group's actions			
(D1) Connectivity - established	Formal channels of	Apart from the monthly cluster	Good evidence that

<p>formal and informal communication links</p> <p><i>Channels of communication exist on paper, so that information flow occurs. In addition, members establish personal connections – producing a better, more informed, and cohesive group working on a common project.</i></p>	<p>communication include the monthly cluster meetings and committee meetings. But members seem to know each other personally and relate with one another in several spheres – neighbourhood, church, village meetings etc.</p>	<p>meetings, members tend to know each other personally with several contact opportunities either at church, parties and other social engagements.</p>	<p>communication among participants in the collaborative groups happened at formal meetings and in informal ways. This is a fact of inter-connectedness between individuals and organisations in the HIV/AIDS Programme Clusters.</p>
<p>(D2) Information exchange</p> <p><i>The existence and use of appropriate information infrastructure to convey all necessary information to one another and to people outside the group.</i></p>	<p>During monthly meetings, minutes are distributed (those not in attendance receive electronic copies) and all discussions were held in an open and frank manner.</p>	<p>Discussions in meetings were usually held in open and frank manner, and records are circulated and read in subsequent meetings – those not in attendance received electronic copies</p>	<p>Robust evidence that there are information systems within the HIV/AIDS collaborative groups that allowed members to be informed as often as they should about what goes on in the collaborations.</p>
<p>E. Resources – include financial and human ‘input’ necessary to develop and sustain a collaborative group</p>			
<p>(E1) Sufficient funds</p> <p><i>The collaborative group has adequate, consistent financial base to support its operations</i></p>	<p>Availability of funding from the Global Fund, which provided anti-retroviral drugs and sundry equipment for the management of persons infected with the virus; in addition to financial support to hold meetings.</p>	<p>With funds for the anti-retroviral treatment programme provided by the Global Fund, as well as fund to hold meetings - resources for network activities were adjudged to be sufficient.</p>	<p>While both collaborative clusters had adequate funds from the Global Fund to do what they want to accomplish, the sustainability of this source is not guaranteed.</p>
<p>(E2) Skilled convener or Facilitator</p>	<p>The contracted Programme Managers of the Global Fund –</p>	<p>The facilitation provided by the Programme Managers of the</p>	<p>Though officers of the HIV/AIDS Programme</p>

<p><i>The individual who convenes the collaborative group has organising and interpersonal skills, and carries out the role with fairness. Because of these characteristics (and others), the convener is granted respect or 'legitimacy' from the other collaborative partners.</i></p>	<p><i>Family Health International (FHI)</i> – provided resources such as stationeries for the secretariat, stipends for participants to cover transport cost, and light refreshment during meetings.</p>	<p>Global Fund at this ART site – <i>Hygeia Foundation</i> – provided logistics support (light refreshment, transport reimbursement) to ensure that the meetings of this cluster take place on a regular basis.</p>	<p>Clusters convened meetings, each site had a facilitating agency – a Programme Manager of the Global Fund, with its Programme Officer acting as a facilitator. In addition, the Programme Managers ensured that decisions taken at the meetings were followed through.</p>
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The relational conceptualisation of the idea of the MCN allowed for the consideration of the narrative-based accounts of participants in the HIV/AIDS Programme Clusters, which alongside observations at meetings and review of minutes of the cluster coordinating meetings provided the bulk of the data upon which the ‘programme cluster’ has been assessed as a ‘system of collaboration’.

As specified by The Global Fund Project’s Integrated Cluster Model, the study findings show that membership was highly inclusive, since all 11 members stipulated by the National Agency for AIDS Control (NACA) were seen to be represented in each cluster, while additional members depending on the local context at each site were also co-opted. The study data also suggests that these agencies and organisations were those that have a ‘stake’ in what the HIV/AIDS Programme Clusters were trying to achieve in each location. Apart from those mostly from service provider points along the clinical pathway taken by HIV/AIDS clients, there were also those who provided care and community-based support services, in addition to client groups that offered peer support to sufferers. These findings concur with an example of a successful collaboration cited by Mattessich, Murray-Close & Monsey (2001), which indicated the need to purposefully communicate and cultivate relationships with a whole gamut of stakeholders, including officials of public agencies, newly-emerging as well as traditionally-involved civic and special interest groups, neighbourhood groups and citizens.

The study data also suggests that in as much as these agencies and organisations in the programme clusters were meant to have maintained their particular approaches to HIV/AIDS care, they worked to complement each other. Nevertheless, in both cases the designation of an Anti-Retroviral Treatment (ART) centre in each of the base-hospitals at Ahoada and Bori acted as the central authority that provided strategic coordination role for each cluster.

Drawing on key lessons from their research on networks, Goodwin et al (2005) report that ability to secure a central position from which to exert leverage and access resources from others in the network is critical to effective management within and across individualistic and hierarchical networks. They note that such a central position also ‘provides a base from which to manipulate and/or steer network goals and functions’ (Goodwin et al, 2005: 7).

Meanwhile, whereas both HIV/AIDS Programme Clusters were seen to comprise the same types of nodes and the nodes seemed to have maintained similar linkages, the study shows that the shapes of the two networks although random in both cases are somewhat different. This observed difference in network outline is due to the relative positions of the ART Clinic, the General Out-Patient Department and the HIV Counseling and Testing Unit within each cluster. In the case of Ahoada (Figure 6.1), where the ‘core hospital medical staff’ look after HIV/AIDS patients, the ART Clinic had fewer linkages (7) than that of Bori (Figure 6.3) with 12 links, in which ‘medical staff seconded’ from the State Ministry of Health supervise treatment at the ART Clinic. On the other hand, the General Out-Patient Department, although not being a member of the HIV/AIDS Programme Cluster in each case (but operated by the respective hospital medical personnel), has more linkages in Bori (6) within its network than that of Ahoada (1). In the case of the HIV Counseling and Testing Units, the relative number of relationships between the two networks (Ahoada - 10 and Bori - 3) is explained by the fact that at the Bori site, the peripheral health facilities that undertake HIV Counseling and Testing services have direct linkages with the ART Clinic, while in Ahoada their links with the ART Clinic is through the HIV Counseling and Testing Unit. But despite this slight variation in the network configurations, each of the HIV/AIDS Programmes Clusters still maintained a network structure that has an organisational core (the ART Centre) with authority to regulate the work of cluster members, through joint provision. As the

HIV/AIDS Programme Clusters attempt to integrate a well-defined set of HIV/AIDS services, Goodwin et al (2005), agree that this sort of network structure is more effective for networks of this nature.

The study data as shown in Table 7.1, reveals that there is strong evidence to suggest that communication among participants in the HIV/AIDS Programme Clusters takes place at formal meetings and in informal ways. With formal channels of communication that include the monthly cluster meetings, as well as ad hoc and standing committee meetings; communication among the participants in the HIV/AIDS Programme Clusters is deemed to have been taking place formally. But as members other than their professional roles tend to know each other personally with several contact opportunities either at church, parties and other social engagements, informal communication among members is also considered to be happening as well. Besides, as the study findings further suggest that since discussions in the meetings were usually held in open and frank manner, with records of meetings circulated and read in subsequent meetings (those not in attendance receive electronic copies); partners within the HIV/AIDS Programme Clusters interact often, update one another, and discuss openly. The findings of D'Amour et al's (2008) research on inter-professional collaboration among health professionals, which suggest that professionals use information systems to reduce uncertainty in their relationships with partners they do not know well, support this data. D'Amour et al (2008) further observe that feedback provides professionals with the information they need to follow up with patients, as well as evaluate their partners on the basis of the quality of the written exchanges and feedback. This they note is an important aspect of establishing relationships of trust.

It is therefore fair to conclude that members in the collaborative groups were as informed as often as they should about what goes on in the collaborations and able to convey information to those outside the group. An instance during the study, the Bori cluster wrote a letter to the officials of the Rivers State Ministry of Health, inviting them to a meeting to discuss issues concerning the operations of the cluster, confirms this assertion. It also demonstrates that other than mutual accountability between cluster members, the clusters have a mechanism to produce a common voice (or to approve a single voice/spokesperson on behalf of the cluster) to relate with external accountabilities. These are additional facts of inter-connectedness between individuals and organisations in the HIV/AIDS Programme Clusters. D'Amour et al's (2008) research also observe: the fact that individuals and organisations are inter-connected, means that there are places for discussion and for constructing bonds between them. They confirm that connectivity, which takes the form of information and feedback systems, committees, etc., allows for rapid and continuous adjustments in response to problems of coordination.

The study findings indicate that there is a sense among members of the HIV/AIDS Programme Clusters of a unique purpose and identity, whereby no other entity in the area is trying to do exactly what each programme cluster is trying to achieve - increasing access to anti-retroviral drugs being the primary objective in each case. Therefore the purpose for maintaining these linkages (holding cluster meetings, working in ad hoc committees and communicating in informal ways) is to ensure that the cluster is able to accomplish its primary objective of getting more people on ARV drugs. In Himmelman's (2002) collaborative framework, this relational content of the programme clusters goes beyond 'networking' - *exchanging information*, since the clusters were seen to be actively working towards a goal beyond sharing information. Furthermore, at the time of the study, each of the

programme clusters has existed for close to two years and holding monthly cluster meetings (although less frequent in one of the clusters) and cluster members were relating with each other in several ways to achieve a common purpose. Moreover, the study data points to evidence of knowledge among cluster members that the practice bases of the organisations involved in the HIV/AIDS Programme Clusters are compatible in terms of client type and issues. At the same time, the research data also notes that cluster members are aware that it would be difficult for a single organisation to achieve by itself, what each programme cluster is trying to accomplish.

In addition, the study data had earlier shown that each of the agencies and organisations in the collaborative arrangements were able to maintain their particular approach to HIV/AIDS care but worked to complement each other. D'Amour, et al's (2008) research confirm that if health professionals are to develop a sense of belonging to a collaborative group and succeed in setting common objectives, they have to be mutually acquainted with each other personally and professionally. Mutual acquaintance at a professional level, D'Amour, et al (2008) note, means knowing each other's disciplinary frame of reference, approach to care and scope of practice. These relational features of the HIV/AIDS Programme Clusters also confirm that the programme clusters have progressed past 'a minimal level of trust, limited time availability, and a reluctance to share turf', which characterise Himmelman's (2002) 'networking' parameter.

The study data also suggests that formalisation of roles and responsibilities probably helped the agencies and organisations involved in the HIV/AIDS Programme Clusters to develop internal systems and procedures to accommodate the multi-disciplinary approach to HIV/AIDS care. Some of these were seen to include: re-allocation of staff functions and

reporting lines, taking on extra work to meet the data capture, processing and transmission requirements of the HIV/AIDS programme, and finding a way to fit in HIV/AIDS patient care and administrative processes with the routine work of the agency. Research undertaken by Thomson, Perry & Miller (2014) suggests that collaboration manifests when joint decisions are taken through the more informal negotiation mechanisms of brainstorming and appreciation of each other's opinion rather than the more formal mechanisms of standards operating procedures and formal agreements. However, also reflecting on earlier research findings, which suggest that collaboration is influenced less by the degree of formalisation than by the consensus that emerges around formalisation mechanisms and the specific rules that are implemented; D'Amour et al (2008), observe that formalisation is an important means of clarifying the various partners responsibilities and negotiating how responsibilities are shared. While Standard Operating procedures (SOPs) or national guidelines for the core HIV/AIDS interventions were observed as the main tools used by cluster members to re-organise their internal organisational processes, the 'mandate' given to the HIV/AIDS Programme Clusters by The Global Fund (and endorsed by the National Agency for the Control AIDS in Nigeria), was seen as the key 'policy instrument' that allowed cluster members to adapt to their operational modalities.

Since this 'policy' is an externally imposed directive, the HIV/AIDS Programme Clusters could be considered as 'mandated' networks, rather than 'voluntary'. Though as Guthrie et al (2010) also found with the MCNs that were studied in Scotland, some ties between some individuals involved in the clusters existed, prior to the formation of the HIV/AIDS Programme Cluster since the nature of clinical work in HIV/AIDS demands some level of interaction among those involved with patient care, especially professionals located within the same base-hospital. However, the study data also indicated that these were rather,

‘partial’ and ‘informal’ ties. Similarly, Sheaff et al’s (2011) findings that in mandated networks, the objectives of the networks were determined by national guidance, and this tends to alter network activities accordingly, also apply here. The Global Fund’s conditions for awarding the ‘Round 5 Grant’ to Nigeria that specified the delivery of HIV/AIDS interventions at the Local Government (district) level through ‘clusters’ of HIV/AIDS service providers was translated into ‘*A Concept Paper on Global Fund Project Integrated Cluster Model*’ by the National Agency for the Control of AIDS (National Agency for the Control of AIDS (2010b). This document, which clearly stated the terms of reference and the operational modalities of the integrated cluster model, served as ‘national guidance’ for the implementation of the HIV/AIDS Programme Clusters. While each of the agencies or organisations has a specific focus or aspect of HIV/AIDS care, such as HIV counseling and testing, prevention of mother to-child-transmission, ARV treatment, home-based care and support as the case may be; the mission of collectively increasing the number of patients on ARVs (the ‘national directive’ from the concept paper) is specific to the HIV/AIDS clusters in each location. And contrary to Guthrie et al’s (2010) findings, the imposition of cluster structures by the mandating body, did not affect engagement of participants within the clusters, in this case.

In addition, the finding by Guthrie et al (2010) that the creation of the mandated MCNs appears to be the predominant mutual aim of participants until they develop significant relationships among themselves to tackle other issues did not hold true with the HIV/AIDS Programme Clusters in Rivers State, Nigeria. Here there seemed to have been (although not explicit) a ‘dual objective’, whereby the ‘national mandate’ to increase the number of persons under Anti-retroviral treatment was pursued by the programme clusters at the same time as relationships among those who have been ‘mandated’ to jointly deliver this outcome were

being fostered. Similarly, unlike, the mandated MCNs in the UK where financial incentives were seen to have played little part within the networks (Sheaff et al, 2011); the HIV/AIDS Programme Clusters in Nigeria were somewhat influenced by the financial resources provided by The Global Fund. Although there was no ‘pot of money’ to be disbursed, the funds provided by The Global Fund in form of ‘medicines’ (a critical input - mainly Anti-retroviral drugs) and for coordination/management of cluster activities made it possible for the programme cluster members to adjust their mode of operation, by aligning care resources based at facility and community levels, along the care pathway; with access to ‘HIV/AIDS medicines’, Anti-Retroviral Treatment (ART) centres located at the base-hospitals.

Nevertheless, as Sheaff et al (2011) observe, legitimacy of evidence-based practice in knowledge management was seen as an additional incentive for cluster members to cooperate; the study data also indicates that integration of HIV/AIDS services might have been the primary objective for cluster formation, but for the member organisations, it was more of capacity development and maintenance, being in the action and the quality care each member provides. Though the study findings also mentioned ‘the need for mutual support for the common good of their patients’.

