

Exploring the interactions between medical professionals and Global Health Initiatives in the Nigerian health system: A case study of the Global Fund grant in Nigeria

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**Samuel Lassa**

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*'Let us not get tired of doing good, because in time we will have a harvest if we do not give up.'*

*Galatians 6:9*

*In loving memory of late Colonel Bzigu Lassa Afakirya*

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## List of Acronyms

|               |  |
|---------------|--|
| AIDS          | Acquired Immune deficiency syndrome                  |
| APIN          | AIDS Prevention initiative in Nigeria                |
| ART           | Anti-Retroviral Therapy                              |
| ARVs          | Anti-Retrovirals                                     |
| ARFH          | Association for Reproductive & Family Health         |
| BMA           | British Medical Association                          |
| CHAI          | Clinton Health Access Initiative                     |
| CHEW          | Community Health Extension Worker                    |
| CHO           | Community Health Officer                             |
| CCM           | Country Co-ordinating Mechanism                      |
| CSO           | Civil Society Organisations                          |
| CSS           | Community Systems Strengthening                      |
| DFID          | Department for International Development             |
| EID           | Early Infant Diagnosis                               |
| FBO           | Faith Based Organisation                             |
| FMC           | Federal Medical Centre                               |
| FMOH          | Federal Ministry of Health                           |
| GAVI Alliance | Global Vaccine Alliance                              |
| GMC           | General Medical Council                              |
| GFATM         | Global Fund to fight AIDS, Tuberculosis, and Malaria |
| GHI           | Global Health Initiative                             |
| H8            | Health 8   |
| HPSR          | Health Policy and Systems Research                   |
| HSS           | Health Systems Strengthening                         |
| HRH           | Human Resource for Health                            |

|        |  |
|--------|--|
| IHVN   | Institute for Human Virology in Nigeria                |
| IMF    | International Monetary Fund                            |
| INGO   | International Non-Governmental Organisation            |
| LGC    | Local Government Council                               |
| LFA    | Local Funding Agent                                    |
| LMICs  | Low and Middle Income Countries                        |
| MDG    | Millennium Development Goals                           |
| MSMs   | Men Who Have Sex With Men                              |
| NACA   | National Agency for Control of AIDS                    |
| NEPWAN | Network of People Living with HIV and AIDS             |
| NFM    | New Funding Model                                      |
| NHS    | National Health Service                                |
| NMCP   | National Malaria Control Programme                     |
| NPM    | New Public Management                                  |
| OECD   | Organisation for Economic Co-operation and Development |
| PCGs   | Primary Care Groups                                    |
| PEPFAR | US President's Emergency Plan for AIDS Relief          |
| PBF    | Performance Based Funding                              |
| PLWHA  | People Living with HIV/AIDS                            |
| PMTCT  | Prevention of Mother to Child Transmission             |
| PHC    | Primary Health Care                                    |
| PR     | Principal Recipient                                    |
| QUALY  | Quality Adjusted Life Years                            |
| RMC    | Resource Mobilisation Committee                        |
| SchARR | School of Health and Related Research                  |
| SFH    | Society for Family Health                              |
| SOP    | Standard Operating Procedure                           |
| SR     | Sub-Recipient  |

|        |  |
|--------|--|
| TRP    | Technical Review Panel                             |
| TWG    | Technical Working Group                            |
| UK     | United Kingdom                                     |
| UNAIDS | United Nations joint programme for HIV/AIDS        |
| UNFPA  | United Nation Population Fund                      |
| UNICEF | United Nations Children's Fund                     |
| USAID  | United States Agency for International Development |
| WAMS   | West African Medical Service                       |
| WHO    | World Health Organisation                          |
| WTO    | World Trade Organisations                          |

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## **Abstract**

Recently, increasing attention has been given to behavioural and relational aspects of health systems, placing actors at the core. Indeed, health systems comprise of numerous actors, and one of the most important and influential is the medical doctor, playing a vital role in policy transfer at the national level (Benson 2013). The influence of medical professionals stems beyond shaping the implementation of health policies, to also potentially altering the policy content and process (Koon & Mayhew 2013). In low- and middle-income countries (LMICs) the health system is a dynamic mix of multiple stakeholders, including supra-national organizations, Global Health Initiatives and Non-Governmental Organizations (Samb et al. 2009), resulting in an environment where contesting interests and values are competing for relevance and authority. This study examined the power dynamics of medical professionals in the Nigerian health system through an in-depth case study of the interactions between the Global Fund grant and Nigerian medical professionals.

Results are based on an in-depth qualitative study involving 34 semi-structured key informant interviews with policy makers, board-meeting observations, and documentary analysis. Data was analysed iteratively in order to gain insight into the power dynamics of medical professionals in policy processes and to analytically identify structural and agential factors within the health system that encourage or discourage professional dominance.

Medical professionals maintained dominance and professional monopoly, thereby controlling policy spaces. Global actors and the local government were challenging interest groups, with a preference for rapid biomedical models that focus on medications and test kits, and the supply of health services, while neglecting social science narratives and demand creation. This work explores such issues in detail and presents



contextual factors of relevance to the Nigerian setting, thereby adding to existing literature on health systems and the sociology of medical professionals

# Chapter 1

## Introduction

### 1.1 Introduction to the study

The purpose of Chapter One is to outline the scope of the work conducted within the framework of this PhD and to introduce the research questions specific to this study. The chapter begins by giving a brief background to the study. Following the background, the research questions are presented and the contents of each of the thesis chapters are outlined.

### 1.2 Background

The overall aim of this thesis is to gain an understanding of how medical professionals interact with Global Health Initiatives (GHIs) and to explore the effects such interactions have on a country's health system, within the context of Low- and Middle-Income Countries (LMICs). Policymaking is a fundamentally complex and dynamic process in the health sector, involving many actors who engage with each other in order to identify and find strategies for addressing health challenges. Among these numerous actors, medical professionals are key actors in this process. GHIs provide avenues for policymaking processes and applying for the Global Fund grant is one of these policy exercises that occur particularly in LMICs. This thesis specifically focuses on understanding the role of medical professionals in the policy processes of the Nigerian health system by using the Global Fund proposal writing and implementation process in Nigeria as a case study. Some scholars have suggested that in policy processes *'The medical profession is reputed to control decision-making in medical care to such an extent that one can speak of professional dominance'* (Immergut 1990:391). For this

reason, medical professionals are going to be the primary focus in this study in order to explore this line of argument.

By definition medical professionals are *'the body of people who work as doctors of medicine'* (Collins dictionary 2015). Medical professionals, also known as medical doctors, abide by the ethics that govern medical practice and *'take up responsibilities that include but are not limited to clinical, teaching, research, leadership, and managerial roles in the line of duty'* (Ojo & Akinwumi 2015:375), with the clinical role being their primary responsibility in the health sector. Some observers have concluded that *'classically, the doctor was originally cast in the role of a healer, around whom latterly the ideal of the professional and professionalism developed'* (van Mook et al. 2009:82). However, a review of existing literature shows that the other responsibilities such as the leadership and managerial roles of medical professionals in certain health systems are not universal and are generally shaped by the social, economic and political factors of the particular context, leading to variations between different contexts (Johnson 1972; Abbott 1993). For this reason a universal definition is usually not straightforward, with some authors saying *'it is hard to construct a common definition, delineating what is ordinarily considered a profession'* (Brante 1988). Although there are other important health professionals in the health sector (both clinical and non-clinical), medical professionals have traditionally been seen by the public as the leading professionals in the health sector, with some calling them *'doctors in the lead'* because of how they are able to influence other health professionals (Witman et al. 2011:477). Secondly, medical professionals in the literature have been seen in western contexts to have the dominant interest in the health policy making process (Alford 1975), but very little is known about how this key group of professionals navigate through the policy making process in LMICS. Finally, the medical profession is regarded as the pioneer occupation in the health sector because of their historical origins as being the

first health occupation with any recognisable formal education (Burnham 1998), which some have pointed to as the reason for their top position in the health occupational hierarchy (Larson 1977).

A historical look at the different phases of policy changes illustrates that health professionals, especially medical professionals, have frequently dominated contested knowledge in order to secure professional advantage at both local and international levels (Arnold 1996). Friedson (1975) has explored how medical professionals in Western societies were able to achieve professional dominance in the health sector and society through a process of 'professionalisation', because in an effort to form a niche for themselves, they had to self-regulate and become immune to the dynamics of the market (Freidson 1975; Abbott 1991). Authors such as Anderson (2009) have found the sociological analysis of professions developed by Friedson helpful in trying to explain what determines the behaviour and performance of medical professionals in a Western context (Andersen 2009). Nevertheless, in LMICs there is little knowledge about how different health professionals, most especially medical professionals, work in negotiating and distributing power in the health policy process. Considering health professionals are involved in policy processes, understanding the behavioural and relational aspects of this leading group of health professional actors is central to analysing the policy processes.

The importance of health professionals in health policy is reflected in the WHO health systems template with Human Resource for Health (HRH) featuring as a major component of the six building blocks of the health system (Murray & Frenk 1999). Research in the field of HPSR has been a contributing factor to the attention given to HRH research which has until recently, largely focused on health worker distribution, retention and training. However, authors such as Adam & Savigny (2012) have called

for a paradigm shift in HPSR from these classical linear reductionist approaches to complex system theories with holistic and multidimensional systems thinking (Adam & de Savigny 2012; Paina et al. 2014; Agyepong et al. 2012). The idea behind this shift is that systems are dynamic with non-linear interconnected networks between structures and agents embedded in other systems (Swanson et al. 2012; Atun 2012; Sturmberg & Martin 2014). In order to better conceptualise these dynamic interactions between structures and agents, Sheikh et al (2011) have suggested that researchers' studies need to go beyond the 'hardware' components (HRH, finance and other components of WHO building blocks) but should also focus on system software such as interests, norms, power, ideas, values and relationships (Sheikh et al. 2011).

Despite this apparent consensus, there is a persistent lack of framing of HPSR questions towards exploring how software issues such as power and values influence policy actors in the process of policy making (Gilson et al. 2011). This has been attributed to the positivist biomedical discourse that dominates the field of HPSR which oversimplifies our conceptualisation of health systems into distinct components from universal conceptual models (Bennett et al. 2011; Gilson et al. 2011; Sheikh et al. 2011). Nonetheless, other researchers more recently have focused on exploring software issues of HRH (Topp et al. 2015). Their findings confirm that issues related to the social and adaptive nature of healthcare providers such as health workers, expose 'hidden power' which is not captured in the study of systems hardware, and they emphasise the need for more studies that reveal hidden dynamics and interactions in health systems (Topp et al. 2015). To fill this knowledge gap of software systems issues in most especially LMICs, academics have encouraged the use of multi-disciplinary approaches in understanding interactions between health system actors and policy processes that shape health systems hardware such as HRH (Paina et al. 2014; Adam & de Savigny 2012; Bennett

et al. 2011). For this reason, this study will focus on the interactions medical professionals are involved in the policy process of a LMIC health system.

The second reason for exploring this research topic is the other challenge facing HPSR: that is, there is emerging evidence that shows that GHIs' narrow use of the dominant biomedical framework in developing health strategies has some adverse long-term outcomes in LMICs (Marchal et al. 2009). For example, Ooms (2015) argues that the strong influence of biomedical science in global health distracts attention from the use of other disciplines in exploring and understanding emerging global health problems (Ooms 2015). In addressing this challenge, it is advocated that a trans-disciplinary approach and participation is needed, in decision-making and as well as in research, in order to develop effective strategies that would strengthen health systems (Paina & Peters 2012). It is important to note, for an approach based on systems thinking and trans-disciplinary approach to be achieved, transcendence of professional and disciplinary boundaries needs to be achieved to promote confidence, participation and co-operation among all stakeholders (Rosenfield 1992). This is because systems thinking does not lie purely within any one discipline, a connection across various fields is necessary (Leischow et al. 2008). With the emphasis on a trans-disciplinary approach to designing health policies, understanding the influence of each health professional group in health policy processes becomes vital in the field of global health. Hence, understanding the interactions between medical professionals and other health professionals groups will help in understanding some of the inter-professional dynamics and challenges to trans-disciplinary approaches in designing health policies.

For LMICs the trans-disciplinary approach is an opportunity to inform health policies and systems with a wider knowledge base and perspective and indeed this highlights the importance of drawing on both social science and biomedical perspectives in

developing health policies (Gilson et al. 2011). For Sub-Saharan Africa, the capacity for, and obstacles in tackling health system problems through a systems thinking approach needs exploration due to a culturally ingrained preference for the biomedical paradigm in shaping the global health agenda by public health scholars and practitioners (Shiffman 2009). Local actors such as medical professionals and other professionals are key actors in the policy process of LMICs (Buse et al. 2012) and the power dynamics of these stakeholders can influence the feasibility of any locally formulated health policy that is context specific to the health challenges.

This qualitative study analyses a policy (Global Fund HIV/AIDS grant), system (Nigerian health system), and actor interactions using a health policy and systems research perspective. Indeed this work aims to address the gap in the literature on the inter-professional dynamics and various power distributions in health policy processes in the Nigerian health system. Researchers who seek to explain how global and local agencies exert influence on the health system of LMICs have seen HPSR as the preferred approach towards understanding how policies are developed and implemented (Gilson 2012). Unfortunately, with most of the studies within HPSR focusing on how policies can influence effective health worker participation and efficiency, there is little evidence to show how health professionals influence the policy process of the health system in the context of LMICs. This study sets out to address this gap by deploying concepts from various disciplines.

The thesis draws upon the concepts of Friedson's sociology of professions and the 'professionalisation process' theory, in order to identify similarities and differences between health professionals in the Global North and Nigeria. Evidence of professional dominance in policy processes, such as the professional antagonism identified by Friedson are important concepts that were considered in this study. In addition, drawing

from Alford's theory of structural interests in health care, this study identifies and presents dominant interests, challenging interests and repressed interests in the Nigerian health system (Alford 1975). Furthermore, insight into the power dynamics of health professionals in policymaking processes are developed using these concepts to analytically identify structural and agential factors within the health system that encourage or discourage professional dominance.

In the context of Nigeria the major HRH challenge however lies in the distribution of doctors and nurses and other health professionals between the rural and urban areas and the internal brain drain of doctors moving into non-clinical projects such as GHIs (Mafe 2012; Labiran et al. 2008). In addition, there is a high degree of inter-professional tension among general health workers and medical doctors (National Technical Working Group 2009). Studies that focus on the HRH component of the Nigerian health system have devoted most of their attention to the number and distribution of health professionals across the country but very few studies in West Africa have explored the influence of health professionals in policy formulation processes and agenda setting. Research in this area is timely and relevant to the ongoing health worker conflicts in the Nigerian health system (Chirdan et al. 2009; Ogbimi & Adebamowo 2006; Osaro & Charles 2014). Even though some researchers have identified health worker conflicts in Nigerian as a major problem (Chirdan et al. 2009; Osaro & Charles 2014; Ogbimi & Adebamowo 2006), these studies do not explain the inter-professional dynamics of power distribution among health professionals. Here we explore the concept of the sociology of professionals in policy processes in Nigeria in order to form a contextual understanding of power dynamics and sources of professional influence and dominance in the health system in Nigeria. All these will be studied in the context of the Global Fund grant in Nigeria, which will reveal how these professional dynamics operate within the health policy space of structural interests.



The Global Fund grant in Nigeria was selected as the case study because of two main reasons. Firstly, The Global Fund has contributed approximately **US\$ 1.5 billion** into the Nigeria health system from 2000 to 2015 (CCM Nigeria, 2015), which makes The Global Fund a major stakeholder in the Nigerian health system. In addition to The Global Fund's commitment to tackling HIV/AIDS, Tuberculosis and Malaria, The Global Fund has increasingly been prioritising strengthening the Nigerian health system through institutional strengthening, capacity building, access provision and health education (CCM Nigeria, 2015b). Because The Global Fund has made an effort to integrate most of these activities into the existing Nigerian public health structure, there has been a close interaction between the The Global Fund grant and the various multisectorial stakeholders in the Nigerian health system who take part in executing the grant (CCM Nigeria, 2015). Secondly, the The Global Fund, through the CCM, has created an open and accessible platform for Community Based Organisations (CSOs), Patient Groups and Private sector bodies to be involved in the deliberative process of policy making in the Nigerian health sector. These two main points show how The Global Fund grant creates a unique environment for the interaction between various health stakeholders, which is different from the way other GHIs in Nigeria operate. These qualities of The Global Fund grant makes it the appropriate GHI case study to use in exploring interactions among various stakeholders from multiple disciplines.

### **1.3 Research question**

*How do interactions between medical professionals and Global Health Initiatives influence the Nigerian health system?*

#### **1.4 Sub research questions**

- Who are the key actors in the Global Fund grant policy process and how do they interact with each other?
- What, and in which ways do medical professionals contribute to the Global Fund grant policy development process?
- What roles do medical professionals play in implementing the Global Fund grant policy?
- Do the technical specifications and institutional procedures influence the opportunities medical professionals have in participating, constructing proposals, and implementing the policies of the Global Fund grant?
- Do these interactions contribute to any outcomes in the Nigerian health system?

#### **1.5 The structure of the thesis**

Chapter Two reviews the background literature and specifically the literature relating to the research topic in an effort to introduce various concepts relevant to the thesis. The chapter presents a narrative literature review that covers the sociological and theoretical aspects of professional power and monopoly. The first part of the literature review explores existing literature relating to professional power, monopoly and the various approach used by researchers in understanding medical professionals. Furthermore, it includes a review of the evolution and origins of medical professionals in West Africa. Finally, existing knowledge relating to the current state of medical professional monopoly will be explored in connection with deprofessionalisation theories.

A mix of terms and terminologies were used throughout the thesis. This was done deliberately so that the appropriate term reflects the purpose in which it was used.

Examples of these terms are Western countries, Global North, Industrial countries, Post-industrial countries, Welfare states and OECD countries, which all refer to mostly the same contexts but were used interchangeably to reflect the developmental timescales of these contexts and the term representative of them at a particular period. In the same way, LMICs, Colonial states, Post-colonial states, Global South were terms used interchangeably for similar purposes. Furthermore, due to the different disciplines explored in the narrative literature review, the terms mostly used in the literature of the individual disciplines of sociology, management, public health, and global health were maintained as much as possible in order to preserve the meaning of the term when it was used. For example, in global health, the term Global North has been used, in management and international politics the term OECD was commonly used, while in sociology the term Western countries were employed. In addition, the term medical professional was used to represent medical doctor in most parts of the thesis.

The second part of the literature review covers the areas of health systems research with a particular focus on the GHIs. This begins with a description of the emergence of GHIs in LMICs, while highlighting the empirical research that explores the interactions between GHIs and country health systems. The rationale for using professional monopoly and other concepts in exploring the interactions between GHIs and medical professionals is elaborated on in the second section. Following this, the review covers the debates about the biomedical and NPM discourses that dominate GHIs' policy-making processes.

Chapter Three outlines the research paradigm of the study, as well as the study design, both of which underpin the methods employed in data collection and analysis. The chapter begins by justifying my epistemological position, which in relation to this study is that of critical realism. Next, it outlines the theoretical framework and discusses the

methodological approach employed in the sampling strategy, data collection, and analysis. As part of this, ethical considerations and the pre-data collection pilot interviews are also outlined. Finally, Chapter Three describes the efforts made in ensuring research rigor, in addition to my critical reflections on my own positionality within the research.

Chapter Four summarises the background and context of the case study. This begins with a description of the Global Fund structures and its programmes in Nigeria. An account of the key features of the CCM and the grant application process under the Global Fund will be outlined. In addition, the chapter discusses the principles guiding the Global Fund and the Nigerian CCM in relation to participation and organisational structure. Finally, the chapter presents an overview of the wider Nigerian context in which the case study is situated. In this section, the demographic data is presented highlighting the country profile of Nigeria. Here the Nigerian health system is presented highlighting the public and private health sector, health financing, and the human resource components.

Chapter Five is the first empirical data chapter, and as such, it is concerned with the participants' accounts of the organisational and funding structure of the Global Fund. This chapter provides an exploration of the participants' experience in relation to the Global Fund's organisational structure in order to understand the dominant paradigms that guide the grant application process in Nigeria. This chapter draws mainly from interview data and observational field notes in order to identify important actors and structural interests affecting the functioning of the Global Fund grant in Nigeria. It contributes to answering the research question related to the identification of key stakeholders and the factors that affect the opportunities health professionals have in participating in, constructing proposals, and implementation of the Global Fund grant.

Chapter Six builds on the findings presented in Chapter Five by highlighting findings that relate to the role and influence of medical professionals and other non-medical occupations in the proposal writing process of the Global Fund grant. Specifically, this chapter considers the reasons for professional dominance, identifies the structures and agential factors that maintain this dominance, and examines the effects of professional monopoly on the proposal process. Finally, the chapter will consider other participants involved in the proposal process, the factors that influence their participation and their interaction with medical professionals. In doing so, the chapter attempts to answer research questions that relate to exploring the role of medical professionals and their contribution to the Global Fund proposal writing process.

Chapter Seven concentrates on the interactions between medical professionals and the Global Fund during implementation. The chapter draws on key concepts from the literature review in order to identify the various sub-groups of medical professionals engaged in implementation and the forms in which their influence is perceived and experienced by others involved in the implementation phase. The chapter discusses the peculiarities of the interaction of medical professionals and the management principles of the Global Fund in the form of NPM. Finally, the chapter discusses the inter-professional dynamics between health professionals during implementation, including issues of professional antagonism and jurisdictional conflicts.

Chapter Eight discusses the key findings of the three empirical chapters within the context of the wider literature and draws links between the findings in this study and the existing knowledge base. The chapter begins by reflecting on the concepts of professional monopoly and its relevance to the results of this study. This highlights the structural and agential factors that enable and indeed encourage professional monopoly, the conflicts between health professionals due to such professional monopoly, and the

consequential effects these have on the health system. Secondly, the chapter discusses the potential threat of the deprofessionalisation of medical professionals in the Nigerian health system due to the interaction of GHIs with medical professionals. Based on the findings of this study NPM strategies used by the Global Fund that have the potential to re-stratify and deprofessionalise the medical profession will be discussed.

Chapter Nine considers the potential implications of the findings for future research, as well as for policy and practice in the Nigerian health system. This includes conclusions regarding the importance of this study in relation to the wider body of literature in global health and other disciplines. Lastly, it proposes ways in which this work could be expanded by suggesting areas for further investigation via future research projects.

## Chapter 2

### Literature Review

#### 2.1 Introduction

This literature review aims to shed light on the interaction of medical doctors and the health systems in LMICs. Firstly, the sociology of medical professionals (also referred to as medical doctors) throughout the thesis will be explored, building on the various concepts about their role in the health system. Central to this will be an exploration of the known literature on medical professionals' influence in the health sector. The literature on medical professionals is important because medical professionals in LMICs are key actors involved in the receiving, interpreting and enacting of international policies and projects. Previously, most international policies and projects were vertically-disease driven interventions that tackled health challenges through targeted '*clinical interventions delivered by a specialised service*', which have over the last decade been replaced by more holistic approaches such as health systems strengthening (Béhague & Storeng 2008:644). A substantial and sustained increase in funding of health systems strengthening interventions by national and international organisations is a reflection of an ongoing shift towards a more holistic approach in designing health strategies (Hafner & Shiffman 2013). Health systems researchers and specialists have championed health systems thinking as a model for enhancing a multidisciplinary approach towards innovation in health policymaking (Adam & de Savigny 2012; Paina et al. 2014; Agyepong et al. 2012). Central to a multidisciplinary approach is the role of health workers of LMICs health systems (Anand & Bärnighausen 2004). Within the overall concern about HRH, the particular interest is in the key role of medical professionals in health policymaking.

The interaction of medical professionals within policy making in GHIs is important due to the growing influence of GHIs in the Nigerian health system (Chima & Homedes 2015). Attention on the interaction of GHIs and HRH has to date, focused on the HRH ratios, incentives, training and retention of health workers, usually termed as the hardware components of HRH (Global Health Workforce Alliance 2011; Sheikh et al. 2011). This narrative literature review moves beyond the numbers and ratios to trace the existing power structures in the health system, with a focus on LMICs such as Nigeria, by specifically exploring the influence that powerful group of actors exert on the health system.

At a theoretical level, this narrative literature review will explore the evolution of the literature on medical professionals with the aim of understanding their role in society, rise to power, and autonomy, before finally analysing their current position in the health system. The foundation of this narrative literature review is strongly informed by Dorothy Mutizwa-Mangiza's empirical research titled 'Doctors and the State: The struggle for professional control in Zimbabwe' (Mutizwa-Mangiza 1999). Mutizwa-Mangiza argues that because much of our understanding about medical doctors is based on Western literature, a comprehensive analysis of the Western literature on the sociology of professions is necessary in order to explore, compare, and contrast similarities and differences between Western and African doctors.

The body of literature on the sociology of professions has evolved and according to Abbott can be classified into four main schools of thought (functionalist, structuralism, monopoly and cultural) that have defined the sociology of professions (Abbott 1988; Macdonald 1999). This section of the literature review briefly describes these viewpoints, by highlighting the various arguments within each of them, and then it finally links them to the scant existing literature on African medical professionals. This



is essential because it highlights that there is a knowledge gap in the sociology of medical professionals in Sub-Saharan Africa, despite statements from prominent sociologists about the importance of a more globally-focused debate (Johnson 1973; Hafferty & Light 1995; Mutizwa-mangiza 1998). For clarity, the literature review will start with the earliest research and then move on to the most recent literature on the sociology of professions, focusing on the medical profession whenever emphasis has to be placed on one particular profession (**Figure 1**).

Recent research on medical professionals argues that the powers and autonomy once enjoyed by Western medical professionals have dwindled in recent times due to the public sector reforms of the late 20th century. These arguments, categorised as deprofessionalisation theories, suggest that recent changes such as spread of neo-liberalism, large corporations, and computerisation have diminished the monopoly that medical professionals possess within society. In the deprofessionalisation theories, a lot has been written about New Public Management (NPM) and how it has reduced professional autonomy, re-stratified the medical profession, and created an expert epistemic community (Hansen et al. 2002; Haas 2004; Hood 1991). This literature review traces the origins of NPM, its effects on Western medical professionals' autonomy and power and its global spread and acceptance.

Finally, the emergence of GHIs that are products of global public-private partnerships for health, have had a huge role in affecting the dynamic of HRH (Samb et al. 2009). GHIs have introduced health care reforms in developing countries that support performance-based financing, incentive structures and task shifting that are foreign to the existing health systems (Soeters et al. 2006). This alters the post-colonial occupational hierarchy that placed doctors on the top of this organisational bureaucracy. This literature review examines the interaction of GHIs and the health system as it

relates to medical professionals, and explains the rationale for using a GHI as a case study in examining the evolving role of medical professionals in the Nigerian health system.

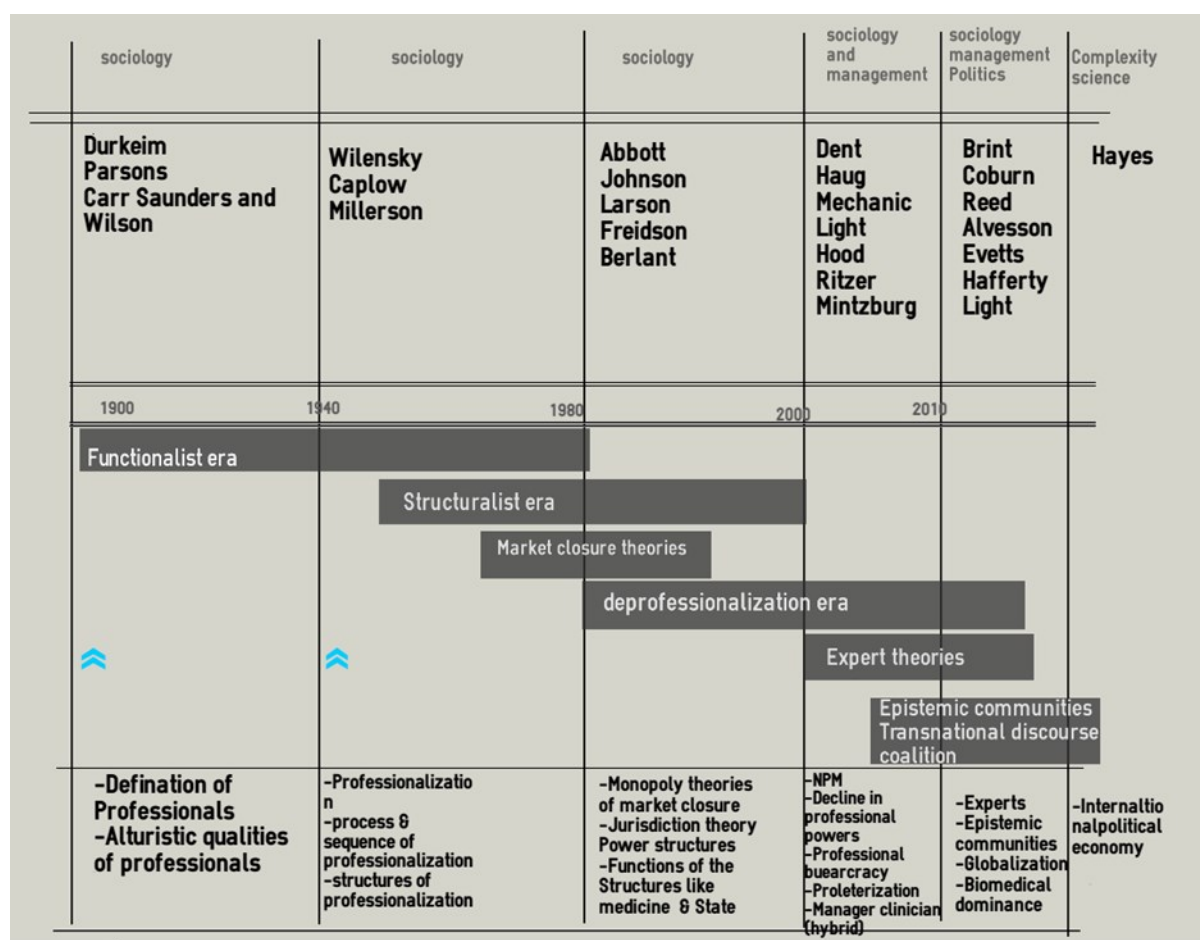
For clarity, the literature review is divided into two sections. The first section focuses on the broader theories of professional monopoly and deprofessionalisation theories. The second section focuses on GHIs and their interactions with national health systems specifically in relation to HRH. Moreover, in the second section an effort is made to explicitly draw out links between GHIs and the theories discussed in the first section of the literature review.

The literature-review search strategy used in this thesis involved a systematic search of the existing theories about medical professionals. Historical accounts of medical professionals' origins and the critical opinions about their characteristics from existing theories to recent research findings revealed key terms such as professional altruistic values, professional monopoly, professional autonomy, professional dominance, professionalisation, deprofessionalisation, biomedical dominance, and New Public Management (NPM). This involved a combination of a historical and theoretical narrative review of the relevant theories. These key terms were systematically used to review scholarly articles (from PubMed, Ovid MEDLINE, Scopus, and Google scholar), books, and other sources. This was followed by a careful selection of the relevant literature related to the research topic and questions. A general narrative literature review strategy was applied to Section Two in order to give an introduction of the salient and critical current knowledge about the key terms such as Global Health Initiative, Human Resources for Health, country health systems and Global Fund. For both Section One and Two a snow-bowling technique of citation search of the reviewed literature was used to trace and include relevant literature.

## Section one

The aim of this section is to follow trends in the development of arguments and wider discussions regarding medical professionals, in an effort to reveal the dominant concepts and theories in the literature on the evolution and changing roles of medical professionals in society. This section thus begins by tracing their historical origins, followed by a critique of the different theories that are important in analysing the influence of medical professionals in society.

**Figure 1: Chronological sequence of literature on medical professionals**



The key arguments in the sociology of professions have revolved around the concepts of altruistic and monopolistic qualities associated with medical professionals of the Anglo-Saxon countries and the United States. Altruist arguments that were popular in the

functionalist era of the mid-twentieth century differentiated medical professionals from other occupations, by concentrating on the self-sacrificing role of medical professionals in society (Durkheim 1957; Parsons 1939; Carr-Saunders & Wilson 1964). Structuralists, who believe these perceived altruistic values mask an underlying self-serving desire by medical professionals for prestige and power in society (Johnson 1972; Larson 1977; Freidson 2001; Berlant 1975), have challenged this normative perspective. Structuralists have identified key social structures in society that have helped medical professionals maintain professional dominance and autonomy. This chapter will examine similarities and contrasts between the Nigerian medical professionals and their Western medical professional counterparts, in order to identify the social structures that encourage professional monopoly and power, with an aim of contributing to the literature on the sociology of medical professionals in LMICs.

## **2.2 The historical origins and growth of the medical profession**

In the early 12th century the medical, legal and theology professions were first incorporated into French and Italian universities (Rashdall 1895). For the medical profession, knowledge from the Latin, Greek, Arab and Hebrew medical traditions was introduced into the University of Salerno, Italy in 1231 to form a medical centre of education, while the University of Paris, France was made a centre for theology and the centre of law was in the University of Bologna, Italy (Rashdall 1895). This development spread to other institutions, which in turn formed a small group of universities known as 'Studium generale'. In order to belong, universities had to receive students from all regions of Europe, have a faculty in at least one of the areas of law, medicine and theology and lessons had to be taught by a master or professional in the respected area of study (Rashdall 1895). Other universities sought this privileged recognition by introducing one of these faculties and received permission either through the Pope or

through the monarchies of that region to be conferred as members of the *Studium Generale* (Rashdall 1895). Over time, the members of these three disciplines came to be referred to as professionals.

Professionals were trained in these specialist settings, and as the continuous growth of specialisation increased from the 20th century onwards, they began to be a major part of the medieval universities (Elliott 1972). This marked the carving out of different professional disciplines and various sub-disciplines developed within their faculties (Rashdall, 1895a). These learned professionals were taught in Latin and were regarded as belonging to ‘gentlemen’ professions while artisans and craftsmen were allowed to train through apprenticeship. Craftsmen were labelled as technicians and those produced from the formal institutions were termed experts or professionals, elevating them to elite status (Freidson, 2001).

A recognised knowledge base is not solely responsible for the professions’ push to high status in society, but by looking at history, we gain some insight into some of these strategies. For example, one of the criteria used in the medieval universities was the privilege given to a Master of any one of law, medicine and theology, with liberty to teach in any university without examination which was granted to them by the Pope (Pope Nicolaus IV; 30 September 1227 – 4 April 1292) (Elliott 1972). This dominance in the university system by the three professions went on for centuries until 1711 when Joseph Addison argued that society was over-burdening the three professions of medicine, law and divinity with responsibilities and that there was a need to broaden the range of professional groups (Addison & Steele 1711). This led to the opening of institutes for academic fields like civil engineering and accountancy in countries across Western Europe and North America (Crook 2008). During this long period before the introduction of other academic institutes, there was total academic dominance in the

university system by the three traditional professional faculties (Crook 2008). Around the same time Europe was undergoing an industrial revolution in the 18<sup>th</sup> century, which created pressure for recognition of other occupations (Mokyr 2003). The industrial revolution in Europe brought along with it economic and social transformation with a need for various skills and disciplines in society (Mokyr 2003).

Furthermore, professionals had ways of imposing their authority in their areas of specialty. Carr-Saunders and Wilson highlighted the creation of bonds to associations by members of the profession to prevent the involvement of other non-members from practising (Carr-Saunders & Wilson 1964). For example, in order to get a seal of approval in 1518, the Royal Society of Physicians incorporated the King of England, which was similar to what was done in other European countries (Carr-Saunders & Wilson 1964). This gave them the power to give qualifications to those they felt were eligible, allowing them to practise and to punish those who broke their ethics and conduct codes. In order to explain medical professionals' privileged status in society, sociologists have studied these historical origins using various perspectives and the earliest approach used is the functionalist approach.

### **2.3 Functionalist theory approach to the sociology of professions**

Flexner's definition of professionals, is appropriate to this study: *'Professionals as (are) intellectual, learned, practical, a result of training, self-organized, and altruistic* (Burnham 1998:72).

Interests in the sociology of professions can be dated back to Thomas who in 1903 in his book 'The Relation of the Medicine-Man to the origin of the Professional Occupations' challenged the 19th century author Herbert Spencer about the evolution of the modern day professional (Thomas 1903:245). Thomas argued that professionals

evolved from the social demand for experts during a phase of division of labour in Europe, rather than from the priestly medicine men who developed into professional practitioners (Thomas 1903). Thomas's empirical study used the historical origins of medical professionals to explain the appearance of professions, which was later seen by sociologists to be a superior explanation of the origins of professions compared to Spencer's explanation (Burnham 1998). In a similar functionalist approach to Spencer and Thomas, Durkheim's writings about the ethics of professionals and the sociology of professions contributed greatly to the functionalist approach which dominated the mid-20th century literature (Macdonald 1999). This section will explore the functionalist approach within the sociology of professions and the strengths and criticism of this approach.

### **2.3.1 Functionalism: The altruistic debate**

The debate about the definition of a professional has been ongoing, with no one clear-cut definition of professionals and non-professionals (Klegon 1978). In early literature, dating back to the European medieval period, professionals were categorized into doctors, lawyers, and priests. The concept of defining the term 'professional' had preoccupied sociologists in the late 1800s and early 1900s who were trying to categorize other occupations and compare them with professional traits (Johnson 1972). As early as 1915, Abraham Flexner did a lot of work in medical education and wrote about the professional status of social workers by comparing their characteristics to the professional traits that formed the basis for the definition of professionals (Burnham, 1998). Flexner's work gave an outsider's view of the medical profession and he characterised professionals as learned intellectuals because of their training, and as practical, self-organised and altruistic (Burnham, 1998). A focus on the altruistic trait in

this definition characterized the writings of most sociologists in this era who were later called ‘functionalists’.

One of the fundamental questions that preoccupied sociologists in this mid-20th century era was ‘do professions perform a special role in an industrial society, economic, political or social?’ (Johnson 1972). Emile Durkheim (1887–1917) credited as one of the most influential authors of the functionalist era gave insights in response to this question. Durkheim’s work centred on the division of labour in an industrial economy, where he identified some divisive forces capable of destabilising the social structure of his time (Durkheim 1957). He posited that professionals were like an occupational group who occupy a mid-point between the state and the family, making them a stabilizing factor in society because of their code of moral conduct (Durkheim 1982). Durkheim proposed that an industrial society would have conflicting interests and that occupational groups would instil a sense of moral and communal order to counter these conflicting interests (Durkheim 1982). Durkheim also focused on the ethics of professionals and showed how their altruistic qualities distinguished them from other occupations (Durkheim 1957). Theories from authors such as Durkheim and Parsons (even though in different eras) focused on the positive influence of professionals and how their role was a regulating factor to the ‘*excess of both laissez-faire individualism and the state collectivism*’ (Durkheim 1957; Parsons 1939; Johnson 1972:12). Even though Parsons work came years after Durkheim, there are lots of similarities between their altruistic characterisation of medical professionals. Parson’s theory of the doctor and patient role, whereby the patient assumes the ‘sick role’ and depends on the doctor’s orders to resolve their illness in order to get well, places a doctor in a superior position of power (Bradby 2012). Parsons also compared professionals with the businessperson, saying the goals of professionals are from an altruistic motivation due to the institutional structures of the profession (Parsons 1939). This set the framework



for other writers in this generation; however, a major weakness of this approach was the neglect of the negative monopolistic features of the professionals, which will be discussed at the end of this sub-section.

The concept of the altruistic qualities of professionals was supported by other writers like Marshall (1939) who went further to say that state control of professionals could undermine the core values of professionals which protect the welfare of the client (Marshall 1939). Parsons, like Marshall, based his argument on the theory that in most cases the client or patient is ignorant of what is good for him and only the professional knows what the client deserves, therefore authority needs to be given to professionals (Parsons 1939; Marshall 1939). Once the state sets the standards then the collective standards of service of professionals would be subjugated to state rules (Marshall 1939). Other writers like Tawney (1921) concentrated on how the enlargement of the professional community would be a force that would tackle individual self-interest in a 'functional society' (Tawney 1922). In a similar approach, Paul Halmos (1971) believed that the ethical qualities of professionals had started to spread to other occupations and society at large and that this would lead to a moral transformation of society (Halmos 1971). The works of these authors are closely related because their findings focused on the altruistic nature of professionals and this is reflected in how professionals have been defined for decades. However, many researchers in more recent studies have contested the altruistic nature of professionals and this will be discussed in the next sub-section. From the literature, authors from different decades have presented the 'altruistic' theme, and it is interesting how the 'altruism' theme has persisted spanning many decades.

### **2.3.2 Critique of the functionalist approach**

Macdonald describes this functionalist approach, which dominated the mainstream sociology of the professions until the 1960s, as an approach which focused on the

definition of professionals and the traits of professionals while lacking in any form of critique (Macdonald 1999). The criticism of the functionalist approach to the sociology of professions is shared by more recent sociologists such as Abbot and Johnson and they labelled this approach a distraction from more critical analysis of the sociology of professions (Johnson 1972). In contrast, Elliot (1972) argues that even though no particular occupation completely fits into the characteristics of the definitions of professions, definitions help in marking out the phenomena and identifying an ideal professional, and for this very reason a functionalist approach is very relevant in this field (Elliott 1972). Other authors, for example Brante (2010) in recent works have reignited the definition debate, introducing new cognitive and social approaches to defining professionals and citing their value in understanding the sociology of professionals (Brante 2010).

A lot of the criticism of the early writing of functionalists in the sociology of professions comes from the mainstream sociologists who regard functionalism as obsolete, with most sociologists embracing conflict-oriented approaches or structuralism (Hewitt et al. 2007). Key areas criticised in the functionalist approach are discussed below:

*Altruism:* Johnson views this term as being too descriptive, lacking in critique of professionals and focusing only on functional traits, in addition to relying on the professionals' own definition of themselves (Johnson 1972). Other authors such as Wilensky (1964) claim that functionalist approaches do not take into account the processes involved in the attainment of these professional privileges (Wilensky 1964), and Larson argues that a functionalist approach does not let us know what professionals are but what they claim to be (Larson 1977). Neo-Weberian approaches prefer to define professionals in terms of the monopolistic control they have over their respective

markets which is a totally different dimension of the professional-client dynamic not captured in the altruism argument (Saks 2005). Brante summarises these statements by saying there are significant differences between professionals which are usually overlooked if we focus only on definitions and traits such as altruism (Brante 1988).

*Professional Authority:* Many see Talcott Parsons as the father of sociology of professions. He cited how the social role of medical professionals (due to their superior knowledge) was to help the ill person because the ill person is helpless and lacks the technical knowledge to help him/herself, therefore the ill person relies on professional authority (Parsons 1939). Rueschemeyer (1964) is critical of Parsons' approach, arguing that the power of self-regulation would make the professionals less accountable in instances where the professional is unable to provide the services required of him/her (Rueschemeyer 1964). Parsons' theory is criticised because it ignores the personal selfish interests of an individual professional and instead assumes some sets of moral rules that he feels medical professionals should adhere to (Berlant 1975). Parsons later attempts to generalise these qualities to the whole profession (Berlant 1975).

*Power :* Finally, the functionalist approach fails to inform us about how professionals acquire power and their ability to influence the environment in which they work (Hewitt et al. 2007). Indeed, a point which is not captured in functionalist approaches, as highlighted by Macdonald, is the notion that professionals are in a position of power and are also social actors who are in constant interaction with society (Macdonald 1999). Moreover, most functionalist sociologists in the early 1900s (including Parsons whose work came after in the mid-1900s) were ethnocentric. For example Parsons and other functionalists of that time generalised the behaviours of Western European and North American professionals and rationalised this as the general behaviour of professionals from different cultures (Gould 1966). Finally, they were criticised for

being unable to account for social change (Brante 1988). Ann Daniel states that because of the inter-dependence of the state and professionals, this dynamic is different in every country with no universal model, in contrast with the picture presented by functionalists (Daniel 1990).

### **2.3.3 Summary**

The debates summarised above led to many definitions with overlapping characteristics. Carr-Saunders and Wilson (1964) laid the foundation in this area in their book 'The Professions' where they described the various traits of a profession (Carr-Saunders & Wilson 1964). Carr-Saunders and Wilson described professionalisation as a process of evolution in society through historical change spanning several centuries leading to professionals forming special bonds with aspects of society (such as the state) in their developmental stages and hence attaining the professional traits (Carr-Saunders & Wilson 1964). Carr-Saunders and Wilson inspired the empirical studies on professionalisation that followed the functionalist era (Morrell 1990). While functionalists such as Carr-Saunders and Wilson struggled to describe the traits and functions to be acquired in the process of professionalisation, the structuralist approaches that followed focused on the structures which guaranteed professional control (Macdonald 1999). The functionalist era, regardless of the criticisms raised, created a body of knowledge about the history of professions, and introduced the narrative of professionalisation that became vital to the sociology of professions.

## **2.4 The professionalisation process and the structuralism approach**

*'Professionalisation is a series of stages, marked by changes in the formal structure of an occupation as it aspires to professional status'* (Elliott 1972:14)

Julia Evetts (Evetts 2005) like Carr-Saunders and Wilson, described professionalism as a change in behaviour associated with particular stages in the professionalisation process (Evetts 2005; Carr-Saunders & Wilson 1964). Similarly, in 1960, William J. Goode (Goode 1960) listed ten traits he argued were characteristics of professionals (Appendix 7). He described these traits as part of a continuum of professionalism and argued that occupations which aim to attain the status of professionals have to acquire most of these traits (Goode 1960). Goode's writings suggest that only a few professions have attained most of these qualities and the medical profession is one of a few that has attained almost all these traits (Goode 1960).

*'An industrialising society is a professionalising society'* (Goode 1960:902): this is a phrase of Goode's which has been used by other researchers and it captures the idea that as society grows and becomes more industrialised, other occupations will attempt to move up the professional ladder (Goode 1960). Carr-Saunders and Wilson saw professionalisation as an occupational development strategy with a goal of attaining higher status and control of work markets, and this model is widely referred to as the occupational strategy model of professionalisation (Morrell 1990). This model does not specify whether most occupations would go through each of these stages and it also does not suggest whether each stage would follow on sequentially from/to the previous/next stage (Morrell 1990). The three main authors who have attempted to illuminate some of these grey areas in describing the professionalisation process are Wilensky, Caplow and Millerson, whose works will be presented briefly, to help generate an understanding of how the literature on professionalisation has evolved.

### **2.4.1 Structuralism**

According to Wilensky, professionalisation follows a series of steps and if successful will lead closer to the professional promised land (Wilensky 1964). The five steps postulated are:

1. Creation of the notion of being a full-time job
2. Establishment of a training school
3. Creation of a professional association
4. Licensing and certification conferment on professional members with legal protection from the law
5. Formal code of ethics to exclude unqualified competitors.

Wilensky identified two barriers that could stall any of these stages in the professionalisation process (Wilensky 1964). One of the barriers is organisational bureaucracy which sets a lot of controls and rules, stripping the autonomy of professionals (Wilensky 1964). Another barrier is the dilemma of structuring a professional knowledge base too vaguely and broadly, showing no real technical expertise, versus the other extreme of a knowledge base that is so narrowly defined that it could be broken down and taught to anyone, thereby losing its speciality aura (Wilensky 1964). This process of defining the knowledge base can be called abstraction and a key issue is the ability of a profession to control its knowledge and skill to a point where it can redefine problems (Abbott 1988) and employ a specialised vocabulary unfamiliar to those outside the profession (Wilensky 1964). It is this abstraction of the knowledge base which gives professions an “aura of mystery”, used to reinforce the prestige and power of professionals (Wilensky 1964). Abstraction of knowledge is the currency used by professionals to create the exclusive jurisdiction that is vital in determining an occupation’s success in the professionalisation process (Abbott 1988).

Caplow in his book about the sociology of work disagrees with Wilensky over the sequence of steps in the professionalisation process. Instead, he outlines them as : 1) establishment of a professional association; 2) change of name to reduce identification with the former name; 3) development and promulgation of a code of ethics; 4) political agitation for support of public power to maintain new occupational barriers; and 5) concurrent development of training facilities (Caplow 1954:139-140). As such, Caplow's and Wilensky's models are in agreement that professionalisation is a sequence of events but differ in the chronology of these sequences. However, although the models contain similarities and some differences, a major critique of both models is their seeming use of a universal model which is insensitive to different contexts (Abbott 1988). However, this adjustment to the social and educational climate of the time is incorporated in Millerson's model (Millerson 1964).

Millerson defines professionalisation as '*a process by which an occupation undergoes transformation to become a profession*' (Millerson 1964:10). The variation in the processes of professionalisation of various occupations is the basis of Millerson's theory, a position that is less restrictive than previous models in terms of set stages. Millerson's theory and approach is different to Wilensky and Caplow's theories because it ignores the use of a universal model of a professionalisation process and treats all occupations as unique entities (Abbott 1988). At the same time, there are similarities among the three authors, particularly in their use of a 'traits approach' and in identifying processes that occupations must follow in order to attain professional status. These models assume that the actions of the occupation will determine a successful professionalisation process irrespective of the powers of governments, rival occupations and the opinion of the clientele (Johnson 1972). Johnson argues that we need to go beyond the linear, unidirectional description of the professionalisation process as a natural growth, and focus on the wide variety of conditions which lead to professional authority, power and

autonomy (Johnson 1972; Macdonald 1999). The theories of professionalisation that focus on the structures created by professionals in the professionalisation process, tend to neglect the wider dynamic of how professionals interact with other occupations because occupations are mutually dependent on each other's success (Haug 1976; Abbott 1988). This is particularly important in the health sector, because it is comprised of other occupations competing for jurisdiction and the more jurisdiction acquired by an occupation, the more they encroach on the boundaries of other occupations in the sector (Abbott 1988).

