Evidence-Based Management: Panacea or Placebo? Insights from Nigerian HIV/AIDS Service Delivery

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New Public Management revolutionized the study of management, but increasingly, practitioners and academics focus on what is called evidence-based management (EBMgt) and new public service. Evidence-based management can be defined as the manner in which organizations utilize data and information to inform decision-making processes and shape managerial practices. This research explored how the Nigerian public health delivery is shaped to address the origins and consequences of changes in managerial practice. It is organized around the notion that organizational performance, specifically service delivery, has two aspects: organizational technology (e.g., leadership techniques) and organizational capacity. The hypothesis in this research is that an organization that adopts an evidence-based management grounded in principles of new public service is better at service delivery. This is due to the shared vision, collaboration, and citizen-centered principles that result in more sustainable impact, provided an organization has the necessary capacity.

This research study used desk research, supplemented by pilot surveys and interviews of seven respondents from six different nongovernmental organizations in Abuja, Nigeria. Through qualitative interviews, themes centered around the incorporation of leadership, staffing capacity, funding streams, and evidence-based approaches to clinical care were assessed in order to understand how HIV/AIDS services are delivered. In addition, respondents were given a quantitative survey that was two-pronged. This first part of the survey assessed the interpersonal

working relationships that respondents have with their managers as well as aspects of the work environment that either positively or negatively affect them. The second aspect looked at the extent to which staff in these organizations incorporate clinical best practices in their job functions.

This study revealed that most organizations incorporate evidence-based management in their daily functions. Excluding the use of data from monitoring and evaluation teams or surveys, most organizations do not have a methodological approach for providing prevention, treatment, and support services to key populations. Nevertheless, the responses from respondents prove that effective organizational technology (i.e., the use of an organization's systems and processes) is not predicated on one preferred leadership style. Rather, evidence-based management when coupled with a host of other factors – sustainable funding, a positive work environment, value sharing, collaboration, and policy setting – can strengthen the manner in which organizational technology can create sustainable impact.

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List of Abbreviations

AIDS - Acquired Immunodeficiency Syndrome

ARFH – Association of Reproductive and Family Health

ASHWAN – Association of Women Living with HIV/AIDS

aRT - Antiretroviral Therapy or Antiretroviral Treatment

CCB - Community Collaborative Board

CEBHA+ - Collaboration for Evidence-Based Healthcare and Public Health in Africa

CRH – Centre for the Right to Health

CVF – Competing Values Framework

EBMgt - Evidence-Based Management

eMTCT - Elimination of Mother-To-Child Transmission

FCT - Federal Capital Territory

HIV - Human Immunodeficiency Virus

HRM - Human Resource Management

HSDF – Health Strategy and Delivery Foundation

iCCM - Integrated Community Case Management

ICPC - Independent Corrupt Practices and Other Related Offences Commission

IRB - Institutional Review Board

KPIs – Key Performance Indicators

LBTQ+ - Lesbian, Gay, Bisexual, Transgender, Queer/Questioning and "plus"

LMIC - Low and Middle-Income Countries

MSM - Men who have sex with men

NACA - National Agency for the Control of AIDS

NASCP - National AIDS and STI Control Program

NGOs - Non Governmental Organizations

NPM - New Public Management

PICOC - Patient Intervention Comparison Outcome and Context

PLHIV - People Living with HIV

PLWHA - People Living with HIV/AIDS

PMTCT - Prevention of Mother-To-Child Transmission

PrEP - Pre-Exposure Prophylaxis

PWID - People Who Inject Drugs

SACA - State Agency for the Control of AIDS

SASCP - State AIDS and STI Control Program

SERVICOM - Service Compact with All Nigerians

SFH – Society for Family Health

UNAIDS - Joint United Nations Programme on HIV/AIDS

USAID - United States Agency for International Development

WHC - Women's Health Co-Op

WSW - Women who have sex with women

Dedication

This is dedicated to my mother, father, brother, family, and friends that have supported me throughout my academic journey. Furthermore, this dissertation is dedicated to those in my academic and professional circle that have supported my growth as an emerging scholar and practitioner.

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1.0 Introduction

In this dissertation study, I will examine whether an evidence-based management framework is a panacea or placebo to HIV/AIDS service delivery in Nigeria. In Chapter Two of this dissertation, I explore the history of HIV/AIDS in the Nigerian context and the various national approaches that have been undertaken by the government at both the national and local levels. In addition, I also examine the adult HIV/AIDS prevalence rate and the inequalities that affect key populations – who account for 32% of new infections in Nigeria (NACA, 2017). These vulnerable groups include commercial sex workers, people who inject drugs, men who have sex with men/women who have sex with women, etc. In this chapter, information flow is analyzed as it relates to how people make judgements. Moreover, the ability for employees to support or oppose an idea is also assessed since information flow can sometimes be asymmetric, especially when there is a lack of awareness in regard to what is happening in the organization. As a result, it is critical that there is an approach for collecting key information and data in an organization. Evidence-based management is a framework that can be used to ensuring that decisions that are made in healthcare are the best fit for not just the organization alone, but also for the people being served.

Rehfuess et al. (2015) suggest that an evidence-based management (EBMgt) approach to addressing HIV/AIDS services is a best practice in public health. In this chapter, I explore the different ways in which EBMgt disrupts the tendency for organization silos to occur among different actors and stakeholders. As a tool that can be used by nongovernmental organizations, I recognize that evidence-based management can strengthen the decision-making ability of a manager which in turn leads to better organizational outcomes. Nevertheless, positive

organizational outcomes are also predetermined on several conditions. In chapter 2, I examine the different schools of thought in public administration and provide an in-depth look into the different components of service delivery – specifically, human resources management and funding.

Chapter Three of this dissertation spotlights two comparative perspectives in public administration: new public management (NPM) and new public service. New public management, an approach to running public service organizations focuses on "creating greater responsiveness to customers, developing organizational structures which encourage innovation and competition, strengthening incentives for performance and creating more output-oriented systems" (Bennett and Muraleeharan, 2000, p. 2). Although, the use of NPM leads to organizations that are able to meet performance metrics, it does not necessarily translate to them having a shared sense of value with community groups, especially key populations that are often neglected during service delivery. In addition, it also does not counteract biases and discrimination that some frontline health workers may have when dealing with vulnerable groups such as commercial sex workers. In this chapter, I posit the notion that a new public management approach for HIV/AIDS service delivery is not suited for the Nigerian setting due to system corruption and the use of public service positions as a tool for pursuing an individual's self-interest. Thus, there ought to be a paradigm shift when it comes to using a framework that cannot only optimize service delivery, but also foster collaboration in an effort to serve the needs of citizens. New public service is a more suitable approach to HIV/AIDS service delivery in Nigeria. Under the new public service approach, stakeholders create programs and policies that put the interests of the citizens at the center. Moreover, they work collaboratively and define their values, missions, and goals., all of which contribute to a shared sense of purpose (Denhardt and Denhardt, n.d.).

Having a shared sense of purpose in a system made up of different stakeholders is important to ensuring that each actor can rally behind a shared vision. This shared vision also does not require a separation of third sector (civil society actors) from the government. Rather, they work alongside the local and federal government in brokering, negotiating, and providing conflict resolutions. In this chapter, I point out to the fact that the new public service approach facilitates a sense of trust and accountability in service delivery. This is quite a stark contrast from the NPM framework which supports inter-organizational competition amongst multiple actors. I cite the work of Fletcher (2001) in pointing out that NPM is akin to task performance whereas new public service involves creating an enabling environment that enables an organization to thrive in its ecosystem. In this chapter, I point out the public distrust of government and how it presents an opportunity for NGOs to step in (Leonard and Leonard, 1999).

Reaching their target constituencies involves the effective use of human capital. In this chapter, I examine the various determinants of worker motivation and employee satisfaction. They include adequate compensation, optimal work environments, manager-employee relations, etc. In an effort to meet expectations, NGOs must ensure that they have sustainable financing mechanisms in order to scale impact. On the other hand, liquid capital can also be used as a powerful means of improving the inter-organizational and intraorganizational workings of an NGO through continuous improvement, lean management, and the strengthening of organizational technology. In Chapter Four, I explore the role of organizational technology in creating sustainable impact. I do so by interviewing the representatives of six different HIV/AIDS organizations based in Abuja.

Chapter Four of my dissertation focuses on how organizational technology can be used as a tool for achieving efficient service delivery and sustainable impact. I begin this chapter by looking at ethical management of HIV/AIDS and how NGOs can foster therapeutic citizenship by

facilitating benefits that citizens might not have access to (Smith, 2012). When organizations ethically manage their programs, they tend to shy away from pursuing their own self-interests. Rather, they focus on how they can utilize their organizational processes to improve service delivery. In this chapter, I spotlight six organizations in Abuja that were selected based on the services provided, funding, demographics, time since inception, and stakeholders within their ecosystem. Practitioners in these organizations were interviewed in order to understand how their respective organizations are using organizational technology – organizational processes, leadership, supply chain management, funding and advocacy – to deliver HIV/AIDS programs and services. Furthermore, I also identify some of the challenges that organizations experience in achieving their long-term goals.

2.0 An Evidence-Based Management Approach to HIV/AIDS in Nigeria

2.1 Introduction

Globally, 37.9 million people are living with HIV, and 21% of people do not know that they have the virus. Africa is home to 69% of new HIV infections, as well as the 91% of HIV positive children (UNAIDS, 2020). Nigeria, the most populous country in Africa has the second largest epidemic in the world (UNAIDS, 2020). The United Nations estimates that Nigeria is set to have the third highest population in the world. Therefore, efforts must be put in place to alleviate the HIV/AIDS epidemic for vulnerable groups of people.

In Nigeria, the National HIV and AIDS Strategic Framework seeks to diagnose 90% of all HIV/AIDS positive individuals so that they can receive the necessary treatment (NACA, n.d). Achieving this involves assessing various aspects of service delivery such as supply chain management, funding, advocacy, organizational processes, organizational leadership, preventive and treatment services. The sum of these individual factors constitutes evidence-based management (EBMgt), which can be used to shape an organization's outcomes. When incorporated within and across nongovernmental organizations, this approach can inform decision-making by aggregating and appraising key information, facts, or data and juxtaposing it from various sources: literature, practitioners, stakeholders, and organizations. In the Nigerian context, EBMgt can be used to challenge preconceived, which in turn promotes a diversity of thought in value-based and mission-centered organizations catering to the needs of key populations.
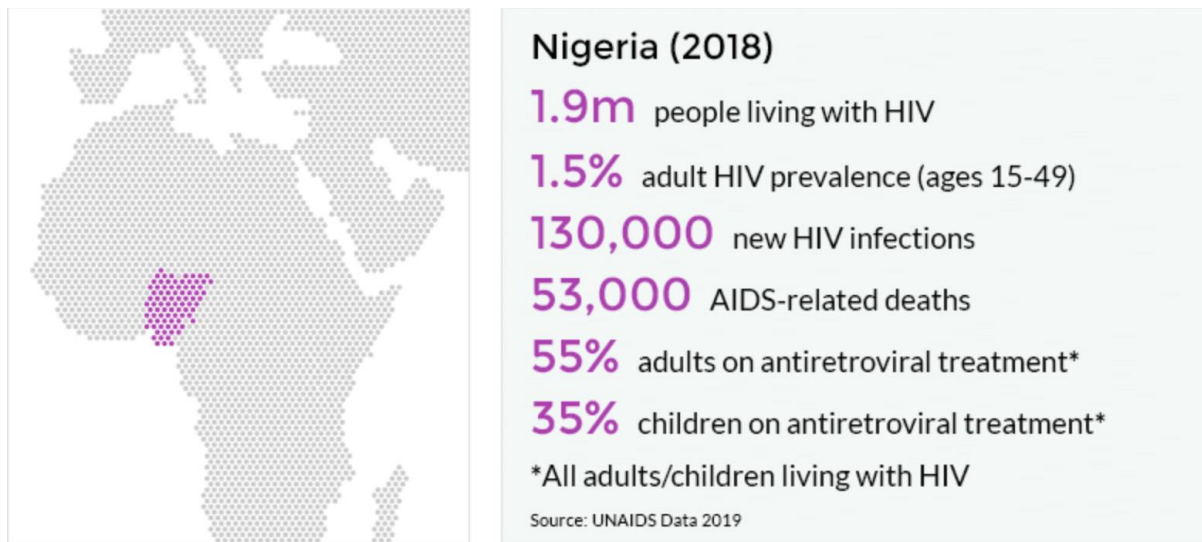
Figure 1 HIV/AIDS - Nigeria Profile
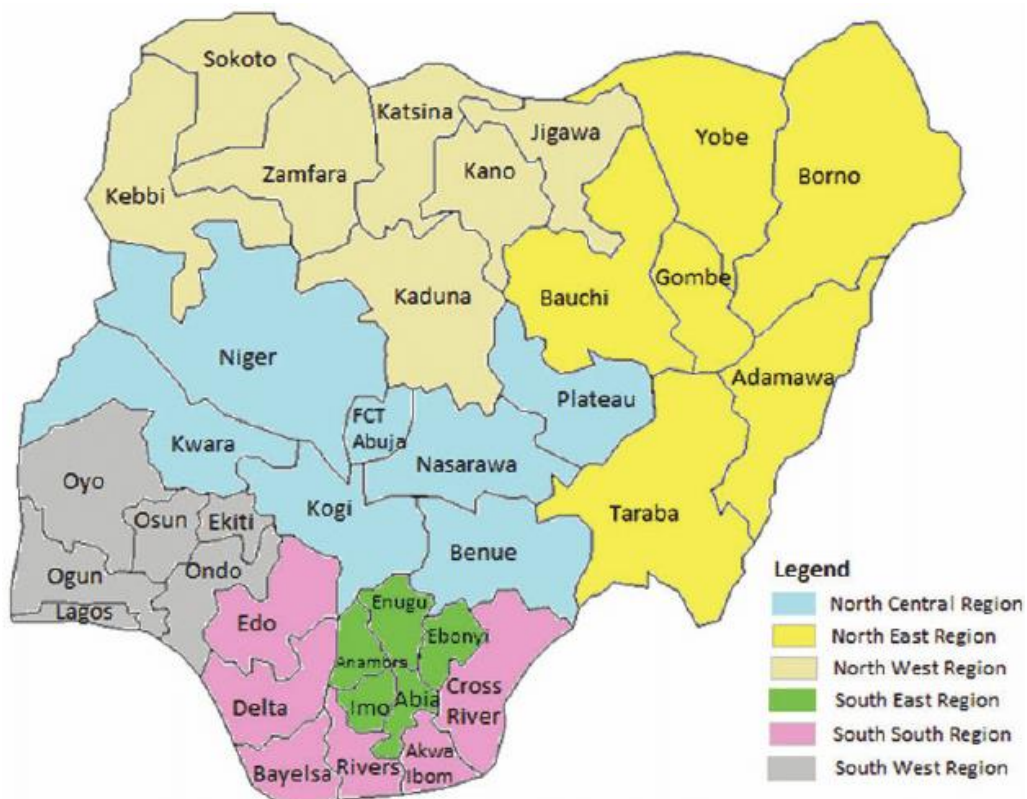
Figure 2 Map of Nigeria

Source: (Gayawan et al., 2014)

As of 2019, it was estimated that 1.8 million Nigerians were living with HIV. With an adult HIV/AIDS prevalence rate (15-49) of 1.4%, Nigeria still has a long way to go in its fight against AIDS. Nigeria's HIV adult prevalence rate has reduced from approximately 6% in 2001 to 1.4% at the end of 2020. Furthermore, 68% of adults with HIV are on antiretroviral treatment (aRT), while only 36% of children are on aRT (UNAIDS, 2020). Six states primarily account for 41% of the persons living with HIV/AIDS (PLWHA). They are: Kaduna, Akwa Ibom, Benue, Lagos, Oyo, and Kano (see Figure 1.0).

The low prevalence rate of HIV does not mean that Nigeria is better than most countries when it comes to tackling the HIV burden. As a matter of fact, Nigeria has the highest rate of new infections based on the number of people that are aware of their status; and it also has the second-largest HIV epidemic in the world (UNAIDS, 2020). It is estimated that 50% of Nigerians with HIV do not know their status, and among the adult population that is aware of their positive diagnosis, only 89% of them are accessing antiretroviral treatment (UNAIDS, 2020). Moreover, there is also no concrete data on the percent of those whose HIV conditions are virally suppressed.

NIGERIA — New HIV infections by age and sex (2017)

Children and adults
36,000 — 170,000
Children (0 - 14) | Adults (15+)

Adolescents
28,000 — 19,000
Adolescent female (10 - 19) | Adolescent male (10 - 19)

Young people
45,000 — 38,000
Young female (15 - 24) | Young male (15 - 24)

Source: UNAIDS Data 2018

Avert⟩ www.avert.org
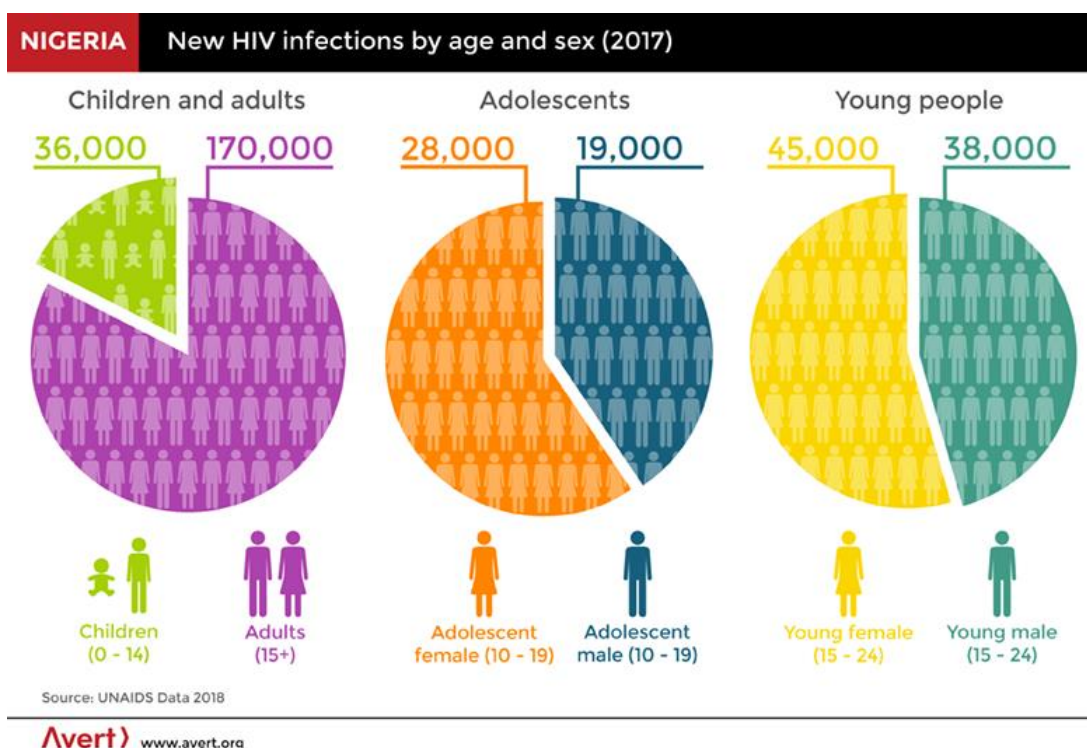
Figure 3 HIV Infections by age and sex

In comparison to the rest of the population, certain groups tend to have a higher HIV burden. These groups include: commercial sex workers (CSWs), sexual minorities, and people who inject drugs (PWID). In addition, women (Figure 3.0) and children tend to be disproportionately affected by the HIV virus as compared to their heterosexual male counterparts. In 2016, public health statistics revealed that 14.4% of sex workers were living with the virus. Despite the high prevalence rate in this group, data collected by NACA (2017) and UNAIDS (2017) shows that 98.1% of commercial sex workers reported using condoms with their last sexual partner and 97.1% of them received a HIV test in the last 12 months (NACA, 2017; UNAIDS, 2017). In a public health behavior study, some of these individuals reported using a condom with their last partner; however, it is unclear if such accounts are true and what the percentage of CSWs living with HIV are seeking treatment. One of the major reasons why female sex workers are less

likely to seek treatment stems from sex work being illegal in Nigeria (Ankomah et al., 2012). They are apprehensive of what the legal consequences of their actions could be. In some cases, being caught by law enforcers can lead to them appeasing the police either through money or sex, and those that refuse to do so can be raped and be more susceptible to HIV.

PWID are also susceptible to HIV since they share needles and syringes. This increases their chances of contracting the virus since drug use has been shown to impair judgment and lead to sexual risk behaviors. The average age of drug use in the country is 15 years which means that people younger than 15 years are equally at risk of contracting the virus. The risk of contracting other STIs also varies for PWID who consummately use drugs, with amphetamine users being the most at-risk (Iriaye et al., 2014).

Sexual minorities such as women who have sex with women (WSW) and men who have sex with men (MSM) also have a high risk of contracting HIV. In Nigeria, laws such as the Same Sex Marriage Prohibition Act criminalize the behaviors of LGBTQ+ members of the society and make it hard for them to seek care which reduces their access to Pre-exposure prophylaxis (PrEP) and antiretroviral drugs. The mere act of requesting access to care does not mean that such services are guaranteed since the decision still falls at the discretion of the healthcare worker. A public opinion poll of Nigerian healthcare professionals revealed that only 30% of healthcare professionals believe that these sexual minorities should have access to health care (NOI Poll, 2016). Thus, stigma not only poses a barrier to prevention, but also stifles access to essential treatment and care for key (vulnerable) populations.

These vulnerable groups account for more than 32% of new infections in Nigeria (NACA, 2017). They are integrated into different parts of the social fabric and it is important that policies and services that are aimed at tackling the spread of the disease are inclusive of them in the design

and implementation stage. Such an approach would enable specific interventions to be created that can cater to their respective needs.

2.2 History of HIV/AIDS in Nigeria

The first case of HIV/AIDS in Nigeria was recorded in 1985 (Balogun, 2010). Two cases of a 13-year-old sexually active girl and a female commercial sex worker were recorded in Nigeria, in the Southern states of Lagos and Enugu (Balogun, 2010). During the late 20th century, Nigeria's HIV/AIDS prevalence rate had steadily increased. In 1991-1992, 1993-1994, 1995-1996, the nation recorded a prevalence rate of 6.2%, 8.2%, and 11% respectively (p. 168). Throughout the past three decades, some statistics did not change. For example, HIV was more prevalent in individuals between the ages of 25-29, and the majority of infections were women. Other factors that were responsible for the spread of the disease included: "high prevalence/presence of untreated STDs among many Nigerians, high prevalence of tuberculosis, and lack of male circumcision among some Nigerian groups." (Balogun, 2010, p. 169). In some rural communities, there was also the belief that sleeping with virgins was a solution for the virus, and this led to an increased prevalence rate among women.

Health research has shown that throughout the years there is a high percentage of people in Nigeria with good and accurate knowledge of the epidemic (Anochie & Ikpeme, 2003; Dalhatu et al., 2016; Ogbuji, 2005). However, an awareness of effective behavior and practices does not translate to positive healthy behaviors or even behavior change (Entonu & Agwale, 2007). Although knowledge has been identified as a positive tool for positive change in all aspects of human endeavor, there are knowledge gaps when it comes to people's abilities to implement such

knowledge. For example, in the '80s and '90s, people traditionally had several misconceptions about both the virus and disease. These misconceptions were held primarily by those with little education. Nevertheless, there was also a significant proportion of the population - who were educated - that believed that AIDS was a "retribution from God for promiscuity and believed that casual contacts could transmit the virus from an infected person to a healthy one" (Deshi, 1987).

Throughout the subsequent decades, knowledge about HIV/AIDS and sexual practices has increased. However, outcomes have not necessarily improved. Ogbuji (2005) highlights that 90% of university students in Ibadan, Nigeria had good knowledge about the disease and its transmission. In a survey of 217 students, only fifty-nine of them attested to being sexually active and among that group, and only nine had admitted to using a condom three months before the study. This suggests that although there was knowledge on how the virus could be contracted, personal preferences took precedence over scientific evidence. People were less likely to use condoms since they "hinder their sexual satisfaction, cause health problems and reduce their sexual interest" (Ogbuji, 2005). As a result, the attitudes of health professionals during the HIV/AIDS service delivery process are important.

Ohnishi et al. (2008) explore the attitudes that caregivers and non-givers in the community have surrounding AIDS and how that impacts service delivery. They present a plethora of factors that lead to positive attitudes towards care of orphans living with HIV/AIDS. These factors include age, koranic schooling, polygamy, belief that there are increasing orphans in the community, and having relatives or friends with HIV/AIDS. The researchers deduced that people who had lower educational status did not have optimal knowledge of HIV/AIDS. On the other hand, younger people, especially younger women tend to have more positive attitudes toward vulnerable populations affected by the virus. Ohnishi et al. (2008) point out that caregivers must be aware that

there is no association between their religious affiliation and changes in preventive behavior. Therefore, it is critical that interventions designed to combat the HIV/AIDS epidemic are structural interventions since the presence of knowledge does not lead to behavior modifications on the individual level.

Balogun (2010) examines the spread of HIV/AIDS in Nigeria by classifying the national response to HIV/AIDS under two eras: 1986-2001 and 2001 - 2007. In 1986, the Ministry of Health's response to HIV/AIDS included the establishment of an 18-Member National Experts ÓAdvisory Committee on AIDS (NECA) whose goals were set to assess the situation on the ground. NECA was later replaced by the National AIDS Control Programme (NACP) in 1988. In 1992, the government launched a national war against AIDS and recognized the intersection between HIV/AIDS and other sexually transmitted infections. This led to a merger that forged the National AIDS and STI Control Programme (NASCP) with each state having its own state AIDS and STI Control Programme (SASCP) (Udoidiong, 2008, p. 171).

NASCP was the precursor for the National Action Committee on AIDS (NACA). In 2007, NACA emerged following an endorsement from the National Council on Health on the need for a multi-sectoral approach to address the national struggle against HIV/AIDS. As a result, "the mandate for NACA is to spearhead "the overall coordination and direction of HIV/AIDS expanded responses of all sectors and at all levels in Nigeria including collaboration with international bodies" (Udoidiong, 2008, p. 171). As part of its approach, NACA works with civil society, faith-based coalitions, business coalitions, and youth networks to combat the HIV epidemic in Nigeria. It is also decentralized and includes operations at the state level – i.e., state action committees, and local action committees on AIDS (LACAs) – in its effort to combat HIV/AIDS.

Balogun (2010) posits that a deep dive into some of the adaptive challenges hindering progress on HIV goals in Nigeria reveals issues surrounding AIDS stigmas, discrimination, and exclusion. In 2005, NACA joined forces with the Federal Ministry of Labour, and Productivity to create a National Workplace Policy on HIV/AIDS. This was modeled after the International Labour Organization that stressed the need for places of work to promote human rights, social justice, and equity in their operational practices. Nonetheless, the federal government did not have a strategic plan that it planned on utilizing in its efforts to protect human rights, instill justice and protection for people living with HIV/AIDS.

The National HIV and AIDS Strategic Framework (2017 - 2021)

The National HIV and AIDS Strategic Framework was set up to ensure the health and well-being of PLWHA, and to also address the high HIV burden in the country by instituting a sustained and effective national response to prevent new HIV infections. The plan seceded the 2010-2015 National Strategic Framework, which "provided a structure and plan for advancing the multi-sectoral response to the epidemic in Nigeria" (NACA, n.d, para. 1). The current framework is crucial is because it is designed to incorporate a 90-90-90 strategy: diagnose 90% of all HIV/AIDS cases; provide 90% of all HIV-positive individuals with sustainable antiretroviral therapy, and achieve viral suppression for 90% of people living with the virus.

Its framework is divided into five thematic areas: i. Prevention of HIV among general and key populations, ii. HIV testing services (HTS), iii. Elimination of mother-to-child transmission of HIV (eMTCT), iv. HIV treatment, and v. care (NACA, n.d). The strategic framework also focuses on the importance of strengthening quality management when it comes to delivering services and achieving HIV targets and antiretroviral drug therapy commodities (NACA, n.d). It suggests the need for an advocacy strategy by which HIV management happens through public

and private actors – as well as local, state, and national actors. Despite the existence of this policy, there are not proposed frameworks for effectively leading HIV programs/services through the change process as they reach their respective communities.

2.3 HIV/AIDS Service Delivery In Nigeria

HIV/AIDS in the National Health System

Despite national and international efforts to combat HIV/AIDS in Nigeria, only thirty-three percent of people living with the virus have access to essential medication and treatment. Thus, there is a large number of people that are in need of HIV/AIDS services. Social stigma, discrimination, and punitive laws for marginalized groups also exacerbate the likelihood of not getting tested and seeking treatment. In order for the country to diminish its rate of infection, evidence regarding the nature of service delivery must be gathered and appraised so as to inform stakeholders and strengthen the decision-making process.