Thomson, Perry & Miller (2014), reflect that collaboration appears to involve forging commonalities from differences rather than finding solidarity through shared interests. The study data also showed that within each cluster, members demonstrated some capacity for compromise. In the Ahoada HIV/AIDS Programme Cluster, restriction of membership to make it more effective caused some dissatisfaction, whereby those excluded refused to cooperate in providing data. This was resolved by ensuring that individual health professionals in all participating health facilities, units and organisations were actively

engaged in training activities. At the Bori HIV/AIDS Programme Cluster there was some displeasure among some members, due to delays in attending to clients already screened and referred from peripheral hospitals and health centres that are members of the collaborating group, at the ART centre. This issue was resolved by ensuring that the agreed care process among participating health facilities were adhered to; in addition to using uniform client records among participating facilities to ensure a seamless care for enrolled patients from any health facility. Nonetheless, there was no indication that member organisations in the two clusters were put under strain in terms of release of resources, or change to their way of working (or their priorities).

Mattessich, Murray-Close & Monsey (2001) in their empirical inquiry of successful collaborations also observe that collaborative groups use adaptive processes to respond to changing operational conditions. The study findings note that each cluster facing different situations was able to adopt appropriate strategies for the collaborative groups to survive. Faced with limited access to clinical resources in managing patient-care: the Bori HIV/AIDS cluster used supernumerary medical staff from the State Ministry of Health; and to be more effective, the Ahoada HIV/AIDS cluster needed to streamline its membership that was well above the core 11 members sanctioned by the National Agency for the Control of AIDS, after they had earlier co-opted several organisations based on their local context. At the same time, in the public service in Nigeria where there is frequent change in medical and nursing personnel at both peripheral primary health care facilities and base-hospitals, the clusters were seen to have managed the staff changes and cluster leadership transitions very well, as such situations were observed several times during the study. This is very important because change of medical and nursing personnel need tact in fostering fresh relationships at a

personal level with the individuals concerned, especially when such persons such as Medical Doctors, take up leadership positions in the clusters by virtue of their professional status.

In relation to Himmelman's (2002) collaboration schema: with 'linkages between cluster members' established, 'professional mutual understanding' taking place, cluster members 'able to alter internal process', the clusters having the 'capacity to adjust to changing operational conditions', and the 'cluster objectives' being the 'reason for developing relationships' among cluster members; the HIV/AIDS Programme Clusters are considered at this point to have attained a *coordinating* status - harmonising operations and/activities in order to make HIV/AIDS services more accessible and less redundant in their respective locations. And as outlined above there is evidence that there is 'behaviour change' among cluster participants - modifying activities and a focus of attention in achieving a common purpose. Nevertheless, to make the step change on Himmlenan's (2002) collaboration continuum, the collaborative literature had earlier observed that more investment in capacity for behavioural change among networking partners would be required (Alexander et al, 2003).

Though the study did not reveal explicit documented data of resource sharing among cluster partners, such as legal agreements or memorandum of understanding, Torres & Margolin (2003: 4) recognise that within collaborative groups, 'knowledge, staff, physical property, clients, money, and reputation are just some of the resources organisations may share'. Some of these elements with respect to sharing resources within the clusters were observed by this study. First, each base-hospital in Ahoada and Bori that also hosts the comprehensive ART centre, provides office and meeting space for the 'support group of people living with HIV', to carry out its activities. Second, the study findings mention that the programme clusters

were the focus of professional trainings and dissemination of new knowledge on HIV/AIDS. Community-based organisations (in particular, faith-based organisations) in the Ahoada cluster, for example, credited their ability to undertake HIV/AIDS-related activities that benefit their constituencies to their participation in cluster activities; since they had access to ‘cluster resources’ (such as Information, Education and Communication (IEC) materials, and ‘resource persons’ etc.) to undertake such individual organisational activities. Third, in situations where these community-based activities involved HIV counselling and testing, ‘trained staff’ and ‘testing materials’, the Local Government Action Committee of the AIDS was believed to have made these resources available to such community-based organisations. And fourth, the minutes of the meetings of the Ahoada cluster also reported the transfer of clinical materials including drugs in excess supply in one facility to others where there were shortages. While these could be seen as examples of sharing resources within the clusters, it also suggests that some participating organisations in the HIV/AIDS clusters could see the act of cluster participation as also being in their self-interest. Thomson, Perry & Miller (2014) accept these features as part of ‘mutuality’ in collaboration, where partner organisations combine and use each other’s resources to strengthen each other’s operations and programmes, and achieve their own goals, including working better with each other than alone.

Following Himmelman’s (2002) standard, it would mean that the HIV/AIDS Programme Clusters progressed into the *cooperating* mode, since there is the added element here in ‘sharing resources’ that actually gets work done and investments in the capacity of other partners. In addition, other than just enhancing the capacity of community-based members in the cluster to be able to carry out their organisational activities effectively, the fact that the Local Government Action Committee on AIDS facilitated the capacity of these community-

based members with ‘technical assistance’ (trained personnel and testing materials) to allow ‘community-based HIV testing and counselling’ (hitherto only allowed in health facilities) to take place; indicates that there is willingness to share resources and enhance the capacity of other cluster members in order to achieve the cluster’s primary objective: more persons placed on ARV drugs. Himmelman (2002) specifies this level of increased engagement of each party and intense degree of exchange as *collaborating*. Therefore, it is fair to conclude that each of the HIV/AIDS Programme Clusters in Rivers State, Nigeria have been considered to have achieved ‘collaboration’ in their attempt to increase the number of people receiving ARV medicines in their respective locations. As Himmelman (2002) reminds us, while collaborating partners share resources, they also share *responsibilities, risks, and rewards*. In as much as these three elements could be present in the last two stages (coordinating and cooperation) on Himmelman’s scale, Wolff (2005) observes that the key distinguishing factor is the significantly increased amount of resource-sharing. The programme clusters under review, were deemed to have demonstrated this fact.

Meanwhile, in terms of cluster governance, the HIV/AIDS Programme Clusters seem to display a ‘distributed leadership structure’ that is similar to the MCNs studied by Guthrie et al (2010) in the UK. As with the MCNs that have an MCN ‘board’, through which a wide variety of stakeholders were represented, and through which decisions relating to MCN activities took place; the ‘Group’ that attends the ‘Cluster Coordinating Meetings’ is seen to function in this manner. And the cluster standing committees such as the ‘pharmaco-vigilance and contact tracing committees’, as well as ‘ad hoc committees’ set up to look into specific issues such as the maintenance of the CD4 Count Machine, are comparable to the ‘core group’ and ‘working groups’ that obtains with those in the MCNs that meet to discuss operational issues related to MCN ‘board’ level decisions. As the study data indicates, this

form of decentralised decision-making was quite evident with the HIV/AIDS Programme Clusters. The main forum for discussing joint programme operations in the HIV/AIDS collaborative clusters was the 'cluster meetings', held monthly. As a member usually represents each service delivery point included in the HIV/AIDS Programme Cluster, attendance at the meetings was based on representation from each of the HIV/AIDS interventions. Thus apart from every organisation participating in decision-making, it is assumed that each participant in the collaborative groups spoke for their organisations. And with the time frame of one month for the meetings, there appeared to have been ample time to take information back to their organisations to confer with colleagues when decisions are made. Consequently, it is reasonable to infer that various levels in each organisation that participated in the collaborative groups have had a fair chance in the decision-making process of the HIV/AIDS Programme Clusters.

However, there was also an element of 'network brokerage', whereby the programme managers of The Global Fund at each cluster site tend to hold the HIV/AIDS Programme Clusters together by 'force of purpose' to deliver programme outcome - increasing the number of persons placed on ARV drugs. The study data indicates that though officers of the HIV/AIDS Programme Clusters convened meetings, each site had a facilitating agency - a Programme Manager of the Global Fund, with its Programme Officer acting as a facilitator and also ensured that decisions taken at the meetings were followed through. As Currie et al (2010), also found out in their study of MCNs in the UK, the reason that concentrated network brokerage was added to the existing distributed decision-making process in the HIV/AIDS Programme Clusters appears to be similar to accountability regimes in public services. Guthrie et al (2010) also found this sort of accountability through the host health

boards in the MCNs they studied in Scotland, despite the MCNs demonstrating distributed leadership forms.

On cluster resources, HIV/AIDS Programme Clusters seem to have adequate funds from the Global Fund, in form of drugs and additional funding for cluster coordinating activities, as the regular State and Local Governments health budgets fund other activities such as staff salaries, clinical equipment, facility maintenance etc. However, since The Global Fund is an external funding source whose consistency may not be guaranteed, there is the question of what may happen to the viability of clusters if the critical ‘drug input’ becomes unavailable. The issue is that the availability of drugs at the ART centre in each cluster’s base-hospital as the study data has shown is a significant incentive that has produced the sort of relational practices that are seen with the HIV/AIDS Programme Clusters, since as earlier noted, it allows the alignment of this ‘vital care resource’ with other care resources located at facility and community levels, along the HIV/AIDS care pathways. The UK MCN studies (where there is an entirely different funding regime, with guaranteed reliability), Sheaff et al (2011), note that financial incentives were seen to have played little part within the networks, as the main incentives for network members to cooperate were the expectation of practical help-in-kind and the legitimacy of evidence-based practice in knowledge management. However, in the Guthrie et al (2010) study they found that there were resource implications (though in incentive terms) for the MCNs. They observe that other than resources associated with leadership in the form of lead clinician and manager roles, there are resource implications for other participants who attend meetings and participate on MCN ‘boards’ and working groups. This is a useful observation, because the irregularity of meetings observed by this study at the Ahoada site was somewhat alluded to difficulties with accessing money allocated for undertaking cluster coordinating meetings.

With respect to local context, as demonstrated by the two case studies, despite adopting similar processes, such as the use of clinical guidelines, co-location, and convening of monthly meetings, a significant difference was how clinical staff at each of the base hospitals interpreted service integration. Whereas in Ahoada, the same set of local clinical staff attended to general (patients with medical problems other than the disease) and HIV/AIDS patients from the same point of care, at Bori, clinical staff seconded from the State Ministry of Health were the focal persons that administered the drug treatment programme. Moreover, as opposed to Ahoada, the anti-retroviral treatment activities in Bori were physically distinguishable from the rest of the hospital functions. Not only were the HIV/AIDS services taking place in a designated building within the hospital premises in Bori, the core clinical staff of the hospital were often reluctant to admit HIV/AIDS into the hospital wards for stabilisation. Thus apart from additional cost of clinical staff to the HIV/AIDS programme at the Bori site, reduction of stigmatisation of HIV/AIDS patients considered as an added network outcome in Ahoada is said to have been somewhat compromised at the Bori site.

These findings confirm Guthrie et al's (2010) observations with the MCNs in Scotland, where the local context was seen to be influential in all issues related to the MCN processes. They report that while one of the policy aims for MCNs was the ability to standardise access to consistently high quality services, regardless of where patients were located; their findings proved this policy objective to be impractical. Guthrie et al's (2010) showed that local issues forced the MCN participants to interpret policy aims in different ways, especially where the 'gold standard' might suggest doing something in a specific way but would not always deliver the best service for local people. This research study had already highlighted how based on local context, both HIV/AIDS Programme Clusters expanded their membership beyond the number stipulated by the National Agency for the Control of AIDS. And the

finding by Guthrie et al (2010) that different localities with their own distinct cultural characteristics accounted for simultaneous tensions, as both MCNs and locality struggled to balance the need for local services and planning to ensure equity and access to services; is also evident with the HIV/AIDS Programme Clusters, as 'HIV/AIDS service integration' at Ahoada and Bori programme sites, other than 'cluster coordination' was implemented differently.

In relation to cluster outcome, the study findings show that, the HIV/AIDS Programme Clusters, which have similar objectives, were observed to have increased the number of patients receiving anti-retroviral treatment from 1124 in 2009 to 2442 in 2011; and 1176 in 2009 to 2547 in 2011 in Ahoada and Bori respectively (see Figures 6.2 and 6.4). Apart from these tangible service changes, the study data also indicates that the HIV/AIDS Programme Clusters made a significant contribution to the education of members, and associated staff while also providing a clear channel for support, advice and guidance to cluster members. These findings are similar to the MCN studies in the UK, though Sheaff et al's (2011) findings showed that with improved primary-secondary care co-ordination, more highly-connected organisations within the networks exhibited better outcomes in terms of reductions in referrals; apart from that, network outputs were predominantly intangibles - guidance, policies, etc. On the other hand, Guthrie et al (2010), based on professional perceptions of MCN impact found some evidence that ranged from the relatively intangible relating to inter-professional and inter-organisational working (achieving inclusion, shared vision, and improved collaboration) to the much more tangible that concern clinical practice and patient care (changing professional practice, enhancing influence and ability to mobilise resources, and examples of service improvement).

The study findings also reveal that there was general knowledge among members in both HIV/AIDS Programme Clusters that the efforts of each member towards the care received by every client determined whether new clients were recruited; those already on treatment were supported to follow through with their treatment; and those who default were traced and brought back to resume treatment. This sense of shared ownership of the process and results probably helped to motivate and enthuse members in the programme clusters about participation in the collaborative group, as they worked to develop ‘collaborative capacity’ that fosters and promotes partnerships (links between pairs, and small groups of members), including the need for joint responsibility in delivering expected results. As the study data noted, virtually all those involved in the HIV/AIDS Programme Cluster in the two sites at Ahoada and Bori were able to point out in some practical terms how critical their individual organisational activities were to the achievement of the group’s results.

Clearly, the foregoing discussions that assessed each of the HIV/AIDS Programme Clusters as a ‘system of collaboration’ demonstrated that apart from very minor differences, there is good evidence to suggest that a remarkable degree of relational practice, in terms of: multiplicity of the links, the volume of exchange including the number of ‘fronts’ on which cooperation occurs, the level of goodwill within the groups, and reliability and trust among members, exists among the agencies and organisations that provide specific HIV/AIDS interventions in each of the sites. And in Himmelman’s (2002) collaboration terms, the HIV/AIDS Programme Clusters in Rivers State, Nigeria are seen to be *collaborating*, since individual professionals or organisational units in the clusters know their respective core activities and when to do them; they also understand and see the relationship between what they do and what the cluster (the coordinated whole) intends to achieve; they share-resources among themselves not only to enhance the capacity of cluster members to carry out their

activities, but also to ‘mutually’ achieve the mission of the cluster. In addition, in appraising the experience of the MCNs in the UK, where the idea of the MCN as a form of service integration has been implemented, there is also strong evidence to suggest that HIV/AIDS Programme Clusters under review exhibited features that were seen to be comparable, in terms of network origin, processes, outcomes and issues related to local context.

Consequently, it is reasonable to assume that since the HIV/AIDS Programme Clusters in Rivers State, Nigeria share similar characteristics with the MCNs in the UK, The Global Fund’s concept of the HIV/AIDS Programme Cluster ‘reflect’ the idea of the MCN, as a means of service integration. And because, each of the HIV/AIDS Programme Clusters has demonstrated the fact of ‘collaboration’ as the most prevalent and intensive form of relational practice, similar to the idea of the MCN, it confirms the relational nature of the clusters.

Therefore, it is fair to conclude that the idea of the MCN is ‘operationally doable’ in Nigeria, and thus ‘technically’ transferable into this setting.

But this research study also recognises that task integration and collaborative service provision at the frontline also include resource mobilisation and policy coordination. As this research noted, HIV/AIDS service delivery system in Nigeria involved various agencies and multiple layers of resource flows, policy and administrative coordination above the service delivery level. Therefore, the overall functionality of the idea of the MCN in Nigeria is bound to be influenced by these super structures, which themselves are subject to the particular context in which health services are delivered in this setting.