### **2.4.2 Summary**

The structuralist concept of professionalisation has proved insightful in analysing structures involved in the process of professionalisation and some traits that professionals acquire at various levels of professionalisation. Professionals have evolved from being a group that had no societal supremacy, to having the power to self-regulate, exclude unskilled people from rights to enter the occupation and create a type of monopoly in the market greatly aided by the state (Freidson 2001). Furthermore, Wilensky predicted organisational bureaucracy as a barrier to the professionalisation process, which is very relevant to the discussion of the current influence of medical professionals in the health system, discussed in later parts of this section. The next approach to be examined is the monopoly approach. This approach focuses on the professionalisation process and examines how this contributes to the monopoly of the labour markets and professional autonomy by professionals.

### **2.5 Power and Monopoly**

*'It is the professions' monopoly over knowledge not easily accessible to the public, coupled with a claim to a public service outlook, which legitimates the professional's*



*authority in dealing with clients, and institutionalises client obligations to trust the professional and comply with his prescription*’ (Haug 1976:84).

Parsons described the professional as an altruistic servant of society and the businessperson as being only concerned about his/her interests in a business transaction because of the different norms that govern their activities (Parsons 1939). This is known as the normative theory of professions. This has been called into question by those who argue that professionals create a social class that limits others from attaining equivalent status, therefore propagating a conformist social control on the rest of society (Parry & Parry 1976; Crook 2008; Freidson 1975; Abbott 1988; Johnson 1972). Abbott (1998) is of the opinion that professionals, in a bid to increase their salary, status and power, use professionalisation and the ideology of professionals to cause a market closure and monopoly control of their work (Abbott 1988). Most of the theories within the sociology of professions centre on the medical profession because medical doctors are one profession that most people in society would meet and the theories generated from the medical profession set the parameter for other aspiring occupations (Larson 1977). In this sub-section, we are going to explore some of the theories about the autonomy and monopoly that medical professions have over health issues, starting with Freidson’s theories. Researchers who use this approach have been referred to as interactionists.

Professional self-regulation, which has been a major feature of the medical profession is seen as *‘a contract by the public to go to the profession for medical treatment because the profession has made sure that it will provide satisfactory treatment’* (Davies 2002:93). Freidson (Freidson 2001) further highlights the source of the power of medical professionals in these four broad categories:

### *1. Division of labour*

Having a monopoly of the division of labour means having the ability to determine the terms, conditions, goals and objectives to which the professionals are accountable, and being able to establish their own boundaries and jurisdictions (Freidson 2001). A monopoly of the division of labour also involves influencing the different specialisations in their fields, determining the tasks which they can carry out and the overall structure of the division of labour (Freidson 2001). This is seen in the medical profession, as it creates an occupational hierarchy whereby the medical doctors are at the top and delegate tasks to other health professionals such as nurses and care workers. In recent times, nurses have been burdened with the day-to-day care and communication with patients, while doctors have assumed a more distant approach to patient care (Witz 2013; Davies 2002). A combination of delegation and the creation of occupational boundaries gives medical doctors this monopoly over the division of labour.

### *2. Controlled labour market*

Professionals are not subject to the market laws of free and open markets, in the sense that they can determine the qualification needed for a task to be carried out in their field regardless of the organisation they find themselves in (Freidson 2001). Therefore, the professionals' governing bodies determine negotiations about payments, making the consumer pay only members of the profession. For example, the American Medical Association were very powerful in the mid-1990s in controlling the payments made to doctors per consultation (Berlant 1975).

Professionals also have a sense of job security because only they can occupy a particular position in an organisation and even if they are self-employed, they will have less competition from un-licensed workers (Freidson 2001).

### 3. *Occupationally controlled training*

Like artisans who control who can be trained, professionals have the added luxury of doing this in settings that are affiliated with higher institutions under circumstances that are controlled by other members of the profession in teaching (Freidson 2001). Although this helps in producing quality professionals, it creates a monopoly in controlling the supply of these professionals in the market.

In addition, professionals formulate their own curriculum and define the knowledge to not only train graduates but also expand the boundaries of their expertise. For example, the ‘medicalisation’ of some health states by the medical profession is an example of this power (Conrad 2005; Abbott et al. 2003).

### 4. *Professional ideology*

Professionals have a certain code of conduct and ideology, which aids their persuasion of the public and state to see their significance in society (Freidson 2001). They do this by highlighting that their work is not aimed primarily at earning a living but at serving society (Freidson 2001).

It appears that Abbott and Crook’s arguments are similar to Freidson’s theories about market closure and the dominant position of medical doctors. Market closure explanations focus on the control medical professionals have in the health field and the challenges other occupations face in their professionalisation process. This has been helpful in studying the evolution of various occupations in the health sector, while

taking into consideration the historical changes that have occurred in society. These key areas highlighted by Freidson laid the foundation in understanding the extent of medical professional monopoly and autonomy. Other authors have theorised how they have come to attain this monopoly through empirical studies and reviewed the history of medical professionals from the pre-industrial era to the present day medical professionals.

In the literature about professional monopoly, two theories have been widely used namely; professional power and the professionalisation project. Even though supporters of both theories claim to differ over their own versions of how medical professions attain their dominance and authority, ultimately, they focus on the interactions and actions of groups and individuals in the construction of an elite occupation termed professionals. The words ‘authority’ and ‘dominance’ have been used by many authors but according to Elston (2002), for clarity medical autonomy denotes *‘legitimated control over the organisation and terms of its own work’* (Elston 2002:61), and medical dominance denotes *‘authority over the other occupations in the health care division of labour’* (Mutizwa-Mangiza 1999:7)

### **2.5.1 Professionalisation project: ‘actions model’**

This school of thought is based on the neo-Weberian perspective of social mobility and suggests that professionalisation is an active collective attempt by a group to pursue professional privileges and prestige (Macdonald 1999). The assumption is that the control of an occupational market (such as healthcare) by one dominant profession is the means to attaining market closure and inevitably excluding non-members of the profession from the market. This active desire for upward social mobility by professions to attain more market power and monopoly has been termed the ‘actions approach’ (Hewitt & Thomas 2007). The term ‘professionalisation project’ attributed to Larson

(1977) in her scholarly work exploring medical professionals in contemporary capitalist societies, described the professionalisation of medical professionals as an attempt to *'translate one order of scarce resources- special knowledge and skills, into another social and economic reward'* (Larson 1977:136).

The professional group's ability to incorporate the production of knowledge with professional practice, in a system whereby the modern university is the producer of knowledge and the producer of practitioners and researchers, is fundamental to the professionalisation project (Larson 1977). Secondly, occupational hierarchy that legitimises the competence of the professional group as being superior to others through the educational system of credentialing, allows for the formulation of a stratified approach in distributing rewards, privileges and income, therefore the monopolisation of the opportunity of income (Larson 1977; Berlant 1975). In summary, the control of market professional services leads to the monopolisation of the market, elevated social status, and work autonomy. In other words, *'market control and social mobility are inseparable'* (Larson 1977:139).

In similar Weberian style, Berlant (1975), in an effort to explain how this monopoly leads to social success, argues that medical professionals have been able to determine the market's supply and demand as it relates to medical issues (Berlant 1975). On the demand side, medical professionals' dominance determines the issues that are of concern to the patient, the solutions and desired outcomes (Berlant 1975). On the supply side, the creation of scarcity of manpower with the legal capacity to provide medical services constitutes monopolisation (Berlant 1975). This is in addition to the legal authority to restrict new membership to this professional group, at their discretion. Max Weber stresses that domination is important to the successful maintenance of monopoly of an 'occupational market' because domination is the ability to make everyone comply

to the professional's authority, in other words domination guarantees authority (Weber 1922). Professional groups attempt to legitimise this authority by persuading the legislative institutions of the state in society to enforce its monopolistic demands (Weber 1922). Berlant explains that the ultimate goal of domination is to exclude competitors from the occupational market through peaceful professional conflict, in order to have sole supply in the market, thereby increasing their jurisdiction (Abbott 1988; Berlant 1975). A claim of jurisdiction and boundaries creates a 'market shelter' for the medical profession (Timmermans 2008).

*Work and jurisdiction:* The claim for jurisdiction is an active process professional groups engage in to increase their professional boundaries and in the process achieve more wealth and prestige (Abbott 1988). With the type of monopoly and dominance over major jurisdictions that medical professionals have in the health occupational market (Kroezen et al. 2013), we would expect some level of interaction between the medical professional and other health occupations. Even though there are sets of tasks each occupation is bound by, the specific tasks associated with each occupation are constantly changing and reshaped due to external forces such as technological advancements and the economy (Macdonald 1999). For this reason, the success of a profession is judged by how much it is able to protect its jurisdiction of work and absorb the jurisdiction of other occupations, leading to a system of constant competition (Abbott 1988). An example of this is the medicalisation of health issues by the medical profession and its ever-growing jurisdiction in not only the health sector but also everyday life of people in society (Light & Levine 1988; Mechanic 1996; Stillman & Bennett 2005; Conrad 2005). Conrad argues that medicalisation of alcoholism, child abuse, hyperactivity, menopause, and childbirth are examples of the medicalisation strategy (Conrad 2005). Conrad goes further by arguing that the medicalisation of childbirth led to the demise of midwives and the rise of obstetricians (Conrad 2005).

As discussed earlier, medical professionals use abstraction to mystify their knowledge base thereby claiming more jurisdiction (Hewitt & Thomas 2007). The medical profession has over the years used abstraction to define new areas and gained control over new turf in the process by expanding its cognitive dominion in the health sector (Abbott 1988). The constant abstraction of the medical knowledge base and professional claim to clinical legitimacy from the public in the early 1900s, created a certain level of social closure, exclusively for medical professionals (Hirschkorn 2006).

The 'actions model' focuses on the active processes medical professionals engage in to influence the environment of the market sector, with the goal of achieving monopolistic autonomy. This perspective is in sharp contrast to the earlier functionalist teachings of Parsons and Durkheim that focused on altruistic qualities. Perhaps most importantly the 'actions theory' enlightens us about the desire by the medical profession to gain upward social mobility through domination of the market and professional authority. Furthermore, medical doctors through their associations ensured limited access into the occupation by other aspiring health occupations, increased their jurisdiction through medicalisation of health issues, and maintained their monopoly through a dominance of the market forces of demand and supply of health services. Although most of the empirical studies used to explain the 'actions approach' were from Anglo-Saxon industrial and Post-industrial countries, the actions approach uses evidence to show the link between a profession's intention to monopolise and successful accomplishment of monopolisation (Berlant 1975). This makes the actions approach a potentially transferable approach to understanding the sociology of professions in other contexts. Section two of this literature review will show how researchers have used the actions of medical professionals to investigate their intention to maintain professional autonomy in different contexts.

Max Weber's theory draws attention to how legal closure of the market attained through the state is vital in the process of upward social mobility in the economic order. This is similarly seen in the works of other action theorists, who acknowledge the social structures that give medical doctors this power of market domination, but the 'power' perspective illustrates this relationship with the state in more detail.

### **2.5.2 Professional power: 'power approach'**

*'The professions are emergent as a condition of state formation and state formation is a major condition of professional autonomy' (Johnson 1982:189)*

Karl Marx explains the relationship of the state and professions in the context of the capitalist workings of society as they relate to production (Macdonald 1999). The power approach used by authors of this school of thought have drawn from the teachings of Karl Marx and to some extent Foucault in explaining the relationship of the state and professionals, leading to forms of social stratification.

Medical professionals are a major component of the health system and as one of the key players and stakeholders in the health sector; they have a unique interaction with the state and the public. The medical profession has over the years benefitted from the legal protection of the state and economic shelters it has built around itself through the social contract it has with the state, claiming to provide the public with specialised and valued skills (Timmermans & Oh 2010). Marx conceptualised the state as an agency with administrative responsibilities in society and a tool for class domination, sometimes used by dominant interest groups such as medical professionals (Marx & Engels 1888). Following Marx's concepts, neo-Marxists have argued that the state has a monopoly of power in a given country and for this reason; they have the power to confer on groups of the society powers such as the legal power given to doctors and their associations (Parry



& Parry 1976). The power the medical profession derives from the state, gave medical professionals the ability to control their market situation in the late 1800s and early 1900s capitalist society (Parry & Parry 1976). As capitalist societies have become more and more knowledge-based, medical professionals as a knowledge-based occupation are an integral part of a capitalist society (Macdonald 1999).

The power of medical professions is a result of licensure from the state, therefore the relationship between the state and professionals is central to any approach based on a theorisation of power (Macdonald & Ritzer 1988). In a review of the historical processes culminating in the creation of a powerful medical profession, Johnson states that the creation of professionals is a consequence of the formation of a state, citing the synergy of the medical profession and the British imperial state as an example (Johnson 1982). In essence, the state gives medical doctors legitimacy through laws that confer on medical doctors the right to practise, award qualifications and supervise its members (Daniel 1990). As the state begins to get more involved in the affairs of health issues, laws that result in the creation of legally privileged restrictions on health issues are created by the state through the interdependence between the state and medical professionals (Parry & Parry 1976). In the case of Britain after World War II, the creation of the welfare state and the National Health Service placed medical professionals in a powerful position by being expert advisers to the state, as well as handling health issues (Berlant 1975). Even though, many medical professionals feared a loss of autonomy through the creation of the NHS and tried to oppose its creation, during the early establishment of the NHS, medical professionals did in fact acquire more power in the British health sector (Greener 2002). Johnson posits that the more intervention from the state in the activities of the medical professionals, the more medical professionals lose their autonomy, while less state intervention leads to greater autonomy (Johnson 1982). Because of different contexts in every society and varying

degrees of state intervention in professional autonomy, there is no universal pattern to a successful professionalisation process. For example, when the government began to make extensive reforms in the NHS in the 1980s, medical professionals lost some of their autonomy and monopoly. Therefore, the power approach is very important in understanding the monopoly and autonomy of medical professionals in different contexts.

Another aspect in the power dynamic approach is the cultural authority medical professionals have that makes society accept their knowledge as valid and true (Daniel 1990). Biomedical knowledge in the 21st century, through technological advancements, has embedded itself in the cultural fabric of society and as such, society has accorded great status to holders of such knowledge (Daniel 1990) This is referred to as the power of knowledge. Foucault states that power is embodied in the prevailing discourse, knowledge, and recognised 'truths' (Lupton 1997). Prevailing truths in modern society, generated through forms of knowledge, have the power to make those who accept them have some form of social discipline and conform to their teachings without the use of coercion (Foucault 1980). Individuals are made to behave in certain ways, defined as the standard conventional way of behaving and informed by biomedical knowledge, which Foucault calls bio-power (Foucault 1980). Discourse produces, spreads and re-enforces power (Foucault 1980). The intellectual as an agent of this form of discourse is part of the institutions that produce the discursive practises that have the power to cause social change (Arney 1982). Foucault goes further to explain this power/knowledge interdependence: '*knowledge and power are mutually and inextricably interdependent. A site where power is exercised is also a place where knowledge is produced...knowledge and power are inextricably and necessarily linked.*' (Foucault 1980:64). The foundations of the medical profession are based on biomedical knowledge and as Foucault explains, the biomedical discourse has become part of

everyday life by shaping how we behave and conceptualise what is good or bad. Therefore, biomedical knowledge gives the medical profession power over the health of individual units of society and in essence control over the health of the population in general.

### **2.5.2.1 Gender**

Florence Nightingale defined the qualities of a nurse and one of those qualities was that she must be a good woman (Adams 2010). The description of nurses as a caring profession by Florence Nightingale reflects one of the type of dominant patriarchal discourses that have put women at a disadvantage in the health sector (Witz 2013). Females in the early 19<sup>th</sup> century in the medical field, were given roles that were more designed to be supportive roles due to the family caregiver status society had socially constructed for women (Adams 2010). Women were given roles as medical nurses or dental nurses to assist the male doctor in carrying out their activities. Because of these, the medical profession has been a prototype in the study of gender and professions and most of these studies have shown a high level of gender segregation. In Celia Davis's article 'What About The Girl Next Door' she explains how through professional self-regulation the regulating body of doctors in Britain (the General Medical Council) was tagged a 'gentleman's club' because of the strong values attached to white gentlemen of the mid-19th century (Davies 2002). Male dominance of medicine led to nurses and midwives establishing their own regulatory system (the United Kingdom Central Council for Nursing, Midwifery and Health Visiting, UKCC) in 1983 but because of the long subordination to medical doctors they could not achieve the same level of institutional self-sufficiency and closure (Davies 2002). These were some of the structural barriers in the era of modern industrial societies that led to the exclusion of women from the positions of high status in the health profession.

The gender theme has been used to understand both the neo-Weberian ‘action approach’ and the neo-Marxist ‘power approach’ of professionalisation. The neo-Weberian perspective argues that professionalisation of the medical profession was a male project, while the professionalisation of nursing and midwifery became a female project, and understanding these processes explains actions involved in the creation of these structural barriers (Crompton 1987). Authors such as Witz argue that focusing on the neo-Weberian actions approach neglects the *‘patriarchal society within which male power is institutionalised and organised’* (Witz 1990:677). This source of power made available to men is the reason behind most of the institutional and structural barriers created to exclude women from the medical profession. More recently, laws against sex discrimination have been used to tackle some of the institutional and structural barriers to women in the field of medicine (Macdonald 1999). Nonetheless, the major barrier women face is the patriarchal discourse in society which is harder to eradicate even with laws (Macdonald 1999). This is in addition to the structural gender inequality barriers women encounter in the progression of their career such as salary inequities, domestic responsibilities, under-representation in higher positions and subtle forms of discrimination (Reed & Buddeberg-Fischer 2001). Most importantly, the gender argument shows how the monopoly and dominance of medical professionals is a combination of both actions and power structures located within society.

### **2.5.3 Summary**

Studying the literature on the sociology of professions provides a detailed analysis of how this body of work has developed over the years and how this field of study has been able to incorporate mainstream sociological theories in explaining the attainment of a professional status. The change in focus from the idea of altruistic qualities put forward by the functionalist sociologists to structuralist and interactionist explanations

has brought into the spotlight monopolist attributes of professionals, previously ignored. However, even though the altruistic argument has been criticised, it laid the foundation for questioning and initiated the discussion about the definition of professionals. Interactionists have gone further and used empirical data to explore the various arguments for and against the altruistic explanations in order to arrive at their conclusions. The advantage of tracing the various arguments from the functionalist, structuralist and interactionists, is that this provides a more holistic definition of a profession, as follows:

*“an occupation that has had the power to have undergone a developmental process enabling it to acquire, or convince significant others (for example, clients, the law) that it has acquired a constellation of characteristics we have come to accept as denoting a profession”*(Ritzer & Walczak 1986:67)

Contrary to what was previously claimed about a linear process of professionalisation, the literature from the monopolist perspective focuses our attention on four areas where professionals have had authority namely: division of labour, control of labour markets, occupational training and certification and professional ideology. This creates a legally protected monopoly (otherwise known as ‘market shelter’) for medical professionals from competition by other occupations. Sociologists of the ‘actions’ and ‘power’ approach refer to occupational market structures of demand and supply in explaining the medical professionals’ creation of a market shelter through autonomy and monopoly. Even though they are two different approaches, they are not in total conflict with each other but rather they complement each other.

The actions model suggests that medical professionals have over time actively pursued prestige and high status in society collectively by controlling the supply and demand of activities relating to health (Berlant 1975). Some of the actions used, for example the

increasing medicalisation of health-related activities, have increased their jurisdiction, while the continuous abstraction of biomedical knowledge has excluded other occupations from the health discourse. This means that medical professionals have both defined the terms of health work and controlled the supply of skilled labour. On the other hand, the power approach focuses on the structures and political processes in society that help medical professionals secure and maintain their high status in society. The relationship of the state and medical professionals is influential in conferring on the medical profession legal authority over rights to practise and autonomy to govern itself and in the process, labelling other competitors as inferior (Daniel 1990). The Foucauldian perspective describes the power the biomedical discourse has in society, which makes individuals trust and conform to its ideas, thereby respecting the agents of this biomedical discourse. In summary, an understanding of these theoretical approaches gives a clear picture of how medical professionals have been able to dominate the health sector and maintain this dominance in industrial and post-industrial European and American societies.

An important area of concern regarding medical professional monopoly is the concentration of power within one profession. This can have negative ramifications for the health system and a good example is seen in the gender theme, whereby the professional powers of medical professionals led to the exclusion of women, through the creation of structural and institutional barriers, which still exist in some contexts. Secondly, the monopoly of demand and supply by medical professionals makes it possible for medical professionals to manipulate the health system in such a way that health priorities are structured around medical professionals, thereby limiting other beneficial non-medical options. An example is the way in which particular conditions or bodily experiences - such as pregnancy and birth - have been 'medicalised' to differing extents in different contexts. Overall, understanding the medical professional monopoly,

rather than focusing only on the altruistic function of medical professionals, gives a more balanced view about the sociology of medical professionals.

As noted above, the literature on the sociology of medical professionals largely focuses on studies carried out in North American and European countries, with few comprehensive studies of medical professionals in the countries of Africa, Asia, and South America. Johnson criticised the little attention given to medical professionals in these regions given the fact that most of the medical professionals in post-colonial countries evolved from imperial state medical professionals (Johnson 1973). In the following section, a historical examination of the medical professionals in Nigeria will help in understanding the professionalisation process of medical doctors in Nigeria by exploring the similarities and contrasts between them and their Western counter-parts.

## **2.6 Medical professionals in West Africa**

Johnson has argued that the social structures in place that define the power, prestige and status of medical professionals in post-colonial countries are different from their Western counterparts (Johnson 1973). He goes further to say that an understanding of medical professionals in post-colonial countries can only be achieved by analysing the relationship between the medical professionals and their colonial and post-colonial states (Johnson 1973). This approach has been used by Mutizwa-Mangiza in exploring medical dominance and autonomy in Zimbabwe (Mutizwa-Mangiza 1999). This section will briefly trace the history of the first involvement of medical doctors in West Africa; examine the symbiotic relationship between colonial medical doctors and the growth of the empire, before highlighting the rise of the indigenous medical doctors in the Post-colonial state.

Western medical doctors first had their influence in West Africa through slave ships where their expertise was used primarily to select slaves who were healthy enough to make it to the final destination in order to increase the profits of the slave traders (Schram 1971). The reputation of doctors grew and in 1789 an Act of Parliament was passed in England, requiring that every ship carrying slaves must have on-board a licensed surgeon (Schram 1971). This was the first documented encounter of western medical professionals and West Africans.

Medical doctors became prime facilitators in the conquest of Africa and some were conscripted into the military forces that were sent to colonies (Cunningham & Andrews 1997). One of the main reasons for this was the discovery of quinine, a cure that helped Western explorers of African lands overcome the deadly febrile diseases of malaria and yellow fever (Schram 1971). Competition between the various European powers caused the discoveries made by medical practitioners in African colonies to be very important because without their knowledge, expertise and treatments, the colonial military personnel would die fast (Cunningham & Andrews 1997). The more Western medical doctors were able to conquer and find cures for tropical diseases the faster the empire grew in its superiority in tropical regions (Arnold 1996).

This symbiotic relationship between the medical professionals and the British Empire led to increasing medical-scientific research in tropical medicine. Discoveries in tropical medicine were central to the increasing social status, power and authority of medical professionals (Mutizwa-Mangiza 1999). In turn, the British Empire was able to develop a universal reputation as a leader in medical science and also to press forward the mission of the empire (Arnold 1996). By the end of the 19th century the controlling group in the healthcare system in the colonies was the Western medical professionals because of the vast regions covered by the European empires and their medical



institutions (Allen & Alan 2000). This rise in status of doctors in the colonies can be linked to two things, one of which was the metropolitan-colonial links created by the professional British Medical Association (BMA) in England, through its transmission of the professional ideology of an independent occupation with levels of autonomy to practise (Johnson 1973). Secondly and most importantly, there was the creation of a corporate patronage system whereby the colonial state was the sole source of demand for the services of the medical doctors in the colonies, which led to the incorporation of medical doctors in the colonial bureaucratic system (Johnson 1973). The realisation by the leaders of the British Empire of the importance of biomedical science in colonial expansion led to the creation of the West African Medical Service in 1902, which was an arm of the British colonial state (Johnson 1973).

In the early 20th century, there were a growing number of doctors going to the coast of West Africa to join the West African Medical Service (WAMS) formed by British colonial governments (Johnson 2010). Enrolment into these high status ranks was reserved only for British expatriates which was insisted on by the metropolitan links with the BMA, through informal agreements (Johnson 1982). This was followed by reorganisation of the service in order not to allow African doctors (who were trained in western institutions) to take up senior positions (Patton 1996). To supplement the limited workforce of the British doctors, other non-doctor roles such as vaccinators, nurses and dressers were given to indigenous Africans (Arnold 1988). This created an ambiguous role whereby Western colonial medical doctors had a hybrid of clinical and mainly administrative roles, which was in contrast to the European metropolitan doctors (Schram 1971). The colonial medical professional was not meant to supply services for a heterogeneous indigenous population but instead to focus on the specific tasks and demands of the colonial state. Much of what the medical doctors did was concerned with satisfying the demands of a single patron - the state – and the profession derived its

powers from the authority of a centralised state (Johnson 1973). The existence of mainly government-owned hospitals made private practice uncommon in Colonial states, because the government made salaries and pensions very lucrative to encourage doctors to come to these West African countries (Johnson 2010).

The segregation of non-British employees from the prestigious medical doctor positions, while relegating African natives to auxiliary state positions, created a hierarchy structure in the health related occupations (Johnson 1973). Unlike the medical doctors in the Western countries, medical doctors in state colonies had both clinical professional roles and bureaucratic roles. This mix of roles medical professionals had was inherited by the post-colonial independent states when power was handed over to them, resulting in medical doctors having a higher perceived status in society (Johnson 1973).

In the years following the First World War, there was a relaxation of laws against the employment of African doctors (Scott-Emuakpor 2010). During the war, the loss of many European doctors who were in the army led to an acute shortage of doctors in the West African sub-continent (Scott-Emuakpor 2010). Secondly, in trying to explore and reach parts of Nigeria the Western doctors were dying and the Nigerians seemed to have immunity towards the harsh weather and some of the local diseases (Scott-Emuakpor 2010). In addition, it was realised that African medical doctors could better pass on the biomedical ideas to the African people than the Western doctor who had no understanding of the traditional cultures (Vaughan 1991). Therefore, it was easier for the indigenous doctors to play the role of the doctor; this was termed 'Africanisation' of the medical personnel (Arnold 1988). Resistance and independence movements also played a major part in this process (Schram 1971).

In these processes of 'Africanisation' and struggle by indigenous medical doctors for recognition, two important aspects are recognised. Firstly, indigenous medical doctors had to struggle for bureaucratic control of the structures that they inherited from the colonial era (Johnson 1973). This involved being the sole provider of health services and leader of the health institutions of the state, while inheriting the professional characteristics of the medical professionals under the colonial regime (Johnson 1973). These characteristics involved the hierarchical order and control of subordinates, through bureaucratic roles, but most importantly, they had to show they possessed the professional qualities and character their Western colleagues possessed.

The second aspect in the struggle by indigenous medical doctors was the responsibility professionals had as the educated social class with the ability to drive through economic and political innovation in the new state (Smythe & Smythe 1960). This placed them in an elite role in society and acquiring a western professional training became a major route for upward social mobility (Smythe & Smythe 1960). The identity of the medical doctor in the Nigerian society was that of an elite individual trained in western education and professional values (Smythe & Smythe 1960). The combination of these two aspects of professional superiority in the state bureaucratic system and their position in society as elites characterised the indigenous medical doctor in the new Post-colonial state.

In 1939 Nigeria established its first medical school in Yaba, which trained doctors who then had to complete the remaining of their training in Europe to be fully recognised doctors (Schram 1971). After independence in 1960, other medical schools sprang up and the Nigerian Medical Council became independent from the British Medical Council (BMC). In the following year some of the Nigerian medical schools became recognised by the BMC (Scott-Emuakpor 2010). Laws were promoted by the Western

trained African professionals to give them more power over their profession and as well to regulate themselves (Last & Chavunduka 1988).

### **2.6.1 Roles of medical professionals**

In the context of Nigeria, medical professionals carry out both administrative and managerial responsibilities, in addition to their clinical professional duties (Ojo & Akinwumi 2015). Some of the administrative duties include:

1. Low-level management which involves supervision of operational activities such as planning patient management (Olumide 1997). This level of management is closely linked to their clinical duties and is the point where frontline medical professionals are usually very visible.
2. Mid-level management involves translation of policies into practice such as implementation of guidelines, division of labour to other health professionals, tactical oversight functions and leadership roles as heads of units (Olumide 1997). These medical professionals are also clinical managers with more responsibility and are usually the experienced doctors. Although they cannot be called elites they usually transit from these roles to occupy elite roles in the future (Olumide 1997; Witman et al. 2011).
3. Top-level management handles strategic policy making and decision making for hospital boards, Ministry of Health at both state and national levels (Olumide 1997). According to the sociology of professions these are regarded as the medical elites, who due to their strategic position in policy making are able to influence policy development significantly (Waring & Currie 2009).

The existing literature tells us that medical professionals in the African context have inherited roles previously held by colonial medical professionals (Last & Chavunduka 1988). The decolonisation of the health sector in post-colonial states was closely linked to the professionalisation of African medical professionals in these now independent countries. As earlier noted, most African medical professionals in the process accumulated managerial, structural and political power from the newly formed states and eliminated traditional healings as a legitimate practice (Last & Chavunduka 1988). This victory for western style medicine as the legitimate practise in the mainstream health sector elevated other ‘auxiliary’ health professionals such as nurses and pharmacists, but these were still considered to be subordinates or support staff in relation to the medical professionals (Last & Chavunduka 1988). However, there is insufficient literature that traces how these roles have evolved under the post-colonial era into present day medical professional administrative and managerial roles. Nonetheless, there are many similarities between the roles of medical professionals in Nigeria and other post-colonial African states (Olumide 1997), which makes Nigeria an ideal case in understanding medical professionals in the Sub-Sharan region. For example, the case studies from Tanzania and Zimbabwe (Harrington 1999; Mutizwa-Mangiza 1999) have shown that medical professionals possess professional monopoly and autonomy in their various health systems, which is similar to the professional monopoly of administrative and management positions by Nigeria medical professional (Olumide 1997). This shows that due to the similar colonial history of most sub-Saharan countries, case studies of similar sub-Saharan contexts might help to explain events in other similar contexts.

From the literature about division of labour in the health sector, *‘partitioning of health care into numerous professions and the medical acts that each may perform is, in a broad sense, determined and monitored by licensing bodies...Therefore, precise*

*boundaries are dynamic and disputable. As a result, “turf battles” often occur’* (Baerlocher & Detsky 2009:858). The structure of medical professional roles in Nigeria reflects a well-established division of labour, similar to the patterns described by Friedson (2001) and Abbott (Abbott 1988). The different levels of administrative, management and leadership roles that medical professionals have in the Nigerian health sector allows medical professionals to assign roles to other health professionals, thereby defining both the boundaries for medical professionals and for other health occupations. In relation to power, at all levels of management, medical professionals possess strategic positional power that enables them to maintain their dominance in the health system. This has angered other health workers leading to ‘turf battles’ such as strikes and even physical confrontations (Ojo & Akinwumi 2015). Therefore, when defining the roles of other health professionals, it is important to note that in the Nigerian context the boundaries are fluid and dynamic. This means that, with the existing monopoly of medical professionals over the top positions in the clinical and managerial occupational hierarchy, the roles of other health professionals are determined by the medical professionals, despite emerging turf battle. For example, a study in Nigeria showed that in facilities whereby other health professionals have challenged the administrative authority of medical professionals to delegate roles, there was an increase in conflicts in those facilities ranging from strikes, physical assaults, absenteeism and resignations (Olajide et al. 2015). *‘Amongst respondents that admitted to the presence of conflict (67.4%), 72 (33.2%) attested that the chances of a conflict were higher when nurses sought influence within the hospital.’* (Olajide et al. 2015:5). These conflicts have led to criticism of the administrative and management skills of medical professionals in the Nigerian system, with some citing deficiencies in their ability to carry out top management duties (Kajang 2004).

## 2.6.2 Summary

The colonial regime in Nigeria was a major factor in shaping the medical profession and determining the power structure necessary for medical authority in the new state. The development of the medical profession in Nigeria is different from that in Western countries; however, the Nigerian medical professional has inherited the pre-existing professional status of medical doctors in the colonial structure.

In the case of Nigeria, the transmission of power was through a historic colonial symbiotic relationship between the state and medical professionals, while in Western states it is argued that this type of medical professional and state relationship was made stronger in the creation of welfare states (Esping-Andersen 1999). For example, in the UK the creation of the National Health Service in 1948 brought medical doctors, nurses, pharmacists under one umbrella organisation (NHS 2015). In this system, the medical doctors enjoyed the state's support as the dominant health occupation in a state-professional relationship, which entrenched a professional hierarchical system (Kuhlmann et al. 2009).

The occupational hierarchy in Nigeria was a result of segregation during colonial rule later adopted by the post-colonial medical doctors, which explains their inherited dominance. Furthermore, the events that followed independence shows the similarities Nigeria medical doctors have with their western colleagues in their desire for greater autonomy and upward social mobility. The struggle for professional autonomy from the British Medical Association (BMA), the creation of state laws protecting their professional dominance and autonomy, and the struggle for control of the bureaucratic structures are examples of this desire for prestige and higher status.

The monopoly of the occupational health market by the Nigerian medical professional has its peculiarities because the professional-client relationship is between medical professionals and the state. Medical professionals are in control of the supply of professional services and professional knowledge while they are subordinate to the demands and patronage of the state. This dynamic is important in determining the professional development of medical professionals from the post-colonial era to the present day. Nigerian medical professionals therefore are concentrated in the high paying state jobs in the urban cities and are heavily dependent on government jobs, making them more susceptible to policy changes by the state. In summary, this section has captured the evolution of the Nigerian medical profession and compared their route to professional autonomy with that of Western medical doctors. This is important because it highlights the peculiarities of the Nigerian medical professional role, which will be discussed again in Chapter Eight.

As discussed previously, the power and monopoly of medical professionals has some potential negative effects and in this section, the literature reveals some of these negative effects. Occupational hierarchy is an example of how professional power can instil an unfair system on other non-doctor occupations in the health sector. This system gives privileges to the medical profession and creates structural barriers with the sole aim of maintaining professional boundaries and power. This is captured in both the colonial and post-colonial health system. This unhealthy power imbalance, which focuses only on credentials, can be a demotivation for other health occupations and in general affect the productivity of the health system. The next section is going to look at strategies used by external forces in limiting this professional power.

Sociologists have tried to identify how changes in state policies and external forces can lead to the deprofessionalisation of medical doctors. Building on the neo-Marxian



perspective, the deprofessionalisation of medical professionals has been studied in order to ascertain the true status of medical professionals in society in the presence of other forces in society. Technology, neo-liberalism, corporate markets, and NPM are changes in society that sociologists believe have deprofessionalised medical doctors (Ritzer & Walczak 1988; Bezes et al. 2012; Sekiguchi 2006; Noordegraaf 2007). In the next section, we are going to look at deprofessionalisation of the modern day medical professional.

## **2.7 Deprofessionalisation or professional bureaucracy**

*'More specifically, deprofessionalisation involves a decline in the possession, or perception that the professions possess, altruism, autonomy, authority over clients, general systematic knowledge, distinctive occupational culture, and community and legal recognition.'* (Ritzer & Walczak 1988:6)

The theory of deprofessionalisation is based on a hypothesis that medical professionals will gradually lose most of the qualities that distinguish them as professionals (Haug 1975). Haug's argument was based on a prediction that the more professionals are faced with greater interaction with external forces such as rapid expansion of knowledge, computerisation of tasks and patient dissatisfaction, the more their professional status will be challenged and after a while they will succumb to these forces (Haug 1972). Professionals can be said to be deprofessionalising when they cannot cope with economic, social or cultural changes, in the process they lose some of the professional privileges and autonomy they previously enjoyed (Sekiguchi 2006). Some authors have explored how neo-liberalisation of health markets has led to the deprofessionalisation of medical doctors (Mechanic 1991; Conrad 2005; Light & Levine 1988). Conrad explored how pharmaceutical companies in the USA have increasingly influenced the definition of disease conditions by lowering the treatment threshold; an example is the use of

Viagra in treating male impotency, which has redefined the treatment boundaries of male impotency (Conrad 2005). Due to a neoliberal market system, companies with capital have the ability to compete with medical doctors in determining treatment options for patients. For example, the influence health insurance companies have in decision-making on drugs of choice, investigation options, treatment choices and remuneration fees to medical doctors, is a reflection of the reduced autonomy of medical doctors (Mechanic 1991). The general argument made here is that over time, technological change and social movements have greatly reduced the knowledge gap between the professional and the client. This has led to structures in society such as pharmaceutical companies, biotechnology and health insurance structures taking up some roles of medical doctors or even simplifying the roles to a level where non-professionals would be able to carry them out. An empirical study in Australia showed the historical shifts the medical lobby in Australia has had in the health decision-making process (De Voe & Short 2003). The research concluded that *'doctors' lobby during Medibank negotiations represents a rare break in the tradition of ultimate medical professional veto power in health policy decision-making and provides empirical evidence that challenges a widely held perception about an inevitable historical path of medical dominance'* (De Voe & Short 2003:343)

Friedson has an opposite opinion to the deprofessionalisation theory and says that the creation of more complex knowledge in the medical field is ever increasing, which is contrary to Haug's assumption that the knowledge gap is closing (Freidson 1983). According to Freidson, arguments about the decline in the public's satisfaction with the medical professional in the context of the United States cannot be directed at the medical professionals alone because there has been a general decline in the public's confidence towards public servants, politicians, and other occupations as well (Freidson 1983). Others have been sceptical about the deprofessionalisation theory and results

from their study disprove the deprofessionalisation theory among medical professionals in Australia but hinted to more of a re-structuring rather than a generalised loss in autonomy (Lewis 2002). However, Friedson's arguments do not address the other processes mentioned such as globalisation, the influence of insurance companies and the spread of neoliberalism that have led to the deprofessionalisation of medical doctors. These are the weaknesses in Friedson's position against the deprofessionalisation, with most of the evidence from the literature and empirical research supporting deprofessionalisation theories (Dopson 2009).

The concept of proletarianisation has been linked to deprofessionalisation theories, and the arguments here mainly focus on medical doctors' source of income rather than on status or autonomy. Proletarianisation is understood to be a process where the worker's income becomes the wage he is paid by organisations or the state and at the same time becomes subject to organisational bureaucracies (Oppenheimer 1972). With the increasing spread of capitalism and the state's involvement in the expansion of the health sector due to the creation of a welfare state, the supplies of advanced medical services and technological advancement have made medical doctors more dependent on corporations (Light & Levine 1988). This is because most of these technological advancements are capital intensive; therefore, the production of these services is dependent on capital investments from state governments and corporations (Light & Levine 1988). Doctors now take up salaried positions in bureaucratic organisations and have to succumb to the regulations of administrative hierarchy (Larson 1977). Larson's study shows that self-employed professionals are gradually becoming salaried staff of bureaucratic organisations because the power of production in society has shifted to capitalist corporations. This type of professional bureaucrat became very common in welfare states of the mid-20<sup>th</sup> century and is similar to the type of medical professional inherited by Post-colonial states.

The growth of welfare states in Western European countries during the mid-20<sup>th</sup> century saw a large number of medical doctors take up employee positions in public and private bureaucracies (Daniel 1990). Medical doctors in this system lose the power to determine administrative goals and objectives in their work environment, thereby becoming subject to top-down decision-making processes (Light & Levine 1988). The inability to impose their professional ideology on the system, forces them to work under set goals of practice and priorities of care, gradually eroding their autonomy (Daniel 1990). The technical autonomy of the work they carry out in the organisations is usually still intact and they become part of an intermediary position in the hierarchy of the organisation. Unlike other non-professional staff of the organisations, the medical professional has the flexibility and privileges of work discretion, control over their work schedules and being masters of their time (Larson 1977). Even though professional bureaucrats have been proletarianised in relation to their income, in other aspects such as status and autonomy, evidence shows they retain some of the professional privileges in the organisations that hire them (Larson 1977). In other words, the medical doctor professional status has been shaped from being self-employed, to being a professional bureaucrat with professional privileges.

Another perspective on theorising the deprofessionalisation of medical professionals is to examine the relation between rationalisation and professionalisation. The theory of rationalisation says *'the more formal rational structures and institutions and their rules and regulations are coming to exercise increasing control over physicians, altering their character by making them more formally rational and, in turn, contributing to deprofessionalisation'* (Ritzer & Walczak 1988:4). The Weberian theory used here starts by differentiating the substantive and formal rationalisation used in management. Medical professionals while making decisions are influenced by their values and ideas such as *'altruistic values, autonomy, and authority over clients'*, and this is referred to

as substantive rationalisation of (Ritzer & Walczak 1988:4). On the other hand, formal rationality used by bureaucratic organisations involves the use of ‘*universally applied rules, regulations, and laws*’ (Ritzer 2011:42). The imposition of formal rationalisation in organisations is in conflict with the substantive rationality of medical professionals (Ritzer & Walczak 1988). This Weberian theory explains how corporate formal rationalisation can over time gradually erode some of the technical autonomy medical professionals possess in organisations. This has become the general current picture of medical professionals in most European countries but the extent to which their ideological and technical autonomy is eroded will vary from country to country. For example in Zimbabwe (a post-colonial state) the medical professionals still have a strong hold of the organisational aims and objectives in the government health institutions which is a major stakeholder in the health structure of the country (Mutizwa-Mangiza 1999). This is in contrast to the position of medical professionals in the UK NHS in the early 1970s and 1980s (Daniel 1990).

The rise of evidence-based medicine in the UK and similar contexts is a good example of the tensions between formal rationalisation of bureaucracies and substantive rationalisation of medical professionals. Evidence-based medicine “*is the process of systematically finding, appraising, and using contemporaneous research findings as the basis for clinical decisions*” (Denny 1999:253). This creates pathways and guidelines for patient management through the critical appraisal of clinical evidence, while reducing individual practitioner autonomy (Denny 1999). Mike Dent (1999) studied the introduction of evidence-based medicine in three European contexts: Britain, Sweden, and Netherlands (Dent 1999). He concluded that evidence-based medicine has been used by the state to ensure quality medical care and has put pressure on the medical professionals to conform (Dent 1999). Doctors in those contexts conformed in order not to have their intentions questioned by the public and as a result have conceded some of

their professional autonomy (in the form of substantive rationalisation) to formal rationalisation (Dent 1999). Evidence-based medicine in these contexts can be seen as an effective tool to the deprofessionalisation of medical doctors.

There are similarities between the Post-colonial and the Western medical professional in the organisational hierarchical structure of bureaucratic institutions. *'The bureaucratisation of work generates a 'hierarchical image of society'* (Larson 1977:238), this leads to a reclassification of positions in organisations based on credentials (Larson 1977). This puts medical professionals in a secure high position in the organisational structure with many privileges, creating a career pathway accelerated by the acquisition of more credentials and educational achievements (Mintzberg 1979). The organisational structure relies on the skills and knowledge of the professionals, making them the operational core of service provision and production (Mintzberg 1979). The professional operational core has the freedom and control over their work while co-ordinating the standards and procedures of the supporting staff (Mintzberg 1979), such as the nurses, care workers, and clerks.

A synthesis of the literature from the functionalist age to the more modern professional bureaucrat, shows a changing dynamic: the transition from the mid-19<sup>th</sup> century Western professional to the current professional bureaucrat model which is similar in most capitalist and state-run Western European welfare health systems and post-colonial states. The deliberate attempt at professionalisation by medical professionals, through monopolistic control of market forces for their professional reward and prestige over the years has declined. The erosion of the professional ideology by formal rationality in determining the output goals and objectives in the health sector, has led to laws and rules that govern medical professionals' decision-making processes. In the past medical professionals were guided by association principles and ethics, now they struggle with

subordination to organisational bureaucracy while trying to maintain their professional qualities of altruism, autonomy, and authority over clients. In essence, even though formal rationalisation has deprofessionalised medical professional, to some degree it has protected the occupational hierarchy that still gives medical professional bureaucrats workplace privileges.

The work environment (in countries such as the UK and US) during the mid-20<sup>th</sup> century placed the medical professional at the centre and separated them from the rest of the staff in a hierarchical fashion. In addition, society saw the importance of professional credentials as a way for upward social mobility and status because of the creation of a market structure that favoured superior professional education credentials as determinants for occupational power and privileges. In recent years, the jurisdictions and boundaries of medical professionals have constantly been re-drawn. The late 1980's saw another reconfiguration of professional boundaries in most bureau-professional regimes, in the form of New Public Management (NPM) (Dent et al. 1999). A change to welfare policies in Europe propagated by the OECD has ushered in a new era of public management. The literature on professionals from a management perspective has explored the shifting boundaries of the medical professional in an era of increased marketisation of the welfare health institutions. Change from the old form of public management has seen a change in the interaction of professionals with their clientele, consequently reshaping the autonomy and monopoly once enjoyed by medical professionals. This recent literature on NPM challenges the notion that medical professionals as professional bureaucrats are still a homogenous group with shared aspirations. It does this by drawing attention to the ongoing re-stratification of the medical profession and erosion of professional powers and jurisdiction by neoliberal values affecting all parts of society globally.

### **2.7.1 New Public Management**

*'New Public Management is the attempt to implement management ideas from business and private sector into the public services.'*(Haynes 2015:9)

Post-industrial Europe created a large workforce growing at a high rate that led to overcapacity in a lot of industries and by the 1960s there were doubts about the efficiency of traditional bureaucratic public sector services (Dent et al. 1999). After the golden era of welfare states in the 1970s, high inflation and slow economic growth due to the financial crisis of the late 1970s and 1980s made most of the Western countries retrench the welfare services by adopting various welfare state forms that suited the state government at the time (Eikemo & Bambra 2008; Esping-Andersen 1999). Some adopted liberal, conservative or social democratic welfare regimes, which had consequences for the role of the state in the health care system (Eikemo & Bambra 2008). In England, the growing dissatisfaction of the government over the bureaucracy of the public sector and professional power introduced a new form of management called New Public Management (Osborne et al. 2002).

New Public Management is a neoliberal policy studied by researchers in order to characterise its components and its interaction with existing public sector structures such as traditional professional roles (Lorenz 2012). New Public Management places emphasis on the private sector principles of cost effectiveness, a shift to client- service orientation, and a promotion of incentives and competition in order to drive up efficiency (Lynn 1998). Hood listed seven qualities of NPM in a definition that has been widely accepted by academics of management:



4. *Hands on professional management in the public sector: active, visible, discretionary control of organizations from named persons at the top, 'free to manage'. No diffusion of power*
5. *Explicit standards and measures of performance: Definition of goals targets, indicators of success, preferably expressed in quantitative terms, especially for professional services*
6. *Greater emphasis on output controls: Resource allocation and rewards linked to measured performance; breakup of centralized bureaucracy-wide personnel management*
7. *Shift to disaggregation of units in the public sector: Break up of formerly 'monolithic' units. unbundling of U-form management systems into corporatized units around product*
8. *Stress on private- sector styles of management practice: Move to fixed-term contracts and public tendering procedures*
9. *Stress on private- sector styles of management practice: Move away from military-style 'public service ethic', greater flexibility in hiring and rewards; greater use of PR techniques*
10. *Stress on greater discipline and parsimony in resource use: Cutting direct costs, raising labour discipline, resisting union demands. limiting 'compliance costs' to business (Hood 1991:5)*

The underlying ideology governing this approach is the assumption that the private and public sector can be run and will function in the same way, by mirroring the organisational and management principles of the private sector in the public sector (Osborne et al. 2002). Firstly, NPM attempts to cut costs by creating competition among public providers, claiming to reward efficient providers while in-efficient providers would be starved of funds (Osborne et al. 2002). Secondly, it assumes competition

will drive innovation among providers of services in their attempts to be cost efficient, thereby improving quality of care (Osborne et al. 2002). Lastly in a bid to increase performance of professionals, managers from the private sector were introduced to implement performance-based frameworks and incentives, with an aim to reduce professional powers (Haynes 2003a). The economic theory underlying these reforms argues that the slow growth of the economy in the 1970s and 1980s could be attributed to the restriction of market freedom by the government (Hughes 1998).

The spread of NPM principles around the world is usually attributed to the OECD and World Bank, who favour neo-liberal policies and adoption of privatisation as a means to improving the efficiency of public agencies (Dent et al. 1999). In Africa, there has been a sweeping pressure on national governments to adopt NPM as a solution to the poor governance issue facing most Sub-Saharan countries (Osborne et al. 2002). Secondly, the weak bureaucratic systems of African countries are blamed for the slow implementation of reforms and policies (Osborne et al. 2002). Lastly, international organisations such as the World Bank, IMF, global private-public partnerships, and Trans-national Discourse Coalitions (group of actors who share a social construct) encourage the adoption of NPM in implementing government reforms and programmes (Salskov-Iversen et al. 2000; Hajer 1993). NPM has received a lot of international support (from dominant bodies) and is adopted by nation states in various forms, thereby attracting a lot of research into its efficiency and comparing it with the old forms of administration.

There is an ongoing change in the way public administration is run around the world, with some countries adopting more drastic and radical forms of NPM, such as in England, while in some countries it is less obvious. The National Health Service in England has experienced a lot of changes since the introduction of NPM and these

processes have been used to study its impact on professionals and their place in a new system (Numerato et al. 2012). How this threatens the position and status of medical professionals has implications for their professional powers and attributes. Managers working on the basis of private sector norms alter the professional hierarchy inherited from the welfare state era and colonial regimes, making the boundaries between professions and other occupations more flexible by focusing on outputs and efficiency rather than professional qualifications. The next section is going to look at the interaction between the traditional professional bureaucracy and NPM.