The decision-making process can often lead to service delivery challenges especially when resources – or the distribution and management of it – are not optimal. Service delivery issues can arise as a byproduct of poor technical management of HIV/AIDS services, lack of country ownership, ineffective supply chain management systems, and the lack of a sustainability plan. More often than not, there is a disconnect that exists when it comes to integrating HIV/AIDS services into the fabric of the Nigerian health system. This is because of the lack of coordination that exists among the multiple actors who more often than not work in silos. Itiola and Agu (2018) reveal that "the emergency response phase to HIV epidemic in Nigeria and other countries saw to the deployment of donors' resources with little consideration for country ownership (CO) and

sustainability" (p. 1). Despite the availability of these emergency response resources, the initial stage of building a national response to the HIV/AIDS response involved international organizations building programs away from hospitals (Oleribe, 2014). Subsequently, the response intensified due to the rate by which people were getting the virus. However, as the prevalence rate of the virus reduced, a lesser proactive response became the order of the day.

Presently, the HIV epidemic is treated as a "lesser disease" that only affects a select few; thus, the epidemic is not getting as much attention as it should. A research study regarding the role media coverage plays in HIV/AIDS in the multi-sectoral and community-based response to HIV/AIDS shows that there has been a dial down in recent years. This has been characterized by a shift from the cognitive (emphasis on decision-making) model to the activity (individual context) model of HIV/AIDS communication. In order to ensure that more positive outcomes are achieved, there ought to be more of a focus on the disease.

Evidence from literature suggests that a shift in paradigm is needed for Nigeria to attain sustainable HIV programs and services. Oleribe et al. (2014) coin the term 'commonization' that makes the disease relatable to other health ailments. The process of commonization integrates the epidemic into the fray of other health disparities whereby it is "seen as a health condition like others. It involves making HIV services available at all levels of healthcare" (p. 1). The process of commonization is a decentralized one that involves "integrating HIV care into the existing fabric of the healthcare system" (Oleribe et al., 2014, p. 4).

Declassifying HIV/AIDS as a special disease is the first step in designing an essential package of HIV/AIDS; however, this has to be in tandem with more country involvement.

"*Early identification of HIV-positive people in need of care through testing, appropriate initial and continued counseling, assessment of HIV disease stage, treatment with Anti-Retroviral*

Therapy for those who need it, monitoring while on treatment for efficacy, adherence and side-effects, detection and management of other complications of HIV infection, provision of sexual and reproductive health services as well as careful record-keeping" (Oleribe et. al, 2014, p. 12).

The design of treatment, care, and services cannot be heavily reliant on foreign donors. Hence, creating a diverse mix of funding streams would reduce the dependence on non-state actors, which would foster a greater level of country ownership. Nevertheless, these treatments and services cannot simply exist in theory, but translate in practice.

Appropriate budgeting is an effective means of ensuring that HIV programs and services get the financial commitment that they require at the country level. Recently, Nigeria launched an initiative that requires all states of the federation to contribute 1% of their monthly allocations to the national response. In 2019, the Network of People Living with HIV/AIDS called on the "federal government to increase support for people living with the disease in order to place more people on treatment" (Akor, 2019, p. 1). As a whole, Nigeria has witnessed an increase in foreign funding for HIV/AIDS services in light of domestic funding still catching up. In 2012, the President's Emergency Plan for AIDS Relief (PEPFAR) and Global Fund for HIV/AIDS accounted for 43% and 33% of HIV spending respectively while domestic spending accounted for 23% (Itiola and Agu, 2018, p. 8).

The low levels of spending on the part of the Nigerian government has led to ineffective supply chain management. HIV/AIDS practitioners advocate for privatization of the supply chain to establish transparency and accountability. Owing to the fact that government funding only covers the procurement of drugs and does not cover other miscellaneous expenses such as port clearance fees and distribution. Therefore, public health programs ought to achieve sustainability – which is defined as the continuity of a program after the termination of donor(s) support (Itiola

and Agu, 2018). As a result of the health system being rudimentarily weak and the over-dependent on international development partners, it has become the norm for programs to be short-lived. This creates a systemic problem wherein the health system is rudimentarily weak. Therefore, Nigeria's ability to self-finance its health sector would require planning and increased government revenue.

Stronger financing mechanisms cannot solely strengthen health outcomes. This is because there are other barriers associated with delivering HIV/AIDS services that include ineffective inter-organizational management, legal ramifications that criminalize certain sexual minority groups, and low number of care facilities (1,078) - as estimated by Avert in the year 2018 - that provide HIV treatment. Furthermore, user fees associated with getting tested prevent financially vulnerable individuals from not only knowing their status but also from receiving treatment. Tyler & Dickinson (2006) identify some factors that hinder prevention of the disease in the African region (p. 104) and they include: materials never purchased and false claims of treatment, procurement and distribution issues, health workers using non-sterile equipment, exploitation of the sale of ART drug, theft, government corruption. Other factors that perpetuate the corruptive practices include officials increasing budget and siphoning off significant volumes of drugs without public awareness, lack of monitoring and oversight, diversion of funds by ministries, and extortion of funds from health workers. Tyler & Dickinson argue that even when resources are present, there is still the tendency to mismanage them.

Systemic Corruption & Organizational Politics

Delivering effective HIV/AIDS services in the Nigerian NGO landscape is often plagued by issues centered around corruption and organizational politics (Smith, 2010). These two conditions can result in the deprivation of essential drugs/treatments from those in dire need. Corruption is a social and institutional issue that affects the delivery of public goods in Nigeria. In

organizations, it is characterized by people seeking to profit off the system by all possible means. In a global ranking survey of 180 countries, Transparency International ranked Nigeria as the 144th most corrupt nation out of 180 countries. (Transparency International, n.d). Two ethnographic studies reveal that despite Nigerian NGOs "sitting at the nexus of significant processes of social and political change, they are caught up in the social reproduction of inequality, exemplifying how local elites navigate the flow of global aid dollars and the politics of patronage to perpetuate inequality" (Smith, 2012, n. d). The grafting practices that are associated with service delivery make it hard to implement bureaucratic accountability. As a result, it becomes nearly impossible for funding stakeholders to verify whether money has been spent for its actual purpose or the reports being presented have been falsified. Many times, it becomes nearly impossible for funders to distinguish between competent organizations/practitioners and those simply pursuing their self-interests.

In Nigeria, practitioners who pursue their own agenda away from donor goals and interests hope to acquire large sums of money. A 2011 national overhaul of the NGO space by the Independent Corrupt Practices and Other Related Offences Commission (ICPC) revealed that seven HIV/AIDS non-governmental organizations were responsible for fifteen fraudulent grants, in total of $474,519,260 from 2003-2009 (Nnochiri, 2011). These grants were disbursed to well-established government and civil society organizations with headquarters in the capital city. A deeper look revealed that illegal funds were transferred outside the country, and that there were also extra-budgetary and undocumented expenditures. Fraud is ubiquitous in the country that even an audit by the Global AIDS Fund revealed that fraud and collusion by the National Agency of the Control of Aids totaled $3.8 million in 2016 (Avert, 2018). Although the proliferation of AIDS-related NGOs in Nigeria has provided advocacy and employment opportunities for people, it has

also led to the phenomenon of "feeding fat on AIDS" in which some practitioners have been able to acquire wealth beyond their job provisions.

Organizational politics also part of the fabric of HIV/AIDS organizations. These actions which are often behind-the-scenes often lead to some employees being financially better off than their counterparts. Pursuing one's self-interests while being involved in HIV/AIDS can be traced back to the 1990s during the onset of the epidemic, when some service providers used their work as a path to riches. Puis Okadigbo, the Country Program Officer of United against AIDS (UAA) in the 1990s was deemed as "greedy and self-aggrandizing" due to how he flaunted his wealth from earmarked funds. Unfortunately, this led to his demise because he chose to be ostentatious "instead of sharing some of his money to cultivate social ties and build a network of followers" (Smith, 2011, p. 13). It is common practice for people to provide financial benefits as a reward to those who comply with altered reporting and accountability procedures. Moreover, a staunch opponent of everyone in an organization being financially better-off through illicit practices could be committing "career suicide", if he or she explicitly opposes the actions of the majority. This is why clientelism has become pervasive in Nigeria. Clientelism – defined as a political or social system whereby support is given to a patron in lieu of a special privilege or benefit – makes it hard for individuals to speak up against organizational malpractices since they are better off supporting organizational ills.. Conversely, when employees decide to go against the status quo by speaking up, their ulterior motives are questioned since the notion of a "good patron is becoming suspect in Nigeria's changing political economy" (Smith, 2011, p. 13). Consequently, people begin to question good practices and raise eyebrows as to what the interests or motives of others are and whether they are trying to reduce an organization's ability to maintain profit.

Organizations are accustomed to conducting business as usual, which can result in the inexistence (or the lack thereof) of capacity building when it comes to staff skill set acquisition; thus, widening the performance-outcome gap (Smith, 2012). In Nigeria, it is common practice for nongovernmental organizations to deliver HIV services in hospitals and clinics. Therefore, NGOs must interact with these private institutions in their efforts to tackle the epidemic. However, these entities face issues with conducting in-service training of health care workers at the primary health care level since there is no widely utilized framework for providing training to HIV/AIDS personnel in clinics and hospitals who lack the necessary skill set.

The level of ineptitude when it comes to performance outcomes is exacerbated by the existence of an ineffective operational plan regarding human capital. This is made evident by mismatching personnel with constituents that might require certain skills that they do not have. It is often the case that State Commissioners often redirect health personnel to be moved from one facility to another that might be lacking the services/specialties that they were trained in (Abimbola et al., 2016). Moreover, there is also the propensity to allocate high-performing service workers to projects that are likely to succeed. This is primarily due to patient uptake being low or drastically plummeting. However, these workers, in comparison with their low-performing peers are not sent to undesirable areas where the quality of life is bad (Abimbola et al., 2016). Hence, it is usually the case that effective service delivery workers find themselves in urban to suburban areas. This raises concern regarding the distribution of human personnel since it creates an imbalance. This imbalance creates a gap in service provision by which there is a high-concentration of well-trained staff in facilities that offer the best services such as prevention of mother-to-child transmission [PMTCT] and the latest antiretroviral drugs (Abimbola et al., 2016). As a result, there is a density-based clustering of skills across organizations and many staff within nongovernmental

organizations are reluctant to provide capacity building opportunities to workers who can easily rise up the ranks and request a transfer to other facilities.

2.4 Rational Decision Making

Providing services to people living with HIV/AIDS involves making crucial decisions, some of which are based on gut feelings and others on rationality. Rational choice theory can be used to understand the manner in which public health services are delivered. Under rational choice theory, individuals make decisions based on rational calculations. These robust decisions involve rigorous in-depth thinking in order to predict all potential possible future-related outcomes. There are two types of rational choice theory to consider: bounded rationality and the rational model. Under bounded rationality, decision makers do not have access to all the information that they need to make critical decisions. Moreover, there is limited time, analytical, and computational abilities needed to evaluate decisions. As a result of all these limitations, managers are more likely to "satisfice"- by choosing the first alternative that meets or 'satisfies' minimum criteria for solving the problem rather than continuing the search for the optimal solution (McDonough and Rodriguez, 2010). More often than not the, choice of the first alternative is often made without examining other critical evidence.

The rational model is similar to an evidence-based management approach since it follows a similar approach in enabling decision makers to make better informed choices. Decisions are made using "facts and information, analysis, and a step-by-step procedure" (Uzonwanne, 2016). Stakeholders become more consistent in their value-making choices and methodological in their approach by: defining the problem, identifying decision criteria, allocating weights to the criteria,

developing/weighing alternatives, and selecting the best alternative. Evidence-based management can be drawn out from "rational interpretation" and it enables organizations to rely less on subjective opinions and be more objective in their daily practices (McDonough and Rodriguez, 2010; Boundless, n.d). According to Baba and Hakemzadah (2012), an EBMgt framework not only makes decisions more rational, but also gives stakeholders a competitive advantage. This is mainly because management by intuition, the alternative approach to basing decisions on evidence (Gaynard, 2010), is hardly defensible. When managers are not rational, the decisions that they make rely largely on personal experiences or traditional beliefs or weak evidence (Rousseau, 2006). However, managers with reliable information and enough time and resources to make and analyze decisions, act on the basis of logic and evidence, rather than on guesswork and hope (Pfeffer and Sutton, 2006). As a result, EBMgt can be used to increase the rationality of decisions being made in organizations (Martelli and Hayirili, 2018).

2.5 Why An Evidence-Based Management Approach?

Evidence-based management is a unique style of management that stresses the need for decisions to be made based on a combination of critical thinking and the best available evidence. The best available evidence is one that comes from multiple sources if possible – practitioners, scientific literature, organizations, and stakeholders. Six different methods are used to collect evidence from multiple sources. They include: asking, acquiring, appraising, aggregating, applying, and assessing. This is done in a thorough manner because sometimes even the best possible evidence can be misleading. In order to reduce the frequency at which evidence is

overstated, there is also a critical appraisal of when and how the evidence is gathered. This establishes trustworthiness and relevance of the data which can be used to either corroborate or refute a test/hypothesis. The use of an evidence-based management approach as it relates to service delivery enables assumptions and current practices to be tested against group conformity that might exist within and across organizations.

An assumption "is a claim, assertion or hypothesis that we believe to be true, even though there is no evidence available (yet)" (Barends & Rousseau, 2018, p. 21). There is a dire need to confirm or refute assumptions when it comes to understanding issues associated with the delivery of HIV/AIDS services. Moreover, assumptions might be stated and hidden and could have dire effects for teams and beneficiaries of treatment and care. The evidence-based management framework lends itself to defining a new or existing problem in a clear manner while seeking evidence for the preferred solution. A critical appraisal of available evidence would seek to unveil assumptions regarding claims being made especially when the data or current practices are called into question. One of the ways it does so is through the development of the PICOC (patient, intervention, comparison, outcome, and context) model when it comes to clinical and context-specific interventions for marginalized populations. For example, could increasing staff training on prevention-of-mother-to-child transmission (PMTCT) reduce the HIV prevalence rate of mothers and children in Northern Nigeria? If so, what according to the evidence would be the best way to approach such efforts, and is there a comparative population to help guide such an intervention? Before this assessment can be made, an underlying assumption that needs to be promulgated is the level of equity that exists when it comes to the resources that facilitate PMTCT training in Northern Nigeria compared to the major metropolitan areas like Lagos or Abuja.

The inability to plan public health interventions carefully with critical evidence wastes resources and leads to suboptimal outcomes with critical evidence. It also perpetuates the cycle of groupthink where there is lack of diversity of thought and conformity in the decision-making process. The grounded nature of evidence-based management also enables groupthink to be challenged since a rigid organizational hierarchy might stifle innovation and a plurality of perspectives. When there is groupthink, there is a higher tendency for decisions to be unanimous even if they require multiple lenses and varying perspectives. The inability to use multiple lenses results in ideas not being properly vetted. Utilizing an evidence-based management perspective when it comes to the conscientious, explicit, and judicious use of evidence diminishes the constant use of heuristics – nonfactual mental notes / shortcuts to problem solving – in the workplace.

Heuristics such as:

i. authority heuristic (belief in the opinion of a person of authority on a subject just because the individual is an authority figure),

ii. representativeness heuristic (mental shortcut that helps us make a decision by comparing information to our mental prototypes)

iii. availability heuristic (mental shortcut that helps us make a decision based on how easy it is to bring something to mind)

iv. halo effect (cognitive bias in which our impression of a person or thing influences how we feel and think about his or her character)

Similar to heuristics, groupthink juxtaposed to organizational politics is killing the Nigerian health industry (Adeniji, 2010). Adeniji notes that there are high levels of distrust amongst health professionals and there is a constant attempt to downplay the value of other groups or characterize them as being unimportant within the organization. These microaggressions and

toxic work practices often stem from individual experiences with people taking sides and deliberately working to sabotage others. For organizations that have direct care professionals, there is a concerted effort to challenge the headship of the medical doctors. Mitigating the effects of groupthink (especially during conflict) is important because the inability to do so can cause a failure in one's ability to maintain standard practices. Adeniji (2010) notes that patients are the ones who suffer when members of organizations make decisions that are "supportive of suggestions made within a group and are dismissive of suggestions made outside the group." Thus, eliminating any rich perspective that can arise from a diversity of thought. According to Adedeji, one of the causal factors as to why groupthink is pervasive in Nigerian health organizations can be attributed to the lack of clearly defined responsibilities and weak interpersonal communication between staff.

A best practice when it comes to deconstructing groupthink is by making an effort to promote diverse thinking so as to falsify preconceived notions, views, and judgments that are not based on facts. An environment that fosters improved interpersonal communication is also important when it comes to responding to constructive feedback in order to better serve PLWHA. Furthermore, it would also allow stakeholders in the organization to form decisions without being apprehensive of what the repercussions may be from having a different perspective compared to the rest of the group.

The science of evidence-based management suggests that decision-making happens either in System 1 (fast and intuitive) or System 2 (slow, deliberate, and rational) thinking. In either framework, systematic errors may lead to negative outcomes and unintended consequences. These errors or externalities can result from staff/personnel working in silos or not having a sense of risk susceptibility when it comes to their actions. Social psychologist, Irving L. Janis posits the fact

that groupthink arises when there are "illusions of invulnerability" and "unquestioned beliefs" (Hart 1991). In System 1 settings, staff members may be quick to jump to conclusions on key programmatic decisions simply because of the perceptions that they have – which might be a byproduct of information asymmetry. Hence, the representativeness heuristic is at play because the predicament being faced might "be too cognitively challenging" or the "preconditions for a solution might not be preapproved" which can lead to a presumed guess. Similarly, entry-level to mid-level staff might be a part of teams whereby there is a high degree of information asymmetry.

Information asymmetry should not only be defined as the lack of awareness as to what is going on within and between teams, but can be classified as the inability for organizations to cross-reference information due to their lack of organizational technology (leadership and processes). Rehfuess et al. (2015) note that an evidence-based management (EBMgt) approach to addressing HIV/AIDS services has been noted as being a best practice to addressing public health concerns. EBMgt integrates the best available knowledge from experts and key stakeholders in a manner that benefits the needs of a population. Janati, Hasanpoor, Hajebrahimi, Sadeghi, & Khezri (2018) also suggest that the application of evidence-based management in healthcare enables judgments to be made based on facts and information by analyzing facts appropriately to make these judgments to a greater degree (p. 1).

In coming up with preferred solutions, evidence from practitioners is juxtaposed with that from the organization, scientific literature, and stakeholders. Brownson, Fielding, and Mayhlan (2009) point out that evidence-based public health as a tool for effective decision-making is based on four major components: best available research evidence, environment, and organizational context, population characteristics, needs, values and preferences, and resources including practitioner expertise. In a survey of health professionals, Vogel et al. (2013) note that health

system decision-making requires a careful consideration of the multitude of variables. As a result, there is a need to support decisions with the best available evidence (p. 1). Smith and Stewart (2017) also argue that evidence tools can also be used as "research-informed advocacy" tools to strengthen policy decisions because they "appear to be objective and credible" (p. 8). Rousseau (2006) refers to the teaching of sociologist Paul Hirschman in asserting that successful evidence-based management understands bureaucratic functions so as to gauge the receptiveness and implications of the recommendations being proposed.

In *Cartel of Good Intentions: The Problem of Bureaucracy in Foreign Aid*, William Easterly makes note of the fact that "bureaucracy works best where there is high feedback, easily observable outcomes, a high probability that the bureaucratic effort will translate into favorable outcomes, and competitive nature from bureaucracies and other agencies" (Easterly, 2002, p. 4). In looking for evidence for preferred solutions, evidence from practitioners is juxtaposed with that from the organization, scientific literature, and stakeholders. In situations wherein bureaucracies might not be the most effective, evidence-based management can be used to acquire, appraise and aggregate data that might support alternative solutions or show organizational ineptitude. For example, 50% of HIV/AIDS testing facilities in a particular state might lack treatment counselors during hospital/government strikes. An EBMgt approach might reveal that health workers want consistent paychecks in order to be reluctant to go on strikes. Whereas the evidence from stakeholders might show that the consequences of a strike can be mitigated if people are referred to seek from secondary or tertiary facilities. Thus, there might inadvertently be a transference of service due to the effect of a variable that affects the relation between a predictor and an outcome. In this case, the strike (moderating variable) may cause an overcrowding of these health clinics (predictor) which lessens the quality of providing care (outcome). EBMgt uses the scientific

literature in determining what to do when it comes to dealing with hospital flows in resource scarce settings. Moreover, an EBMgt framework would utilize evidence from facilities showing bottlenecks (demand > supply) and how times spent on counseling and scarcity for antiretroviral drugs point at ineffectiveness in the bureaucratic framework.

2.6 Promoting Evidence-Based Health Care In Africa

In a World Health Organization (WHO) interview with Charles Shey Wiysonge, Director of the Cochrane Institute South Africa, the use of evidence-based healthcare is framed as a tool for driving research internally based on national priorities (Wiysonge, 2017). EBMgt in the African context discourages a heavy reliance on research that emerges from high-income countries since such findings may not be applicable to the African context or fail to understand the historical underpinnings of healthcare delivery. The use of an evidence-based approach to address health challenges in Africa facilitates the process of building effective partnerships and collaborating with decision makers. In some cases, it might even lead to the development of new and customized guidelines (based on international frameworks) that are applicable to the local context.

Forland, Rohwer, Klatser, Boer, and Kizza (2013) explore a Collaboration for Evidence-Based Healthcare in Africa (CEBHA+) that was established with partners from the following countries: Ethiopia, Uganda, Rwanda, Burundi, Tanzania, Malawi, Zimbabwe, and South Africa (Forland et al., 2013, para 1). It was established as a means of achieving the Millennium Development Goals 4, 5. and 6 (reducing child death rates, improving maternal health, and combating HIV/AIDS). The evidence-based collaborators noted that evidence-based approaches to healthcare in Africa are critical to ensuring that Africa-specific research and systematic reviews

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do not "overgeneralize when making conclusions" (Forland et al., 2013, para. 2). Nonetheless, the effective use of evidence-based management approaches in Africa requires sustainable collaborations between researchers, policy-makers, and clinicians. These partnerships should also prioritize the development of strategies for the dissemination and implementation of evidence at all levels. Thus, a significant amount of attention ought to be placed not on the process by which the evidence is gathered, but on how it is disseminated. Rehfuess et al. (2015) highlight that CEBHA+ spends significant time in ensuring that research can be conducted with existing interest, expertise, and resources, which in turn leads to the development of customized avenues for reporting findings.

Young, Garner, Clarke, and Volmnik (2015) suggest that "evidence-based clinical care, the integration of current best available research evidence with clinical expertise and patient values and preferences, is gaining momentum in the African region" due to the manner in which it is made to fit the local context (Young et al., 2017, p. 2). They cite the Cochrane Review Groups of HIV/AIDS and Infectious Diseases and their audacity to challenge global policy while still ensuring that clinical guideline development was being authored by Africans. The use of evidence-based practices has also led to a shift in the discourse by which government stakeholders are held accountable. As a result, evidence does not confirm policy decisions, but rather informs the direction of the policy. In Nigeria, the Effective Health Care Research Consortium uses an evidence-based approach to inform new or amended policies or guidelines by developing tools for policymakers and improving access to systematic reviews. Similarly, evidence-based approaches to healthcare can become the new norm for nonprofit organizations where answers to relevant research questions are not solely driven by the agendas of funders or researchers (Young et al., 2017). Instead, the methodology behind the data can be used as a means of informing the outcome.

Evidence-based management can be used as a program design tool for shaping the manner in which services are rendered. Howard et al. examine the role of evidence-based science in fostering desirable implementation outcomes for vulnerable women in South Africa (2017). This specific population consumed alcohol and other drugs which contributed to the rate at which they transmitted HIV due to decreasing condom use and increasing risky sex behaviors (Howard et al., 2017). They highlight the implementation of the Women's Health Co-Op (WHC) - an evidence-based women-focused intervention aimed at providing risk-reduction information for alcohol and drugs, HIV and sexually transmitted infections, and gender-based violence. The program facilitates the achievement of these outcomes by providing behavioral skills training for sexual protection and safer sex communication (Howard et al., 2017). Through focus group discussions and interviews, it became apparent that the sensitivity of topics made it arduous for interventions to be adopted. Other issues that existed were: length of the intervention, delivery format, and staffing constraints. The researchers found that an evidence-based approach is not a be-all and end-all tool for "addressing issues of substance use, sexual risk, and intimate partner violence" (para. 3). The design of evidence-based health care approaches requires a close examination of staffing constraints; specifically, the need for staff to have the "necessary training to conduct behavioral interventions and to properly communicate with patients" (para. 30). Effective delivery of intervention programs requires that knowledge gaps in delivering collaborative and integrated services are closed so as to mitigate any work that happens in silos.

Closing knowledge gaps enables stakeholders to derive pathways for customizing interventions. Howard et al. (2017) highlight the fact that through the use of evidence-based approaches, three positive facilitators are evident: i. high perceived need for the intervention in the community - health providers found innovative ways to invest resources despite the constraints

they faced. ii. the participants were willing to participate in the program because of the perceived benefits, iii. Outside of monetary gains, the staff were also committed and more invested in the program. Implementing the WHC program enabled staff to get additional training, mentoring, and capacity building. The use of evidence-based approaches/interventions requires adaptability and keen knowledge of the context or on-the-ground conditions. Even after the project was conducted, a community collaborative board (CCB) was formed that informed other stakeholders. In order to achieve optimal outcomes and make the HIV program even more sustainable, the CCB recommended the use of community workers rather than nurses to deliver interventions. Moreover, they also modified the intervention content to "address concerns about intervention length and sensitivity issues raised during the formative phase" so as to increase the effectiveness of services (Howard et al., 2017, para. 48)

Rehfuess et al. (2016) postulate that evidence-based approaches increase value and reduce waste (Chalmers et al., 2014; Ioannidis et al., 2014; Macleod et al., 2014) especially in resource-constrained settings. They also suggest that it is a best practice for addressing health problems. In the African context, they present the case that evidence-based decision-making ought to happen through a consortium of health-care practitioners and policy-makers. This would allow for a thorough assessment of "cost-effectiveness", "persona; values", "preferences", "feasibility", "acceptability", and "equity".

Ledger (2010) argues that "taking an evidence-based approach to management is not of itself a comprehensive solution to the problems facing organizations today" (para. 18). The reason for this is that decision-making in an EBMgt framework is more transparent and traceable which can be antithetical to organizational practices. Nonetheless, appraising different forms of evidence is not an easy feat since clinical and non-clinical knowledge can vary in their level of importance.

In order to mitigate this variance, it is important that attention is paid to "efforts to marginalize valuable professional experience in pursuit of an idealized form of scientific management and organizational design" (p. 96).

Placing emphasis on professional skill set is critical to ensure that service effectiveness is a top priority across all levels of the value chain. Janati et al. (2018) call attention to four basic kinds of evidence that managers can use in their daily practices. They include:

I. Hard evidence: Scientific and research evidence, facts and information, political-social development plans, manager's professional expertise and ethical-moral evidence.

II. Predictors: Stakeholder values and expectations, functional behavior, knowledge, key competencies and skill, evidence sources, evidence levels, uses and benefits of government programs

III. Evidence-based management barriers: Managers' personal characteristics, decision-making environment, training and research systems, organizational issues

IV. Evidence-based management processes: Asking, acquiring, appraising, aggregating, applying

When applied effectively, these different enabling factors can significantly strengthen a manager's decision-making ability and lead to better organizational outcomes. Furthermore, the authors advocate for the use of this framework across different levels in a nonprofit organization. This is because EBMgt can significantly reduce the impact that red tape has on critical decisions while still standardizing processes in an accountable and transparent manner. Furthermore, it can give rise to a system of checks and balances which can be crucial in mitigating corruption within an organization and the effects of other unforeseen challenges.

2.7 The Critical Role of NGOs in Combating HIV/AIDS

Leonard and Leonard (1999) explore the role of NGOs in an unpredictable African healthcare landscape by presenting a compelling argument that NGOs have the "institutional capacity to deliver high quality care whereas private practitioners, even with good intentions will not succeed" (para. 2). They assert that NGOs are less susceptible to information asymmetry - as compared to their government counterparts. This can be attributed to the fact that NGOs are not limited by preimposed structures and they primarily operate in a marketplace where everything is fair game. Therefore, NGOs are better positioned to use effective information flows in an EBMgt framework to improve organizational outcomes.

Less information asymmetry can make institutions highly-functional. Leonard and Leonard (1999) also highlight that the public perception of NGOs in most African countries is far better off than government services to the point that "most people are prepared to pay a premium over government facility charges in order to use them" (p. 20). They also make the case that a patient is likely to use an NGO service since that patient's focus is on maximizing the quality of his/her medical care, and has a stronger vote of confidence in the service provided by NGOs. Thus, he/she decides to go with an NGO for care/treatment because of a stronger belief that utilizing the services of the organization is likely to lead to better outcomes. The tendency for NGOs to achieve better outcomes has started the phenomenon of various national governments contracting out health services to NGOs. In countries like Zimbabwe, Tanzania, and Ghana, mission health services are now running district hospitals. Although the outcomes of NGOs managing hospitals have not all been positive, there is greater flexibility to hire and fire staff based on budget, resources, and quality outcome measures.