7.2 Contextual Feasibility

The findings that the HIV/AIDS Programme Clusters in Rivers State, Nigeria exhibited structural and socio-metric characteristics as networks, and demonstrated the fact of collaboration as the organising logic, are strong indicators that the idea of the MCN in Nigeria can work, at least as an inter-organisational collaborative entity. But a further concern is if they can function as alternative modes of health service delivery within the Nigerian health system.

The basic premises of this research study are that clinical networks by resolving the issue of health service fragmentation could enhance health system performance, which may include: (i) the achievement of better health outcomes for patients; (ii) the improvement of individuals' satisfaction with the health system; and (iii) keeping health provision financially sustainable for both individuals and the economy as a whole. But whilst that logic may have appeal, the institutional environment within which this reform takes place will strongly influence whether or not as a mode of organising services, the idea of the MCN can remain viable. As noted earlier, Walt & Gilson (1994) reflecting on the failures of health sector reforms in developing countries in the 1980s and 1990s, also recommended that apart from the *content* of reforms, sectoral health reforms should also take into account the role of the *context*, the *processes* and the *actors*; and how they influence these reforms, and in some cases determine their success. These issues were also highlighted in the policy transfer literature (Benson & Jordan, 2011; Dussauge-Laguna, 2012; McCann & Ward, 2012; Dolowitz & Marsh, 2012; Swainson & de Loe, 2011). There has been some attempt (Montenegro et al, 2011) in using Walt & Gilson's (1994) framework for policy analysis to draw lessons from combating health care fragmentation through Integrated Health Service Delivery Networks (IHSDNs) in the Americas, which concludes that integration processes

are difficult, complex and long-term. Moreover, integration requires extensive systemic change and commitment by health workers, health service managers and policy makers.

Therefore, as this study data indicated, a health sector reform agenda of this nature will necessarily demand a shift in institutional arrangements with new rules, norms and belief systems that could tackle structural issues (in the case of Nigeria) related to the segmentation of the publicly organised health system into three tiers - Federal, States and Local Government Areas, with different modalities for financing, delivery and management. And the stratification of the population by the privately sanctioned health system, based on income levels, types of employment, ability to pay and social status. Alongside appropriate political, legal and administrative frameworks; the key ingredients of such institutionalisation process may include the generation of interactive spaces for dialogue and exchange of ideas among actors - policy makers, managers, providers and users; as well as demonstrable early gains with measurable results, including benefits to individual network participants that encourage and sustain efforts to move forward (Montenegro et al, 2011).

As this research study assumes the position that adopting the idea of the MCN as an alternative health service delivery model is a health sector policy reform issue; the critical focus is how clinical networks interact with other organisations within the health delivery system and their relationship with the rest of the political and economic system, especially how they get the resources they need to continue to exist (Roberts et al, 2004). Consequently, a set of four key parameters considered to be essential to analysing the institutional context of health sector reforms are used to assess the main features of the HIV/AIDS prevention and care services within the Nigeria health system, with respect to the prevailing conditions that may facilitate (or constrain) the ability of collaborative service delivery, inter-organisational

service provision or similar approaches to enable the idea of the MCN to function as an alternative health service delivery mode. Again these conditions are researcher imposed and once more they have been adapted from a wide spectrum of sources both in theory and practice but have been largely influenced by insights put forward by critical commentaries on health sector reform process (Collins, Green & Hunter, 1994; 2000; Cassels, 1995; Berman & Bossert, 2000; Walt & Gilson, 1994; Roberts et al, 2004); but summarised by Roberts et al (2004) as particularly focused on the *political feasibility* of a given policy proposal. The two key questions here are: (i) can the policy be adopted? (ii) can it be implemented? They suggested that the likelihood of getting a policy adopted is assumed to depend not only on the skills and commitment of its advocates (and opponents), but also on the established situation.

Accordingly, they include the following dimensions: (i) *Political and Regulatory Framework* - refers to laws, regulations, directives and technical guidelines at national and state levels that affect the implementation of a policy of collaborative service delivery; (ii) *Administrative Process and Procedures* - political and administrative planning tools, for the public management of collaborative service delivery, including specific processes and procedures established within the health service delivery system to manage collaborative service delivery; (iii) *Financial Flows (Funding) and organisational capacity* - availability of public or private financial resources, and capacity of organisations and agencies to plan and implement the collaborative service delivery model; and (vi) *Stakeholders Actions* - referring to conditions that offer specific motivation (or disincentives) to the main stakeholders, politicians, policy makers, bureaucrats, health professionals and managers, and patient groups to participate in a collaborative service delivery process. On this basis deductions are made as to why collaborative service delivery in Nigeria could be a possible reality or an unlikely

proposition, and to give a sense in deciding if the idea of the MCN could become an alternative health service delivery mode in Nigeria.

Political and Regulatory Framework

The study data showed that there is national governments' commitment to a multi-sectoral approach as demonstrated by the formation, staffing and funding of a National HIV/AIDS Control Programme; and the establishment of one national AIDS coordinating authority with a *broad-based multi-sectoral mandate* for HIV and AIDS, in addition to similar levels of commitments and institution of coordinating bodies at the lower tiers of government - States and Local Government Areas, where actual implementation takes place. As Nigeria is a federal country with, 36 semi-autonomous States; an Act of the National Assembly (Parliament) established the National Agency for the Control of AIDS (NACA). This law gives legal backing to this coordinating body, with the authority and mandate to work with lower level coordinating bodies, State Agencies for the Control of AIDS (SACAs) and LGA Action Committees on AIDS (LACAs). It also confers the national agency, the political authority to facilitate the multi-sectoral response roles given to the coordinating entities at all levels. In addition, there are national guidelines and technical directives - One National Strategic HIV/AIDS Plan and One National Monitoring and Evaluation Framework, to operationalise multi-sectoral response to HIV/AIDS prevention and services in Nigeria.

This research study had earlier observed that the different loci of political power (Federal Government, 36 States and 774 Local Government Areas) and the diversity that exists in Nigeria creates potential cleavages. While collaboration between these units should be the natural course of action for public service delivery, notable tensions amongst them requires recourse to the use of legal instruments. These findings confirm the point made by Swainson

& de Loe (2011: 60), that policy transfer ‘arrangements premised on the strong authority of unified central government may not be transferable to a federal state where power is shared among levels of government’. Therefore, in order to coordinate a multi-sectoral response to the HIV/AIDS problem in this setting, the national government having committed to this principle needed to initiate new institutions that would support policy coordination and system alteration for inter-agency service provision. Moreover, the fact that prior to this time, the Federal Ministry of Health seen as a federal coordinating body (rather than national) was seen not to have been able to exercise full control in coordinating State and Local level HIV and AIDS activities due to the semi-autonomous status of States in Nigeria.

Driven by global policy on HIV/AIDS prevention and service provision (though predicated on accessing external funding for HIV/AIDS control); the formation, staffing and funding of a National HIV/AIDS Control Programme; and the establishment of one national AIDS coordinating authority with a *broad-based multi-sectoral mandate* for HIV and AIDS, could be said to be instrumental to how the new structures and practices seen in the HIV/AIDS Programme Clusters examined by this study, have made a visible commitment. As the law (an Act of the National Assembly - Parliament) setting up the National Agency for the Control of AIDS (NACA) gives it legal backing with the authority and mandate to work with lower level coordinating bodies; the 36 States and 774 Local Government Areas were compelled to set up State Agencies for the Control of AIDS (SACAs) and LGA Action Committees on AIDS (LACAs) respectively. One can infer that transposition of this specific global HIV/AIDS agenda to sub-national levels also allowed stakeholders on the frontline of HIV/AIDS service delivery to take advantage of the legislative change to develop linkages and relate in new ways.

The policy transfer literature agrees with the findings of this study that international agencies have become platforms for debate and carriers of policy ideas across borders (Marmor, Freeman & Okma, 2005) and the production and mobilisation of knowledge is central to the way that many of these exert influence in the world (Nay, 2012; Sturdy, Freeman & Smith-Merry, 2013). Citing a notable source, Sturdy, Freeman & Smith-Merry (2013) explain that the way international organisations are able to ‘structure knowledge’ include: (i) classifying the world, creating categories of actors and action; (ii) fixing meanings in the social world; and (iii) articulating and diffusing new norms, principles, and actors around the globe. But in the context of HIV/AIDS, Freeman (1999) reflects that national responses, apart from the availability of the HIV test and new drugs, were shaped by international exchange of information among networks of professionals, in addition to the advocacy activities of those most directly affected by the disease. Freeman (1999) thus re-states the significance of ‘policy diffusion’ in health policy, where there is successive adoption of ‘policy innovation’. The finding that the policy of HIV/AIDS Programme Clusters as ‘service integrators’ builds upon other initiatives in the policy transfer arena, as outlined above; is also supported by Swainson & de Loe (2011: 67) in a case of ‘Environmental Water Allocation’ policy in Australia, who reported that ‘legislation, policies and strategies at multiple levels of governance, greatly facilitated its adoption in this context’.

Administrative Processes and Procedures

As the study data indicates, Nigeria has as a National Policy on HIV/AIDS that sets the policy framework for service coordination through provisions that permit the mobilisation of resources including the development of public-private partnerships to leverage funding from local and international sources; as well as coordinate the allocation of equitable finance for programme activities across the country. The national policy also stipulates the development

of programmes for appropriate care of persons with HIV related conditions and AIDS, in addition to agreeing to sharing information among major stakeholders for policy making and programming. In addition, with the creation of National, States and Local multi-sectoral entities - public sector ministries, departments and agencies, private sector, donors, NGOs, CBOs, FBOs and client groups, are deemed to share coordination functions.

The study findings also note that there is a specific health sector response to HIV/AIDS in Nigeria, led by the respective Ministries or Departments at all levels. At State level, as this study has illustrated, a package of interventions - core HIV/AIDS prevention service elements constituted into 'an HIV/AIDS Programme' delivered at several sites for defined populations, is available. And at each site, the members of the HIV/AIDS Programme Team were well defined, comprising: hospital units, or health centres, Non Government Organisations including Community-based organisations and private agencies, undertaking HIV/AIDS prevention and service interventions. At the same time, two documents, a Strategic Plan and a Programme Memorandum at the State level set out the direction and framework for implementing specific HIV/AIDS interventions at the periphery, with strategic goals, specific objectives, planned activities, targets and performance indicators, for a given period. But these are lists of intentions lacking prioritisation of what can be possibly achieved in the set period; and no indication of how various interventions would be integrated at the point of care.

Availability of policy frameworks and plans for particular service initiatives while necessary; inter-agency collaborative service provision may require additional conditions for translation into practice. As outlined above, political and administrative planning tools for the public management of collaborative service delivery for HIV/AIDS in Nigeria exist. And there is

good evidence to suggest that HIV/AIDS service coordination that eventually benefits individual clients is presumed to have been attempted at four levels - policy, organisational, programme and client. The focus of collaboration is different at each level but all are ultimately aimed at aligning systems and procedures for collaborative service delivery. Nonetheless, this research acknowledges that HIV/AIDS policies and plans despite their collaborative orientation towards a multi-sectoral, multi-organisational approach did not naturally translate into collaborative service delivery. Even with standard operational procedures, including treatment guidelines at the client level, individual professionals, units, and facilities looking after the same population of clients did not naturally constitute themselves into HIV/AIDS programme teams and integrate HIV/AIDS interventions for their client population. Only where 'deliberate actions' were taken either voluntarily or mandated by an authority did such collaborative work ensue.

These findings are in keeping with a study undertaken by Miles & Trott (2011) in an attempt to find out how publicly funded organisations in the UK can 'work together' with the 'same service users' to deliver something of 'public value'. They note that a 'source of authority' over the 'service system', whether vertically through leadership, or horizontally through rules of engagement, and community of practice; 'determined that collaboration should happen, that services should be more holistic rather than fragmented. This approach was then promoted, policed and protected (Miles & Trott, 2011: 29). Since deliberate action to catalyse and promote collaboration is needed, the assumption that sub-sets of health professionals looking after the same population would necessarily work together through referral pathways or other mechanism does not hold, because without intervention, there would be no 'systematic' collaboration. Goodwin et al's (2005) research also reported the need for a

specific network coordination function that is financed, pro-active, and in control of information, knowledge and/or incentives at the centre of a network.

Financial Flows (Funding) and organisational capacity

The study data revealed that while the Federal Government of Nigeria and to a lesser extent some State Governments, as well as large private sector organisations provided some funding for HIV/AIDS prevention and service; by far a significant proportion (over 75%) of HIV and AIDS investment in Nigeria is noted to have come from external sources, mainly international donors - the US Government through the President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund and the World Bank. The Global Fund has applied some of its funding to collaborative service delivery by mandating the implementation of an integrated service delivery model for HIV/AIDS prevention and service provision across the country, for which evidence of its effectiveness is still being accumulated.

One contextual factor that could influence policy transfer, identified by Swainson & de Loe (2011), is the levels of financial resources available for successful implementation of policies and programmes. Overall, public spending on the health sector in Nigeria by all the three tiers of government does not match the health needs of the population. While figures from the State and Local Government are not readily available, a Health Expenditure Review covering the period of 2009 to 2011 undertaken by Okorosobo & Asoka (2013) revealed that despite increasing budgetary allocations to the sector in absolute terms, the average Federal Government health budget of 6% fell very short of the 15% target agreed by African Heads of States in Abuja in 2002 (Abuja Declaration). The report noted that health expenditures were dominated by recurrent spending, which constituted over 70% of total allocations (with significant portion taken up by personnel costs), while capital spending averaged only 30%

over the period. Spending on complementary service delivery inputs such as drugs, medical equipment and logistics were found to be negligible. Moreover, as several health departments and agencies had weak management systems, only about 60% of the annual capital budget is usually utilised, as they lacked ‘absorptive capacity’ to even utilise what is even available. Swainson & de Loe (2011) also recognise that administrative and organisational capability is another factor that influences how a given policy will fit in a particular environment.

Okorosobo & Asoka (2013) concluded that whereas funding gaps exist, lack of core funding for the health sector in Nigeria is not the issue, and that ample funding from domestic sources are obtainable. The real challenges are the lack of absorptive capacity and misapplication of resources, and weak execution capacity of healthcare agencies. Invariably, these systemic constraints have led to the perceived dependent of the country on external funds to carry out specific health interventions aimed at reducing maternal and child mortality, as well as tackling major health problems such as Malaria, Tuberculosis and HIV/AIDS. Be as it may, as demonstrated by this research study, with over 75% of HIV and AIDS investment in Nigeria coming from external sources, over dependence on international donor funding for HIV/AIDS prevention and service delivery in Nigeria could undermine the capacity of inter-organisational collaborative groups to function as collaborative entities in the long-term, and therefore may discourage collaborative service delivery.

Stakeholder Actions

It is reported (National Agency for the Control of AIDS, 2008) that the Integrated Cluster Model for inter-organisational collaborative HIV/AIDS service delivery as mandated by The Global Fund is known to have existed in at least 60 sites across 13 States. Each site corresponds to a locality (usually a strategic Local Government Area), where a ‘cluster’ of

related services, including Counseling and Testing, Anti-retroviral Treatment, Prevention from Mother to Child Transmission, Home-based care, User support groups, TB treatment and Orphan and Vulnerable Children support programmes; work together to jointly provide needed HIV/AIDS services. But as Dolowitz & Marsh (2012) reflect, the ‘games’ transfer agents engage in shape what is borrowed, where it comes from, how it is understood, how it is sold, where it is used in the policy cycle and how the information is used (reused) as a policy works its way through the development and implementation process.