### **2.7.2 NPM versus professional bureaucracy, or a hybrid of both?**

One of the primary goals of NPM is the curbing of professional power and control in public organisations through the introduction of specific forms of management. This is partly drawn from the general notion that professionals have had too much control of public services and are more focused on enhancing their professional status and rewards than actually providing quality and effective service to the citizens (Haynes 2003a). Where previously public administration was carried out by professionals in merit-based public service, managers now are favoured because they focus on outputs tailored to the goals of politicians and may lose their job once they fall short of the set objectives (Hughes 1998). The control of hospital management is gradually shifting from hospital committees to a new cadre of managers drawn from the public and private sector who are not health professionals by origin. Because of the difference in the way managers and medical doctors rationalise decisions there have been cases of growing tension between managers and medical doctors (Walt & Gilson 1994). For example, one study examined *'how the profession of medicine views itself and its situation in a world of emboldened managers'* in the US, Britain and Sweden (Rosenthal 2002:62). The study showed how the introduction of new management principles led to tension and

dissatisfaction among medical doctors in the work place. This is summed up in this quote: *'The most important drivers in the academic doctors' lives used to be success in research, making honest and good contributions to the progress of medicine, teaching medical students and residents and being proud of the clinical care they gave. That has all been replaced by the 'operating margin'. And that has created significant amounts of disaffection'* (Rosenthal 2002:61). As professional bureaucrats, medical doctors enjoyed workplace autonomy and occupational hierarchy, which is now being threatened by NPM.

By imposing managers on medical professionals, there was a belief among policy makers that it would weaken professional powers and autonomy, but after some years of reform there is now a fundamental shift toward the use of health professionals and training them as managers themselves (Dopson 2009). Another aspect that favours the use of clinical managers is the fact that the nature of management in public service makes the distinction between professional roles and management roles very difficult (Haynes 2003b). The use of the hybrid clinical manager was informed by studies that showed that clinical managers were better equipped to handle performance problems than general managers (Dopson 2009). Harrison and Ahmad in their study of UK clinical managers concluded that *'an important source of legitimacy; doctors' clinical decisions, made within the limits of a biomedical model which does not threaten capitalism, are a politically invisible medium for health-care rationing'* (Harrison & Ahmad 2000:142). After an initial government attempt to create a controlling management cadre who would curb professional powers, medical professionals have colonised these management roles (Ferlie & Geraghty 2005). Other studies have examined NPM and medical professionals in different contexts and have seen that local context is a major factor in medical professionals' ability to colonise management positions (Immergut 1990; Bezes et al. 2012).

An implication of these clinical manager roles for medical professionalism, is the possibility of an encroachment on the clinical autonomy medical professionals have in health organisations (Exworthy & Halford 1999). A reason for this is that clinical managers are forced to think more in managerial terms while they manage the other regular doctors and by so doing they encourage other doctors to think in managerial terms (Exworthy & Halford 1999). In addition, because the new hybrid doctors are able to incorporate clinical audits and market-based managerial skills, they have the added ability to better control their colleagues (Flynn 2012). With this shift towards a more entrepreneurial thinking medical professional, questions are being asked about the extent to which management has replaced the dominant medical autonomy.

In summary, the combination of NPM values with the existing medical professional values has created a hybrid clinical manager with entrepreneurial values, ushering in an era of compromise that encourages collaboration between managerial and professional values. To some, this hybridisation of manager/medical professionals is just a redistribution of the powers of the medical profession in various sub-groups in the form of clinical managers and is hence an internal control by the medical professionals and not a deprofessionalisation (Exworthy & Halford 1999; Ferlie & Geraghty 2005). An opposite argument is that the state has been able to make the medical professionals self-regulate themselves to provide more effective and efficient services through an external imposition of medical audits and evidence based medicine (Bezes et al. 2012). This external control forces medical professionals to focus on set objectives created by the state (Coburn 2014). Both arguments are based on Western contexts, rather than drawing on global comparisons. However, the argument for an internal control by medical professionals is backed by inferred observation without strong evidence to back the claims. While the data from interviews with medical professionals in Western countries shows that they do not see clinical managers as a form of consolidation of

medical power but rather they see clinical managers as *'selling out to administration'* and being a source of external control on medical professionals (Rosenthal 2002:64). In addition, when clinical managers do not achieve the goals set out by the government they are vulnerable to being sacked (Rosenthal 2002), which shows a strong controlling power from the government rather than an organised redistribution of medical powers from within the profession. Although the picture presented in Rosenthal's research show similarities in the US, UK and Sweden, the controlling forces in the US come not mainly from the government but from market forces and a complex network of other prominent stakeholders such as the pharmaceutical industry and a variety of payers (Rosenthal 2002). Therefore, the external control argument is supported by more evidence in the US and UK context, in contrast with Sweden. With the creation of two types of medical professionals in the system (clinical manager and practitioner), the next section will briefly look at the differences between these two categories of professionals.

#### **2.7.2.1 Re-stratification by NPM**

In countries such as the UK and the US, the state's emphasis on more control of medical professionals through the adoption of management principles has created a small group of medical elites who set the standards for practice and inform policy through research (Freidson 2001). This has led to a re-stratification of the medical doctors in most parts of Western Europe and the US. According to Bezes et al, current initiatives in France and Europe, arising from NPM, have re-stratified the medical professionals into three prominent categories: the scientific elites, the managerial elite and the rank and file practitioners (Bezes et al. 2012). Bezes et al's classification is informed by Freidson's re-stratification theory, which Freidson derived through an observation of the American healthcare system. Due to the similarities in power and status of the scientific and

managerial elite, they are usually discussed together as one elite medical doctor group. Other researchers have also grouped the scientific and managerial elites as a '*corporate elite of medicine*' (Lewis 2006:2126). Within this group, there is an overriding emphasis on organisational professionalism and on how medical doctors should operate. Organisational professionalism focuses on the use of external controls such as guidelines and rational legal forms of control (Bezes et al. 2012). In the hierarchical structure of the organisation, this small group of elites have gone up the professional ladder in order to attain this prestigious status (Freidson 2001). The use of the professional discourse by these clinical manager elites is a strategy to get the best out of their fellow medical professionals and motivate them but it is not used in an attempt to protect professional autonomy or monopoly (Bezes et al. 2012).

The second group of medical professionals are the rank and file practitioners, otherwise known as the frontline medical doctors (Lewis 2006). This group do not have managerial responsibilities and are being supervised through the established standards and guidelines created by the elite clinical managers (Friedson 1985). The rank and file doctor is subject to scrutiny of his/her clinical decisions and a deviation from these set guidelines will need to be justified before medical superiors (Mahmood 2001). Even though the rank and file doctors are given discretionary opportunities in carrying out their duties, these are increasingly being guided by the elite researchers and clinical managers, leaving the rank and file doctors with less freedom and professional autonomy (Mahmood 2001). The dominant principle in this group of medical professionals is the occupational professionalism whereby there is a shared identity which is collegial and a mutually supportive trust between colleagues and patients (Bezes et al. 2012).

The process of 'reprofessionalisation' of the medical elites has replaced their occupational values with organisational ones and increased political control of frontline medical professionals (Harrison & Dowswell 2002). The question of whether or not this control is internally driven or externally driven from the top is still to be determined but Evetts argues that the increasingly market-driven values being adopted point to a more externally driven force (Evetts 2006). In addition, Susan Pickard says a stratification of medical doctors is as a result of a few group of doctors renegotiating boundaries in order to secure their jurisdiction, leading to an elite cadre of staff (Pickard 2009). The acceptance of new rationalisation processes by this elite group of professionals may be of benefit to them while the rank and file group who are subject to these new ways of rationalisation may resist (Pickard 2009). *'Both the accepting of managerial roles and hierarchical accountabilities, and the adoption of evidence-based medicine and other externally validated procedures and processes indicate the degree to which medical professionals have subjected themselves to 'liberal rationalities' (Pickard 2009:255).* Furthermore, the division of labour once controlled by medical professionals in the bureaucracies is now decided by the market-driven rationalisation, because in the NPM era the state decides the shape and size of the medical workforce (Coburn 2014).

There is no doubt the NPM discourse has affected the dynamics in the medical profession. The collective superiority of the medical doctors in the occupational hierarchy is challenged by a hybrid of new clinical managers, who are more aligned to political control and market values than collegial association or professional values. The explanation that supports the argument of an external control as a cause of the re-stratification process has been drawn from observation of health systems such as the US and parts of Western Europe. Even though evidence of this re-stratification in developing countries is poorly understood, the explanations in the various Western country contexts are relatively similar. The general inference is that a homogenous



medical ideology has been altered into two: occupational professionalism shared by rank and file doctors and the organisational professionalism based on managerial principles shared by medical elites. Discretionary medical autonomy once enjoyed by medical professionals is now been governed by evidence-based medicine and prescriptive guidelines; these are created by government agencies run by medical elites. It is important to note that the demand for an academic and research group of medical professionals to create guidelines has increased in recent times. This is as a result of society's demand for more forms of rationalisation in the health sector and also an illustration of how external societal factors control the internal division of labour, once controlled by the profession itself (Coburn 2014). The common collective goal of professionalisation as a homogenous entity has been split into the top elites reclaiming jurisdictional boundaries for themselves while abandoning the lower level rank and file in their attempts to resist external control of its autonomy and authority. Coburn et al believe that this type of NPM external control over medical doctors has eroded medical dominance (Coburn et al. 1997). The 'divide and rule' concept of the NPM through re-stratification of the medical profession has undermined the monopoly, authority and autonomy of medical professionals (Weisz 2006). After a review of the research data in understanding the dynamics of NPM and the changing role of medical professionals, there is a convergence of views about the current status of medical professionals in the Western European context and that is: a heterogeneous profession with less collective autonomy and professional power.

#### **2.7.2.2 Spectrum of management's interaction with medical professionals**

The use of NPM to reduce medical power is dependent on the context in which it is applied (Numerato et al. 2012). For this reason, the deprofessionalisation from NPM can be seen as a spectrum of interactions, from management hegemony to professional

resistance (Waring & Currie 2009). At the one end, managerial hegemony is a situation where the medical doctor's mind is colonised by the managerial ideology, thereby their main identity reflects a managerial one (Numerato et al. 2012). The second is co-optation of management where the forces of management are invisible to the medical doctors (Harrison 2009). In this, there is an acknowledgment by the medical professionals that they need to be guided by management principles within their professional jurisdiction, but are faced with minimal management interference, which is in contrast to the management hegemony. The third is hybrid identities, whereby there is a merging of clinical professional and managerial responsibilities into managerial positions (Kitchener 2000). The fourth is strategic adaptation, and it relates to situations where professionals accept management principles but see management as an external force (Numerato et al. 2012). In this scenario, they still maintain strongly their professional perspective, identity, and culture. They follow the management principles and strategies as a means of safeguarding their job and in the process try to build structures, and barriers that would make them eventually independent of the external forces of management. Lastly, the professional opposition is the outright resistance by medical professionals of the management discourse (Numerato et al. 2012). In this scenario, medical professional recognise the conflicting cultures of traditional clinical discourse and the business-driven discourse of NPM. This results in a struggle for power between these two conflicting cultures.

Conceptualising the spectrum of the impact of management on the deprofessionalisation of medical professionals is important because various resultant interactions are possible. Empirical studies have shown varying levels of interaction management has with medical professionals (Berg et al. 2000; Levay & Waks 2009; Harrison 2009). Some interactions have an aggressive, forceful, and sometimes confrontational interaction such as the management and professional opposition (Wolff & Schlesinger 2002;

Numerato et al. 2012). Other interactions are more subtle conceding some amount of ‘soft autonomy’ to medical professionals while still upholding NPM evaluation principles in clinical practice (Levay & Waks 2009).

### **2.7.3 Summary**

After reviewing the literature on the deprofessionalisation of medical professionals, we are forced to question the impact management has had on medical professional monopoly. The control mechanisms of NPM have gone a long way in bridging the knowledge gap between the patient and the medical doctor, exposing clinical mismanagements and creating an environment whereby efficiency and effectiveness is of primary concern (Weick & Sutcliffe 2003; Light & Levine 1988). In light of these claims, it is appropriate to say NPM has had a positive effect in reducing professional monopoly in order to promote a system that is sensitive to the needs of other non-medical doctor stakeholders.

Despite the importance of regulating professional monopoly, the various forms of interactions can define the outcome in various contexts. For example, management reforms in the NHS by the UK government as regards junior doctors’ contracts has led to professional opposition such as strikes and protests (Stone 2016). In contrast, in the Netherlands, medical professionals manipulated the system in such a way that management guidelines reinforce their professional autonomy (Berg et al. 2000). Similarly, in some instances informal expert networks were created, resulting in some considerable amount of professional power by the medical elites (Numerato et al. 2012). Although, NPM is useful in regulating professional autonomy and monopoly, it is important to understand the context, the possible types of interactions and how NPM is implemented in deciding whether the outcome is desirable or not. In addition, the re-stratification of medical professionals needs to be considered while analysing the

interactions, because the various medical sub-groups are affected differently and react differently to NPM strategies.

On the issue of whether the biomedical/neoliberal discourse has an impact on medical professional monopoly, it is difficult to pick a position because few studies have tried to address them in combination. Although, in theory some claim the NPM uses biomedical discourse to create guidelines that it uses as a tool of external control, thereby leading to a deprofessionalising effect. However, the biomedical discourse on its own puts the medical professional in the centre of the health system and therefore leading to an increase in professional power.

## **2.8 Summary of Section one**

Section one has presented the various theories and concepts concerning the influence of medical professionals in society. Sociological concepts relating to medical professionals have begun to incorporate management and administrative concepts in order to understand the changing roles of medical professionals in society. An understanding of the various models and concepts about medical professionals is very important to this study due to the lack of research in the literature on LMICs medical professionals. Hence, attributes of the different concepts and models can be applied when appropriate in the discussion of the results.

The altruistic argument, even though challenged, cannot be excluded because it is the normative argument used by medical professionals to justify their prestigious role in society and has been the criteria society has used to judge the intentions of medical professionals. The ‘actions’ and ‘power’ approach to studying professional monopoly enlightens us about the advantage of using both approaches. While tracing the history of medical professionals in West Africa, the literature further reinforces the claim that

medical professionalisation is not universal and therefore each context is unique and needs further studies. This reveals some cultural factors, which are influential in placing Nigerian medical professionals in an elite group in society. Finally, the deprofessionalisation theories aid in the exploration of the complex factors that strengthen and weaken the professional monopoly. This is important because it allows us to view professional monopoly as a dynamic multidirectional process, which can be best understood by the exploration of the complex changing social, political, and economic environment of medical professionals. A broad understanding of these concepts enables the researcher to analyse patterns of medical professional influence and the mechanisms involved in the process, which is superior to simplistic descriptive explanations.

The next section reviews the literature concerning GHIs and their interaction with country health systems with a particular focus on HRH. In the process of reviewing the literature, relevant concepts discussed in the above section will be highlighted and studies that have applied such concepts in identifying medical professional influence will also be discussed.

## **Section Two**

### **2.9 Emergence of Private-Public Partnerships and the Global Health Initiatives**

The mid-1980s saw the emergence of the World Bank and the IMF as the leading forces in global health with others such as the World Trade Organisation (WTO), pharmaceutical companies and certain private actors, having an increasing influence (Youde 2012). Moving into the 1990s, a new phenomenon of Private-Public Partnerships (PPP) in global health began, although some argue that this was not a new

phenomenon but instead marked a re-emergence of the inter-war era of private philanthropy by the Rockefeller Foundation and other organisations (Birn & Fee 2013). The most prominent of the private philanthropic foundations was the Bill and Melinda Gates Foundation, which was launched in 2000, with a huge budget of US\$1 billion from Bill and Melinda Gates, and additional funds from Warren Buffet (Youde 2012). Co-operation between the Gates Foundation and other inter-governmental agencies led to the formation of additional partnerships such as the GAVI alliance, which is a partnership between the Gates Foundation, private sector firms, UN agencies, governments and NGOs, with a specific mandate to support the development of new vaccines and to promote vaccine coverage (Youde 2012).

Another key moment was the formation of the Global Fund to fight AIDS, Tuberculosis, and Malaria (henceforth: Global Fund), launched in 2002. The Global Fund is a joint initiative by the G8 and the UN with the aim of drawing up funds from the private and public sectors of donor countries and distributing them among recipient countries for the fight against HIV/AIDS, Tuberculosis (TB), and Malaria (Harman 2011b). Following this, many additional partnerships, networks and organisations sprang up, devoted to various health concerns globally. This proliferation of diverse entities resulted in substantial fragmentation and anarchy at the global and local levels with numerous parallel lines of mostly disease-specific intervention plans (Hill 2011). In realisation that the MDGs would not be met and acknowledging the fact that sustained momentum on progress was elusive, the global actors prompted action. In London a partnership agreement between the G8, UN agencies, GAVI alliance, Global Fund, Gates Foundation, African Development Bank and the UN development group was signed in 2007 in order to help strengthen the health systems of poor countries and to harmonise their activities in health systems strengthening programmes (Buse et al. 2009). This focus led to the International Health Partnership and subsequently the H8

(Health 8). Since then, many of the key global health actors have increasingly focused their attention on strengthening health systems, in addition to their existing programmatic agendas (Rushton & Williams 2011).

### **2.9.1 Global Health Initiatives and National Health Systems**

Despite the recent focus on health systems, GHIs were initially oriented primarily towards specific diseases. As such since 2000, the proliferation of Global Health Initiatives has resulted in large funding into fighting the diseases with the highest burden and the diseases which have attracted the most funding are HIV/AIDS, TB and Malaria (Bernstein et al. 2007). The influx of funding into the national health systems of developing countries through these disease specific initiatives has attracted research into the impact of these GHIs on the country health systems. In 2009, Badara Samb et al researched into the impact of GHIs on national health systems by assessing the programmes of the Global Fund, GAVI, the US President's Emergency Plan for AIDS Relief (PEPFAR), and the World Bank (Multi-Country AIDS Programme-MAP) (Samb et al. 2009). The research reviewed a total of 15 papers published after the call for papers by the WHO to investigate the interaction between GHIs and health systems. Most of the research focused on the WHO six building blocks framework health systems (World Health Organization 2007a). Samb et al criticised the one-dimensional approach of the research studies, saying they focused on biomedical interventions, cost effectiveness, and efficiency, and lacked long-term evaluations of complex interactions that may arise in health systems (Samb et al. 2009). This gap in the understanding of the interaction of GHIs with country health systems has become one of the primary focuses of HSPR and the academic community has become very sensitive towards the mid to long-term consequences of these interfaces.

Evidence from systematic reviews and empirical evidence have also shown that GHIs have fragmented the national health systems they are operating in (Balabanova et al. 2010; Spicer et al. 2010; Warren et al. 2013; Cavalli et al. 2010), hampering decision making in a fragile policy-making structure in the process (Spicer et al. 2010). Studies evaluating the effects of GHIs on health systems have also been seen as biased because many of them used data from evaluations carried out by or on behalf of the initiatives themselves (Biesma et al. 2009). In addition, another systematic review highlighted other problems in the quality of evidence such as small sample size, poorly designed studies, limited number of countries studied and predominantly anecdotal evidence (Oliveira-Cruz et al. 2003). Although, evidence on the impacts of GHIs on national health systems have been mixed, studies to date have acknowledged the limited scope of available data and advocated for more innovative multi-disciplinary research that would explore the complex nature of the health system (Biesma et al. 2009; Spicer et al. 2010; Warren et al. 2013; Bernstein et al. 2007; Samb et al. 2009).

In a study assessing the interaction between GHIs and country health systems in Mali, Cavalli et al report that parallel programmes of GHIs weaken the country health system (Cavalli et al. 2010). They further explained that due to the fragile nature of Mali's health system, although GHI programmes were effective in strengthening parts (such as preventive services) of the health system that were vital for running their programmes, they created extra workload for health facility staff and disrupted curative services (Cavalli et al. 2010). Although the study focused on only one country's health system, it provides empirical evidence that GHIs can have strong and unintended consequences for other aspects of the health system. In addition, because Mali's health system is fragile, there are limitations in the generalisability of the findings to other LMICs with more stable health systems. Based on the growing body of evidence from other studies regarding the consequences of parallel programmes of GHIs, there have been calls for



more empirical studies that would raise awareness of the interactions between GHIs and country health systems (Mills 2005; Hanefeld 2008; Warren et al. 2013).

Spicer et al conducted a multi-country study exploring the effects GHIs had on HIV/AIDS programme coordination mechanisms in eight countries (Spicer et al. 2010). The research focused on coordination structures in different contexts and assessed three GHIs namely: The Global Fund, PEPFAR (President's Emergency Plan for AIDS Relief) and GAVI (Global Vaccine Alliance). The study concluded that GHIs had positive effects on the coordination structures of country systems but also undermined the country's ownership of the coordination structures (Spicer et al. 2010). This research is unique in its focus on a particular component of different health system contexts and its in-depth exploration of one particular topic area. Studies such as this help in building the foundation for further in-depth empirical research, which has been lacking in some of the vague inconclusive research that relied mostly on secondary data. For this reason, this thesis is informed by Spicer et al's study in exploring the effects of GHIs on one particular country health-system actor (medical doctors), which has been identified as a knowledge gap after reviewing the literature.

In summary, we can acknowledge from the reviewed literature that there are positive influences by GHIs on country health systems, but other system-wide consequences do exist. There is inadequate in-depth evidence from existing research that can be used for prospective examination of the effects of GHIs. Research that focuses on a specific subject area can be more informative and helpful in creating opportunities in understanding context specific complexities, which is seen in studies that focus on specific areas such as HRH.

### 2.9.1.1 GHIs and HRH

Most researches that have studied the effects of GHIs on the Human Resource for Health (HRH) component of health systems have focused mainly on production and strengthening, distribution and retention (Samb et al. 2009). A study by Cailhol et al, analysed the HRH strategies of GHIs tracing its effects and policy shifts in five countries (Cailhol et al. 2013). The research concluded that because HRH strengthening strategies were complex, there was a need for implementation of mid to long-term strategies and this was lacking in the HRH policies reviewed (Cailhol et al. 2013). *‘HSS proposals should be scrutinized carefully according to each country’s context and broader factors, since the “one size fits all” strategy has proven its inefficiency and sometimes its counter-effectiveness’* (Cailhol et al. 2013:12). There was recognition of the lack of evidence on the political and social dynamics of strong institutional actors such as health professionals. This supports the call made by Dussault and Dubois for studies that explore the strong professional dominance which pre-exist some of these GHIs (Dussault & Dubois 2003).

Even though it is well recognised that the success of health interventions is reliant on the ability of health professionals to provide these services effectively and efficiently, there is little research in this field (Chen et al. 2004). Dussault reviewed studies that looked at the impact of professional monopolies on the performance of health services delivery in low and middle-income countries (Dussault 2008). The study traced the existence of professional monopolies in post-colonial countries and alluded to the fact that these professional monopolies were inherited from former colonial powers, which have now created an occupational hierarchical system (Dussault 2008). The scale-up of services through delegation of tasks to other staff cadres has been limited by the resistance from these professional monopolies (Dussault 2008). The study discovered

that in contexts where there was little opposition from health professionals in delegation of tasks, the outcomes were usually more favourable than in contexts where there was stronger opposition (Dussault 2008). In contexts where there was more state regulation in health labour markets, there were less policy challenges. The study used a small number of research studies from LMICs due to the lack of research in studying professional monopolies in LMICs. This was seen as a major limitation of the study. Secondly, some of the research examples used were national health policies and not GHIs. This was also because little research exists that focus on professionals' interaction with GHIs. However, we will see in later parts of this Chapter that this might not be a limitation in itself because of the similarities between national health policies and GHI policies.

Human Resources for Health (HRH) in most countries have existing structures in the health system, therefore the influence of these institutional structures and key actors usually exist before the introduction of GHIs into national health systems. Due to the lack of empirical evidence about the interactions of professionals and GHIs, studies that examine the power structures of professional monopolies and how they influence national policies can be helpful in understanding the interactions between professionals and GHIs. An example of this type of research was the comparison between the introduction of enhanced roles for nurses in England and Portugal (Temido & Dussault 2015). In England, the strong position of the government in creating regulation and legislation for a broad role for nurses in the health system, made it difficult for medical doctors to resist its implementation, even though they were opposed to the reform (Temido & Dussault 2015). In contrast, Portugal's Medical Council were in strong opposition to the expansion of nursing roles into tasks such as prescribing medicines and this was a major barrier to the introduction of new nursing roles in Portugal (Temido & Dussault 2015). The research concluded that the understanding of

contextual factors such as powerful stakeholders is important in conceptualising the feasibility of policy implementation. Studies such as these can give prospective information about possible interactions that can occur when GHIs are introduced into the health system. Even though GHIs are different from national reforms, GHIs still interact with the same professional structures that exist in the health system and encounter the same challenges health sector reforms confront.

In the context of Sub-Saharan Africa, Dorothy Mutizwa-Mangiza studied the relationship between medical doctors' autonomy and the state of Zimbabwe. The study carried out key informant interviews of doctors who were in various grades in the Zimbabwean health system, extensive documentary analysis, and non-participant observations (Mutizwa-Mangiza 1999). The research revealed that doctors in Zimbabwe were able to exercise their professional autonomy in opposing government health reforms, in contrast with some Western contexts (Mutizwa-Mangiza 1999). This results are similar to the review carried out by Rigoli and Dussault that identified studies which showed that medical professionals were the major obstacle to health reforms that attempt to use delegation of tasks as a strategy in scaling up health access (Rigoli & Dussault 2003). In both studies, weak government regulation of the health sector labour market created opportunities for medical professionals to exercise their professional autonomy and power for their own benefit. However, Dorothy Mutizwa-Mangiza went further to explain that the influx of GHIs into the health system of Zimbabwe has significantly influenced national health policies and in turn has started to affect medical professional monopolies (Mutizwa-Mangiza 1999). This shows how the global perspective is important even for local professional monopolies.

In a similar Sub-Saharan context, Harrington examined *'the status of medical professionals in Tanzania, in the context of the political and economic developments*

*since independence*' (Harrington 1999:207). The study revealed that medical professionals have held a privileged position in Tanzanian society since colonial rule through independence to the present. The research observed the various tactics used by medical professionals in their efforts to maintain the status quo, which are similar to the professionalisation tactics of Western medical professionals described above in Section one. Finally, the study described how this professional status has been threatened by the introduction of the liberalisation of health markets and structural adjustment reforms by aid agencies and global institutions (Harrington 1999). These externally-induced reforms are similar to policies introduced by GHIs, and they show how GHIs can have an influence on professional autonomy leading to adaptive mechanisms by medical professionals in order to retain the status quo.

From the range of studies cited above, GHIs' policies and national health policies are similar in their ability to influence professional power. Therefore, the use of studies that explore the power relationships between medical professionals and national health policies can improve our understanding of the interactions between GHIs and medical professionals. Policies can affect medical professional power and in the opposite direction, medical professionals can influence the processes that develop these policies. This is seen in a study in Australia that examined the power of medical professionals in the policy process, in order to identify how influence is structured in health policy (Lewis 2006). The research investigated influence using structural analysis to identify influential individuals located in powerful positions throughout the network of the policy process. Medical professional elites were seen to be most influential. *'In short, a medical degree still provides a useful entree into health policy networks, providing personal and positional resources, and ties. If there has been an internal re-stratification within medicine, then doctor-managers seem likely to represent the new breed taking on different roles. Medical expertise is a potent embedded resource*

*throughout this network.*' (Lewis 2006:2134). This research highlights the importance of exploring structural actors rather than professional associations and unions in exploring professional dominance. By using this method, this research was able to refute the claim by a previous study (De Voe & Short 2003) that suggested a decline of medical dominance in Australia's decision-making process. The research approach taken by Lewis, is very significant in the debate about medical dominance for two main reasons (Lewis 2006). Firstly, the research is unique because it identified individuals that were positioned in strategic positions of power and traced their professional backgrounds to an elite medical group, while other studies explored medical professionals as a group. Secondly, the literature has been dominated by deprofessionalisation theories in Western countries but this study highlights the importance of contextual differences in countries, which challenges the generalisation claims of the universal deprofessionalisation theories in various contexts.

In summary, although the interaction of GHIs and HRH in LMICs is poorly understood, the significant amount of evidence from empirical studies indicates that professional monopolies influence both local health policies and GHIs. An appreciation of the empirical evidence to date, points to the fact that professional monopolies can best be understood through a conceptualisation of local contextual realities and power structures. While the factors that underlie these relationships of professional monopoly in LMIC have not been explored extensively, the studies suggest a certain level of power play between national governments and professional power structures and a strong relationship between GHIs and professional power.

Arts and Tatenhove have argued for more use of the concept of power in the study of policy processes (Arts & Tatenhove 2004). Of the various layers of power, they argue that the best description to explain the professional power structures was structural

power: *'structural power refers to orders of signification, legitimisation, and domination, which are 'materialised' in discourses as well as in political, legal and economic institutions of societies. Mediated by these discourses and institutions, (collective) agents give meaning to the social world, consider some acts and thoughts legitimate, and others not, and are enabled or constrained to mobilise resources to achieve certain outcomes in social relationships'* (Arts & Tatenhove 2004:351).

Exploring the power perspective in understanding how medical professionals exercise power was the approach used by Nugus et al (2010). Their study investigated the inter-professional relations in the Australian health sector by evaluating the circumstances in which medical professionals used various forms of power (Nugus et al. 2010). Their findings showed that medical professionals had a dominant power over other health workers but exercised two different forms of power in different circumstances (Nugus et al. 2010). Collaborative power was used when medical doctors encouraged more involvement in patient management from other health workers, displaying their ability to encourage participation, thereby an expression of their leadership role (Nugus et al. 2010). The study highlighted this could be mistaken for a loss of jurisdiction but was actually an expression of their dominating power. The second was through competitive power and this was when they were able to set the tone and language for discussion, and in the process excluded other health occupations from constructive deliberation in sensitive matters (Nugus et al. 2010). The authors stated that viewing medical power through the lens of domination can be mistaken for conflict but by viewing power as diverse and distributed, we can appreciate the negotiated order in which power can be used tactically and strategically by those who possess it (Nugus et al. 2010). According to Arts and Tatenhove, this type of approach is useful in current policy studies (Arts & Tatenhove 2004), and this is the path taken in this study. In connection with GHIs, the

two areas the literature highlights as the dominant discourses used to exercise power are biomedical and neoliberal discourse.

#### **2.9.1.2 Biomedical discourse bias of GHIs**

*'Neoliberalism is largely consistent with the biomedical construction of AIDS, which reduces the AIDS pandemic to its individual clinical and behavioural dimensions.'* (O'Manique, 2004:5)

The significance of discourse is in its power to shape society (Fairclough 1995). Discourse has the ability to create a boundary, which professionals use to exclude other forms of knowledge (Hansen et al. 2002). Discourse is defined *'as any practice by which individuals imbue reality with meaning'*(Ruiz 2009:2), and of the various practices, the verbal discourse is of greatest importance to sociologists (Ruiz 2009). This is because language as a tool of discourse shapes social practice, *'social identities, social relations and systems of knowledge'* (Krause Hansen et al. 2002:110). In the field of health, the biomedical discourse has dominated both national and global knowledge networks (Adam 2011). Ever since the post-colonial era, the biomedical model has underpinned many new global health initiatives and has been embedded in most global health policies (Kay & Williams 2009).

Empirical research has shown that there is a dominance of the biomedical discourse in health policy. Research by Halfmann et al, traced the prominence of biomedical approaches in the health policies for minorities in the USA. The research discovered that in health bills in the US there has been a gradual increase in the number of health bills with an emphasis on the biomedical paradigm such as biomedical research and interventions (Halfmann et al. 2005). The prominence of biomedical dominance in policy increased significantly after 1988, when there were movements for an increase in biomedical research proposals focusing on HIV/AIDS and women's health (Halfmann



et al. 2005). They concluded that biomedical dominance in US health policies has inhibited innovation in tackling racial and ethnic health disparities (Halfmann et al. 2005). Similarly, Harrison and Ahmad researched into medical autonomy and the UK state at the micro, meso and macro level of the health system (Harrison & Ahmad 2000). The biomedical model remains prominent at the macro level of policy making in the UK and this is captured in the concluding remarks from the study: *'However, there is little to suggest that the model of ill-health implied by these organisational developments has made inroads into the biomedical model, and indeed it might be argued that the constitution of PCGs (Primary Care Groups) around doctors reinforces the latter'* (Harrison & Ahmad 2000:135).

As shown in the empirical studies above the power the biomedical discourse has in the health system of Western countries is reflected in the dominant health policy directions. *'What is troubling is the narrow focus of enquiry into disease – itself related to the power of biomedical discourse and the authority granted to physicians in western societies'* (O'Manique 2004:6). Studies have also shown that the biomedical discourse is also very prominent in the global health arena (Meier & Fox 2010). An example of this is seen in the HIV/AIDS campaign by the World Bank, Global Fund and other global health partnerships which has largely focused on biomedical approaches such as extending anti-retroviral treatment (O'Manique 2005). An ethnographic study by Laurier Decoteau explored the normalisation of the biomedical culture in South African communities through the rolling-out of ARVs (Laurier Decoteau 2013). The research identified the importance of ARVs but stated that the narrow focus on ARVs as the main approach to fighting the HIV epidemic has replaced indigenous cultures that view the body as communal with a biomedical paradigm that atomises the body (Laurier Decoteau 2013). The South African government's use of CD4 counts and ARV adherence as tools to judge the eligibility for disability allowance among the citizens,

has instigated a system of biomedical citizenship. Biomedical citizenship instils a system where life choices are tied to the adherence to certain biomedical principles in everyday life in order to access the benefits of citizenship. The process whereby a citizen has to abandon the cultural components of their lives and adopt the disciplinary strings attached to biomedical technologies is referred to in this paper as ‘exclusionary inclusion’ (Laurier Decoteau 2013).

The paper by Laurier Decoteau is an example of empirical studies that have shown how the biomedical discourse can be used as a source of power in society. According to Foucault the effects of power can be seen when the procedures of a given discourse becomes continuous and adapted throughout society, shaping our daily lives (Foucault 1980). The power to influence the way we think about our health choices is the moral authority biomedical science has over individuals and medical experts are the arbitrators of this authority in society (Lupton 1995). In the modern liberal democracies, experts who lay claim to specialised truths have become agents of the governing powers (Miller & Rose 1993:93, in Lupton 1995). This biomedical power flows through knowledge systems and expert networks, which the government uses in the creation of goals for administration (Salskov-iversen et al. 2013).

The health systems strengthening activities of GHIs have been questioned and some studies point to the conclusion that GHI strategies are actually focused on biomedical interventions targeting specific disease entities that end up weakening the health system (Marchal et al. 2009). The six building block framework of the WHO used by most GHIs’ HSS programmes, has been criticised for being a product of pre-existing biomedical discourse in the field of public health (Van Olmen et al. 2012). Reducing a complex health system to six structural components is a mechanical approach, which

creates a universal model of the health system and poorly reflects the local complexities of health systems (Van Olmen et al. 2012).

A call for a paradigm shift from a purely biomedical emphasis in research and policy in global health has surfaced in the academic world of health systems research (Adam & de Savigny 2012). There is an increasing awareness that there is a danger of framing health research and policy agenda from a purely biomedical point of view (Walt & Gilson 1994). In HIV/AIDS research most of the funding is directed towards biomedical HIV prevention and even though social scientist are involved in a multi-disciplinary team, there is rarely any *'in-depth, reflexive social science research on the broader implications of interventions'* (MacQueen 2011:4). Some pre-conceptions have prevailed and made the biomedical model more appealing, further institutionalising it and, making it more attractive for GHIs. One of which is the preconception that a proven biomedical technology exists, while the social science research area in HIV/AIDS is a poorly tested area (Adam 2011). The second preconception is the notion in health research that qualitative research is not as rigorous as quantitative research, and is subject to the researcher's bias. This has led to a relegation of social science research in attracting funds from GHIs and global health actors (MacQueen 2011). These preconceptions are some of the reasons why medical practitioners and researchers are favoured to lead HIV/AIDS interventional research designs (MacQueen 2011).

### **2.9.1.3 Neoliberal NPM foundations of GHIs**

A study in Australia explored the power and influence of medicine and economics in agenda setting in Australia and discovered that professionals with economics training have become the most influential actors in agenda setting (Lewis & Considine 1999). Results from the study showed that economic concerns shaped the health policy agenda. This was attributed to the *'general trends of globalisation and an emphasis on neo-*

*liberal economic impact on the direction of health policy in individual countries'* (Lewis & Considine 1999:393). Similarly, most global actors such as the World Bank and IMF value neoliberal policies and GHIs are similar in this respect. The marketisation of health products as commodities through Quality Adjusted Life Years (QUALY) is an example of how neoliberal principles have begun to guide global health actors in rationalisation of health decisions (Kay & Williams 2009). These values also help in encouraging the use of NPM in achieving cost efficiency and competitiveness (Kay & Williams 2009). Incentives, performance based funding, auditing and accounting parameters used in managing GHIs are some indicators of the influence of NPM in healthcare management in developing countries.

Performance-based funding (PBF) has become one of the major tools GHIs use in their implementation process. The argument made here by GHIs is that PBF motivates innovation from healthcare providers in service provision, as well as being a means of focusing on competence rather than on professional hierarchy (Brown et al. 2013). PBF is an effective quantitative tool global actors can use to keep track of the performance of funded initiatives (Soeters et al. 2006). Consumer voice is also sometimes used an assessment tool in the disbursement of funds in PBF (Soeters et al. 2006). In rolling out programmes, its predicted PBF has the potential to speed up implementation rate and competition among providers (Low-Beer et al. 2007). In the literature there is little evidence of the success of PBF but there has been a widespread adoption of PBF by GHIs (Brown et al. 2013). Some authors have attributed this widespread adoption of PBF to the bias policy makers have for NPM rather than evidence of PBF's efficiency (Ireland et al. 2011). This is seen in the Venice statement on GHIs and health systems which called for stronger commitment to PBF in health programmes, with a claim that PBF would create an incentive for better coordination of disease-related country health investments (Atun et al. 2009). A review in 2013 of GHIs PBF in African countries

informs us that a lot is unknown about the long-term effects and the design and implementation has to be context-specific, which is rarely the case in most GHIs (Meessen et al. 2011). The lack of evidence on PBF's efficiency needs attention and the origins of PBF needs exploring to identify the rationale for its adoption by GHIs (Brown et al. 2013).

*'Task shifting is defined as delegating tasks to existing or new cadres with either less training or narrowly tailored training'* (Fulton et al. 2011:2). Task shifting has become necessary in the scaling up of health programmes in the developing countries due to shortages of medical doctors and nurses (World Health Organization 2007b). The urgency in achieving health targets by tackling the HIV/AIDS pandemic has seen a push by global actors for the adoption of task shifting as an immediate solution to the health worker crisis the Sub-Saharan region is currently experiencing (Callaghan et al. 2010). Framing the health workforce in numerical values is important to show the gaps and shortages but it distracts us from the underlying issues such as external brain drain, high workload, power and trust issues, which are some of the root causes of the problem (Marchal & Kegels 2003; Connell et al. 2007; Chen et al. 2004; Topp et al. 2015). By so doing task shifting becomes a quick fix to an already overburdened health system without addressing the long-term problem (Huang & Berman 2008). Another danger of task shifting is that it focuses on the care of HIV/AIDS patients while neglecting other health services that need attention as well (Huang & Berman 2008), and this causes a fragmentation of healthcare provision in the system. Due to the pressure on health providers and implementers by the funders to achieve their targets, there has been a massive scale-up of informal and formal task shifting in rolling out HIV/AIDS programmes (Oomman et al. 2008; Cailhol et al. 2013). In view of the glaring evidence about the root causes of HRH shortage, the WHO and other researchers have continued to present more evidence about the cost-effectiveness of task-shifting (Long et al. 2011;

Mdege et al. 2013; Buttorff et al. 2012; Oomman et al. 2008). In summary, the focus on incentives and cost-effective quick short-term results over-shadows the long-term system-wide effects of task shifting (Lehmann et al. 2009).

### **2.9.2 Power in relation to the sociology of professions**

This section would draw links between the wider body of literature about power and the sociology of medical professionals, in order to place the theories of the sociology of professionals in the context of global health governance. The word power has been used loosely in normal daily life and in various disciplines, power can mean different things. In relation to the sociology of professions, sociologists who have viewed professionals as wielders of power are said to have used a power approach. Neo-Marxists authors in the field of sociology of professions such as Johnson and Freidson (Johnson 1972; Freidson 2001) who '*focused on the relations between the producer and consumer of professional services*' are said to have used the power approach (Macdonald 1999:4). However, the most prominent power approach author Freidson refrained from using the word 'power' and instead used the word autonomy and how its acquisition leads to dominance over other occupation (Freidson 1988). The second perspective inspired by Foucault, is more concerned with the relationship between knowledge and power, which can be seen in the works of Larson and Macdonald (Larson 1977; Macdonald 1999). In the literature of some of these authors, the Knowledge-Power relationship was not explicitly used or mentioned but there was an implicit argument that professionals through their ideological framework legitimise the power they possess in their body of knowledge (Larson 1977; Macdonald 1999).

Power has various definitions but the definition by Giddens is used in this thesis: '*power is (meant) the ability of individuals or groups to make their own concerns or interests count, even where others resist. Power sometimes involves the direct use of force, but is almost always also accompanied by the development of ideas (ideology)*

*which justify the actions of the powerful.*' (Giddens 1993:54). The concept of power in the sociology of professions has been more focused on the social characteristics of the powerful and the powerless, rather than the forms of power. This is because in the sociology of professions there have been arguments about the relevance of these categorisations to the field, which has seen the popularity of its use drop, with more authors focusing on the social characterisation of professional power in the society (Hall 1988; Rueschemeyer 1986; Macdonald 1999). Hall (1988) says that analyses of professionals is *'more meaningful...to examine the roles and activities of the professions in a wider societal context'*, rather than qualifying the power which was the criticism of the traits approach of functionalists (Hall 1988:274). However, due to the multi-disciplinary approach of this research topic, and in order to directly engage with the field of global health governance, a more explicit concept of power has to be adopted.

Although this research does not aim to extensively explore the concept of power, the policy process, which is central to the case study, makes understanding the power relations involved important. The power debate is a hotly contested one but empirical studies of researchers choose the concept that best relates with the research topic (Arts & Tatenhove 2004). For this reason four forms of power will be linked to the literature on sociology of professions: compulsory power, institutional power, structural power and productive power (Barnett & Duvall 2005). Compulsory power which is closely linked to Dahl's formulation, aids in linking identifiable actors A who have the power to make actor B carry out an action they otherwise would not have done (Dahl 1957). However, the literature of medical professions according to the power approach does not necessarily focus on static or identifiable situations, but comparisons can be made to the division of labour explained by Freidson, whereby medical professionals have the power to delegate duties to other health occupations (Freidson 2001). This can be

interpreted as compulsory power, however, in the context of the sociology of professions, it is rather the power to not allow other occupations carry out duties within the jurisdictional boundaries of medical professionals (Abbott 1988). In any case, the use of this taxonomy is subject to the context in which the medical profession is being studied, as has been stressed throughout the existing literature. For example, if a health institution is completely possessed by the medical profession, as was the case in some post-colonial states, it could be said that the medical professionals can use the institutions as an instrument to shape and constrain other health occupations. However, in some western contexts this may not be the case and in recent times actors have expressed power in more subtle forms rather than the more overt form of compulsory power (Barnett & Duvall 2005).

Productive power '*concerns discourse, the social processes and the systems of knowledge through which meaning is produced, fixed, lived, experienced, and transformed*' (Barnett & Duvall 2005:55). This is very similar to the approach that focuses on the knowledge-power dynamic as the source of medical professional power, adopted from Foucault's theories (Foucault 1981). Conceptualising medical professional power as productive goes beyond analysing structures, it emphasises the focus on social relations and how we understand day to day events of life, solutions to our problems and what we accept as truth (Harvey 1996). Foucault explains this by highlighting the history of the medical knowledge and how it has been able to make the human body an object of human knowledge, thereby medicalising the issues related to the human body, in such a way that society are reconstituted to understand the human body through the biomedical lens. Foucault traces this reconstitution to the modern era, which has led to the dominance of the biomedical discourse that exists in society (Macdonald 1999). Furthermore, the biomedical discourse is the foundation of the medical professional ideology. In relation to professional power, '*those who can*



*develop and monopolise the language and concepts to be used in an area of social life do indeed have power rooted in knowledge*' (Macdonald 1999:179). As pointed out by Freidson, a professional ideology is one of the ways in which the medical profession convinces society of its importance (Freidson 2001) and this ideology is similar to the ideology Giddens refers to in the definition of power: *'Power...is almost always also accompanied by the development of ideas (ideology) which justify the actions of the powerful.'* (Giddens 1993:54).

Productive power, which in relation to medical professional is synonymous with the biomedical discourse, is central to medical professional power because *'analysis of productive power is to focus on how diffuse and contingent social processes produce particular kinds of subjects, fix meanings and categories'* (Barnett & Duvall 2005:57). This explains why health problems are defined in biomedical terms and understanding, while solutions of these problems are conceptualised through the biomedical lens. This biomedical power is not contained in one context but has spread globally. Medical professionals are regarded as biomedical experts, hence positioning them as dominant actors in the framing of health priorities.

However, Foucault understands power as diffuse and not concentrated, and according to him biomedical power can be referred to as bio-power: *'Bio-power refers to the type of power dispersed throughout society that is **productive** in this fashion. It operates through techniques of disciplining, ordering, ranking, making visible and subjecting to knowledge'* (Gaventa 2003:3). This now compels us to conceptualise biomedical power further, by analysing areas in society where this power is reproduced and how it structures society. Therefore, to explore biomedical power further, analysis has to go beyond the domains of the medical profession. Hajer states that this type of discourse *'do not "float" in the world; they can be tied to specific institutions and actors'* (Hajer

1993:46), which is similar to Agrawal's explanations: *'power functions through language, discourses, and institutions'*(Agrawal 1996:470). Hence, institutional and structural power are another important aspects in our understanding of how biomedical power functions in society and how it favours medical professionals.

Institutional and structural powers are easily mistaken and are commonly used interchangeably by authors. As regards to the discussion on discourse *'discourse structuration occurs when a discourse starts to dominate the way a society conceptualises the world'* (Hajer 1993:46). The structural power involved in this type of dominant discourse is similar to that which is highlighted in the literature about professional autonomy and monopoly. *'Structural power shapes the fates and conditions of existence of actors in two critical ways. One, structural positions do not necessarily generate equal social privileges; instead structures allocate differential capacities, and typically differential advantages, to different positions'*(Barnett & Duvall 2005:53). Structural power in the context of medical professionals can be seen to be responsible for the occupational hierarchy that differentiates the privileges of medical professionals and that of other health occupations. This type of differentiation, creates a market closure in the health sector, which limits certain roles and strategic positions to medical professionals and this is captured in the literature that describes professional monopoly. The empirical study by Lewis (2006) is a typical example of how structural power of the biomedical discourse leads to positional power, whereby medical professionals are able to steer the directions of policy making (Lewis 2006). This type of structural positional power is also referred to as dispositional power because it *'fixes agencies (actors) in organizations in terms of meaning, rules, and resources (they prescribe certain positions, roles, and views)* (Arts & Tatenhove 2004:348). By going beyond the focus on actors (which exposes the compulsory power), exploring productive and structural power exposes the hidden power that makes both

the dominant (medical professionals) and the dominated (other health occupations) actors accept and reproduce the biomedical discourse rather resist it (Hajer 1993; Arts & Tatenhove 2004). Occupational hierarchy is central to these forms of power, because this makes actors involved accept their position on the occupational ladder even before they are absorbed into the job market, which is similar to the ‘internalisation’ of roles described by Colin Hay (Hay 2002b) .

*‘A discourse is successful, if many people use it to conceptualise the world, it will (then) solidify into an institution, sometimes as organisational practices, sometimes as traditional ways of reasoning. This process is called discourse institutionalisation’*(Hajer 1993:46). This type of institutional power shapes the direction in which decisions are taken in agenda setting, limiting the options available in problem solving. The sociology of professions points to evidence of institutional power, such as the use of the biomedical discourse in evidence based medicine in the health sector (Bensing 2000; Yamey & Feachem 2011). In the global context, the biomedical paradigm has dominated global institutions such as the WHO (Lee 2015), and this paradigm is established in similar institutions, thereby shaping the choices of both global and local actors (Barnett & Duvall 2005). This is because the system allows for bias, which excludes conflicting agendas, resulting in an unequal distribution of the collective awards (Barnett & Duvall 2005). Unequal distribution of collective awards in the context of professional power is seen in the salary structure, career progression and work privileges enjoyed by medical professionals described by Larson in the sociology of professions (Larson 1977). In other words, institutional power can also be understood as certain actors exercising both structural and productive power through institutions in order to exercise indirect control over others (Barnett & Duvall 2005). *‘Institutional power is actors' control of others in indirect ways...through the rules and procedures that define those institutions, guides, steers, and constrains the actions (or non-actions)*

*and conditions of existence of others.*'(Barnett & Duvall 2005:51). Therefore, institutional power is identifiable through tools such as guidelines and rulebooks used in institutions, which now enables certain actors to exert influence on other actors.

These links between medical professional monopoly and all the forms of power described above helps to explain aspects of medical professional power. However, because of the complexity of the various dimensions of power, we need to go further and link these forms of power by answering questions that explain how discourse (productive power) creates networks (structural power) and how these networks influence institutions (institutional power) (Gaventa 2003). However, this linear description on how biomedical discourse progresses to dominate structures and finally becomes institutionalised can rarely be unpicked in that particular sequence (as described by (Hajer 1993)), because historical contexts are filled with '*networking and discursive formations*' unknown to the researcher (Gaventa 2003:15). Hence, in analysing the power of medical professionals, rather than a linear description, a characterisation of these forms of power, and the processes that aid their diffusion through the various domains is an alternative option.

Kelley Lee (2015) says that in the field of global health, these '*forms of power deserve our concern*' (Lee 2015:258). Lee (2015) goes further to explain by saying that studies that explore these forms of power in the health sector would '*illustrate how the perceived scientific or moral legitimacy held by a few leads to wider acceptance of what should be done in global health policy*' (Lee 2015:258). By acknowledging Lee's (2015) argument, studying the forms of power of medical professionals in the health sector can be a useful case study for global health research and the critical link between the sociology of medical professionals and the global health research.