2.8 Conclusion

In Chapter Two, I present a case as to why evidence-based management is a rigorous framework that can be used for understanding how a multitude of factors can position an organization to achieve its theory of change, which in turn can lead to sustainable impact in the long run. Incorporating the use of evidence in everyday organizational behavior involves not only looking at the manner in which data is aggregated, but also how it is disseminated. As a mechanism for informing decision-making, EBMgt can reduce information gaps amongst stakeholders. It can also foster a greater quality of service by looking at how organizations fair comparatively amongst each other. In order to ensure that the evidence is not manipulated, nonprofit organizations are often viewed as being best suited for collecting evidence since they are not heavily plagued by systemic corruption and political tides, compared to their government counterparts. Nonetheless, it is important that NGOs share a common vision and a set of values so as to meet the interest of citizens, even if they are competing for the same funding pools. Organizations that do this are not only able to reduce the service gap for key populations, but are also able to improve their learning capacities, reduce the information gap in their networks, and create a more resilient environment for their employees and stakeholders. In Chapter Three, I will look at the different systemic and institutional factors that NGOs have to grapple with when it comes to providing HIV/AIDS services.

3.0 Public Administration Approaches to HIV/AIDS Service Delivery in Nigeria

3.1 Introduction

Public service organizations rely on effective feedback loops in their daily interactions with other entities. In an effort to combat HIV/AIDS, these NGOs often find themselves being part of a system of governance known as "polycentric governance" whereby there are numerous actors with semi-autonomous decision-making powers. Organizations, as members of the service delivery ecosystem can employ numerous management techniques. One of them being the new public management framework which stresses the importance of delivering high performance outcomes through the application of high efficiency and productivity techniques. Nevertheless, this framework does not prioritize the interests of the citizens, and can lead to stakeholders pursuing their own interests even if it is against the moral good. As a better alternative to new public management, new public service encourages stakeholders to share the same set of ideals and values that are aligned with the citizenry. Even when these values are shared, organizations need to nurture their human capital through a variety of means – continuous quality improvement, lean management, employee engagement, etc. – in order for the interests of the citizens to be integrated in the design of public health interventions. Chief among these numerous factors is the importance of funding which can lead to higher compensation on one hand, and enable an organization to scale impact, improve internal processes, and run sustainable programs/services.

3.2 An Overview Of The Public Administration Literature

The provision of feedback is an effective way of closing the information symmetry gap in HIV/AIDS service delivery. Herman (1941) suggests that feedback setups tend to have a greater awareness of community needs since they are able to identify broad social goals and have the autonomy - that does not exist in traditional government - to meet their goals. Even when civil sector actors directly interact with each other on a 1:1 basis, they often find themselves having to report to multiple people so as to close feedback loops.

Easterly (2002) notes that there is a collective action problem among "multiple principals that inhibits designing an optimal principal-agent contract" (p. 8). In this context, a "principal" is defined as a grantor/funder or a national stakeholder with power/interest, whereas the "agent" is a local nongovernmental organization receiving aid. According to Easterly, each principal tries to pursue their own objective and neglects the other principals' objectives. As a result, the agent can become disincentivized and unable to meet set objectives which can result in expertise not being commonly shared. Hence, organizations are faced with the complexity of meeting multiple objectives, some of which can be integrated or built upon one another. The use of an evidence-based management approach would enable actors to design institutional responses – based on a plethora of sources - that are adaptable to a changing health delivery ecosystem (Carlisle and Gruby, 2017).

Institutional responses to diseases connote a form of governance known as "polycentric governance" whereby there are multiple forms of semiautonomous decision-making channels. Evans (1996) notes that engaged and autonomous non-government actors can enhance the state's capacity to deliver essential goods and services. A polycentric model is one that encourages policy entrepreneurs to find the most innovative solutions for the most pressing issues. In this scenario,

two governing authorities exercise power over a common issue plaguing a common group of people. Using South Africa as an example, Lieberman (2011) notes that in the African context, a polycentric system of governance creates "state-governance synergy" which allows non-governmental organizations to enhance the state's capacity to deliver goods and services. With this in mind, Lieberman (2011) also notes that smaller municipalities often face challenges when it comes to intergovernmental relations due to the lack of an integrated approach. Hence, there is a need for a shared vision and agenda when it comes to being able to coordinate the delivery of health interventions through efficient channels in order to ensure that the best alternatives are in the market while still meeting the needs of those being served.

Ensuring stakeholder satisfaction requires the use of organizational technology (i.e., processes) whereby numerous actors all working together in an integrated way to achieve a common goal. Vincent Ostrom argues the idea of polycentricity – a complex framework for governance in which there are multiple centers of semi-autonomous decision-making. According to Ostrom, "achieving good governance requires both knowledge and will on the one hand, and supporting and constitutional arrangements on the other hand" (p.176). Ostrom identifies three ways in which polycentric institutional arrangements work best: many autonomous units formally independent of one another, choosing to act in ways that take account of others, through processes of cooperation, competition, conflict, and conflict resolution (Ostrom, 1991, p. 225). Aligica and Tarko (2011) acknowledge that public governance designs and arrangements are useful in limiting social conflicts and satisfying the preferences of as many people as possible. This is because complex design arrangements often take into account ideals such as individualism, freedom of choice and freedom of association.

Berkes (2010); Blomquist (2009); Folke et al. (2005); Gelchich (2014) note that "polycentric governance systems are dispersed among governmental and non-governmental actors, achieving predicted functionality may require forums designed to bring decision makers together for deliberation and learning" (Carlislie and Grugby, 2017, p. 12). They also specify the need for decision-making units to participate in cross-scale linkages – a point of interaction or cooperation among actors that exist at different scales or at different levels of political or social organization (Heikkila, Schlager, & Davis, 2011). Accordingly, an effective polycentric system of governance is one in which stakeholders, organizations, and practitioners are provided with the opportunity to deliberate and learn as they work towards building their collective capacity in order to scale impact.

3.3 New Public Management

As organizations adapt to the external environment that they find themselves in, they learn to improve their internal and external workings in the process through performance and growth in service delivery. New public management (NPM), an approach to running public services organizations focuses on "creating greater responsiveness to consumers, developing organizational structures which encourage innovation and competition, strengthening incentives for performance and creating more output-oriented systems" (Bennett and Muraleedharan, 2000, p.2). NPM emphasizes the need for the government to transition from direct provision of services to indirect modes such as policy-making, regulation, coordination, and contracting (Bennett and Muraleedharan, 2000). This can be attributed to the lack of clarity of roles, responsibility, and accountability in public health systems.

Ibietan (2013) explores new public management in the Nigerian context and looks at the ways in which it can be used as a tool to facilitate effective public service. In his analysis, he points out that there are structural barriers and encumbrances to the implementation of public sector reforms (Ibietan, 2013, p. 53). He cites Obi and Nwnegbo (2006:253) who describe NPM as a "management culture that emphasizes the centrality of the citizen or customers, as well as accountability for result" (p. 54). In doing so, it takes lessons from the private sector whereby management is oriented around contracting out, limited-term contracts, monetary incentives and a freedom to manage. However, in the Nigerian context, there is tendency for "organized interest groups and bureaucrats to push for more and advance selfish narrow interests to the detriment of the silent and disorganized majority that fund state expenditure" (Stoker, 1991:239)

New public management fails to examine the enabling environment that influence how an organization performs. For example, a local NGO situated in a religious setting might outrightly refuse treatment to a commercial sex worker or someone that identifies as "gay/lesbian" simply because of the belief that AIDS is a punishment for their illicit behaviors. Although the antiretroviral therapy that is within the organization might still reach other people living with HIV/AIDS, there is still a shortcoming in the decision-making process for specific groups which can reduce their access to care, and worsen their susceptibility to fragile outcomes.

The microaggressions in patient care cannot be simply solved under a New Public Management approach that is fixated on performance in the market. NPM is very similar to public choice theory in the sense that it fails to utilize a public service ethos, and focuses on the overall interest of the actor in the market and not on the collective good of those receiving services. Therefore, the focus on outcomes-based performance measures when coupled with a high degree of flexibility at the discretion of the technocrat, can result in decisions that might be cost-effective,

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but can also alienate the poor and society's most vulnerable from having access to social services (p. 59). Although NPM encourages the need for accountability and transparency as a pivot of good governance (p. 59), it does not detail who ought to be responsible for maintaining such good practices. The shortcomings of NPM in Nigeria have been characterized by issues surrounding revenue leakages, lack of fiscal discipline, and narrow self-interests being pursued for political gains (p. 59). Ibietan (2013) posits that under the new public management framework, performance should be evaluated based on results instead of blind and unproductive conformity with bureaucratic rules and instructions. Moreover, an understanding of the context at hand reduces the likelihood to formulate wrong prescriptive solutions.

The Nigerian government set up a Bureau of Public Enterprises and a National Council on Privatization to adopt principles from the private sector and apply it to the public service arena. However, such efforts were futile since the private sector and public service approaches to achieving their respective missions significantly differ from one another. As a result, it is important that any cross-sector approach to delivering public goods and services is not solely entrenched in market-driven interests. Although approaches like new public management have steep origins in public choice theory, there is no guarantee that top-level administrators avoid using their public agencies to pursue their self-interests. Moreover, there might even be a likelihood to ignore strong evidence that might counteract their respective decisions and in some cases, ignore cultural factors, all of which perpetuate the status quo.

Sigamani (2012) suggests that an understanding of new public management reveals the need for alternative systems for service delivery and evidence-based empirical research on health systems organizations (p. 166). In more recent times, opponents of new public management have called for a more useful and citizen-centered approach to the shortcomings of new public

management. As a more contemporary framework, new public service goes beyond the focus on decentralized structures (new public management). It hones in on the need for collaborative structures within and outside the organization.

3.4 New Public Service

New public service is an approach to management that is a departure from new public management, which primarily focuses on accountability to those receiving services "a.k.a customers" and how decision-making can be decentralized. Under the new public service paradigm, actors work together to eliminate functions that do not serve effective purposes. Moreover, they also organize programs and policies so that organizations and communities are free to create their own defined visions, missions, and goals, all of which contribute to the system's overall purpose. In the new public service model, citizens' interests are served, as well as values, norms, and standards (Denhardt and Denhardt, n.d.)

The new public service model is predicated on active and involved democratic citizenship. The use of democratic citizenship emphasizes that the public administrators are not only accountable but serve as the middleman between the citizens and the government. By using a democratic citizenship approach, new public service focuses on the rights and obligations of citizens as defined and protected by the Nigerian legal system. Lawmakers have the ability to influence the political system, and the state (and relationship) that it has to citizens should promote their self-interests. In order to do so, the new public service model stresses the need to build coalitions as well as non-private agencies that can achieve policy objectives. Denhardt and Denhardt (n.d.) emphasize that it is not enough to serve the needs of citizens. Rather, stakeholders

ought to pursue the public interest through shared values instead of pursuing their individual self-interests. Once values are shared and known, public servants are able to build trust and collaboration not only among citizens, but among those being served.

Osborne, Radnor, and Nasi (2012) point out that the very nature of service delivery is so complex that understanding how to effectively deliver services requires using a service-dominant logic that is a departure from product-dominant public management theory. The former focuses on operational functions and the client as the target and the transaction being one-sided. On the other hand, the latter emphasizes co-creation and co-production between the different roles of public service organizations, citizens, and service users (Osborne, 2018, p. 225). As a service management theory, the new public service model shows how the inter-organizational and systemic nature of public services can be used to lead to more efficient and effective health care delivery.

Efficient health care delivery is predicated on optimal productivity levels. Osborne, Radnor, and Nasi (2012) make the bold claim that operations management within public services can only boost productivity levels. However, a new public service approach adds value to the service provider and beneficiary (Osborne, Radnor, and Nasi, 2012). It fosters trust and collaboration between people receiving services and providers, and it puts the needs and interests of communities at the forefront. It "places the experiences and knowledge of the service user at the heart of effective public service design and delivery" (p. 149). As a result, organizations are able to understand the service user's needs in order to provide high quality services even during periods of uncertainty.

In the HIV/AIDS delivery space, nonprofit organizations find themselves constantly having to lead through change so as to meet the needs of key populations. Denhardt and Denhardt

(2015) highlight the fact that the new public service model is an effective framework for understanding the motivating force for propelling the actions of nonprofits. Likewise, it also enables nonprofits to respond to highly turbulent, sudden and dramatic shifts. They show that this framework takes into consideration that society is ever-changing, and as a result involves interdependence and cooperation across sectors. The interconnected nature that the new public service paradigm embraces calls for a citizen inclusive, decentralized practice that is in accordance with the articulated values and needs of a community. (Alexander & Nank, 2009, p. 364). Under the new public service paradigm, these community-based networks enable organizations to create a solution to government failure.

Alexander & Nank (2009) define government failure as the existence of little accountability and trust, or the lack thereof. As a result, they suggest the use of the new public service approach, a framework that can be used to navigate through failure. Denhardt and Denhardt (2000) highlight that new public service serves rather than steers civil society. This is because the new public service framework does not simply elicit a "yes" or "no" answer. Rather, it fosters a unique level of collaboration by which active citizenship is characterized by public service officials playing more than a service delivery role. Under the new public service framework, governments work alongside civil society leaders in brokering, negotiating, and providing conflict resolutions. Denhardt and Denhardt (2000) also point out that the new public service approach results in the creation of shared interests and shared responsibility. They explain this in further details by arguing that unconstrained and authentic discourse concerning the state of affairs in society leads to a "broad-based vision for the community, the state, or the nation can be established through a set of ideals for the future" (p. 5).

HIV/AIDS organizations utilize various internal and external resources in order to optimal quality care to the communities that they serve, amid the lack of government support. Lieberman (2007) highlights the notion that societies that are ethnically divided and fragmented are less likely to mobilize "around the idea of risk from a stigmatized condition" (p. 1). As a result, they tend to have governments that are "less likely to provide policies because of lower demand and the potential for political resistance to actions viewed as unwelcome and/or unnecessary" (p. 1). As a remedy for government ineptitude, Aligicia, Boettke and Tarko (2019) recognize that public governance confronts issues associated with collective coordination. It does so by emphasizing the normative individualism of organizations as an essential building block when pursuing collective action. In addition, they also note that there are a set of factors that shape the public–private interface and the governance architecture. These factors can be classified as organizational technology and include: the technology available for producing the good or service and the mechanism available for monitoring and enforcement; and the social context in which the good or service is provided, involving people's preferences and beliefs.

These ideals for the future can be achieved by having discretion that is constrained and accountable, and not as wide and entrepreneurial (New Public Management) or only limited in the hands of a few administrative officials (Old Public Administration). Lastly, one of the reasons for implementing a new public service approach is because of the information symmetry that comes with it. Denhardt and Denhardt (2000) suggest that collaborative structures with leadership are shared internally and externally which allows "risks and opportunities to reside within the larger framework of democratic citizenship and shared responsibility" (p. 557). As a result, public servants do "not merely respond to the demands of "customers," but focus on building relationships

of trust and collaboration with and among citizens" (p. 555). As a public service model, new public service is inclusive since it gives communities a seat at the table when decisions are being made.

Table 1 Comparative Perspectives in Public Administration

Table 1 Comparing Perspectives: Old Public Administration, New Public Management, and New Public Service			
	Old Public Administration	New Public Management	New Public Service
Primary theoretical and epistemological foundations	Political theory, social and political commentary augmented by naive social science	Economic theory, more sophisticated dialogue based on positivist social science	Democratic theory, varied approaches to knowledge including positive, interpretive, critical, and postmodern
Prevailing rationality and associated models of human behavior	Synoptic rationality, "administrative man"	Technical and economic rationality, "economic man," or the self-interested decision maker	Strategic rationality, multiple tests of rationality (political, economic, organizational)
Conception of the public interest	Politically defined and expressed in law	Represents the aggregation of individual interests	Result of a dialogue about shared values
To whom are public servants responsive?	Clients and constituents	Customers	Citizens
Role of government	Rowing (designing and implementing policies focusing on a single, politically defined objective)	Steering (acting as a catalyst to unleash market forces)	Serving (negotiating and brokering interests among citizens and community groups, creating shared values)
Mechanisms for achieving policy objectives	Administering programs through existing government agencies	Creating mechanisms and incentive structures to achieve policy objectives through private and nonprofit agencies	Building coalitions of public, nonprofit, and private agencies to meet mutually agreed upon needs
Approach to accountability	Hierarchical—administrators are responsible to democratically elected political leaders	Market-driven—the accumulation of self-interests will result in outcomes desired by broad groups of citizens (or customers)	Multifaceted—public servants must attend to law, community values, political norms, professional standards, and citizen interests
Administrative discretion	Limited discretion allowed administrative officials	Wide latitude to meet entrepreneurial goals	Discretion needed but constrained and accountable
Assumed organizational structure	Bureaucratic organizations marked by top-down authority within agencies and control or regulation of clients	Decentralized public organizations with primary control remaining within the agency	Collaborative structures with leadership shared internally and externally
Assumed motivational basis of public servants and administrators	Pay and benefits, civil-service protections	Entrepreneurial spirit, ideological desire to reduce size of government	Public service, desire to contribute to society.

Source: Denhardt, R., & Denhardt, J. (2000)

3.5 New Public Management In Nigeria

New public management can lead to stronger performance outcomes; nonetheless, it does not necessarily translate to higher levels of employee engagement and the ability to reach key populations. Ibietan (2013) explores new public management in the Nigerian context and looks at the ways in which it can be used as a tool to facilitate effective public service. In his analysis, he

points out that there are structural barriers and encumbrances to the implementation of public sector reforms (Ibietan, 2013, p. 53). He cites Obi and Nwnegbo (2006:253) who describe NPM as a "management culture that emphasizes the centrality of the citizen or customers, as well as accountability for result" (p. 54). In doing so, it takes lessons from the private sector whereby management is oriented around contracting out, limited-term contracts, monetary incentives and a freedom to manage. However, in the Nigerian context, there is a tendency for "organized interest groups and bureaucrats to push for more and advance selfish narrow interests to the detriment of the silent and disorganized majority that fund state expenditure" (Stoker, 1991:239)

Examining organizational effectiveness entails looking at different building blocks. These include: productivity, stability, morale, integration of formal and informal aspects of the organization, maximization of employees' potentials and values contributed to society (Ibietan, 2013, p. 57). He also goes on to suggest that public organizations "must be subject to routine renewal in order to justify their existence and relevance" (p. 57). Although, Ibietan presents a compelling argument as to why the outcome-based approach for new public management is an effective tool, he fails to examine the enabling environment that influence how an organization performs. For example, a local government clinic situated in a religious setting might outrightly refuse treatment to a commercial sex worker or someone that identifies as "gay/lesbian" simply because of the belief that AIDS is a punishment for their illicit behaviors. Thus, alluding to the shortcomings in the decision-making process especially when certain groups certain groups of HIV positive individuals, which can further worsen their fragile outcomes.

Microaggressions in public health delivery cannot simply be solved under a New Public Management approach that is fixated on performance in the market. It is similar to public choice theory in the sense that it examines individual interests and not the collective national good.

Furthermore, a new public management approach fails to capture the public service ethos since it gives precedence to outcomes-based performance measures. These outcomes-based performance measures when coupled with a high degree of flexibility, result in decision-making that might be cost-effective but can also alienate the poor and society's most vulnerable from having access to social services (p. 59). Although NPM encourages the need for accountability and transparency as a pivot of good governance (p. 59), it does not detail who ought to be doing such said reporting. In Nigeria, there have been issues surrounding revenue leakages, lack of fiscal discipline, and narrow self-interests being pursued for political gains (p. 59).

Therefore, it is crucial that the number of players in the health care delivery space are expanded to not only include select public stakeholders, but also civil society actors. New public service goes beyond the focus on decentralized structures (new public management). As a more contemporary framework, it hones in on collaborative structures from both the internal and external vantage point of an organization. Ibietan (2013) posits that under the new public management framework, performance should be evaluated based on results instead of blind and unproductive conformity with bureaucratic rules and instructions.

In Nigeria, the government set up a Bureau of Public Enterprises and a National Council on Privatization to adopt principles from the private sector and apply it to the public service arena. However, such efforts were futile since the private sector and public service approaches to achieving their respective missions significantly differ from one another. As a result, it is important that any approach to delivering public goods and services is not solely entrenched in market-driven interests. Although approaches like new public management have steep origins in public choice theory, there is no guarantee that top-level administrators avoid using their public agencies to

pursue their self-interests. Moreover, there might even be the tendency to ignore strong evidence that might counteract their respective decisions.

3.6 Integrating New Public Service In Evidence-Based Management

Denhardt and Denhardt (2000) point out that a new public service framework builds coalitions of various actors that mutually meet to agree upon their needs. In the process of concluding on what the best path forward is, the group assesses the different dimensions of public service - political, economic, and organizational. Osborne, Radnor, Kinder, and Vidal (2015) argue that a service-oriented framework works best when providing sustainable public services. Their major proposition is that the service-oriented framework enables greater governance of public service organizations. As a result, organizations that simply focus on increasing their internal efficiencies already fall short since effective public organizations that stand the test of time operate in a systems manner.

Secondly, they highlight the notion that organizational sustainability ought to be embedded in an organization's operational plans since it is a critical tool for having desirable outcomes. Norman (2000) notes that "service firms can only be successful if they embrace the overall service system" (Ibietan, 2006, p. 6). However, achieving long-term sustainability is dependent on long-term relationships in the system and the ability to be innovative. Innovation is co-produced and occurs through an effective knowledge capture. Co-production does not happen from a business as usual stance but happens at the behest of, and controlled by service professionals. These service professionals whether clinical staff or stakeholders are positioned to capture knowledge. Although the authors do not explicitly use the term "evidence" they refer to a three-pronged knowledge

portal that is synonymous to the evidence-based management framework: technical knowledge (in the HIV context, this would be the science)- the sticky knowledge (performance/behavioral data from the users), and contextual data (which encompasses data from other stakeholders) [p. 10].

Osborne, Radnor, Kinder, and Vidal (2015) hone in on a key element of the NPM framework and why it is not the most appropriate paradigm for some public sector organizations. According to them, this framework "imposes a product-dominant logic onto public services rather than understanding the fundamental differences between product and services management" (p. 11). Unlike its predecessor, the new public service framework is deeply rooted in a sustainable business model that embraces the service nature of public service organizations. They include: system, experience, relationships, value, innovation, value, and co-production. In addition, the new public service framework stands out from the NPM approach since service providers are regularly interacting with their users and getting real-time feedback. As such, this service framework allows program designers to focus on the experience of the users rather than just checking boxes to meet metrics/outcomes.

3.7 New Public Service As An Optimal Framework For Service Delivery

Eneanya (2018) defines public service as "an activity of state which involves interaction with citizens as customers" (p. 2). Public service is an institutional arrangement whereby the government (or an actor in place of the government) adopts to be the middleman between a basket of resources and the needs of the citizenry. Nonetheless, the delivery of goods and services can occur through multiple arrangements. Some of which include: direct delivery of services, privatization, alternative service delivery, and decentralization of service (Kettner & Martin,

1995). There is not a one-size fits all approach to service delivery in settings that might be under resourced or complex. Bates and Holton (1995) define service delivery as being a "multi-dimensional construct". As a result, there are so many factors to consider when delivering a service.

The new public service framework is most suitable for public service delivery in settings wherein one actor has a unique value proposition that the whole system can leverage on. The actor is fully aware that his or her overall performance can be strengthened or improved by being embedded in a system that allows it to operate optimally. Guest (1996) makes the case that performance is an outcome akin to the process of balancing a scorecard. The process of balancing the scorecard goes beyond being competent. As Fletcher (2001) puts it, contextual performance involves going beyond "task performance" but rather fostering behaviors that allows an organization to be effective in its ecosystem. (Eneanya, 2018, p. 2).The new public service approach can undoubtedly lend itself to creating an enabling environment that allows an organization to perform well. Unlike other paradigms, it stems from a dialogue of shared values whereby interests among citizens and community groups are negotiated and brokered. Hence, a middle ground is created to meet mutual interests. Unlike other public administration paradigms, it reduces the latitude by which goals are set. The group uses their collective discretion in deciding the manner in which the goals are set. Nevertheless, the set goals are constrained and accountable (Denhardt & Denhardt, 2000).

Goal setting is a critical component of public service delivery. Buchner (2007) explores the psychology behind goal setting processes at the organizational level. He presents three theories that relate to performance management when it comes to having goal-oriented organizations. They include expectancy theory, goal-setting theory, and control theory. He uses these theories to point

out that not only do people behave based on what they are expecting as a job outcome. Their behavior is a byproduct of their level of perception, and clearly defined goals have the ability to influence people's behavior / performance. Latham & Locke (1979) point out that once people are aware of their goals, they are able to perform well and evaluate their actions. Under the new public service school of thought, this is democratic theory in action - stakeholders have equal access to information and are equally able to control the agenda (Denhardt and Denhardt, 2000). He also cites the systems theory approach whereby organizations that perform well do not exist in silos. They exist in open systems and are connected to one another. According to Miller and Rice (1967), these open systems are transformative spaces by which performance is not solely based on outcomes. Rather, it is determined by the contributions that individual actors make to the environment that they find themselves in.

3.8 Service Delivery Issues Affecting Organizations

HIV/AIDS organizations face service delivery issues due to the lack of fundamental human capital that arises from a shortage of supply in personnel, mistrust of the system, and steep cycles of clientelism. Bärnighausen, Bloom, & Humair (2016) point out that in South Africa, shortages of human resource personnel treating HIV/AIDS is in itself a barrier to reaching universal antiretroviral treatment (p. 1). Thus, plans to scale-up massive coverage would call for the need for a massive recruitment of human personnel. If factors were already unfavorable, countries have to grapple with numerous external phenomena such as "brain drain (high emigration of trained health workers), limited incentives for health workers, fiscal constraints, limited budgets" (p. 3). The United States Agency for International Development (USAID) and Management Sciences for

Health highlight the importance of high-quality HIV/AIDS services being dependent on the availability of qualified and trained healthcare workforce in sufficient numbers in the right place, at the right time (MSH, n.d). Yang and Kassekert (2009) posit the fact that whenever trust in leadership is high, the relationship between innovative culture and job satisfaction is higher. Brown et al. (2015) suggest that there is a positive relationship between workplace performance and employee trust. They suggest that the amount of training received by employees is positively associated with employee trust, whereas workplace tenure, hours worked and trade union membership are all inversely associated with employee trust. Thus, one can infer that better trained employees who spend a reasonable amount of time at the workplace are happier and perform better.
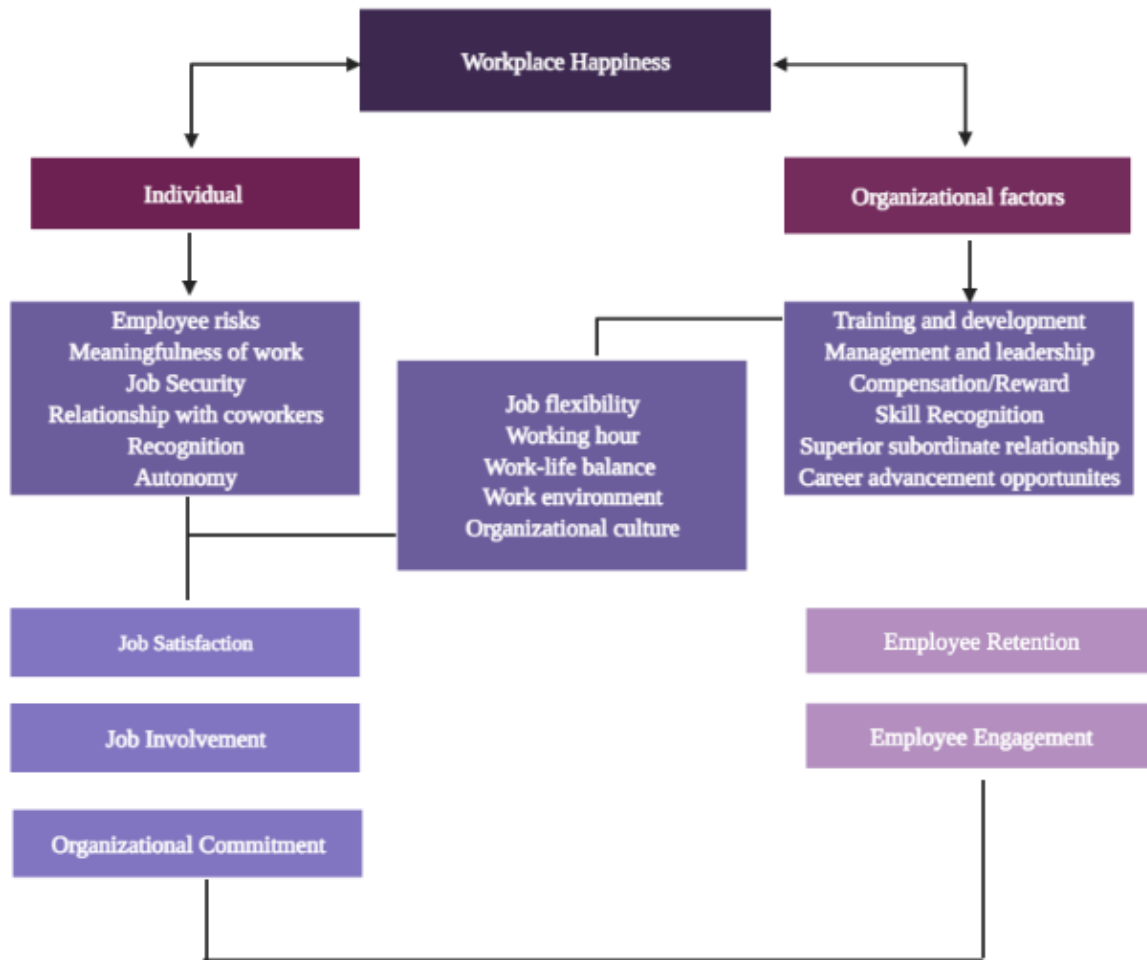
Figure 4 Parameters of Workplace Satisfaction (Happiness)

Source: (Roy and Konwar, 2020)

The satisfaction (happiness) of employees in public service organizations can lead to greater productivity (Saari and Judge, 2004; Roy and Konwar, 2020). Luoma (2005) and Leshabari et al. (2008) show that in low- and middle-income countries (LIMC) health workers have poor motivation which stems from a combination of factors such as "poor salaries, poor working conditions, inadequate infrastructure and limited opportunity for career development or training" (p 2). Ogundeji et al. (2016) recommend the need to provide trainings and workshops for health workers while seeking to equip health facility managers with the appropriate managerial skills,

priority setting support, and necessary infrastructure. In a systematic review of the literature regarding HIV/AIDS community health workers, Mwai et al. (2013) show that more trainings lead to better job performance. However, training alone is not sufficient when it comes to improving the work of community health workers. This is because community health workers face a plethora of challenges: poor recognition, remuneration and supervision; lack of psychosocial support; and poor involvement in decision-making. Despite the enormous number of challenges faced, there is "evidence that scale-up of antiretroviral therapy (ART) can reverse some of the negative social economic impacts of HIV on individuals, families and communities, with positive changes in life expectancy, demographic composition and fertility" (Mwai et al., 2013, p. 5). There are significant benefits of improving employee performance. Effective employee performance has been proven to lead to more streamlined processes and workloads. Pinto et al. (2018) suggest that HIV trainings when coupled with evidence-based interventions lead to increased performance on outcomes since staff collaborate more and feel more satisfied with their jobs**.**

3.9 Reforming Service Delivery In Nigeria

Eneanya (2018) explores the historical underpinning of public service delivery in Nigeria. He asserts that from 1960 to 1999, Nigeria was entrenched in a bureaucratic model which was heavily characterized by multiple regime changes. This led to endless delays and inefficiencies in service delivery of programs and services to citizens. The lack of accountability measures led to the introduction of the "Service Compact with all Nigerians" (SERVICOM) initiative from 1999 - 2007. The goal of SERVICOM was to embed a performance management system into service delivery in Nigeria. This performance management approach focused on the "development of

vision and mission statements capable of building consensus on a broad development strategy" by which the responsibility of critical stakeholders was spelt out (Eneanya, 2018. p.4). Moreover, it also led to the establishment of standard processes such as needs identification, participatory budgeting, and planning. If that was already not sufficient, an index score was allocated to public institutions. This index score assigned specific weights to its individual components: service delivery (30%), timeliness (24%), information (18%), professionalism (16%), and staff attitude (12%). (SERVICOM, 2003).