The study data had already noted the fragmented nature of the public health system in Nigeria operated by the three tiers of government: Federal, State and Local Government Areas (LGAs), with many different agents responsible for aspects of the same service. As this is due to the ‘differentiated polity’ (Rhodes, 1994; 1997; Rhodes at al, 2003), characterised by political devolution into 36 States; institutional fragmentation and inter-dependencies; state level public sector Ministries, Departments and Agencies (MDAs) have no direct line relationship with the federal counterparts but rely on them to give national policy direction. Although relationships *between* the 3 tiers of government in their collective responsibility for the delivery of HIV/AIDS services in Nigeria have been clearly defined, through policy and legal instruments, the challenges that exist in the power relationships *within* and *between* the Federal and State levels, limit the ability of stakeholders to undertake effective policy coordination, manage financial flows, and streamline accountability for collaborative service delivery.

In federal contexts, much like the European Union (EU) with the European Commission, Member States, Regional and Local Governments, and other Federal Countries, in which vertical relations between centres of power exist; extensive collaboration is needed where

sub-national governments are required to implement policies and legislation from higher levels (Steyle, 2008; Rodrigo, Allio & Andre-Amo, 2009; Charbit, 2011). States in Nigeria often contest territory in several areas with the Federal government, the health sector inclusive. As already stated in this research study, the 1999 constitution of the Federal Republic of Nigeria is silent on health matters. While health is assumed to be a 'concurrent responsibility' between the three tiers of government with Local Government Areas understood to be the main implementing agencies of primary health care, there is only a vague reference to Local Government responsibility for health: 'LGA's are responsible for the provision and maintenance of health services' (Federal Government of Nigeria, 2004). An overarching health law (the National Health Act) aimed at correcting this constitutional anomaly, but regrettably dwelling more on the structures of a national health system as opposed to the reform of institutions has been a target of interest groups 'jostling for positions to maximally benefit from it' (Asoka, 2013b: 5). Unfortunately, recent efforts too at amending the national constitution totally overlooked the health sector. Asoka (2013b) was concerned that the failure to use the constitutional review to at least help define the framework of rules structuring the behaviour of agents (individuals and organisations) within the health sector in this federal country was a huge missed opportunity.

But of greater concern is that usually Federal Legislation can be interpreted in the States in several ways, parts of it that are relevant would be implemented, while others would not be carried out. Asoka (2013b) referred to numerous cases where State interpretations have stood following legal judgment and in practice. A case in point is the law (NHIS Decree 35 of 1999) establishing the National Health Insurance Scheme (NHIS). Reporting on the challenges of implementing this programme with reference to unresolved challenges with the States, Asoka (2012: 4) observed:

States other than their health facilities being providers, felt left out in the scheme of things. Most would rather prefer to monitor health insurance provision in their domains by establishing State Health Insurance Boards. It was alleged that this was the original plan as presented in the draft NHIS Bill of 1996. The position of the States is not helped by the Council of the NHIS who attempt to invoke a clause in the Federal Constitution that gave exclusive right to the use of the term 'insurance' to the Federal Government. To avoid any constitutional confrontation, progressive States intent on providing health insurance for their citizens tend to adopt clauses such as 'social health protection' or managed care'. So far only three States – Cross River, Bauchi and Jigawa are said to have some reasonable relationship with the scheme. What has mainly stalled progress is the desire of the States to have a decentralised system that gives them the right to manage their contributions by establishing and operating 'health funds' within their sphere of influence, rather than being micro-managed by a federally driven programme from Abuja.

No doubt disagreements of this nature undermine the intention of a 'collaborative federalism' that could have transposed a similar culture into national micro systems. So, similar to the 'process of the transfer of the idea' of a 'national health insurance scheme', Dolowitz & Marsh (2012) caution that the motivations underpinning an agent's use of foreign information is critical to understanding the transfer of ideas into new settings.

Swainson & de Loe (2011) also signal that policy transfer is inhibited when a jurisdiction's social context or characteristics (such as embeddedness, trust and social capital) and political context (dominant ideology, citizen participation, role of the state) are dependent on particularly distinctive values or institutions. This study had earlier noted that the strength of informal arrangements - patronage politics, traditional authority, extra-legal arrangements and activities, often circumvent or replace the formal system. It also reported that a large proportion of social, economic, and political transactions in Nigeria take place outside the

formal system, even where a formal system exists. While ‘informality’ could be advantageous to inter-professional and inter-organisation collaboration, such relaxed attitude also calls for the bending of rules where these may be important. Although distinct cultural standards are maintained within the health sector, healthcare service agents are noted to be swept along by events and forces at play elsewhere in the broader political economy of the country. This study has also identified that in relation to persistent vested interests being displayed by key health sector actors, the behaviour of both Federal and State Health Authorities in Nigeria is influenced by a desire to retain existing channels of expenditure and the political and financial opportunities that these provide. Therefore, irrespective of formal rules and technical operational guidelines, a significant obstacle to be overcome in order for collaborative service delivery to take root in Nigeria, is how these existing cultural norms that are widely seen as appropriate and normatively sanctioned are dislodged and lose their force.

Considering the above discussions, it is fair to deduce that the institutional environment within which the HIV/AIDS Programme Clusters studied have attempted service integration in Nigeria for HIV/AIDS prevention and care services, exhibited features that were largely supportive of collaborative service delivery. Given that some critical factors, in particular a legal framework, administrative processes and procedures, and availability of funding were responsible for the HIV/AIDS institutional arrangements seen in Nigeria, it suggests that this favourable contextual foundation could have facilitated the emergence of the HIV/AIDS Programme Clusters as ‘functional collaborative entities’. Notwithstanding the elaborate institutional arrangement for HIV/AIDS in Nigeria, which supported the notion of a policy on inter-organisational coordination, and that has seemed to have altered the linkages and relationships among frontline health professionals and organisations to deliver integrated services for HIV/AIDS clients; extending institutional change broadly to effect collaborative

service delivery as an alternative service delivery mechanism within the Nigeria health system may face serious challenges.

As demonstrated by this study, specific incentives may be required to encourage health professionals and managers to participate in collaborative service delivery. Accordingly, (i) availability of resources to function as a collaborative group, in terms of core funding for service inputs, as well as skilled facilitation along with additional resources to carry out collaborative activities; and (ii) the motivation of individual organisations seeking to derive benefits from participating in a collaborative group, such as: access to resources, enhanced organisational competence through training, and recognition as a skilled provider; seemed critical. Moreover, it may appear that specific organisational conditions allow health service organisations to jointly plan and implement collaborative service provision. As this research study found out: (i) tangible specialised skill sets, (ii) information-based resources (service features and utilisation data etc.), and (iii) time required to undertake collaborative group activities, are key resources needed by organisations to effectively engage in collaborative ventures.

On the whole, this research study considers that despite the favourable institutional context that allowed the HIV/AIDS Programme Clusters under review to attempt inter-agency HIV/AIDS service provision, transforming the established difficult Nigeria environment for collaborative service delivery as revealed above is a herculean task. Consequently, replicating this model (the approach to remaking of institutions, such as the HIV/AIDS case, towards integrated service delivery) broadly in the Nigeria health system may not be possible since notable environmental challenges that are systemic appear restrictive. But as shown by this case study, there may be the possibility of inter-organisational policy coordination, alteration

to service delivery systems and enhanced organisational capacity leading to service integration where proposed changes to the institutional framework is linked to the flow of funds. Meanwhile, funding for the health sector in Nigeria, even with external financial support has been known to be inconsistent with the health needs and demand for health care. And changing the prevailing budgetary structure to a programmatic approach (supportive of collaborative service delivery) along with a culture of financial accountability (leading to allocative efficiency) seemed far-fetched as powerful interests (individuals and organisations) may continue to resist change.

Based on these findings, it is reasonable to conclude that *the idea of the MCN although doable, may not function properly within the institutional environment that prevails in Nigeria.*

Nevertheless, recognising that the constrictive operational context in Nigeria makes venturing into new activities in general difficult, it is still possible to build a ‘strategic case’ for intervening in this environment, with the intention of using collaborative service delivery to implement change within the Nigerian health sector. As the *contextual factors* that may affect the implementation of collaborative service delivery become obvious, the other key requirements include: (i) determining the *intended outcomes* of implementing collaborative service delivery; and (ii) identifying the *activities* collaborative service delivery expects to accomplish in order to achieve the desired outcomes (Connell & Kubisch, 1998). A systematic linkage between activities, outcomes and contexts of collaborative service delivery then explains how and why clinical networks in Nigeria may work. Of course, it is already taken for granted that with adequate funding and skilled facilitation, clinical networks can exist as collaborative ventures in Nigeria.

7.3 Interventional Feasibility

The main problem being addressed by clinical networks is that poor access to the full range of care and support services required by patients suffering from chronic illnesses such as HIV/AIDS, which leads to poor health outcome for this patient group, is due to the lack of integration among different health and psychosocial service providers. As documented by this research study, to get health professionals and care givers better able to improve patient outcomes with enhanced efficiency both for the client and healthcare system, service integration at the point of care is proposed. Acknowledging that adopting a policy of collaborative service delivery on its own, threatened by the complex institutional setting in Nigeria may fail to bring about this change, this research using this HIV/AIDS case study approach suggested a *Theory of Change* (see Figure 3.4) - how clinical networks can implement change within the Nigeria health system.

Taking into account the political economy analysis as already outlined by this study, the theory of change for implementing HIV/AIDS clinical networks makes some basic assumptions based on the conceptual framework for setting collaboration in context that leads to service integration in Nigeria. Though the lack of integration among HIV/AIDS service providers is a reflection of the traditional health delivery system in Nigeria (fragmented, poorly managed and inadequately financed basic health care services with low political profile); the root causes, which mask these apparent features (and that must be tackled) include: (a) failure of political leaders to invest sufficient effort and resources to improve health services, (b) the structure and organisation of health services that are not fit for purpose, and (c) health workers and managers who lack the capacity to improve the health delivery system. But as presented in the Theory of Change for HIV/AIDS Clinical Networks in Chapter 3 (Figure 3.4), it is possible to foster collaborative service provision by: (a)

advocating, challenging and holding political leaders to account for their stewardship by getting them to fund healthcare services and related reforms, (b) undertaking policy reforms to support collaborative service delivery; and (c) linking these policy reforms to institutionalise collaborative activities among healthcare providers.

In the UK NHS, where there has been consistent focus on governance reforms towards networks of organisation, Goodwin et al (2004) report that early impressions from the implementation of MCNs suggested a series of management challenges, such as: (i) the importance of reforming administrative arrangements as an integral strategy; (ii) the ability to change existing budgetary flows and capital planning processes in order to work across boundaries; (iii) the demands of greater mobility for key professional staff with loyalty to both network and their institutions; and (iv) problems of accountability and clinical governance responsibility within a 'virtual organisation'. Therefore, it is expected that once these activities are accomplished - delivery of quality individual HIV/AIDS interventions, policy reforms, and institutional change aimed at integrated service provision, the formation and maintenance of collaborative activities among individual service providers delivering direct HIV/AIDS interventions would take place. It is also assumed that the output of these inter-agency collaborative efforts would improve access to a comprehensive package of HIV/AIDS care that range from drug treatment, through psychosocial, and nutritional support, to palliative care and rehabilitation of orphan and vulnerable children. It is expected that once this is attained, the number of people receiving HIV antiretroviral prophylaxis and treatment would be increased, in addition to overall patient well-being and client satisfaction, which is the intended outcome of the integrated HIV/AIDS service provision programme.

Again with reference to the conceptual model in Figure 3.3, the entire system for change is triggered by the nature of HIV/AIDS as a chronic disease that requires a broad-range of prevention and care services, which are expected to be provided by numerous providers in several settings over long durations. In responding to this challenge, it is assumed that group actors in the HIV/AIDS organisational field that envisage a possible outcome for HIV/AIDS services will tend to undertake collaborative activities aimed at overcoming the obvious difficulties. Although collaborative actions among HIV/AIDS providers result from the complex feature of HIV/AIDS as a disease, the ability of this group to develop and maintain an on-going collaborative entity that allows it to accomplish the intended goal of improved access to HIV/AIDS prevention and care services depends on policy and institutional reforms, which help to change the perception of the problem and its solution among stakeholders.

The basic premise of this research study is that Managed Clinical Networks by resolving the issue of health service fragmentation could enhance health system performance, which may include: (i) the achievement of better health outcomes for patients; (ii) the improvement of individuals' satisfaction with the health system; and (iii) keeping health provision financially sustainable for both individuals and the economy as a whole. On the basis of this Theory of Change, the Integrated HIV/AIDS Service Provision initiative that was attempted in Rivers State at the two HIV/AIDS Programme Clusters in Ahoada and Bori was assessed to determine: (a) if changes in the performance of the health system in Rivers State have taken place; (b) through what processes have the changes occurred; (c) the contributions of the HIV/AIDS Programme Clusters to these changes; and (d) whether the assumptions of the theory of change hold true, in terms of conducive institutional conditions for collaborative work in the health sector.

As stated in the findings of this study, taking 2009 as baseline year for the development of collaborative activities among HIV/AIDS service providers at the study sites in Rivers State, each of the HIV/AIDS Programme Clusters were seen to have increased the number of persons on anti-retroviral drugs by over 50% in two years. This is considered to be a significant change in the performance of HIV/AIDS service delivery when compared with pre-collaboration period (as shown on Figures 6.2 and 6.4) in Rivers State. Since all collaborating members take ownership of these results, the increase uptake of anti-retroviral prophylaxis and treatment is deemed to have been due to effective linkages between HIV testing and counseling centres (both in house and peripheral referral sites) and timely access to anti-retroviral drugs at the Anti-Retroviral Treatment (ART) centres located at the base hospitals in Ahoada and Bori; as well as services to support treatment adherence, and retention of those on treatment undertaken by other collaborating partners either co-located within the base hospitals or community-based. Though patient satisfaction and cost data are unavailable, it is assumed that with provider collaboration, critical issues that result from lack of service integration: late referrals, unnecessary delays for treatment, transfer to inappropriate settings of care, unnecessary suffering as patients navigate through the care process and additional costs arising from these service bottlenecks; are significantly reduced and some eliminated (Dudgeon et al, 2007). Moreover, as care and support services were noted to have extended beyond drug treatment to include, psychosocial support for PLHIV experiencing social exclusion, HIV stigma and discrimination, as well as support services to help ameliorate poverty and food insecurity of orphan and vulnerable children, following the death of their parents from AIDS; HIV/AIDS clients are more likely to be more satisfied with this holistic approach.

Therefore, the specific contribution of the HIV/AIDS Programme Clusters is their collective ability to provide a ‘comprehensive package of HIV/AIDS prevention and care services’ within their respective spheres of influence. And this is presumed to have been possible by individual provider capacity to deliver ‘quality specific direct HIV/AIDS interventions’, but profoundly the ability of members to ‘form and sustain collaborative groups’ for HIV/AIDS prevention and care services. Nevertheless, in order for individual service providers to jointly develop inter-agency collaboration capacity, ample resources to fund core HIV/AIDS interventions have to be available, in addition to getting the policy and institutional environment right.