### **2.9.2.1 The power of the biomedical discourse and Global health governance**

Global Health Governance (GHG) is a term often used by many experts in the field of global health to explain by whom, where and what policies are made and who has the power to influence the process (McCoy et al. 2009). Many authors frequently attempt to define it according to how they view the global health arena (Harman 2011a; Youde 2012; Marten 2016), which has made *'a single definition of global health...contested and elusive'* (Marten 2016:208). However, of importance to this work is the viewpoint that the global health field has seen the emergence of a multitude of institutions such as the Global Fund taking centre stage in the governance of global health, within a complex adaptive network of actors (Hill 2011). Nonetheless, it can be argued that Global Health Governance (GHG) is not the *'creation of a supranational authority with the legitimacy to impose globally binding laws and regulations'* but rather *'it covers a range of formal and informal agreements, principles and understandings that inform acceptable behaviour'* (McInnes et al. 2012:86). This is one of the central reasons for increased attention in the academic field into how priorities are framed in the global health governance arena (Shiffman 2009). This sub-section explores why the framing of the GHG agenda is relevant to the sociology of medical professionals, as well as connections between these two areas of research.

An improved understanding of the various framings of the GHG agenda enables us to explore and uncover where power and authority lay in the global health space and to better understand whose interests are better served or not by the resultant policies and practices. As noted above, forms of power such as institutional power frequently result in the uneven distribution and/or clustering of power to various actors, above and beyond others. In the literature on GHG, the biomedical paradigm has been identified as a major discourse, dominating the way global health issues are shaped and reported (Lee 2009b; McInnes et al. 2012). It has been postulated that this can be traced back to the

dominance of the biomedical paradigm in the treatment of individuals during the pre-world war era, which was then ‘transferred’ to the field of public health and international health and now dominant in the global health field (Lee 2009b). Simply put *‘Global health has its roots in biomedical sciences, building strongly on empirical observation, replicable experiments, and proof of an intervention working’* (Hanefeld 2016:279). Even though there are contesting ideas such as social medicine, nonetheless medical advancements, technology and vast amounts of funding into biomedical research have seen the dominance of the biomedical paradigm increase rather than resulting in a hybridisation of ideas (Lee 2009b). An example of this is the way in which a majority of the global health research funding is directed towards biomedical research (Maclean et al. 2009), and how over the years the framing of evidence based policy making is in most terms a reflection of how well a policy is firmly grounded in Evidence-Based Medicine (EBM) (McInnes et al. 2012). *‘As a result, EBM has become the primary mode of scientific, rational enquiry for contemporary biomedicine and clinical practice and the key frame for the health policy community...language is strategic in that the adoption and use of terms...while simultaneously categorising and condemning other forms of reasoning as inferior’* (McInnes et al. 2012:89). By excluding other forms of discourse, the biomedical discourse has a productive power in the global health field and its ideas are reproduced in both health policy making and health research (Lee 2015).

This is of relevance to global health researchers, because an uneven paradigm balance in the conceptualisation of global health is unhelpful to the growth of global health research, since an overwhelmingly dominant biomedical discourse can lead to the suppression of multi-disciplinary problem solving in global health (Ooms 2014). This power dynamic is important because even though it exists, and is apparent, very rarely are these issues discussed in academic cycles (Ooms 2015), and research remains

limited in this area. Shiffman and other researchers have called for research that would explore the various forms in which this hidden power of discourse is distributed and exercised, in order for us to mitigate against its more disruptive effects (Shiffman 2014; Hanefeld & Walt 2015; Lee 2015; Brown 2015). Shiffman states that *'epistemic and normative (power) invoke both structural and productive power'* (Shiffman 2014:297). According to Shiffman structural power is represented *'in the existence of a cadre of individuals'* (Shiffman 2014:297), similar to occupational hierarchies in the health sector described in the sociology of professions (Freidson 2001). And productive power that *'create concepts for thinking about health priority-setting'* (Shiffman 2014:297), which is similar to monopoly of knowledge by the medical profession (Larson 1977). With the existence of a variety of forms of power in the global health arena (Brown 2015), there is a need to unveil some of the intentions of actors who use these forms of power *'to obtain job security; to acquire resources and prestige for their institutions; to advance national interests; and to profit financially'* (Shiffman 2015:498). The medical profession in various contexts have drawn upon similar forms of power, in order to gain monopoly and dominance over other health occupations, hence the sociology of professions can be used to explore some of what Shiffman (2015) describes.

Current understanding in the GHG literature, indicate that the biomedical discourse is institutionalised into the GHG architecture (Lee 2009a). Therefore, identifying how some of these structural and productive powers of the biomedical discourse in the global context are reproduced through institutions in local contexts adds to our understanding of global health. The discursive monopoly of the biomedical discourse at the global level described by Lee (2015) is similar to the monopoly of knowledge by medical professionals described by Freidson at the local level (Freidson 2001). In a 'glocalising' world (Kickbusch 1999), there is potential in seeking to draw links between the biomedical dominance at the local and global level. Therefore, a deeper understanding

of how and whether global institutions diffuse a dominant biomedical paradigm to the local context is important. And in the process, exploring whether this has an influence on how local actors frame ideas and solutions at the local level or take advantage of this power ‘*to obtain job security*’ and ‘*profit financially*’ (Shiffman 2015:498), will be important to policy and practise. Ooms states that exposing these powers in the field of global health will enable experts declare their normative stance when deliberating global health issues, which in turn may lead to increased accountability and inclusiveness in the field of global health research (Ooms 2015).

### **2.9.2 Summary**

The influence global structures and actors have on national health systems can be understood by observing the interactions of GHIs with components of national health systems. According to the literature, the public-private partnership has become the growing trend in delivery of aid to developing countries; they also create an avenue for international and corporate actors to influence national health system reform. The effects of the interaction between GHIs and national health systems are still poorly understood, largely due to limited data and a lack of adequate research.

A further analysis of the literature points towards two factors that have characterised GHIs, namely; biomedical discourse and New Public Management (drawing on neoliberalism). The biomedical discourse has dominated the health policy approach of most GHIs in the HIV/AIDS field, in the process relegating contrasting paradigms to the background in the global health arena. One of the effects this has is the elevation of biomedical experts above their counterparts in other disciplines and concentrating efforts on cheaper biomedical strategies of ‘test and treat’ rather than on holistic approaches. Neoliberal policies, such as Performance Based Funding, spreading through development agencies ‘*instil a competitive environment and systematically re-configure*



*actors around newer forms of expertise and power centres'* (Kapilashrami & O'Brien 2012:449). Competition encourages implementers to innovate with new strategies of achieving prescriptive and strategic targets. Task shifting is one of the strategies used by implementers in this competitive environment and it has the ability to reconfigure existing health systems. Task shifting also has the ability to change the dynamics of the health workforce and implementers poorly understand the far-reaching systemic effects.

Although it is believed that neoliberal policies reduce professional monopoly, conversely, biomedical discourses re-inforce medical monopoly. In theory, the neoliberal discourse together with the biomedical discourse creates guidelines, which break down the tasks of medical professionals into smaller tasks, thereby limiting the room for professional freedom of autonomy. In reality, the impact these two main discourses in combination have on the medical profession's monopoly is poorly understood in LMIC.

With a changing environment and an influx of new powerful actors such as GHIs, an examination of GHIs' technical and procedural specifications that guide their actions is necessary to comprehend the new role of medical professionals in the changing health systems. Acknowledging the dominant discourses in GHIs helps in identifying areas that can influence the relevance of medical professionals, in addition to exposing the use of forms of power such as epistemic power (ability to shape understanding of a discipline) to achieve self-serving or normative goals. The use of GHIs as a case study in understanding expert groups, key stakeholders and system structures adds value to understanding the global health architecture.

## **2.10 Chapter Summary**

This chapter has offered a review of the literature in understanding medical professionals' interaction with health systems and the factors that affect their role in the

health system both nationally and globally. The first part of this chapter reviewed the existing literature by demonstrating the past and current evolution of medical professionals in both Western countries and Nigeria. By so doing, the literature review has described the various characteristics and qualities, collective behavioural actions, and the source of power and autonomy medical professionals have acquired over the long course of their history. Political, social, and economic factors in society underlie both their rise to prominence or decline in influence in the health sectors. Accordingly, due to the diverse complex factors that differentiate medical professionals in different contexts, the literature identifies the key dimensions leading to medical professional autonomy and dominance, namely; clinical autonomy, economic autonomy, collective self-regulation, and monopoly of demand and supply of health services. As such, the relevance and influence of medical professionals depends on the weakening or strengthening of these dimensions, in relation to the country contexts.

The reviewed literature has highlighted the neoliberal ideology of New Public Management as a key factor that poses a challenge to the autonomy and monopoly of medical professionals in organisational hierarchies. The forces that propagate the NPM discourse have successfully incorporated this ideology into public administration of the health sector in a stated attempt to improve audit and accountability while consequently challenging the professional powers of doctors. However, the literature on Western health systems has shown how medical professionals have re-negotiated their roles in these processes by diversifying into clinical manager roles and monopolising experts groups. A lack of studies in developing countries on how changes in management principles can change the influence of medical professionals in the health system needs to be addressed. A mixture of sociology and management approaches is relevant to study this dynamic and this is one of the conceptual frameworks adopted in this study. This is in agreement with suggestions by Gilson et al (2011), who argued that *'Health*

*policies and systems are complex social and political phenomena, constructed by human action rather than naturally occurring...thus, demands we take steps to build understanding across disciplinary boundaries...and building inter-disciplinary understanding'* (Gilson et al. 2011:6)

Developing countries' health systems have become increasingly susceptible to the influx of GHIs that have transformed the HRH dynamic in the countries. Most research on the interaction of GHIs with HRH of developing countries have focused on the perceived efficiency, effectiveness and scale of HRH, while neglecting the holistic institutional and structural changes in the power relations affecting the health professionals, especially the medical professionals. This study attempts to explore the various potential areas of power and discourses that medical professionals use in an attempt to influence the policy-making process. Hence, this study will explore the dominant discourses in the GHI case study in the international political economy, in addition to highlighting the local (national) outcomes and power interactions that result from the GHI's policy processes.

In summary, the reviewed literature reveals how important an inter-disciplinary approach to understanding the structural and behavioural interaction of medical professionals and health systems, is relevant to health systems and policy research.

## **Chapter 3**

### **Methodology and Methods**

#### **3.1 Introduction**

This chapter presents the study design that was selected to best address the research questions. This chapter first re-introduces the research question and sub-questions of the thesis. This is followed by a general introduction to the emerging field of Health Policy and Systems Research (HPSR). This will involve a review of the various debates about the use of HPSR in the field of public health and the rationale for adopting this approach in this study design. Lastly, this chapter will review the methods used for data collection and analysis that were best suited to answer the research questions.

An explanation of how the research was carried out, including a description of how a pilot study was used to inform the sampling technique and interview guide is presented in this chapter. Similarly, this will include the methods used in data collection and the various adjustments made in the field in order to counter the challenges faced. In addition to this is a description of how ethical approval was acquired and how the data was managed and analysed to arrive at the results of the study. Finally the efforts made to mitigate the limitations of the study methodology by the use of my positionality will be discussed.

#### **3.2 Restating the research questions**

The study was a HPSR study, which looked into health policy in the context of Nigeria and explored how local actors such as health professionals develop and implement health-related proposals. A qualitative methodology was used involving key informant

interviews, board-meeting observations, and document analysis. The main research question is:

*How do interactions between medical professionals and Global Health Initiatives influence the Nigerian health system?*

The project used a case study approach, analysing the health system through the lens of one specific policy. The research question has three components that classifies it as a Health Policy and Systems study: policy (Global Health Initiative), system (Nigerian health system), and actor interaction (medical professionals). In order to answer the main research question the following specific questions were explored:

- Who are the key actors in the Global Fund grant policy process and how do they interact with each other?
- What, and in which ways do medical professionals contribute to the Global Fund grant policy development process?
- What roles do medical professionals play in implementing the Global Fund grant policy?
- Do the technical specifications and institutional procedures influence the opportunities medical professionals have in participating, constructing proposals, and implementation of the Global Fund grant?
- Do these interactions contribute to any outcomes in the Nigerian health system?

### **3.3 Epistemological position**

It is pertinent at this point to clarify the epistemological standpoint of the researcher because this affects the methodology adopted in this thesis. According to Rubin and

Rubin 2012, there are two main dominant research paradigms; the positivist and social constructionist paradigms (Rubin & Rubin 2012).

Constructionism *'emphasises that knowledge is actively "constructed" by human beings, rather than being passively received by them'* (Ritchie et al. 2014:13). Research based on the social constructionist paradigm challenges the idea of *'fixed universalistic'* realities and seeks to supplant them, with more *'fluid particularistic'* variants of our perceived reality (Holstein & Gubrium 2013:14). Social constructionists challenge the way we think about observed events by raising our awareness (Hacking 1999), not as an attempt to present universal truths but to improve our understanding of the various interactions surrounding us (Holstein & Gubrium 2013). In essence, the goal of most social constructionists' research is to seek to understand how *'social experience is created and given meaning'* (Denzin & Lincoln 2011:8).

Positivists attempt to identify causes that influence resultant effects, thereby reducing these into small discrete concepts, on the basis of which hypotheses are developed and tested (Creswell 2008). The positivist paradigm, which is more often than not synonymous with quantitative lines of enquiry, *'processes meanings that are measured in quantities, amount, intensity, or frequency'* (Denzin & Lincoln 2011:8). The orientation of positivism is based on theory-testing through quantitative methods, but this is ill-suited to research that seeks to investigate poorly understood contexts. The deductive nature of quantitative research will not aid the aim of creating theories about the social context (Bryman 2012), which is central to this topic.

**Table 1: Key elements of knowledge paradigms as applied in HPSR (Gilson, 2012)**

| Knowledge paradigm                                      | ←----->  |   |   |
|---|--|---|---|
|   | Positivism   | Critical Realism  | Relativism<br>(interpretivism /<br>social constructionism)  |
| Types of questions addressed                            | Is the policy or intervention (cost)-effective?  | What works for whom under which conditions?   | How do actors experience and understand different types of interventions or policies?<br><br>What are the social processes, including power relations, influencing actors' understandings and experiences?                                |
| Related disciplinary perspectives                       | Epidemiology<br>Welfare economics<br>Political science<br>(rational choice theory)   | Policy analysis<br>Organizational studies   | Anthropology<br>Sociology<br>Political science<br>(sociological institutionalism)   |
| Key research approaches and methods                     | Deductive: Hypothesis driven<br>Measurement through surveys, use of archival and other data records<br>Statistical analysis<br>Qualitative data collected through, for example, semi-structured interviews and interviewing procedures | Deductive and inductive (theory testing and building)<br>Multiple data collection methods including review of documents, range of interviewing methods, observation | Inductive<br>(maybe theory building and/or testing)<br><br>Multiple data collection methods including in-depth interviewing (individuals and groups), documentary review but also participant observation or life histories, for example. |
| HPSR articles that illustrate the paradigm (see Part 4) | Björkman & Svensson, 2009  | Marchal, Dedzo & Kegels, 2010   | Riewpaiboon et al., 2005<br>Shiffman, 2009<br>Sheikh & Porter, 2010   |

Critical realism is another perspective in the HPSR knowledge paradigm spectrum, highlighted in Table 1 above. Unlike positivists, critical realists ‘*seek to explain change by referring to the actors who change a situation under influence of particular external events (such as an intervention) and under specific conditions*’ (Marchal et al. 2010:2). In addition, critical realists believe that in-between cause and effect there are a myriad of influential factors including actors and contexts, which help explain social phenomena (Gilson 2012). For example, in exploring complex social systems in the workplace, critical realism is appropriate ‘*because it is an “empirically grounded” explanation of a social phenomenon that is couched in terms of structures and mechanisms that are reproduced overtime, where that reproduction is itself explained*’

(Hodgson 2004:62). A study by Hood to understand inter-professional working in schools stated '*A broadly functional way of managing complexity envisages a type of inter-professional practice characterized by coordination and information sharing, an arrangement between agencies and practitioners to agree on "clear goals" and responsibilities, on "open and honest" communication, and so on. Yet setting up an "expert system" can only increase complexity...Complexity means that the dynamics will change on a case-by-case basis, requiring a kind of reflexive adaptability*' (Hood 2012:10).

Interactions between actors and agencies in a health system are fundamentally responsible for the various social phenomena that exist in that context (Shiffman 2009). Health Policy and Systems Research has within it three distinct paradigms (**Table 1**) and the epistemological standpoint of this thesis is that of critical realism (Gilson 2012). Critical realism is in-between positivism and social construction. A social constructionist believes that reality is actually constructed through social interactions between people (Shiffman 2009). Shiffman (2009) suggests that social constructionists '*argue that what human beings call 'reality' is not something objectively "out there" waiting to be discovered but is constructed through social interactions*' (Shiffman 2009:609). Social constructionists see these ideas/realities as constituted by actors (Gilson 2012). Unlike the social constructionists, the critical realist believes there are things (intransitive objects) in the world which exist regardless of the activity of actors (Zachariadis et al. 2013; Hood 2012). Critical realism argues that reality comprises distinct levels: '*the empirical domain that is made up of what we experience through our senses, the actual domain that exists regardless of whether or not it is observed, and the real domain that refers to underlying processes and mechanisms*' (Ritchie et al. 2014:5).



The critical realist has the ability to test hypotheses and to build theory, not being confined to either end of the paradigm spectrum. An important aspect of the critical realist standpoint is that *'critical realism is a specific form of realism whose manifesto is to recognise the reality of the natural order and the events and discourses of the social world and holds that we will only be able to understand - and so change - the social world if we identify the structures at work that generate those events and discourses'* (Bryman, 2012:29). The acknowledgement that our knowledge about reality is not faultless and that there is a need for repeated examination of reality to improve our understanding is the basis for the critical realist paradigm. In addition, critical realism allows for a mixture of methods and approaches, both qualitative and quantitative.

Being a critical realist allows the researcher to go beyond appreciating the valid arguments of the positivist and social constructionist, and argues that *'real structures exist independently of and are often out of phase with the actual patterns of events'* (Bhaskar 1978:13). *'In the social world, the dimension of human agency greatly increases the complexity of interactions and the difficulty of formulating causal explanations'* (Hood 2012:7). Due to the multiplicity of causal mechanisms in open systems, critical realism enables the researcher to have the flexibility of using our knowledge on transitive structures (from an empirical realist perspective) and intransitive structures (from a transcendental idealist perspective) to build on our understanding of existing events and phenomena (Collier 1994).

Finally, the personal construction of reality by both researcher and research participants, demands a great concentration upon details and an exploration of the contexts in order to reveal a sound understanding of the research topic. Hence, the positionality of the

researcher and the relationship of the participant to the data are very important in exploring this research topic and this theme will be looked at later in this chapter.

### **3.4 The field of health policy and systems research**

Researchers who seek to explain how global actors and local agencies have influence on the health systems of LMICs have drawn on HPSR as the preferred research approach towards understanding how policies are developed and implemented (Gilson 2012; Sheikh et al. 2011). In addition, the influence that global and local actors have on each other can be explored within this perspective (Bennett et al. 2011). HPSR covers four key areas: health policy, health systems, health policy analysis and health systems strengthening (Gilson 2012). These overlapping areas are critical to the understanding of how actors and interests drive policy that affects implementation processes in complex health systems of LMICs.

Complex causality is critical to understanding HPSR. Health systems are a result of multiple interacting actors and structures that have different layers of networks (de Savigny & Adam 2009). Due to the continuous interaction between different networks embedded in the health system, the double reflexivity of these networks means *'interventions and policies often do not generate the same impacts over time and in different places'* (Gilson, 2012:36). This unique nature of unpredictable causality in health systems is what encourages the use of various theories and paradigms in HPSR (Sheikh et al. 2011).

Some authors argue that due to the dynamic interplay between the visible 'hardware' components (such as the human resources and finance) and the 'software' components (such as interests, power and relationships), HPSR needs to use a balance of methodologies from diverse disciplinary backgrounds, in order to avoid any disciplinary

capture from the dominant biomedical positivist paradigm (Mills 2012; Bennett et al. 2011; Sheikh et al. 2011). As a result, HPSR draws from a broad spectrum of research paradigms, ranging from the positivist approach to a relativist approach (Gilson et al. 2011). According to Marchal et al (2012), there is a growing use of the critical realist paradigm to guide the methodology of theory-driven health systems research (Marchal et al. 2012). As already indicated, this is the approach adopted in this thesis.

Three distinct levels of analysis are relevant in HPSR, namely; macro, meso and micro (Table 2). This study explored how policies were developed and implemented through the interaction of various actors, especially medical professionals. Another aspect explored was the influence medical professionals had on policies at the grassroots level. The component that dealt with how policies were developed was a meso level analysis, while the component that analysed how medical professionals influence policies at the grassroots' level was a micro level analysis. Although touching on aspects of the 'macro' level, a full 'macro' level analysis is beyond the scope of the current PhD project because of time constraints and the fact that the study question specifically looks at the local level of policy processes. The limitation of excluding the macro level analysis is that global events which directly affect the local policy making process were not fully explored. The advantage of focusing on the meso and micro level analysis is the feasibility of more in-depth explanation of local events in the policy making process. These points will be discussed again in the final chapter of the thesis.

**Table 2 : Showing the different levels of analysis in Health Policy and Systems Research (HPSR) (Gilson 2012).**

| <b>Level of analysis</b>            | <b>MACRO<br/>Architecture and Oversight of Systems</b>   | <b>MESO<br/>Functioning of Organisations and Interventions</b>   | <b>MICRO<br/>The Individual in the System</b>   |
|-------------------------------------|--|--|---|
| <b>Normative/<br/>Evaluative</b>    | <ul style="list-style-type: none"> <li>- How can political parties be effectively involved in a country's health planning process for universal health coverage?</li> <li>- Does a new funding mechanism protect the poorest households from the catastrophic costs of accessing care?</li> <li>- Can community accountability mechanisms have impact on health outcomes?</li> </ul> | <ul style="list-style-type: none"> <li>- How access to and uptake of a screening and treatment programme for an epidemic condition be maximised?</li> <li>- What are the reasons for the efficiency of community governance structures in administering a decentralised fund scheme?</li> </ul>  | <ul style="list-style-type: none"> <li>- What financial and non-financial incentives will best encourage health workers to locate in underserved communities?</li> <li>- Does individual coaching offer better support to health system managers than formal training?</li> <li>- Do conditional cash transfers encourage individual behaviour change in use of health care?</li> </ul> |
| <b>Exploratory/<br/>Explanatory</b> | <ul style="list-style-type: none"> <li>- Why do informal health markets continue to flourish in areas where publicly provided services are adequate?</li> <li>- What norms underpin the effective exercise of oversight by communities?</li> </ul>   | <ul style="list-style-type: none"> <li>- How do pay for performance arrangements interact with local accountability structures?</li> <li>- Who do organisations involved in the implementation of health policies prioritise some aspects of their mandate more than other?</li> <li>- How has the introduction of subsidies for institutional deliveries changed household birthing practices?</li> </ul> | <ul style="list-style-type: none"> <li>- Why do frontline health providers frequently diverge from recommended clinical guidelines?</li> <li>- How has engaging traditional practitioners in government clinics changed laypersons' perceptions of public service?</li> </ul>   |

Although Health Service Research and HPSR may seem similar, the former is mostly concerned with research about the organisation and culture of those who provide care

(Pope & Mays 1995). Its starting position is the service delivery function of the health system (Gilson 2012) and it is mostly used to evaluate service delivery in developed nations. In contrast, HPSR focuses on the components of the health system (or building blocks, as proposed by the WHO; governance, finance, information, service delivery, human resources, medicines, and technology (World Health Organization 2007a)) that interact to produce health outputs and outcomes. In this research, the starting point was the examination of one of the components of the health system, which was the human resource component, in order to explore in particular how medical professionals influence policy process.

### **3.5 Theoretical and conceptual framework**

Authors who adopt critical realism have reasoned that *'once phenomena are recognised they can then be thoroughly examined, theories may then be generated and empirically tested, and the researcher can delve deeper into structures of social reality to ensure that a comprehensive picture emerges'* (Wilson & McCormack 2006:49). This theory-driven approach is increasingly being used in HPSR (Marchal et al. 2012). This study seeks to appraise and to apply in the Nigerian context certain theories that were originally developed in various Western contexts. This will be achieved by using the theories explored in the literature review (despite the theories having been developed within other contexts) to analyse the processes involved in the interactions of medical professionals and GHIs. In Chapter Two, the following theories were reviewed: professionalisation theory (market closure theories) (Larson 1977; Freidson 2001; Berlant 1975), and deprofessionalisation theory (Haug 1975; Oppenheimer 1972). These conceptualisations themselves are informed by the two main theories of Foucault on knowledge and power (Foucault 1981) and Max Weber's theory of social stratification (Weber 1922). The relationship of these theories and my critical realist

standpoint stems from the realisation that health systems are open systems and a constant conjunction of events is inevitable, therefore the application of multiple disciplinary perspective is necessary. This section will highlight the prominent theories explored through this critical realist lens, because the process of theory testing and building is inherent in critical realism.

The theory of professionalisation discusses the processes involved in the rise of some occupations up the social hierarchy of class, status, and power. Most of the literature on these professionalisation theories focuses on medical professionals because they have been the most successful in attaining and maintaining their professional status. The interlocking of social structures and social actors in the professionalisation process of medical professionals is attributed to the collective action of the professional group as a whole (Larson 1977). In describing this theory, scholars have used the Weberian theory of social mobility and social stratification to place professionalisation in the wider literature of the sociology discipline (Macdonald 1999). Explanations of market closure theories are part of the broad theoretical framework of this thesis that seeks to identify proponents and counter forces that influence medical professionals in the context of the Nigerian health system.

In addition to the professionalisation theory, the deprofessionalisation theory of medical professionals will be explored through focusing on the interaction of NPM initiatives and medical professionals. In the literature, the deprofessionalisation of medical professionals has been linked strongly to NPM in Western contexts. In contrast, this interaction in developing country contexts is poorly understood. Even though formal rationalisation is spreading globally, the degree to which it affects medical professionals in different contexts varies. *'The basic issue is the degree to which rationalisation is instituted and the form that rationalisation takes, not the mere fact of rationalisation'*

(Friedson 1985:20). Therefore, it is very important to explore this poorly understood dynamic of medical professional influence and decline in the context of the Nigerian health system.

To be able to theoretically explore intentions and how actors organise and adapt themselves in policy spaces, an understanding of the dominant discourse is central. The exercise of power and moral claims about knowledge are closely linked (Shiffman 2014), therefore viewing actions and inactions through the theoretical lens of dominant discourses helps in highlighting the sources of normative and epistemic power: *'far from being in opposition, improving health requires exerting epistemic and normative power, particularly to expand service access and to alter social structures that lead to illness and death. Many in the global AIDS movement operate from just such a premise.'* (Shiffman, 2014:298). Thus the aim in this study I was able to situate the Nigerian example in the broader global health context, by identifying the dominant discourse that shaped and informed specific actions.

### **3.6 Study design**

#### **3.6.1 Rationale for study design**

When developing and selecting an appropriate study design the incorporation of existing literature and theory is central to understanding how the research may be carried out (Ritchie et al. 2014). The literature review ensured that the research question was relevant and had the potential to add to existing knowledge. *'That once a researcher has decided what he/she is interested in studying (i.e. motives, purpose, personal agenda), the specifics of his/her research question will determine the choice of the best tools to use and how to use them'* (Denzin & Lincoln 2011:288). The starting point of the research question developed from my personal interest in studying issues surrounding HRH in the health system. This is because all throughout my medical

training and medical practise in Nigeria, poor staffing levels have always been a critical problem in the rural hospitals and this uneven distribution of health workers in rural and urban cities has been of interest to me. Stakeholders in the health system have attributed this to poor investment from the government, while the government has continued to make improving salaries and remunerations of health workers a health sector priority and currently the government spends 85 per cent of the health budget on salaries and remunerations (The Budget Office of Federation 2016). Despite these efforts by the government, the HRH crisis has still not improved (National Population Commission 2013; CCM Nigeria 2015b) and this has led to my renewed HRH interest, and in particular issues and processes surrounding professionalization of healthcare workers.

While reviewing the literature on HRH, I realised that health professionals are best understood when their various group dynamics are explored in detail rather than focusing on general explanations. Due to the iterative process of studying the literature on HRH and modifying and refocusing the research question, key concepts emerged, such as, professional monopoly and Alford's theory on dominant interests (Freidson 2001; Alford 1975), which sensitised me to study medical professionals in particular. The literature review further revealed the gaps in terms of understanding the current position of medical professionals in LMIC health systems. Focusing solely on medical professionals enabled me to explore medical professionals in more depth rather than focusing on all health professionals in general, and I selected this depth of research over breadth. However, it might have been very useful to study medical professionals alongside other health staff, but for practical reasons (PhD time and resources), this was out of the scope of the current research. As a first step, it was more realistic, and indeed more interesting and useful, to concentrate in depth on medical professionals. The gap in the literature about medical professionals in LMICs and my background as a Nigerian medic aided in narrowing down the professional group and context setting.



My experience on how medical professionals are able to dictate and influence the process of policy making in the Nigerian health system was of personal interest to me because of my medical background and experience in being in such a privileged position. As a junior medical professional in a subordinate role, I observed that medical professionals always made all the decisions. Later, after my brief period as a medical professional in the Nigerian public service ended, I was able to observe the decision making as an outsider while being an MPH student in the UK and then as a PhD student, co-supervised by UK and Nigerian academics. Through my prior connections with the Nigerian public sector, I was able to observe policy-making processes most specifically in institutions I formerly practised through informal discussions with former colleagues. As a practising doctor in the UK, I was able to see different aspects of medical expertise and medical power, in contrasting contexts. My personal experience and the gaps in the literature about medical monopoly in LMIC health systems helped shape my research question.

Furthermore, studies from Lewis (2006) and others explored medical professional monopoly in policymaking processes and these studies showed that medical professional monopoly has an influence on the policymaking processes. My brief experience in the Nigerian health sector and the gap in the literature in LMIC contexts influenced my decision to understand Nigerian medical professionals in the health policymaking process. Furthermore, policymaking in LMICs is a relevant topic in HPSR, with numerous researchers using case studies of a single health initiative in exploring this type of health system topic (Walt et al. 2008). The choice of the Global Fund as a case study for the research question was informed by my review of existing health initiatives best suited for the research question. The open platform and multi-stakeholder process of the policy making process of the Global Fund (S. L. Dalglish et al. 2015; Brown 2009) made it the most favourable case study to explore the research

question. This is because it is easier to gain access to the Global Fund policymaking process in the Nigerian context than other GHIs' policy processes. Secondly, the Global Fund encourages an open deliberative multi-stakeholder participation in the policy process that seeks to encourage stakeholders to set the agenda according to country priorities. Because of this policy-making design, it enables researchers to observe how stakeholders interact (most especially medical professionals) during deliberative processes and how strategies and policies evolve over time through these interactions.

Literature about how the Global Fund operates was explored and the proposal writing process was identified as the appropriate policy process to be examined. Understanding the theories about the spaces in which interactions in the health system can be explored (Gilson 2012) and the existing knowledge about the structure of the Global Fund in Nigeria led to the mapping of the study design within the meso and micro level. Identifying the specific institutional site, the CCM, was critical in designing the case study because *'we locate the interaction of actors in specific institutional 'sites' or arenas where ideas are expressed, strategies played out, 'decisions' made and power games fought out. Through involvement in such episodes, people learn the discourses, practices, and values embedded in established governance processes'* (González & Healey 2005:2061).

The academic literature on how the Global Fund operates (Dräger et al. 2006; Brown 2009) revealed how the CCM in Nigeria would be an appropriate case to investigate the phenomena in the research question. However, *'Policy decisions often have their roots in longer term processes and the choice of time frames for research is an important factor. Temporal issues thus also affect research design'* (Walt et al. 2008:312). For this reason, a cautious effort was made to identify the correct time for data collection (Jan-

Jun 2014), the unit of study (CCM) and the location of the unit of study (Abuja). By understanding the level of complexity of the CCM policymaking process, it became obvious that the case study design would benefit from the integration of various perspectives through multiple qualitative data sources and triangulation of the data sources. The lack of existing research about the Global Fund or CCM in Nigeria informed the choice of a qualitative methodology in order to generate original themes particular to the Nigerian setting. Before the field visit, the unit of study in the case was thoroughly researched in-order to know the composition of the participants, key stakeholders and the activities of the CCM that would be explored. Details of the stages of the policy process that were explored are explained in the section below, with a specific aim of only focusing on the meso and micro level activities.

A qualitative methodology was suitable here because there has been little research done around the research question, therefore there is a need to identify and refine potential themes of interest (Silverman 2009). In addition, as noted earlier, when dealing with identifying human experience and subjectivity some stories can be missed by quantitative questions; therefore a qualitative approach best suits the aims and objectives of this study (Silverman 2009). Furthermore, another argument for using a qualitative method in this thesis is because it allows the researcher to explore complex human behaviours and interactions in understanding social phenomena in natural settings (Pope & Mays 1995).

### **3.6.1 The case study design**

The case study design was used in this thesis because it allowed for an in-depth investigation of processes and interactions in one specific policy context. Yin (Yin 2003) says the case study *'allows investigators to retain the holistic and meaningful characteristics of real-life events- such as....organisational and managerial processes,*

*international relations and the maturation of industries*' (Yin 2003:2). Case studies used in HPSR are usually aimed at trying to answer research questions that are formed from a critical realist perspective, either for explanatory, descriptive or exploratory purposes (Gilson 2012).

A critical point in starting a case study is the selection of the research strategy and the decision as to whether the research question selected would be explanatory, descriptive, or exploratory.

a. Research

*How do interactions between medical professionals and Global Health Initiatives influence the Nigerian health system?*

The framing of the research question makes the case study explanatory in nature. Yin (2003) stated that 'how' and 'why' questions are explanatory in nature and are asked about an existing set of events, over which the researcher has little or no power (Yin 2003).

The next step outlined by Yin (Yin 2003) is the highlighting of areas within the scope of the research that would be illuminated by the case study. These are called the propositions or objectives and they reflect areas where I look for evidence to answer the study question (Yin 2003).

b. Sub-questions

- Who are the key actors in the Global Fund grant policy process and how do they interact with each other?

Most policy processes involve actors in the form of institutions, organisations, or professional groups and how they interact with each other is vital to the outcome of these policy processes. The Global Fund

policy process in Nigeria as a case study helps in highlighting some of these hidden or informal processes not represented in policy documents. The case study shows how these actors influence policy formulation and implementation in a typical health initiative in Nigeria's health system. The purpose of this objective was to move attention from focusing on structural explanations of organisations (who are stakeholders) involved in the health systems, towards a more actor-focused analysis (Long 2001). Norman Long (2001) argues that active participants through their capacity to act can have strategies in their dealings with both local and global actors (Long 2001) leading to a structural policy change.

- What, and in which ways do medical professionals contribute to the Global Fund grant policy development process?

The positions and viewpoints that crucial players such as medical professionals take on policy matters is a major factor in the success or failure of programmes and initiatives (Walt 1996). To be able to theorise the interaction of medical professionals with GHIs in the context of Nigeria, an in-depth examination of the policy process was needed to develop an understanding of the role they play in the Global Fund policy process.

- What roles do medical professionals play in implementing the Global Fund grant policy?

In LMICs, few studies examine the ways in which medical professionals act and how power is distributed in the health policy implementation processes (Koon & Mayhew 2013). This study seeks to address this gap by looking at implementation at the local level (healthcare services level),

while exploring the various roles and forms of influence the medical doctors have in the implementation process.

- Do the technical specifications and institutional procedures influence the opportunities medical professionals have in participating, construction of proposals, and implementation of the Global Fund grant?

At the level of priority setting in GHIs, there has been a paradigm shift towards multidisciplinary collaboration with an aim to include more socio-economic perspectives. This study will examine how this paradigm shift applies on the ground in Nigeria and whether institutional procedures influence the inclusion or exclusion of any particular professional group.

- Do these interactions contribute to any outcomes in the Nigerian health system?

This study focuses on the interactions between medical professionals and the Global Fund grant, with the aim of using a critical realist lens in understanding the content-mechanism-outcome configuration of the case study. This sub-question will examine whether there are any resultant outcomes or consequences caused by these interactions for the Nigerian Health system.

It is important to explain the direction and temporal issue regarding the study. This study was retrospective and this is in line with policy analysis that focuses on present-day policy. Gill Walt (Walt et al. 2008) recommends the retrospective approach for studies that look at policy analysis, while using prospective studies for policy evaluations.

#### c. Unit of study

Defining the case is a fundamental aspect to the case study and a case can be an individual, event, programme, implementation process or organisation (Yin 2003). In this study, the case was the proposal writing process and the policy implementation process of a specific GHI. This allowed for the investigation of the actions of the various agencies involved. In addition, it allowed for the exploration of the different engagements medical professionals have at all levels of the implementation process.

Furthermore, the other criterion for selecting the case was because the Global Fund policy process is open to all stakeholders within the health system. Therefore, researching this policy space created by the Global Fund helps to produce explanations to the interaction of medical professionals with other professional disciplines in both private and public sectors.

Other GHIs in Nigeria such as the PEPFAR, Global Fund, GAVI, and World Bank were considered. The Global Fund initiative was chosen because it is the initiative known to give actors and agencies control over the programme development from the proposal phase of decision-making through to implementation. Therefore, this open participation created opportunities to analyse the behaviours of individual groups, most especially the medical professionals. Other GHIs only allow for involvement of partners and individual group actors' participation at the implementation phase.

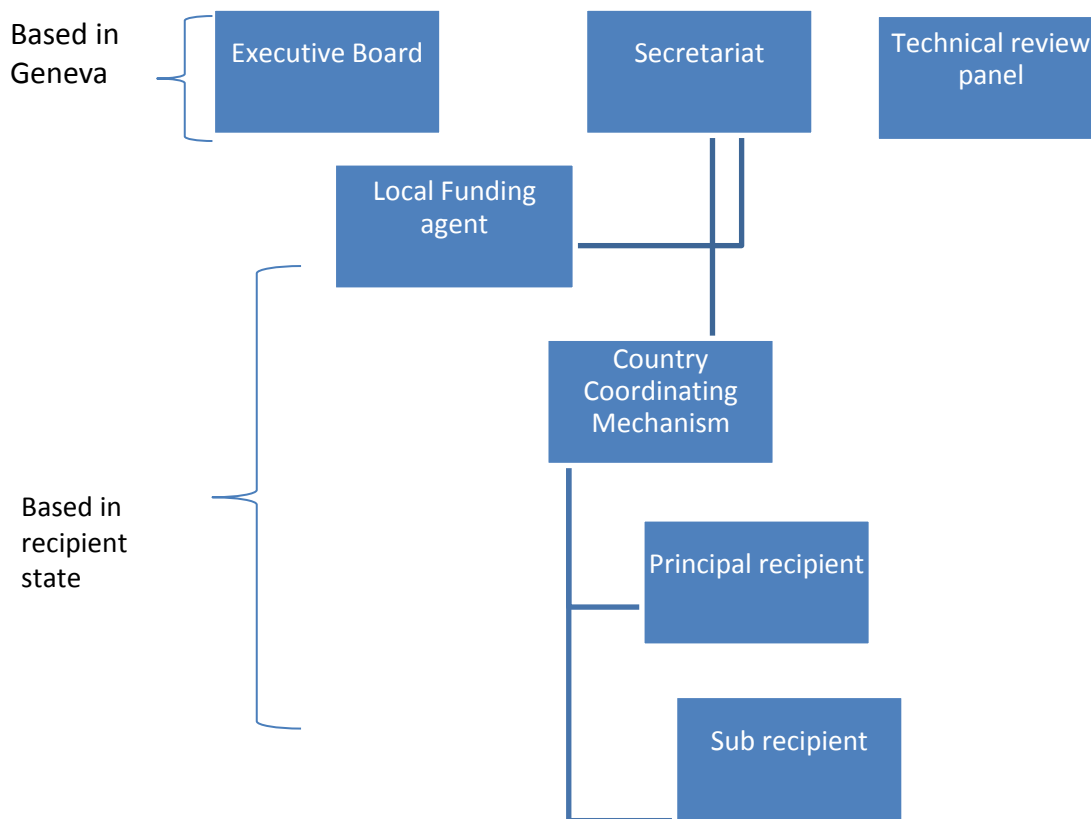
The Global Fund has three active grant programmes but in 2010 it started to merged the HIV/AIDS and TB components in what it called a consolidated grant (Mccoy et al. 2012; Pullen & Garmaise 2014; Global Fund 2015d). Previously these three components were different with independent grant application processes and Principal recipients (PRs). The Malaria component is still independent of the HIV/AIDS and the Tuberculosis components. These

programmes only overlap at the point of implementation in the PHCs. In previous grants, the HIV/AIDS component had the largest coverage and funds, while the Malaria and Tuberculosis component covered only a few areas in the country. With the merging of the HIV/AIDS and TB grant, the new consolidated grant is now the largest Global Fund grant in Nigeria.

For the reasons outlined above, the unit of analysis in the study was the Global Fund Consolidated HIV/AIDS/TB grant of the Country Co-ordinating Mechanism (CCM) (**Figure 2**). CCMs are central to the Global Fund's commitment to local ownership and participatory decision-making. This country-level multi-stakeholder partnership develops and submits grant proposals to the Global Fund based on priority needs at the national level. After grant approval, they oversee progress during implementation (CCM Nigeria 2015a). CCMs include representatives from both the public and private sectors, including governments, multilateral or bilateral agencies, non-governmental organizations, academic institutions, private businesses and people living with the diseases (CCM Nigeria 2015a). Previously, the CCM of the recipient country applied for grants in what was called a 'Rounds Based Funding' and in 2013, the Global Fund changed it to an ongoing rolling consolidated grant, in what is called the 'New Funding Model'.



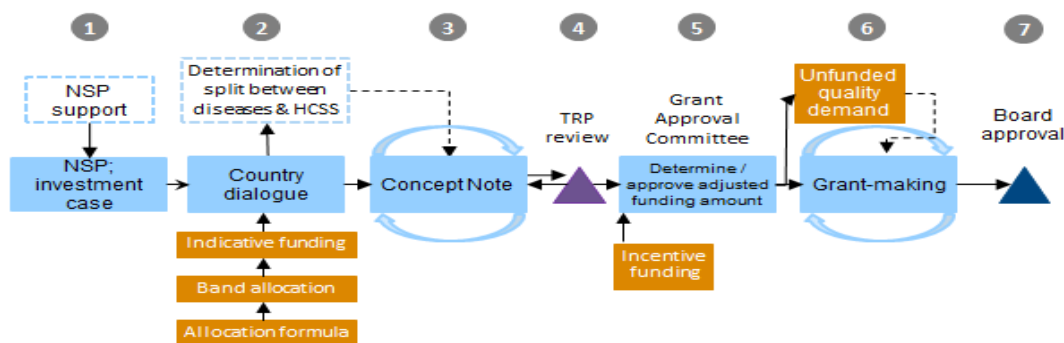
**Figure 2: Showing Global Fund organisational structure**



This study only centred on the consolidated HIV/AIDS and TB programme of the Global Fund. The focus was on the core activities that occur in Nigeria and this involves the interaction of the local (national level) stakeholders.

The programme is divided into various phases (Figure 3).

**Figure 3: Showing Global Fund grant development process (Global Fund 2013b)**



The stages that offered data for the unit of analysis were stages 1, 2, 3, and 6, while stages 4, 5, and 7 do not take place in Nigeria and do not involve actors from the recipient country (Figure 3). This led to the exclusion of Stages 4, 5 and 7.

### 3.7. Ethical considerations

In social research, ethical guidelines are important in identifying the boundaries of good and bad practice: *‘Ethics guides us through a range of concerns, dilemmas, and conflicts that arise over the proper way to conduct a study’* (Neuman, 2014:69). In carrying out academic research there is the dilemma of balancing the search for knowledge and causing harm to those who participate in the study (Neuman 2014). In that case, it is the responsibility of the researcher to be aware of the ethical obligations and principles regardless of whether the participants are aware of these or not.

The first step to ensuring ethical considerations is the acquisition of formal requirements. Ethical approval was secured before the fieldwork from the SchARR Research Ethics Committee and the National Health Research Ethics Committee, Nigeria. Ethical clearance was obtained from SCHARR on the 10<sup>th</sup> of December 2013, following which I applied for an ethical clearance with the Ministry of Health in Nigeria

through the University of Jos and the CCM, Nigeria. These ethical approvals are attached in Appendix 4, 5 and 8 of this thesis.

The next step relies on the researcher making sure they keep to ethical procedures and principles. In making the first approach, the CCM secretary was informed by letter about the details of the study highlighting the aims, objectives, and methodology. The letter described the three methods while also stating the aim of the study and duration. Participants who showed interest in participating in the research emailed me directly and conversations in the emails were kept confidential. Participants received emails containing the information sheet and consent form before any interview. Prior to the beginning of interviews, the information sheet was explained to the participants who had not read it or had questions to ask in person. The consent form was then collected and participants were made aware they could opt in or out of the interview at any time.

The potential for harm or distress to the participants was minimal because the study did not focus on individuals but used data they provided to examine the interactions of medical professionals with other stakeholders. The potential risks of some participants being identified in transcripts and eventual analysis was countered through strict adherence to confidentiality and anonymity throughout data collection and analysis. Pseudonyms were used during transcription and there was no access to the interview recordings and transcripts beyond the supervision team and principal researcher. Strong passwords and firewalls were put in place and personal computers were not used in data storage or analysis. The recordings were stored in an encrypted memory hard drive and the interview data will be destroyed after 6 years (from the date of first interview 10<sup>th</sup> of February 2013 to 10<sup>th</sup> February 2019) by deleting and then destroying the memory hard drive.

The interviewees were told after the interview that they could contact either the principal investigator or the supervisor of the project within one month of the time of the interview if they did not want any part of the interview recording to be used.

### **3.8 Preparing for data collection**

Prior to data collection, I investigated the schedule of previous and current Global Fund activities in Nigeria in order to commence data collection at the time where most of the participants would be available. Upon confirmation of ethical clearance from Scharr ethics committee, the secretary of CCM was contacted over the phone and via emails, informing him about the aims, objectives, and methodology of the study. The CCM secretary sought approval from the Executive secretary of the CCM on my behalf, attaching my research proposal and application letter. A letter of approval and introduction was obtained by the 31<sup>st</sup> of January of 2014, and this granted me permission to approach participants and obtain relevant documents from the CCM. The CCM also provided a list of members, PRs and SRs that were under the newly consolidated HIV/AIDS and TB grant. All members, PRs, SRs and relevant stakeholders were sent an email with an attachment of the approval letter. This made it easier to approach members and book appointments.

Pre-test interviews on AIDS Prevention Initiative in Nigeria (APIN) staff served as a process for getting reasonable feedback about the interview equipment, style of interview and interview guide. For example as regards to the interview equipment, I was able to adjust noise reduction levels and figure out the best distance to place the recorder between interviewer and participant. With the interview guide, after the pilot interviews I merged similar sub questions under the main interview themes in order to allow the participants more room to express themselves in more detail. This

modification made me not confine participants to prior themes. In addition, I was able to figure out what prompts and probes interviewees would feel most comfortable.

### **3.9 Sampling and recruitment**

#### *Stage 1: Documents*

Documents from the Global Fund website were used to give context and details of the Global Fund structure and the CCM Nigeria structure, in order to choose the appropriate sampling technique to be applied. The purposive sampling technique was selected. One reason for choosing purposive sampling is that it is more rigorous than simple snowballing: because the researcher has clear reasons for selecting a particular mix of participants. In addition, the researcher has some protection from the danger of simply interviewing those who are most willing or most visible. The documents used in deciding the sampling technique included constitutional and operational guidelines of the CCM, Global Fund reports, consultant reports, academic papers focusing on the Global Fund and the Nigerian context. For instance, the previous CCM proposals highlighted the various groups (Private sector, public sector, patient population) involved in designing the proposals and the constitutional and operational guidelines aided in defining categories (such as PRs, SRs and consultants) to target in the purposive approach.

#### *Stage 2: Interviews and purposive sampling technique*

The initial stage involved identifying the participants relevant to the research. The spectrum of roles that had a bearing on the subject area of the study was obtained from the CCM. From this list, I sought to recruit those with the appropriate professional and organisational backgrounds that were involved with the CCM in the co-ordination and implementation of the Global Fund grant. This included CCM members, PRs, SRs and relevant consultants and partners. This purposive sampling method helped in delivering

the spectrum of participants that I needed for my small sample size (Bryman 2012). The purposive sampling identified participants based on profession, organisation, organisation's sector (private, public, NGO, CSO, CBO, FBO, patient population and donors), level of involvement in the process, position in their organisation, and years of involvement with the Global Fund grant. Most interview requests and appointments were made via emails but follow ups were made through telephone calls and texts. Due to the position of some of these policy elites repeated e-mails, phone calls and texts message were used to gain initial contact with them because some of these people were in very senior positions and were difficult to contact.

### *Stage 3: Interview and snow balling sampling*

The snow balling technique was used to complement the purposive sampling and was used when interviewing the participants from the initial sampling list. The advantage of the snow balling sampling was the flexibility in involving more people who were not identified initially from the list obtained from the CCM. The snow balling *'technique offers real benefits for studies, which seek to access difficult to reach or hidden populations.'*(Atkinson & Flint 2001:1). In relation to this study, the snowballing technique was used to be able to get different viewpoints from a wider range of stakeholders. During interviews, participants were asked if they knew past members or other people who had insight about the Global Fund grant that would be of benefit to the research question. Most importantly, stakeholders that were thought by other participants to hold particular points of view relevant to the research topic were included into the sampling list. This process led to the inclusion of past members not included in the existing list, such as, a past Global Fund portfolio member for Nigeria, and some aggrieved stakeholders who were not regarded as active participants by the CCM. In addition, during observation meetings, careful monitoring of meeting proceedings and informal discussions with policy makers helped in identifying potential

informants. This enabled the interviews to explore a very wide variety of perspectives and build a clearer picture of the issues.