Nonetheless, SERVICOM failed because it was extremely centralized in nature and did not trickle down in terms of how it assessed the delivery of pro-poor services at the state and local levels. In addition, the government budgeting system was also fixed. Therefore, there was no real incentive for exceeding targets since that did not lead to financial gains for public offices or technocrats. Other attempts to reform the public service delivery process in Nigeria have also been challenging. In 2012, President Goodluck Jonathan introduced the performance contract approach which was a more improved modification of the former. There were targets set for measuring performance and incentives were also provided. However, the performance contract approach lacked a means of assessing citizen engagement. Therefore, the outcomes being reported could actually have been far from reality. Eneanya (2018) also notes that there were not any measures set in place for improving accountability or assessing public service performance in a transparent manner.

More recently, President Muhammadu Buhari introduced the efficiency unit approach in the Federal Ministry of Finance. Ashike (2015) highlights that this approach was meant to establish a new culture of service delivery that is grounded in efficiency, value for money, prudence, and integrity (Eneanya, 2018, p. 6). Unfortunately, this new system does not reprimand bad and

unethical performance in government. It is vague in nature and does not list key performance indicators (KPIs). Hence, there is no clear knowledge of what good performance is and how it is being measured. This leads to a "complexity in both the outcomes we seek to deliver and the systems we create" (Eneanya, 2018, p. 7). Although attempts to reform public service delivery have failed, it has become apparent that the success of any public delivery reform does not happen over time. Therefore, attempts to reform public delivery must be sustainable and require "government to display political will and conduct institutional reforms at the federal, state, and government levels" (Eneanya, 2018, p. 9).

3.10 How NGOs Step In Amid Government Challenges

Governments are significantly faced with public sector challenges such as: institutional capacity, multiple mechanisms of accountability, declining public service ethics, declining social values and civil service morale; and corruption, etc. (Economic Commission of Africa, 2003, p. 30). In an ideal world, civil servants are tasked with the responsibility of managing the institutions of governance. Nonetheless, they face significant challenges with managing civil services due to how polarized and politicized civil services are resulting in a lack of motivation and a high level of demoralization. As a result, governmental entities lack the institutional capacity to effectively carry out the needs of the public and promote their overall interests. Accountability from multiple ends also seems to be a challenge for public servants. Heeks (1998) defines accountability in multiple dimensions: managerial, political, financial, and public. The United Nations Economic Commission for Africa notes that "public administrators are answerable to the public on how well they have safeguarded their interests" and "in that same vein, public servants are answerable to

politicians" (United Nations Economic Commission for Africa, 2003, p. 33). The process of being accountable is not as easy as it seems. It involves defining the tenets of public service ethics — which includes both social values and the civil service morale. This framework of thinking is one that might seem foreign in most African public service settings because in many African societies, there is no system of reinforcing values which leads to various government entities pursuing a "wealth at all costs approach" (Economic Commission for Africa, 2003, p. 34). The value-based approach is an integral part of new public service since it looks at how public servants are not only gatekeepers of the law but must maintain the community values, political norms, professional standards, and citizen interests (Denhardt & Denhardt, 2000).

In order to understand how values are enforced, it is critical to look at the rate at which information flows and the presence or absence of a customer-oriented service approach in service delivery. Heeks (2002) notes that the work of government is very information-intensive and requires information to support internal management, public administration, public services, and public awareness (Economic Commission for Africa, 2003, & Heeks, 1998). The necessary information that public administrators need to inform and influence decision-making is two-fold: information that leads to greater efficiency in work streams as well as robust, concise and comprehensive information shared with the public. One of the major challenges of government that has been in the discourse is that governments have exhausted their capacity to be the sole service provider (Ali & Ghazali, 2020). Historically, governments have explored the numerous ways in which they can have citizens be more engaged in the delivery of public services. In Nigeria, the wicked problems that society faces have given rise to a third sector in public governance — self-organized bodies (civil society) that work alongside the government to address some of society's most pressing challenges. Ali and Ghazali (2020) note that the government

alone cannot address these issues and they are complex, unpredictable, and involve competing interests.

The Economic Commission of Africa notes that "governments should promote dialogue with NGOs to reduce mutual suspicion and enhance partnerships in public service delivery" (p. 54). Specifically, public service delivery research has shown that NGOs tend to reach people that are in hard-to-reach communities that are often marginalized and underserved. However, the ability for NGOs to achieve desired outcomes is predicated on their ability to be "transparent in their objectives in order to reduce government concerns about subversive activities" (United Nations Economic Commission of Africa, 2003, p. 12). The Commission notes that the existence of NGOs does not make them immune to organizational inequalities. In an effort to counteract organizational shortcomings, NGOs that find themselves in the African public service space can apply the fundamental tenets of the African Public Service Charter: equality of treatment for the people that they serve, neutrality (anti-discrimination measures for employees), legality (compliance with the law), and continuity (an approach to embedding sustainability in their organizational functions) (p. 29). These fundamental tenets can be achieved vis-a-vis effective human resource management structure and policies.

3.11 Human Resource Management

An overview of Human Resource Management in Nigeria

Nkoli (2011) examines the problems associated with human resource management in Nigeria's public sector. He identifies the problem with the public sector as being related to: work motivation and compensation, ethics, values, work attitude, recruitment, and selection process.

Throughout Nigeria's history, recruitment has always been plagued by four main factors: political pressure, theory vs practice of who you know, federal character principle of representation, and state of origin among staff in the same department. These independent factors play a role in the following outcomes: the ability of the employee, will to work, and situational factors (Nwachukwu, 1985; Korman, 1977). In a study of 190 public service professionals in Enugu, only 13% of interview respondents believed that inadequate work compensation and motivation of employees did not affect productivity. Similarly, only 24% and 21% of respondents viewed their work productivity rates as being immune to inadequate motivation and poor compensation within the department and poor ethics and value respectively.

Most respondents highlighted the fact that recruitment in Nigeria for public service roles goes beyond the formal processes of going through official channels. The interviewees responded as follows:

- 26% of them attested to the "Practice of Ima Mmadu" whereby who you know determined whether you got the job

- 21% of respondents cited the "Federal character principle of representation"

- 16% noted the common state of origin, and another 16% cited political pressure as being the factor that influenced them getting the job.

Despite the existence of a diverse, equitable, and inclusive policy such as the "federal character principle of representation"[1], informal ways of operations have a greater say on who is hired for the job. In the event that such said person does have the necessary skill set, job satisfaction must

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[1] "The composition of the Government of the Federation or any of its agencies and the conduct of its affairs shall be carried out in such a manner as to reflect the Federal Character of Nigeria and the need to promote national unity, and also to command national loyalty thereby ensuring that there shall be no predominance of persons from few States or from few ethnic or other sectional groups in that Government or any of its agencies."

be prevalent in the public service organization. Nkoli (2011) suggests that when people have a great feeling regarding the work that they do, their job attitudes significantly improve. Thus, organizations should reiteratively work to improve the work attitudes of their staff especially since it is one that permeates all aspects of public sector life (Onondugo, 2008). Nkoli (2011) also recommends that productivity can be improved through the following measures: annual performance appraisal and evaluation of workers, proper recruitment and selection processes, and promotion of the workers on a regular and merit basis.

The sociology of employee relations in Nigeria

Opute (2020) explores the concept of human resource management in Africa and highlights the "armchair" approach that is used to determine emoluments – whereby employees do not get the appropriate compensation based on their skill set. Rather than utilizing an objective system to determine whether an applicant is worthy of a position, "gut feeling" is heavily relied on which leads to people being in positions that they are often not qualified for. Osinbanjo, Gberevbie, Adeniji and Oludayo (2010) note that research has revealed that, no matter how well intentioned that may have necessitated the establishment of an organization, either by the government or private interests; the goal for establishing such organization may never materialize without the availability of competent and hardworking employees (pg. 9).

Competent and hardworking individuals are not a sufficient condition for achieving change in a public service organization. This is because success of employees is dependent on the level of supervision and mentorship that they receive. Eseka (2009) and Adebayo and Ogunsina (2011) demonstrate that success for supervision in the workplace depends on the supervisory behavior employed and the individual supervisor involved. Dubrin and Maier (1993) note that the type of supervision – ranging from autocratic to democratic – utilized by the leader as well as the

perception of supervisor credibility and desirability have positive effects on employee job satisfaction and motivation for higher productivity.

In the Nigerian context, supervising employees can be a tradeoff for achieving workplace targets. Arrendondo et al. (2018) suggest that during service delivery processes, program managers are often bombarded with multiple competing demands which results in them struggling to find time to provide actionable feedback to volunteers / program staff. In a study of community-based organizations in the nonprofit space, researchers noticed that management interventions led to a cheaper cost of HIV programs for female sex workers when management training, feedback loops, communication tools, goal setting, and planning tools became part of the daily work. In the management intervention for Abuja-based community-based organizations (CBOs), lean management – i.e., long term continuous improvement – was also introduced as a tool for effective financial, workplace, and personnel management. Organizations responded well to management interventions and became equipped with the necessary framework to continuously improve and achieve long-term efficiency and quality. Thus, supporting the notion that investments in human resource management is critical for achieving an organization's desired outcomes. Even so, these investments cannot just focus on the financial remuneration for employees, but should also look at the non-financial incentives that influence health workers' behavior.

Health worker motivation in Africa

Matheur and Imhoff (2006) argue that the health sector in Africa is afflicted by a human resource crisis that is heavily characterized by the lack of health worker motivation. In Benin and Kenya. Through a semi-structured interview with civil servants in the Ministry of Health at the district level, health workers expressed feelings of demotivation and frustration especially when it came to being unable to satisfy their professional conscience (contrasts between self interest and

concern for others) while pursuing their vocational goals. Some of these sentiments were attributed to a lack of the necessary human resource management tools needed to advance professionally. Surprisingly, these workers who are often seen as being the highest-paid among their cadre, recorded the lowest level of workplace satisfaction. Health workers that participated in the interviews cited the need for professionals and professional goals such as recognition, career development and further qualification as being ways they can meet their own personal and organizational goals.

Mathauer & Imhoff (2006) explicitly point out that decentralization of organizational functions does not automatically lead to optimal health outcomes. Even when health administration efforts are decentralized, key functions such as human resource management, overall staff distribution, remuneration, and promotion might be quite centralized. Therefore, it is important that resources are distributed equitably and made available to employees based on their needs and wants. They also distinguish between the will-do and can-do components that employees can have in the health delivery space when it comes to getting the job done. As a result, good leadership at the top cannot be overlooked since health workers often look to leaders in their workspace who are role models for adhering to organizational goals. When these role models do not lead by example, the likelihood for health workers to drive forward any change in the will-do component reduces. Moreover, health workers place high values on being recognized by their superiors as well as their colleagues and patients. Hence, good working relations with superiors and colleagues are motivational factors that can lead to more productive work environments.

The critical need for effective training and collective participation in organizational processes is an important function of HIV/AIDS service delivery. Proper training of healthcare workers should be viewed as a means of maintaining employee morale and motivation. Mathauer

& Imhoff (2006) also make it known that the mere act of having staff participate in organizational activities is not synonymous with actual decision-making. As a result, staff can sometimes have a passive undertaking to workplace activities that do not translate to them actually effecting change. Mathauer & Imhoff (2006) propose five (5) different steps that can lead to an effective human resource management process in an organization; (i) search for excellence: contribution of the whole staff body to quality improvement efforts (ii) orientation on quality as an outcome as much as on the quality of the process (iii) strong emphasis on self-evaluation of individuals and organizations (iv) more autonomy and responsibility for health workers (v) focus on participation and self-realization, empowerment and to a certain extent, the emancipation of health workers.

3.12 Human Resource Management (HRM) Performance In Africa

A major HR challenge in the African health care industry is that the size of the workforce is disproportionate to the burden of diseases. Gile, Samardzic, & De Klundert (2018) note that the shortage of health workers is a reflection of the high demand for health programs and services. As a result, "implementation of human resource management (HRM) practices is needed to improve the situation for a depleted and overstretched health workforce, and patient outcomes" (para. 1). On the other hand, hard resource management includes financial resources, equipment, organizational infrastructure, etc. Gile, Samardzic, & De Klundert (2018) note that stakeholders cannot only focus on the hard practices, even though they have been shown to improve performance outcomes such as quality of care, patient experiences, etc. The effective application of hard HRM positions an organization to achieve its goals/targets, but broader interventions are still needed to have a more sustained workforce.

A broad set of interventions known as soft human resource management (HRM) include training and development needs, tasks and roles clarification, training and delegation, motivation, etc. can significantly boost workplace performance when used in tandem with the hard practices. According to their literature review of existing work, soft HRM and hard HRM can affect:

- Employee outcomes (employee performance, job satisfaction, turnover intention, retention, etc.), team performance outcome, etc.)

- Team performance outcome

- Organizational outcomes (quality of care, waiting time, staff shortage reduction, etc.)

- Patient outcomes (patient care, clinical outcome)

According to their systematic review of human resources management literature, interventions aimed at improving skills and motivation practices lead to effective communication/feedback practices, teamwork, and supervision. As a result of these conditions being present, organizations experience improved employee satisfaction, motivation, retention, and performance. Nonetheless, the ability for African organizations to professionalize human resource management practice as a function/department is yet to be studied. Gile, Samardzic, & De Klundert (2018) stress the importance of tailoring HRM practices to fit the needs of the organization at hand through an effective use of internal and external factors that are relative to the unit (organization).

Conflict Management in Nonprofit Organizations

Organizations go through their respective journeys, and managing human capital within the organization can give rise to individual or group differences in interests, beliefs or values. (Onyejiaku, Ghasi, & Okwor, 2018, p. 37). In *Management of Conflict and its Implications on Nigerian Public Sector Organizations*, the authors explore management of conflict and its implications on Nigerian public sector organizations by looking at how conflict emerges within

Nigeria public service organizations. They cite the work of Pondy (1992) in stating that "the absence of conflict may indicate autocracy, uniformity and stagnation within an organization". Therefore, conflict in an organization should not be seen as a bad thing. Specifically, it can even signal the lack of groupthink since conflict may be indicative of "democracy, diversity, growth and self-actualization" (p. 38). They suggest that disputes occur when interests, goals or values of different individuals or groups are incompatible with each other. Moreover, conflict can often involve a range of behaviors and attitudes that are in opposition between managers and the people that they are supervising.

Robbins (1998) classifies conflict as either being vertical or horizontal. In vertical conflicts, differences in status and power between groups are larger than in the horizontal conflicts whereby the point of disagreement is between members of the same level / colleagues. In an attempt to avoid conflict, three strategies are recommended. They are the following:

- Collaboration: People who lean towards this style try to meet the needs of all people involved. These people can be highly assertive but unlike the competitors, they cooperate effectively and acknowledge that everyone is important. This style is useful when you need to bring together a variety of viewpoints to get the best situation, or when the situation is too important for a simple trade off

- Accommodation: People who prefer this style try to find a solution that will at least partially satisfy everyone. Everyone is expected to give up something and the compromiser also expects to relinquish something. Compromise is useful when the cost of conflict is higher than the cost of losing ground, when equal strength opponents are at a standstill and when there is a deadline looming

- Avoidance: People tending towards this style seek to evade the conflict entirely. This style is typified by delegating controversial decisions, accepting defaults decisions, not wanting to hurt anyone's feelings. It can be appropriate when victory is impossible, when the controversy is trivial, or when someone else is in a better position to solve the problem.

As a solve to conflict, Onyejiaku, Ghasi, & Okwor (2018) suggest that managers should do the following;

(i) develop diverse and appropriate strategies to resolve emerged conflicts

(ii) employees should be educated on how to manage their superiors and subordinates

(iii) organizations should be provided with seminars/workshops on a periodic basis to learn about conflict resolution and how it can be managed for organization effectiveness.

In order to mitigate conflict, managers should also realize that "conflict can be fueled through a plethora of means including: "priorities and perceptions of community members and groups vis-à-vis those of development organizations, and by the impact of funds on often desperately poor communities" (Gruber & Caffrey, 2005, para 1).

3.13 HIV/AIDS Funding

Partnership Framework for HIV/AIDS funding

In 2010, the United States government launched a partnership framework agreement with the government of Nigeria to provide at least 50% of its HIV/AIDS funding by 2015 (Ndoh, 2013, p.5). These financial resources are important in tackling the burden of HIV/AIDS in the country. Nonetheless, it is also important that the country does not get overly dependent on the provision

of such financial resources. In reality, an overdependence on these resources can lead to programs being unsustainable and lacking country ownership. The history of HIV/AIDS funding in Nigeria can be traced as far back as 1986 when the first HIV/AIDS case was reported (p.6). The vast majority of the funding in Nigeria has come from international donor agencies such as: The Presidential Emergency Plan for AIDS Relief (PEPFAR), Global Fund for Tuberculosis, AIDS, and Malaria (GFTAM) (p.6). Before 2003, people living with HIV did not have access to antiretroviral treatments and key interventions such as: CD4 counts and viral load count. However, that all changed with the launch of PEPFAR. Since then, 15.9 billion dollars has been committed to fighting the HIV/AIDS pandemic in Nigeria (p.7). The financial investment in the country is mostly geared towards supporting HIV/AIDS prevention, treatment, care, support, and health systems strengthening.

In an interview with health policy professionals that are directly working on HIV/AIDS funding in the Nigerian landscape, Ndoh (2013) reveals that policy stakeholders who are involved in the funding of HIV programs view public-private partnerships as being a requisite for program sustainability of HIV/AIDS services (p.17). However, public-private partnerships should not just mean that business is done as usual since bureaucracy and red tape can often stifle any decision-making process. In addition, excessive budgetary appropriations of HIV services can often lead to programs and services not reaching those that it is intended for. Last but not least, respondents that were interviewed referenced the need for more local antiretroviral therapy in order to reduce the supply chain gaps when it comes to people being unable to get these key medications. In light of these policy recommendations, there is a clear need for transparency of HIV/AIDS funds in order for stakeholders to have full awareness of how their financial resources are being used for key programs and services.

Affording HIV services

Achieving HIV national and global targets requires that HIV programs/services are provided at lower cost(s) and on a wider coverage level. Saleh et al. (2018) explore Nasarawa state in Nigeria shows that the cost at which services are provided for HIV is not only higher but the coverage level is significantly lower compared to other similar regions in Kenya, Tanzania, and Cote d'Ivoire. The authors suggest that funding needs are significant for AIDS response even though public resources are constrained.

In a comparative analysis of Nasarawa state to other Nigerian states, Saleh et al. (2018) assert that the struggle to finance HIV/AIDS programs in the long-term is one that is not just akin to Nigeria but is a unique challenge that affects low-income countries (LIC) as well as their low middle-income counterparts (LMIC). Even when the economy is growing at an alarming rate, there is still a need for resources to be mobilized sufficiently and for general government expenditure to increase.

Domestic funding through innovative and accountable means

Domestic funding of nonprofit organizations is a way to create sustainability for HIV/AIDS programs in Nigeria. Organizations that receive sustainable domestic funding are better positioned to achieve their theory of change, create conducive work environments, and work effectively with cross-sector stakeholders. In a five-year progress report that looks at HIV/AIDS by an indigenous organization, Oleribe et al. (2017) explore how an organization was able to offer decentralized, commonized, and integrated HIV services that reached 164,746 pregnant women living with HIV. In addition, this program also managed a staff of 500 healthcare workers in program management.

The program was known as the Excellent and Friends Management Care Center (EFMC) HIV/AIDS program and it was based in Nasarawa – a state that often has one of the highest HIV

rates in the country and Abuja. Funding was used to instill change processes to over 388 people in the form of HIV management, monetary evaluation, leadership management, and effective communication. Oleribe et al. (2014) alluded to the fact that employees are more concerned about working conditions than pay. Although employees had a high turnover rate which was triggered by poor remuneration, staff modulation was often at the greatest heights when leadership styles of the top managers were conducive to the work-life balance of the employees being managed. Furthermore, the use of funding as a change management driver also facilitated close collaboration with other various government health offices.

During this five-year program, the National Agency for the Control of AIDS (NACA) began to galvanize local funding from the government and private sector in order to ensure that it can be sustainable. Nonetheless, program stakeholders realized that dependence on external funding is not sustainable especially when the funding is tied to various stipulations that might not be met by organizations. Instead of seeing foreign aid as "be-all and end-all" approach to tackling the epidemic, the government should assume full ownership of HIV financing in the country.

Public spending to tackle the epidemic requires innovative approaches that go beyond providing people with key treatment, but also engages cross-sector stakeholders. Remme et al. (2016) suggest that annual public HIV spending in affected countries can significantly increase from $ 3M to $ 11B. However, in order to achieve this increase, it is important for countries to tap into all their fiscal options. As more work is done to combat the HIV/AIDS epidemic, there needs to be a balance of both international and domestic financing since domestic financing cannot tackle the burden of HIV/AIDS alone.

Remme et al. (2016) suggest that HIV funders should engage in broader health and developmental outcomes which can lead to the promotion of health and all policy when it comes

to emphasizing the gains of ending HIV/AIDS. Furthermore, the link must be made at such robust levels on how HIV/AIDS progress positively correlates to development and social outcomes. Engagement of stakeholders can lead to program efficiency and sustainability which in turn creates a more cohesive framework for finding ways to co-finance national HIV response. These potential approaches can be through the following:

i. sources for generating new resources (revenue mobilization),

ii. sharing existing resources differently (reallocation),

iii. spending existing resources better (efficiency gains).

Remme et al. (2016) also note that "previous analyses have only considered spending for services within the health or HIV boundaries, and do not consider how spending in other sectors that also influence HIV or health may contribute to effective financing of the HIV response." (p. 42). Therefore, there is a need for HIV financing to be integrated into larger financing approaches in other sectors in order to make HIV financing more integrated and more sustainable over the long term.

Using public financing for the good of the people

In a study of 14 African countries including Nigeria, Remme et al. (2016) explored the notion of fiscal space by exploring how public financing can be used to achieve HIV targets over the next five years. The term fiscal space "is used to describe the budgetary space available to allocate public resources through specific objectives, without damaging other developmental or macroeconomic objectives" (Roy and Heuty, 2009; World Bank and IMF, 2006). Remme et al. (2016) note that there are six main sponsors for increased physical space spending which includes (i) conducive macroeconomic conditions to economic growth (ii) improved taxation/revenue

generation (iii) borrowing (iv) reprioritization (v) sector-specific earmarked sources of revenue (vi) efficiency gains.

Duarte & Hancock (2017) examine the role of HIV/AIDS funding in South Africa and examine the relationship between funding and achieving HIV/AIDS outcomes. Annually, millions of dollars are invested into tackling HIV/AIDS in Africa due to the fact that it has the largest burden of the disease. South Africa alone accounts for 39% of HIV/AIDS cases in Africa. (p. 2) In addition, South Africa and Nigeria are both respectively the fastest growing rates of new infections with Nigeria having the most AIDS-related deaths worldwide (p.2). In terms of donor funding, Africa receives 57% of all global HIV/AIDS funding (p. 3). These funding sources primarily come from the United States and the global fund which accounts for 80% of total funding followed by the United Kingdom, World Bank, and Sweden (p. 3). Throughout the years it has become clear that there is a need to diversify funding for HIV/AIDS programs/services. Doing this would result in countries not being overly dependent on external foreign funding. Furthermore, it would also lead to greater country ownership by fostering accountability at all levels of society. Duarte and Hancock (2017) suggest that public spending for HIV/AIDS programs and services is managed at the national government level and sustained over time. Nevertheless, they caution that the government is not the owner of all the resources by which change happens since the ability to correctly identify, size, and prove the governmental corruption is difficult to assume and retrieve (p. 4).

Sustainability of donor funding

Government cannot work in silos and requires the use of collaborative structures to achieve HIV/AIDS targets. Therefore, the third sector (i.e., n nongovernmental organizations and civil society) can play an effective role in alleviating the HIV/AIDS burden through the provision of

quality care and services for not only PLWHA, but also the general public. Olakunde & Ndukwe (2015) posit that the "dwindling of donor funds sustainability (the capacity to maintain program services at a level that can provide ongoing prevention and treatment for a health problem after the termination of major financial, managerial, and technological assistance from an external donor) of these achievements has come under serious threat, necessitating exigent mitigating measures." (p. 684).

Historically, the rate of increase for HIV/AIDS funding has actually been on a steady decline. For example, between 2009-2012, the rate of percentage increase in external funding dropped from 17% to 8.2%. (NACA, 2014). This ongoing phenomenon creates a conundrum for Nigeria since it is one of 51 countries that depend on international aid for more than 75% of its HIV-related expenditure (WHO, 2014). Since funding streams are not as high as they used to be, it is important that several pathways are explored to mitigate financing gaps that arise from donor-funding. Olakunde and Ndukwe (2015) recommend that funding streams are diversified through HIV/AIDS-dedicated taxes, levies, private sector contributions, and public–private partnerships. The diversity of funding mechanisms can play an intrinsic role in tackling the "backdrop of dwindling donor support" and improving domestic funding (p. 687).

3.14 Conclusion

In Chapter Three, I explore the different dimensions of public administration as it relates to service delivery. I also show how government efforts geared towards reforming service delivery in Nigeria have been futile. This can be attributed to the disconnect that exists between bureaucrats and their employees when it comes to transforming the manner in which services are delivered to

the public. As a result, the work of third sector actors (i.e., NGOs in the civil society space) can be a solution to the systemic ineptitude that exists in public service delivery. Funding plays a critical role for NGOs since they require liquid capital to maintain their operations. Bearing this in mind, organizations must diversify their funding streams in order to meet the changing demands of funders. As stakeholders in the public governance arena, NGO practitioners should be more fixated on ensuring that the interests of the citizenry are met, rather than simply achieving positive performance outcomes and meeting donor requirements. In spite of the shared sense of purpose that they have amongst each other, NGOs have to keep a keen eye on the intrapersonal and interpersonal relationships that exist in their ecosystem so as to promote optimal working environments. Chapter Four of this dissertation will examine the interplay between systems, processes, and leadership functions and how these factors can enable organizations to have efficient service delivery and sustainable impact.

4.0 Organizational Technology Applications to HIV/AIDS Service Delivery

4.1 Introduction

The citizenry is more trusting of non-governmental organizations than state actors in the service delivery space. As a result, people are more receptive to the provisions of these third sector actors. Arguably, professionals in the NGO space ought to have an individual and collective moral and ethical decision-making compass that can help them derive solutions to common issues/problems. Accordingly, pursuing the moral good involves being strategic in the manner in which resources are utilized to achieve a specific target. Specifically, organizations that have the capacity to scale, can utilize the sum of their inner and external resources and processes – also known as organizational technology – in an innovative manner that would allow them to improve service delivery and achieve sustainable impact in the long run. In order for organizational technology to be effective, it must be grounded in evidence and be inclusive of different stakeholders within and outside an organization's ecosystem.