Resources for HIV/AIDS prevention and care services, like any typical health service initiative encompass a wide range of inputs from health facilities, personnel, drugs, medical equipment and consumables. Due to the nature of HIV/AIDS both as a chronic health problem but also as a complex societal issue, additional resources for multi-sectoral policy coordination, multi-agency programme planning, and service implementation are required. But with about 70% of health budgets in Nigeria going into personnel costs, there are bound to be huge gaps for effective HIV/AIDS programming efforts. As this research study had earlier reported, these funding gaps were perceived to have been filled by international donor agencies and in particular the Global Fund that apart from funding the supply of anti-retroviral drugs, also provided additional resources for supporting the collaborative activities of the HIV/AIDS Programme Clusters. Other than direct financial grants, the country was seen to have also benefited from global knowledge and expertise on HIV/AIDS that hugely influenced the national HIV/AIDS policy, programme planning and implementation; including an integrated inter-agency collaborative service delivery agenda. At the national level, there was active participation of a broad range of stakeholders from the commercial

private sector to civil society organisations, who made notable contributions (financial and human resources) albeit little but remarkable in terms of advancing the national goal of controlling the HIV/AIDS epidemic. Therefore, considerable amount of resources (financial and otherwise) are believed to have been mobilised for a programme of integrating HIV/AIDS service provision in the country.

Similarly, the rules and norms that traditionally governed the practices and structures of HIV/AIDS service providers that formed the HIV/AIDS Programme Clusters in Rivers State were seen to have changed. And these were considered to have been formalised through the Integrated Cluster Model foisted on the group of individual providers delivering direct HIV/AIDS prevention and care services in each location by the funding agency - the Global Fund. The fact that the cluster model was operational in only 2 sites (those funded by the Global Fund) out of the 6 ART sites in Rivers State seems to confirm this impression. Secondly, apart from being mandated, it would also appear that since the nature of HIV/AIDS (being a 'wicked problem') demands 'collaboration' as the logic of organising joint action among stakeholders, changing the institutional framework to conform with the this new form of practice tends to establish collaborative activities among the HIV/AIDS service providers (Cropper, 2001). As earlier noted by this research study, despite being an infectious (communicable) disease, HIV/AIDS takes on a chronic feature whereby people living with HIV/AIDS continue to require care from different professionals in different settings over a long period of time, going into years.

In addition, the central position occupied by anti-retroviral therapy that has led to dramatic reductions in illness and death of HIV and AIDS patients meant that to progressively increase and sustain the transformation of the lives of people with HIV (who are now living longer

and leading normal lives); formal linkages between anti-retroviral treatment and other care and support services needed to be established (WHO, 2011). No doubt as this study found out, in both HIV/AIDS Programme Clusters in Rivers State, the ART centres located in the base hospitals in Ahoada and Bori formed the fulcrum around which the HIV/AIDS prevention and care interventions were linked. However, since formal collaborative associations among HIV/AIDS service providers in the other ART sites in Rivers State did not happen, in spite of strong need for prescribed connections among them; one can deduce that effecting institutional change in this instance requires additional instruments, other than a strategic service that plays a central role.

The theory of change for this initiative recognised specific policy reforms in support of collaborative service delivery, as one of three ingredients (activities) needed to be undertaken to attain the programme objectives of integrated HIV/AIDS service delivery. The role of international agencies setting national HIV/AIDS policy agenda, in particular UNAIDS in globally promoting a multi-sectoral, inter-agency collaboration as the solution to resolving the complex problem of HIV/AIDS has been well established by this research study. Related to this, is the use of powerful incentives as demonstrated by this case study - funding from the Global Fund to implement the Integrated Cluster Model, as a means of promoting this policy solution. At the national level, despite being responsive to the global pressure to be committed to the multi-sectoral, inter-agency collaboration agenda with the establishment of coordination bodies at all tiers of government, there were no deliberate actions to overcome the institutional challenges inherent in the Nigeria system (political tensions between the Federal and State governments; the strength of informal arrangements that tend to override formal rules; and entrenched vested interests); earlier highlighted by this study. Therefore, although Rivers State had a State Agency for AIDS Control and similar organs at the district

level - Local Government Area Action Committees on AIDS; both the State HIV/AIDS Strategic Plan (for multi-sectoral coordination) and the State HIV/AIDS Health Sector Plan (for inter-agency collaboration), did not articulate a policy of collaborative service delivery. With its direct funding of at least of one the ART centres in the State, it is expected that the State Agency for AIDS Control with a multi-sectoral mandate would champion such a policy aimed at making collaborative service delivery attractive to all shades of stakeholders.

The lack of change in the policy agenda in relation to service integration other than the rhetoric of multi-sectoral coordination and inter-agency collaboration is seen as the missing element in this interventional attempt at service integration for HIV/AIDS in Rivers State. Given that apart from the ART sites supported by the Global Fund, the other ART sites failed to develop and maintain collaborative working mechanisms among individual HIV/AIDS service providers in the various locations, supports this claim. Moreover, as indicated above, even with Strategic and Operational Plans for achieving set goals and objectives for specific HIV/AIDS interventions within the health service, there were no documented evidence of models and processes of implementing collaborative service provision for HIV/AIDS in Rivers State. Nevertheless, in reviewing the approach of service integration adopted by the HIV/AIDS Programme Clusters in Rivers State, the acceptance of the Integrated Cluster Model to be implemented in two sites, assumes adoption of this model as a policy solution to the lack of integration among disparate HIV/AIDS service providers. An evaluation of this sort helps to provide evidence to support or refute the notion that specific policy reform that changes the institutional framework for collaborative actions among health care providers is vital to advancing an agenda for collaborative service delivery in the health service. Therefore, providing the evidence base for collaborative service delivery in Rivers State is

one major contribution this research study is making towards service improvements that enhances health system performance.

Finding that connected health and psychosocial care services for HIV/AIDS patients exist in Ahoada and Bori, and that utilisation data from individual services (difficult to obtain from the other ART sites) can be accessed from one point in each of the sites; are indications that a major change has taken place within the health delivery system in Rivers State. And service integration is deemed to have been demonstrated in each of the ART sites under review as functional inter-agency collaborative groups for HIV/AIDS prevention and care services were seen to be operating, as HIV/AIDS Programme Clusters in Ahoada and Bori respectively. Moreover, since this assessment showed that the context and the need for a programmatic intervention did not change, and the activities of the Integrated HIV/AIDS Service initiative under examination seemed to have been significantly linked to the outcome, the Theory of Change is considered to be valid.

Consequently, it is logical to conclude that *the idea of the MCN is doable and can function in Nigeria, where deliberate actions to achieve a desired outcome are undertaken based on an expressed theory of change.*

In testing notions of how a particular theory of change can bring about intended results in Nigeria, policy makers and health planners need to develop a specific 'strategic business case' for any service initiative that demands clinical networks as an approach to service integration. Central to this is how to implement clinical network in a particular context to bring about these result.

7.4 Transfer of the idea of Networks and Collaborations into New Settings

Reflecting on the foregoing empirical discussions along with the theoretical material in the earlier chapters (Chapters 2 and 3), it might suggest that networking and collaborative activities aimed at combating service fragmentation through clinical networks is capable of being used universally - in different regions of the world and in different institutional contexts, including contexts that are perhaps 'policy hostile'. It may be possible to 'explicitly construct' networks or collaborations in order to achieve a desired objective in any context. This research did indeed find inter-professional and inter-organisational collaboration among the teams and organisations that work together to provide services for HIV/AIDS patients in Rivers State, Nigeria. It may therefore be feasible to catalyse the formation or extension of collaborative practices among organisations in environments in which there is relatively limited experience of such a principle of working. Gray's (1989) conceptualisation of collaboration suggests that collaboration (and similar inter-organisational relational practices) represent a 'soft technology' that joins together the capacities of individuals and groups to achieve significant outcomes. Himmelman's (2001; 2002) 'collaboration continuum' proposes four forms of relational practices (networking, coordinating, cooperating, and collaborating) that strengthen that collective capacity in a step-wise or progressive fashion. This research found Himmelman's framework to be useful in differentiating the quality of relationships among multi-organisational networks that have formed to address the 'wicked problem' of HIV/AIDS in Nigeria by integrating services for HIV and AIDS patients. The fact that collective actions undertaken by members of the HIV/AIDS Programme Clusters reviewed by this study remarkably increased access to vital health services indicates that 'value' has been created through the implementation of a networking and collaborative initiative in this resource-limited setting. The governance of the different qualities of relation was not specifically addressed by Himmelman (2001; 2002), but research into managed

clinical networks has started to explore how effective systems of care might be fashioned and sustained.

This study has indicated the extent to which organisational, institutional and service features required for service integration have been put in place and provided some evidence to support the assumption among global health professional and practitioners that the notion of collaboration for service delivery among health providers is a transferable concept, even in resource constrained environments. But because people in different national policy communities tend to see things differently (Marmor, Freeman & Okma, 2005); institutional change instigated by particular policy reforms aimed at establishing a culture of ‘joint working’ among health care providers in these settings are crucial conditions that would enable inter-agency service delivery groups to survive and thrive. The analysis of the two cases of HIV/AIDS networks suggests that certain conditions may facilitate or act as barriers to the development of strong, formal networks in the different settings.

Although the main focus of this research is on collaboration that occurs at the service delivery point (beyond the strategic and governance levels), observed evidence from this study reveals that for two main reasons, these super structures impose considerable pressures on the viability of collaborative activities on the frontline. First, as indicated by the study, the institutional arrangements for HIV/AIDS prevention and control in Nigeria showed that control of the resources required for core health services inputs and programmatic activities to foster collaborative activities among health care providers reside mainly with administrators in government at Ministries, Departments and Agencies (MDAs) outside the health sector (though health planners and managers in Ministries or Departments of Health maintain some influence) at Local, State and Federal levels. In addition, Guthrie et al’s

(2010) findings of the implementation of MCNs in the UK recognise that MCNs need resources of various sorts to carry out their governance role in terms of promoting integration and coordination. They pointed out that these sort of collaborative groups require supplementary resources (financial, human, time etc.) to carry out their main tasks: sending out notices, organising and holding meetings (general and committees), developing procedures to streamline care processes, negotiating disagreements, managing conflicts and building consensus. Therefore, even where an issue activates participants in an organisational field, collective action in response to such a challenge may not ensue if resources are lacking, since they constitute significant binding constraints to inter-agency collaborative initiatives, as this study also suggested.

And second, as the study also showed; the policy environment and the institutional arrangements for health service delivery in Nigeria, influenced by the wider political economy of the country, limits the ability of collaborating partners to effect change without purposive actions towards reforming the collaborative context. The policy transfer literature (Swainson & de Loe, 2011; Benson & Jordan, 2011; Dussauge-Laguna 2012; Dolowitz & Marsh, 2012;) suggests that irrespective of how policy and institutional changes for collaborative service delivery have emerged: (i) facilitation by global policy entrepreneurs through transfer of ideas; (ii) incentives provided by international donors to adopt an integrative approach to service delivery; (iii) local ‘change agents’ actively defining national health policy agenda with a view to increasing access to health services through system restructuring; and (iv) a crisis such as the HIV/AIDS epidemic that provides an opportunity that put the challenge of service fragmentation on the policy agenda, collaborative groups are bound to benefit from such transformative events. Otherwise, for collaborative groups to

function as they should, policy and institutional conditions suitable for them to emerge and grow have to be created.

On these bases, this research concludes that it would be very difficult for collaborative service provision to emerge and thrive as an alternative service delivery model within the Nigeria health system, therefore *the idea of the formalised MCN although feasible, may not function properly or be sustainable within the institutional environment that prevails in Nigeria.*

Nevertheless, the research study also observed that, though the institutional environment may be hostile to the idea of the MCN, there are yet certain institutional features that may promote this idea, as a form of service integration in the Nigerian setting. Asoka (2010) in his historical accounts of how people attempt to overcome structural impediments inherent in the Nigerian system, found that despite the environmental limitations, which influence the choices and opportunities available to people in Nigeria, collective action is proving useful in dealing with ‘issues that define outcomes’ for the common good. This has been the case with HIV/AIDS clusters, which have been formed with the characteristics of managed clinical networks clearly evident. The networking and collaborative initiative implemented in this resource-limited setting has the potential to be sustained on this basis, because it has produced value. Furthermore, collaboration, as an idea, might also diffuse, influencing practice elsewhere, since Heymans & Pycroft’s (2003) Drivers of Change Analysis of Nigeria implies that collective models are likely to emerge in response to the structural barriers and institutional norms that direct inter-personal and inter-agency behaviour in Nigeria.

Policy and institutional analysis may also help, by charting a course by which the conditions for service integration through collaborative service delivery may be set. Heymans & Pycroft's (2003) Drivers of Change Analysis of Nigeria explained the approach to understand how institutions have evolved, how they interact with agents and structures, and how agents contest the territory of institutions. Fashioning a deliberate course of action of how change may happen that incorporates the methods needed to actualise this change is therefore, critical to instituting a policy that allows integrated care through implementing the idea of the managed clinical network.

As this study also suggested, an interventional approach using a 'theory of change' methodology could in addition enable health reformers not 'to accept the problem as defined by the agenda-setting processes in their countries' (Roberts et al, 2004: 66). The theory of change for HIV/AIDS clinical networks in Nigeria (Figure 3.4) incorporates: (i) developing and sustaining inter-agency collaboration for HIV/AIDS (the collaborative process); and (ii) policy reform that fosters collaborative service delivery (the challenge to existing institutional arrangements) illustrates, an outcome pathway, which presents the conditions that must be in place to reach the desired goal. Thus, the concern for the likelihood of attaining desired outcomes becomes central when designing and executing a given collaborative service delivery initiative.

In this sense, innovation in clinical networks could be considered, as the capacity to design and implement such entities with the intention of achieving specific health outcomes. This can be done on a case by case basis: (i) generally across the health service in one location (primary health care at the district level - to improve the health status of a given population); (ii) for a particular health problem that has chronic disease characteristics similar to

HIV/AIDS (diabetes, cancer, mental health etc. - to enhance the health outcomes and well-being of a client group); and (iii) specialised service delivery initiatives (maternal, newborn, and child health services - to reduce illness and death among specific vulnerable populations). But fundamentally, innovatively re-organising the health system in this manner requires that health managers and clinicians develop the necessary skills and competencies to tackle the operational and contextual issues highlighted by this research study, in order to adopt integrative approaches to service delivery. These include: (i) putting in place a ‘collaborative initiative’ as a means of overcoming the challenges of service fragmentation; (ii) the need to develop the policy and institutional framework in order to facilitate collaborative service delivery; and (iii) the ability to assess and manage the flow of events that lead to the desired outcomes.

The study therefore, proposes the adoption of this ‘change methodology’ that link theory to action and carrying out such a reform agenda on the basis of an explicitly designed theory of change.

Chapter Summary

A key objective of this research study is to test the emerging findings against the feasibility of implementing change within the Nigerian health system through *clinical networks*. But given that this is an exploratory study, this chapter discussed the feasibility of clinical networks in Nigeria from three different aspects (operational, contextual, and interventional feasibilities) based on the findings of the networking activities of the two HIV/AIDS Programme Clusters in Rivers State that were evaluated by this research, along with the institutional and HIV/AIDS contexts within which they operated. The chapter concluded, as it looked at the transfer of the idea of networks and collaborations into new settings, by

linking the empirical discussions from this chapter with the theoretical viewpoints in the previous chapters.