### *Limitations*

Selection bias was a potential limitation, because the list contained only those presently actively involved with the Global Fund grant, and therefore past members and partners could have been left out in the initial phase of sampling. Furthermore, the sensitive nature of the political environment in the health development sector could have made the CCM secretariat leave out individuals with controversial views. The snow-balling strategy was helpful in reducing this limitation because through snow-balling I was able to identify many participants who would have potentially been missed by relying too much on advice from the CCM secretariat.

In addition, there is a potential of recall bias from participants during the snow-balling, with some of them being able to only recall familiar and popular individuals while leaving out the controversial and unpopular individuals leading to a one-sided perspective. However, attending meetings helped in identifying patient population networks and CSO networks that were not on the initial list given to the CCM or mentioned by participants.

### **3.10 Triangulation of data sources rationale**

According to researchers, triangulation of data sources in qualitative studies has a role in enhancing validation of the evidence (Ritchie et al. 2014). There is a debate about whether triangulation of data sources can actually reveal the overall truth of the phenomena being studied (Silverman 2009; Denzin & Lincoln 2011), however, researchers are advised to be led by their research aim and *'their views on the integrity of different methods for investigating the central phenomena under study'* (Lewis & Ritchie 2003:38). Silverman (2010) warns against naively aggregating sources of data

in order to arrive at the whole picture because ‘ *this whole picture is an illusion which speedily leads to scrappy research based on under-analysed data*’ and vague theoretical conclusions (Silverman 2009:134). For this reason, researchers are advised during triangulation to identify one data set that they can analyse in more detail in order to reveal a particular phenomenon rather aggregation of data in the pursuit of the illusive complete picture (Silverman 2009).

Another important factor in choosing to triangulate the data sources in this study is the critical realist orientation of the researcher. ‘*Critical realists seek to utilise interviews and other social research methods both to appreciate the interpretations of their informants and to analyse the social contexts, constraints, and resources within which those informants act...thus an evaluation of the adequacy of competing accounts of this social reality, albeit one that often emphasises its layered and complex character.*’(Smith & Tony 2012:6-7).

The aim of using triangulation in this study is to give the findings of the interviews more context and clarity, rather than to use an aggregation of different sources of data in arriving at an overall truth. In relation to this study, triangulation of the document review and the non-participant observation was to give more clarity of some of the research findings and confirm evidence that were presented by the interviewees. In achieving this, the first step was to generate themes from the interview data that would form the analytical framework for the full data analysis. This framework was then used as the basis for coding and analysing the complete set of interview transcripts and the documentary and observation data. This approach is one of the ground rules in triangulation (Fielding & Fielding 1986), and this prevents the novice researcher from the potential difficulties encountered in analysing one data set and then moving from one data set to another without any proper guide.



### **3.11 Key informant interviews**

Semi-structured key informant interviews are a way of accessing the insider's views and perspectives about their world and experiences (Murphy & Dingwall 2003). This normally would be very difficult to achieve through structured interviews that have pre-set themes (Murphy & Dingwall 2003). Semi-structured interviews aim to uncover rationales and assumptions among the different groups of actors and gives an insight to how they behave (Murphy & Dingwall 2003). In this study, the aim was to use semi-structured interviews and complement the data from the interviews with observational data and documented data.

The interviews explored the dynamics of the interaction between various professional groups in the CCM and the power play involved in agenda setting during the grant application processes leading to the implementation process. The interviews were important in providing information about the case study not captured in the pre-data analysis period.

Interview topic guides directed the semi-structured interviews (see Appendix 1). The interview guide was framed from prior themes informed by the literature search process, research aims, and discussions with supervisors and from reading relevant documents. The advantage of the semi-structured interview was that it made interviews flexible, which accommodated for periods where participants discussed relevant issues not covered in the interview guide. During the series of interviews, there was a progressive improvement in my interview style and approach. This was reflected in the way I used probes and prompts to encourage participants to elaborate more on important issues and the way I revisited previously discussed issues without disrupting the flow of the interview. For example, in the process of the interviews I began to increasingly use probes such as 'what do you mean by that' and 'When you say things like the power

play; is the power play in the interest of the organization or the person?'. An example of where a prompt was used is in the extract below:

*Participant 28: When I say ministry of health, am also referring to doctors because they are the ones leading the ministry of health. Is Doctors that lead basically even in the private sector, is doctors that lead the process yea?*

*Interviewer: So how would you describe their influence?*

### **3.11.1 Participants' Characteristics**

Participants (n=34) all held positions within organisations involved with Global Fund activities, particularly at the proposal development stages and implementation. The majority of participants were programme managers, whose job descriptions ranged from carrying out Global Fund activities for their various organisations during implementation to being hired as consultants in the Global Fund proposal process. Others were directors who were the highest decision-making cadre of the organisation, overseeing the whole programme. In addition, consultants who were brought into the Global Fund programme by the CCM for their expertise in areas lacking by the members and participants were also interviewed. There was a member of the CCM secretariat involved in day-to-day running of CCM activities and a member of the Country proposal team of the Global Fund in Geneva among the study participants, who were also included in the study. Medical doctors formed the majority of participants (n=17) and the remaining 17 came from other professions (Table 3). The average number of years working with the Global Fund grant was 5.5 years.

**Table 3: Showing the background characteristics of the study participants**

| Characteristic                 | Number    |
|--------------------------------|-----------|
| <b>Sex</b>                     |           |
| • Male                         | 22        |
| • Female                       | 12        |
| <b>Professional Background</b> |           |
| • Medical professional         | 17        |
| • Finance Expert               | 2         |
| • Health Economist             | 1         |
| • Public Health expert         | 4         |
| • Management expert            | 1         |
| • M & E expert                 | 3         |
| • Pharmacist                   | 2         |
| • Social Scientist             | 2         |
| <b>Position</b>                |           |
| • Programme Manager            | 20        |
| • Consultant                   | 2         |
| • Director                     | 1         |
| • Deputy Director              | 9         |
| • Member Country Proposal Team | 1         |
| • CCM secretariat              | 1         |
| <b>Sector</b>                  |           |
| • <b>Private</b>               | 22        |
| • <b>Public</b>                | 12        |
| <b>Organisation</b>            |           |
| • INGO                         | 12        |
| • Local NGO                    | 11        |
| • CCM Secretariat              | 1         |
| • CSO                          | 1         |
| • Patient community            | 1         |
| • Government agency            | 7         |
| • Global Fund                  | 1         |
| <b>Average work Experience</b> | 5.5 years |

All but one of the interviews were conducted in-person, whilst the remaining one was conducted via the telephone. I had to be pragmatic in adjusting my interview appointments due to the busy schedule of most participants. Several attempts at contacting most of the participants were made because of the participants' busy schedules. In some cases, the participants had to be reminded close to the time of the interviews in order to make themselves available. The difficulty in getting appointments

with participants led me to making unscheduled visits to the offices of these individuals. These kinds of visits gave me face-to-face contact with participants and created chances for conducting interviews at the nearest available opportunity. In some instances, I had to wait in corridors outside meetings to introduce myself to the selected participants, which yielded positive results in getting interview appointments.

Creating a rapport with the participants was the most useful skill in getting participants to respond to interview requests. In situations where selected participants were difficult to contact over the phone or via emails, face-to-face contact made them feel at ease and in most instances, they were ready to give interviews on the spot. During observations of CCM meetings, when approached for interviews, participants responded positively. The majority of the interview appointments were secured through this method. The value of creating a good rapport prior to conducting interviews was found to be a key element:

*‘Those of us engaged in naturalistic research know that the first few days in the field are crucial for the success of a research project. Often in a very short period, researchers must introduce themselves, manage impressions, and establish a trusting relationship with participants and other members of the community under investigation... Moreover, it has been argued that only an intense, trusting relationship between a researcher and participant can ensure the trustworthiness of a qualitative report’ (Pitts & Miller-Day 2007:177-178)*

I used a digital audio recorder in conducting my interviews with the permission of the participants. In addition, I made notes during the interview, which included my thoughts, impressions, body language of the participants, important subjects I had to follow up on, and contact details of suggested key informants that participants felt would be of help to the research. Information sheets relating to confidentiality and

anonymity of interviews were sent before interview appointments. I further explained confidentiality in detail at the start of the interview before they signed the consent forms.

Most interviews lasted between 40 minutes to one hour with an average of approximately 45 minutes. The majority of the interviews conducted were in personal offices, three in restaurants, and one over the phone. All participants were keen on seeing the results of the research as a paper, so that it would inform the Nigerian health system and give valuable advice on the policy processes.

### **3.12 Observations of CCM meetings**

#### ***3.12.1 Design***

The non-participant observation method was employed here, with a view to gaining a better understanding of the interactions referred to during interviews such as patterns of professional influence and/or marginalisation. The observation process focused on the verbal and non-verbal communications between the participants at the meetings as well as the content of the meeting. Informal aspects, such as apparent tensions and differences of opinion and differing levels of participation among different members were observed and recorded. The observations were designed to be non-participant observations with the overall aim of seeing in action situations informants described. This approach can identify gaps or inconsistencies in interview accounts. In this way, it can improve the validity of the research.

In observational methods, the researcher can either be an overt or covert participant. An overt participant researcher would be made known to the group under study, while the covert participant researcher gains access without the knowledge of the subjects (Creswell 2008). In this study, I was an overt non-participant observer. The CCM secretariat approached the CCM members through emails, which included my

participant information sheet. This made the presence of the researcher known to everyone in the meeting before the meetings. The intentions of the study were made clear to everyone. Participants who had any objections to my presence were told to make their reservations known to the CCM secretariat before the meeting. Fortunately, no objection to my observation of the meetings was raised.

### **3.12.2 Rationale**

Observations occurred in the natural setting of the participants and because the researcher was a non-participant, the behaviour of the participants was hardly influenced, even though most participants were made aware of my attendance prior to the meetings. The observation provides an opportunity for the visualisation of the events and behaviours described by interview participants in their natural environment. It provided a picture of the trend of events by putting the documentary and interview evidence in context. The advantage of using this approach is that it allows the observation of real life behaviour, while on the other hand it can be time-consuming. For example, the discussion about poor invitation processes raised by interview participants was better understood while observing how invitations were sent out and the poor turnout of stakeholders (as described in section 6.3.5.1).

Observational methods in qualitative research are *'the fundamental base of all research methods in social and behavioural science'* (Angrosino & Rosenberg 2011:467). Observational methods require the researcher to watch in a systematic way the behaviours and actions of the study population or subject in their natural settings (Mays & Pope 1995a). Simply put by Goffman, *'submit oneself in the company of the members to the daily round of petty contingencies to which they are subject.'* (Goffman 1961 cited in Smith 2006:115). The non-participant observational method helps in giving first-hand experience and in exploring issues that participants feel awkward in discussing (Creswell 2008). In non-participant observations, unnoticed and unusual

occurrences can be recorded as they happen so the accounts of the participants could be better understood through the interpretation of the occurrence of these events as they happen (Bhaskar 1978; Hood 2012). This is because *'understanding social phenomena involves a "double hermeneutic" of interpreting other people's interpretations'* (Hood 2012:7), which is closely linked to critical realism. These are some of the reasons for using a non-participant observational method in studying participants in the setting in which they work. For example, my own and other participants' experience during the invitation process that preceded the meetings enable me qualify and interpret some of the action and inactions during the meetings observed in section 6.3.5.1.

### **3.12.3 Collection**

The first meeting I attended was on the 5<sup>th</sup> of March 2014, which was meant to be a planning session organised by the CCM's secretariat. The aim of the planning session was to unveil the main objective of the 'New Funding Model' and strategise a road map to a successful grant proposal. Due to the importance of the meeting and need for expert opinion, experts from PRs, SRs and other agencies were invited. This group comprised of 50 participants, who were either members, alternate members of the CCM, or non-voting stakeholders. The exact breakdown of those in attendance could not be accounted for because minutes of the meeting was not made available to me. Information on the actual designation of everyone in the meeting was not available to me from the CCM secretariat, even after several requests. I was introduced to everyone in the meeting as an observer and therefore I was not involved in any activity that took place. Although non-members were part of the deliberation process, only those representing the CCM members and secretariat staff had the final say through mutual consensus on key issues. After lunch, the expert representatives of the CCM went into a separate meeting to make final decisions. I was not allowed to attend this meeting, which lasted 2 hours. The impression was that sensitive final decision were going to be made in the closed

door session and presented the next day. Even though there was a wider group meeting earlier in the day, final decisions were still made within a group of selected experts.

On the 6<sup>th</sup> of March 2014, there was an open general CCM meeting involving the Heads of the CCM member organisations. This meeting was to launch the road map of the grant writing process and to get feedback from the expert group meeting, which took place the previous day. In this meeting, I was not introduced to the participants because I was told a formal introduction to all those attending had been made the previous week. There were over a hundred participants in attendance. The meeting featured presentations from experts on strategies that would be utilised in the ‘New Funding Model’. The Chair of the meeting who was the Head of a government agency, then took questions from those in attendance.

At the time these two meetings were held, I had already spent two months in the field and I had made contact with a majority of the participants in the meetings. This made me feel comfortable in the presence of the participants and during lunchbreaks I was able to book appointments for interview meetings. The gatekeeper to the CCM meetings was a secretariat staff member with whom I was in contact with at all times in order to grant me open access to all the meetings. The prior interviews with some of the participants built the relationship between me and the participants, creating solid relationships that bridged the rather tense environment during proposal writing periods.

#### ***3.12.4 Processes***

The process of conducting the observations was informed by the research questions and objectives of the study. In addition, interviews pointed to activities that needed to be observed. For example, when a participant that was a medical doctor mentioned a lack of dedication by non-medical doctor stakeholders, this non-verbal observation was only obvious in one meeting in Chapter Six (section 6.3.5.2). These non-verbal observations



would easily have been missed if the researcher did not apply this iterative process. The first step was a mapping of the setting and aggregation of sitting arrangements. I kept field notes to record all my meeting observations, which included my thoughts, participant body language observations, diagrams clustering certain groups together such as NGOs, CSO, Government agencies, and a section in my notes to show the general proceedings and items discussed in the meetings. These field notes did not follow any structured checklist or pre-coded themes, in order to avoid the impact of any preconceptions before the meetings. However, I was aware of the type of information that would be relevant to the research topic and theoretical framework and avoided being distracted by other activities. After the meeting, I made final versions of my descriptive observations field notes and my reflective inferred field notes where my detailed reflective accounts were recorded. Theoretical associations were written down in field notes, so I could trace my thought process later during data analysis. Field notes are crucial in observational methods *'because of the human frailties of human memory, ethnographers have to take notes based on their observations'* (Bryman 2012:447). A judgement was made about the tools needed to take field notes and I selected a pen and paper because this method looks less intrusive to participants as compared to using an audio recorder.

Everyday I wrote down some reflections on the note taking process and made sure the data was up to date. Records were kept in chronological order and a map of the physical space to help remember details was kept, with an explicit awareness of keeping my direct observations separate from the activities that were inferred by me in my reflective accounts.

### **3.13 Documentary sources**

#### ***3.13.1 Rationale***

Data from documentary sources in triangulation can enable the researcher to analyse and interpret data relevant to the research topic, in order to corroborate findings from other sources of data (Silverman 2009; Yin 2003). In addition, in qualitative research documentary analysis can aid the researcher to comprehend the organisational culture and ethos, as well as informing us about what goes on in the organisation (Bryman 2012). In this case study, the documentary analysis mainly helped in framing the context and in understanding the underlying mechanisms in play that stimulated the interactions being investigated. In this study, documentary analysis contributed to understanding the style, codes, and language used during meetings, in addition to alerting the researcher to topics that needed to be probed while interviewing participants. This method was useful in giving a contextual background to past events and because it permitted a better understanding of the content of the Global Fund policy process. It was therefore relevant to all the study objectives, and complemented the recalled accounts of participants. This is captured in chapter Four under section 4.2.2.

#### ***3.13.2 Data collection***

Material evidence collected from relevant actors in the policy process included previous proposals applied for by the recipient country, the old and new guidelines for the grant writing process, and evaluation reports. Access to these documents was obtained through the Country Coordinating Mechanism (CCM), and the Global Fund website. The type of documents needed for this part of the study was identified through interactions with staff of the CCM and other key informants interviewed during the course of the study. For example, some participants highlighted documents that they used in making decisions, writing proposals, and implementing Global Fund

programmes such as the document highlighted in Appendix 9. Also, prior to data collection, documents relating to the activities, organisational structure and general information about the Global Fund were obtained from the internet, as a way of familiarising myself with the case-study setting. Familiarisation of this nature improved the rigour of the interviews and observations, as I was able to follow and actively engage with conversations when participants used technical language and acronyms. This enabled the interview to proceed with a natural flow, and reduced the need to interrupt participants in order to ask for clarifications. For example, an understanding of the broad contents of the various Global Fund grants (Round 1, 5, 8, 9 and consolidated grant) enabled me to understand comparisons drawn between past and current grants by participants. This was used in tracing how participants' perceptions about previous grants still persist in current grants seen in section 6.2.4. For the observations, being familiar with relevant documents enabled me to link up arguments made in the CCM meetings most especially in the CCM technical meeting. For example, the overall strategy of the Global Fund '*The Global Fund Strategy 2012-2016: Investing for Impact*' document (The Global Fund 2011) was widely cited in both country Epi-analysis and during the CCM meetings in almost all presentations. Therefore, being familiar with this document, enabled me to understand the presentations. This was an iterative process involving data analysis of the other sources of data and the review of relevant data, which led to a deeper understanding of the interactions. The accumulated documents were categorised into documents about the Global Fund's policies and guidelines, documents on the CCM Nigeria and documents about the Nigerian context. A list of these documents is summarised in Appendix 9. Because some of the documents were used more than once for designing the study design, sampling, designing of the interview guides and in the thematic analysis, the documents are listed according to their sources.

### **3.14 Data analysis**

The use of three complementary methods augmented the study by drawing on multiple sources of evidence. This aids in addressing historical, attitudinal and behavioural issues (Yin 2003). The data analysis process was iterative, allowing for reflection, and refining of ideas in all stages of the data analysis. Even though, data analysis is a distinct stage in many study designs, in this study data analysis also occurred throughout the data collection phase and during the writing stage, as recommended by Creswell (2008) and others. *'Data analysis in qualitative research will proceed hand-in-hand with other parts of developing the qualitative study, namely, the data collection and the write-up of findings'* (Creswell 2008:195).

#### **3.14.1 Processes during triangulation**

The first step was to identify the various documents that would inform the interview guide and give contextual understanding of the case study. For example, previous proposals, guidelines and other empirical studies (The Global Fund 2013; CCM Nigeria 2015a) made me structure the interview guide into three broad sections about the Global Fund organisational structure, proposal writing and implementation, which made the discussions with participants a lot easier. The second step was the application of the interview guide in the interview process, which then informed the researcher on additional sources of documents to be collected for analysis. In addition, some documents were used as a guide in the purposive sampling of the list given to the researcher by the CCM. During the process of interviewing participants, familiarisation with the sample of participants helped the researcher know the relevant meetings that would be beneficial to this study. This resulted in the identification of two meetings. This early stage was an iterative cycle, with each method pointing the researcher to relevant sources of data and this continued until there was data saturation, however,

more meeting observation would have been desirable but time constraints were a limiting factor.

The second stage involved the application of triangulation to analysis and synthesis of the interview, documentary and observational data. An inductive process of identifying themes in the interview data and combining it with the apriori themes from the literature created the coding framework, which was used to analyse the rest of the interview data. After analysing the entire interview data a well-defined theoretical framework was created, in which a robust coding framework was used to analyse the document and observational data. The addition of the documentary and observational data refined and gave more context and clarity to the analysis, contributing to the final theoretical framework of the study.

In addition, to the points raised earlier about the partial nature of the triangulation process in selecting a central data set, it was known early during the study that the interview data was the most suitable in understanding the phenomena investigated. This was because there were few apriori themes concerning the research question in the existing literature pre-data collection. And during data collection, the interviews were able to cover more topics, experiences, and themes than the documents and observation data. The theoretical model was hence developed through apriori themes identified as relevant to the phenomena to be investigated in the research questions and the interview data gave this theoretical model its structure and meaning. The contents of these documents were then analysed and coded under the relevant themes of the theoretical model drawing links that enriched the understanding of the themes and corroborate some of the evidence cited by participants. The iterative process of clarifying the interview data with documents helped in creating the picture of the wider context. Most especially, during reporting of the findings, information from the documents helped in

summarising the evidence synthesised during the data analysis stage. For example, in section 6.2.4, the documentary evidence from the OIG Report 2016 was able to summarise and corroborate participants' accounts on the wastage of medical supplies.

For the observational data, field notes and reflective summaries were collected from two meetings of the CCM. The observations were unstructured and hence did not use a checklist or guide. This was because the study design aims to allow evidence/events relevant to the research questions to develop in their natural setting rather than making generalisation of events into set themes in a checklist. The researcher was aware that interviewing participants and observing concurrently in the field could bias the researcher towards focusing only on issues discussed in the interviews, and therefore took steps in order to reduce this bias. For example, participants in interviews highlighted the use of biomedical language and data during meeting presentations and interactions. However, focusing on identifying only biomedical dominance in meetings would have made it impossible to observe the lack of participation of other groups such as the CCM secretariat and the representatives of patient groups. This is because these themes were not apparent to the researcher before data analysis. However, the issues discussed in the interviews and the apriori themes made the researcher more alert and vigilant about observing the relevant issues to the research which otherwise would have been missed through the documentation of everything that occurs. For example, being aware of occurrences of conflicts of interest by influential organisations made the researcher map the organisations into categories such as PRs and SRs, in order to draw links with the arguments made about conflicts of interest made during interviews by participants. The theoretical framework was then used to code the observational field note reports, draw links to the other sources of data and aid the researcher in reflecting on how exposure and full immersion into the field influenced the data analysis and

thesis write-up. This immersion in the field aided the researcher in triangulating and synthesising the three sources of data together in the presentation of findings.

Limitations encountered in the triangulation process related to barriers encountered in accessing some documents relating to the policy process, which encouraged the researcher to rely more on the interview data. For example, the CCM meeting minutes after TRP recommendations are sent to the Nigerian CCM during the grant-making process would have given deeper descriptions of the process. Furthermore, observations were limited to only a small process of the policy-making process; therefore, observations were limited to only a small section relevant to the theoretical framework. Other relevant observations would have included the complete process of the country dialogue and Global Fund implementers retreat, which would have revealed a wider interaction among other non-CCM stakeholders not mentioned in interviews. These limitations did not significantly affect the robust nature of the study; however, it contributed to the reflections made by the researcher during the write-up stage.

There is also an ethical responsibility on the part of the researcher to share the findings and publications with the participants because this was stated in the consent form. In addition, a copy of the findings will be given to the CCM to keep in their library, which can be used as a source of information to other researchers. In the final version of the thesis and the copy that will be provided to the CCM, there will be no identifiable information of any of the informants. With a general overview of how these data sources were triangulated, the various individual processes of analysis will be described in the following sections.

### **3.14.2 Interview data framework analysis**

In analysing the study data a 'Framework Analysis' was employed, which is one of the preferred methods of analysing health policy research (Ritchie & Spencer 2002). The

framework analysis aids in defining, categorizing, theorizing, explaining, exploring and mapping of data (Ritchie & Spencer 2002). The Framework Analysis has five key steps, which are: (i) familiarization; (ii) identifying a thematic framework; (iii) indexing; (iv) charting and mapping; and (v) interpretation (Ritchie & Spencer 2002). I choose Framework Analysis because it makes it easy to reconsider and rework ideas throughout the research process. It also makes it possible for other people to judge the steps taken during data analysis and the conclusions drawn at the end of the study, thus increasing transparency and overall rigour (Ritchie & Spencer 2002). However, one critique of the Framework Analysis is that it carries the risk of suppressing the interpretive creativity of the researcher (Dixon-Woods 2011). In order to address this risk I circulated draft interpretations to study supervisors for comments at the early stages and discussed initial ideas in detail among the study team.

Familiarisation of the data was achieved through transcription of the data. After transcription, I reviewed the transcribed data to rectify mistakes during transcription and to further familiarise myself with the data. My supervisors reviewed some interviews selected at random, to evaluate the familiarisation process and the quality of data. This stage proved vital because I was able to consider and reflect upon emerging themes and codes that formed the foundation of the data analysis.

In the next stage, I made a list of priori themes developed from my documentary analysis and literature review. Parts of the data best suitable in the apriori themes were labelled as codes, while the rest of the data was processed through open coding. The open coding generated more codes and gradually these codes were aggregated (according to their similarities) to form themes. A second re-coding process was done in order to make sure every part of the data had been coded, while my supervisors coded some interview transcripts and compared with mine to check for reliability.



Categorisations of the themes into theme charts from the complete set of coded data formed the template for the summarisation of the data. The theme chart comprised of themes, sub-themes and sub-sub themes, presented in Appendix 6.

Data summarisation involved synthesising the data and condensing the information under each theme, sub-theme, and sub-sub theme by para phrasing the quotes without losing the words used by the participants. Another chart showed sample quotes extracted directly from the data that I later used in the results section. This created a thematic matrix and made the descriptive writing stage possible. Descriptive accounts refined the accounts para phrased in the thematic charts into understandable sub-topics and categories. Finally, the descriptive accounts were used to develop the explanatory accounts. Explanatory accounts were generated through the aggregation of descriptive accounts that had similar concepts, which made it possible to link associations between themes. This stage required the use of logic, drawing up of information from the literature and linking up the data with the theoretical framework in the creation of the explanatory concepts.

During the data collection and analysis phases, I considered the advantages and disadvantages of using computer-assisted analysis of qualitative data (Silverman 2009). Upon careful consideration, and familiarisation with specific computer software programmes, I decided to use NVivo (version 10).

### **3.14.3 Observational data Analysis**

Descriptions and inferred meaning field notes were kept apart and the events from the two sets of field notes were linked according to time, date, and place. The observations were then coded separately using the themes generated from the theoretical framework. For example, 'poor invitation process' came up in both the observational notes and the inferred meaning reflective field notes. From the analysis of these observational data, a

theoretical understanding of the meetings was achieved and a narrative story of the events that happened during the meetings was made, focusing on the relevant aspects that helped in understanding the research questions.

### *Synthesis*

During supervisions this narrative story was expressed to the supervisors placing the researcher in the story and explaining the links with the interview and documentary data. This process allowed alternative explanations to be considered or ruled out. A significant step in the understanding of sections of the data relied on the reflective process during which all the different sources of data were synthesised together. For example, this enabled me to make links between the poor participation of non-medical professionals, as identified in the interviews, and the dominance of the biomedical discourse during the meeting proceedings, which was shaped by biomedically focused proposal guidelines seen in the documentary evidence. Making these links contributed to developing a coherent story of the case study.

### *Limitations*

Researchers look at their data through a particular lens, but are able to reflect on these limitations and to expose their findings to external scrutiny. At the beginning of the research, I reflected on any personal bias I may have had in order to understand any bias that might develop during interpretation of the data and any bias the participant community could have towards the research topic. It is very difficult to be subjective and objective equally at the same time (Kawulich 2005). Due to the sensitivity of the research, there may be some form of exclusion the researcher may be unaware of such as not being invited to social events, the use of language that the observer does not understand or even participants moving away from the researcher when having serious conversations (Kawulich 2005).

Due to the snap shot nature of the cross-sectional observation in the study, it is difficult to observe most of the experiences of participants and the evolution of some of these phenomena over time (Carlson & Morrison 2009). The time limit of 6 months for data collection did not allow for more observations. Secondly, even though I fully immersed myself into the fieldwork process, it is particularly difficult to observe decision-making processes because most times *'such processes of 'making' policy are not necessarily overt or clearly bounded. The ways in which decisions 'emerge' rather than taking place at a single point in time, and which are often unobservable to the researcher, can be particularly difficult to unpack and explain'* (Walt et al. 2008:310). In addition, organisational behaviour and culture during implementation could not be observed. However, the nature of the in-depth descriptions from participants was able to reduce the impact this limitation had on the study.

Familiarisation with the participants was done through direct conversations with CCM member and other external participants and consultants and through these interactions; I was able to listen to participants' perceptions and views about the policy process. A major limitation was the large size of the meeting, therefore creating rapport with everyone was not possible causing me to manage my time wisely and focus on mainly meeting with the obvious influential personalities in between meeting sessions. These limitations were acknowledged and at the end of the thesis, their contribution to the overall thesis was reviewed.

#### **3.14.4 Documentary data analysis**

Most of the evidence from the documentary analysis formed the basis for the analysis presented in Chapter Four. Official documents were the only source for the documentary analysis. A thematic analysis of the documents was done, using the theoretical framework that had been developed from the analysis of interview data. The thematic analysis was applied to the documents listed under the headings CCM

documents and Global Fund website documents (because they were documents directly used for proposal writing, products of the proposal writing processes or were documents directly related to the Global Fund/CCM structure), while thematic analysis was applied to smaller sections of other documents that were seen to be relevant to the proposal process or in understanding the context, which were identified through a snow-bowling technique of citation search of the general literature on the Global Fund and the Nigerian context.

### *Synthesis*

In synthesising the documentary evidence, an effort was made to capture both the surface and deeper meaning of the data, and studying existing literature made this process thorough. For example, the concept of '*test and treat*' was used in proposals (CCM Nigeria 2015b) but a deeper understanding was achieved when the existing literature was reviewed (Kippax 2012; Adam 2011), which helped in providing broader meaning to the findings in the discussion section. While synthesising the documentary evidence with the other sources of data, the authenticity and credibility of the data had to be confirmed, in order to prevent inaccurate conclusions.

### *Limitations*

In the initial planning prior to data collection, minutes of meetings were considered part of the documents to be reviewed, but I was unable to obtain the required meeting minutes that would inform the study. There were two main reasons for this. Firstly, there was poor record keeping of the minutes and after requests were made to the CCM secretariat and NACA, I was not able to obtain the minutes. Secondly, staff of both the CCM secretariat and NACA feared some of the minutes could potentially have sensitive information about some organisations or individuals contained in the minutes. My ethical obligations as a researcher prevented me from using data with any potential to cause harm to anyone and therefore I decided not to use meeting minutes. This had an

impact on the study because some of the boardroom interactions and disagreements mentioned by some participants were not able to be corroborated and confirmed with minutes of meetings. This was one of the reasons the interview data was the central data set used in the theoretical framework.

### **3.15 Research rigor**

This section will highlight the measures put in place to ensure rigor of the research, as this is essential to all academic research. According to Bryman, the necessary areas needed to be covered for qualitative research rigor are: credibility, transferability, dependability, and confirmability (Bryman 2012). Due to the nature of qualitative research, determining the quality of the research is different from the quality check of quantitative research (Mays & Pope 1995b).

#### **3.15.1 Transferability**

Generalisability of research methods involves being able to predict an occurrence when the same research tools are applied to different subjects (Donmoyer 2008). In other words it is a form of external validity or transferability of the research results, which is the preoccupation of quantitative research (Bryman 2012). Due to the interpretivist epistemological background of most qualitative research, transferability is restricted because of the generally small sample size and the focus on depth of the subject matter rather than breadth of findings (Bryman 2012). The dynamic nature in human behaviour is another limitation to the application of transferability, *'comprehensive and definitive experiments in the social sciences are not possible and that the most we can ever realistically hope to achieve...is not prediction and control but rather only temporary understanding'* (Cziko 1992: 10). This type of *'thick descriptions'* encouraged in qualitative research gives rich detail that can be used to understand and compare certain

elements in the social environments of other similar subjects but not necessarily creating broad generalisations (Bryman 2012:392).

Another approach to transferability in qualitative research is achieved by specifying the type of generalisability applied in the study. The three ways of achieving generalisability are: theoretical, inferential and representational (Lewis & Ritchie 2003).

In this research, I attempted to address transferability through an in-depth exploration of the participant perspectives with the use of concepts and theories in the literature. This approach aims to give theoretical generalisation (Lewis & Ritchie 2003). To some degree, I produced evidence that could be used to support existing theories and evidence explaining occurrences peculiar to the case study. This ensures that not only does the study inductively develop interpretations that are similar to existing theories but it also was able to make us better understand those theories.

Representational generalisability is *'the content or "map" of the range of views, experiences, outcomes or other phenomena under study and the factors and circumstances that shape and influence them, that can be inferred to the researched population...The second issue is the degree to which the sample is representative of the parent population sampled'* (Lewis & Ritchie 2003:269). In this study, I achieved representational generalisation through the purposive sampling technique, which carefully picked relevant participants from all the levels involved in CCM policy making representing the views of CCM stakeholders.

### **3.15.2 Credibility**

Credibility involves the ability to *'stress on multiple accounts of social reality...Another technique they recommend is triangulation'* (Bryman 2012:390). This research was able to draw on multiple methods - interviews, observations, and documentary analysis- to arrive at the findings. Credibility is also referred to as internal validity (Bryman 2012).

In analysis, the interpretation from one part of the data was applied to other parts of the data in checking for accuracy of the analysis process.

I spent six months in Abuja in order to understand the context of the case study, while recording my reflections in notes. Unofficial discussions among participants during meeting breaks and the body language of participants during the fieldwork, served as invaluable sources for ‘thick descriptions’ in understanding the phenomenon studied. Spending long periods in the field develops the in-depth understanding of the researcher leading to better validity of the results (Creswell 2008).

### **3.15.3 Dependability and Confirmability**

Quantitative research applies reliability by ensuring that the research findings can be replicated in a different setting using the same methods (Lewis & Ritchie 2003). Qualitative research on the other hand focuses on the dependability of the research through an auditing process achieved through peer review justification of the data collected, analysis, and interpretations (Bryman 2012). In ensuring dependability, I reviewed all transcripts three times after transcription in order to avoid mistakes. A comparison of the codes created by supervisors and by me led to an ‘intercoder agreement’ on the transcripts reviewed (Creswell 2008). Furthermore, proper documentation on the processes and procedures carried out during the process was recorded together with the raw field data, field notes, reflections, and data collection tools. The software Nvivo helped in keeping track of all analytical steps and changes.

Confirmability ensures that I did not let my personal bias affect the way I viewed the data. My supervisors constantly probed every theoretical explanation and ensured I backed my interpretations with evidence from the data. The constant scrutiny made me accommodate various perspectives before arriving at the results, and then tested the findings in front of a wider audience through conference presentations and seminars.

### **3.16 The Researcher's Role**

Qualitative research findings are a product of interpretations by the researcher. The researcher is involved in extensive and sustained interactions with participants, where their personal bias, values and background play a huge role (Creswell 2008). It is important that these researcher backgrounds and experiences be stated in the research in order to give readers a perspective to how some inferences and insights developed during the course of the study. *'Reflexivity involves a self-scrutiny on the part of the researcher; a self-conscious awareness of the relationship between the researcher and an other'* (Bourke 2014:1).

#### **3.16.1 What role did my positionality play?**

My experience in the field of public health has had an influence on the focus of the research. Firstly, I am a medical doctor trained in a Nigerian university and I worked in Nigeria for a year in a teaching hospital. My experience as a medical doctor in the Nigerian healthcare system has given me some insight as to how medical professionals interact with the environment around them and how relevant they are to most aspects of the healthcare sector. During this time, I was taught the ethics of medicine, and society regarded me as a medical professional. I have experienced first-hand the influence doctors have over other health professionals in a health facility. For example, when non-medical professionals were explaining how medical professionals command respect from other health professionals in the health system, I was able to clearly visualise this because I have seen these events in action. Even as a medical student, other health professionals treated us with a lot of respect because they knew it was only a matter of time before they became answerable to us (medical students). With this experience, the framing of my research question has been influenced by my past insider role in the Nigeria health system. During data collection, I was aware of the accounts of non-



doctor respondents, while also understanding the perspective of the doctors because of this past insider role.

In the following year in 2008, I travelled to England to undertake a Masters in a Public health programme. This period was the turning point in my research career because it exposed me to the non-biomedical debate concerning health issues. My acquired knowledge in the field of public health then enabled me secure a job in the Global Fund unit of the National Agency for HIV/AIDS in Nigeria (NACA). I was involved in most activities such as programming, evaluation, and proposal writing for the PMTCT grant of Round 9 of the Global Fund grant. During that period, I made many contacts with partners involved in Global Fund activities. This gave me an insider's access, enabling me to meet individuals who later became relevant key informants in the study. I understand the context of the study environment and I have added insight into some cultural behaviours such as non-verbal language used by participants. This is because during my time there, I noticed similar power struggles between medical professionals and non-medical professionals such as double promotions for medical professionals while other non-medical professionals had to work through the ranks. For example, when a consultant medical professional is hired, they are given an assistant director position while other occupations do not enjoy this privilege. These non-verbal struggles by non-medical professionals were explained during my interviews but my prior experience in NACA enable me to fully contextualise the meaning of these discussions during interviews. My decision to use the Global Fund programme as a case study was informed in large parts by my experience in NACA, because I began to understand that the policy space created by the Global Fund allowed for interactions between health professionals from all fields, making some of these non-verbal power struggles possible. For example, during the unsuccessful Round 10 bid by Nigeria I began to understand that the proposal process was unique in the sense that no other GHI in Nigeria at that

particular time had such an open policy space that was willing to invite as many interested stakeholders from different professional backgrounds. Even though after my fieldwork I realised that within this open policy deliberative space there were many exclusionary barriers.

Following this, I worked in the department of public health in a university for 2 years as a lecturer and gained some theoretical knowledge and background regarding the subject area. This helped in drawing some conclusions about the Nigerian health system, which were relevant to the understanding of policy processes in Nigeria. The seeming lack of national government interest in tackling the growing tension and HRH crisis in the health sector has led to several strike actions by the various health worker associations in the country. Some strike actions have lasted up to 6 months, crippling the health sector and in situations where the government resolves one strike action, another competing association usually embarks on a fresh strike action. This understanding of the HRH context I gained in those 2 years made me very aware of the different professional groups and perspectives in the health sector. I took this into account, while sampling participants from the various interest groups reflected in this study.

### **3.16.2 How did I use my positionality in different spaces?**

During the data collection, there were so many instances where I had to send repeated reminders to participants to book interview appointments. This elite group of decision makers had busy schedules which made having access to them very difficult. Pursuing these elite individuals pushed me to use unconventional tactics such as waiting in meeting corridors, impromptu visits to their offices, and using their close colleagues to initiate first contact. Interestingly, the unconventional methods worked mainly due to my status as a PhD student from a top international university. The PhD student status

gave me some credibility among this elite group of participants and on realisation of this advantage, I gained more confidence in approaching my interviewees.

Once participants realised that my study was solely for the purpose of academic research and was not an evaluation of their roles or organisations, they suddenly began to express themselves more and to reveal more on the subject matter. A number of participants were very interested in the research topic, evident by the way in which participants were ready to extend the interviews considering their tight schedule. I got a lot of encouragement from participants' interest in my research topic, which fuelled my desire to explore all the issues raised in the interviews. This was important in building my confidence, considering the fact I had a difficult start at the early stages of data collection in tracking participants for interviews. Most participants showed a lot of interest in seeing the final results of the research and wanted to keep in touch and this was the highlight of my interviews.

Finally, as a Nigerian medical doctor I had the impression that non-doctor participants would not engage or would have reservations about talking with a doctor about medical dominance. On the contrary, the non-doctor participants saw me as a medical doctor with a different perspective compared to the regular Nigerian doctor. For example, some of them highlighted my international exposure and interest in researching such a delicate issue as a reason to why I would see things differently compared to the regular Nigerian doctor. In addition, some participants saw this as an opportunity to air their own views about the health system. On the other hand, medical doctors were free to express their views and their honest opinion in most of the issues raised. This sense of comradeship enabled the doctors to express their true perspective. However, it is important to state that my positionality as a medical professional in Nigeria was mainly beneficial in getting access to interviews and documents and had a limited influence in

the way the research was carried out or how the data was analysed. This is because my limited working experience in Nigeria of only 3 years did not give the kind of insight that would greatly influence or alter the findings or the synthesis of the research but rather my positionality helped in being able to reflect on the broader contextual realities that are relevant to the wider Nigerian society. This is the reason the study followed the thorough process of creating a theoretical framework that guided the synthesis of the findings. Preliminary interpretations were discussed in depth with supervisors and also exposed to critical debate through seminar and conference presentations such as the oral presentation of the data findings in the Health Systems Global symposium in Cape Town, 2014.

### **3.16.3 Concluding my reflections: two sides to my story**

During my PhD studies, I was able to obtain GMC (General Medical Council) registration, which I then used to secure a number of clinical observer roles in NHS (National Health Service) hospitals. After that, I practised as a part-time junior doctor for a few months, which gave me first-hand experience of what it is like to be a doctor in a European or British context. In addition, this exposure was key in aiding my understanding of the literature on New Public Management (NPM) and the sociology of professions. Experiencing both contexts provided me with a better informed and contextualised understanding of the literature on the one hand and the Nigerian case-study results on the other. From my reflections, medical doctors in Nigeria are in an era of professional bureaucracy, retaining much professional power and autonomy. In contrast, the NHS doctor (similar to most OECD medical doctors) is in an ongoing interaction with the forces of NPM and the effects of this on his/her professional power are more evident in this context compared to the Nigerian context. Recently, the British government has placed a cap on payments to medical doctors and has threatened to increase their working hours in addition to a reduction of their salary. Junior doctors

have met this with a strike action. Meanwhile in Nigeria, medical doctors have recorded a major victory in the protection of their professional boundary, maintained the occupational hierarchy, and increased their salary. All these outcomes were achieved through the strong influence the medical doctors have over the government, often at the expense of other health workers. All these events have influenced my reflections throughout this study. Some of these themes presented in this section will be discussed in depth in Chapter Eight.

#### **3.16.4 Reflections on political sensitivity**

During data collection, three important participants refused to be interviewed. One of these gave me detailed information that helped me gain some perspective and reflect on the research questions but stressed that they should not be quoted in the thesis. Most participants refused to sign the consent form and preferred to give only a verbal consent. This might have been influenced by the fact that most of the participants' organisations want their staff to be apolitical and therefore participants did not want to risk losing their job. In addition, during the field visit there was an OIG investigation of Global Fund grant in Nigeria, which I was not aware of at the time and this visit may have affected the way participants responded to some of the questions. However, my background as a Nigerian PhD student enabled me to have a more in-depth discussion and I was able to use my personal experience in order to understand the wide range of perspectives expressed by the participants. It is still unknown if the participants would have engaged with an outsider such as a non-Nigerian or non-health professional in the way that they engaged with me. I was fully aware of this insider and outsider power dynamic between myself as the researcher and participants, because I increasingly noticed how participants discussed some issues with me as though they were an open secret. On the other hand, the widespread corruption in the country had the potential to make participants conceal important information in the interviews. However, I have

considered this possibility during my analysis of the data, and have not found any instances in which participants evaded questions or appeared to withhold information.

Finally, the report from the OIG report (OIG Report 2016b) revealed widespread financial irregularities by most of the PRs and SRs. In hindsight, this may have been the reason why some participants refused to be interviewed. While reflecting back, it was obvious that participants from INGOs and government organisations were more diplomatic in their answers and did not directly name and implicate their organisation or similar organisations while answering questions but those from the CSO and patient population were more forthcoming in their criticisms of other organisations as well as their own. Due to the sensitivity of some of this information given by participants due to my positionality, I was careful in considering this and made efforts in presenting the data in such a way that the anonymity of participants was protected, as promised.

### **3.17 Chapter summary**

In this chapter, I have presented the epistemological position and methodological framework that has guided this research. I have outlined the various steps taken to collect data that would be required to explore my research questions. I have given a comprehensive review of how my study design is linked to the methodological framework and sampling technique in this case study. Furthermore, I have addressed some of the concerns related to research rigors and ethical considerations encountered through the research process. I have also discussed the framework used to analyse the data and in the process discussed the various qualitative methods employed.

The next chapter focuses on the empirical data. It provides detailed contextual information about the case study, mostly collected via documentary evidence, which is vital in understanding the context and background of the case study.

## **Chapter 4**

### **Global Fund Grant in Country context and Country setting**

#### **4.1 Global Fund HIV/AIDS programme in Nigeria**

The Global Fund is a product of a meeting in Okinawa in 2000 when leaders of the G8 deliberated on the threat of poor health internationally and how it could affect development (Thomas 2001). The burden of HIV/AIDS, tuberculosis (TB) and malaria, were highlighted and it was agreed that the G8 would involve all stakeholders in tackling these three main diseases (Rushton & Williams 2011).

In Abuja in 2001, African leaders made a pledge to increase funding to tackle the three main diseases of HIV/AIDS, tuberculosis and malaria because they were killing the productive population of the continent (Youde 2012). In addition, they encouraged donor countries to increase their funding to assist in fighting these diseases. This acknowledgement by the donor and recipient countries led to the creation of the Global Fund in 2001 after a United Nation General Assembly special session on HIV/AIDS (Global Fund 2015f). The Technical Working Group (TWG) produced the platform and parameters on which the Global Fund would be based (Global Fund 2014a). The Fund's evolution from an initiative immune to the politics of the UN has seen the Fund restructure the global health governance architecture (Maciocco & Stefanini 2007). Specifically, this has been made possible by its ability to bring public and private stakeholders together, in an era when the existing influence of the WHO was waning (Youde 2012).

The Global Fund was created to be a financing agent by receiving funds from donor governments and private stakeholders like Bill Gates, in order to finance projects developed by the recipient countries (Maciocco & Stefanini 2007). The Fund focused

on the three main disease entities captured in the Millennium Development Goals; HIV/AIDS, tuberculosis (TB) and malaria (Global Fund 2015f). Currently, The Global Fund's board has 20 members divided into two blocs. The donor bloc has eight seats for donor countries, one for private sector, and one for private foundations. The implementation bloc has seven seats for developing countries, two for NGOs and one seat for communities affected by either HIV/AIDS, TB or malaria (Global Fund 2014a). Over the years, The Global Fund has become the second major engine of international health financing after PEPFAR. To date the Global Fund has received over US\$40.3 billion from its leading donors: The United States, France, United Kingdom, Germany, Japan, European Commission, Canada, Bill and Melinda Gates Foundation, Italy and Sweden (Global Fund 2014a). Recipient donors from developing countries have benefitted from the grant and the top ten recipient countries in descending order are; India, Ethiopia, Nigeria, Tanzania, Rwanda, Congo DR, Zimbabwe, Zambia, China and Malawi. In the process, The Global Fund reports it has been able to provide 6.1 million HIV positive people with antiretroviral therapy, detect and treat 11.2 million tuberculosis patients and distribute 360 million insecticide-treated bed nets (Global Fund 2014a).

Irrespective of The Global Fund successes, they have come under attack from critics who question the structure of the Fund. Colleen O'Manique says the general global health approach towards the HIV/AIDS pandemic is viewed through a biomedical lens and a few global actors, of which the Global Fund is a part, shape policy directions through this lens (O'Manique 2004). Ingram says the Global Fund has been an instrument in the spread of a neoliberal system of values that favours the shift towards a fragmented health system that caters for a few in society while encouraging the neoliberal policies of competition, commodification and privatisation of health services (Ingram 2009). Even with the Fund's pluralistic approach to governance, the push for its



existence (during the Bush administration) reflected the pressure from global actors towards institutionalisation of neoliberal ideals (Ingram 2009). Finally, Poku alludes to the fact that the Global Fund is prone to international neoliberal politics because it is similar in structure and composition to the World Bank's AIDS Trust Fund, which had heavy influence from pharmaceutical companies and the US state's Treasury (Poku 2002).

In the Global Fund's new approach to tackling the three main diseases, they have generated a new approach to the disbursement of funds to recipient countries (Global Fund 2011). This approach targets high-risk populations more strategically. It implies that the Fund will identify countries with the highest prevalence of the three main diseases and fund interventions that have been proven to have high impact in reducing disease burden (Global Fund 2011). Countries are encouraged to focus their proposals on how they would channel the Global Fund funds to high-risk populations (Global Fund 2011). This narrative gives the impression that the guidelines take the emphasis away from previous calls for holistic proposals, in favour of proposals that will focus on high-risk populations identified through epidemiological studies.

#### **4.1.1 Country Co-ordinating Mechanism**

The Country Co-ordinating Mechanism (CCM) was created to be the core partnership mechanism at country level for mobilising Community Based Organisations (CSOs), multilateral and bilateral institutions for the drafting of proposals to the Global Fund. There was an emphasis by the Global Fund on encouraging countries to have at least 40% of the CCM comprised of CSOs (Feachem & Sabot 2006). The CCM is a major component of the Fund's commitment to one of its core principles of country ownership (Global Fund 2014a). This is achieved by representation from various sectors and stakeholders such as the government, multilateral and bilateral agencies, non-

governmental organisations, academic and private institutions and people living with HIV, TB or malaria (Global Fund 2014a). Apart from encouraging participation from stakeholders, the CCM nominates Principal Recipients (PR) responsible for implementation of the programmes (Global Fund 2015a). The CCM is encouraged by the Global Fund to select their Principal Recipients from government and non-government agencies, while the PRs now select Sub-Recipients (SR) from a list of CCM approved SRs who will help in executing the projects (Global Fund 2015a). Under the New Funding Model (NFM), the CCM is guided by a set of minimum rules in the selection of members. One of the rules involves the CCM undergoing annual performance self-assessments with technical assistance from an approved Global Fund list, namely: the U.S. Government (USG), French 5% Initiative, The International HIV/AIDS Alliance (except in countries where this entity is a Global Fund recipient) and a pool of consultants working for the Global Fund Secretariat (Global Fund 2015a).

Evidence from studies so far suggests that the attempt to make the CCM an avenue for promoting CSO advocacy through active participation in the implementation process has been below expectations in most countries (Harmer et al. 2013; Kapilashrami & O'Brien 2012). In some instances, the CSO advocacy has been overshadowed by government agencies because the CSOs have weak capacity and are unable to influence government decision-making in Global Fund proposals (Harmer et al. 2013). More crucially, governments dominate the CCM, monopolise the process and exclude CSOs from crucial decision-making circles, making it difficult for the CCM to invite interested parties from all sectors during the design of programmes (Feachem & Sabot 2006). In Nigeria, medical professionals dominate the Ministry of Health and draft the National Strategic Plan (Ransome-Kuti 1998), on which are used to inform the production of the Global Fund proposals. In addition, a lack of information among NGO

and CSO representatives limits their involvement in proposal writing processes (Youde 2012).