4.2 Ethical Management And Organizational Technology

Ethical Management of HIV Services

In an ethnographic case study, Smith (2012) explores the interconnected nature among inequality, morality, and corruption in Nigerian HIV/AIDS NGOs. Smith suggests that "local opinions of particular NGOs and their leaders turn less on whether donor resources were misused

and more on the ways that people who accumulate the benefits of corruption use them socially."
(p. 1). Among Nigerians, the degree to which corruption is tolerated or condemned is less on
whether donor resources were misused and more on the ways that people who accumulate the
benefits of corruption use them socially (Smith, 2012). Thus, corruption in the Nigerian setting is
easily incorporated into the day-to-day operations of an organization as long as it is done covertly.
People are also more trusting of nonprofit organizations than the government since NGOs are
champions for the provision of key services for PLWHA. Furthermore, Nguyen (2010) suggests
that NGOs have fostered therapeutic citizenship whereby they facilitate any benefits that citizens
can claim from the state. However, there is a downfall to this which is characterized by the inability
of citizens to demand for access to key services which can benefit them. For example, inequalities
and morality affect people's accessibility to HIV/AIDS services which can lead to people not
asking for treatment or being denied the services at local clinics/hospitals. However, inequality is
not just experienced during the patient(s) and the service provider.

Smith (2012) argues that "organizations experience inequalities both within and amongst
themselves in the provision of services" due to the patron-client relationship that they operate in
so as to compete with one another. As a result, there is an inequality that arises from the
predicament of deciding whether to comply with the moral economy (i.e., effectively and ethically
using resources for what they are) as well as, whether to use their collective morality in shying
away from preconceived notions or judgment of people such as commercial sex workers, sexual
minorities, etc. Corruption arises when inequality and immorality are used to achieve targets and
goals that are not in the best interest of the people being served. There is also a likelihood to be
corrupt in HIV/AIDS organizations since there can be a disconnect between the people that these
NGOs serve as well as the funders that they report to. In several instances, corruption might be

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part of an organization's culture and be acceptable if it does not disrupt daily operations. Therefore, fighting corruption involves changing a whole system as well as having morally competent and ethical employees.

Human capital is a primary driver of an NGO's internal and external outcomes. Therefore, it is critical to examine ownership of control and power in an NGO, and to understand that people might be intrinsically or extrinsically motivated to build their career platforms through an NGO. As a result, these individuals might align themselves more closely with a patron so as to have the most optimal outcomes. This alignment with the patrons might not be always in the best interest of the people being served and this can lead to inequality in their practices. Smith (2012) also argues that access to dollars is a linchpin by which organizations are able to achieve their goals. In many cases, morality is undermined by the perceptions and judgment that people make of their work. This can either be characterized by people's refusal to offer services to key populations or their ability to stray from the moral economy and pursue their respective individual's self-interest.

Ethical decision-making is not based on self-interests and can effectively foster change, which in turn impacts the lives of PLWHA. Asuzu (2006) explores the morale by which prevention and control of HIV/AIDS occur in Nigerian facilities. According to him, there is a lack or failure to obtain informed consent before screening patients for the disease. In addition, Nigerian facilities are also plagued by health worker discrimination and abandonment of patients who are positive. The US Institute of Medicine (2011) recommends that there are two moral imperatives that should guide moral and ethical decision-making. According to them, there should always be a morally acceptable approach to decision-making that looks at the macro and meso levels. At these levels, the art and science of decision-making should focus on the "need to pursue justice in the distribution of benefits and burdens; and at the micro level, to ensure that decisions are in the best

interests of patients" (p. 163). Furthermore, they advocate that effective decision-making is a community-based participatory approach that requires affected individuals to either directly or indirectly (through group representatives) have a seat at the table, which in turn would influence HIV/AIDS service delivery.

Organizational Technology

Neuby. B.L (2016) defines organizational technology as the sum total of man-made contrivances or developed processes that alter, refine, or create new goods and services delivered by organizations. He posits that organizations that adopt technology, learn, and mature, but do so at an uneven pace. Therefore, the use of organizational technology to improve service delivery and sustainable impact is one that is a continuous process. Several organizations that look into adopting technology do so without a clear goal or policy in mind. Nevertheless, the use of technology does not alter hierarchy and management styles nor decrease red tape. Organizations are more likely to adopt the use of technology when it comes to "keeping up with the Joneses" since it not only makes them competitive, but allows them to exhibit the same kind of behaviors that their peers might display.

In an effort to boost productivity and streamline processes, it is actually common practice for organizations to adopt technology even when there is not a clear goal or policy in place. Heintze and Brettscheinder (2000) highlight that "without proper management, policies, and support, technology can be counteractive to an organization's mission – reducing the organization's effectiveness due to the hierarchy, management styles, and red tape that may be associated with a specific kind of technology. Thus, the organization might have found a way to manage without actively incorporating it in its operations. Even when incorporated into an organization's

workflow, an evidence-based approach to understanding it is required. This is because it allows for the following questions to be asked:

i.   Who has access to said technology?

ii.   How is data used and verified?

iii.   Are control and access to data only utilized by a few, and to what extent is the use of technology inclusive of the key stakeholders within an organization.

In 2009, the Nigeria HIV/AIDS National Strategic Framework emphasized the need to strengthen the national capacity for gender-sensitive monitoring, evaluation, surveillance, research, and adoption of new HIV/AIDS technology. In spite of that, there was no timeline as to when the milestones of technological goals need to be achieved. One of the objectively verifiable indicators is to establish three facilities for producing technology that can lead to better and more effective management of HIV/AIDS in Nigeria. However, the technology is not listed and it is not made known the extent to which financial resources are available for expanding on such necessary technology. The goal of the framework is to produce materials on HIV technology and integrate them into HIV education, there is no focus on whether or not the stakeholders that need to be educated have the necessary means of operating their technology or even assessing such infrastructure. As a collective, organizations have been unable to coax the Nigerian government on what its plans are for adopting key technology in the fight against HIV/AIDS.

MacLennan & Belle (2013) suggest that external factors and industry pressure have been recognized as having positive effects on the adoption of technology. (p.3). Notwithstanding, individual factors are not strong alone for the adoption of organizational technology. This is because organizational factors can subsume individual factors (Hausmann et al. 2010) when it comes to the relationships of different entities within the organization. Intra-organizational

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acceptance is dependent on a wide array of factors such as centralization & formalization, organizational structure, skills & expertise of human resource capital as well as demand of slack resources available – cash, people, machinery, etc. (Hackney et al., 2006).

MacLennan & Belle (2013) also note that a service-oriented architecture – software technological applications – can result in a significant change in the way in which resources function. It can change an organization's process philosophy (interaction level) and infrastructure (business procedures and policies) which can come at a high cost even though the economic returns are significant. In order for technological innovation decision-making to happen, an organization must have a push from its external environment which only arises when there is an industry characteristic that it can adapt to as well as technology support infrastructure and conducive government regulations. Once these conditions are present, the organization would need to have the formal and informal linking structure in place for it to begin its learning journey.

The process by which organizations fully embrace organizational technology – particularly, information, communication, technology (ICT) is predetermined by four Cs: connectivity, cost, capacity, and culture (Bukachi & Walsh, 2007). Connectivity can be defined as the speed by which usage levels of internet networks affect processes. Thus, institutions might be reluctant in continuing the use of technology when it acts as an impediment. Similarly, an organization has to also weigh the cost of any technological innovation that it may choose to undertake since it does not often come at a cheap price. The price of adopting technology in the organization must be weighed alongside line items in the budget. Thirdly, internal capacity to manage the technology infrastructure is the topmost priority. According to Bukachi & Walsh, local expertise and human resource capacity as well as the organizational structure needed to support the effective use of ICT in organizations remains a challenge for many organizations (p. 1627).

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Lastly, the work culture plays a role in how health information is used. For many entities, health information is internally disseminated through word of mouth, even amid technological resources. Therefore, the introduction of workplace technology in the African setting cannot replace the oral culture of doing work that primarily characterizes these organizations. Rather, it must be used in tandem through a mix of old and new (more modern) technologies.

The effective use of organizational technology in a nongovernmental organization can strengthen the delivery of care to people living with HIV/AIDS; however, it does not alter hierarchy or management style or reduce red tape (Luna-Reyes and Gil-Garcia, 2014; Pandey and Bretscheneider, 2014). There are many times when knowledge transfer does not run effectively within the unit (organization) and this can unfortunately affect the ability of the absorptive capacity of the organization (Cohen and Levinthal, 1990) as well as the manner in which they can contribute to civic space.

Gagnon and Dragon (2002) depict that NGOs operate in a concrete system of action in a manner characterized by a "social system dynamics that are grounded in the behavior of groups of actors who develop particular strategies in a set of relationships that are subject to constraints of the environment" (pp. 19-20). In order to operate in this ecosystem, an organization must have an information system that allows it to acquire, implement, and use technology (p. 20). The acquisition of the appropriate technology should permeate all levels of the work environment – including interaction with stakeholders – and have long-term effects on productivity, organization of work, and job satisfaction (p. 29).

4.3 Service Delivery Evidence From Stakeholders

HIV service delivery cannot only focus on status awareness

Public health research shows that stakeholders like those in the private sector can be effectively engaged in the fight against HIV/AIDS through policy setting. The Nigerian Business Coalition Against AIDS (NIBUCAA) – is a coalition of leading businesses that are committed to fight the HIV/AIDS pandemic at all levels of intervention within the health systems and private sector workforce (NIBUCAA, n.d.). From 2014 - 2015, the private coalition – in conjunction with the National Agency for the Control of AIDS (NACA) and Ministry of Labour and Productivity – worked in creating the first-ever HIV/AIDS workplace policy (NACA, n.d). This was adopted by several private organizations, 170 small and medium sized-enterprises (SMEs) in 12 Nigerian states. Nonetheless, the policy was implemented as a vertical program providing mostly HIV testing services and informational services to the workplace (p. 52). Therefore, the rudimentary factors that increase one's risk for the virus were not tackled through disease control and prevention programs such as the provision of condoms or through the promotion of safe sex practices and behavior among the workplace populace (p. 53). As a result, individuals might become more aware of their disease status, but that does not translate to long-term HIV prevention practices. Despite its shortcomings, NIBUCAA utilized the principle of greater involvement of people living with HIV/AIDS as a means of ensuring that these individuals are able to move the HIV needle forward by having a seat at the decision table, which in turn can lead to an economically prosperous and inclusive workforce

The interconnected nature of combating HIV/AIDS and business outcomes

Evidence shows that stakeholders can accelerate efforts to combat HIV/AIDS by making the case of an economic impact on the Nigerian household. Therefore, efforts to combat the

epidemic must highlight the positive correlation between the disease burden and the economic impact on the Nigerian household. (Mahal et al., 2008). In a 2004 random survey of 6400 people living with the virus, it was noted that living with HIV worsens the quality of life due to the direct private healthcare costs and indirect income loss per-HIV positive individual. Specifically, 36,065 Naira ($94.60) per month which represents 56% of annual income per capita in affected households. Furthermore, there is also a considerable loss of work time and family time due to caregiving. Knowing this, NIBUCCA has made the case for why combating HIV/AIDS leads to better outcomes for Nigeria. In an advocacy meeting organized by MTN - the largest mobile phone company in Nigeria - Olusina Falana, the former executive secretary noted that "the earlier we mainstream our resources to turn the tide against it, the better it will be for tomorrow's business" (UNAIDS, n.d., pg. 1)**.**

Engagement of National HIV stakeholders in HIV Response

Public health findings suggest that the private sector can be used as an effective tool for "contributing significantly to antiretroviral therapy (ART) and prevention of Mother to Child Transmission (PMTCT) of HIV service delivery in Nigeria" (Ezechi et al., p. 1). In-depth interviews with 60 individuals – representing national policy-makers, public health, and private sector administrators, etc. – were conducted to assess the challenges and barriers to the provision of ART and PMTCT as well as the need for specific recommendations on how to solve these problems. With national plans to decentralize ART, the stakeholders being interviewed responded that the private sector is a resource that can be leveraged to alleviate the patient load on public facilities, provide services at shorter times, reduce stigmatization, and provide more flexible scheduling (Anígilájé et al., 2013). Moreover, they noted that the private sector's involvement in

national HIV/AIDS response should not be siloed, but rather involve interactions with health care centers, faith-based hospitals, and traditional birth attendants (p. 4).

Engaging with these multiple parties also involves a reorientation of how the private sector functions. Respondents highlighted that the private sector is in the business of making profit while ART and PMTCT service provisions are "expected to be free" (p. 5). As a result, their contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) has been low – 29,127 (16.3%) of the 179,178 enrollees in 2012. Furthermore, they also noted that this has led to the inability or lack thereof to support regular maintenance and replacement of deteriorated lab equipment – such as the CD4 machine (the instrument responsible for counting the number of white blood cells) in the body. A more in-depth level of involvement from the private sector can result in PLWHA not needing to pay for services – a practice that is often implemented to cover the maintenance costs of equipment (p. 5).

Engaging the private sector does not only mean cross-sector engagement, but also private health care providers. This particular group has the ability to intervene in the health care delivery process by, which would "alleviate the patient load on public facilities, provide services at shorter waiting times, reduce patient's stigmatization, and provide more flexible appointment scheduling" (Ezechi et al., 2014, p. 6; Feeley et al., 2007; Ramiah & Reich, 2005; Ramiah & Reich, 2006). Ezechi et al. (2014) recommend that private health care institutions are incorporated into a model of service delivery that enables civil society organizations and primary health care centers to work hand in hand with one another.

4.4 Engagement Of Stakeholders

Clinical Engagement of Stakeholders in HIV Prevention

Stakeholders must be engaged on the latest advancements in HIV treatment and prevention in order to scale impact at the individual, community, and national levels. The global health organization, FHI 360 presents the notion that stakeholders are critical allies in HIV prevention research (MacQueen et al., 2012, p. vi). In conducting a clinical HIV prevention trial, there are five groups that should be engaged at the clinical level: local community members, health care programs and service providers, researchers, funding, agencies, and regulatory bodies, HIV and AIDS policymakers and advocates, and trial participants, families, partners, neighbors, coworkers.

According to them, good-quality engagement of stakeholders should require an ornate level of effort - before, during, and after the trial. This would allow such entities to play a critical role in implementing interventions as well as in disseminating research findings (p. xvi). As a result, the general public can be mobilized and participate in the rollout and delivery of effective HIV prevention tools and development while they are being identified. In the Nigerian Canadian Collaboration on AIDS Vaccine (NICAAV) Study – a mixed-methods study – research explored the role that community based organizations (CBOs) and community members can play in HIV vaccine research in Nigeria. Folayan et al. (2019) suggest that after being exposed to pertinent knowledge, community stakeholders actually have a significant increase in knowledge about HIV vaccine research design and implementation. This was achieved through a community based participatory research process that involved:

- Engagement of not only CBOs but as well as the media and community advisory boards. These stakeholders all worked together to develop an advocacy agenda that targeted key prominent members of the community.

- Building capacity of community based organizations, the press, and members of the inter-organizational community advisory board to conduct community awareness and HIV education activities.

Despite the increased level of knowledge, stakeholders in the study noted that the low budgetary allocations limited community coverage. Specifically, 60% of the respondents were not satisfied with the level of financial support. As a result, they were limited in their ability to integrate the current knowledge gained from the Nigerian Canadian Collaboration on AIDS Vaccine (NICCAV) project into existing organizational programs. Therefore, increases in HIV clinical knowledge should be coupled with the creation of an enabling environment for stakeholders to implement key lessons over the long run.

Socioecological engagement of stakeholders

Despite the progress made in the fight against HIV/AIDS, Nigeria still has the highest number of new pediatric HIV infections (Dirisu et al., 2020). Key informant interviews (KIIs) were conducted with twelve stakeholders on some of the issues associated with the uptake of prevention of mother-to-child transmission (PMTCT) services in Kano (Northern Nigeria) – the second most populous state in Nigeria. Stakeholders that were interviewed represented PMTCT implementing partners, service providers, and community leaders. During these interviews, respondents explained some of the reasons as to why heightened knowledge on HIV does not translate to long–term healthy positive behaviors. On the individual level, a member of the State Authority noted:

"*The level of awareness is high. To me, there is hardly any community that you will enter and will talk of HIV/AIDS, even in local terminology they all know. They must have heard at least once or twice about it. . .I can't believe that there is anybody now in the community that you say*

(ask about) HIV/AIDS or 'kanjamau' [Hausa slang for HIV] . . .that will not know it. But awareness of ways of getting infected, transmitting it. . .getting (i.e., knowing) your status. . .preventing it, treatment and care, that one I can say is. . . low" (p. 4).

Table 2 HIV Awareness in the North

State/No	States in the zone	Awareness: Heard of HIV AIDS	Awareness: AIDS does not have a cure	Number of men and women interviewed
1	Jigawa	83.5	57.4	756
2	Kaduna	99.0	76.1	919
3	Kano	90.4	68.2	762
4	Katsina	92.3	40.2	628
5	Kebbi	75.8	67.6	728
6	Sokoto	84.4	62.3	756
7	Zamfara	69.9	71.4	658
	North-West	**85.0**	**63.3**	**5,207**
1	Benue	93.1	77.7	886
2	Kwara	72.3	59.1	611
3	Nasarawa	72.0	65.6	672
4	Niger	89.9	60.2	779
5	Kogi	97.1	69.2	804
6	Plateau	91.2	68.0	810
7	F.C.T	94.8	64.9	657
	North-Central	**87.2**	**66.4**	**5,219**
1	Adamawa	95.0	82.1	891
2	Bauchi	75.3	68.6	574

3	Borno	65.3	56.3	517
4	Gombe	91.9	76.5	804
5	Taraba	96.2	71.8	907
6	Yobe	86.7	67.2	490
	North-East	**85.1**	**70.4**	**4,183**

Source: (Chiwa et al., 2018)

Table 3 Awareness of Positive Behavior Health Practices

S/No	States	Stay with one uninfected partner	Use of condom every day	By abstaining from sex	Avoiding sex with CSWs	By reducing no. of sexual partners	By avoiding sex with people with multiple sexual partners	By avoiding sharing of sharp objects	No. of men and women
1	**Adamawa**	84.6	56.2	69.2	79.6	65.7	81.2	86.7	938
2	**Bauchi**	68.5	35.7	60.0	63.5	48.6	54.5	60.7	763
3	**Benue**	82.5	74.2	77.3	64.1	63.6	66.2	80.1	951
4	**Borno**	56.0	16.5	39.2	48.8	39.1	41.3	46.0	791
5	**Gombe**	85.0	61.0	78.4	77.0	73.0	77.8	79.3	875
6	**Jigawa**	70.2	20.2	40.0	58.2	46.6	60.8	68.1	906
7	**Kaduna**	97.9	79.2	88.3	79.0	78.8	85.6	95.7	928
8	**Kano**	85.1	38.7	70.0	75.8	59.2	72.1	80.6	843
9	**Katsina**	76.0	26.0	66.9	60.2	58.4	56.2	54.9	680

10	Kebbi	57.1	23.0	36.7	44.7	24.9	34.4	49.5	959
11	Kogi	86.7	70.0	76.9	75.2	72.1	79.0	82.7	829
12	Kwara	57.8	45.9	38.1	33.5	33.3	37.0	56.6	844
13	Nasarawa	60.7	47.9	55.9	41.0	38.5	41.0	51.3	934
14	Niger	81.3	52.6	76.0	78.9	72.4	75.3	73.1	868
15	Plateau	77.8	56.9	73.0	57.0	55.7	63.4	75.0	888
16	Sokoto	78.3	51.5	64.4	75.4	65.8	69.0	74.3	895
17	Taraba	91.5	63.2	78.9	75.5	74.3	77.3	83.0	943
18	Yobe	71.8	25.8	58.5	68.3	48.2	60.9	72.3	565
19	Zamfara	54.0	25.8	49.1	42.5	38.3	43.4	47.9	941
20	F.C.T	85.7	79.3	74.6	63.8	67.9	72.9	79.6	694
TOTAL		**75.4**	**47.5**	**63.6**	**63.1**	**56.2**	**62.5**	**69.9**	**17,035**

Source: (Chiwa et al., 2018)

On the interpersonal level, there is a gender bias associated with the disclosure of an individual's HIV status to their respective spouse/partner. Women, in particular, are afraid that they would be deemed as being unfaithful once their husbands get to know about their HIV status which can lead to them being sent away from their homes or divorce. In the community, stigma is

the main driver for why people choose to shy away from PMTCT programs. Most members of the community do not know what PMTCT is; as a result, they are easy to label people seeking such services as HIV positive individuals when that is not the case. The perceptions that people have also prevent some individuals from seeking antenatal care and/or even delivery by skilled birth attendants due to superstition and these fears can even be heightened when hospitals are known in the community for particular HIV services. Thus, women might not be able to receive prevention and/or treatment services anonymously.
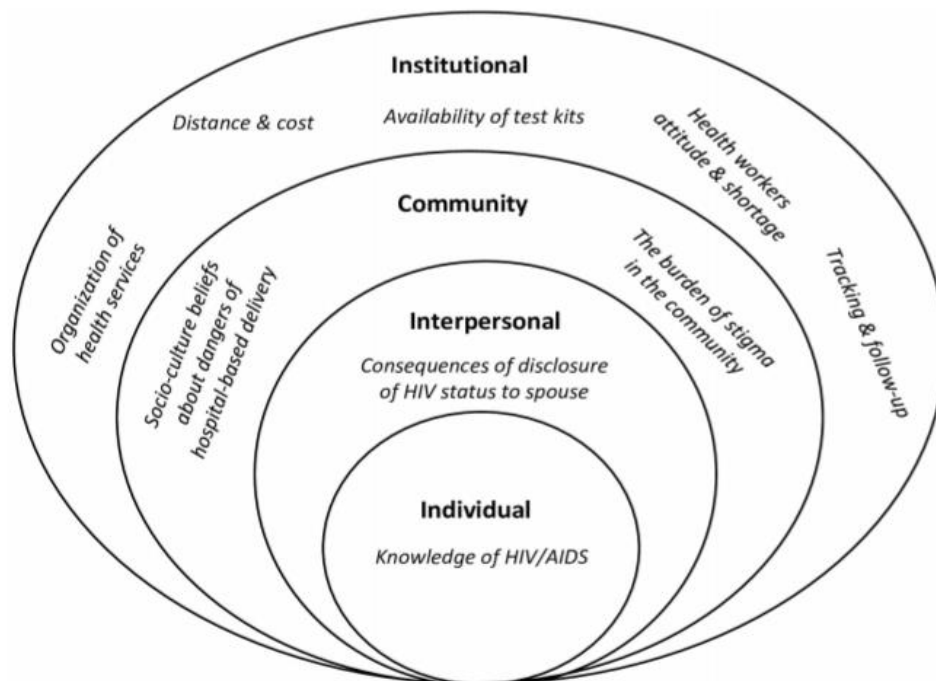

Fig 1. Social ecological model of barriers to PMTCT in Kano state, Nigeria.

Figure 5 Barriers to accessing PMTCT services

(Dirisu et al., 2020)

4.5 Hypothesis

In this exploratory research study, I posit the notion that high organization technology when coupled with high organizational capacity leads to efficient service delivery and sustainable impact.

I define organizational technology as the use of evidence to inform and influence decision-making in an organization. In this context, evidence is defined as the collective makeup of leadership styles, processes, technology infrastructure, and shared networks (grounded in a shared vision for public service) that enhance the ability of a nongovernmental organization to deliver quality HIV programs and services. For the purpose of this study, I also define organizational capacity as the ability for organizations to have the human resource capital needed to make processes more efficient and streamlined.

Table 4 Hypothesis

	Low Organizational Capacity	High Organizational Capacity
High Organizational Technology		Hypothesis: Efficient Service Delivery + Sustainable Impact
Low Organizational Technology		

4.6 Methodology

This research study utilized a structured phenomenological approach that was supplemented by a survey (based on Brown et al, 2015). Purposive sampling was used to identify respondents in the research study. This nonprobability means of sampling was used to select a sample composed of organizations, stakeholders and practitioners. The rationale behind the use of purposive sampling is that those chosen for the study should be selected based on their roles, responsibilities and programming responsibilities. The study sample would be key staff members from a mixture of single multiple-mission organizations. Interviews were conducted in the federal capital city of Abuja – home to the headquarters of so many HIV/AIDS programs and services. By limiting the location to one city, I was also able to control for the numerous geographic inequalities that exist when it comes to working in other security-risk prone areas.

Inclusion Criteria (Organizations):

These organizations will be selected based on the following criteria:

- Funding: Two organizations that primarily rely on local funds shall be selected while two organizations that primarily rely on international funding / grants shall be selected.
- Services: All organizations that are selected shall be chosen based on clinical and advocacy services being offered. Upon initial contact, each representative of the select organizations would be asked to confirm the HIV/AIDS services that are being offered by their organization.
- Demographics: All organizations selected shall serve mothers and children as well as marginalized groups commercial sex workers, sexual minority groups. They shall operate within the Greater Abuja area, preferably the surrounding villages/local government areas.

- Length of establishment: Any organization that has not provided more than seven years of HIV/AIDS programs and services shall be excluded

- Network: The four organizations shall be based in Abuja, Nigeria. That said, all four must have worked or currently work on projects in other parts of Nigeria. This is intentional and done with the purpose of ensuring that practitioner judgement/expert opinion is heavily entrenched in the local context.

Inclusion Criteria (Practitioners):

Interview respondents must have at least 3 years of experience in their respective organizations and at least 7 years in public health (preferably, HIV/AIDS). Furthermore, they must either be middle management or part of the senior management team.

Exclusion Criteria (Practitioners):

Practitioners that only handle administrative and bureaucratic functions without interaction with advocacy and/or clinical aspects of HIV/AIDS service delivery.

4.7 Organizational Profiles

Seven practitioners from five organizations in the Abuja Federal Capital Territory were interviewed between October 2020 – January 2021. Due to the ongoing COVID-19 pandemic, it was extremely arduous to access a larger pool of mid to senior-level employees. Several of the organizations that I reached out to were unresponsive and those that responded had no timeline for resuming work due to the disruptions caused by the pandemic. The seven respondents that eventually decided to participate in the study represented the following organizations:

- Association for Reproductive and Family Health (ARFH)
- Centre for the Right to Health (CRH)
- Association for Women Living with HIV/AIDS (ASWHAN)
- Health Strategy and Delivery Foundation (HSDF)
- APIN Public Health Initiatives (APIN)
- Society for Family Health (SFH)

Association for Reproductive and Family Health (ARFH)

ARFH is a Non-Government Organization established in 1989 with the mission to initiate, promote, implement in partnership with other organizations, sustainable sexual/reproductive health and other contemporary public health information and services for adults and youth. ARFH`s mission rests on meeting the sexual and reproductive health needs of disadvantaged rural and urban communities through innovative low cost but quality interventions and efficient management. Our vision of enhanced quality of life including reproductive health and rights of individuals and communities in Nigeria and elsewhere in Africa is the driving force behind our various sexual and reproductive health programmes. ARFH has been at the forefront of health workforce development in Nigeria, with strongest niche in Family Planning and RMNCH. ARFH is a leading indigenous NGO supporting the Government of Nigeria to implement its task-shifting & task sharing policy through the capacity building for all cadres of health care providers including Physicians, Nurse midwives, and CHEWs. The focus of the organization also includes programming for worsening health profile such as high mortality rate, high new born morbidity and mortality, high poverty level, gender based violence, low Contraceptive Prevalence Rate (CPR), and high burden of HIV, Malaria and Tuberculosis.

In our over 30 years ARFH has contributed significantly to the reduction of these burdens in disadvantaged communities through innovative approaches that increase access of women, girls,

children and families to essential/basic health services including SRH, Gender mainstreaming into organization's programme, Family planning, and Adolescent Health. In addition, ARFH is reputed for the implementation of several innovative, high impact community-focused initiatives. ARFH has implemented major programmes that have nationwide coverage and with very large scope. Few of these included the National Reproductive Health and HIV Prevention Programme through the NYSC popularly known as PET project and Family Life and HIV Education. The two programmes are reputed to be part of the most impactful youth focused interventions in Africa. With the PET programme, ARFH has been able to train Master Trainers across the 36 States and FCT. Besides, the programme has been able to train more than Two Hundred Thousand Nigerians who passed through the NYSC Programme as Peer Educator Trainers and they have also in turn mentored more than 3,000,000 Peer Educators. On the FLHE Programme, ARFH has been able to train more than 20,000 teachers and more than 2,000,000 in-school youths have been reached with this programme.