Chapter 8: Conclusion

This concluding chapter summarises the key findings of the research and comments on the significance of the findings in terms of the development of understanding of clinical networks. Further, the contribution the research has made to the continuing debates about ‘whether’, ‘how’, and ‘why’ an idea might travel across jurisdictions is considered. At the same time, the agenda for future research into options for service innovation as a part of health sector reform in Nigeria and other settings are also identified. Specifically, the thesis suggests, by way of final conclusion, that research might consider how early assessments of the feasibility of policy transfer could set consideration of a range of modes of service integration, of which collaborative service organisation is one, into the policy appraisal, and especially where the context in which development, maintenance and spread of the policy is hostile or challenging.

In taking the implementation of ‘programme clusters’ for care and support for HIV/AIDS in Nigeria as its focus, the study set out to understand how and why the ‘idea of the managed clinical network’ might have been considered ‘transferable’ as a mode of organisation and governance of health services in this setting. The history of health policy and the principles on which services have been organised are in certain ways antipathetic to the principle of collaboration that is central to this ‘managed service network’. Yet, HIV/AIDS is perhaps the most likely site in which to see such principles in action and to learn about the feasibility of developing collaborative practices in service organisation and governance in such a setting. Although ring-fenced monies were allocated to this experiment, nevertheless, the general condition of resource constraint was also present and the study also offered an opportunity to examine the likely sustainability of such networked arrangements. This research study has been an attempt, therefore, to investigate ‘whether’, ‘how’, and ‘why’ the emerging use of

‘managed clinical networks’ as a means of resource sharing and service integration in the UK and other advanced nations, such as Australia and the USA, would be relevant to the conditions found in developing countries. And the key research question is: *whether ‘the idea of the managed clinical network’ could be an effective means of service integration in a developing country setting, and if so how and why?*

Though this research tends to pose managed clinical networks as an alternative to predominantly state and market based systems of health care respectively, the intention is not to avoid a larger and essential role for both statism and markets. The main arguments are that, first; that by comparison with the logics of hierarchical and bureaucratic control and competition, collaboration across the traditional boundaries of agencies or business units is the distinguishing logic and relational quality of managed clinical networks. This allows networks to be used as a way of improving patient access to services, service quality and equity. As means of integrating services, networks may enable these common interests to be more effectively realised. And they may also help health service organisations better to achieve their own objectives, not least by sharing scarce distributed resources. In theoretical terms, service networks and the collaborative relationships between organisations and their representatives that hold these together are intended to secure the two forms of ‘advantage’ highlighted by Huxham & Vangen (2005): first, collectively, more could be achieved, since the pooling and linkage of complementary resources and expertise would enhance the effectiveness of care and support. But equally, membership of the collective effort would bring benefit to each organisation.

Second, Himmelman’s (2002) framework provided a valuable benchmark for discriminating the key features of networking within the ‘programme clusters’ that provided care and support

services for HIV/AIDS patients in Nigeria. It usefully distinguishes between intensities of relational practice from simple information sharing through to forms of practice (he labels 'collaboration'), which require networked organisations to actively consider and to invest in capacities across the whole service network. The aim of this research was to locate and distinguish between intensities of relational practice rather than, as in previous studies of clinical networks (Currie et al, 2010; Ferlie et al, 2010; Sheaff et al, 2011), to focus on the structure of relations, as a way to assessing the fact of and potential for collaboration within the HIV/AIDS Programme Clusters that were evaluated by this study. The creation of the context in which the development of collaboration becomes a feasible, alternative mode of governance for delivering care, is, the study finds, as possible and effective as the implementation and use of markets, and the hierarchical procedures and mechanisms that are typically used to govern service organisation and delivery.

8.1 Statement of principal findings

The findings from this research study showed that the HIV/AIDS Programme Clusters in Rivers State, Nigeria that were examined, exhibited structural and socio-metric characteristics as networks: they were well-articulated systems of vertical and lateral, collaborative relationships between services and organisations which were responsible for care elements for people with HIV/AIDS. And there was strong evidence, based on the 'operational feasibility assessment' to demonstrate that the fact of collaboration - that is, the *intensity* of cooperative relations, within these HIV/AIDS Programme Clusters, had also been realised.

It is important to tease out the factors that have contributed to the development of the clusters as a formal managed network.

It would be possible, perhaps, to argue that it was only when the resources were made available by The Global Fund for the prevention, treatment, and rehabilitation of those infected by the virus and those affected by the impact of the disease in Nigeria, that the necessary catalyst and incentive for collaborative ventures emerged. The hospitals, health centres, and units that entered into these HIV/AIDS collaborative arrangements, certainly recognised the importance of the Global Fund. Such a well-packaged and sharp catalyst is a plausible explanation for the development of the clusters and collaborative relations observed. The development of organisational arrangements specifically to secure programme funding is very common in health programmes in developing countries (Cassels, 1995; Putzel, 2004; England, 2006; Buse et al, 2008).

However, while the resources made available to facilitate a collective response were undeniably key incentives to work together, the research found that it is not unlikely, following Huxham & Vangen (2005), that some other common bases for collaborative advantage, might also have been at work and that these had already taken effect.

These other bases include prior, general mandates and other policy incentives from Government to collaborate, including promotion of the integrated cluster model for HIV/AIDS programming by the National Agency for the Control AIDS in Nigeria. A second, powerful rationale for development of the service clusters model, then, was the recognition in centres of power of the disease as a ‘wicked problem’, requiring collective action (Ferlie et al, 2011). Generally in Nigeria, Heymans & Pycroft (2003), and Asoka (2010) make the point that the restrictive operating environment at both the macro and micro levels, also serves to encourage some multi-stakeholder actors to adopt collaborative

practices as a pragmatic approach to tackling ‘difficult problems’ that share similar features as ‘wicked problems’.

Prior to the institution of the ‘integrated cluster model’ by The Global Fund, there were pre-existing ties among individual professionals and health facilities keen on streamlining service provision. Overall, there was a sense that both the Ahoada HIV/AIDS Programme Cluster and the HIV/AIDS Programme Cluster in Bori could potentially have emerged voluntarily, and in these two cases had already done so, at least in part. Guthrie et al (2010) made a similar observation in their review of managed clinical networks in Scotland and Ferlie et al (1996) argued that professional networks in health care are, in general, to be expected. The presence of two policy documents (Rivers State HIV/AIDS Strategic Plan 2010 - 2015; and Rivers State HIV/AIDS Control Programme: The Health Sector Strategic Plan 2010 - 2012) at the State level amplified and made more locally specific the government mandate to develop ties among HIV/AIDS service providers in the two locations, and there was a recognised need to link support services for the anti-retroviral drug treatment programme in the State. Both of these were strong indicators for the development of forms of collaborative and integrated working arrangement. Organisations had already been drawn into collaboration, somewhat less intentionally in response to an invitation by the ART site in each of the centres, in Ahoada and Bori that were seeking partners to provide HIV/AIDS prevention and care services; and alliances and networks had developed as a core organisational strategy. Community pressure, and advocacy processes for people living with HIV looked to encourage such partnerships to benefit their members directly. All of these were pressures that had led to somewhat ‘centred’ network of collaborative relations, although in both cases these were limited.

The two cases considered here went beyond such organic forms of professional network: these were formally constituted and governed. The ties between member organisations, which were mainly referral pathways, were seen to be too weak to foster service integration. The two policy documents, although referring to the idea of joint working among the main programme organisations and agencies, had failed to elaborate a strategy through which this would be undertaken. There was no ‘convener’ with authority or resources to make this happen. It was, at best haphazard. Those interviewed in each of the networks distinguished strongly between their attempts at organising themselves into networks when the Anti-Retroviral treatment was introduced and the later networks that emerged from the Global Fund support. The latter specified the idea of the ‘cluster’ and the components of the cluster as a managed clinical network as a requirement for receiving the grant. Therefore, it is fair to conclude, using Guthrie et al’s (2010) terms that the HIV/AIDS Programme teams in Rivers State, Nigeria may initially have been ‘voluntary networks’ formed as individual professionals, groups and organisations identified HIV/AIDS service coordination, as an issue for which they felt some degree of collaboration would be useful. Later, these fledgling networks were transformed into ‘mandated networks’ by the ‘integrated cluster’ policy of the Global Fund with specified network membership, and a set of governance processes through which to co-ordinate the activities of HIV/AIDS service providers and so increase the number of HIV/AIDS under anti-retroviral treatment.

In as much as the collaborative networks in this case study did emerge voluntarily, they soon acquired most of the properties of mandated bodies with formal structure, legitimacy and credibility. But the informality of prior engagement, which had enabled members to willingly participate, rather than rely on instructions through formal relationships of authority and control, makes it difficult to define these networks simply through reference to their origin.

Guthrie et al (2010) also made a similar point in observing that distinction between formal mandated networks and more informal voluntary networks was not clear-cut. They suggest that such difference of origin should be of little concern so long as the network is perceived to be delivering results: the right choice of network form could depend on the local context. Furthermore, as noted by Ferlie et al (2010) finding hybrid forms, as in the case of the HIV/AIDS programme clusters in Nigeria; where the networks grew out of pre-existing organic networks and later become mandated, is not unusual.

In line with the observations of Cropper, Hopper & Spencer (2002), the structures of each of these HIV/AIDS clinical networks is derived from definition of points of entry to care, points of care delivery and the connections between. And the task of setting out mechanisms and principles governing the relations between points of care is the care pathway as displayed in Figure 5.5. Although Cropper, Hopper & Spencer (2002: 2) envisaged that ‘all professionals concerned and involved with care delivery are de facto members of the network’, the findings from this research study note that certain key professionals (groups) may be excluded either by design or because they fail to participate in the network. In this instance, the ‘integrated cluster model’ of the Global Fund clearly defined the membership though drawing from the HIV/AIDS care pathway and the guidelines. But some medical and nursing staff with multiple roles in both networks who felt less committed to HIV/AIDS did not become involved with the networks.

Following the principles of the integrated cluster model for HIV/AIDS as handed down by the Global Fund, the two networks included: a single entry point to access anti-retroviral drug treatment services; joint working across organisations with a common goal of increasing the number of HIV/AIDS patients receiving anti-retroviral drugs by sharing information, tasks

and responsibilities; and a holistic approach to the needs of HIV/AIDS patients. Whilst there were these common elements, each of the HIV/AIDS Programme Clusters studied tended to design and deliver an integrated HIV/AIDS service differently. This is perhaps not unexpected as Williams & Sullivan (2009) found with efforts to integrate health and social care in the UK. They noted that operationalising these principles and interpreting the nature, purpose and practice of integration could prove to be highly problematic, since actors tend to have different views on what is possible or desirable and the achievement of standardised forms of practice are the exception rather than the rule.

The two HIV/AIDS cases studies similarly reveal the importance of local context in translating an idea or policy. Despite adopting similar processes such as the use of clinical guidelines, co-location, and convening of monthly meetings, clinical staff at the base hospitals interpreted service integration quite differently. The two fundamental differences proved to be related to the *degree of embeddedness* of the network and programme into ‘normal’ service facilities and arrangements. Whereas in Ahoada, the same set of local clinical staff attended to general (patients with medical problems other than the disease) and HIV/AIDS patients from the same point of care; at Bori, clinical staff seconded from the State Ministry of Health were the focal persons that administered the drug treatment programme. Moreover, as opposed to Ahoada, the anti-retroviral treatment activities in Bori were physically distinguishable from the rest of the hospital functions. Not only were the HIV/AIDS services taking place in a designated building within the hospital premises in Bori, the core clinical staff of the hospital were often reluctant to admit HIV/AIDS into the hospital wards for stabilisation.

Williams & Sullivan (2009) saw such differences as arising from the extent to which professionals and organisations were prepared to negotiate power and authority in service integration. And this locality effect could be said to give rise to different network processes. As shown by the two HIV/AIDS case studies, integration can be interpreted differently at a locality level. Such understanding can influence the way in which interventions are managed, and this may lead to different network governance structures and outcomes. This is consistent with work in developed country settings, which examined implementation of an urban renewal network policy/programme and found that ‘despite the fact that all the cases were based on the same public programme promoted at the regional level, the programmes were quite different locally in terms of their governance models and the renewal policies promoted.’ (Ysa, Sierra & Esteve, 2014: 650).

Based on the findings, the HIV/AIDS networks, which have similar objectives, were observed to have increased the number of patients receiving anti-retroviral treatment at both sites. These results were attributed to task integration through the care pathway; where agreed protocols were seen to have supported care-givers in delivering appropriate care and clinical decision making. Looking at network effectiveness in this manner, the Scottish NHS in the UK (Scottish Executive, 2002) reported that Managed Clinical Networks apart from providing a wide range of benefits to patients and delivering excellent value for money; are an appropriate vehicle for promoting best practice and for sharing expert skills and knowledge nationally. In addition, similar to the findings from the MCNs in the UK, the HIV/AIDS networks were observed to have made a significant contribution to the education of members, and associated staff while providing a clear channel for support, advice and guidance. Moreover, as the HIV/AIDS networks in this research study have also demonstrated; because of their role in collecting audit data and therefore building an

evidence-base for the condition or treatment they support, the networks are well placed to act as catalyst for change where the need exists. It is therefore fair to conclude that the HIV/AIDS networks under review have been successful in bringing about 'whole system' improvements for service delivery for this disease within their respective geographical locations. And this could be attributed to the structures that support the provision of multidisciplinary care; whereby the network structures were important in facilitating the engagement among appropriate staff in different organisations and agencies involved in delivering care for the population of HIV/AIDS patients in each of the districts.

Apart from this level of engagement among service providers around anti-retroviral drug treatment, there was also the influence of project managers of the Global Fund that tend to hold each network together by force of purpose and compelled the network participants to be jointly accountable for the network results. With funds for the anti-retroviral treatment programme provided by the Global Fund, resources for network activities were adjudged to be sufficient. This combination of conditions therefore supports Provan & Milward's (1995) assertion to a large extent that network effectiveness is dependent on centralised network integration along with external control that is direct and non fragmental; in addition to a situation where the system is stable and resources are adequate. As Ysa, Sierra & Esteve (2014) and other papers on network effectiveness (Kelman, Hong & Turbitt, 2013; Turrini et al, 2010) also support this claim, network research is just starting to engage empirically with these questions.

Meanwhile, as the findings also indicated, task integration in coordinating HIV/AIDS services was more of a means (the process - the coordination of things) of achieving the higher objective of increasing the number of patients with HIV/AIDS receiving anti-retroviral

treatment (the outcome - joint production). While both process and outcome indicators provide useful means of determining network effectiveness, some commentators caution that networks require time to achieve their aims. An assessment of the effectiveness of managed clinical networks on the quality of diabetes care in the UK (Greene et al, 2009) noted that while network focus on clinical collaboration was effective at improving clinical process and outcome; delivering care to whole populations across the organisational and professional boundaries required sustained work over a long period. But as networks evolve structural indicators, the number and quality of relationships among network participants, are also critical to network effectiveness. As demonstrated by the HIV/AIDS networks, the many and strong relationships between members, as well as the high levels of participant engagement facilitated service integration that led to the increase in the number of patients receiving anti-retroviral drug treatment in each of the sites. This logic of 'structure – process – outcome' proves useful in understanding network outcomes irrespective of the stage of network development. In summary, these findings suggest that while the coordination of tasks (and some self-interested collaborative exchanges) seemed to be the process through which the HIV/AIDS networks operated: 'value is produced through joint production'.