#### **4.1.2 Technical Review Panel and the Local Funding Agent**

According to Brown and Barnes (2011), in order to understand the policy dimensions of the Global Fund, an in-depth look at the Technical Review Panel (TRP) and Local Funding Agent (LFA) is necessary. This is because the Global Fund claims that its Board's decisions are based on the technical apolitical information and strategies which are clear and measurable (Brown & Barnes 2011). The Technical Review Panel is the expert body which informs the board on technical decisions while the LFA evaluates performance and adherence to agreed work plans (Brown & Barnes 2011).

##### 4.1.2.1 Technical Review Panel

The Technical Review Panel is meant to be an independent impartial team of experts who determine the acceptability of proposals and look at feasibility strategies in the proposal (Brown & Barnes 2011). They are recruited by the secretariat on the basis of their expertise in HIV/AIDS, tuberculosis and malaria as well as cross-cutting issues and their assessment of the proposal in most cases is what is used by the Global Fund board in approving proposals (Brown & Barnes 2011). In the New Funding Model, the TRP is meant to look at the technical clarity and strategic focus of the proposals. By this process the TRP can consider which country grant proposal is ready for grant approval or advise on a revised proposal from the recipient country CCM (Global Fund 2014b). The Global Fund claims that the TRP by providing technical advice, enables the board to make apolitical decisions, which is one of the strengths of the Global Fund compared to other humanitarian organisations (Isenman et al. 2010; Brown & Barnes 2011).

The TRP has been criticised as being the biomedical arm of the Global Fund because of its Western-dominated approach, in a context in which it lacks enough experts with knowledge of developing countries (Brown & Barnes 2011). The dominance of a Western approach towards the grant evaluation process could arise from the fact that a majority of the technical review panel have a Western medical background (Global Fund 2015g), or it could arise from the biomedical bias associated with the global health architecture. However, in recent years the Global Fund has tried to make appointments of members in the TRP that reflect a wider range of experts with experience from various backgrounds. However, regardless of the members in the TRP, the guidelines from the Global Fund and the TRP's recommendations are very specific in prioritising the use of biomedical technologies, with a majority of its funds channelled towards strategic vertical goals such as 'test and treat' and high risk group interventions (Global Fund 2014a).

#### 4.1.2.2 Local Funding Agent

In overseeing the performance of the grant, the Fund hires accounting firms to audit and screen the capacity of PRs (Global Fund 2014a). A policy of one Local Funding Agent per country is used, chosen from either PricewaterhouseCoopers or KPMG management consultancies; in countries where these two are not available then other auditing firms are used (Brown & Barnes 2011). In executing their role, the LFA evaluates the performance of the funds disbursed and measures the absorptive capacity for more funds by PRs. This makes it possible for the Global Fund to monitor the adherence of PRs to the implementation plans of the grant, given the lack of ground presence of the Global Fund in recipient countries (Brown & Barnes 2011).

Critics cite the focus on accountability, strict measurable targets and performance-driven results by the LFA as demonstrating an uneven balance in power between the

Global Fund and the recipient countries (Brown & Barnes 2011). In addition, the inadequate experience of these LFAs in health-related issues results in a lack of acknowledgement of local contexts in evaluations of grant performance. For example, this is seen in a study that showed how KPMG's less stringent criteria in assessing performance in recipient countries has triggered the release of more funds than in countries using other LFAs (Lu et al. 2006). This lack of experience by the various LFAs leads to these kinds of inconsistency. In summary, the use of LFAs in evaluation forces recipient countries to conform to neoliberal values in order to gain approval from the Global Fund.

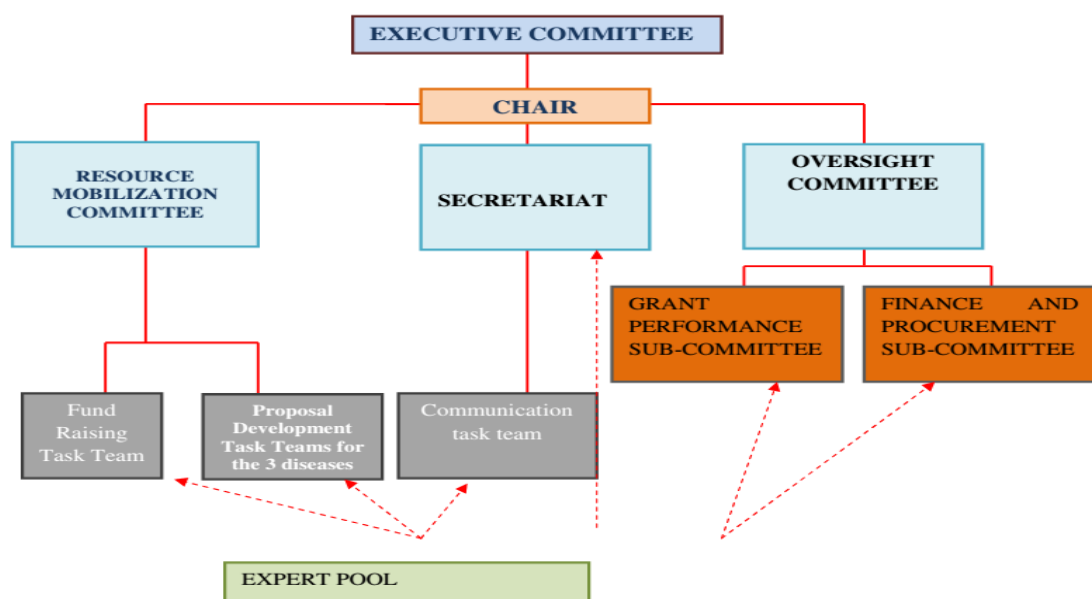
#### **4.1.3 CCM composition and the proposal writing process**

In 2002, the Federal Republic of Nigeria constitutionally approved the creation of a Country Co-ordinating Mechanism (CCM) with a mandate to submit Global Fund proposals on behalf of the country and oversee grant performance (Price 2008). Since then, the Country Coordinating Mechanism (CCM) has run Global Fund activities and grants in Nigeria and their secretariat is located in the capital, Abuja. It has a chairperson who is the Minister of Health and four other secretariat staff (CCM Nigeria 2015a). There are 53 members of the CCM with 25 members and 28 alternate members, all coming from different organisations, both government and non-governmental, and from different sectors such as education, labour and agriculture (CCM Nigeria 2015a). Alternate members are substitute nominees from the same agency with a CCM member. They attend meetings in situations whereby a CCM member cannot attend a meeting, in order to maintain their organisation's presence during voting or decision-making. The CCM has five principal recipients namely: Association for Reproductive & Family Health (ARFH), Institute of Human Virology (IHVN), National Agency for Control of

AIDS (NACA), National Malaria Control Programme (NMCP), and Society for Family Health (SFH).

There are three main committees identified in the CCM: The Executive Committee, Resource Mobilisation Committee, and the Oversight Committee (Youri 2008). The Executive Committee is the governing body that is involved in voting and in coordinating the other committees and the secretariat (Youri 2008). The Resource Mobilisation Committee is tasked with proposal development and raising funds for other activities not covered by the Global Fund grant. Experts dominate the core of this committee because of the technicalities involved in proposal writing, strategy formulation, and selection of PRs (Price 2008). The oversight committee carries out the ongoing monitoring of grant performance and participation of all stakeholders (Youri 2008). The structure of the CCM is created to handle both the technical specifics and accountability functions of fund management, which is of primary concern to the Global Fund. The diagram in Figure 4 shows the structure of the CCM.

**Figure 4: Structure of the CCM (Youri 2008)**



The constituencies and number of seats according to stakeholders groups are as follows:

1. NGOs and CBOs - 10
2. Government sector - 6
3. Development partners - 4
4. Academia, FBO, and religious organizations - 2 each
5. PLLWHAs -1 (Youri 2008).

Election for the CCM leadership is achieved through a democratic process of secret ballot. Meetings are held every 2 months with six ordinary meetings and two extraordinary meetings every year (Youri 2008). During a meetings a quorum can be achieved with a 50% attendance and the CCM secretariat tries to achieve this through early notification to members through emails, texts, and phone calls (Youri 2008).

The Global Fund from 2000 to 2015 has disbursed **\$1.5billion** to the CCM to tackle HIV/AIDS, tuberculosis and malaria (CCM Nigeria 2015a). Of the major grants, HIV/AIDS has received about **US\$ \$591,766,678** already disbursed (CCM Nigeria 2015a). The Local Funding Agent that monitors the performance of the grants in Nigeria is PricewaterhouseCoopers, Ghana (CCM Nigeria 2015a). The CCM meetings are scheduled every quarter and then more frequently during grant writing periods. The only PR under the HIV/AIDS grant that is a government agency is NACA. Under the New Funding Model, there has been a merger of the HIV and TB grants called a consolidation, which started in 2010 (Mccoy et al. 2012; Global Fund 2015f; Global Fund 2015d), aimed at harmonising the activities of the two because of the overlapping activities experienced in the past.

**Figure 5: Global Fund disbursements in Nigeria (CCM Nigeria 2014)**

| GRANT NUMBER  | PRINCIPAL RECIPIENT (PR)                                    | YEAR |      |      |                  |      |                  |      |      |
|---------------|---|------|------|------|------------------|------|------------------|------|------|
|               |   | 2009 | 2010 | 2011 | 2012             | 2013 | 2014             | 2015 | 2016 |
| NGA-H-NACA    | National Agency for Control of AIDS (NACA) (HIV)            |      |      |      | US\$ 424,916,949 |      |                  |      |      |
| NGA-H-ARFH    | Association For Reproductive And Family Health (ARFH) (HIV) |      |      |      | US\$ 45,105,310  |      |                  |      |      |
| NGA-H-SFHNG   | Society for Family Health (SFH) (HIV)                       |      |      |      | US\$ 49,423,343  |      |                  |      |      |
| NGA-T-ARFH    | Association For Reproductive And Family Health (ARFH) (TB)  |      |      |      | US\$ 95,124,879  |      |                  |      |      |
| NGA-T-IHVN    | Institute of Human Virology Nigeria (IHVN) (TB)             |      |      |      | US\$ 16,336,184  |      |                  |      |      |
| NGA-809-G11-M | Society for Family Health (SFH) (MALARIA)                   |      |      |      | US\$ 216,708,810 |      |                  |      |      |
| NGA-809-G14-M | National Malaria Elimination Programme (NMEP) (MALARIA)     |      |      |      | US\$ 294,011,688 |      |                  |      |      |
| NFM           | New Funding Model (NFM) Allocation                          |      |      |      |                  |      | US\$ 499,490,420 |      |      |

The proposal writing process normally has seven stages, which are outlined in Global Fund documents as follows:

*Stage 1*

*Strengthening of national strategic plans*

*A National Strategic Plan is developed before initiating a funding request to the Global Fund using an inclusive multi-stakeholder process. Internationally agreed frameworks aid in developing these frameworks, jointly assessed through a trustworthy, independent, multi-stakeholder process usually led by the Ministry of Health (Global Fund 2013b).*

*Stage 2*

*Alignment of the Global Fund’s process to existing country dialogue*

*This involves the alignment of health National Strategic Plans of the country with the Global Fund’s specific programmes like the HSS programme. This open dialogue involves a diverse number of key stakeholders such as Governments, donors, partners, civil society, and the CCM (Global Fund 2013b).*



### *Stage 3*

#### *Design and submission of a concept note*

*The concept note captures (i) a country's context, a description of national plan, (ii) request to the Global Fund, which consists of prioritized needs to be financed from the indicative funding amount, and (iii) the full expression of demand including additional interventions or programme elements that could be covered by available incentive funding or if additional resources become available. This concept note/proposal is then taken to the Global Fund secretariat (Global Fund 2013b).*

### *Stage 4*

#### *Independent review of concept notes by the TRP*

*The technical review panel looks at the proposals, reviews the technical aspects of the proposal to establish its feasibility, and then passes its recommendations to the secretariat for further review by the Grant approval committee (Global Fund 2013b).*

### *Stage 5*

#### *Determination of upper budget ceilings by the Grant Approval Committee*

*The Grant Approval Committee usually examines other qualitative aspects of the grant if the TRP have approved the proposal. They will then get an indication of the upper ceiling of the amount to be given to the particular recipient (Global Fund 2013b).*

## Stage 6

### Grant making

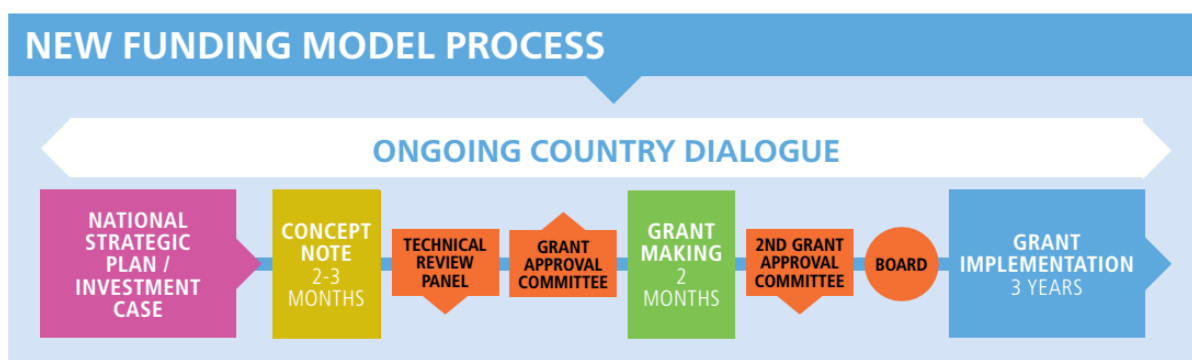
*This is a new process is made by the Global Fund to increase negotiation between the secretariat and the recipients through the CCM on modalities that will lead to disbursement of funds (Global Fund 2013b).*

## Stage 7

### Approval of grants by the Global Fund Board

*This stage is the final stage that includes all the activities of grant approval by the Global Fund board, including the signing of the agreement and finally implementation of the programme (Global Fund 2013b).*

**Figure 6: New Funding Model Process (Global Fund 2013b)**



The description above (Figure 6) shows a stepwise process of how the Global Fund has structured the proposal writing process. In reality, at the country level most of these processes are influenced by other context specific factors, which would be discussed in the findings chapters.

## **4.2 Nigeria: general context**

The sub-Saharan African (SSA) region has an estimated population of 840 million people and Nigeria has the largest population of the African continent's 47 countries (Maponga et al. 2012). Nigeria is located on the Western part of the continent with a population of approximately 150 million (Maponga et al. 2012). It is a former British colony, which gained its independence in 1960 similar to most African countries and it became a Republic in October 1, 1963.

Nigeria is divided into six geo-political zones namely: North-East, North-West, North-Central, South-East, South-West and South-South. It has a total of 36 states and its capital Abuja is located in the centre of the country geographically. There are approximately 375 ethnic groups scattered across the country though the Igbos, Yorubas, and Hausas are the three major ethnic groups (National Population Commission 2013). The Northern part of the country is predominantly Muslim and the Southern part is predominantly Christian, while there are scattered practices of traditional African beliefs in both North and South (National Population Commission 2008).

The economy was mainly driven by agriculture before the discovery of oil in 1956 (National Population Commission 2008) and the oil and gas industry now accounts for about 99% of the export revenues and more than 50% of the government revenues (Kombe et al. 2009). The oil and gas industry makes Nigeria the seventh largest oil-producing nation of the world. Other economic activities such as mining, agriculture and banking are additional sources of revenue to the country. Despite all these major sources of income there is a large inequality gap and massive unemployment rate of 23.1% (National Population Commission 2008).

**Figure 7:Map of Nigeria (National Population Commission 2008)**



There is widespread inequality, with about 54% of the population living on less than a dollar a day (Kombe et al. 2009). Several attempts at economic reforms to privatise the market sector of the economy in order to stimulate growth have led to an increase in GDP growth rates of 6% during the period 2004 – 2007 (Maponga et al. 2012). However, wide scale corruption has meant that a significant problem of wealth distribution remains.

Nigeria has some of the worst health indicators and is ranked 187<sup>th</sup> out of 191 Member States by the WHO study (Tandon et al. 2002). Nigeria has a HIV/AIDS prevalence of 3.4% and maternal mortality ratio of 1,100 per 100,000 live births (National Agency for the Control of AIDS 2015). While infant mortality is among one of the highest with 99 per 1000 live births, the under-five mortality rate is 191 per 1,000 live births and a total life expectancy of 48 years (Kombe et al. 2009).

**Table 4: Nigerian health indicators (World Health Organization 2015a)**

| Indicator   | Year      | Estimate    | Source  |
|---|-----------|-------------|---|
| <b>Demographic</b>  |           |             |   |
| Total population  | 2007      | 148,093,000 | UN Population Division 2007                             |
| Annual population growth rate                                       | 2005-2010 | 2.1         | UN Population Division 2007                             |
| % of population in urban areas                                      | 2007      | 50          | UN Population Division 2007                             |
| Crude birth rate (births per 1,000 pop.)                            | 2007      | 40.2        | UN Population Division 2007                             |
| Crude death rate (deaths per 1,000 pop.)                            | 2007      | 16.9        | UN Population Division 2007                             |
| Life expectancy at birth (years)                                    | 2006      | 48          | WHO 2008  |
| <b>Socioeconomic</b>  |           |             |   |
| Gross national income, purchasing power parity, per capita (Int.\$) | 2008      | 1,770       | World Development Indicators Database 2008, World Bank* |
| Per capita total expenditure on health (Int.\$)                     | 2006      | 50.0        | WHO 2006 data   |
| Adult literacy rate, both sexes (%)                                 | 2006      | 71          | UNESCO 2006   |
| <b>Health</b>   |           |             |   |
| HIV prevalence, adults (15–49) (%)                                  | 2007      | 3.1         | UNAIDS 2007   |
| Annual TB Incidence (all cases/100,000)                             | 2006      | 311         | WHO 2008  |
| Maternal mortality ratio (per 100,000 live births)                  | 2005      | 1,100       | WHO, UNICEF, UNFPA and World Bank, 2007                 |
| Total fertility rate (per woman)                                    | 2006      | 5.5         | WHO 2008  |
| Infant mortality rate (per 1,000 live births)                       | 2006      | 99          | WHO 2008  |
| Under 5 mortality rate (per 1,000 live births)                      | 2006      | 191         | WHO 2008  |

\*The World Bank. 2008. Gross national income per capita 2007. <http://siteresources.worldbank.org/DATASTATISTICS/Resources/GNIPC.pdf>

\*UNESCO Institute for Statistics. 2006.

[http://stats.uis.unesco.org/unesco/TableViewer/document.aspx?ReportId=124&IF\\_Language=eng&BR\\_Country=5660&BR\\_Region=40540](http://stats.uis.unesco.org/unesco/TableViewer/document.aspx?ReportId=124&IF_Language=eng&BR_Country=5660&BR_Region=40540)

\*UNAIDS. *AIDS epidemic update 2007*. 19 November 2007. Geneva, Switzerland.

#### 4.2.1 The Nigerian health system

The National Health Policy in Nigeria divides the public health system into three tiers; primary, secondary and tertiary (National Population Commission 2013). Under the National Health Policy, primary health care is the responsibility of the local governments. The state governments manage secondary health care, which consists of general hospitals (National Technical Working Group 2009). The tertiary level of health care is constituted of specialist hospitals, teaching hospitals, Federal Medical Centres (FMC), and medical research institutes, which are placed under the responsibility of the federal government, under the Ministry of Health. Additionally, Nigeria runs a pluralistic health care delivery system with both western and traditional health delivery (National Population Commission 2013). Statistics show that approximately 70% of the population patronise traditional healers (Kombe et al. 2009). Other providers of health include private for-profit, nongovernmental organizations (NGOs), community-based

organizations (CBOs) and faith-based organizations (FBOs). This heterogeneous mix of health providers in the health system has seen people accessing health care from a variety of sources.

#### **4.2.1.1 Public health sector**

In 2005, it was estimated that there were 34,173 health facilities in Nigeria (Directory of Health Facilities in Nigeria 2014a). The government facilities account for only 20% of the health service provision in the country (Kombe et al. 2009), whilst 66% of the health facilities in Nigeria are in public ownership (Directory of Health Facilities in Nigeria 2014b). The tertiary institutions are the highest level of healthcare and act as referral centres to other health facilities. They are equipped with modern facilities and are a source of knowledge production and diffusion to primary and secondary health centres. There is at least one tertiary hospital in every state (TWG-NSHDP Health Sector Development Team 2009). There are 83 tertiary institutions in the country and they account for only 0.2% of all health facilities (Directory of Health Facilities in Nigeria 2014b).

A total of 3992 secondary health centres are located in the local governments of the states, staffed with specialist doctors in the major departments of medicine, surgery, paediatrics and obstetrics and gynaecology. These centres account for 12% of all health facilities (Directory of Health Facilities in Nigeria 2014b). Other health professionals including nurses and lab technicians form part of the staff strength of these health centres. The primary health centres constitute 85% of the health centres (TWG-NSHDP Health Sector Development Team 2009) and are meant to be the link between the community and the health system, staffed with nurses, community health extension workers and environmental health workers. They provide the basic health services of health prevention, promotion and curative services and they refer severe cases to the

secondary or tertiary institutions. The Local Government Councils (LGC) are responsible for the management of PHCs and these PHCs are the entry point to the health system (CCM Nigeria 2014). Disparity in LGC management styles and income has seen staffing levels at PHCs differ substantially. PHCs are managed as a collaboration between a community group called Ward Development Committee, health workers and the LGC OHC department (CCM Nigeria 2014).

**Table 5: Summary of health facilities in Nigeria (CCM Nigeria 2014)**

| Type         | Ownership     |               | Total         |
|--------------|---------------|---------------|---------------|
|              | Public        | Private       |               |
| Primary      | 21,808        | 8,290         | 30,098        |
| Secondary    | 969           | 3,023         | 3,992         |
| Tertiary     | 73            | 10            | 83            |
| <b>Total</b> | <b>22,850</b> | <b>11,323</b> | <b>34,173</b> |

#### 4.2.1.2 Private health sector

Private Out-Of-Pocket (OOP) expenditure accounts for over 95% of the total health expenditure in the country and the private sector provides health services for up to 65.9% of the population (World Health Organization 2015b; Onah & Govender 2014; Kombe et al. 2009). These providers include private-for-profit organisations, faith based organisations, health dispensaries and traditional healers (Onah & Govender 2014).

#### 4.2.1.3 Health financing

Health care funding by the government has declined in recent years to about 3.5% of the government's expenditure (Kombe et al. 2009). The single largest source of funding for health in Nigeria is out of pocket which is about 65.9%, followed by the government with 26.1%, firms at 6.1% and then development partners such as the Global Fund, PEPFAR and DFID with 1.8% (Kombe et al. 2009). This 26.1% of the government financing includes federal, state and local government's expenditure (Kombe et al.

2009). The expenditure of development partners in health maybe the least of all health expenditure but the concentration of their funds on the three disease entities already referred to is the reason why GHIs programmes and policies in the country have a very strong influence on the direction of Nigeria's health policies.

#### **4.2.1.4 Health information systems**

There is gross under funding of information systems networks in Nigeria and the existence of parallel reporting systems makes sharing of health data difficult. Coordination between the different systems is virtually non-existent and the numerous HIV/AIDS programmes funded by different global actors has created up to six different HIV/AIDS specific patient management systems with different technical standards (Kombe et al. 2009).

#### **4.2.1.5 Other areas**

Civil Society Organisations (CSOs) are described as the voices of the citizens and are intended to help keep health providers and government in check. However, they lack the technical capacity, advocacy skills, and networking resources needed to influence health policy processes and protect the interests of the ordinary citizen (Kombe et al. 2009). CSOs and NGOs direct most of their attention towards the HIV/AIDS aspect of the health system because of donor funding to those areas, thereby neglecting other areas of the health system that need their advocacy (Kombe et al. 2009). Attempts by some CSOs and NGOs to influence the policy process have often yielded poor results (Kombe et al. 2009).

#### **4.2.1.6 Human Resource crisis in Nigeria**

Unlike other Sub-Saharan countries, Nigeria has a good doctor to population ratio of 30 per 100,000 people and 100 per 100,000 people for nurses (Mafe 2012) but the major



problem is in the distribution of these health professionals between the rural and urban areas. These rural areas form about 70% of the total population and suffer most of the mortality and morbidity burden in the country. In addition, the health indicators of the Northern part of the country are poor compared to the urban Southern part of the country (World Health Organization 2015a).

Currently the country produces about 2000 medical doctors per year and 5500 nurses per year (Kombe et al. 2009) from its pre-service training institutions. This shows there are actually enough doctors and nurses being trained. However, it is the lower cadre professionals who are posted to the rural areas and their numbers are inadequate. The doctors and nurses who stay in urban areas are still being produced in greater number than the much-needed lower cadre. Furthermore, about 26% of medical doctors are practising outside the country in both OECD and non-OECD countries (Mafe 2012). Even with the high attrition rate due to the brain drain, there exists a positive flow of fresh graduates (Kombe et al. 2009). The federal government loses US\$184,000 for every doctor that migrates out of the country (Marchal & Kegels 2003). In addition, there is a high level of poor interpersonal relations and inter-professional friction among health workers and medical doctors (Osaro & Charles 2014).

#### **4.2.2 The Global Fund HIV/AIDS grant in Nigeria**

In 2002, the Nigerian CCM submitted its first Global Fund proposal called the Round 1, with a focus on the expansion of PMTCT (Prevention of Mother to Child Transmission of HIV) and the creation of PMTCT centres of excellence around the country (CCM Nigeria 2001). It focused on the creation of six centres of excellence for PMTCT, to be located in six tertiary medical centres. The FMOH and NACA were meant to be the only PRs, with other organisations serving as SRs that would implement the programme in the six selected states, chosen due to their high prevalence rates. At that moment, the proposal was solely focused on comprehensive hospital care for PMTCT. It was not

integrated to other hospital services and it had no system-wide component. The prevalence of HIV/AIDS in Nigerian in 2001 was 5.8% and the country was faced with little funding in the prevention of HIV/AIDS and a weak health system inherited from the military regime that handed over to the democratic government in 1999 (CCM Nigeria 2001). Sadly, corruption and a lack of country coverage saw the Round 1 grant fail to achieve considerable results in the fight against HIV/AIDS. *'The NACA Round 1 grant was unable to secure Phase 2 funding due to poor performance against set targets, an inadequate M&E system, data unreliability as well as tardy and insufficient reporting by the PR.'* (OIG Report 2011:3).

In 2005, the Nigerian CCM applied for another round of Global Fund funding called the Round 5 and this coincided with the time when other stakeholders such as PEPFAR, CDC, and the World Bank had their own parallel grants that had also been consolidating the Round 1 grant of the Global Fund. However, due to the limited coverage of the Round 1 grant, treatment with ARVs only reached 6% of the affected population (CCM Nigeria 2005). In 2005, the HIV/AIDS prevalence had dropped slightly to 5.0% and the general epidemiological picture of the spread of the disease was clearer to stakeholders (CCM Nigeria 2005). With this new information the Round 5 grant was designed to scale up HIV/AIDS treatment in tertiary, secondary and primary health centres in all 38 states (CCM Nigeria 2005). The scale up of services was to include ARV treatment, related counselling and testing, PMTCT and community care for HIV/AIDS treatment (CCM Nigeria 2005). The more ambitious Round 5 had four PRs but was still plagued with corruption, poor reporting and duplication of results (OIG Report 2011). *'The Round 5 grants recorded better performance although some targets for key indicators were still not met.'* (OIG Report 2011:3).

The Round 8, 9 and 10 call for country proposals by the Global Fund was aimed at Health Systems Strengthening (HSS) because *'A key message is that programmes are part of any health system, and it is impossible to scale up services to any significant extent without a stronger health system.'* (World Health Organization 2011b:2). The Nigerian CCM was only able to secure funding for Round 8 and Round 9, with proposals that were focused on HSS cross-cutting interventions by consolidating on the relative success of the Round 5 grant. The aim of Round 8 was to scale up the HIV/AIDS services to all states in the country in 13 Service Delivery Areas (SDA) and in the process strengthen the health system. The areas in the health system that were identified as weak included: *'weak referral linkages', 'critical shortage of human resources', 'dilapidated health infrastructure', 'weak public/private partnerships', 'weak institutional and capacity', 'inadequate strategic information base' and 'inadequate decentralisation of services'*(CCM Nigeria 2008). This was the first time CSS (Community Systems Strengthening) was mentioned and the aim was to involve more community stakeholders in the implementation process (CCM Nigeria 2008).

While the Round 9 grant in 2009 was also focused on consolidating Round 5: *'In round 9 the gap in access and coverage of HIV services to rural communities will be bridged by further decentralizing HIV/AIDS prevention, care and support services to the PHC and community levels, while expanding ART services through establishing 194 new ART sites in secondary health facilities.'* (CCM Nigeria 2009:2). Central to this decentralisation process was the implementation of task shifting in the ART sites due to the poor referral linkages that were limiting the progress of the ongoing grants. Task shifting was not mentioned in the proposal but a review of implementation guidelines from a joint report by UNAIDS and WHO showed how implementers were advised to use task shifting in bridging this implementation gap: *'In order to address these issues...considering task shifting as an option for filling in existing gaps of required*

*health personnel.* (WHO|UNAIDS 2011:17). During this period donor funding had also dropped and implementers were desperate to try strategies with potential for yielding quick results because of increased competition among implementers leading to ‘*a covert environment of competition for the limited resources*’ (CCM Nigeria 2015b:37).

Even after all these adjustments in strategies to scale up ARV dissemination through the Global Fund grants, a recent OIG report showed that the grant was ineffective in all areas of programme implementation (OIG Report 2016a). In addition, during this period, PEPFAR was beginning to have more influence in the Nigerian health system, as is apparent from PEPFAR’s 69% of total available funding for HIV/AIDS in the Nigerian health system with the Global Fund providing only 2% (CCM Nigeria 2015b).

**Figure 8: OIG Report ratings from 1 to 5 (OIG Report 2016:7)**

Below are the OIG’s overall ratings of the implementation of the Global Fund grants to Nigeria:

| <b>Audit objectives</b>  | <b>Rating</b>                           | <b>Reference to findings</b> |
|--|---|------------------------------|
| <b>1. Design and the effectiveness of internal control environment</b>                   |   |                              |
| <b>1.1 Procurement and supply chain management</b>                                       | <b>Ineffective</b>                      | <b>1.1</b>                   |
| <b>1.2 Financial management</b>  | <b>Ineffective</b>                      | <b>1.2</b>                   |
| <b>1.3 Program management</b>  | <b>Ineffective</b>                      | <b>1.3</b>                   |
| <b>2. Design and effectiveness of Global Fund risk management framework for Nigeria</b>  | <b>Ineffective</b>                      | <b>2</b>                     |
| <b>3. Effectiveness of implementation arrangements for Global Fund grants in Nigeria</b> | <b>Partial Plan to become Effective</b> | <b>3</b>                     |

The New Funding Model (NFM) of the Global Fund has been designed to learn from the successes and failures of previous grants by setting ‘*out ambitious targets and focuses on the highest-impact interventions targeted at the key drivers of the epidemics and at the most vulnerable populations... It has been designed to help the Global Fund*

*invest resources more strategically*' (The Global Fund 2013b:2). The most significant changes in the new model include: the introduction of more engagement from the Global Fund secretariat in country dialogue, more strategic investment and a consolidation of the HIV and TB grants (The Global Fund 2013). Because of this new strategy the NFM Concept Note by the Nigerian CCM focuses primarily on six high impact states selected from an Epi-analysis of the HIV/AIDS prevalence in the country (CCM Nigeria 2015b). This is a shift from previous grants that had a wider and more holistic coverage. But in many ways the NFM is similar to the more vertical first Round 1 grant that targeted only six health centres. Finally, the Global Fund in this new model have adjusted their business model to only fund strategies that have been proven to be value for money: *'Value for money involves getting the maximum health impact on the three diseases... also recommended that the Secretariat designs and implements other incentives to facilitate PRs themselves to adopt and allocate more resources to the most cost-effective interventions'* (Comprehensive Reform Working Group 2011:14). In order to achieve this the Global Fund will *'Identify ways to reinforce the application of performance-based funding...and moving towards payment-for-service'*(Comprehensive Reform Working Group 2011:17). With this new change and the NFM being in its early stages it is difficult to assess if the Global Fund is reverting to a more vertical approach while departing from the broader HSS strategy of previous grants, eventhough most of the the document reviewed point towards a more vertical approach.

### **4.3 Chapter summary**

A chapter describing the case study context is vital when focusing on one particular organisation because it serves as an introduction to the activities of the case study context. This chapter helps in situating the thesis within the context of the case study. It also summarises the historical development of the Global Fund as a leading actor in the

global health governance architecture and goes further to describe the organisational framework of the Fund. The CCM, which is the body that represents the Global Fund in the context of Nigeria, is the centre of focus in this study. The information in this chapter combines the documentary sources that describe the case study and country context. Most of the information given in this chapter uses the information from the Global Fund sources such as the CCM Nigeria and the Global Fund. The ensuing results and discussion chapters draw upon the contextual information provided in this chapter to present deeper insights into the ideas, themes, and events discussed.

## **Chapter 5**

### **Technical and procedural specification in the Global Fund's organisational and funding structure**

#### **5.1 Introduction**

The previous chapter introduced the case study, situated within the Global Fund HIV/AIDS programme in Nigeria. In this chapter, and the subsequent two chapters, the empirical findings from the research conducted with CCM members and implementers of the Global Fund HIV/AIDS programme will be explored.

The sociology of professions tells us that medical professionals try to create a certain professional monopoly in the health sector in a bid to remain relevant and protect their professional boundary. With the help of Friedson's contribution to the sociology of professions, we will understand the structures and processes that are responsible for medical dominance in the health system and how this can be linked to a growing epistemic community of professionals mostly composed of medical professionals in the Nigerian health sector.

In light of these arguments, this chapter discusses the ways in which the Global Fund structure interacts with and influences medical professional powers within the health sector. In particular, the first part of the chapter examines how the Global Fund structure is shaped to influence the professionals that are involved in the health policy process of the Nigerian health system and in the process; we will identify an elite group of key stakeholders in the programme structure.

The second part of this chapter examines the ways in which technical specifications and institutional procedures operate and the effects they are seen to have on the process of

constructing proposals and on the implementation of the grant through the inclusion of some perspectives at the expense of others. This entails demonstrating how the technical specifications and institutional procedures reflect biomedical dominance and NPM in their content and style. Lastly, this chapter explores some focal points in the Global Fund structure that highlight the key interactions between medical professionals' influence (dominant interest), and other contesting interests (challenging interests) previously not identified in the literature. The findings in this chapter draw from the all three sources of data.

## **5.2 Professional influence and Dominance: Identifying the Dominant interest group in the policy process**

This section identifies influential stakeholder interests in the Global Fund structure, their mode of influence, and the processes that enable and encourage the development and use of this influence. This theme is identified from the interview accounts through the data analysis concerning the structural peculiarities of the CCM and Global Fund grant in Nigeria. The extracts in this chapter show the complex processes that have created a dominant block of interests, and highlights the unique characteristics of the Global Fund that either empowers or erodes the powers of these interest groups. The chapter begins by reflecting on accounts that focus on the composition of the CCM membership and on members' strategic interests.

### **5.2.1 Composition of CCM participants**

The idea of the creation of a CCM in recipient countries by the Global Fund is to encourage representation and participation from various sectors and stakeholders through a process driven by CSOs. This sub-section aims to compare and contrast the intended composition of the CCM and the actual Nigerian CCM.



The Nigerian CCM is composed of public health experts, social science experts and medical doctors, including representatives from various sectors such as the Labour Congress, Union of Journalists, Civil Society Organisations, donor community and international and local NGOs. There are also representatives from the patient population, stakeholders in the health sector and other relevant non-health stakeholders such as the Ministry of Education and Labour. Usually invitations to CCM meetings are sent to representatives of the CCM member organisations, and at meetings the selected delegates give their contributions in a consensus based decision-making process. The CCM is mandated by the Global Fund to have delegates from the government, development partners, academic sector, NGO sector, people living with the disease, Faith Based Organisations, and private sector (Global Fund 2015d). Organisations from these sectors are selected by the CCM and the organisation picks a delegate from within the organisation to represent them. Delegates are meant to be technically competent, based on their organisation's core functions. The 53 member CCM has committees such as the Executive Committee, Resource Mobilisation Committee, and the Oversight Committee responsible for various functions. These Committees aim to share the various roles of the CCM amongst themselves with a view of ensuring they secure Global Fund grants. The participants are conscious about the central role the CCM plays in co-ordinating the policy process that leads to a successful grant application. This expectation is captured in the extract from participant 20, where he explains what is demanded from the CCM:

*That should be the work of CCM that is their mandate. That is why they are there to coordinate all the activities including the proposal writing because they are the ones that will submit on behalf of the country to Global Fund whatever*

*document the proposal writing team comes up with will be subjected to RMC or CCM (Participant 20: Medical Doctor)*

This captured in the documentary evidence below:

***Section 2: Core Principles***

*ii. Focus on the creation, development and expansion of partnerships among all relevant players within a country, and across all sectors of society, including governments, civil society,, multilateral and bilateral agencies, and the private sector; (Guidelines and Requirements for Country Coordinating Mechanisms:(Global Fund 2015c:6))*

Different members in the CCM can bring their expertise in, to see that the proposal covers all the major areas needed. Participants' accounts showed that, the CCM is the designated body with the power to decide the direction and concept of the proposal process, while the RMC is responsible for overseeing the writing process and submitting the final draft to the CCM executive for final approval. This is captured in all the country proposals because in every proposal the CCM has to show the structure of the CCM (CCM Nigeria 2001; CCM Nigeria 2005; CCM Nigeria 2009; CCM Nigeria 2015b; Youri 2008; Price 2008; CCM Nigeria 2008).

The Global Fund has promoted CSO activity in the policy process and participants agree that the CSOs are a prominent force in the CCM, although, some participants doubt CSOs' capacity to influence the proposal writing stage. Despite the fact that the CCM board has the power and an oversight function of co-ordinating a multi-stakeholder proposal writing process, many participants emphasised that in reality the process is driven by the expert consultants and big NGOs:

*And why did I bring this up? It's because sometimes the discussion at the CCM level are only generating the ideas that are passed on to somebody else to write a proposal, I am not sure how many CCM members can actually sit down to write it... I know that in this country and other countries today outsource it to an NGO (Participant 30: Medical Doctor)*

Most participants claim that the CCM has not been strengthened to the level where it can actually co-ordinate the proposal writing process effectively because of the CCM's limited funds. The CCM has a secretariat vital to the running of the CCM operations. The documentary evidence below shows the responsibility of the CCM secretariat during stakeholder meetings:

- *Support an inclusive dialogue process*
- *Facilitate access to technical assistance*
- *Engage with countries to determine specific access to funding timelines*
- *Provide feedback on performance of existing grants and strategic investments through the Portfolio Analysis, the iterative process and on-going feedback during implementation*
- *Communicate availability of funding and apply qualitative factors to determine funding levels*
- *Discuss split between diseases and cross-cutting Health Systems Strengthening efforts (Information Note for Country Dialogue (Global Fund 2013:19))*

However, the poor funding of the CCM by both the government and the Global Fund was identified as the major reason why Nigeria has a weak CCM. This was captured in

both participant extracts and CCM reports (Youri 2008). Unlike the CCM members who are paid by their parent organisations in carrying out Global Fund related activities, the CCM secretariat staff are usually full-time paid staff. Over the years, the Global Fund has been able to decide on an arrangement whereby the government would provide 20% of the overhead costs of the CCM secretariat while the Global Fund provides the rest in the New Funding Model (Pullen & Garmaise 2014). Participant 10 explained how the funding stream for the CCM secretariat works, and captures this point:

*...a recipient country for that matter had to mobilise resources in country for them to be able to establish their own secretariat and see how the grant could be effectively managed in country. But over-time, that did not work fine for most countries, so Global Fund put in place a mechanism, by saying, okay, we will be giving you like \$50,000 every year, but it's insignificant, (Participant 10:Management expert)*

The recent interventions by the Global Fund have still not solved the problem of the insufficiency of funds in the CCM secretariat. Some participants claim that in most instances, the CCM secretariat staff or members just sit in meetings without any meaningful contributions and accept the suggestions of the powerful organisations that drive the process. Although the CCM initiates the proposal writing process by sending out invitations, their co-ordinating presence is hardly felt and this can be linked to the fact that the CCM relies on organisations to fund the proposal writing process and hence can hardly speak against them:

*Until we ensure that, yes, when all of us come to that place, our voices are equal, you won't say because PPFN is a national NGO spread all across, so when PPFN talk, kwaaam (bangs table), you accept it because it is PPFN; SFH is a very big organization, when SFH talk, kwaaaaam (bangs table), you accept it and when CCM does not have the fund, and these big organizations are the ones driving the process, why won't CCM listen to them; so we need to ensure that the voice of all stakeholders are equal, we also need to ensure that CCM is well-funded to be the prime coordinator of the (proposal writing)...it's not like oh, they just come and sit down and listen, they should be seen to be driving the process. At least I can say that without fear or favour, that all the ones I have participated, CCM just come, they sit down, when we want them to talk, we ask them questions, they don't drive the process, but that's one of their work; they should drive the process, they should not be invited to the place, they should be the one inviting people to the place, yes, at some point, they write letter to say we want to start another grant, they do it; but the real design and all those things, they just come and sit down, may be because the CSOs are supposed to be the ones really writing it, but let your (CCM) coordination presence be really felt strongly (Participant 8: Non-doctor Public health expert)*

The extract from participant 8 is a reflection of what is generally perceived by most of the members and stakeholders in the Global Fund programme interviewed for this study. It shows how weak the CCM is in influencing proceedings when these top organisations are involved due to the poor funding of the CCM. This point will be developed further in Chapter Eight, with reference to empirical studies in other contexts.

In view of the Global Fund's primary goal to use the CCM as a platform for a CSO led

multi-stakeholder decision-making structure, the empirical evidence instead illustrates how susceptible the Nigerian CCM is to the influence of existing dominant interests. The poor funding of the CCM secretariat further makes the CCM weak in carrying out its coordination function, making it exposed to the influence of a few powerful organisations. The CCM is a potentially influential decision-making structure, which in the context of Nigeria, contrary to its original design, has become a platform for the extension of particular expert and individual influence through the representation of powerful health organisations. Some of the characteristics of the influential individuals will be covered in later parts of this chapter and Chapter Six.

In the exploration of the composition of the CCM, the RMC is a vital component to the decision-making process. The next section will go deeper from an organisational viewpoint to a more individual and group level, in order to identify roles and key professional influences.

### **5.2.2 Key dominant stakeholders**

This section seeks to identify the professional background of the elite class of individuals who are affiliated to strategic organisations, thereby placing them in the RMC, which subsequently confers on them significant power in the proposal writing process. The sub-section, drawing from interview, observational and documentary data, focuses on positional power in the Global Fund structure and identifies the professional background of this elite group. This approach will identify areas of positional power in the CCM and then identify the professional background of those who occupy those spaces. Lewis (2006) argues that this approach is more appropriate in exploring professional dominance within a health policy network than seeking to identify influence of professional groups and associations (Lewis 2006).

The RMC is a key committee in the CCM, which helps select PRs and SRs and has a final say in the content of the proposal when it is finished. The RMC was formerly known as the Technical Review Panel of the CCM until 2008 when the name was changed to the RMC but their role in the CCM has not changed (CCM Nigeria 2008). The RMC is chaired by a WHO member, with members from other key partners such as the UNAIDS and CCM secretariat forming the rest of the committee:

*'The Resource Mobilization Committee (RMC) of the CCM Nigeria is chaired by WHO... The RMC coordinates proposal development activities for CCM Nigeria' (Country proposal – Round 9 (CCM Nigeria 2009:9))*

The RMC selects the PRs and SRs from the criteria advertised by the Global Fund and scores the applicants based on the Global Fund's eligibility criteria, before sending the shortlist to the CCM board for final approval. The selection of PRs and SRs is an essential process because it determines the organisations that get to implement the grant applied for by the country. Because organisations implement the grant on behalf of the Federal government, successful PRs and SRs become major players in the health system and this is a major source of power because, as participant 8 stated previously, 'who has the funds decides'. This makes the work of the RMC very important and confers on its members a position of authority and we can use this as a focal point in identifying key professional influences. Participant 1 who is a member of the RMC tells us about the function they carry out and gives an idea of the kind of professionals found in this vital group:

*For those of us in the UN, we are mainly doctors, because it's disease specific, HIV; I am thinking of all those who were members, they were mainly doctors, (Participant 1: Medical doctor)*

The RMC member stated that during her membership, the committee was mainly constituted of medical doctors like herself. Analysis of that data illustrates a small group of professionals mostly made up of medical doctors, who control key decision-making processes on behalf of the CCM. This strategic power by the RMC members enables them to decide the final content of the proposal before it is sent off for grant signing. Therefore, regardless of the deliberations at the writing stage, only a few influential figures have the final say. This is captured in the extract from participant 9 who has experience from the most recent grant round application process:

*Yea, at the end, the final say, there are just very few people that at the end decide, you know, the direction of the proposal. And there are a lot of discussions on anything because of the number of people, the number of hands that contribute to the proposal and there are a lot of discussions on many, many things. So at the end two, three people actually decide. They lead together with a couple of more influencing personalities and these influencing personalities varies depending on the proposal, depending on the organization. It is more yea in the Global Fund for example; I think Aisha (not real name (medical doctor)) was pretty influencing. You know personally we had a lot experiences that are all better than this and the seniorities they are the ones that obviously take the decision and normally they are just a few of them who participated in the proposal. (Participant 9: Finance expert)*



*Whatever he (RMC lead) says should go in any case they are the ones who signed off the final document. So even if you air your own opinion at the end of the day, they will still maintain the position they are already convinced about*  
*(Participant 28: Medical Doctor)*

Participants believe that a process of deliberation exists but are aware of the ultimate power that lies in the hands of the top-level medical elites of the RMC. Interestingly, some of the RMC members are not members of the CCM, because the CCM appoints experts to the RMC in order to benefit from expertise unavailable in the CCM. This is common practice in the CCM of other countries (Pullen & Garmaise 2014). From the empirical data, the Nigerian CCM usually appoints medical professionals from INGOS to the RMC. The empirical evidence goes beyond identifying the influence of medical professionals within the RMC, it emphasises the rather direct power that these elites have on the policy process. The extract below explains the two levels of decision-making; the first proposal writing stage comprising a broad range of professionals and the final critical stage, which the influential medical elite group control. These processes happen at the national level or meso-level of policy development; therefore, there are two levels of decision-making at the meso-level.

*we start with a large group of people and you continue to narrow down, narrow down to the CCM resource mobilisation committee that finally reviews and I think those people have the greatest influence on the proposal...you start with forty, fifty people, professionals working on a proposal and then it whittles, it*

*goes down to five people; so those five people are the people that will have more influence on the proposal at the end of the day; especially where there are conflicts, where there are conflicts... there is no formal voting or anything, but the opinion with the strongest force will always prevail; and then the people (RMC members) at the last bus-stop before the grant goes out will also have more influence on what the final output is (Participant 21: Finance expert)*

We have looked at the funding framework and explored how funding gaps have created opportunities for dominant interest groups to exert their influence. In addition, we identified how a small group of elite medical professionals are able to exert a lot of influence on the proposal document through the RMC.

Given the claims by the Global Fund that the CCM encourages the broadening out of deliberative spaces and incorporation of different views, the data from observations of CCM meetings is important. Whilst the observational data of CCM meetings was restricted to two events, these periods of observation did give me an opportunity to examine some of the interactions of the CCM proceedings mentioned by some participants.

In one of the meetings, I observed a consistent level of interaction between the professional experts (comprising mainly of medical professionals) and the rest of the participants in attendance. Throughout the meeting, there were presentations that looked at disease trends, with a biomedical focus from the technical experts representing top organisations such as the WHO, UNAIDS, PEPFAR, UNICEF and hired consultants, with NACA spearheading the proceedings. However, there was a visible lack of leadership by the CCM secretariat during the proceedings. This is important because the

Global Fund expects the country CCM to exhibit some level of leadership qualities in meeting deliberations and the Global Fund uses this as a criteria in the Eligibility and Performance Assessment of CCMs. *'The EPA (Eligibility and Performance Assessment) is intended to enable the CCM to take ownership of this process, enabling it to meet the requirements and **fulfil its leadership role effectively**'*(Emphasis added (The Global Fund 2015a:2)). During the meeting, the content of presentations had a core biomedical emphasis on how the health challenges could be solved and very few alternative perspectives were explored. A participant in the meeting interrupted the discussion to stress the need for more social science input to explain behaviours rather than the focus on only epidemiological trends. The comment by the participant echoed the evidence in the observation field notes. The same influential participant in the process emphasised that most of the HIV/AIDS funds were invested in treatment, care, and human resources but little attention was shown to demand creation. According to the WHO, demand creation refers to *'individuals or communities willingness and/or ability to seek, use and, in some settings, pay for health services'* (World Health Organization 2016).