ARFH has been working to improve the quality of life of underserved and vulnerable communities affected by HIV/AIDS, and other sexually transmitted infections (STIs). As a nonprofit organization, ARFH delivers the following kinds of HIV/AIDS services:

- Community sensitization, mobilization, and education
- HIV Testing Services
- Active search for vulnerable populations especially pregnant women
- Sexual network testing to identify positive clients linked to index clients
- Referral of communities especially positive clients for the uptake of services in designated health facilities
- Psychosocial and adherence support to people living with HIV (PLHIV)

ARFH is totally an indigenous organization by two eminent and able founders - Prof. O. A. Ladipo and Mrs. Grace Ebun Delano. The duo is backed by a skilled, experienced and dedicated work force of 154 staff with core of highly resourceful consultants with wide range of experience in Sexual and Reproductive Health programming from different geo-political zones. Capability of ARFH staff include conducting training, research, service provision, provision of technical assistance, communication, resource material development, advocacy, mobilizing stakeholders' participation and sound project management. ARFH currently boast of 155 staff spread across five different locations and working under various donor funded projects. Out of this number, 23 are in Management cadre while 51 are highly skilled professional from different academic backgrounds and disciplines with varying professional experience ranging from 1 year to 35 years. There are also 78 support staff who diligently serve behind the scene to ensure effective functioning of the organization's systems.

ARFH currently implements Seven donor supported project including the Global Fund (TB & HIV); USAID ICHSSA OVC Project; PEPFAR SURGE project, Bill and Melinda Gates supported RASUDiN Project, UNFPA and NURHI project. The organization implements projects and grants in all the 36 States and FCT but specifically has Offices in Ibadan which serves and the Headquarters and supervise the South-West Region except for Lagos that has a Standalone office due to the peculiarity of the State. There is also a mega office in Abuja, FCT where most of ARFH projects are coordinated from and hosts the President /CEO, the Directors and other top echelon of the organization. There is an office in Port-Harcourt that coordinates the South-South and South-East regions. When necessary, ARFH opens a project office in states when the nature and scope of projects necessitate this.

One of the biggest constraints that the organization faces is donor fatigue. This has created more short-term projects instead of long-term sustainable ones. As a result, ARFH is unable to sustain the impact of some of the projects being implemented across 36 states and FCT beyond donor support.

Centre for the Right to Health (CRH)

The Centre for the Right to Health (1999) is charged with the remit of researching, training, providing services, and advocating for the full realization of health in Nigeria. It also seeks to "promote respect for ethics and human rights in healthcare policies and practices especially for vulnerable and marginalized groups in Nigeria." With 10 tenured staff and more than 25 part-time staff and volunteers, the HIV/AIDS programs that CRH offers primarily focus on treatment and prevention. The Centre for the Right to Health pairs people living with HIV/AIDS to a network of primary health institutions where these individuals can receive quality and continuous treatment. Furthermore, they also promote "respect for ethics and human rights in healthcare policies and practices especially for vulnerable and marginalized groups in Nigeria." CRH employs a transformational and collaborative leadership style. In a transformational leadership system, there is a mutual "relationship of mutual stimulation and elevation that converts followers into leaders and may convert leaders into moral agents" (McCloskey, n.d, p. 2; Burns, 1978).

CRH provides a wide array of services in order for vulnerable and marginalized groups in Nigeria to realize the right to health. Firstly, there is a HIV/AIDS/STI prevention and impact migration program that focuses on information, education, communication (IEC) of HIV prevention care and support. Furthermore, it also targets HIV+ pregnant women in order to prevent mother-to-child transmission of the virus. As part of its community sensitization efforts, the Centre for the Right to Health also conducts outreach to vulnerable populations. Other programs offered

by CRH include; maternal newborn and child health (MNCH), sexual and reproductive health rights, and drug dependency and addiction prevention. In addition to conducting HIV mitigation (control, treatment, and prevention) projects, the Centre for the Right to Health has been a pioneer in the HIV/AIDS service delivery space. It set up the first stand-alone HIV Testing Site center in the nation's capital. It also runs a female drug treatment centre and an HIV/AIDS drug treatment centre as well.

Like many other organizations, CRH faces significant financial constraints. This can be attributed to the fact that it relies heavily on international grants to maintain its operations. Unfortunately, the number of grants it has been securing over the past few years has been on a decline which has led to significant staff layoffs. Without adequate capital, the Centre for the Right to Health cannot foster cross-sector partnerships and collaborate with other stakeholders. In addition, liquid capital is also needed to reduce the burden that it has on current staff - who are often overworked and burnt out.

Association for Women Living with HIV/AIDS (ASHWAN)

The Association for Women Living with HIV/AIDS was created in 2004. Unlike other organizations, they focus heavily on engaging men since they are the heads of the home. Like most HIV-funded projects, staff are only employed based on funding availability. For one of its signature projects, "Community Care in Nigeria," ASHWAN hired 13 people, its highest number of staff members. Unfortunately, the project ended after three years. Currently, there are about six staff members representing: programs, finance, accounts, monitoring & evaluation, administrative, and a driver. Nonetheless, several of its programs are supported by volunteers. ASHWAN uses a collaborative style of leadership whereby the work is evenly distributed. However, direction does come from the top – i.e., the director provides instructions on what needs to be done, and then

everyone follows. As an organization, the team is very collaborative and sits around a table to discuss how to proceed on work plans and organizational initiatives.

Since its establishment, it has set up 650 support groups across 36 states and Abuja. Over the years, the organization has combated issues around stigma and discrimination. Specifically, they have collaborated with other organizations in the Federal Capital Territory in the signing of the HIV Anti-discrimination bill into law. All through their years of establishment, they have mobilized 500 women for the uptake of prevention of mother-to-child transmission (PMTCT) services. In two states (Benue and Plateau) and Abuja, they have conducted community mobilization activities by educating the public (including 200 men) about the importance of PMTCT. ASHWAN employs a very methodologically sound approach in generating data from health facilities through the effective use of monitoring and evaluation officers. These personnel regularly visit the field on a regular basis (quarterly / monthly) to ensure that the data coming from the communities is verifiable. Subsequently, community sensitization and community mobilization efforts are conducted through outreach so that key populations like women can access PMTCT services.

Funding is a challenge for ASHWAN. The organization only has short-lived grants which often last for six months. Furthermore, staff are not on a consistent salary. Unlike other established organizations, ASHWAN does not have access to Global Funding (for undisclosed reasons). Therefore, it is a challenge mobilizing resources to scale impact. Similar to other organizations, unlocking funding streams is critical for ASHWAN. This would allow ASHWAN to widen its existing reach.

Health Strategy and Delivery Foundation (HSDF)

The Health Strategy & Delivery Foundation (HSDF) was founded in 2013. It was established to improve the quality of decision-making and execution in the health sector. Throughout its existence, it has focused on multiple diseases and has emerged as a leading and formidable thought leader in the public health sector. The range of services provided by HSDF (from 2013 - 2018) varied from HIV+ testing of infants to identifying bottlenecks in the system that affect the turnaround time of test results. HSDF embedded a specialist within the government's State's Agency Control of AIDS Program to share and transfer knowledge/skill in 5 of the states (Akwa Ibom, Cross Rivers, Bayelsa, Rivers, Nassarwa) and the Federal Capital Territory. By embedding specialists within each state's program, HSDF is able to facilitate operational planning by supporting the development of simple, concrete, state-led plans to scale elimination of mother-to-child transmission (eMTCT) of HIV services. This unique model enables the government to have a scale-up plan that entails performance tracking and stakeholder alignment/collaboration.

HSDF has a staff of 50 people in its Abuja office (headquarters). Staff are also spread in other regions - Kaduna (North) and Lagos (Southwest) Imo (South-east). Unlike other organizations, HSDF does not directly interface with marginalized and vulnerable populations such as women/children, commercial sex workers, men-who-have sex with men (MSM); rather, it strengthens the capacity for the government to deliver key services to vulnerable people living with HIV. As a health organization, HSDF is part of technical working groups and committees. As a result, it is positioned to contribute towards various quality data verification processes at the state level. Nonetheless, the in-house capacity is continuously being built   to perform rigorous data analysis for different stakeholders in order to improve service delivery outcomes.

HSDF is a dynamic and open-minded team where staff across all levels of the organization are encouraged to share their skills and perspectives. , Professional development is self-driven however, opportunities arise for technical and non-technical staff to be trained by the organization. Due to the fact that it offers services to the government, there are very few documents that can be shared with the external public.

APIN Public Health Initiatives

For more than 17 years, APIN Public Health Initiatives has been providing comprehensive HIV/AIDS services when it comes to care and treatment of PLWHA as well as PMTCT services. It current has, " over 300,000 individuals on HIV treatment across over 370 facilities in 7 states(APIN, n.d). APIN also ensures that people that are co-infected with tuberculosis and HIV receive TB treatment immediately so that their HIV status is not complicated. The organization is made up of different units of people who work in clinical,prevention operations, monitoring and evaluation.

APIN is well funded to place people on ARTs. However, it does face constraints that are not within its purview such as strikes,security. The unpredictability of the Nigerian environment - facilities and communities - affects the movement of staff, supply chain materials, and services. Despite these unforeseen challenges, APIN is committed to providing technical skills to staff who in turn provide technical assistance to stakeholders – National Agency for the Control of AIDS, State Agency for the Control of AIDS, Ministry of Health, Civil society organizations, etc. Moreover, capacity building of government agencies is also important for ensuring that the stakeholders that the organization works with – government agencies, facilities – are well equipped to deliver HIV services. APIN embraces a visionary style of leadership which allows it to be innovative and pioneer new initiatives. It also seeks to be a competitive organization when it comes

to donor funding since it relies heavily on grants in order to achieve its needed impact. Grants are the major driving tool by which the organization is able to make an impact. In competing for grants, APIN is able to leverage its past experiences to show its unique value proposition. APIN carries out its projects strictly through evidence-based management.

"We don't work in isolation. We work with stakeholders. Before you start any work, you engage them, you carry them along, you tell them what you want to do. And you bring it to the table and based on evidence that is available, you implement or you don't implement. Or you change the way you want to implement it." - APIN Respondent.

Society for Family Health (SFH)

Arguably, the Society For Family Health (SFH) is one of Nigeria's most prominent organizations working to combat HIV. SFH implements the Global Fund Round 5 Project with the overall goal being to reduce HIV/AIDS-related mortality and morbidity through six objectives:

1. To scale up comprehensive HIV/AIDS treatment, care and support for people living with HIV/AIDS to all the 37 States in the country.

2. To expand access to Testing and Counselling services to cover 37 States of the country.

3. To strengthen the role of the community, civil society organisations and networks of PLWHA in providing and supporting HIV/AIDS treatment and care.

4. To increase access to care and support services for OVC in 37 states of the country.

5. To increase the capacity of the private sector to implement workplace HIV/AIDS program in 12 states.

6. To strengthen the capacity of implementing institutions for effective programme management, coordination, monitoring and evaluation.

SFH complements government efforts at the state and national level by ensuring that there is provision of HIV prevention, care, and treatment services. It also supports the efforts of the government by collaborating with test control agencies in six states. Moreover, effort focused on awareness and stigma eradication. In addition to providing support for the general population, SFH also focuses on key groups that are either affected or susceptible to HIV – linking people who test positive to key services, increasing condom use among target groups, etc. As an organization with a staff of approximately 500 people, the Society for Family Health does not prescribe to a specific leadership style. Rather, a situational assessment of the activity or goal informs the style of management that ought to be used - which can either be top-down or bottom-up, transformational, etc.

The use of different leadership styles is a byproduct of the ability to deliver cost effective results based on flexible performance agreements with donors. The high level of donor satisfaction that SFH – when coupled with the fact that the organization has been in existence since 1985 – that makes it easier for the organization to receive funding. Despite the availability of funding, donor policies can also strengthen or weaken the opportunities that local organizations have.

"During the Trump administration, they came up with the local organization network that was trying to fund local NGOs. When RFAs (request for applications) come out, they specifically state it is for local NGOs since they had an idea of a Journey towards Self Reliance / Local Organization Network. So for those kinds of donor policies, organizations like SFH are favored compared to large international organizations." - SFH Respondent

SFH also credits its sustainability to a diversification of funding streams which led to multiple streams - DFID, USAID, Global Fund, AIDS Fund, UNESCO – and not just on one major funder. Moreover, the technical skills that its employees bring to the table significantly add value

to the organization such as using quantitative and qualitative evidence to design key interventions. As a forward thinking organization, SFH is keen on integrating its HIV services into its overall delivery of health so that people can have high quality, optimized and cost-effective health. The organization also acknowledges the importance of policy and agenda setting that can facilitate and enhance service delivery.

KP Care-2 Project: The KP Care-2 Project is an SFH offshoot project that arose from funding from the United States Agency for International Development (USAID) that focuses on optimizing the programming for key populations – female sex workers, MSM, PWID, transgender, prisoners and people in closed settings such as internally displaced persons. Grounded in the principle of human dignity regardless of one's social status, the theory of change for this project is based on "the assumption that if access to quality HIV services for KPs is increased, then utilization by KPs will increase and the burden of HIV will decrease among KPs and in Nigeria overall" (para. 5). This entails mobilizing select reform-minded religious leaders who are willing to create HIV awareness in their churches and mosques, and creating an enabling environment for key populations to form a community based association within the network wherein they are provided with the governance, program management, and data analysis skills. The KP Care-2 Project is heavily built on evidence. A step that involves:

1. Looking at the total number of people infected with HIV/AIDS in the state

2. Looking at the number of people who are in treatment

3. Determining the gap that exists so as to ascertain the level of impact that is needed

4. Using existing data from the Nigeria HIV/AIDS Indicator and Impact Survey (2019) – a national-household survey conducted by the National Agency for the Control of AIDS – to

calculate the number of key populations in the state. National Agency for the Control of AIDS.

5. Seeking these key populations in hot spots, and working with them to identify partners in their sexual networks.

4.8 Findings

Table 5 Summary of Findings

	Leadership Style	Theory of Change	Evidence-based Management Approaches	Incorporation of New Public Service	Organizational Technology	Key Outcomes/ Milestones
Association for Reproductive and Family Health	Visionary	Mobilize people for behavioral and attitudinal changes that promote the best sexual and reproductive health practices	Decisions and interventions are based on findings from research and surveys – either national or organizational.	Networking and partnership with other relevant other NGOs. Resource mobilization from government facilities to meet mutually agreed upon goals.	External facing – ARFH develops information, education and communication (IEC) materials on the national scale to raise public awareness on HIV/AIDS	Implements programs in 36 states. Strengthened the capacity of more than 500 community based organizations to respond effectively to the social and health needs.

Center for the Right to Health	Collaborative & Transformational	Creating a Nigeria where healthcare is available and accessible by treatment, care, and support for HIV/AIDS and opportunistic infections. Research, document, advocate, and secure the human rights of health workers, women, and vulnerable populations	Research and field evaluation of activities and programs	Collaboration with other community-based organizations	Dwindling-organization is currently trying to stay afloat. Lack of adequate funding has led to reduction in staff, technological infrastructure, and key processes.	Set up the first HIV Testing Site in Abuja Operates a female drug centre in Abuja Runs a drop in centre for key populations

Association for Women Living with HIV/AIDS	No ascribed style	Improving the lives of women with HIV through advocacy, treatment, care, and support & counselling.	Data quality assurance checks by monitoring & evaluation teams	It is an association representing the interest of citizens who are women living with HIV/AIDS. This is a national coalition.	No technology infrastructure since work is done on a project by project basis. Processes and work streams are decentralized – national coordinators, national board officers, zonal board officers, etc.	650 - HIV support groups across 36 states and FCT. Played an instrumental role in having the HIV antidiscrimination bill signed into law in 2014. Mobilized 500 women for the uptake of PMTCT and antenatal care.

| Health Strategy and Delivery Foundation | Collaborative | Support Nigerian government agencies at the federal and state level in their efforts to eliminate mother to child transmission of HIV by strengthening their service delivery capacity to deliver quality HIV programs and services. | Embedding a technical specialist in the State Agency for the Control of AIDS office to ensure that advancement in HIV treatment is at the forefront of government service delivery. | Not applicable. The organization is directly involved in capacity strengthening which does not explicitly mean that it uses a new public service approach. | Data analytics is conducted internally, yet it can be scaled up to meet high demands. Technical innovation drives processes aimed at improving the government's ability to deliver services. | Works with the government to increase eMTCT site coverage in intervention states. Engage private healthcare facilities to report HIV/AIDS data on national platforms |

APIN Public Health Initiatives (APIN)	Democratic	To provide cutting edge, innovative, and sustainable approaches to address HIV/AIDS vis-à-vis comprehensive treatment and care services as well as through the prevention of mother to child transmission.	A holistic approach is used to analyze evidence. This not only involves the work of the monitoring and evaluation department, but also engagement of stakeholders from NACA, SACAs, the Ministry of Health, and other civil society members.	Working side by side with civil society members to ensure that the interest of citizens are captured during the fight to combat HIV/AIDS.	The unpredictability of the Nigerian enabling environment poses a huge challenge for the use of organizational technology. This affects movement of supply chain materials but also services as well as the ability to do community outreach.	250,000 patients have been placed on treatment since its existence. APIN has also played a fundamental role in preventing mother to child transmission of HIV/AIDS for the people that it serves..

Society for Family Health	Varied – situational analysis is used to determine the leadership style to employ	If access to quality HIV services for key populations is increased, then utilization by KPs will increase and the burden of HIV will decrease among KPs and in Nigeria overall.	A robust methodologically sounding approach for reaching people that is built on existing infrastructure, set up by the National Agency for the Control of AIDS.	SFH approaches HIV awareness by creating a shared value from a multireligious and multicultural perspective while still working with public authorities and civil society organizations.	SFH has technological infrastructure since it has been in operation for more than three decades. The creation of the KP Care 2 Project also allows for specific interventions to be created that are geared towards vulnerable groups.	Provides services in 36 states plus FCT to CSWs, MSMs, PWID. Worked with the state agency for the control of AIDS in six states. These efforts complimented the government's response to HIV. Allocated resources to other organizations. Played a role in the creation of a stigma bill at the state house of assemble.

Leadership Styles Defined:

Visionary: A form of transformational leadership that offers opportunities to foster the capacity of an organization to meet the needs of its constituents. This occurs in creative ways, despite complex and uncertain times, by providing a framework that can become a touchstone for setting goals; determining priorities; aligning structures, policies, and beliefs with principles; and assessing progress (Taylor et al., 2014).

Collaborative: Collaborative leadership is a management practice in which members of a leadership teamwork together across sectors to make decisions and keep their organization thriving (DiFranza, 2019).

Transformational: Transformational leadership: the leadership style in which "leaders inspire followers to transcend their own self-interests for the benefit of the organization; leaders can have a profound and desirable effect on followers to make the required change" (Robbins 2003, p. 253).

Democratic: Democratic leadership is termed as the most effective leadership style (Lewin, Lipitt, and White, 1939). Democratic leadership relates to increased follower productivity, satisfaction, involvement, and commitment (Hackman & Johnson, 1996). They delegate authority to followers and also give ongoing support and focus for the challenging works. (Sharma & Singh, 2013).

4.9 Results

Themes

    1. Leadership Styles

Public health literature suggests that leadership capacity building should involve addressing the core needs of core technical and management capacities which requires more time and a deeper level of engagement and collaboration (Curry et al., 2012). When organizations fail to invest the time and resources in their leadership framework, they get poor leadership which results in a tardy performance (Govender, 2017, p. 192; Niemann & Kotze, 2006). The findings from the interviews with the practitioners reveal that there is not a preferred leadership style for achieving desired outcomes. During the interviews, respondents actually struggled to capture a particular type of leadership style that they employ in their respective organizations.

The Society for Family Health – a model public health organization – utilizes a situational analysis to inform the leadership style that it needs to use. As a result, the leadership style is always varied based on the context at hand. It is important to note that even when a leadership style is used by an individual or a department, such an approach might not translate to the rest of the organization. At the Health Strategy and Delivery Foundation, members of the senior management team collaborate heavily with one another through meetings and goal-setting processes. Nonetheless, those who are lower ranked staff might receive cues from those at the top. Regardless of the leadership style being employed, Govender (2017) posits the notion that effective leadership development in the African setting should achieve the following:

- Provide guidelines for developing health care leaders within the context of health care goals
- Facilitate improving leadership across all levels in the organization

- Continuously encourage health professionals to develop their leadership skills and knowledge

- Ensure that the development of leadership capabilities is an ongoing process and fully integrated into the working environment

2. NGO Funding

According to UNAIDS, NGO managers may be compelled to follow the money since beggars cannot be choosers. With that in mind, NGOs are finding out that "traditional funding sources are often inefficient to meet growing needs and rising costs" (UNAIDS, n.d., pg. 1). None of the practitioners interviewed from any of the organizations alluded to other means of securing funding such as their involvement in public-private partnerships – like the Nigerian Business Coalition Against HIV/AIDS – or engagement with other corporate social responsibility (CSR) initiatives. Perhaps, it could have been attributed to the way that the questions were asked.

In Nigeria, funding for HIV/AIDS organizations results in the "haves" and "have nots" Those that have funding have a competitive advantage over their peers when it comes to not only receiving large grants but being able to scale impact – SFH, APIN. Moreover, they have also come to realize the importance of multiple funding streams in order to be less dependent on one particular funder. In an interview with a practitioner from the Association of Reproductive and Family Health, donor fatigue was cited as being one of the major challenges for sustainable HIV/AIDS funding across all 36 states and Abuja, Federal Capital Territory. Donors can be apprehensive of the project sustainability since their work with actors in the third sector often revolve around timelines – which might not be in tandem with the continuous needs of a particular community.

3. Organizational Capacity

Two of the six organizations seem to be adequately staffed – Society for Family Health (SFH) and APIN Public Health Initiatives. Nonetheless, the year in which they were both founded does not play a role in determining their level of staffing. SFH was founded in 1985 and APIN in 2008. One can make the case that the level of staffing is predetermined by how well funded an organization is.

Among all six organizations, SFH seems to be the most financially secure organization due to its multi-donor and multi-year grant status in initiatives like the KP Care 2 Project. However, the presence of grants does not necessarily translate to an organization being easily able to access them. On the other hand, an organization like APIN Public Health Initiatives is tirelessly working to ensure that it not only leverages its experience in the HIV/AIDS delivery space, but is closely aligned with the donor needs. Organizations that have optimal capacity also have specialization of labor when it comes to the work being done. At APIN for example, there is a team of doctors, nurses, lab scientists as well as those that support clinical, monitoring & evaluation, and program and operations. Another theme that was relevant across NGOs is that some HIV/AIDS organizations do not have a fixed staffing capacity by which they operate. For the Health Strategy and Delivery Foundation, organizational capacity is determined based on the project need. Thus, it is easy for staff to be disbanded immediately after the project closes.

4. Evidence-Based Management

All interview respondents highlighted an organizational practice: evidence is incorporated into their organizational practices. Nonetheless, it is hard to determine the extent to which the approach is thorough. When asked to describe the manner in which evidence was used in the organization's practices, several respondents noted that evidence was primarily utilized by

monitoring and evaluation teams while before, during, and after field visits. Three of the six organizations –Association for Reproductive and Family Health (ARFH), Center for the Right to Health, and the Association for Women Living with HIV/AIDS – explored the inner workings of an evidence-based management approach within the boundaries of an organization.

"Evidence-based decisions and interventions are based on findings from researches and surveys be it national surveys or organization-based surveys. We evaluate the outcomes of the decisions through baseline and end-line evaluations are always conducted to determine the outcomes of all interventions and strategies." - Practitioner at Association for Reproductive and Family Health.

Nevertheless, three other organizations show that the use of an evidence-based management approach requires a systems thinking perspective wherein . This results in organizations like ASHWAN playing a key role in the creation of national policies like the HIV/AIDS Antidiscrimination bill. As part of its technical capacity strengthening efforts, HSDF actually embedded a technical expert to work with the state agencies for the control of AIDS. This was done to ensure that knowledge gaps were eliminated and any sharing of information across parties was symmetric. As a result, this would lead to the integration of scientific and technical information in implementation and advocacy plans at the state level. Working with SACAs is a key step in working to combat HIV/AIDS; however, it simply is not sufficient as a public health effort. An organization like APIN Public Health Initiatives utilizes the theory of evidence-based management by juxtaposing evidence from not only the scientific literature, but from the organization (the work of the monitoring & evaluation department), practitioners (civil society members), stakeholders (NACA, SACA, Ministry of Health) etc. In the preliminary academic literature that was examined, evidence-based management has mostly been depicted as a tool that

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can be used to inform decision-making. In the case of the Society for Family Health, evidence-based management is actually used to identify key populations in the KP Care 2 Project.

"The project is evidence-based. We use evidence in making decisions and allocating targets for the program. We look at what all the other HIV partners are doing. Firstly we do an analysis of the total number of people that are infected with HIV/AIDS in the state and the number of those on treatment from each of these partners, and identify the gap left. We also use evidence to determine the number of KPs in a state. During mapping, we do prospect mapping of where KPs congregate and seek them out." - Practitioner at Society for Family Health.

Evidence-based management can be used as a tool for reaching vulnerable groups of people, especially those in hard-to- reach areas. It requires the following steps:

- Ask: Translating a practical issue into an answerable question – Where are the key populations in the state who need access to HIV treatment?
- Acquire: Systematically searching for and retrieving the evidence – Using the Nigeria HIV/AIDS Indicator and Impact Survey to find the prevalence rate for key populations.
- Appraise: Critical judging the trustworthiness of the evidence – Looking at national household survey and juxtaposing data with HIV mapping
- Aggregate: Weighing and pulling together evidence – Determining the hot spots where key populations can be accessed
- Apply: Incorporating the evidence into the decision-making process – Decide on how access to quality HIV services will be increased, in order for key populations to utilize the services with ease.

- Assess: Evaluating the outcome of the decision taken – Utilize data management systems to capture, and interpret results.

In the long run, the use of evidence-based management approach for reaching key populations should move the needle forward for SFH in their efforts to ensure that "95% of key populations living with HIV know their status and are able to access treatment, care, and support services which would in turn lead to their HIV being suppressed" (Society for Family Health, n.d). Conversely, evidence-based management can be used for strengthening an organization's internal capacity, in terms of employee compensation, satisfaction, and motivation.

" Even during salary review, we find out how our partners are doing in terms of compensation to know if we are being competitive or not. We also take regular staff satisfaction surveys to know how we can do more to motivate them optimally." – Practitioner at Society for Family Health

5. Information flow in organizations

According to the interview respondents, there is not an information gap in their respective NGOs. Most of them fairly agree that they are informed about changes not only to their jobs but to their organizations. Nonetheless, an employee that is not aware of organizational changes is more than likely going to be unaware of changes to his/her job. A respondent from the Centre for the Right to Health highlighted this likelihood by pointing out the information asymmetry that permeates the organization. It is also important to note that Employee X at CRH highlighted the practice of not being called often to join meetings.

6. The impact of effective leadership styles on the work environment

Leadership styles vary and there is no ne particular style of leadership that works over the other. The seven respondents from Abuja-based organizations with varied leadership styles (democratic, collaborative, transformational, visionary) alluded to this. Respondents responded to the efficiency of the leadership style used at work in the following ways: strongly disagree (1), neutral (2), agree (1), strongly disagree (3). Using SPSS, the responses on leadership style were cross-tabulated with different work environment outcomes so as to get a deeper insight into the work culture and workplace behavior. Practitioners that strongly agreed with the efficiency of the leadership style used at work also strongly agreed with the following statements:

1. My manager has worked to improve upon issues from last year
2. My manager makes me feel part of a team
3. My manager's morale sets the tone for our office morale.

The general consensus is that managers are working to resolve problems in their organization (6 out of the 7 respondents). Nevertheless, one of the respondents who responded to the leadership style being inefficient at work strongly disagreed with the notion of the manager working to resolve conflict. Surprisingly, not everyone who was interviewed believes that their respective manager holds the organization's best interest at hand. Even though employees might be skeptical about a manager's intent, 71% of the respondents view their managers "as being strong leaders" and "recognizing success as well as failures.

The findings reveal that an employee who views an organization's leadership style as being inefficient is likely to perceive the workplace as having less than desirable outcomes. The results from the survey also reveal that organizational technology lays the groundwork for more effective use of organizational capacity in achieving a set goal. In the survey findings, respondents that

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attested to leadership styles being efficient overwhelmingly view their managers as having the best interest of the organization at hand, which enables the organization to achieve their targeted outcomes. Interestingly, none of the respondents classified their manager as being a weak leader. Only one of the organizations supported my hypothesis and this was the Society for Family Health – an organization with clearly defined processes as well as the capacity to deliver key HIV/AIDS interventions to key populations across the country.

7. Evidence-Based Approaches to Clinical Care

In the Nigerian setting, there are no defined guidelines or clinical standards by which organizations have to comply with (Aliyu et al., 2019). Although clinical guidelines have been developed by the United States President's Emergency Plan for AIDS Relief (PEPFAR) and Global Fund for AIDS, Tuberculosis, and Malaria (GFATM), there is no requirement that organizations ought to follow them.

Silva et al. (2017) suggest that it is critical to investigate the clinical primary network of organizations in their efforts to control HIV/AIDS. This can be done by examining some best prevention practices such as the examination of diagnostic testing centers and the inclusion of the rapid tests in the primary health care network (Brasil, 2015; Soares, 2012). According to Silva et al. (2017), the implementation of rapid testing is dependent on four dimensions: team awareness and dissemination of rapid testing procedures for target audiences; adequate physical space and equipment; availability of inputs and material and organizational workflow, with a definition of the roles. The interview respondents were provided with a questionnaire to assess the HIV/AIDS control actions being taken by their organizations. The results (Appendix VIII) show that organizations have consistent access to training materials from the Ministry of Health and National

Agency for the Control of AIDS (NACA) when it comes to the management of HIV/AIDS and other sexually transmitted infections (STIs). Despite the awareness level, these organizations are not primary healthcare institutions and not all of them might have adequate supply – including condom supply – of medications needed for treatment of STIs or perform rapid HIV/AIDS testing.