Although the collaborative entities in the case study had management structures for coordinating activities, it also required the Programme Managers of the Global Fund to facilitate procedures and act as network coordinators to hold the network together by force of purpose. But the coordinating bodies jointly took decisions with representatives from participating hospitals, health centres and units. Therefore, network coordination could be said to be non-hierarchical. And since the coordinating bodies met only once a month (cluster coordinating meetings), the networks (HIV/AIDS Programme Clusters) functioned effectively without the mediation of the coordinating bodies. These are in keeping with

findings by Sheaff et al (2011) that stress the importance of the need to establish and maintain direct link with network members, and not just links to the coordinating body. Provan & Kenis (2008) also observe that in health and human services, this sort of shared participant governance in networks is common as they are often considered to be an important way of building community capacity.

Provan & Kenis (2008) categorised network governance into three major forms. These are: (i) participant-governed networks - governed by network members themselves with no separate and unique governance entity; (ii) lead organisation governed-networks - where a core agency assumes the role of network leader because of its central position in the flow of clients and/or key resources; and (iii) network administration organisation - a separate administration is set up specifically to govern the network and its activities. On this basis one could assume that despite the presence of a lead agency - the anti-retroviral clinic, with sufficient clinical resources and legitimacy, as well as some elements of network brokerage provided by the programme managers of the Global Fund; both HIV/AIDS networks, which adopted a similar governance approach, were entirely governed by the organisations that comprised the networks. And this is formalised through the regular monthly meetings of representatives from the designated hospital units, organisations and agencies that make up the networks. While there was no formal administrative entity, administrative functions and coordination functions were performed by the appointed network management - Chairman, Secretary and Treasurer, in addition to network committees either ad hoc or permanent who acted on behalf of the entire network in between meetings. Consequently, despite the differences in size, resource capabilities and performance, power within the networks with respect to network decision-making is judged to be more or less symmetrical (Provan & Kenis, 2008).

In reflecting on the context in which these HIV/AIDS collaborative bodies related; it is safe to conclude that the networks took into account the complexity of working in the Nigerian environment, and therefore operated in less challenging settings. By focusing collaborative engagement on the patient care pathway and bringing representatives from all key interests and stakeholders to develop a structured approach to service delivery, most of the environment risks were seemed to have been minimised. Moreover, the external resources brought in by the Global Fund, and the facilitation provided by its Programme Managers could also have moderated the intrinsic vested interests. In addition, while these networks still have to deal with corrupt practices and patronage values that persist in the health sector, the change of behaviour sought was not significant. Ferlie et al (2010) agree with this explanation and added that other indicators of the dimension of complexity may include: scale, size of population affected, challenging geography, and extent of social deprivation or multi-culturalism.

Finally, the programmatic approach in the response to the HIV/AIDS epidemic seemed to have thrown up two different translations in the way the medical component of HIV/AIDS services are configured. The main reason has been the attitude of treating HIV/AIDS as something special rather than as a disease (England, 2006). The model where routine clinical services were more integrated with that of medical care of HIV/AIDS appears to be the favourite option. Apart from reducing overall cost of service provision, the mitigation of stigmatisation of HIV/AIDS is a useful outcome for this set of patients. And this level of inclusiveness, where key individuals such as medical officers play a major role along the patient care pathway is said to be significant for the success of networks (Guthrie et al, 2010).

8.2 Concluding Statements

The Global Fund's idea of HIV/AIDS Programme Clusters is in many significant ways comparable to the idea of the MCN; and so implementation of the 'Programme Clusters' in Nigeria has afforded an opportunity to explore the feasibility of transfer of the idea / technology of Managed Clinical Networks (MCNs), which has been the focus of experiments in collaborative/network organising of health services of a number of advanced economies into a less advanced environment. In assessing whether or not the idea of the MCN has proved to be feasible/transferable, and whether it might apply to other services, this study has provided a number of insights.

First, the HIV/AIDS Programme Cluster as centre of authority for coordination, as a set of resources made available and used for collective benefit, and as a mandate to integrate that provides an identity, and has value to all, is judged to be 'equivalent' to the idea of the MCN.

Second, compared with practices of HIV/AIDS care organisation outside of these two case studies, the HIV/AIDS Programme Cluster is seen as a 'well-articulated system of collaborative relationships' between services and organisations responsible for elements of care for people with HIV/AIDS - and not just emergent or partial connections between related service providers, more typical with HIV/AIDS care and support services not supported by The Global Fund in Nigeria. In addition, a level of intensity of relationships with the HIV/AIDS Programme Clusters has been established - not only information exchange, but also investments and commitment to a shared enterprise.

Third, given the 'fact of collaboration' within the HIV/AIDS Programme Cluster in Nigeria, the idea of the MCN is considered to be 'operationally doable' in this context, and therefore

‘technically’ transferable. But because the HIV/AIDS programme ‘cluster model’ challenges the exiting institutional arrangement in Nigeria, the ability of collaborating partners to sustain the clusters without reforming the institutional context is not clear.

These insights suggest that while the idea of the MCN might be feasible in practice in developing countries, feasibility does not mean ‘spread’, ‘change in policy’ or ‘institutionalisation’. Therefore, further research is recommended, to explore ‘whether’, ‘how’, and ‘why’ the policy/idea of the managed clinical network, as an alternative means of service integration, might be situated in an institutional context that is characterised by a mix of modes of governance (hierarchy and markets) typical of Nigeria, and the possibility of ‘sustainable transfer’ into this environment.

Other than coordination and cooperation, with increasing levels of investments on each other’s capacity to achieve the HIV/AIDS programme clusters’ main aim; the research findings demonstrated evidence of additional features that make for collaboration. In producing the ‘shared task’, whether it is services or knowledge, managed clinical networks can identify some features of collaboration in the process (Goodwin et al, 2005). But for them to create value (e.g. productiveness) it is the intensity of collaboration rather than the structure of the set of the relations that is important. Himmelman’s (2002) collaboration continuum has proved to be a useful instrument for determining stages of relational intensity - because, to create the ‘step change’ from one level on Himmelman’s (2002) scale to a higher one, more investments in capacity for behavioural change is required among networking partners. The exploration of the capacity for managed clinical networks, to ‘systematically introduce and sustain collaboration’ is an appropriate yardstick for measuring their feasibility. Therefore, in order to be taken forward and recommended, notions of integrated care have to

demonstrate this dual capacity: participants being able to collaborate in a systematic and sustained manner, and the collaborative entity having the ability to produce value.

8.3 Contribution to Public Policy

The global policy community's concern on how best to improve healthcare services in low- and middle-income countries remains an on-going debate. In the past three decades or so there have been attempts to 'transfer ideas' that seem to be 'promising' from other jurisdictions (mainly advanced economies) into these settings, based on knowledge about different health systems and how they work. The chief 'vectors' involved in the transmission of 'new ideas' into these 'resource-constrained health systems' have been international development agencies, in particular those with global mandates such as the World Bank, the World Health Organisations and related agencies. 'Explaining why different countries do what they do in the way they do, difficult though it is, may in fact be easier and academically more satisfying than identifying what works and whether or not it might work equally well in different contexts' (Freeman, 1999: 2). This research study had attempted the latter. Though an exploratory study, it has made an incursion to begin to lay down the 'procedure' for undertaking such an exercise. It suggests an approach that 'explores the capacity of accounts of an idea to systematically introduce and sustain its essence (core principle) in the new jurisdiction'. Basically, this approach could be seen as a 'tool' - a methodology for evaluating the transfer of a given policy or idea, on three dimensions (operational, contextual and interventional feasibilities), which could be employed to assist global policy professionals/practitioners in assessing how policy ideas are likely to be adopted in new jurisdictions, prior to transfer of such ideas into new settings. In this instance, this research study has attempted to 'introduce a method to investigate the conditions prevailing, potential for adoption' and therefore the feasibility of networks, 'ahead of transfer'.

Nevertheless, this study has also brought to the fore the lingering issue of how best to undertake policy transfer in the broader global health arena that takes into account, the natural inclinations of countries to do things differently. As a 'Health Policy Adviser' in international health development, this was the core reason that made me to ask the question several years ago: clinical networks in developing countries, how feasible? And this was in response to repeated calls by the World Health Organisation for the adoption of clinical networks in developing countries, and recognising its role in the global transfer of ideas in the health sector. Whether this calls for the need to routinise feasibility studies of this nature to assist both donors and recipients of development aid in situations where ideas or technologies are being introduced into new areas for efficiency gains or service improvement, can not be determined at this moment.

8.4 Personal Reflection

From my previous professional experiences as: a trainee in General Medical Practice working in a Rural Mission Hospital, a programme coordinator of a Community-based Health Project in a disadvantaged area, and Owner / Manager of a Private Medical Practice in a small industrial town; I had acquired an insight into the inner workings of the health system. I was also aware that the health system as constituted could do more to improve the health status of the population even in the face of the limited health care resources. However, reflecting on how my role as a medical doctor has evolved and expanded to include management and leadership of the health sector, it has become obvious to me that certain global events have influenced my career choices, including my decision to undertake this research study by enrolling on the Doctor of Business Administration (DBA) in Health Planning and Management at Keele University.

Notable among others were: first, the Alma Ata Declaration of 'Health for All' by the World Health Organisation (WHO, 1978) that called for the necessity to train and develop community-oriented medical professionals (Schmidt et al, 1991). This was driven by a need to redefine an effective role and function for doctors working at the community level in the context of overall human development (Adeniyi-Jones, 1964). And second, the promotion of General Practitioners (GPs) as ~~the~~ medical professionals of first choice capable of coordinating care for a panel of patients (irrespective of age, sex or disease organ that is afflicted) along with the emergence of Family Medicine as an academic discipline (Stephen, 1982), as a response to the growing concern about fragmentation of patient care, which has resulted from medical specialisation (Herndon, 2004). But the most recent, is the World Health Organisation's initial request to explore an alternative organisational model, the 'virtual integration model', to help strike a balance between the inefficiencies and unresponsiveness that occur with the public health services and the loss of financial protection and strategic coordination perpetuated by the private sector (WHO, 2000). It was this idea that aroused enough interest in me to consider undertaking research to critically examine the opportunities and challenges of putting in place a 'virtual health system' for developing countries.

It has been observed that aside from an informed population of consumers, some other conditions are necessary to hold together such a 'virtual health network'. These have been identified to include: a shared vision and information, and a variety of regulatory and incentive systems, which are designed to reward organisational goal achievement or otherwise punish capture, incompetence and fraud (WHO, 2000; Jennings, Miller & Materna, 1997) My worry then was that given the situation in most developing countries: weak economies, poor infrastructure, unstable political climate, lack of technological know-how

etc.; ‘are the conditions necessary for creating such a health network obtainable?’ If not, are there opportunities inherent in the emerging political, economic, social and technological arena, such as globalisation, information and communication technologies, public-private partnerships etc. that could make this possible? Even then, what are the main challenges: entrenched medical culture, shifting values, quality control, moral integrity, new work patterns etc. - that should be overcome? What is the possibility of such a system operating in the entire health system of a country? Or will the virtual health system be more feasible from a sub set of a national health system? Or will it operate more effectively as a ‘collaborative network’ that transcends geographical boundaries? If so, how will it be put in place?

I had envisaged that these are some of the questions a research study of this topic will try to answer, with the main objective of finding out, how a supporting framework for exchanging information is developed in order to create a ‘virtual health system’ from a large set of autonomous and semi-autonomous health service providers, which would provide health gains for ordinary consumers in developing countries. I was convinced that by identifying and analysing the critical factors required in creating a match between the supply and demand sides of this health care service delivery equation, such a study will be filling a major knowledge gap.

However, this particular research study on the ‘feasibility of managed clinical networks in developing countries’, has taken me on a somewhat different trajectory, as it attempted to help me appreciate ‘notions of integrated care, in a case of policy transfer’. While not completely off the track of exploring how possible a virtual integrated health network could work in developing country settings, it has provided me with deeper insights into the essence of this phenomenon, which is ‘collaboration’. At the same time, I have acquired a ‘tool’ - a

methodology for evaluating the transfer of a given policy or idea, on three dimensions (operational, contextual and interventional feasibilities) prior to implementation - to me help assess how global initiatives in relation to health system development are likely to be operationalised in resource-limited environments. I also see that this research study has provided significant background and content to help me to continue to think about the original questions I raised (outlined above), when I started inquiring about the ‘feasibility of virtual health systems in developing countries’; and also respond to my initial hunch about the idea of the managed clinical network as a model of service integration, at the start of this particular research study. Fundamentally, the research findings provide an understanding that in order to be taken forward and recommended, notions of integrated care have to demonstrate a dual capacity: (i) the ability for participants, to collaborate in a systematic and sustained manner, and (ii) the collaborative enterprise, having the capacity to produce results that is of value. These outputs, I predict could influence the future direction my professional career may take - research, consulting, leadership etc.

Chapter Summary

This final chapter has reviewed the main findings of the research study, noting that the lack of integration among individual service providers (seen to be the main issue of care fragmentation) is only a symptom of a wider problem, which is the ‘dominance of markets and hierarchical forms of governance’. And yet, we have found that service networks that cut across those modes of governance can be established and can be formalised. Based on the literature on networks, this thesis has sought to explain: firstly, why the specific policies on clinical networks developed the way they did within the Nigerian context; and secondly, the pattern of development and characteristics of the networks that were formed to organise and govern HIV/AIDS services in two case study locations in Rivers State, Nigeria. It also

outlined some insights arising from the study about introducing ‘systematic collaboration’ as an example of policy transfer. Given the extent to which policy transfer and borrowing across global contexts occurs, and the importance of appropriate transfer, this thesis has been an attempt to develop a way of understanding both a priori assessment of policy for transfer and the way in which policies might ‘land’ in a new context and its ex post assessment. Finally, in noting the contributions of the research to public policy debates on policy transfer, this conclusion suggested some further areas of research that would help in understanding whether it is possible to sustain and spread models of collaborative service delivery in resource-limited environments heavily dominated by particular modes of governance that are potentially inimical to the policy idea.