The extract below from my observational field notes, is illustrative of this interface. It details my interpretation of these expert led proceedings in a meeting that was meant to engage a wider audience:

*With an obvious lack of data, the meeting still progressed with presentations on the national and state epidemic impact analysis report and the majority of the presenters were medical experts from the leading NGOs, NACA, UN agencies, and PEPFAR. All the experts gave their Epi-analysis showing the increasing trend of HIV/AIDS spread with an unmet need for ART at 57%. There was a feeling in the room that not all these reports were new information to the*

*audience and it dwelled on scientific indices, and had little answers to behavioural patterns fuelling the increasing trend and poor accesses to health services that was leading to the low demand in the country. This prompted [an influential personality] to say ‘we need social science to push for better explanation of why (epi-analysis trends)’. This was then followed by a comment [from a representative of a very influential organisation] in support but this did little to change the direction of the meeting, which appeared to have a fixed agenda. One of the representatives [from the human rights groups] highlighted the neglect of the rights and inputs from the patient population but nothing was said or done from the side of the CCM to address this issue. At this point of the meeting, it was visible to everyone that NACA had set the agenda and was not ready to change the course of the meeting due to the suggestions raised. The next point in the agenda was the presentation of a team of 32 members to write the proposal/concept note selected by the RMC and most of the members were experts from the ‘big’ organisations with only one CSO member and no one from the patient population. A member [of a patient group] raised this visible exclusion of the patient population from the core team but an un-official comment was made that the matter would be looked into and the meeting progressed. Someone [from one of the Labour organisations] later highlighted why there were about 8 PRs in the core team while the CCM had only 1 member in the core team but this was countered with a statement from one of the PRs saying that most PRs had a dual role of being CCM members and PRs of the Global Fund grant. A member [from one of the Labour organisations] then asked the audience whether the dual role does not pose a conflict of interest issue with the PRs protecting their interests as CCM members and as PRs. This was met with silence and the meeting continued with no one addressing the*

*questions raised (Notes from observations of Global Fund meeting on the National and State epidemic impact analysis, 6<sup>th</sup> of March 2014).*

The point made by a member of one of the Labour organisations highlights the Global Fund's stance in the CCM guidelines about conflicts of interest.

**Requirement 6:** *To ensure adequate management of **conflict of interest**, the Global Fund requires all CCMs to:*

*Develop and publish a policy to manage conflict of interest that applies to all CCM members, across all CCM functions. The policy must state that CCM members will periodically declare **conflicts of interest** affecting themselves or other CCM members. The policy must state, and CCMs must document, that members will not take part in decisions where there is an **obvious conflict of interest**, including decisions related to oversight and selection or financing PRs or SRs. (Guidelines and Requirements for Country Coordinating Mechanisms: Emphasis added (Global Fund 2015c:17))*

The extract is illustrative of the interplay between the dominant interest groups and the patient population represented in the form of labour groups, CSOs and patient population groups. Within this case study the voice of the non-experts or the consumers' voice is usually not heard or acted on and the proceedings are led by powerful organisations mentioned above with conflicts of interests due to their dual role as leading members of the decision-making body of the CCM and beneficiaries of these decision making process. Participant 28 in the extract below also supports this observation:

*We are a principal recipient so we coordinate and implement. We coordinate as a national body and for Global Fund we do not necessarily implement; because PRs should not implement but we manage the grant for Global Fund in Nigeria. However, NACA is also part of CCM so in that light, NACA is also part of decision making through the CCM that is for Global Fund (Participant 28: Medical Doctor)*

A combination of observations and interviews cited above have shown that the processes of agenda-setting and decision-making under the Global Fund grant in Nigeria are controlled by a group of elite medical professionals in the CCM. The triangulation of these sources of data shows how these powerful individuals in these strategic organisations can suppress opposing interests and manipulate the process in their favour, even working against Global Fund guidelines to further their own agendas. They also have the positional power to suppress the expression of other alternative ways of framing health problems and have direct influence on the policy process. A participant described how this dominance has created tension between the powerful NGOs and the less powerful CSOs.

*The CSOs look at the big NGOs as if they just want to take the money and the big NGOs look at the CSOs like "you do not have any capacity, so when you get the money what are you going to do with it? You are just going to blow it". So during proposal writing there is always that tension (about) where the money flows (to)? Do you keep a chunk of it within actual structured implementing type*

*partners (NGOs) or the more local but civil society organisation that are more membership owned? So those kinds of things that is actually the kind of tension that plays out and in more recent times (Participant 33: Health economist)*

Analysis of interview, documentary and observation data shows that these dominant organisations are occupied and led by medical professional experts. For example, the RMC member (Participant 1) said they were mainly medical doctors; secondarily the outsourcing of some of the decision-making processes to consultants and the evidence from the observation field notes, show how this positional power has dominated other less powerful interest groups. The extract below is further evidence of this:

*I will give straight example because this is civil society we do not hide it, if you go to APIN (AIDS Prevention Initiative in Nigeria), APIN has almost 91% of doctors there, and IHVN (Institute for Human Virology in Nigeria) almost have 98% doctors there. Almost everybody is a medical doctor. I do not know whether it is stated in their policy before they came to Nigeria or sometimes...it is only a few that do not have medical doctors there (Participant 32: Non-doctor public, health expert)*

In summary, a group of medical professionals through their affiliation with powerful health organisations and their membership in the RMC possess strategic power in the Global Fund proposal-writing process. They operate as a local elite epistemic community in the Nigerian health system that dominates the policy processes, leading to a crowding out of other contesting interests and repressed interests such as the patient

population. The positional power the RMC members have enabled them to directly affect proceedings of meeting and their use of the biomedical language is another expression of the dominance the biomedical discourse has in such proceedings. It was apparent that for some of the participants their contribution to the decision-making process was simply their physical presence at the CCM and other group meetings. We will now go further to see the various stages of the proposal process and the role of this elite epistemic group in the various stages.

### **5.2.3 Proposal writing done in stages**

The previous section has provided some examples of how a few professional experts have considerable influence in the Global Fund structure in Nigeria. The findings in this sub-section go further to explain how the contextual realities the Global Fund grant faces, around existing powerful interests, distort equal representation, which is contrary to the original design by the Global Fund to create a proposal process that ensures a representative view of a broad range of deliberative discussions. To understand how influence flows in the policy process, a broad overview of the proposal writing stages is necessary. By so doing, we are able to highlight the mode in which this dominant group exerts their positional power over the proposal writing process.

The proposal writing process is divided into two stages, with the first stage consisting of a phase where all the stakeholders from various fields, backgrounds, professions, and partners meet to brainstorm about possible ways of achieving the aims set out by the Global Fund and CCM. The next phase of the first stage involves just a few people who trim and streamline the document in order to produce a final draft, which focuses on issues relevant to the country. In the second stage, the RMC tailors the final draft to include the interests of the stakeholders and partners, and aligns these to the national strategic plan. Participant 19 explains this process:



*So, for that you find that proposals are done in stages. The first stage is where you have a larger house, bringing people with different backgrounds, all professions, all partners, both internal and external, and there is a kind of brain-storming and a larger document is developed; then after that you have a more of a technical team that comes up with a more technical thought than what has been designed by that larger house and now starts trimming down; at that stage all the opinions must have been taken into consideration and then the technical team comes to synergise the issues, trim down the issues and ensure that as much as possible all in-puts from the different partners are considered, as long as they are relevant to where the country is heading to, with respect to that proposal. Then you find that the last stage will be a smaller team that will now finalise and present to stakeholders (Participant 19: Non- Doctor M&E expert)*

It is apparent from the data that the second phase of the first stage is very important because there is a narrowing of the participants according to professional backgrounds and specialisations, even though invitations are sent to partners and stakeholders and not individuals. Consultants handle this process in most cases and this has been highlighted earlier. Participants claim that the consultants hired usually have a medical background with public health experience. The consultants help in asking the right questions or in making sense of the required proposal content. Other participants claim that outsourcing and getting support from these consultants is helpful because these consultants bring practical feedback from the field and this practicality in proposal writing is important.

During the process of proposal writing, some of the hired or donated consultants were from the WHO, USAID, UNAIDS, and CHAI (Clinton Health Access Initiative). The WHO gives technical support in situations such as proposal writing and in reviewing the proposal before submission; they are seen by participants as very important consultants in the process of writing. The CHAI also provides consultants who are very much involved in the costing, which makes the proposal operational, and aids the country in accessing the fund as much as possible. As participants stated:

*Consultants are hired to help moderate, clean up the language and hand-over to CCM. The CCM still has the resource mobilisation committee. The consultants may come back if there are questions from the TRP; TRP is the Global Fund's Technical Review Panel that reviews the proposal first and then sends it back, there may be need to call the consultant back if there are technical issues that require more meetings and more engagements. But otherwise it goes, once the consultants hand over the draft proposal, the RMC of the CCM takes over. (Participant 21: Finance expert)*

*We also had international consultants from WHO who were supporting the country; and other bi-lateral organisations supporting the country like USAID, WHO, UNAIDS, who were complementing our efforts in the writing of the proposal, (Participant 31: Medical doctor)*

The two critical stages that shape the proposal content were identified as the second phase of the first stage and the second stage of the final draft. Hired consultants from organisations such as the WHO, UNAIDS influence the first stage, while members of the RMC that control the final stage of the proposal draft are staff of similar influential

organisations such as WHO, UNAIDS, CHAI and USAID. The extract below cites documentary evidence that shows that most countries use consultants in writing proposals and another document that shows how WHO and similar organisations' documents guide these consultants during proposal writing.

*'Countries are encouraged to write cost-effective and practical national plans, from which the proposal should be drawn. Frequently, consultants help countries to write the proposals, which are long and quite complicated.'*(Overview of the Global Fund to Fight AIDS, Tuberculosis, and Malaria: Centre for Global Development, Washington, DC (Schocken 2006:5).

*This document targets the writing committees of the applicant countries, and the consultants, involved in the development of tuberculosis (TB) proposals to be submitted to Round 11 of the Global Fund to Fight AIDS, Tuberculosis and Malaria (hereafter, Global Fund). It aims to provide guidance on key aspects of the process of proposal development. (Guidance to develop Global Fund Round 11 proposal for tuberculosis control(World Health Organization 2011a:7))*

This elite group of medical experts are influential actors and they influence the policy process either as hired consultants or as representatives of the leading organisations. Their positional power in the influential organisations enables them to affect the direction of the proposal writing process and its final output. They rely on structural factors of the whole proposal writing process in the system that create a favourable environment for this influence. This section exemplifies the modes in which these dominant experts exert their power on the proposal process, through their shaping of the direction of proposal writing process proceedings because they are given positional power in the overall structure of the process.

Global Fund proposal guidelines and processes are part of the Global Fund structure and participants' accounts, along with observation data, shows how these guidelines and processes influence the role of elite epistemic experts identified in this section. The guidelines and processes actually facilitate the influence of elite experts in the context of this study.

### **5.3 New Public Management and Biomedical paradigms: the controlling paradigms of challenging interests**

In the previous section, we concluded by identifying the influential medical professionals in the Global Fund structure, their mode of influence, and the processes that enable and encourage this influence. This section seeks to identify the specific underlying principles in the Global Fund that shape and guide the policy process. As such, this section focuses on the prescriptive nature of the proposal guidelines and process, by revealing the examples of the preferred specifications and guidelines used in the proposal writing process.

#### **5.3.1 Prescriptive guidelines of WHO and UNAIDS**

Some participants feel the little details of the proposals are guided by the WHO and UN guidelines and in situations where there are conflicts or disagreements the final decision is made according to the WHO guidelines. The WHO guidelines are used as a reference point for the adoption of country protocols in these processes similar to the WHO document cited above (World Health Organization 2011a). The two extracts below shed more light on this point:

*The whole proposal writing process is governed by standardised principles or standardised if I can use the word guidelines by WHO, UNAIDs so those serve as a reference point for finalisation of decisions (Participant 3: Medical doctor).*

In some instances, the WHO guidelines make it difficult to align the country contexts and the guidelines. This can sometimes be a source of confusion among participants in the process rather than being a clear reference point, and this is expressed in the extract below:

*You go to a number of states at the PHC level, you don't find a doctor; you don't find a nurse/midwife; but deliveries (childbirth) have to happen, deliveries (childbirth) are taken by extension workers, so are the extension workers now skilled birth attendants or not? So there was this fight between the WHO's definition of skilled birth attendant and what happens in the country. (Participant 15: Medical doctor).*

Participants are of the opinion that if the portfolio of the country is already set by the Global Fund with fixed budgets in such a way that a path is shaped for you to follow, then the process is already prescriptive. The guidelines are specific on the activities they are willing to fund and when the work plans are created, they are not flexible during implementation. Sometimes the guidelines are so prescriptive that if they are not followed properly it results in delays in getting the TRP's approval for grant signing. Participant 22 explains some of these points in the extract below:

*Global Fund should not be prescriptive. They are too prescriptive. What they should do is to let us know how much you have, let us know the areas you want those monies to be spent, and those areas you want the monies to be spent should actually align with the country's roadmap. In HIV & AIDS, you have the national survey framework, for health as a whole; you have the national survey health development plan. So you (Global Fund) should give guidelines and not prescriptions (Participant 22: Medical Doctor)*

The Global Fund relies on Epi-data analysis, and country background statistics as condition precedents in the proposal, which limits some country level regional specific contextualisation of the proposals. This becomes a problem for a government that does not routinely collect most of the type of data needed and in most Sub-Saharan countries, there is a problem of poor data collection (Jerven 2013). Therefore, participants complained that during proposal writing, in some instances they were unable to come up with supporting evidence to back their strategies.

Unlike the PEPFAR programme whereby many of the changes can be made in a rapid and timely manner, the Global Fund grant is very unresponsive to contextual or operational difficulties on the ground, and changes have to go through many bureaucratic processes. In the proposal guidelines as well, the Global Fund sets targets and outcomes that it aims to achieve, and expects the proposal to capture this in a broad framework. The major problem with using a broad framework in Nigeria originates from the fact that there are different contexts within the country (considering the six geo-political zones) and these make broad frameworks very difficult to implement. A

reference to the prescriptive nature of the process is illustrated by participant 32 below who uses the analogy of a gutter, as a reference to ‘a designed path’:

*The contextualising your own country concept actually does not come to play in Global Fund. Because one, the budget is fixed after which just as they are saying that the Global Fund board are certain to deliver and they have approved allotted funds to each country portfolio. So whatever thing you are going to be doing in the world will have to fit into those portfolios that's part one...their rigid system so rigid, everything is already spoon feeding, that's why I said, there is already a gutter (designed path) for you so you must pass through (Participant 32: Non-doctor public health expert)*

This claim by the participant above is corroborated by the documentary analysis: for example the exact below shows that the Report of the Comprehensive Reform Working Group for The Global Fund advised The Global Fund to evolve from its ‘one-size fits all’ business model:

*A central finding of the CRWG is that the Global Fund needs to re-examine its business model. It should move away from a one-size-fits-all approach to a differentiated and calibrated model(Report of the Comprehensive Reform Working Group(Comprehensive Reform Working Group 2011:10)*

This sub-section presents the views of most participants, who argue that the guidelines of the Global Fund are prescriptive, which leaves little room for the contextualisation of

proposals. This section presents a picture of a rigid proposal writing process which limits the options proposal writing teams have and we go further in the next section to show the principles that govern the options made available to the proposal writing teams.

### **5.3.2 Content and emphasis in a prescriptive process**

According to participants quoted in the previous section, the Global Fund puts policy restrictions and spending limitations around the guidelines. This section will explore in more detail the emphasis by the Global Fund on a prescriptive process and the principles that inform the content of the prescriptive guidelines. We will start by analysing the accounts of participants on their views about the prescriptive nature of the Global Fund proposal-writing proposal. Lastly, we will analyse the content of the guidelines and the preferred strategy of the Global Fund in a bid to identify the key principles that shape the Global Fund policy process.

Participants state that even though the Global Fund proposal writing process of past grant rounds did not have a prescriptive agenda, they sense that the Global Fund is now subtly becoming more prescriptive. An example of some of the ways in which the Global Fund encourages countries to abide by the prescriptive guidelines of global actors is captured in the documentary evidence below:

*When preparing their HIV NSPs and investment cases, countries should also take into account international commitments, such as those made at the UN General Assembly High Level Meeting (HLM) on AIDS in New York in 2011, to be reached by 2015. The commitments of the 2011 Political Declaration on HIV and AIDS include ten specific targets to reduce new HIV infections, eliminate new HIV infections among children, increase the number of people on HIV treatment and eliminate stigma and gender-related barriers to effective responses. Other global commitments and targets may also*



*be reflected, including the Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive.*

*Various tools and guidance documents have been made available to countries by UNAIDS and other technical partners to support the creation and/or strengthening of HIV NSPs and investment cases, provide support in developing strong national strategies within the frame of strategic investments, and help to address the most difficult allocation and prioritization choices required for impact. This includes the UNAIDS' HIV investment case tool and process guide which countries are encouraged to use. ( Global Fund Information Note: Strategic Investments for HIV Programs(Global Fund 2015b:9)).*

In sections of the proposal forms where recipient countries are meant to demonstrate supporting evidence, the Global Fund now gives suggestions on the type of evidence to fill in those sections of the proposal. In addition, the Annex 2 of the Global Fund Information Note: Strategic Investments for HIV Programs, highlights specific intervention activities for the various aims the Global Fund wants applying countries to capture in their proposals (Global Fund 2015c). For the countrywide analysis as well, they have a guideline on how to fill the template and carry out the activities. Some of these guidelines by the Global Fund direct recipient countries to use specific activities and international protocols in drafting a proposal and this makes some participants feel there is a preferred strategy the Global Fund would want to see captured in proposals. *'It seems they have the answers to the questions they want you to answer'* as participant 32 said. Some sense that over the years, the Global Fund has become more like other donors who micro-manage the activities and recommend strategies and approaches. Participant 11 illustrates this point in the extract below:

*But over time I think Global Fund is losing on...its earlier advantages over other funding mechanisms, because it is unnecessarily becoming rigid, it's also unnecessarily becoming you know micro managing the grant in such a way that subtly they actually want to define how grants are run in fact they are beginning to suggest, not just suggest, even recommend strategies and approaches that perhaps may not be in line with the country's thinking. (Participant 11:Non-doctor Public health expert)*

Some of these micro-managing techniques of the Global Fund are highlighted in the documentary evidence below:

*Spending more time in country will provide the Secretariat with the opportunity to conduct extensive dialogue with all partners and to engage them in reviewing available analyses of impact data to facilitate their work in guiding the development of the concept note. Examples include participating in program reviews or mid-term reviews and participating in donor coordination meetings or facilitating safe spaces for secure consultations with key affected population networks and civil society where necessary (Information Note for Country Dialogue (Global Fund 2013:16))*

The above extract highlight the more hands-on involvement the Global Fund Secretariat in Geneva wants to have in the processes of proposal development. Participant 11 goes further to explain that, even though the country sets its priorities through the National Strategic Framework, the Global Fund still sometimes tells the country what it thinks is right and should be a priority in the proposal writing process which to some is a fundamental flaw:

*So, they probably claim you know that they have experiences from other countries that could be brought to bear. But not understanding the fact that diseases, yes may be universal, but in terms of how it is going to be solved either managed or eradicated as it were should be contextualised. HIV has a community phase and so they should look at it within that community rather than do some kind of generic description, which really does not work, and there are pockets of examples. So in a nutshell I think Global Fund is losing what we thought earlier was its major strength by getting involved in the day to day management of the grant (Participant 11: Non-doctor Public health expert)*

Previously, during country stakeholder meetings of the Nigerian CCM, the Global Fund secretariat was not actively engaged in the process, but the Global Fund secretariat now wants to play an active role in the process of priority setting and country dialogue among stakeholders. This is captured in the documentary evidence below:

*Country Dialogue will vary across all countries based on national planning processes for the health sector and for each of the three diseases. The Global Fund Secretariat will take an active role in Country Dialogue, through increased engagement with country stakeholders, and will work with partners to ensure support at key points in the process. Active engagement will occur prior to the development of the concept note and continue during grant-making and grant implementation to maximize the impact of approved funding. (Information Note for Country Dialogue (Global Fund 2013:16))*

However, this decision by the Global Fund to be actively involved in the priority setting in-country has a negative effect on the participation of country stakeholders. In a meeting, the Global Fund was among the stakeholders with whom the government body (NACA) was in agreement on major issues. Participant 13 explains how the presence of the Global Fund in a CCM meeting limited others stakeholders' confidence in airing their own views for fear of being blacklisted by the Global Fund and the Nigerian Government:

*For me I think Nigeria needs to lead the process but Global Fund was also having a very big say in how we are going to lead the process and for me that is a concern. We need to make our own analysis and really know what the problem is and not have because of external forces have the donor really guide us as to where the problem is. I think that is the first thing that is wrong. In such meetings when the donor is also there, most stakeholders do not have a say. They might not want to come out and lay open their thoughts because of the mere fact that the government of Nigeria is the one that is even going to give them the funding. And if the government of Nigeria is now going along with [what] the donor wants, then it is only natural that the other stakeholders will just try not to voice out their opinions and see what happens (Participant 13: Medical doctor)*

When asked about the type of evidence requested by the prescriptive guidelines, Participant 4 said the guidelines and the whole grant process is quantitative in terms of evidence. This is clearly illustrated in the extract below:

*They are usually pretty quantitative, they are pretty quantitative from my own...unless I will have to go back and look at the proposals and compare it with which I haven't done. They are pretty quantitative, so you have to actually come up with very robust evidence that is very quantitative....probably, most things tend to be. (Participant 4: Pharmacist)*

The extract above clearly points out the preference of the Global Fund guidelines for quantitative evidence, which are set out as goals, health outputs, and outcomes, informed by biomedical knowledge. Examples of these are; number of ART drugs distributed, number of people to be tested for HIV, number of mother to child transmissions prevented. The Global Fund wants the country proposal to reflect these types of quantifiable health outcomes. Another participant was in agreement about the Global Fund's preference for quantifiable evidence in designing both clinical and non-clinical activities.

Documentary evidence from the Global Fund's strategy for investing in developing countries reflects the Global Fund's focus on specific health outcomes guided by quantitative biomedical strategies. This is illustrated in the Global Fund's goals for 2012-2016 (Global Fund 2011) below (emphasis added):

*'The High- Level Panel stated that **"To be effective, the Global Fund should be more targeted... [It] must be much more assertive about where and how its money is deployed; it should take a more global look at the disease burden and better determine who needs the money most."** Through*

*Global targets: 7.3 million People alive on ARTs*

- *PMTCT: HIV-infected pregnant women to receive ARV prophylaxis and/or treatment*
- *HIV testing and counselling*
- *Prevention intervention services delivered for most-at-risk-populations*
- *Male circumcision'*

*(The Global Fund Strategy 2012-2016 : Investing for Impact (The Global Fund 2011:5)*

The statement is an example of the emphasis on a biomedical paradigm such as the ‘test and treat’ strategy above, which limits the engagement of local contextual knowledge when CCM members sit to develop proposals. This is captured in the documentary evidence:

*HIV counselling and testing will be implemented using a provider initiated...in line with the WHO option B approach using test and treat strategy (TB AND HIV CONCEPT NOTE Investing for impact against tuberculosis and HIV (CCM Nigeria 2015b)).*

Although the Global Fund in the document encourages ways of strengthening community systems, it goes further to suggest strategies in achieving community strategies but is not conclusive on its commitment to support community strategies:

*'Its Framework Document promotes a rights-based approach with an emphasis on strengthening the participation of affected communities in health governance and ensuring that interventions reach the most affected countries and communities. The “Gender Equality Strategy” and “Sexual Orientation and*

*Gender Identity Strategy”, along with support for community systems strengthening are further contributions made by the Global Fund to advancing human rights in the context of the three diseases’ (The Global Fund 2011:17).*

The document further reads:

*‘At the same time, there has been concern that the Global Fund not lose its focus on health; rather its efforts to address human rights challenges should come from evidence that they impede efforts to improve health and fight deadly epidemics’(Emphasis added (The Global Fund 2011:17)).*

These types of inconclusive statements about the Global Fund’s commitment to community strategies are the reason why many of the participants have the impression the Global Fund would favour a proposal that uses predominantly universal bio-medically proven strategies. This is because when reading the policy documents of the Global Fund there are clear terms as to the biomedical strategies; on the other hand, it expresses support for but remains indecisive about whether it would fund community strategies.

Accountability and value for money rank high in the priority areas of the Global Fund’s strategy, which is captured in a statement in the Global Fund’s document:

*‘ Improve focus on quality, consistency, and sustainability of services delivered. Through discussion with applicants and partners in the course of the iterative proposal development process, encourage inclusion in proposals of independent programme evaluations that focus on the quality, consistency, impact, and sustainability of services delivered. **Incorporate quality-of-service assessments into value-for-money evaluations**, without imposing parallel or unnecessary reporting demands on countries.*

*Undertake more extensive evaluations of value for money, including sustainability assessments, to support decisions on continued investment and allocation by countries, the Global Fund, and other donors.* ' (The Global Fund 2011:15. Emphasis added)

The focus on strong NPM-based cost-effectiveness models in grant management and on biomedical strategies by the Global Fund is a primary reason why participants see the Global Fund proposal writing process as prescriptive. This sub-section shows the increasing emphasis on a more prescriptive process by the Global Fund compared to the original mandate by the Global Fund for a country driven process. The analysis of the data indicates that predominately biomedical and NPM principles shape the prescriptive process, which is reflected in the guidelines and eventual content of proposals.

### **5.3.3 Rationale for a prescriptive proposal process: Balancing accountability and flexibility**

Building on the description about the prescriptive nature of the Global Fund's guidelines, some participants have explained why they think the Global Fund is prescriptive and one of the prominent reasons discovered in the data centred on 'accountability'. This sub-section explores the rationale for the increasing prescriptive nature of the Global Fund policy process.

A participant said the rigidity of the guidelines is an attempt by the Global Fund to safeguard the funds against misappropriation. These restrictions aid in limiting the country to specific disbursement criteria. The fallout of safeguarding the fund is that the guidelines end up being prescriptive. Other participants also appreciate that the Global Fund has to show accountability and transparency in grant management to its



consortium of donors, by giving clear guidelines to recipient countries. The extract from the interview with Participant 30 illustrates these points:

*The intention behind it is not to be prescriptive, it is to safeguard the funds but at the end of the day, its limits and almost restricts the country on the way the funds is used. You see it has its good and bad sides. Yea, eeh the prescriptive..., I think what appears prescriptive is a fall out from an attempt to safe guard their funds and it will happen with everyone who gives money. (Participant 30: Medical Doctor)*

The corruption index in the country is high, therefore in Nigeria the Global Fund places restrictions on the proposals, and work plans, which makes implementation difficult. From documentary evidence, there is reporting of widespread corruption in the Nigerian system. For example :

*The investigation examined the work of a sub-recipient, Nigeria's Department of Health Planning, Research & Statistics (DPRS). It found evidence of systematic embezzlement, and identified US\$3.8 million of irregular spending.*

*(Audit Report: Global Fund Grants to the Federal Republic of Nigeria(OIG Report 2016:33))*

Whilst the previous point is apparent from the data, some participants are of the opinion that in trying to safeguard the funds the Global Fund has put in place strong instructions and restrictions, making implementation not feasible and feel there should be a balance between accountability and letting the activities run:

*Again, people talk about the need to have greater accountability, minimising risks, to put some instructions and restrictions. But like I always say if your internal processes are so strict to prevent people from implementing that intervention, then it's useless. The whole essence of having those internal processes is to ensure smooth implementation of any intervention. So donors must bear that in mind. We are not proud to say, maybe the corruption index is high here; but that is the reality. (Participant 15: Medical doctor)*

In summary, data analysis has made it apparent that the Global Fund structure of prescriptive guidelines, which relies heavily on quantitative biomedical evidence, has restricted applying governments from developing context-specific proposals and these frustrations were captured in the extracts above. The rationale of the continued pressure to enforce principles that reflect NPM priorities in grant management is understood by the participants but they argue that emphasis on a rigid NPM like principle has limited the optimal implementation of the grant due to contextual realities that this system of management ignores.

#### **5.3.4 Consequence of a prescriptive process: inflexibility in implementation**

*Although, something we have already taken up with the Global Fund; which is the need for more flexibility, flexibility in the sense that yes you work through the CCM and you have principal recipients to deliver on certain components of the grant; but presently the way the work-plans and the budget are structured it doesn't give much room for much flexibility. Yeah, when the country may be submitted, that was what they thought was the best way to go about it. But when*

*you start implementing there is a big difference between when you come up with your proposal and when you start implementing, and that's why you have what is called formative evaluation. If in the process of implementing, may be 3 to 6 months of implementation, you feel may be there is need to tweak some of the things you put in the activities or may be programming some funds. There should be greater flexibility, I am not saying totally rigid, the time to respond and approve should be faster. We have seen grants struggle, everybody believes that this is the right way to go but it takes like 6 months to one year to go through the processes before you eventually get that nod. By the time you get the nod, 6 months to one year from the time you had the conviction that that will work, other things may have come up; then you get the approval and it's no longer useful. (Participant 15: Medical doctor)*

The extensive extract above gives us an overview of how flexibility is important to the implementation of the grant even before the proposal process begins. This sub-section focuses on the consequence of rigid prescriptions on the policy process and the solutions for mitigating this limitation.

The proposal process is set up so that alterations to the originally approved proposal submitted to the Global Fund are very difficult to put in place during implementation. This rigidity in altering the proposal document during implementation is because of the bureaucratic hurdles within the Global Fund structure. This has affected the implementation of the grant in a negative way. Some believe the PRs should be given more power to make the grant flexible in such a way the Global Fund can still hold the stakeholders accountable financially.

Lack of flexibility can lead to duplication of the efforts of other donors. For example, the procurement of equipment already made available by other donors is still procured under the Global Fund grant just because it is already stated in the work plan.

*I will give you another example, last year we never got one DBS (Dry Blood Sample) card for the dry blood sample for the EID (Early Infant Diagnosis) and all those. We never got one, because we were depending on one other organisation, that is in the country to supply; the process of procurement we held to it strictly, and that was what kept the procurement of those sample cards; even as we speak, we still have not gotten those cards...I think the grant requires some flexibility, because at the point of conceptualisation, some of these challenges were not seen, now when you are implementing, when you see them, the grant should be flexible enough to ensure that we respond immediately to those challenges, if not the impact you want to make, overtime, you will not get it (Participant 8: Non-doctor Public health expert)*

Sometimes meetings and trainings are spelt out in the work plan but during implementation there may be some additional training or meetings required to make the intended impact but the Global Fund does not give room for this flexibility. The extract below illustrates how the participants feel flexibility is important to a proper roll out of the Global Fund programme in the community:

*Performance based is good, but they should still be flexible. It is too rigid. At least from my experience, there was a time I was rolling out activities...but*

*during the course of rolling out those training, I discovered that the government people I am training lacked knowledge in particular areas where I am supposed to roll out trainings in...particularly they lack knowledge in management, that means we need to do a lot of trainings for management, and Global Fund grant will not allow that, until another grant comes and sends you that (Participant 22: Medical Doctor)*

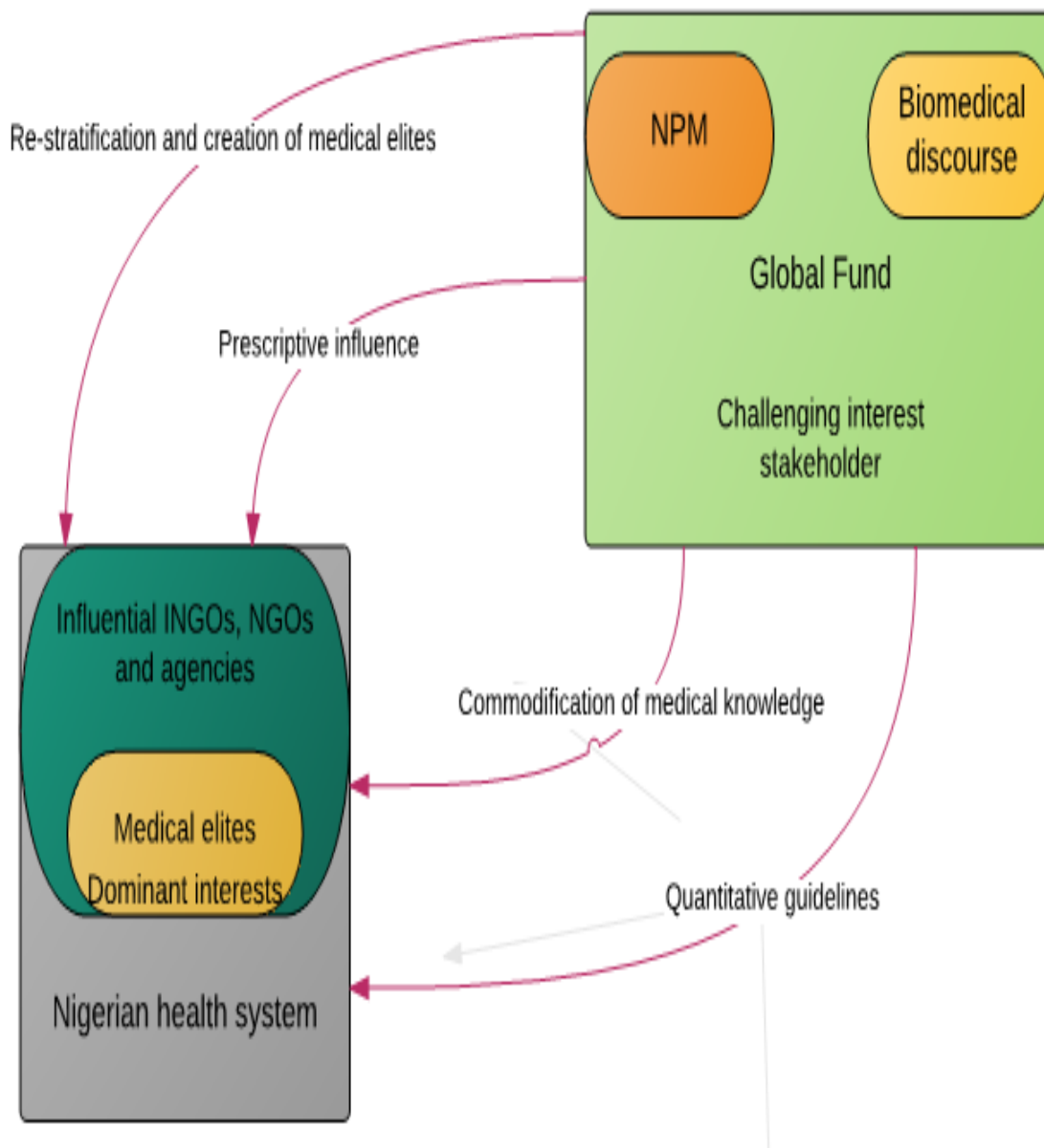
Interestingly some participants went further to say that the same SRs under the PEPFAR and Global Fund performed better under the PEPFAR programme because there were more funds for flexibilities in the field. In contrast, another participant is of the opinion that maybe in the past this flexibility was misused by recipient countries but he could not give any evidence to support his point. However, an audit of the Global Fund grant in Nigeria by the Office of the Inspector General (OIG) of the Global Fund, revealed serious instances of fund misappropriation and among various organisations and recommended *'more stringent treasury management requirements'* (OIG Report 2011:12).

The prescriptive nature of the Global Fund, its lack of flexibility and top-down approach has created difficult work plans for implementers to follow and participants in the study expressed this. The work plans of the Global Fund are usually created and modified at the top level of management between the Global Fund and CCM's stakeholders in such a way that implementers are unaware about how to make these work plans operational. Furthermore, performance indicators are decided without the input from implementers concerning the feasibility of those strategies on the field.

This sub-section highlights some of the consequences the prescriptive process has on implementation such as duplication of activities, waste of resources, and the creation of bureaucratic barriers. The data analysis illustrates how participants have compared the Global Fund's rigid approach to PEPFAR's flexible approach, with most favouring the latter. This is significant because participants are of the opinion that the Global Fund's lack of flexibility hinders the potential for health impact that the prescriptive work plans were created to ensure.

This section has presented the views of the participants about the proposal process, and the majority of the participants described it as a prescriptive process that is heavily reliant on quantitative biomedical and NPM like principles. They also say there is a risk the Global Fund can lose local support from implementers because of its recent deviation from its original core principles of a country-driven policy process to a more rigid prescriptive process. Although the data analysis points to other potential reasons for this prescriptive process such as accountability and safeguarding of funds, the potential of collateral consequences to the grant can lead to waste of resources, poor implementation and duplication of activities.

**Figure 9: Summary of themes in Chapter Five**



### 5.7 Chapter Summary

The current chapter has explored the role of technical specifications and institutional procedures in shaping opportunities for medical professionals' participation in constructing proposals and in implementing programmes of the Global Fund grant. Specifically, examples of institutional procedures within the Global Fund structure facilitate medical professionals' influence leading to the creation of an elite epistemic group of medical professionals within the CCM. Whilst chapter Four showed how in

theory the Global Fund has created a unique funding framework different from other donor agencies, in reality this funding framework has made dominant interests such as the elite medical professionals more influential in the proposal writing process. As a result, this hands-off approach of the Global Fund in limiting funding for the proposal writing process has exposed the process to influence from dominant interest groups (with the financial capacity to fund the proposal process), by giving them the opportunity to steer the proposal writing process.

The findings have highlighted the prescriptive nature of the Global Fund grant proposal process and the preference for quantitative biomedical data and for NPM approaches in the process. Arguably, this is in conflict to the original design of the principles of the Global Fund, which were intended to support country-driven context specific strategies. This increasing lack of flexibility by the Global Fund has reduced the country's ability to contextualise strategies, consequently limiting the stakeholders and implementers to the use of quantitative biomedical strategies in executing the grant. Interestingly, this prescriptive nature of the proposal process has created an environment for public health expert consultants mostly drawn from the medical profession to steer the path of the proposal. The preference of these experts for the biomedical paradigm, highlighted from the observational notes, gives a picture of a local epistemic community with influence to control agenda setting proceedings through these dominant organisations. The combination of prescriptive biomedical guidelines and a powerful biomedical epistemic community was identified as a possible source of biomedical dominance in the agenda setting in the Global Fund grant writing process.

In relation to the concept of power, the positional power that medical professionals have in the structure of the CCM is seen as a reflection of the professional monopoly they enjoy in the policy spaces of the CCM. This is similar to the structural power of the



biomedical paradigm discussed in the literature because structural powers *'do not necessarily generate equal social privileges; instead structures (power) allocate differential capacities, and typically differential advantages, to different positions'*. In this situation, the structural power of the biomedical paradigm is biased towards medical professionals and positions them in strategic policy positions in the CCM structure. Therefore, the structural power of the biomedical paradigm maintains medical professional monopoly. This further enhances their ability to affect the policy proceedings of the CCM. At the same time, the biomedical dominance within the policy process in the form of guidelines is an example of institutional power which is a reproduction of the already existing productive power of the biomedical discourse at the global level. From the findings both the structural and institutional forms of biomedical power play a role in positioning medical professionals in strategic positions within the Global Fund structure.

Finally, it is apparent from the data that the management principles that the Global Fund encourages are similar to NPM principles. In relation to the influence of epistemic experts on the CCM and the findings on the prescriptive biomedical and NPM process, these findings infer that the process is strongly aligned with and reliant on biomedical experts' knowledge base. These prescriptive quantitative guidelines can affect the influence of a certain group of professionals, thereby increasing the influence of experts with a biomedical background in the whole Global Fund grant proposal process. The findings in this chapter present significant questions concerning professional influence and dominance, epistemic communities and NPM. Building on the findings from this chapter captured in Figure 9, how the guiding principles of the Global Fund affects professional influence in the proposal-writing phase will be explored in the next chapter. It was not clear from the data whether these main aspects were the central reasons for a biomedical framing of issues or whether it was just due to a lack of evidence from

alternative disciplines. This will be discussed in more detail when analysing the proposal process in Chapter Six.

## **Chapter 6**

### **Professional Influence in Proposal writing**

#### **6.1 Introduction**

This chapter presents the findings that relate to the role and influence of medical professionals and other non-medical occupations in the proposal writing process of the Global Fund grant drawing on observation and interview data. These findings will aid in identifying the various interest groups and their role in the development of the country proposal. As part of this, data highlighting issues such as participation, inter-professional tensions, and professional boundaries during the grant writing process will be discussed.

Most professionals in the study stated directly or implicitly that though there were a variety of occupations involved in the Global Fund grant proposal process, there were unequal levels of influence between the various occupations. The various forms in which dominant professionals influence the proposal making process are explained and presented here based on the themes that were prominent in participants' accounts. In the light of this, the findings presented in this chapter will raise questions about professional monopoly in the policy process of the Nigerian health system.

#### **6.2 Professional dominance and dominant interests**

The aim of this section is to map out the medical professional influence in the proposal writing process and the Nigerian health system. This section will explore the professional influence highlighted in the previous chapter, by first explaining the reasons for this professional dominance, identify the structures and agential factors that

maintain this dominance and finally will examine the effects of professional monopoly on the proposal process and future trends to this dominance.

### **6.2.1 Medical professional influence on the overall health system**

The aim of this sub-section is to describe the medical dominance identified in the previous section in the context of the entire Nigerian health system. In describing the influence of medical professionals in the proposal writing process, participants qualified this dominance by giving some insight into the medical dominance felt throughout the entire health system.

Most participants said the Nigerian health system gave medical professionals an advantage because the health system's occupational hierarchy places medical professionals above other occupations in both managerial and clinical roles. This influence over time has spread into independent private-public partnership programmes such as the Global Fund. HIV/AIDS programmes were depicted as being prone to medical professional influence because HIV/AIDS has been categorised as a specialised medical field by most health sector institutions in Nigeria. Participants believe that even though at the national level, programme design and management skills are more needed than clinical skills, nonetheless, medical doctors dominate management, and policymaking at all levels of the health sector. As participant 19 stated:

*Based on my experience so far with the Global Fund, maybe because most of the programme, in fact all the programmes are health-based, people who have health backgrounds, particularly those in medical lines have more influence...basically those who have medical backgrounds have more influence.*  
*(Participant 19: Non- Doctor M&E expert)*

Most participants interviewed said medical doctors dominated private and public support agencies and organisations invited to support the proposal writing process, even though attempts have been made by the FMOH to invite other support agencies with less medical influence, in order to mitigate for the negative effects of medical influence in FMOH policymaking processes. Even most of the medical doctor participants agreed that they have more advantage in the health system than other health occupations in occupying both clinical and administrative positions in most health organisations. Participant 3 commented:

*Well it is probably as a result of the way the national health system is managed in the sense that it is assumed that the doctors lead the team so most times you have the doctors dictates or states how they want the programmes to run. Now this should not always be and that is why on the reproductive health side under the ministry of health, its being addressed where they make sure they bring other supporting occupations on board so that we have a more holistic.... so it's not deliberate, it just happened by default over the years (Participant 3: Medical doctor)*

*Of course again because you have in this clan (CCM proposal writing team) anyway because the medical professional leading most of the government health agencies and even the partners which are also part of the decision making process. You basically have them leading the process in terms of decision making you know with regards to proposal writing priorities, and all that. I mean that is a fact (Participant 28: Medical Doctor)*

Due to this professional monopoly, medical professionals have a strong presence in the TWG (Technical Working Groups) for HIV/AIDS, TB, and Malaria in the FMOH. These TWG are also directly involved in all stages (reviewing, implementation, changing, revising, and creating) of the proposal development. Apart from thematic areas such as logistics, finance, and lab science, the medical professionals head the majority of the other thematic areas in the FMOH.

*Interviewer: So, am I right to say that medical professionals actually have a very strong technical influence on implementation both at the state level and country level?*

*Participant 12: They do, we ( medical professional) sit in policy, technical working groups where policies are reviewed, implemented, changed, revised, created; at least I know this organization is very strong in making them present at such working groups. (Participant 12: Medical doctor)*

*Right, for example, TB is a thematic area, you have about six, seven thematic areas; you have DOT expansion; who else does expansion in the ministry, is a doctor; you look at PPM, who else does PPM in the ministry, is a doctor; you look at TB/HIV. Except areas that really require other expertise like may be lab scientist, logistics and community; apart from that, you have doctors heading all other areas, and that makes them more in number and that's why (Participant 2:Medical doctor)*

Medical professionals manage organisations such as the NACA and FMOH that are usually the lead in these processes, while the consultants or experts hired who facilitate these proceedings from the WHO, UN and INGOs usually have a medical degree.

*Because I mentioned that many CCM outsourced to a consultant or to an NGO, in the cases where they outsourced to a consultant or invite experts to help them. Who are the experts, WHO staff, UN staff, people who are programmes in INGOs, who are they, they are medics and if you check, many of them are trained as physicians, had either a residence (post-medical diploma) or Masters in public health. So am answering your question from the other end. You asked who are those who are not? And I started with those who are. (Participant 30: Medical Doctor)*

*Interviewer: where would you say the Global Fund unit actually gets their work force from, which professional background would you say?*

*Respondent: within NACA*

*Interviewer: Yes*

*Primarily it is from medical professionals, that is number one then that is the major one that is it basically then you also have social sciences and then financial team (Participant 28: Medical Doctor)*

From the data, it is apparent that professional monopoly by medical professionals in the Nigerian health system exists and the Global Fund grant writing process is no exception. This professional monopoly exists and is apparent from the occupational hierarchy in the Global Fund processes that gives medical professionals the positional power they possess in the health system. In some instances, efforts were made to mitigate against this medical dominance, which infers that stakeholders in the health system are aware of this professional monopoly. The factors that participants understood to be the reasons why medical professionals possess this professional dominance will be explored in the next sub-section.

### **6.2.2 Medical professional influence in proposal writing**

*Interviewer: So from the picture you painted, who would you say have the most influence in the proposal writing itself, the professional background?*

*I think it is probably the doctors (Participant 33: Health economist)*

Medical doctors, most especially those with public health experience, greatly influence the Global Fund proposal writing process; in fact, in most participant accounts they were characterised as ‘drivers’ of the proposal process. Medical professionals’ views in most instances were able to supersede those of other professionals and they were able to drive their ideas through on the CCM board. Even though there were various thematic areas in the proposals, the technical influence of this group of public health doctors spreads across all thematic areas of the process.

*Okay for the Global Fund general, I would say mainly doctors, especially those that have a background in public health... So mainly public health doctors looking at the trend, all the principal recipients for the Global Fund, most of the*



*individuals at the helm of affairs and most of the individuals that are involved in decision making for the implementation of the grant, are mainly medical doctors with public health background. Yes I can say that (Participant 17: Pharmacist)*

Influence on the proposal writing process was described as skewed towards medical professionals and the participants stressed the need for more experts in the field of management to better co-ordinate proceedings. Most participants preferred to use the word ‘medical influence’ than the word ‘medical dominance’ but felt medical influence had a negative effect on the opportunities for participation from other non-medical professionals. This limitation in the co-ordination of the proposal process is highlighted in the quote below.

*But I will think that it is more medical, so in terms of the coordination part of it there is usually a gap. So one of the reasons why we are supporting is that we recognise that this is a gap...and that is because a lot of people are health people and not necessarily management people or writing people or literary people, (Participant 4: Pharmacist)*

*So for my part where we were basically working on the programmatic technical part of the proposal, there are mainly doctors. And I think that is because they were mainly the leads in their organisations of the health programmes. There were doctors there and those were the people that came in so that is my take on it (Participant 34: Medical doctor)*

### **6.2.3 Reasons for medical professional dominance in proposal writing**

Analysis of the data informs us about the factors that enable medical monopoly and there is a clear distinction between the society-wide factors (structural factors) that contribute to their influence and those specific to the proposal writing process (agential factors). Here, I am drawing on the concept used by Hay in the categorisation of structural and agential factors as a means of understanding the dynamics of influence and power (Hay 2002b).

#### **6.2.2.1 Societal wide factors- 'structural'**

In Nigeria, the dominant view is that medical professional influence and leadership and power are legitimate and 'normal'. This places medical professionals in a privileged position in society, which some participants believe should not be the case but they accept the existence of these societal-wide perceptions:

*More often than not, what happens is that because the medical doctor is the head or occupies a higher cadre in terms of position you know his opinion is usually the one referred to. I think it is not about superiority of that knowledge anymore it is more about perception of the superiority of knowledge (Participant 28: Medical Doctor)*

Cultural factors peculiar to the Nigerian context contribute to the existing occupational hierarchy, where those with a high profile such as professors are given more respect and therefore maintain a privileged position in deliberations. A study argued that the national culture for seniority has greatly influenced the bureaucratic culture of

organisations in Nigeria, resulting in a bureaucratic culture with strong features of 'respect for seniors, hierarchy and constituted authority' (Ekeke 2015:2). In the extract below participant 30 gives a clue to the source of the societal advantage medical professionals possess and suggests that these perceptions of medical superiority are irrelevant in programme management:

*Number two; I do not know if it is the profile, I do not even know if it is about culture or more of a respect thing or if it is a cultural thing. If a prof is speaking, everything he says must be right. I mean, why I should even want to argue with a prof. Meanwhile from my experience it is all ivory towers when you are talking about programme management (Participant 30: Medical Doctor)*

*So, it is more about knowledge of the context, depth of knowledge or technical expertise. And I think may be in Africa, you know having this kind of profiles have a lot of respect so they are listened to more than business consultant for example. (Participant 9: Finance expert)*

A salient feature, consistent across all the interviews was that the Global Fund's initiative is regarded as a health initiative, and public health initiatives are under the health sector in the context of Nigeria. Throughout the data participants directly or indirectly referred to health as the domain of medical professionals and this is captured in the quotes below:

*The first thing you need to look at is, if the country decides that they are writing a proposal on HIV & AIDS. So automatically, the first thing that will come to your mind is public health physician (medical doctor with public health experience), and if you are looking at public health physician, you do not just get a public health physician based on practice...so you need a practical hand before you will be able to put together a proposal. (Participant 10: Management expert)*

*Interviewer: So, in the whole process, which professionals would you say were mostly influential in writing proposal?*

*Medical, because you know it is a public health proposal and basically you will expect that the public health specialists, I mean doctors... (Participant 31: Medical doctor)*

*Doctors do a great job, and this is a health initiative, so you expect them to have reasonable say, to play a critical role, (Participant 21: Finance expert)*

From the data above, it was obvious that some of the participants have internalised the view that it is appropriate for medical professionals to play a superior role in taking the lead in the health policy process. Similarly, some participants alluded to the view that medicine being an established profession with access to resources and a research base that legitimises clinical input, positions doctors better than other occupations in conceptualising health issues. One of the participants went further to differentiate a

public health expert with a medical degree from those without a medical degree, by expressing how the clinical knowledge of medical doctors gives them more insight into the whole picture of the disease in question, in addition to their public health skills. In the conversation below, a participant expresses this view:

*Now in Nigeria, virtually everybody is doing an MPH, whether you are a doctor or not; but the fact is that the advantage they have is our medical background, it gives you an insight into the actual pathology of the disease, pathogenesis, the aetiology, all the signs behind that disease. It is not just looking at the public health aspect, you are also looking at the clinical aspect, in the process of providing the services, you expect some clinical indices to change for the better. So they are both combining their clinical medical skills as well as their public health skills to respond to the situations where you have drug reactions... So it goes beyond just public health aspect, there is also the clinical aspect;*  
*(Participant 23: Medical Doctor)*

Similarly, there is a feeling by some that the reason for the influence doctors have is due to their training and versatility in applying their skills in non-clinical areas of the programme, which makes them conceptualise HIV/AIDS programmes better than other occupations. Participant 22 is of the view that medical professionals' ability to conceptualise public health programmes better than other professionals can be traced to the extended training curriculum of medical professionals. This is in addition to the fact that they can also later acquire the public health qualifications to supplement their biomedical knowledge:

*Yeah, it is understandable. The medical doctor will spend more years in school, and most of the time the medical doctors in different public health positions have post-graduate certificates. So they are knowledge experts (Participant 22: Medical Doctor)*

Interestingly the argument about ‘hard’ and ‘soft’ science comes into play when the data is analysed. Some participants differentiate those who are only public health experts from public health experts with a medical background. Participant 9 explains how the evidence of medical professionals is more reliable due to its fact base, while the suggestions of pure (non-clinical) public health experts are perceived as vague. He cited the danger in not accepting advice from public health experts with technical medical expertise:

*Probably, people who have technical experience because it is difficult to go against fact based you know, technical experts. When they propose something because it is supported you know by facts, so probably am not sure which kind of profiles they had, but doctors it's very risky to go against advice you know given by doctors. Whereas for public health experts there is not often a clear objective part or truth so if it is okay to go against an advice given you know by public health experts or business experts (Participant 9: Finance expert)*

Another participant echoed this view:

*They are about the oldest and they have number they are more in number and when you look at the health. And medical sciences in most higher institutions most universities in Nigeria, you find out that you get accreditation first for*

*medicine than others that's one...until recently you are only allowed to a Masters in public health if you are a medical doctor. They did not allow other health professionals participate. There are still some universities that still insist that you must be a medical doctor before you can do your Masters in public health. So because of that, that is my own opinion I felt that is why you have medical doctors dominating (Participant 17: Pharmacist)*

The extract above shows another dimension to the dominance medical professionals possess, in the form of autonomy in the licensing of credentials. Their historical origin as the pioneering health occupation has afforded them the professional autonomy to restructure the health education system. Medical professionals have used this licensing autonomy to exclude other health occupations in order to maintain the dominance of the public health field. According to the literature discussed in Chapter Two, this is one of the qualities of a professional monopoly.