Having the necessary resources and supplies at one's disposal is necessary, but more important is being trained on HIV/AIDS issues as well as treatment and prevention skills. Among those interviewed, only respondents from APIN Public Health Initiatives and Society for Family Health received training within the last five years. Although the connection between funding and likelihood/tendency to receive training was not measured, it is worth noting that these two organizations are the most funded entities. Despite funding streams, representatives from all six organizations identify sex workers, homosexuals, and drug users as being vulnerable to HIV/AIDS. However, that does not translate to services being offered. The interview respondent from the Health Strategy Delivery Foundation highlighted the fact that outreach to these key groups was not even introduced as a focus area at the onset of their HIV/AIDS program. Fortunately, subsequent programs and interventions started to design programs catered for these key populations.

In theory, nongovernmental organizations are in the service of these key populations, however, there might be so many factors (funding, staff turnover, etc.) that prevent them from reaching their targets. An organization like the Center for the Right to Health lags behind its peers when it comes to delivering condoms outside its physical space, monitoring people diagnosed with HIV/AIDS, and offering prevention of mother-to-child transmission services (PMTCT) services. The inability to reach pregnant women can make these groups more susceptible to HIV since they account for at least 32% of pregnant women living with HIV received antiretroviral treatment to

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prevent mother-to-child transmission and only 34.7% were tested for HIV as part of their antenatal care (UNAIDS 2017; National Bureau of Statistics (NBS) and the United Nations Children's Fund (UNICEF) 2017).

4.10 Discussion

The findings of this research study mirror the evidence from the literature. Respondents that alluded to the effective use of leadership in their organizations also seem to have higher job satisfaction (Yang and Kassekrt, 2009). The Society for Family Health (SFH) is a prime example of an organization that has been delivering services for more than three decades and has a leadership style that is built on contextual analysis which results in multiple forms of leadership being used. Hence, a one style approach does not fit all situations and employees are regularly consulted about changes to their job and organization, which in turn fosters trust. Zak (2017) notes that effective dissemination of information can lead to earned respect and trust, but also more productive and engaged employees.

Trust in leadership can also lead to a longer retention rate (Zak, 2017). In the case of SFH, it is common to see staff spend more than a decade in the organization while still climbing up the career ladder. The value of trust in the organization cannot be understated. Trust creates a stronger reverence among employees for their managers (Mineo, 2014) and it also is the "glue that binds a leader to his/her followers and provides the capacity for organizational and leadership success" (Mineo, 2014, p. 2). Even when organizations are under-resourced, trust in effective leadership

can be a glue that intrinsically keeps team members of an organization (i.e., in the case of the Center for the Right to Health).

The research findings also suggest that selected HIV/AIDS organizations offer mid to senior-level staff members opportunities to collaborate with other management colleagues which allows them to test out new ideas and juxtapose the different forms of evidence that is needed for effective decision-making. Denhardt and Denhardt (2000) present the case that collaboration with leadership – whether internal or external – strengthens a new public service approach since it allows for "risks and opportunities to reside within the larger framework of democratic citizenship and shared responsibility" (p. 557). As a result, public servants do not merely respond to the "demands of customers", "but focus on building relationships of trust and collaboration with and among citizens" (p. 555). Therefore, the ability to collaborate with leadership in the long run can actually lead to a departure from simply meeting performance-outcomes (New Public Management) to serving community groups through shared value creation. (New Public Service).

In creating value through their individual missions, the six organizations – regardless of funding level – either utilize their monitoring and evaluation and/or advocacy efforts as a critical part of the evidence-based management approach to organizational learning. Organizations like ASHWAN primarily focus on advocacy and stakeholder mobilization (women and mothers) through the different networks at the national and state levels; whereas, HSDF and APIN primarily focus on program strengthening and technical implementation through monitoring & evaluation activities.

Strengths & Weaknesses

The strength of this research study is that it is not only practitioner-led, but also strikes a balance in comparing and contrasting real-world perspectives to the academic literature. A significant weakness of this study is the small sample size and the lack of variety in job levels. The inability to access a larger and more representative also meant that my findings were unidimensional and only limited to mid to senior-level managers.

4.11 Limitations

COVID-19 Pandemic: This research study was conducted during the COVID-19 pandemic. As a result, I was unable to interview respondents in person. Due to this global pandemic, I had to conduct my interviews virtually through the Zoom platform. COVID-19 also limited my access to staff members in some of the prospective organizations that I was looking at. Most of the mid to senior-level staff members were either unavailable or promised to get back to me at a much later time, which led to delays in my research plan / timeline. Another limitation of this study was that some of the selected staff decided to complete the interview through written format instead of oral. This took away the art of the dialogue and the ability to make key inferences from having an engaging conversation.

Sample Size: The sample size that was selected was very small. I had planned to interview at least 20 professionals for my research study. As a result, it would be very hard to establish any level of significance between the variables. The inability to get a wider sample pool also increased the likelihood of having statistically insignificant results.. Moreover, the small sample size resulted in the inability to actually gauge the extent to which the interview respondents are truly

representative of the larger population. It also prevented me from being able to mitigate the effects of a social desirability bias on my findings.

Interviews: The interviews often had technical glitches. The internet speed in Nigeria was not always the fastest and this impeded my ability to get information at various times. Furthermore, some of the respondents not that detailed in their answers which made it difficult for me to draw conclusions at times or ask follow-up questions.

Limited access to data: The respondents that were interviewed did not share hard organizational data with me. As a result, it was challenging to distinguish between the evidence from practitioners (expert opinion) versus organizational evidence. It also resulted in me having to search through the public databases to verify as much information as possible.

4.12 Threats To Validity

Internal threat to Validity: Social desirability bias – an internal threat to validity – was identified in the research study. This is because the interview respondents who hold various top level positions might be apprehensive that answering the questions fully could lead to some negative outcomes. Thus, there might be a need to answer questions in a way that paints their respective organizations in the best spotlight. Due to the mixed-methods approach that was utilized as well as the small sample size, there was no loss / dropout of interview respondents, especially since the period of engagement was short. Selection bias was also another threat identified since the interview respondents did not represent a wide array of job levels in the organization.

External threat to Validity: The small sample size means that the findings from this study might not be applicable to a larger population whose views might significantly differ from the group of middle and senior-level staff members interviewed. The unrepresentativeness of this sample also limits the ability to larger inferences on organizational behavior in HIV/AIDS organizations.

Construct Validity: The questions that were asked during the structured interview measured different aspects of organizational technology. However, there was no particular question that was asked on the availability of technology infrastructure in each of the respective organizations. As a result, I had to either use my inductive reasoning skills – based on organizational materials as well as earlier interactions – in figuring things out, and in some cases, I had to reach out to interview respondents after the interview to inquire about key processes and systems.

4.13 Implications

The use of evidence must be incorporated into a nonprofit's use of organizational technology in order for it to achieve continued improvement in healthcare outcomes. Uneke et al. (2020) recommend that organizations utilize an evidence-based policy framework that allows them to properly define / refine policy problems, review context issues, initiate policy priority setting, use rapid response services, etc. (p. 1). Nonetheless, accessing such evidence is not an easy feat. Ezenwaka et al. (2020) point out that evidence-informed decision-making is limited by constraints in the "interaction of factors between users (supply-side) and producers (demand-side) of evidence. (p. 1). As a result, there is a need for "stronger research collaborations, institutionalization of health

policy and systems research" and frameworks for getting research into policy and practice" (p. 1).Bello et al. (2020) recommend that the enabling infrastructure needs to be created so that organizations can improve the manner in which they incorporate it into decision-making. Stakeholders like the National Agency for the Control of AIDS (NACA) can work with nonprofit organizations in order to ensure that organizations are equipped with the necessary tools needed to aggregate and analyze evidence. This would improve the overall delivery of health services, regardless of funding or staffing levels.

Effective organizational technology vis-a-vis public leadership can position an organization to achieve its theory of change through various interactions within and outside of the organization. Morse (2007) builds on existing literature by framing public leadership as a type of leadership that evokes collaboration and concerted action among diverse and often competing groups. (Muhammad, 2014, p. 2). Therefore, it is imperative that organizations work together to serve the common good even if they are competing for the same funding streams. Leadership can also be used as a tool to achieve the very essence of new public service which is predicated on the notion of serving which is negotiating and brokering of interests among citizen and community groups, thereby creating shared values (Denhardt & Denhardt, 2000). An organization that leverages its public leadership power and couples it with a new public service approach – a unique level of collaboration by which active citizenship is characterized by public service officials playing more than a service delivery role – is able to build coalitions of public, nonprofit, and private agencies to meet mutually agreed upon needs.

Organizational technology can be used as a mechanism for achieving policy outcomes. As organizations tirelessly work to address the needs of those that they serve, it is important that they "use the best available evidence and expand the role of researchers and practitioners to

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communicate evidence packaged appropriately for various policy audience" (Brownson, Chriqui, and Stamatakis, 2009, p. 8). Organizations can use their respective technologies to influence policies by highlighting lessons learned from the field and perspectives from key informant interviews. In addition, they can also incorporate evidence by using their closeness to the everyday citizen to identify specific policy elements that are likely to be effective in reaching key populations (Brownson, Chriqui, and Stamatakis, 2009).

4.14 Conclusion

Evidence-based management (EBMgt) is a panacea to HIV/AIDS service delivery in Nigeria because it can strengthen and facilitate the effective and strategic use of organizational technology within and outside an organization. Barends, Rousseau and Briner (2014) highlight the value-add of evidence-based management by suggesting that EBMgt enables organizations to evaluate the outcome of a decision which also contributes to their organizational learning and performance, especially in novel and non-culture situations (McNees, 1990; Tetlock, 2006; Anseel, Lievens, & Schollaert, 2009; Ellis & Davidi, 2005). Needless to say, evidence-based management cannot be used by itself for solving service delivery challenges.

Organizations that are well equipped to use evidence-based management as a mechanism for improving their technology have two fundamental characteristics: adequate funding and human resource capacity. Funding is a priority for third sector actors and without such said liquid capital, organizations are unable to cross the stagnation chasm – which is characterized by inadequate funding, fragmented ecosystem, and a talent gap. Deiglmeier and Greco (2018) note that even with

advocacy and network approaches to sustainable social impact, organizations still require funding resources to navigate relationships and complex interdependencies. In actuality, organizations with readily access to grants and other sources more likely to practice evidence-based management. The evidence from literature, stakeholders, practitioners and organizations suggest that funding as a driving source for better organizational outcomes has to be innovative and be able to support growth and diffusion while still being an opportunity for "mutual learning, support, adaptation, and persistent pursuit of impact" (Deiglmeier and Greco, 2018, p. 5). In the Nigerian setting, it is essential that sustainable funding is country-led and country-owned.

Evidence also suggests that the provision of funding also needs to be coupled with specific leadership targets aimed at improving the workplace and the interpersonal relationships between managers and their employees. Leadership must focus on mitigating information gaps so as to make organizations more symmetric when it comes to the manner in which information is shared and disseminated. Simply having a shared vision and set of common ideals does not make an organization immune to information asymmetry. As a result, it is critical that organizations are continually improving and adapting in order to meet the interests of those that they provide services to as well as well their employees.

Nongovernmental organizations are positioned to reach key populations who might sometimes be excluded from government interventions. On the other hand, evidence shows that the public is trusting of the work of these NGOs (Leonard and Leaonard, 1999). In Nigeria, NGOs are more effective than government when it comes to delivering services because they are able to access funding streams and less subject to bureaucratic red tape. This allows them to leverage their respective and collective networks, build capacity, access information, participate in policy dialogues, secure citizen engagement and target the broader policy context" (McDonough and

Rodriguez, 2010). Thus, there is a sizable opportunity for these third sector actors to advocate people living with HIV/AIDS and mobilize them to seek treatment, care, and prevention services. An evidence-based management approach to service delivery also reveals that sustainable impact involves being able to influence policy. However, this does not occur in silos. An organization's theory of change must be interconnected to the work of other peer organizations in the service delivery space. This would allow the organization to foster dialogue that incorporates multiple sources of evidence as part of its decision-making process in order to yield better and more optimal outcomes (McNees, 1990; Tetlock, 2006). NGOs working collectively – grounded in evidence – in an ecosystem and building cross-sector coalitions to meet mutually agreed upon needs (Denhardt and Denhardt, 2000) would enable third sector actors to assess how Nigerian citizens – who are either susceptible to or affected by HIV/AIDS – can be effectively served. As they work across the aisle, HIV/AIDS practitioners in nongovernmental organizations should build customer-centric models for service delivery, manage risks, and be dedicated to continuous improvement (Okafor, Fatile, and Ejalonibu, 2014).

5.0 Conclusion

Evidence-based management is the driving force for making decision-making more cognizant of bias and systemic failures (Nini, 2020). As a result, it can be used as a successful tool for increasing organizational performance. Han and Dobbins (2009) suggest that stress and cognitive overload can undermine decision-making quality. As a result, practitioners in public service organizations can be easily susceptible to working in silos or even not seeking critical feedback on various decisions affecting their portfolio of programs. The effective use of evidence-based management (EBMgt) must take this into account especially when practitioners are unable to critically assess the evidence that is made available to them due to time constraints. The current literature is predicated on the unstated assumption that stress and time constraints can be easily managed in an organization through effective leadership skills and strong manager-employee relations. Nevertheless, it is also quite clear that decision-making happens often in System 1 thinking whereby decisions have to be made fast and intuitively (Hart, 1991).

An effective use of evidence-based management in the daily operations of an NGO needs to take into account the competing demands in an organization that might lead to practitioners forsaking such a framework. As much as EBMgt might be encouraged in an organization, it is critical that there is clarity on who the users of the framework are. In the research study with seven practitioners, it seemed to be the case that their organizations all used EBMgt in one manner or the other. However, it was quite uncertain if this framework was only being used by mid to senior-level managers or junior staff members. Thus, it is important that the users of this framework are defined in order to understand how information/data is received but also how it is being interpreted.

The interpretation of data/information leads to judgment calls being made in the organization. Aloini et al. (2018) suggest that such judgment and practice should be made on "rational, transparent, and rigorous evidence that could lead to an exploration and evaluation of the pros and cons of alternatives" (p. 2063). Evidence-based management can be a mechanism for understanding the cost-benefit implications of certain public health interventions. This could lead to more services being streamlined as well as greater efficiency in patient flow. Aloini et al. (2018) argue that an EBMgt paradigm can be used to point out differences between actual patient clinical pathways and established guidelines. Practices such as these are incremental steps that can introduce various dimensions of innovation into the fabric of an organization.

As organizations innovate and redefine their organizational technology, it is crucial that the best available evidence is seen through three dynamics – rank, fit, and variety. This would allow for a more contextual and situational analysis on the factors that are at hand. The effective use of EBMgt enables organizations to evaluate different situations critically so as to increase the quality of decision-making. The quality of decision-making is built on the ability to weigh different alternatives and also integrate the voices of citizens into the process. In the context of this study, it was not known whether organizations that have struggled with getting funding have conducted a comparative analysis of other similar organizations within a similar or different setting. Such an approach could inform the grants that they pursue or the types of strategic collaborations that they are part of. Gillam (2014) suggests that organizations that are able to use the available evidence in their practices are able to improve the quality of the services that they deliver.

Although the academic literature highlights the notion that happy employees are more productive employees, it is not known whether productive employees deliver better quality services. Nevertheless, social and behavioral research points out to the interplay between an

organization's culture and organizational efficiency (Aktas, Cicek, and Kiyak, 2011). None of the respondents that were interviewed seem to be in hostile work environments and/or have managers that are toxic for their well-being. During the interviews, the respondents were not asked whether their organization culture shifts often or whether it is static. This would be critical in examining the role leaders play in encouraging the incorporation of evidence in the organization. If under resourced organizations with limited funding and fragmented staff members are unable to incorporate evidence into their organizational processes, what can be a solution for them? Furthermore, to what extent is the use of a new public service approach characterized by shared values and cross-sector collaboration sufficient enough to make up for gaps that arise from the lack of EBMgt in the organization?

Lastly, Aktas, Cicek, and Kiyak present the Competing Values Framework (CVF). According to them, this framework refers to "whether it has a predominant internal or external focus and whether it strives for flexibility and individuality or stability and control" (p. 1561). In this dissertation study, it is actually not known whether values can compete within and between organizations seeking to address the same adaptive challenge. Although Aligica and Tarko (2011) suggest that public governance designs and arrangements are useful tools in limiting social conflict, there is still more research that needs to be done in terms of what happens when NGOs with a shared vision are competing for the same funds. Could this shared sense of purpose (as suggested by the new public service approach) result in organizations becoming disconnected from one another and pursuing their organizational interests in an effort to achieve their respective sustainable impact goals? Arguably, one can make the case that the use of evidence-based management amongst organizations is a strategic move for competing entities that seek to access a resource pool of information as they subtly wait to outshine their peers.

Appendix A Organizations

Appendix A.1 Correspondence & Informed Consent for Research Participation

Email Template:

My name is Tegan Joseph Mosugu, and I am a Nigerian-American student currently completing doctoral studies in Public & International Affairs at the University of Pittsburgh, Graduate School of Public & International Affairs. I am reaching out to you because I am interested in the work being done at __. Thus, I would like to have more insight on how X is impacting HIV/AIDS service-delivery, as well as opportunities for further impact and growth.

My dissertation research focuses on the following: Evidence-based management: Panacea or Placebo? Evidence from the Nigerian HIV/AIDS Service Delivery. I truly believe that I would be able to get insight from your organization. I wanted to know whether it would be possible for me to interview some of your staff. Ideally, I would be very grateful if I can interview any administrative, programmatic and management personnel. Thank you for your time and consideration. I look forward to hearing from you

Best,
Tegan Joseph Mosugu

Study title	Evidence-Based Management: Panacea or Placebo? Insights from HIV/AIDS Service in Nigeria
Researcher	Tegan Joseph Mosugu

We are inviting you to participate in a research study. Participation is completely voluntary. If you agree to participate now, you can always change your mind later. There are no negative consequences, whatever you decide.

What is the purpose of this study?

The purpose of this study is to examine whether organizations that adopt an evidence based management grounded in principles of new public service - shared vision, collaboration, and citizen-centered health care delivery – are positioned to provide services and have more sustainable impact, provided it has the capacity to do so.

What will I do?

Participation should take about 45 minutes to 1 hour of your time to contribute through Zoom interviews. You will be required to answer interview questions that are based on HIV/AIDS service delivery. Interviews will be audio-recorded and transcribed.

Risks

Possible risks	How we're minimizing these risks
Breach of confidentiality (your data being seen by someone who shouldn't have access to it)	Identities and responses will be kept strictly confidential and audio-recordings erased immediately after transcription.

There may be risks we do not know about yet. Throughout the study, I will tell you if we learn anything that might affect your decision to continue participation.

Other Study Information

Possible benefits	Your participation in this study will help practitioners gain a better understanding of whether evidence-based management can be used as a successful tool to enhance HIV/AIDS service delivery.
Estimated number of participants	7 (1-2 per organization)
How long will it take?	45 minutes – 1 hour minutes per participant interview
Costs	None
Compensation	None
Future research	Your data will not be used or shared for any future research studies.

Recordings / Photographs	This will be a Zoom interview and you will have the option to opt out from it being recorded. The recordings will be used for transcribing purposes only and erased immediately after transcription.
	The recording is necessary to this research. If you do not want to be recorded, it will be hand jotted.

Informed Consent for Research Participation

Confidentiality and Data Security

Where will data be stored?	On the principal investigator's personal computer
How long will it be kept?	Until June 1st, 2021

Who can see my data?	Why?	Type of data
The researcher	To conduct the study and analyze the data	Only de-identified will be stored (no names, birthdates, address etc. attached to the data)
The IRB (Institutional Review Board) at the University of Pittsburgh The Office for Human Research Protections (OHRP) or other federal agencies	To ensure we are following laws and ethical guidelines	Only de-identified will be stored (no names, birthdates, address etc. attached to the data)

Anyone (public)	If we share our findings in publications or presentations	Only de-identified will be stored (no names, birthdates, address etc. attached to the data)

Your personal information will be used as long as necessary for this study. Contact the investigator, in writing, if you want to end your permission to use your personal information. If you do this, no more information will be collected, but the information already collected will still be used. If you end your permission to use your personal information, you will not be able to continue in this study.

Contact information:

For questions about the research	Tegan Joseph Mosugu	+2348145755496 tem69@pitt.edu
For questions about your rights as a research participant	IRB (Institutional Review Board; provides ethics oversight)	+1-412-383-1480 askirb@pitt.edu
For complaints or problems	Tegan Joseph Mosugu	+2348145755496 tem69@pitt.edu
	IRB	+1-412-383-1480 askirb@pitt.edu

Appendix A.2 Informed Consent for Oral Interview

Photographic, Audio Taping, Video Taping or Written Media Consent for Research

Title of Project: Evidence-Based Management: Panacea or Placebo? Insights from HIV/AIDS Service in Nigeria

Principal Investigator: Tegan Joseph Mosugu

Research Location: Virtual/Remote

Participant's Name: _____

You are a participant in the research study titled, Evidence-Based Management: Panacea or Placebo? Insights from HIV/AIDS Service in Nigeria The study leader is requesting that you allow audio-taping. The requested audio-taping will be used for transcription of your in-person interview related to the ongoing study.

I give my informed and free permission for participating in the above-described activities. I agree that I will not have any rights to the media captured or used for this study or University of Pittsburgh purposes.

Principal Investigator: Do you agree to proceed?

Participant Response: Yes or No

Appendix A.3 APIN Public Health Initiatives

Interview Questions

1. What does your organization do in terms of service delivery?

Comprehensive HIV/AIDS and services – care and treatment. Prevention of mother to child transmission.

2. What outputs and outcomes has your organization achieved from inception to date?

APIN has placed over 300,000 patients on treatment – currently in care.

Prevented mother 2 child transmission, people that have TB/HIV receive treatment and are cured of TB not HIV. For HIV you have to take lifelong drugs which ensures that it is suppressed.

3. What is the staff profile of this organization?

    a. Doctors

    b. Various medical personnel, nurses, lab scientists.

    c. Clinical unit, M&E (data management) operations, and programs (technical).

    d. Operations(admin) – support programs to achieve these results

    e. Accountants

4. What techniques are used to manage this organization?

a. CEO, directors, board of directors

b. Decisions that CEO may not take; he takes it to the board for approval first

c. Corporate organization

5.How are the constraints on the organization?

a. Environmental constraints, facilities and communities. Nigeria strikes from time to time, clashes, demonstrations (Endears) that affect our work. We may not be able to go to facilities and communities. Challenges that affect businesses: COVID has also been challenging, it has affected our working environment, movement supply chain materials, masks, affected services

6. What can be done to improve organizational ability to deliver services?

a. Provide capacity to staff – technical skills to deliver services across borders

b. Capacity building – government agencies. Provide technical skills to work with government agencies

7. How is this organization uniquely positioned to have impact and reach its target demographic?

a. Organization evolving itself to be competitive – to get grants and make impact. Funder tells you what they want and APIN gets the edge – experience it has had over the years

8. Does your organization utilize any evidence in decision-making and service delivery?

a. Yes

8b. If so, how does your organization evaluate the outcome of the decision based on such evidence

We engage stakeholders, we do not work in isolation – not just organizations but also stakeholders: Government agencies, state aids control agencies (SACAs), federal level (NACA), MINISTRY OF HEALTH, CIVIL SOCIETY

Monitoring & Evaluation firm work.

i. Indicators that they are tracking determine how funders/donors will grade us   ii. Clear and concise questions, how do you achieve that?

We have a monitoring and evaluation framework for whatever we do. We have indicators we track; it is based on these indicators tracked that we are graded.

9. What has been your organization's experience of dealing with marginalized and vulnerable populations; particularly, women/children, commercial sex workers and men-who-have sex with men, etc.

a. Special populations – we work KPs and we know their peculiarities issues such as stigmatization, discrimination, etc. We engage them appropriately– we work with civil society to engage them to know their challenges. Without stakeholder engagement, it is impossible to identify/address challenges.

10. In what ways is your organization connected to other nonprofits and government agencies in the HIV/AIDS service delivery space?

11.Does APIN have a board or just individual leaders?

a. APIN has a board. We have a Chief Executive Officer, Directors, Board of Directors. For checks and balances, we have decision-making processes.

Appendix A.4 Association of Reproductive and Family Health (ARFH)

Interview Questions

1. What does your organization do in terms of service delivery?

    i. Community sensitization, mobilization and education.

    ii. HIV Testing Services

    iii. Active search for vulnerable population especially Pregnant Women

    iv. Sexual network testing to identify positive clients linked to index clients

    v. Referral of communities especially positive clients for uptake of services in designated health facilities

    vi. Psychosocial and adherence supports to PLHIV

2. What outputs and outcomes has your organization achieved from inception to date?

    a. ARFH has implemented programmes in various areas; HIV, TB, Reproductive health, maternal and child health, youth-focused programmes, maternal and child health etc. across all the 36 States of Nigeria and FCT with impacts

    b. ARFH has developed programmes that have been institutionalized in the country with national coverage such as the National Reproductive and Health and HIV & AIDS Prevention Programme through the NYSC. Also, the Family Life and HIV Education which in curriculum based HIV intervention was the brainchild of ARFH which was a product of the initial Life Planning Education Programme of ARFH

    c. ARFH has developed various Manuals and handbooks and other IEC materials on sexual and reproductive health which is nationally being used

d. Through the OVC Programmes, ARFH has restored hope and dignity to many families especially though Household Economic Strengthening, Block Granting for vulnerable children to be able to attend schools without out of pocket payment for levies etc

e. In terms of case detection, ARFH has contributed significantly to HIV and TB Case detection and service uptakes.

f. ARFH has strengthened the capacity of more than 500 Community Based Organizations to be able to respond more effectively to the social and health needs of their communities.

3. What is the staff profile of this organization?

ANALYSIS OF ARFH STAFF STRUCTURE

Project	Management	Programmes/Professional	Support Staff	Male	Female	Total
ARFH GEN	4	6	22	11	21	32
HIV	**6**	**17**	**8**	**27**	**7**	**34**
NURHI	1	1	6	4	4	8
ICHSSA	9	9	18	22	14	36
RASUDIN	1	12	8	12	9	21
SURGE	0	2	1	1	2	3
TB	2	4	14	14	6	20
UNFPA	0	0	1	1	0	1
Total	**23**	**51**	**78**	**92**	**63**	**155**

4. What techniques are used to manage this organization?

   a. Visionary

5. How are the constraints on the organization?

   a. Donor fatigue. There is always the need for more funding to be able to sustain implementation of impactful project across the 36 States and FCT

   b. Project sustainability is a challenge as donor funding has timelines while needs of communities are continuous

   c. Retaining highly skilled staff is dependent on fund availability

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d. Lack of commitment from government to sustain some of the impactful programmes such as the National Reproductive Health and HIV Prevention Programme which is youth focused with a lots of results to show for it

6. What can be done to improve organizational ability to deliver services?

    a. Continuous funding from donors

    b. More support from government to domesticate some of the key impactful programmes

7. How is this organization uniquely positioned to have impact and reach its target demographic?

    a. ARFH is constantly in connection with the various communities across the states of Nigeria to know their emerging issues and develop proposals and programmes to address such challenges

    b. ARFH also identify disadvantaged population and communities and place priority on them in the interventions

    c. ARFH is fully connected to government structures across national and sub national levels to support in driving their programme and policies to the rural and hard-to-reach communities

    d. There is regular networking with other partners to ensure effective synergy in programme designs and implementation for more effective impacts on the communities

8. Does your organization utilize any evidence in decision-making and service delivery?

    a. Yes. Decision and interventions are based on findings from researches and survey be it national surveys or organization based survey

8b. If so, how does your organization evaluate the outcome of the decision based on such evidence.

    Baseline and end lines evaluations are always conducted to determine the outcomes of all interventions and strategies

9. What has been your organization's experience of dealing with marginalized and vulnerable populations; particularly, women/children, commercial sex workers and men-who-have sex with men, etc.

   a. ARFH has various interventions focusing on Pregnant Women and Children especially on Household empowerment for vulnerable families. There is also key attention to Pregnant women. Although, no particular project for Men who have sex with men and sex workers, services are provided to them as the case may be especially for children of Sex workers who are made vulnerable due to the work status

10. In what ways is your organization connected to other nonprofits and government agencies in the HIV/AIDS service delivery space?

   a. There is effective networking and partnership with other relevant NGOs and State partners in the area of co-implementation where necessary

   b. All policy issues set by the country and states on HIV & AIDS are honored

   c. The organization also participate in stakeholders meeting

   d. There is partnership also in the collection of commodities from government facilities and other partners when the needs arise.