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APPENDIX – I: **FACTORS INFLUENCING SUCCESSFUL COLLABORATION** (Mattessich, Murray-Close & Monsey, 2001)

CATEGORIES	FACTOR
A. Environment	<p>1. History of Collaboration or Cooperation in the Community A history of collaboration or cooperation exists in the community and offers the potential collaborative partners an understanding of the roles and expectations required in collaboration and enable them to trust the process.</p> <p>2. Collaborative group seen as leader in the community The collaborative group (and by implication the agencies in the group) is perceived within the community as a leader – at least related to the goals and activities it intends to accomplish.</p> <p>3. Political/social climate favourable Political leader, opinion-makers, persons who control resources, and the general public support (or at least do not oppose) the mission of the collaborative group.</p>
B. Membership Characteristics	<p>4. Mutual respect, understanding, and trust Members of the collaborative group share an understanding and respect for each other and their respective organisations: how they operate, their cultural norms and values, limitations, and expectations.</p> <p>5. Appropriate cross-section of members The collaborative includes representatives from each segment of the community who will be affected by its activities.</p> <p>6. Members see collaboration as in their best interest Collaborative partners believe the benefits of collaboration will offset costs such as loss of autonomy and ‘turf’.</p> <p>7. Ability to compromise Collaborating partners are able to compromise, since the many decisions within a collaborative effort cannot possibly fit the preferences of every member perfectly.</p>
C. Process / Structure	<p>8. Members share a common stake in both process and outcome Members of the collaborative group feel ownership of both the way the group works and the results or product of its work.</p> <p>9. Multiple layers of decision-making Every level (upper management, middle management, operations) within each organisation within the collaborative group participates in decision-making.</p> <p>10. Flexibility The collaborative group remains open to the varied ways of organising itself and accomplishing its works.</p>

	<p>11. Development of clear roles and policy guidelines The collaborative partners clearly understand their roles, rights, and responsibilities; and how to carry out these responsibilities.</p> <p>12. Adaptability The collaborative group has the ability to sustain itself in the midst of major changes, even if it needs to change some major goals, members, etc., in order to deal with changing conditions.</p>
D. Communication	<p>13. Open and frequent communication Collaborative group members interact often, update one another, discuss issues openly, and convey all necessary information to one another and to people outside the group.</p> <p>14. Established informal and formal communication links Channels of communication exist on paper, so that information flow occurs. In addition, members establish personal connections – producing a better, more informed, and cohesive group working on a common project.</p>
E. Purpose	<p>15. Concrete sustainable goals and objectives Goals and objectives of the collaborative group are clear to all partners, and can realistically be attained.</p> <p>16. Shared vision Collaborating partners have the same vision, with a clearly agreed upon mission, objectives and strategy. The shared vision may exist at the outset of the collaboration; or the partners may develop a vision as they work together.</p> <p>17. Unique purpose The mission, goals or approach of the collaborative group differ, at least in part, from the mission and goals or approach of the member organisations</p>
F. Resources	<p>18. Sufficient funds The collaborative group has adequate, consistent financial base to support its operations.</p> <p>19. Skilled convener The individual who convenes the collaborative group has organising and interpersonal skills, and carries the role with fairness. Because of these characteristics (and others), the convener is granted respect or ‘legitimacy’ from the collaborative partners.</p>

**APPENDIX – II: FIVE-DIMENSION SEVENTEEN-INDICATOR COLLABORATION
SCALE (Thomson, Perry & Miller, 2014)**

DIMENSION	OPERATIONALIZATION
A. Joint decision making	<p>1. Partner organisations take your organisation's opinion seriously when decisions are made about the collaboration</p> <p>2. Your organisation brainstorms with partner organisations to develop solutions to mission-related problems facing the collaboration.</p>
B. Administration	<p>3. You, as a representative of your organisation in the collaborations role, understand your organisation's roles and responsibilities as a member of the collaboration.</p> <p>4. Partner organisation meetings accomplish what is necessary for the collaboration to function well.</p> <p>5. Partner organisations (including your organisation) agree about the goals of the collaboration.</p> <p>6. Your' organisation's tasks are well coordinated with those of other partners</p>
C. Autonomy	<p>7. The collaboration hinders your organisation from meeting its own organisation's mission</p> <p>8. Your organisation's independence is affected by having to work with partner organisations on activities related to the collaboration.</p> <p>9. You, as a representative of your organisation, feel pulled between trying to meet both your organisation's and the collaboration's expectations.</p>
D. Mutuality	<p>10. Partner organisations (including your organisation) have combined and used each other's resources so that all partners benefit from collaborating.</p> <p>11. Your organisation shares information with partner organisations that will strengthen their operations and programs.</p> <p>12. You feel that what your organisation brings to the collaboration is appreciated and respected by partner organisations.</p> <p>13. Your organisation achieves its own goals better working with partner organisations than working alone.</p> <p>14. Partner organisations (including your organisation) work through differences to arrive at win-win solutions.</p>

E. Trust	<p>15. The people who represent partner organisations are trustworthy.</p> <p>16. My organisation can count on each partner organisation to meet its obligations to the collaboration</p> <p>17. Your organisation feels it worthwhile to stay and work with partner organisations rather than leave.</p>
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APPENDIX – III: **STRUCTURATION MODEL OF COLLABORATION** (D'Amour et al, 2008)

DIMENSION	INDICATOR	DESCRIPTION
A. Shared Goals and Vision	1. Goals	Professional values in the form of common goals, with particular reference to the consensual and comprehensive nature of the goals.
	2. Client-centred orientation vs. other allegiances	Symmetry and convergence of partners' interest towards the client needs, overrides individual organisational or private interests.
B. Internalisation	3. Mutual Acquaintanceship	Professionals must know each other personally and professionally if they have to develop a sense of belonging to a group and succeed in setting common objectives.
	4. Trust	Collaboration is possible when professionals have trust in each other's competences and ability to assume responsibility
C. Governance	5. Centrality	The existence of clear and explicit direction that is meant to guide action, Towards collaboration.
	6. Leadership	Shared leadership – all partners must be able to have their opinions heard and to participate in decision making
	7. Support for innovation	Collaboration cannot hold without a complimentary learning process and without the organisations involved drawing on internal and external expertise to support this learning process.
	8. Connectivity	Refers to the fact that individuals and organisations are interconnected, that there are places for discussion and constructing bonds between them.
D. Formalisation	9. Formalisation tools	Formalisation allows the collaborative group to clarify the various partners' responsibilities and negotiate how responsibilities are shared. Key tools include: inter-organisational agreements, protocols, information systems etc.

	10. Information exchange	Refers to the existence and appropriate use of an information infrastructure to allow for rapid and complete exchange of information between professionals.
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APPENDIX IV - Framework and Questions to guide Interviews

Project Title: the Feasibility of Clinical Networks in Nigeria

Investigator: Dr Tarry Asoka

(A) Collaborative Formation, Structuring and Activities

1. What sort of HIV/AIDS services does your organisation provide?
2. Are you aware of any other organisations that provide similar or related services in your locality (Local Government Area or Senatorial District)?
3. What specific projects or issues have you worked (or are you working) with any of these organisations?
4. Was (or is) the relationship formalized through some mechanisms such as: terms of reference, protocols, memorandum of understanding, externally recognized purpose, interorganisational agreements, information systems etc? And is this relationship continuous or just ad hoc?
5. What do you feel are the important goals for working together on these specific projects or issues?
6. How was membership of this project group decided? And should any other organisations have been included? Why?
7. Was there one organisation or person who was instrumental to the formation of this project group? Did they continue to drive the process?
8. Did any external body (e.g. State Government or National Agency) dictate any aspects of the project membership structure?
9. How and why did your organisation get involved?
10. What is it that your organisation stands to gain or lose by your participation?

(B) Collaborative Processes and Maintenance

1. Questions about joint project operations: meetings and their frequency, sub-committees or working groups, communication between meetings, responsibility for coordination and setting up meetings, decision making process. And what have been the key agenda items for the project?
2. Do professionals in participating organisations know each other personally and professionally? And what are the mechanisms for exchange of information between professionals?
3. Are there particular issues that have been a source of tension for some participating organizations or individual professionals? And how were they (or are they being) resolved?
4. What factors tend to bring and /or keep participating organisations and individual participants to be more committed to collaborative actions?

(C) Collaborative outcome

1. What has the project group been able to achieve (or failed to achieve) by working together? And how has this affected care for HIV/AIDS patients?
2. Is there a shared ownership of the results? How and why was your organisation critical to the achievement of the project group?
3. Has your organisation benefited in any way? Has some participating organisations benefited more than others?

APPENDIX V - List of Persons Interviewed

S/No	CODE	Designation	Organisation
Ahoada HIV/AIDS Programme Cluster			
1.	A1	ART Site Coordinator – Cluster Chairman	Medical Officer, General Hospital, Ahoada
2.	A2	FBO Focal Person – Cluster Secretary	Seventh Day Adventist Church
3.	A3	LGA Action Committee on AIDS (LACA) Manager	Ahoada East LGA
4.	A4	Medical Records Officer	General Hospital, Ahoada
5.	A5	Laboratory Scientist	General Hospital, Ahoada
6.	A6	Coordinator support group	Udhur-Gbushi Support Group, Ahoada
7.	A7	FBO Focal Person	First Baptist Church, Ahoada
8.	A8	HIV Counselling and Testing (HCT)	General Hospital, Ahoada
9.	A9	Prevention of Mother To Child Transmission (PMTCT) Focal Person	General Hospital, Ahoada
10.	A10	Focal Person for OVC, Ahoada	Rivers of Hope
11.	A11	Pharmacists	General Hospital, Ahoada
12.	A12	Focal Person for OVC, Abua/Odual LGA	Kupe Foundation
13.	A13	TB Supervisor	TB Control programme, Ahoada East LGA
14.	A14	Focal Person	Primary Health Care Centre, Ahoada
15.	A15	Chief Medical Officer in-charge	General Hospital, Ahoada
Bori HIV/AIDS Programme Cluster			
16.	B1	ART Focal Person –Cluster Chairman	Laboratory Scientist, General Hospital, Bori
17.	B2	Peer Counsellor - Cluster Secretary	Support Group
18.	B3	Medical Officer (on National Youth Service)	General Hospital, Bori
19.	B4	LGA Action Committee on AIDS (LACA) Manager	Khana LGA
20.	B5	Support Group Coordinator	Bori Support Group
21.	B6	Prevention of Mother To Child Transmission (PMTCT) Focal Person	General Hospital, Bori
22.	B7	HIV Counselling and Testing (HCT) Focal Person	Pope John Paul Hospital, Eeken
23.	B8	ART Doctor	State Ministry of Health

24.	B9	HIV Counselling and Testing	General Hospital, Terabor
25.	B10	Pharmacist (on National Youth Service)	General Hospital, Bori
26.	B11	Medical Records Officer	General Hospital, Bori
27.	B12	TB Laboratory	General Hospital, Bori
28.	B13	Pharmacist (on National Youth Service)	General Hospital, Bori
29.	B14	Counsellor	
30.	B15	Volunteer	
31.	B16	Chief Medical Officer in-charge	General Hospital, Bori
State Level			
32.	S1	State HIV/AIDS Programme Coordinator	State Ministry of Health
33.	S2	Executive Director	State Agency for AIDS Control
34.	S3	Technical Adviser to Commissioner of Health on HIV/AIDS	State Ministry of Health
National Level			
35.	N1	Head, HIV Treatment,	Federal Ministry of Health
36.	N2	Deputy Director, Programme Coordination	National Agency for AIDS Control
Global Fund Programme Managers			
37.	P1	Programme Officer, Rivers State	Family Health International (FHI)
38.	P2	Programme Coordinator, Rivers State	Hygeia Foundation

APPENDIX VI - List of Key Documents Reviewed

1. *Africa Health* (Nigeria Edition) – January 2012 to March 2014
2. Federal Republic of Nigeria (2004) *Constitution of the Federal Republic of Nigeria, 1999 CAP. C23 L.F.N.* Abuja: Federal Republic of Nigeria
3. Drivers of Change (DOC) Analysis of Nigeria (Heymans and Pycroft, 2003)
4. Federal Ministry of Health (FMoH) (2004a) *Health Sector Reform Program: Strategic Thrusts and Log Framework*, Abuja: Federal Ministry of Health
5. Federal Ministry of Health (2004b) *Revised National Health Policy*, Abuja: Federal Ministry of Health
6. Federal Ministry of Health (2010a) *National Strategic Health Development Plan (NSHDP) 2010 – 2015*. Abuja: Federal Ministry of Health
7. Federal Ministry of Health (2010b) *National Guidelines for HIV and AIDS Treatment and Care in Adolescents and Adults*, Abuja: Federal Ministry of Health
8. Federal Ministry of Health (2012) *Proceedings of 55th National Council on Health*, Abuja: Federal Ministry of Health
9. Minutes of Ahoada Cluster Coordination Meetings (February 2011 to July 2012)
10. Minutes of Bori HIV/AIDS Programme Coordination Meetings (January 2010 to August 2011)
11. National Agency for the Control of AIDS (2009) *National Policy on HIV/AIDS*, Abuja: National Agency for the Control of AIDS
12. Nigeria Academy of Science's Strengthening Health Systems in Nigeria (Odubanjo et al, 2009) Nigeria Health Sector Political Economy Report (Anyebe et al, 2005)
13. Federal Republic of Nigeria (2014) *National Health Act CAP. X. XX*. Abuja: Federal Republic of Nigeria
14. Norwegian Agency for Development Cooperation - NORAD's Good Governance in Nigeria (Amundsen, 2010),

15. Overseas Development Institute (ODI)/UNICEF Nigeria's Social Protection in Nigeria (Holmes et al, 2012)
16. Rivers State Agency for the Control of AIDS (2009) *Rivers State HIV/AIDS Strategic Plan 2010 – 2015*. Port Harcourt: RIVSACA
17. Rivers State Ministry of Health (2009) *Rivers State HIV/AIDS Control Programme: The Health Sector Strategic Plan 2010 – 2012*. Port Harcourt: Department of Public Health

APPENDIX VII: MATRICES OF DATA SETS

S/No.	Attribute /Issues	Ahoada HIV/AIDS Programme Cluster	Bori HIV/AIDS Programme Cluster
<i>A</i>	<i>Cluster Identification</i>		
1.	Location (Local Government Area)		
2.	Date started		
3.	Contact (focal) person		
<i>B</i>	<i>Cluster Membership</i>		
1.	Number of members		
2.	Categories of members (professionals, units, facilities, and organisations)		
3.	HIV/AIDS services provided (prevention, treatment, support)		
4.	Membership Register		
<i>C</i>	<i>Cluster Activities</i>		
1.	Venue of cluster meetings		
2.	Date of meetings (frequency)		
3.	Officers of the Cluster (Chairman, Secretary, Treasurer)		
4.	Communication channels through which meetings are convened – invitation letter, e-mail, text message etc.		
5.	Responsibility for setting up cluster meetings		
6.	Sub-committees or working groups (standing or ad hoc)		
7.	Agenda items (key issues discussed at cluster meeting)		
8.	Decision making process during cluster meetings		
9.	Communication with members in-between meetings		
9.	Communication among members outside the cluster meetings (and the means)		
10.	Funding of meetings and other cluster activities		
11.	Facilitation at cluster meetings and other cluster activities		
12.	Training, workshops or conferences (in-house or outside)		
13.	Social activities other than core cluster activities		
<i>C</i>	<i>Cluster Members' Characteristics, Activities & Relationships</i>		
1.	Types of HIV/AIDS service providers		
2.	Representation in the cluster		

3.	Key roles in the cluster		
4.	Knowledge of other cluster members (personally and professionally)		
5.	Interactions with other cluster members (formally and informally)		
4.	Key interests for participation in cluster activities		
5.	Benefits derived from cluster membership and participation		
6.	Challenges encountered due to cluster membership and participation		
7.	Areas of missed opportunities		
8.	Expectations for the future		
9.	Funding of cluster member activities		
<i>D</i>	<i>External Linkages (links and Relationships)</i>		
1.	Base-hospital hosting the ART Centre		
2.	Local Government Action Committee on AIDS (LACA)		
3.	Local Government Area - Health Department		
4.	Rivers State Ministry of Health		
5.	Rivers State Agency for Control of AIDS (SACA)		
6.	Federal Ministry of Health		
7.	National Agency for the Control of AIDS (NACA)		
8.	The Global Fund – Programme Managers		
9.	Other Organisations		
<i>E</i>	<i>Cluster Achievements</i>		
1.	Number of persons on ARV, default rate etc.		
<i>F</i>	<i>Other Matters</i>		
1.	Specific features		
2.	Other issues		