   Appendix IV: Society for Family Health - SFH-KP-CARE-2 Project

   Interview Questions

   1. What does your organization do in terms of service delivery?

a.   SFH has always been involved in service delivery, in terms of family planning, child health, HIV prevention, with specific reference to HIV/AIDS. We provide counseling and testing.

b.   Communicate to people the reality of HIV/AIDS. Then moved on to addressing the issue of stigmatization by coming up with awareness programs that encourages the public to relate with HIV infected people without discrimination. We also come with individual / one on one, and mass media campaigns channeled towards individual behavior and social change.

c.   We also provide HIV/AIDS services. We embarked on testing services. Initially, people were scared because the results could come out positive and needed support will not be available to them. We then moved on to providing treatment. Those who are positive get put on treatment immediately after testing. Those who are negative get put on Pre-exposure prophylaxis (PREP) particularly key populations like men who have sex with men, people who inject drugs, transgender, female sex workers, and prison inmates. There was a period we received complaints on condom breakage, we later found out that it had to do with user behavior. So, we placed more emphasis on building individual skills on the use of condoms.

2. What outputs and outcomes has your organization achieved from inception to date?

Our initial program was on the prevention of HIV/AIDS. The next phase of the plan was on building institutional capacity because we cannot do it alone so we need government support. So, we collaborate with control agencies in about 6 supporter states where we worked closely with government to ensure that they take ownership of the HIV

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response in their respective states. That had a lot of impact. For example, we have seen how governments allocate resources to fighting against HIV/AIDS in addition to donor resources. We have also seen how we have been able to support the states to pass the Anti-Stigma Bill. When we started our ENR (Enhancing Nigerian response to HIV/AIDS) program, none of the states had passed the HIV Anti-Stigma Bill. We realized that stigma was an issue that was preventing people from accessing HIV services. By the end of the project, all the 6 states supported by the project had passed the HIV anti-stigma bill

3. What is the staff profile of this organization?

It is difficult to tell at the moment. I am managing the KP CARE-2 which is a bit detached from SFH. Looking at all the projects, I will say we are about 500. We implement lots of projects and have about 2-3 HIV projects. For the KP CARE-2 project, we have about 50 program/project staff, about 200 frontline health workers, about 100 peer navigators, and another 100 as case managers (people who ensure that those who are enrolled in treatment are retained on care). SFH-KP-CARE-2 project is a KP focused HIV prevention, treatment and care services grant being implemented in Bauchi and Adamawa states at the moment. USAID currently funds 3 KP projects in Nigeria. These are, KPCARE-1 being implemented in Lagos, Cross Rivers and Akwa Ibom states in the South by Heartland Alliance. KP CARE-2 being implemented in Bauchi and Adamawa states in the North by the Society for Family Health. EPIC being implemented in Bayelsa (South) and Niger states (North) by FHI360.

4. What techniques are used to manage this organization?

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We use a mix/hybrid approach. When we have to work with colleagues from other organizations in a consortium platform, we use a collegial system. We use a collaborative approach when dealing with our partners. When drawing a work plan, we also work closely with the beneficiaries themselves, state (SACA - State Action Committee on AIDS) & local (LACA - Local Action Committee on AIDS) governments and security personnel.

5. How are the constraints on the organization?

a.   Major challenges - Nigeria being multi-religious and multicultural, religious extremism, and anti-gay laws.

6. What can be done to improve organizational ability to deliver services?

We:

a.   Prioritize and advocate human rights principles in public health service delivery

b.   Ensure confidentiality in dealing with KPs (don't ask, don't tell)

c.   Strategically engage and work closely with reform-minded religious leaders (across both religions)

d.   Are looking to empower KP groups to have their own organization in order to enhance sustainability when the project is over.

7. How is this organization uniquely positioned to have impact and reach its target demographic?

Look at the treatment gap and address it. We don't wait for them to come to us, we seek them out in their bunks, hotspots and other high-risk locations. Once one case is

identified, we reach out to their social and sexual networks to carry out HTS and administer ART and PREP as necessary. We also monitor them for side effects.

8. Does your organization utilize any evidence in decision-making and service delivery?

a.   The project is evidence-based. We use evidence in taking decisions and allocating targets for the program.

We look at what all the other HIV partners are doing:

Firstly, we do an analysis of the total number of people that are infected with HIV/AIDS in the state and the number of those on treatment from each of these partners, and identify the gap left. We also use evidence to determine the number of KPs in a state. We also do programmatic mapping of where KPs congregate and seek them out when mapping and provide services. We use evidence from data to ensure that our services target those who need them the most. Even during salary review, we find out how our partners are doing in terms of compensation to know if we are being competitive or not. We also take regular staff satisfaction surveys to know what we can do more to motivate them optimally.

9. In what ways is your organization connected to other nonprofits and government agencies in the HIV/AIDS service delivery space?

We work closely with other NGOs that are implementing HIV programs. If we come across a partner of KP who is not a KP, we refer those cases to IPs who work with the general population. We also refer children of KPs to partners that are implementing Orphan and Vulnerable (OVC) services. It is a client-centered approach that brings

everybody together as part of the ecosystem. We are also connected to local NGOs who we call community-based organizations.

Appendix A.5 Society for Family Health - SFH-KP-CARE-2 Project

Interview Questions

1. What does your organization do in terms of service delivery?

   a.   SFH has always been involved in service delivery, in terms of family planning, child health, HIV prevention, with specific reference to HIV/AIDS. We provide counseling and testing.

   b.   Communicate to people the reality of HIV/AIDS. Then moved on to addressing the issue of stigmatization by coming up with awareness programs that encourages the public to relate with HIV infected people without discrimination. We also come with individual / one on one, and mass media campaigns channeled towards individual behavior and social change.

   c.   We also provide HIV/AIDS services. We embarked on testing services. Initially, people were scared because the results could come out positive and needed support will not be available to them. We then moved on to providing treatment. Those who are positive get put on treatment immediately after testing. Those who are negative get put on Pre-exposure prophylaxis (PREP) particularly key populations like men who have sex with men, people who inject drugs, transgender, female sex workers, and prison inmates. There was a period we received complaints on condom breakage, we later found out that it had

to do with user behavior. So we placed more emphasis on building individual skills on the use of condoms.

2. What outputs and outcomes has your organization achieved from inception to date?

Our initial program was on the prevention of HIV/AIDS. The next phase of the plan was on building institutional capacity because we cannot do it alone so we need government support. So we collaborate with control agencies in about 6 supporter states where we worked closely with government to ensure that they take ownership of the HIV response in their respective states. That had a lot of impact. For example, we have seen how governments allocate resources to fighting against HIV/AIDS in addition to donor resources. We have also seen how we have been able to support the states to pass the Anti-Stigma Bill. When we started our ENR (Enhancing Nigerian response to HIV/AIDS) program, none of the states had passed the HIV Anti-Stigma Bill. We realized that stigma was an issue that was preventing people from accessing HIV services. By the end of the project, all the 6 states supported by the project had passed the HIV anti-stigma bill

3. What is the staff profile of this organization?

It is difficult to tell at the moment. I am managing the KP CARE-2 which is a bit detached from SFH. Looking at all the projects, I will say we are about 500. We implement lots of projects and have about 2-3 HIV projects. For the KP CARE-2 project, we have about 50 program/project staff, about 200 frontline health workers, about 100 peer navigators, and another 100 as case managers (people who ensure that those who are enrolled in treatment are retained on care). SFH-KP-CARE-2 project is a KP focused HIV

prevention, treatment and care services grant being implemented in Bauchi and Adamawa states at the moment. USAID currently funds 3 KP projects in Nigeria. These are, KPCARE-1 being implemented in Lagos, Cross Rivers and Akwa Ibom states in the South by Heartland Alliance. KP CARE-2 being implemented in Bauchi and Adamawa states in the North by the Society for Family Health. EPIC being implemented in Bayelsa (South) and Niger states (North) by FHI360.

4. What techniques are used to manage this organization?

 We use a mix/hybrid approach. When we have to work with colleagues from other organizations in a consortium platform, we use a collegial system. We use a collaborative approach when dealing with our partners. When drawing a work plan, we also work closely with the beneficiaries themselves, state (SACA - State Action Committee on AIDS) & local (LACA - Local Action Committee on AIDS) governments and security personnel.

5. How are the constraints on the organization?

a. Major challenges - Nigeria being multi-religious and multicultural, religious extremism, and anti-gay laws.

6. What can be done to improve organizational ability to deliver services?

 We:

a. Prioritize and advocate human rights principles in public health service delivery

b. Ensure confidentiality in dealing with KPs (don't ask, don't tell)

c.   Strategically engage and work closely with reform-minded religious leaders (across both religions)

d.   Are looking to empower KP groups to have their own organization in order to enhance sustainability when the project is over.

7. How is this organization uniquely positioned to have impact and reach its target demographic?

Look at the treatment gap and address it. We don't wait for them to come to us, we seek them out in their bunks, hotspots and other high-risk locations. Once one case is identified, we reach out to their social and sexual networks to carry out HTS and administer ART and PREP as necessary. We also monitor them for side effects.

8. Does your organization utilize any evidence in decision-making and service delivery?

a.   The project is evidence-based. We use evidence in taking decisions and allocating targets for the program.

We look at what all the other HIV partners are doing:

Firstly we do an analysis of the total number of people that are infected with HIV/AIDS in the state and the number of those on treatment from each of these partners, and identify the gap left. We also use evidence to determine the number of KPs in a state. We also do programmatic mapping of where KPs congregate and seek them out when mapping and provide services. We use evidence from data to ensure that our services target those who need them the most. Even during salary review, we find out how our partners are doing in terms of compensation to know if we are being competitive or not. We also

take regular staff satisfaction surveys to know what we can do more to motivate them optimally.

9. What has been your organization's experience of dealing with marginalized and vulnerable populations; particularly, women/children, commercial sex workers and men-who-have sex with men, etc.

Primary investigator skipped this question since it had already been answered earlier.

10. In what ways is your organization connected to other nonprofits and government agencies in the HIV/AIDS service delivery space?

We work closely with other NGOs that are implementing HIV programs. If we come across a partner of KP who is not a KP, we refer those cases to IPs who work with the general population. We also refer children of KPs to partners that are implementing Orphan and Vulnerable (OVC) services. It is a client-centered approach that brings everybody together as part of the ecosystem. We are also connected to local NGOs who we call community-based organizations.

Appendix A.6 Health Strategy & Delivery Foundation (HSDF)

Interview Questions

1. What does your organization do in terms of service delivery?

   i. HSDF provided technical assistance to seven high-burden states to strengthen their efforts to scale up eMTCT interventions. These states are

Akwa Ibom, Bayelsa, Cross River, Federal Capital Territory (FCT), Kano, Nasarawa, and others. HSDF supports state-led execution by increasing the availability of quality eMTCT data and facilitating its utilization for decision making.

2. What outputs and outcomes has your organization achieved from inception to date?

    i.   Early infant diagnosis. Data gathered was used to assess why HIV+ infants were not accessing testing.

    ii. HSF has also worked to identify bottlenecks in the public health system when delivering HIV care.

    iii. HSF worked with state governments by having a technical specialist embedded within each state's agency for sexually transmitted infections (SASTI) Control Program

    iv. HSDF supported ongoing implementation of early infant diagnosis (EID) operation services, electronic medical records in one state to improve private facility reporting, and integration of HIV counseling and testing into maternal, neonatal and child health week in two states.

3. What is the staff profile of this organization?

    i.   Abuja Office (50 staff), Lagos Office, Kaduna, Imo, Niger

4. What techniques are used to manage this organization?

    i.   Collaborative. The team leads work with the CEO to strategize

5. How are the constraints on the organization?

    i.   Physical space constraints – projects close out. There is the constant need to get on new projects

6. What can be done to improve organizational ability to deliver services?

      i. Trying to build capacity in data analytics internally

      ii. In house capacity / data analytics hub to analyze data for different stakeholders and data management

7. How is this organization uniquely positioned to have impact and reach its target demographic?

      i. It uses innovative approaches to strengthen state-led execution of eMTCT programs in order to achieve national targets.

8.

    a. Does your organization utilize any evidence in decision-making and service delivery?

    b. If so, how does your organization evaluate the outcome of the decision based on such evidence

    HSDF address the following challenges that need evidence-based interventions:

Underreporting of HIV treatment services provided and poor provider adoption of technological infrastructure.

- The main reporting problems observed at facility-level were irregular completion of a monthly summary form (MSF) and inaccurate data reporting on the MSF

- Lack of consistency in database reporting:

- Facility adoption of NHMIS registers, not knowledge, appeared to explain the big difference between the states. We believe the key driver of better facility-level reporting in CRS is the relatively high adoption of the official NHMIS registers by facilities as their primary patient

registries (Exhibit 4). By contrast, facilities in AKS were inundated with multiple registers, including theirs, likely causing confusion and non-adoption.

- Local government monitoring & evaluation staff complained of inadequate training and logistics for data upload.

- Non-use of the data tools because of their complexity, the effort to complete them, the weak incentives and management systems that influence compliance, and confusion caused by the availability of multiple types of data tools and various reporting platforms for the same data

- Lack of clarity about how to submit data to the LGA and about who will bear the effort/cost (Will the facility submit? Will the LGA arrange pick-up?)

Evidence-based approach for eliminating Mother to Child Transmission OF HIV/AIDS (Organization)

The national goals are ambitious but achievable through strong state leadership of elimination of mother-to-child transmission (eMTCT) programs and the use of innovative approaches. The goal of HSDF's eMTCT team is therefore to strengthen state-led execution of eMTCT programs in order to support the states to achieve the national targets. We support state-led execution by increasing the availability of quality eMTCT data and facilitating its utilization for decision making. Our team provides technical assistance to 7 'high burden states' to strengthen their efforts to scale up eMTCT interventions. These states are Akwa Ibom, Bayelsa, Cross River, Federal Capital Territory (FCT), Kano, Nasarawa and Rivers.

Step 1: Diagnose

HSDF conducts a diagnostic to establish a fact base, with a quantitative examination of patient need, service delivery, and the gaps between them;

Step 2: Design

HSDF supports operational planning by supporting the development of simple, concrete, specific, state-led plans to scale eMTCT services focusing on the levers that need to be improved to achieve rapid scale;

Step 3: Deliver

HSDF supports the state government to execute the scale up plan by tracking implementation progress against clear targets. Specifically, we support reporting and tracking of performance; trouble-shooting of emerging bottlenecks; and stakeholder alignment and collaboration

Results

Scale up of eMTCT services:

Responding to the baseline analyses identifying low coverage of eMTCT services in some areas state governments have activated more eMTCT sites and a supported increased eMTCT service provision across private healthcare facilities in the intervention states.

Improved collaboration between key stakeholders:

Creation of a regular forum for partners and state officials during which progress made and challenges faced in the execution of eMTCT services are discussed. Such fora have now been institutionalized in four states: Akwa-Ibom, Cross River, Rivers and Bayelsa.

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Improved eMTCT data reporting:

HSDF has actively engaged private healthcare facilities to report eMTCT data on the national health reporting platforms and has also facilitated access to these platforms by key state officials. These interventions have resulted in the increased listing of private healthcare facilities on the district health information system (DHIS) platform and improved eMTCT data reporting respectively, which in turns increases data available to monitor and evaluate progress, and inform decision making.

9. What has been your organization's experience of dealing with marginalized and vulnerable populations; particularly, women/children, commercial sex workers and men-who-have sex with men, etc.

    i. Do not really work directly with these groups

10. In what ways is your organization connected to other nonprofits and government agencies in the HIV/AIDS service delivery space?

    i. Government and other partners

    ii. Technical working groups and committees. Contribute and we were also part of data quality validation groups. meetings to review state level data

Appendix A.7 Centre for the Right to Health (CRH)

Interview Questions

1. What does your organization do in terms of service delivery?

PROGRAMS

HIV/AIDS/STI Prevention and Impact Mitigation

- Developed and disseminated information, education, communication (IEC) materials on HIV prevention care and support

- Prevention of Mother to Child Transmission of HIV through education, HIV testing of pregnant women and accompanied referral of HIV positive ones to facilitate treatment and specialized care.

- HIV prevention interventions- outreach, peer education, HIV counseling, testing and referrals for youth, women, men, sex workers, men who have sex with men, injection drug users, uniform personnel and road transport workers.

- Treatment, care and support for HIV/AIDS and opportunistic infections.

- Syndromic management of STIs, TB and Hepatitis testing and referral for treatment

Maternal Newborn and Child Health (MNCH)

- Train traditional birth attendants (TBA), community health extension workers (CHEW) and midwives on safe delivery, providing emergency obstetrics care, and family planning; to serve as Community Response Persons (CORPs) to promote 16 Key Household Practices (KHHP) to reduce maternal, newborn and child morbidity and mortality.

- Community education campaigns and awareness on sexual and reproductive health and male involvement

- Renovated and equipped primary health care centers with instruments and supplies for delivery and family planning; trained health workers/community volunteers to manage and sustain the centers.

- Building a movement for respectful maternity care and accountability for negligent deaths

- Strengthening antenatal clinics in the selected communities through health education, counseling, routine laboratory screening including HIV testing and treatment for common infections including malaria and STI.

Human Rights, Especially Sexual and Reproductive Health and Rights

- Research, documentation and advocacy to promote and secure the human rights of women, youth, people living with HIV/AIDS other marginalized populations;

- Mediation, litigations and legal counseling to redress violations;

- Trained variety of stakeholders including media, lawyers, judiciary, human rights activist, health workers, employers, law enforcement agents and vulnerable populations on health and human rights including HIV and other sexual and reproductive rights issues;

- Educated vulnerable population about their human rights and mobilized them to demand accountability

Health Systems Strengthening

- Promoting professional excellence among health professional

- Human rights, ethics and related training for health professionals

- National nursing excellence award and essay competition

- Dialogue with health workers on quality health care and accountable services

Primary Health Care via Health on Wheels

- Mobile primary health care delivery services and health education that target predominantly women and children in rural and slum communities which provide testing

and treatment for common diseases like malaria, typhoid, HIV, STI, respiratory tract infections, diabetes, hypertension and family planning services

Drug Dependency and Addiction Prevention, Treatment and Support

- Community outreach and education on substance abuse prevention and care
- Drug dependency and addiction treatment, counseling and support services for people who use drugs and their families

2. What outputs and outcomes has your organization achieved from inception to date?

- Set up the first stand-alone HTS centre in Abuja
- Runs a Female Drug treatment Centre in Abuja
- Runs a drop in Centre for Key Populations
- Conducts HIV impact mitigation projects

3. What is the staff profile of this organization?

10 tenured staff and more than 25 Volunteers and part time staff

4. What management techniques are used to manage this organization?

Transformational and collaborative management styles How are the constraints on the organization?

5. What can be done to improve organizational ability to deliver services?

6. How is this organization uniquely positioned to have impact and reach its target demographic?

Collaborative and partnership with CBOs and other stakeholders as we only contribute to solving development agendas in health

7. Does your organization utilize any evidence in decision-making and service delivery? Yes

7b. If so, how does your organization evaluate the outcome of the decision based on such evidence.

Via research and field evaluation of activities and programmes

8. What has been your organization's experience of dealing with marginalized and vulnerable populations; particularly, women/children, commercial sex workers and men-who-have sex with men, etc.

9. In what ways is your organization connected to other nonprofits and government agencies in the HIV/AIDS service delivery space?

    Partnerships and collaboration and information sharing

Appendix VII: Association of Women Living with HIV/AIDS (ASHWAN)

The research questions for the qualitative component will ask the following:

1. What does your organization do in terms of service delivery?

    Advocacy, prevention, treatment, care and support and counseling

    ASHWAN – Women, children and girls and presence, members in the facilities also attend to the men..

    During advocacy, we work with men, we focus on women, girls and children

2. What outputs and outcomes has your organization achieved from inception to date?

    Registered in 2004. Officially existence in 2002. CAC and board in 2004.

- ASHWAN there was no support group. 4 persons working for the organization. 650 support groups across 36 states and F.C.T. We have a board set up. National coordinators were elected, national board officers, zonal board officers.

- 3 years: Delegate forum. National coordinators

    Stigma and Plateau State and FCT

    HIV Antidiscrimination bill into law in 2014

    We mobilized 500 women for uptake of PMTCT and ANAC

3. What is the staff profile of this organization?

> We employ based on projects. Focus is on community care in Nigeria. 13 staff. 6 right now in ASHWAN

4. What management techniques are used to manage this organization?

> No specific technique.

5. How are the constraints on the organization?

> Funding

6. What can be done to improve organizational ability to deliver services?

   a. Accessing the Global Fund – we are unable to assess this funding stream. Staff are not on salary. We need more resource mobilization and funding support from partners

7. How is this organization uniquely positioned to have impact and reach its target demographic?

> We are able to tackle prevention of mother to child transmission of HIV. We know the issues and we know where it pinches. We are a women-led organization and we have a wider coverage across 36 states, and not only just at the national level.

> We are visible in all the states

8. Does your organization utilize any evidence in decision-making and service delivery?

   b. Strategies are employed based on the result that we want to achieve. (Note: Intended outcomes inform the evidence that ought to be used)

8b. If so, how does your organization evaluate the outcome of the decision based on such evidence

   a. ASHWAN uses baseline surveys to understand the behavior of key populations. E.g. they conduct this kind of research to understand factors that are still preventing services from

being sought after *(**Primary investigator forgot to ask this question, but the answer was alluded to in an earlier part of the interview).***

9. What has been your organization's experience of dealing with marginalized and vulnerable populations; particularly, women/children, commercial sex workers and men-who-have sex with men, etc.

   a. We have experience dealing with them. We have a project called PITCH - partnership to inspire and connect with HIV response. In that project, we have MSMs, sex work. What we do with them is advocacy. We work together with them and place them on treatment. Sex workers have an issue with Nigerian police. Our relationship with them is to see that those that are positive are receiving the treatment. We ask the police that we would like to bring the drugs for those arrested. When they go to rally to give their voice, we join them. We make their issue a general issue

10. In what ways is your organization connected to other nonprofits and government agencies in the HIV/AIDS service delivery space?

   c. ASHWAN is not part of regional bodies. We are just an no that is dependent. When they have programs, we attend. We are part of the country coordinating mechanism (CCM) – we struggled to have a representative there. Outside NACA, that is the only place where we have our voice.

ASHWAN acquires technology on a project by project basis.

Appendix A.8 Best Practices in HIV/AIDS Clinical Care

Note: This survey was based on the "assessment of HIV/AIDS care in Brazil"

Rosendo Da Silva, R. A., Castro, R. R., Pereira, I. R., & Silva de Oliveira, S. (n.d.). Questionnaire for assessment of HIV/AIDS control actions in the primary care. *SciELO Analytics*. Retrieved from http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0103-21002017000300271&lng=en&nrm=iso&tlng=en

1. I have access to materials from the Ministry of Health and National Agency Control of AIDS (NACA) regarding the management of HIV/Aids and other STIs (sexually transmitted infections)

   o Never

   o Rarely

   o Sometimes : CRH

   o Always : HSDF, ASHWAN, APIN, ARFH, SFH, SFH KP-CARE 2

   o Not Applicable

2. I am aware of the measures used to control HIV/AIDS in primary care

   o Never

   o Rarely

   o Sometimes: CRH

   o Always : HSDF, APIN, SFH, SFH KP-CARE 2, ARFH

o Not Applicable: ASHWAN

3. There are outreaches or surveys carried out to identify the specific groups or areas most vulnerable to HIV/AIDS infection

      o Never

      o Rarely

      o Sometimes: CRH, ARFH

      o Always: APIN, SFH, SFH KP-CARE 2

      o Not Applicable: HSDF, ASHWAN

4. The health unit is supplied with medications for treatment of STIs (Sexually Transmitted Infections)

      o Never

      o Rarely

      o Sometimes: CRH, ARFH, SFH

      o Always: APIN, SFH KP-Care 2

      o Not Applicable: HSDF, ASHWAN

5. I have participated in training/qualification on issues related to HIV/AIDS control in the last five years

- o Never

- o Rarely: CRH

- o Sometimes: ARFH

- o Always: ASHWAN, APIN, SFH, SFH KP-CARE 2, HSDF

- o Not Applicable

6. Information and awareness campaigns are conducted for HIV/AIDS prevention in social facilities in the area covered by the health unit

  - o Never

  - o Rarely

  - o Sometimes: ASHWAN, CRH

  - o Always: HSDF, APIN, ARFH, SFH, SFH KP-CARE 2

  - o Not Applicable

7. How often does your NGO conduct information and awareness campaign about risk behaviors for HIV infection in the coverage area of the healthcare unit

  - o Never

  - o Rarely

  - o Sometimes: ASHWAN, CRH

  - o Always: HSDF, APIN, ARFH, SFH, SFH KP-CARE 2

o Not Applicable

8. The rapid or serological test is offered to every person with symptoms suggestive of HIV/AIDS

    o Never

    o Rarely

    o Sometimes: ASHWAN, CRH

    o Always: HSDF, APIN, ARFH, SFH, SFH KP-CARE 2

    o Not Applicable

9. The health facility provides material for rapid HIV/AIDS testing

    o Never

    o Rarely

    o Sometimes: CRH, ARFH

    o Always: HSDF, APIN, SFH, SFH, KP-CARE 2

    o Not Applicable: ASHWAN

10. How often do you receive training to perform rapid HIV/AIDS testing

    o Never

    o Rarely: ASHWAN

    o Sometimes: CRH

o Always: APIN, ARFH, SFH, SFH KP-CARE 2

o Not Applicable

11. Health education on healthy living habits is conducted in social facilities in the area covered by your NGO?

  o Never

  o Rarely

  o Sometimes: CRH, ARFH

  o Always: ASHWAN, APIN, SFH, SFH KP-CARE 2

  o Not Applicable

12. Are sex workers, homosexuals and drug users identified as vulnerable to HIV/AIDS?

  o Never

  o Rarely

  o Sometimes

  o Always: HSDF, ASHWAN, CRH, APIN, ARFH, SFH, SFH KP-CARE 2

  o Not Applicable

13. How often do you offer services to sex workers, homosexuals and drug users?

o Never

o Rarely

o Sometimes: CRF, ARFH

o Always: ASHWAN, HSDF, SFH, SFH KP-CARE 2, APIN

o Not Applicable

14. Is the rapid test offered to partners of people diagnosed with HIV/AIDS?

o Never

o Rarely

o Sometimes: CRH

o Always: HSDF, ASHWAN, APIN, ARFH, SFH, SFH KP-CARE 2

o Not Applicable

15. Is the HIV serological test required for all pregnant women?

o Never

o Rarely

o Sometimes: CRH

o Always: HSDF, ASHWAN, APIN, ARFH, SFH, SFH KP-CARE 2

o Not Applicable

16. Is HIV/AIDS testing requested at the first prenatal visit?

      o Never

      o Rarely

      o Sometimes: CRH

      o Always: HSDF, ASHWAN, APIN, ARFH, SFH, SFH KP-CARE 2

      o Not Applicable

17. Are pregnant women identified with HIV/AIDS referred for medium and high complexity

   services monitored by the health unit?

      o Never

      o Rarely

      o Sometimes: CRH

      o Always: HSDF, ASHAN, APIN, ARFH, SFH, SFH KP-CARE 2

      o Not Applicable

18. Does the delivery of condoms occur outside the physical space of the NGO?

      o Never

      o Rarely

      o Sometimes: CRH

      o Always: HSDF, ASHWAN, APIN, ARFH, SFH, SFH KP-CARE 2

o Not Applicable

19. Are condoms not only provided at specific times?

    o Never

    o Rarely: ASHWAN, ARFH

    o Sometimes: CRH, APIN

    o Always: HSDF, SFH, SFH KP-CARE 2

    o Not Applicable

20. Is the amount of condoms the unit receives per month enough to meet the demand?

    o Never: CRH

    o Rarely

    o Sometimes: ARFH, SFH KP CARE-2

    o Always: SFH, APIN

    o Not Applicable

21. With the distribution of condoms, is guidance provided on male use?

    o Never

    o Rarely

    o Sometimes: HSDF, CRH

o Always: ASHWAN, APIN, ARFH, SFH, SFH, KP-CARE 2

o Not Applicable

22. Are people who are diagnosed with HIV/AIDS monitored by your NGO?

o Never

o Rarely

o Sometimes: CRH

o Always: HSD, ASHWAN. ARFH, SFH, SFH-KP CARE 2

o Not Applicable: APIN

23. Does your NGO provide educational materials regarding HIV/AIDS?

o Never

o Rarely

o Sometimes: CRH, ARFH

o Always: HSDF, ASHWAN, APIN, SFH, SFH KP-CARE 2

o Not Applicable

24. Do you always notify individuals that you test for HIV about their status within 48 hours?

o Never

o Rarely

o Sometimes

o Always : HSDF, ASHWAN, APIN, ARFH, SFH, SFH KP-Care 2

o Not Applicable

25. Is early detection for failure of antiretroviral therapy and referral to the specialized service performed?

o Never: HSDF

o Rarely

o Sometimes: CRH, ARFH, SFH

o Always: ASHWAN, APIN, SFH KP-Care 2

o Not Applicable

26. Are people diagnosed with HIV/AIDS referred by your NGO to other health facilities?

o Never

o Rarely

o Sometimes

o Always: HSDF, ASHWAN, CRH, APIN, ARFH, SFH, SFH KP-Care2

o Not Applicable

27. Is an active search conducted for people whose HIV diagnosis was positive but who did

not return to receive the result?

- o Never

- o Rarely

- o Sometimes: CRH

- o Always: ASHWAN, APIN, ARFH, SFH

- Not Applicable: HSDF, SFH KP-Care2

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