In summary, this sub-section highlights the structural factors linked to medical professional monopoly in the Nigerian health sector. These were similar to those seen in a study of the Nigerian civil service and how cultural practices are reflected in bureaucratic cultures of seniority and hierarchy in Nigerian organisations (Ekeke 2015). Cultural factors, which give added privileges to individuals ranked high up in society such as the occupational hierarchy in the health sector, help maintain professional dominance. In addition, the general assumption is that public health in Nigerian is a specialisation of the medical field, hence the notion that it is only natural for medical professionals to better conceptualise public health strategies. Their licensing autonomy in the health education sector, further maintains their monopoly in the public health field, through exclusion of other health professionals. Lastly, there is a certain level of

internalisation by participants of the view that medical professionals possess superior knowledge, in both clinical and non-clinical roles in the health sector. Hence, the notion that medical professionals conceptualise health issues and health strategies better than other occupations, which then justifies their monopoly. This assumption expressed by participants is a reflection of Hay's theory of material-ideational dialectic whereby, actors internalise understandings of their structured context, which in turn shape how they understand their environment (Hay 2002a). Hay states that '*First, the recognition of the (discursively) mediated nature of our experience of, and engagement with, the structured context in which we find ourselves suggests the power of those able to provide the cognitive filters, such as policy paradigms, through which actors interpret the strategic environment*' (Hay 2002a:214).

#### ***6.2.2.2 Agential factors specific to the proposal writing process***

When participants were asked about the composition of the Global Fund staff in the various organisations involved in the proposal process, they spontaneously answered by suggesting that medical professionals outnumbered other health occupations. Participants stated that there are more doctors that work for partners and organisations involved in the Global Fund proposal writing process than any other profession. Participants cited the clinical component of the treatment for HIV and TB as a reason for their numbers. The clinical division of most NGOs and implementers is usually bigger than other sections, therefore, when delegates from these organisations are sent to represent their organisations, the pool they select from is largely composed of medical professionals. In the extract below, participant 33 explains why there are large numbers of medical delegates involved in the proposal writing of the Global Fund HIV/AIDS grants:



*What I noticed was that these organisations, the ones who do implementation, they always have what they call medical or clinical units. Mostly populated by medical doctors with further training in public health...of cause the thing is that if you look at the entire ART, you are more likely to have organisations bring may be one doctor each and all that and you have more number of doctors but because the lab area is very specialised, and not every organisation will have those lab experts. (Participant 33: Health economist)*

It is important to highlight here that the organisations and agencies at the top level referred to by the participants are not involved in attending to patients or direct provision of clinical care but hold a top-level management position, while other lower level organisations (not involved in proposal design) provide the clinical care at facilities. Participants referred to all organisations involved in implementation of the Global Fund grant as implementers. The top-level implementers are the PRs and SRs such as INGO, some influential national NGOs and special government agencies such as NACA. Most PRs and SRs use the lower-level organisations such as regional NGOs and health facilities for on-field implementation of the grant. However, some PRs and SRs over the years have been able to develop capacity at the community level to be able to implement directly without the use of lower-level intermediaries. Nonetheless, this is very rare.

Most participants shared the idea that occasionally having greater numbers of one profession involved in proposal writing can make some viewpoints have more preference. Participant 33 supports this claim and in the extract highlights the significance of having a large number of medical professionals, citing that when there

are differences of opinions those with a larger number out number others in debates and influence:

*I think it is because it is a game of numbers. Like when you have the lead people who are designing the overall strategy for the proposal, coming from one side than the others, naturally this will happen. (Participant 33: Health economist)*

Participant 14 gives us an example of an instance where a large number of clinicians spearheaded a proposal writing process. The importance of this extract is the fact that it demonstrates how this occurrence is not limited to the HIV/AIDS proposal.

*I think the one that readily comes to mind is the last grant that we wrote, the one for the MDR TB grant, where the community folks were trying to express the fact that they were not given enough prominence in the TB programme; because the TB programme is mainly about clinical, clinical; if you go to the office, national TB programme, may be like the doctors will up to 90% of the staff...in the TB programme, in fact, like 90% of them are doctors. May be you have sprinkling, like two laboratory staff, two pharmacy staff (Participant 14: Medical doctor)*

Some participants saw the association between medical influence and the preference for biomedical language as another reason why medical professionals dominate the proceedings. One participant noted that meetings were sometimes overshadowed with medical language and only those sound in biomedical science could contribute to discussions, even though most times the topic of discussion has nothing to do with

medical evidence or science. Participant 30 uses an example of what happens in meetings to explain how the use of language can be a source of exclusion:

*Let me give an example if you are in a meeting where you are supposed to be putting together a proposal and you are a non-medic and someone comes there to say 'oh no, what we should be doing is triple therapy, we should be focusing more on triple therapy and how to get CD4 machines'. What I mean is that Medical doctors use medical language, which does not lead to a meaningful discussion with other occupations during meeting. So when I say dominate, it is more about number one the type of language they use, (Participant 30: Medical Doctor)*

Participants' accounts illustrate the ways in which, the use of medical language has caused an exclusion of non-medical stakeholders in meeting deliberations, focusing mostly on the biomedical discourse of disease prevention, thereby neglecting the community component of the health system. In this sub-section, the two main agential factors identified were the larger number of medical representatives and the predominant use of the biomedical discourse during meetings. The synergistic effect of crowding out other opinions through larger medical professional representation also strengthens the biomedical discourse in meetings, which as a result shapes the conceptualisation of the health strategies developed. An overview of the structural and agential factors in the data is helpful in identifying sources of power that maintain dominance and explain why many people have internalised the superior position of the medical profession during policy formulation.

#### 6.2.4 Effects of medical dominance

Most participants (including those who were medical doctors) perceived the influence of a medically dominated agenda in the proposal writing process as having negative effects that hindered the programme from achieving its targets. Due to the overwhelming focus on clinical strategies in programme design, alternative viewpoints were easily rejected because they were not seen as being evidence-based, therefore making technical medical approaches hard to argue against. The uneven balance of ideas and contributions that favour clinical efficacy have little practical feasibility during implementation leading to operational challenges. In the extracts below participant 9 explains why the imbalance can lead to operational challenges. The following extracts from participants 9 and 32 give examples of these operational challenges:

*So several aspects should be taken care of and led by profound expertise in those areas. So there should be the business profile, there should be as important as you know the clinical profile, the technical experts because all of these, the combination of these contribution makes the proposal solid efficient and effective. Otherwise, there would be too much unbalance towards a clinical efficacy but it will not be practical because of the many operational challenges. Supply chain challenges you know, it would not be feasible because it is not sustainable. (Participant 9: Finance expert)*

*So if you bring for instance, if I bring ARV to you, it does not make sense because you are negative, it would not make a sense in another 6 months. You*

*will not even listen to it. That is actually, what they (Global Fund PRs and SRs and CCM) are doing because they are interested in the procurement. They (Global Fund PRs and SRs and CCM) are procuring drugs and pushing it to people who are actually non-existent. (Participant 32: Non-doctor public health expert)*

The domination of procurement of drugs in the proposal as described above, is seen in the recent Concept Note which shows greater than 80% of the funds being allocated to facility based treatment and care under the Module: PMTCT (Prevention of Mother to Child Treatment), Treatment, care and support, TB Care Prevention and Treatment, MDR-TB (Multi-Drug Resistant TB) and TB/HIV. In contrast, prevention which focuses on biomedical strategies such as testing and distribution of condoms to targeted vulnerable groups, takes up 7% of the proposal and 2% is aimed at Community Strengthening Strategies. In Figure 10 below, evidence of the breakdown of funds according to specific strategies is shown which highlights some of the concerns raised in the interview extracts about the preference for procurement of drug rather than community based strategies.

**Figure 10: Focus of application mapping TB AND HIV CONCEPT NOTE Investing for impact against tuberculosis and HIV (CCM Nigeria 2015b:48)**

| Module  | Allocation         | %           |
|---|--------------------|-------------|
| Prevention for General Population                                   | 6,500,000          | 2%          |
| Prevention programs for Vulnerable populations (MSM )               | 4,721,435          | 1%          |
| Prevention programs for Vulnerable populations (FSWs)               | 6,686,487          | 2%          |
| Prevention programs for Vulnerable populations (PWID)               | 3,592,078          | 1%          |
| Prevention programs for adolescents and youth, in and out of school | 2,000,000          | 1%          |
| PMTCT   | 27,478,841         | 8%          |
| Treatment , Care and support  | 148,453,913        | 42%         |
| TB Care Prevention & Treatment                                      | 67,461,012         | 19%         |
| MDR-TB  | 33,227,398         | 9%          |
| TB/HIV  | 6,979,530          | 2%          |
| CSS   | 6,000,000          | 2%          |
| HMIS -M&E   | 12,000,000         | 3%          |
| PSCM  | 11,000,000         | 3%          |
| Program Management  | 15,679,793         | 4%          |
| <b>Totals</b>   | <b>351,780,487</b> | <b>100%</b> |

Most of the participants had vast experience in previous Global Fund grants and this made them able to highlight examples from various Global Fund proposals. Most participants claimed that because most of the previous proposals were predominantly based on medical insight, during implementation operational challenges encountered in the field led to poor performance of the grant. Clinical judgement in this case could rarely predict the operational challenges in the context of Nigeria. Hence, proposals' budgets are frequently aimed at buying drugs, upgrading of facilities, and training of health staff, while neglecting how to improve access to services, or how to strengthen communities and social structures. However, as participants stated in addition to the documentary evidence, these clinically dominated approaches have continued to prevail:

*But on the other hand you find out they are not pragmatic in terms of you know open to new learning or contribution from some other sectors or cadres of*

*professionals. They are not usually open to that because of some, I do not know the reason anyway, but they are not usually open to that. That is all I can say. So you find out that most times even when that strategy or approach is not giving result, it subsists you know. (Participant 28: Medical Doctor)*

Participants were worried about the ongoing wastage that sometimes result from bio-medically biased strategies and admitted it was of growing concern among stakeholders, donors and the patient population.

*In fact, it is actually ridiculous sometimes when you are designing programmes, you want to include community component, and they say, no, no. **Instead of doing community component, they say scale up ARVs, then you buy ARVs, at the end of the day, they will go and take the drugs because they will expire and then you go and pay people to go and destroy the expired drugs. Because there is no demand,** so there needs to be more involvement of people who will go beyond the science, I mean the physical science, the public health, or medical science and go to how to get people to use the services.(Emphasis added)*  
*(Participant 21: Finance expert)*

*If you go to Guadalupe PHC, it is in Delta state, they keep giving them PMTC ARVs for pregnant women at the facility, but they have only one pregnant woman who is positive. But because they reported that they have decided to be pushing those PMTC drugs. The facility is given almost 100 packages for refills and at the national level it is counted ...but those ARVs are there expiring, so*

*when you are looking at the national indicators and they are telling you low uptake. It is not low uptake it is because we have not even seen those ones that are positive there first so you need to go and find them first before you start screaming low uptake. (Participant 32: Non-doctor public health expert)*

Evidence of the wastage of medical supplies due to low uptake of the supplies in the community is seen in the documentary evidence of an OIG report below:

*As a result, the OIG noted 20 tons of expired HIV commodities at the central medical store, most of which were Global Fund purchased commodities and 15 tons at the state medical stores which have accumulated since 2005. The value of those commodities couldn't be calculated due to the state these drugs were stored. (Audit Report: Global Fund Grants to the Federal Republic of Nigeria (OIG Report 2016:13))*

Biomedical concepts are necessary in framing a health intervention, but they need to be allied with other perspectives, with each playing their appropriate part. These opinions were expressed in the extracts below:

*So that is the programme, I think, that has been so clinically dominated, that has stifled the programme. We are now realising that we need to be broader minded, we need to expand our thinking into other ways of getting things done. (Participant 14: Medical doctor)*

*Right now, we do not know the actual number that should be on treatment. We are anticipating that they are 3.5m people living with HIV in Nigeria. People on*



*treatment are a little above 570,000. So where are others, where are the remaining? Are they in Geneva or they are in US? They are in Nigeria but because there is no community system to bring those remaining infected people out. So out of that 571,000, they are estimating that about 100,000 of them have defaulted. So that is a huge chunk. So when you look at those things you get to see that the real issues have not being addressed. So once it is addressed you get to see something coming out of it. So it's our sincere hope that we get to that.*  
(Participant 32: Medical Doctor)

*Then you talk about the gap, is there really gap? The way I define gap is people who are available and willing to take drugs...but the drugs are not available, that is how I define gap. I don't define gap by population measure, they say (medical professional experts) 3%, 3.4% of people (the Nigerian population) are HIV positive, you haven't tested them to know if they are HIV positive, you haven't even done their CD4 count to know if they are eligible for ARV and all that... So the gaps have to be redefined (Participant 21: Finance expert)*

As the statements above illustrate, poor conceptualisation of community mobilisation by clinicians has played a role in the poor integration of community support systems into strategies. This has resulted in high defaulter numbers and poor tracking systems in the TB grant. Clinicians most times do not communicate with the community and hence cannot understand their problems. As some participants described, when faced with community approaches clinicians usually reject them and increase the supply of health services, favouring supply over demand. This has done little to ensure sustainability of

health programmes in the long-term. However, as a participant stated below, there is a struggle for conceptualisation of community involvement strategies:

*I will say they have, but I will say that they have not fully conceptualised the community involvement in making the grant work, because if they had, this grant would have done more than it should be doing because we have done so well in the aspect of supply. I will say, my own impression; but demand for services is still a challenge. (Participant 23: Medical Doctor)*

*I have given the TB programme as an example, we are only detecting 17% of the cases, so we need people that can think outside the box to actually think that the patient is sick, the patient will definitely come and meet me...You need people that can actually think of how are we even going to look for these patients the remaining 83% that are not coming to the hospital? (Participant 14: Medical doctor)*

*Currently the example I want to give you, there is a national huge issue the TB and the HIV is not integrating, the TB, HIV and the community are not integrating. So what is causing it? Because the concept, the fund is allotted to give people ARV, give people ARV, there is no fund to say at what point does people given ART meet with where they live. At what point do we ensure that the community support them not to quit coming to take ARV. At what point do we ensure that there is a feedback to us whether they are living fine or they are not living fine. At what point do we see whether they are defaulting... So that is what*

*is happening because the huge budget, you can go check it yourself, is placed on buying ARVs drugs just that and pushed to the facilities. There is no community component. The community component there is like 0.5% out of the entire grant, which would not be able to do anything...Because if anybody decides to say am stopping, am not doing again (taking ARVs) they stop and they even change (change facility) and when they get to the new facility, because that new facility is pursuing targets they want to enrol more people they will quickly enrol you without wanting to know what is the history (Participant 32: Non-doctor public health expert)*

In addition to the interview extracts above, the lack of leadership in integrating community participation to the National framework is captured in the document below:

*not enough attention has been paid in strengthening community systems, even with long history of talks about community ownership and participation. The mechanism to achieve this has been weak and leadership diffused. The vacuum has often tended to be filled by CSOs/NGOs, yet this has resulted in the need for some upfront capacity building which have not been readily forthcoming. Neither donors nor government have any sustainable strategy for engaging CSOs (TB AND HIV CONCEPT NOTE Investing for impact against tuberculosis and HIV (CCM Nigeria 2015b:21)).*

This sub-section has highlighted the major effect of medical dominance in proposal writing. Wastage of funds because of low uptake of ARVs has been the major source of concern to the participants. Biomedical strategies have encouraged the procurement of ARVs, which later are expired due to low demand for the health services provided in the proposals. In the next section, we are going to look at the trend of medical

professionals' influence in the proposal writing process and their increasing number in partner organisations.

### **6.2.5 Trend of doctors' dominance**

*From my experience, I think this is just a normal trend. I started working with Global Fund, before I joined this organisation; I started as far back as 2006, that's exactly what I observed since then, I have participated in many proposal writing, right from 2006, I have participated in writing proposal like three different grants, but mainly malaria and HIV, and that has been the trend. Mostly people with medical background take the lead and influence the proceedings of most of these activities (Participant 19: Non- Doctor M&E expert)*

This sub-section aims to describe the trend of medical professionals' visible presence in implementing and supporting agencies of the Global Fund. The Global Fund grant is quite young compared to other health programmes in Nigerian and the trend of doctors leading similar grants has been a constant picture in the Nigerian health system, according to participants. Participants were split in their views about the trend of medical professional migration from health facilities to programme management. Some participants said this growing medical professional migration is a recent event while some participants argue that it has been an ongoing phenomenon. However, most agreed that since the introduction of GHIs into the Nigerian health system, there has been a rapid increase in medical professionals migrating from health facilities into programme management of projects. This is also captured in other studies that describe this type of internal brain drain in the Nigerian health system (Chima & Homedes

2015). Another participant called the process a 'repackaging' process whereby medical professionals are recycled back into the system as public health experts after acquiring a Masters in Public Health (MPH), and then re-employed back into the system as public health experts.

*Even though you know most, recently public health came up and we have seen the values of actually having public health professionals also lead the process, but you find out that in most instances, the medical professionals have that public health, they will go and update that knowledge and then come. So it's intertwined. It is still the same person (Participant 28: Medical Doctor)*

*We had medical doctors, and when you talk of medical doctors, we had medical doctors of 10, 20 years' experience. We had medical doctors of several qualifications. We had medical doctors they had just their MBBS but with plenty of experience. We had medical doctors with fellowships; we had medical doctors with Masters degrees in public health, Masters degrees in health policy, and Masters degrees in health economics. (Participant 22: Medical Doctor)*

*Yes, what we have now is national dialogue and we are all the same set of people that have been running this process in the past years so nothing is going to change (Participant 5: Social science expert)*

The same public health experts have been in the system for so long that they are always the same ones running the process and with a further increase in doctors 'repackaging' themselves, this has led to a trend of doctors outnumbering other professionals in the local public health arena.

*With also the Nigerian context of the labour market as well, you get to see medical doctors who were actually designed to stay back in these facilities, migrating to come and manage these projects. Well it is a fundamental error but it is happening and there is nothing anybody can do about that. (Participant 32: Non-doctor public health expert)*

*In Nigeria, we have at least six medical doctors in this office; none of them is a clinician, none of them is practicing, we are doing deskwork. (Participant 8: Non-doctor Public health expert)*

*Before I came back, I was working in England, I was working for a health consultancy, and our major client was the NHS. It was a private organisation but none of us was a doctor; we all studied public health, health management, but here public health is dominated by doctors, and here mostly everybody in the office is a doctor, I am one of the few numbers that are not, and that shows the context. (Participant 26: Non-doctor public health expert)*

Many researchers and government documents have also reported this trend of an internal brain drain due to the introduction of GHIs in the Nigerian health system (Uneke et al. 2008; Chankova et al. 2006; Labiran et al. 2008; Chima & Homedes 2015).

This section has examined medical influence in the proposal writing process, by building on the findings of professional monopoly from the previous chapter. The historical origins of the Nigerian health system, which, as this thesis argues, has been structured with an occupational hierarchy that favours medical professions above others, is now replicated in the policy process of the Global Fund. From participants' experience, we were able to identify this influence and draw some links with the existing medical professional monopoly on the entire health system. Secondly, the data gave an idea of some of the ways in which this professional monopoly is sustained, which we classified into structural/societal factors and agential factors according to the literature about power and influence (Arts & Tatenhove 2004; Hay 2002b).

Participants went further to cite areas they perceived were affected by professional monopoly in the Global Fund's proposal writing process. Participants argued that emphasis on biomedical approaches led to poor utilisation of funds and poor conceptualisation of demand generation strategies. Finally, the findings gave an indication of the internal brain drain in the Nigerian health system caused by the increasing number of medical professionals' migration into programme management. The acquisition of public health qualifications is one of the strategies medical professionals use in transiting from clinical positions in the health system to management positions in public health organisations. Many of the participants sensed this trend would only maintain medical professional monopoly in the coming years.

In the next section, the data identified key non-clinical interest groups, which participants believed could potentially make insightful contributions to the proposal

writing process. Even though the participants described a broad range of groups and professionals involved in the proposal process, they focused on three groups in particular, namely; field workers, social science experts, and patient groups. These will be discussed under the sub-headings in the next section.

### **6.3 Interdisciplinary systems thinking and Participation of Repressed interests**

In Alford's theory, the patient population are classified as repressed interests (Alford 1975). CBOs and other patient organisations were recognised in this study as those who protect the interests of the patients, community, and population. Alford's theory did not include other health occupations and non-health occupations under the repressed interests, but it termed repressed interests as *'opposite of dominant ones (although not necessarily always in conflict with them); the nature of institutions guarantees that they will not be served unless extraordinary political energies are mobilised'* (Alford 1975:14). In this study, the other non-medical professionals and the patient interest groups have been identified as opposite to the dominant medical interests and are therefore termed as the repressed interest group. The aim of this sub-section is to explore the role of other occupations and patient interest group in the proposal writing process and the effect that interaction between medical professionals and other occupations has on participation.

#### **6.3.2 Field workers**

Participants in this study referred to field officers as a group of health workers working directly in the community such as Community Health Extension Workers (CHEWS). They are a cadre of health workers (para-professionals) created by the government to fill in the health worker gaps in rural areas (Ross & Bailey 2013). Field officers can be



important in giving contextual realities that inform programme design but they were hardly involved by the CCM organisers. A majority of participants were of the opinion that involving this group would reduce dependence on generic WHO and Global Fund operational guidelines. Participant 22 who is a medical professional expresses the importance of involving these field workers in the extract below:

*The missing links are the communities, and we cannot fully link up with the communities without those guys that are custodians of the community when you are now referring to health care workers. These are people who actually go to school to learn about how the community works, how health intervention should be in the community. The junior community health extension worker, the community health extension worker, the community health officer, I think those are the guys being played down and they should be brought up more.*  
*(Participant 22: Medical Doctor)*

The Global Fund under the New Funding Model recently introduced a process called country dialogue, as an activity that would be aimed at encouraging participation from a wider group of stakeholders within the various regions of the country. This is part of the Global Fund's New Funding Model concept, which they are introducing globally. At the time of data collection, this activity had only been tested for the first time and was at its initial stages. The extract from the documentary evidence below describes the process in more detail:

*Country dialogue refers to the ongoing process that occurs at the country level to develop health strategies to fight the three diseases and strengthen health and*

*community systems. It includes national strategic planning processes, mid-term and program reviews and other partner-led processes...should be open, inclusive and participatory and include implementers; the government—including the National Ministries of Health, Finance and Planning; the private sector; the public sector; civil society; academia; networks of key affected populations including women's organizations; people most who are vulnerable based on the epidemiological context, including people living with the diseases; bilateral, multilateral and technical partners (Information Note for Country Dialogue (Global Fund 2013:1))*

Field officers have often voiced their discontent at their lack of involvement in CCM processes in previous years, but little has been done to address the issue. One factor highlighted as a limitation to the involvement of CHEW is the difficulty in attracting the right mix of field workers that would be reflective of the diverse nature of Nigerian communities. Some participants cited financial and logistical difficulties as reasons for their lack of involvement. Others felt that a smaller, number of participants made it easier to co-ordinate meeting sessions, and therefore preferred leaving CHEW out of the meetings. Nevertheless, most of them were very optimistic about how a country dialogue would bridge this gap in communication with CHEWS.

*I think because they never get-to-get university degrees like the other health professionals. So they do not have that sophistication as B.Sc. Nursing will have, that MBBS medical doctor will have, that a BA psychology will have. You know they do not have that degree, it's probably inferior complex on their own part, not putting themselves out there to be noticed and it's probably oppression on*

*the part of the other health professionals playing them down (Participant 22: Medical Doctor)*

*I think the one that readily comes to mind is the last grant that we wrote, the one for the MBR TB grant, where the community folks were trying to express the fact that they were not given enough prominence in the TB programme; because the TB programme is mainly about clinical, (Participant 14: Medical doctor)*

There were indications of optimism from participants that there will be more involvement of community field officers in the New Funding model of the Global Fund, which has placed emphasis on a country dialogue.

### **6.3.3 Non-clinical disciplines**

According to most participants, policy makers have a narrow scope of options in terms of how to conceptualise the behaviours of communities in order to inform health policymaking in Nigeria. This was widely cited as a systemic weakness caused by poor integration of social science concepts into public health strategies. Most participants referred to social science as disciplines that included sociology, psychology, and disciplines involved in behavioural sciences. In addition to these disciplines, others used the word social science to refer to non-clinical disciplines such as health economics, statistics, and politics. Due to participants' lack of clarity in their reference to social science, this study has aggregated all the data referring to the non-clinical specialities under this sub-section. This form of token recognition, is another form of biomedical dominance, whereby other disciplines are not given proper recognition but are ill-defined into the 'social science' heading. In other words, they are not actually paying

attention to these areas of work that are not biomedical and this is captured in the extract below:

*Well, I think the social sciences cover the health economics, even the logistics aspect too, so social science is quite broad, there are so many of them; talking about the psychologists, the medical psychologists and everything, when you are dealing with human beings, the ethicists and all that. It is quite a blanket; it covers all these professions, to me. (Participant 23: Medical Doctor)*

There is a certain level of realisation among the participants that understanding how communities behave hinges on a synergy of social scientists' and biomedical experts' trans-disciplinary participation. They claim that holistic explanations would need to go beyond relying on traditional methods of epidemiology and bio-medical knowledge. While thirteen of the participants argued for more social science input into Global Fund processes and acknowledged the gap in this area, others thought that a complete deviation from biomedical approaches would be better than a hybrid of biomedical and non-biomedical science. They based their argument on the assumption that as long as medical professionals maintain their dominance over the health sector, no considerable change can be achieved.

*Like the social mobilization, the gender issues, we are not focusing and paying more attention to those issues, to make the programme achieve the kind of targets we want to achieve. I think we are focusing a lot on buying drugs and things like that, more than getting the community to accept, to even change their*

*health behaviour; so to that extent, I think we will need a change, but I do not think that there will be material changes. The medical doctors will continue to have an upper hand, which is not unexpected because it is a public health issue.*  
(Participants 21: Finance expert)

*I think going forward, you still need to get more social scientists, and probably we have not gotten enough, even though they were there, probably their voice was not well heard, or they did not conceptualise the community involvement aspect, so there will be need for more social scientists to look at demand creation for services and linkages of services.* (Participant 23: Medical Doctor)

Demand creation in the health system can be improved by the use of community mobilisation models of the social science disciplines, which can bring to light some of the contextual peculiarities in the country. This gap has been highlighted by stakeholders in country proposals, whereby they have admitted that the country has no National CSS (Community Systems Strengthening) framework available. This is captured in the documentary extract below:

*More often than not, while government policies recognize the need for community systems to be mobilized for an all-inclusive process, the mechanism through CSO is given scant attention, this is responsible for non-availability of National CSS framework. (TB AND HIV CONCEPT NOTE Investing for impact against tuberculosis and HIV (CCM Nigeria 2015b:44))*

Although, participants admit there is a tendency for everyone to prefer preconceived bio-medical explanations that look at the Nigerian population as one harmonised

community, which are easier to understand rather than complex un-tested non-biomedical explanations. In addition, a major contributing factor to this inclination is the scientific community's preference for quantitative data and research, which has lowered encouragement for qualitative research in the Nigerian health system.

*For example, the most at risk population, it not just medical. If you are writing a proposal for most at risk population, you cannot just sit down and your thinking it is just medically oriented. Even though those people need health services, but the most important thing is how do they think, how do they behave? So you can attract them to access those services. May be you need people with social science background, may be in the areas like sociology, you understand.*  
*(Participant 19: Non- Doctor M&E expert)*

There was ambiguity on the range or type of social scientists needed. However, some participants pointed to the fact that if operational research funding is shared to other non-biomedical disciplines for research, it would serve as a good opportunity to discourage biomedical dominance. In addition, social scientists can help in understanding health workers and group dynamics that have led to disharmony among health workers on the supply side.

*Even within the supply side, they (non-clinical occupations) still have a role to play. Talking about these intergroup conflicts currently happening within hospitals, these are within the purview of health management so we need clear-cut people (non-clinical occupations) with the understanding of how to manage group dynamism. (Participant 11: Non-doctor Public health expert)*

Contributions from non-clinical disciplines are an obvious gap in the proposal process. Contextualisation of both the demand and supply of health services have been poorly understood, which participants feel is a major gap in the development of practical and feasible proposals. With the inclusion of non-clinical occupations in the repressed interest category, this section has identified the second group of stakeholders who have been marginalised due to biomedical dominance in the deliberative space.

#### **6.3.4 Patient interests**

The patient population according to Alford's theory are a repressed interest group. The findings in this study support this view. Most participants agreed that patient interests should be at the heart of the programme design, and should have precedence over all suggestions from other interest groups. This sub-section is aimed at exploring the views of participants about the role of patient interests in the formulation of proposals.

Decision makers and implementers see patients as beneficiaries of the health system, and one of the participants suggested that the patient population should be treated similarly to customers or clients of services, where their suggestions are important. In so doing, the assumption is that the patients would be given a chance to evaluate the programme and quality of care. The major challenge to this is the current communication gap between the patients and the service providers. Participants also believe it is pertinent for patients to be involved in designing the programme if stakeholders want to achieve accountability, quality of care, integration of services and empowerment of neglected at risk groups.

*But right now I think we should be more focused on the patients...but of course I think in the past there has never being a platform where the consumer of the service will have a say. To say” yea this is what we are getting”, “this is what we hope to get”, “this is what we think we should be getting”. Patients just go to the clinic, we get what so ever is given to us, and we even say “thank you” but sometimes its baffles me*

*Many times we see the service providers as the king and we used to worship them you know when they give us even Septrin, we thank them a lot that they are doing us a favour but we would not know that Global Fund is somewhere paying for all these. (Participant 5: Social science expert)*

A participant felt over recent years experts used their patients’ perceived need in policy-making meetings, rather than the patients’ real need. To complicate the situation, community-based organisations that are meant to be the voice of the patient population hardly have any influence during meetings, as illustrated in Chapter Five, and a majority of the participants agreed that this was a prevalent problem in the proposal proceedings.

*The last one we did, I cannot remember if they were part of it. So I cannot remember any of the key affected population being part of that proposal writing team. So they should be involved in proposal writing too. And of course people who are living with the virus. When you think of TB too, those who are patients, or those who have had it, you know their experience matters a lot. (Participant 20: Medical Doctor)*



Apart from the appeal by the patient population to be given better services, participant 5 (also the representative of the patient population) believes they can be part of problem solving. Participant 5, in the extract below gives an example of instance whereby the patient population was actively trying to solve operational problems during implementation:

*Global Fund is making all these provisions, they are paying for the CD4 count machines but people living with HIV still pay for CD4 count test. There are situations whereby the patient community especially in Isolo General Hospital in Lagos state, the support group of persons living with HIV contributed money to repair a CD4 count machine. In central hospital in Benin, people living with HIV in the support group they also paid money to repair the CD4 count machines. And we were feeling that okay well fine we should not only be the consumer of the services but at the same time, we can also be part of the solution... So I think we should be able to synergise (Participant 5:Social science expert)*

This claim is illustrated in an OIG report:

*For example, frequent equipment breakdowns were flagged over a period of three years. In addition, CD4 and hematology machines and poor maintenance were identified, but no action plans were initiated to resolve them, resulting in the unavailability of hematology reagents in 46% of the health facilities visited. These issues were identified for Isolo (Audit Report: Global Fund Grants to the Federal Republic of Nigeria (OIG Report 2016:19))*

Lack of patient involvement in the process has seen people still patronise traditional healers, further separating them from western style health institutions. Among participants, there is a general fear that the ever-growing gap between the policy processes in Nigeria and patients will lead to poor service utilisation and ultimately a lack of confidence in the community about Western-style health service provision.

To summarise, this sub-section represents concerns raised by participants in relation to representation of some 'repressed interest groups' in the proposal writing process. In this study, three sets of repressed interests were identified, namely: field workers, non-clinical disciplines, and patient interests. These repressed interests, who are a heterogeneous group, are similar in their opposite interests to the dominant interests of the medical professionals. First, the patient population were identified as a repressed interest group who have concerns about access to quality health care but are excluded from deliberations in the Global Fund proposal writing process. Secondly, we were led by the data to other under-utilised non-clinical occupations that have the potential to add much needed value to the quality of the proposals and create demand for health services. The occupations identified were: social science experts and community field officers. Poor utilisation of patients' input in finding solutions, loss of the patients' confidence in the health system and poor contextualisation of health strategies were seen as consequences of a lack of participation of these repressed interest groups in the policy process.

The next section will build on the subject of exclusion by exploring the participation of non-clinical occupations in the proposal writing process.

### **6.3.5 Participation**

Accounts from participants indicated that even though there were guidelines on comprehensive participation of stakeholders during the proposal process, in reality they

felt that participation was not equal among the various occupations and organisations. The aim of this section is to highlight the main reasons for unequal participation in the development of proposals. To achieve this we will highlight the ways in which invitations are made to participants, followed by the commitment and quality of participation of the three sets of repressed interests.

#### ***6.3.5.1 Invitations to participants***

Invitations for participation are usually sent to relevant organisations by the CCM through the government agency NACA. A major flaw cited with this system of invitation is that the necessary key skills and competencies are not identified before sending invitations and thereby the individuals that would add value to the process are not identified. In addition, invitations lacked clarity about the objectives and desired impact of the proposed grant application. Late invitations were also made with short notice of sometimes just three weeks, which affected the participation of stakeholders because this made it difficult for experts to acquire permission from their workplace to attend proposal writing.

*It is a tasking process most times. I think they use about two, three weeks at the national level in which people need to leave their primary assignment and be there. So considering the fact that now, the donor environment is more performance based, that becomes a real challenge for people to leave their core duties and actually show up. (Participant 3: Medical doctor)*

*The other thing is that the resource mobilisation committee will call but not everybody attends so I think we have always had an issue of attendance at the RMC. (Participant1: Medical doctor)*

During my observation meetings, I was able to see some of these patterns, described by participants, in action, which took place on the 5<sup>th</sup> March 2014. This is captured in the observation notes below:

*This meeting of various stakeholders was to develop a road map for the proposal writing process. Invitations were sent round to the various relevant organisations by NACA two weeks in advance but they did not give any information about the venue and date of the meeting in the invitations. There was no detailed information from NACA or the CCM secretariat about the meeting and it was unclear whether there was a lack of proper arrangement or maybe they were keeping this information secret. On the day of the meeting, most delegates complained about being informed about the venue two days in advance and there was a visible absence of some key delegates. Delegates who were present had little time to prepare for the meeting and were not clear about the agenda of the meeting (Notes from observations of Global Fund meeting on concept note and road for New Funding Model , 5<sup>th</sup> of March 2014).*

The observation field note is added evidence that illustrates how poor co-ordination of invitations limits full participation from stakeholders in the context.

### 6.3.5.2 Lack of commitment from non-doctor delegates

This sub-section focuses on the participation of non-clinical stakeholders during meetings. The aim is to identify the attitude of this repressed group in the deliberative process of actual CCM meetings. My field note observation (5<sup>th</sup> March 2014) findings highlight some of the concerns about the attitude of some non-clinical delegates during meetings.

*Prominent individuals [from the leading health organisations] led the meeting. They were all medical doctors and had a template about the timeline and road map they had already designed among themselves. In addition, they were the only ones who had a clear understanding about what the Global Fund wanted to achieve in the 'New Funding Model'. One important observation made was that the CSOs were not very active in the process and the active participation was among the government delegates and the NGO delegates who were doctors. The CCM secretariat members were present but were not moderating or attempting to encourage participation from other delegates. Most of the delegates had left after the lunch break and from my observation only the active medical doctor members were left behind to continue the meeting. Important issues were discussed after the lunch break such as terms of reference for hired consultants and the composition of proposal writing teams. Comparing the involvement of the delegates from the top organisations, government organisations and other delegates, there was **a lack of commitment** in the activities of the meeting by the CSOs. While the delegates from the NGOs and government agency NACA were very active in leading the agenda from start to finish. (Notes from observations of Global Fund meeting on concept note and road for New Funding Model, 5<sup>th</sup> of March 2014).*

The findings in the observation was also expressed by participants in the data, alluding to scenarios where the attitude of the non-doctor participants led to sections of the proposal not done due to lack of commitment from the non-doctor delegates. Some participants' accounts described a sense of feeling among medical professional participants that other professionals are not as dedicated and committed to the writing process as doctors.

*Again, that depends on commitments too, some attitudinal issues come up, and you find out that you invite these guys, they do not really come; but again, you can try to sensitise them on their importance, why they need to put pen on paper to get a better quality of service. Sometimes a doctor is forced to write a segment he is not meant to write, because the person to write it does not show up and then there is a timeline for the submission of such proposals, so if other professionals can actually sit down and do a good job on their own sections, that will help. (Participant 23: Medical Doctor)*

A participant stressed that the poor participation of CSOs was due to their struggle in recruiting the right work force to write parts of the proposal, and this was a contributing factor to CSOs' lack of impact in these proceedings. The result of this is a situation where biomedical experts write sections dedicated for community activities and interventions. Some medical professional participants expressed these concerns.

*Yea, that is what I was just explaining to you. I mean that plays out at least in every proposal writing I have being part of, but it is not as simple as that. I have being part of writing a CSS proposal before where the community focus people*

*wanted all sort of fancy programming and everything, but would not sit down for 30 seconds to look at the proposal. They were happy with us writing the proposal and then putting their name there to implement. So when you have people who are more NGO type, more hospital focused doing these things, naturally they are going to lean towards what they know and what they are comfortable with (Participant 33: Health economist)*

The quotes above highlight two main issues concerning participation. Firstly, the non-doctor delegates invited are unaware of their role and importance in the whole process; therefore, they exhibit reluctance to attend the meetings. As a result, the active participants saw this as a lack of commitment and dedication to the process. Secondly, a participant argued that it maybe be due to a lack of capacity by CSO organisations which makes them handicapped in sending delegates who can have an impact on the proposal writing process, triggering a one-sided participation. This is further corroborated by the documentary evidence below, which highlights:

- *Capacity of implementing CSOs is comparatively weak. This is because they do not have enough exposure and resources*
- *There are challenges to coordination of CSOs and institutionalization.*
- *The ability of CSS practitioners to attract and retain competent staff is weak, and overstretched. (TB AND HIV CONCEPT NOTE Investing for impact against tuberculosis and HIV (CCM Nigeria 2015b:44))*

The sub-section argues that the marginalisation of non-clinical stakeholders has led to a nonchalant attitude and disinterest of this repressed group in the proposal writing process, which has been sensed by the medical professionals as a lack of commitment

and dedication. However, the process of invitation and the preparedness of medical professionals aided by their internal networks, all favour medical professionals' active participation and hinders participation of non-clinical occupations.

#### **6.3.5.3 Quality of participation**

The quality of participation depends on the delegates nominated by organisations nominate to represent them in the meetings. Therefore, the delegate's knowledge and readiness to state their case during deliberations is important. Some participants cited a lack of clear understanding of responsibilities between different stakeholders and organisations as a major obstacle to quality participation. In addition, limited information on the type of contributions needed to complement the proposal writing process is lacking. Participants cited the grant's inflexible work plan as a reason for demotivated participants and believed that if participants were aggregated according to their profiles and not as organisations, it could help improve participation and make everyone have an equal voice during deliberations.

*Then you know it actually depends on who is representing whom. Some people are more proactive, more committed; they make sure their voices are heard.*

*But at the same time, even though it could be more participatory. But maybe we need to have different fields come in not just health, have other sectors labour and productivity, agriculture, have more representation from those sectors too; because right now, we have involved the women affairs and even that representative I did not see her in the last meeting and same with the education representative. I think it should be broader than that, a multi-sectoral approach,*



*a more participatory approach involving different groups. (Participant 13: Medical doctor)*

In summary, while participants widely accepted that there were areas in which experts with a non-medical background would improve the quality of proposals, they felt the short proposal writing timeline, poor co-ordination of meetings and a lack of clarity of meeting agendas by NACA and the CCM affects the participation of non-doctor representatives. Some participants recognised poor engagement of non-doctor delegates as the main reason behind the lack of motivation and dedication, thereby, prompting medical doctors to fill up vacant roles in a bid to complete the document. From both the interview evidence and the observation field notes it is apparent that in the context of Nigeria, there are obstacles to full participation of all stakeholders, which is one of the main CCM goals set out by the Global Fund in their guidelines:

*Good Governance: Equality Among Members*

*67. The Global Fund considers all members of a CCM to be equal partners, with full rights to expression and involvement in decision-making in line with their areas of expertise.*

*68. The Global Fund recommends the following good practices to help CCMs ensure that decisions reflect the voices of all CCM members and constituencies:*

*i. CCM members - and in particular Chairs and Vice-Chairs - are encouraged to support a culture of fair and open discussion in CCM meetings, and equal participation in decision making by all members (Guidelines and Requirements for Country Coordinating Mechanisms (Global Fund 2015c:18))*

This section explored the theme of repressed interests by first identifying the stakeholders who belonged to this group and explained how the marginalisation of this interest group by the dominant interests has affected multi-stakeholder participation and interdisciplinary systems thinking. The structural limitations have marginalised this important group in the health system and their potential to improve the quality of proposals have been highlighted. Poor participation and lack of interdisciplinary thinking are the major consequences brought about by the marginalisation of repressed interested groups.

#### **6.4 Jurisdictional boundaries and subtle conflicts**

Alford's theory tells us that the dominant interest group is made up of the core medical professional monopoly and other health occupations (Alford 1975). Even though the institutional structures favour all the occupations under this group, the medical professionals dominate by monopolising the institutional structures to favour them more than other occupations (Alford 1975). Abbott's theory of professional jurisdiction tells us that these health professionals are in constant conflict with each other in an attempt to claim more jurisdiction in the health sector (Abbott 1988). This section focuses on the conflicts that are due to professional background differences in the deliberative process of proposal development.

In the setting of the Global Fund, most participants stated that professional conflicts and antagonism were not a barrier to proposal writing or implementation at the national administrative level. However, their perception was that at the facility level, professional conflicts and antagonism is inevitable. A number of participants shared similar views revealing that professional rivalry was subtle in the Global Fund

programmes at the national level and was more obvious in the facilities of the public sector:

*They (medical doctors and non-doctors) are talking because of their background. So the kind of decisions they (medical doctors and non-doctors) might want to see happen, the kind of action they (medical doctors and non-doctors) might want to take, might be influenced to a very large extent because of their (medical doctors and non-doctors) own background. Some times that can also bring logger heads per say, it might not be very open. Some kind of quite stuff but you feel it that it actually happens. So it is there but it is not as much as you can get at the facility hospital level (Participant 27: Procurement and supply expert)*

There were examples of conflict happening among doctors, pharmacists, and lab scientists but because the proposal writing has a lead person, conflict is usually resolved and agreements are reached through him/her. This is interesting because they come from the same biomedical background; therefore, it is sort of a medical doctor-pharmacist professional conflict.

*Another example I can cite is in terms of drug prescription between pharmacists and clinicians. It has happened even in my office in a meeting. The pharmacist was trying to explain what the current drug regimen is, as per the WHO current guideline and the clinician just cut in and interrupted, you could see the disagreement actually not just coming from the drug regimen that the*

*pharmacist was trying to talk about, you could see that it was more on a professional level. (Participant 7: M&E expert)*

*But the point is that at the end of the day the doctors are not really fighting with anybody because they are the most in number so they have that influence same as all the other core clinical area (Participant 33:Health economist)*

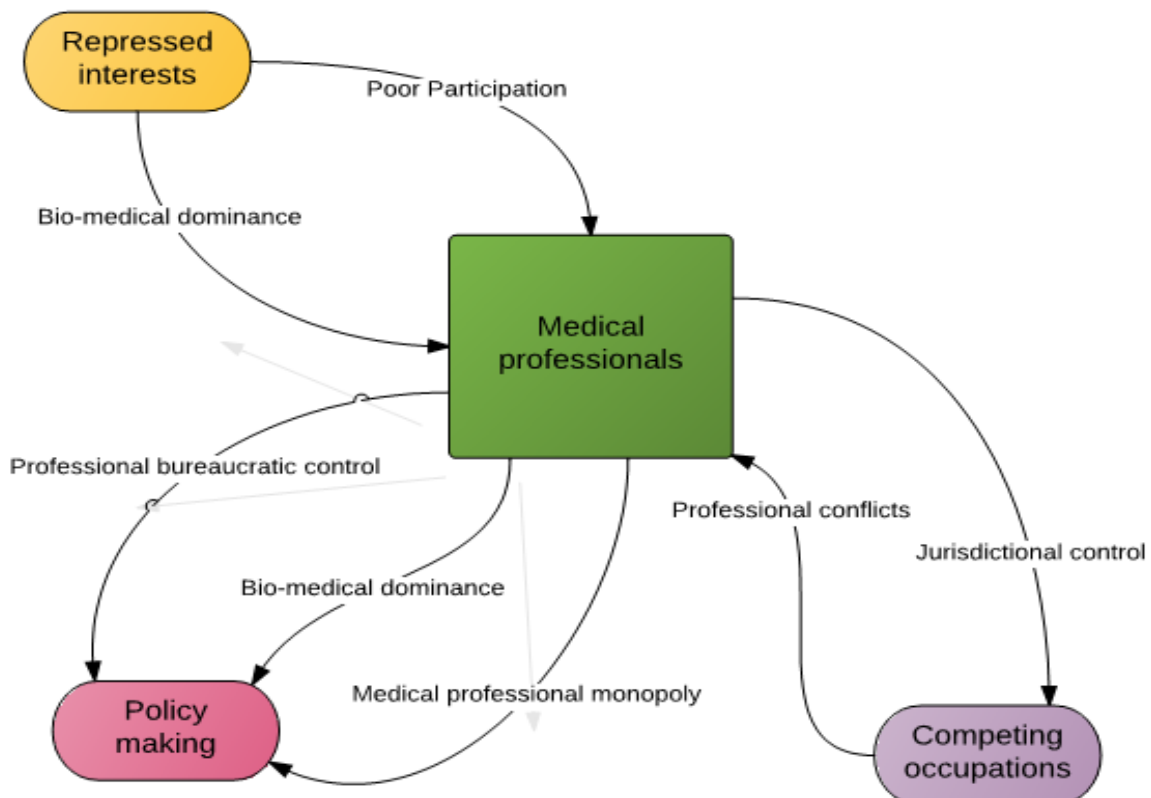
A participant highlighted how a treatment regimen that would make medical doctors the focal point of ARVs administration at the facility level was adopted because the medical professionals did not want to relegate the duty of prescribing ARVs to nurses or community extension workers. This unfortunately was adopted even though it was obvious that the inadequate number of medical professionals in the rural settings would be a challenge to the adopted ARV strategy. Another participant cited an instance whereby laboratory scientists tried to protect their professional boundary by favouring policies that would restrict the use of CD4 laboratory machines to only laboratory scientists. These narratives paint a picture of a power tussle between health professionals struggling to protect their professional boundaries by means of supporting policies favourable to their profession regardless of the health systems effects.

*In fact, it was a challenge when they were trying to step down PMTCT to the facilities... In fact that is one of the reasons in Nigeria we are using option A at the PHCs because in option B you do not need any decision. It is either the person is positive or negative. If the person is positive and is a pregnant woman, you place the person on option B that is the triple combination of ARVs....but because of those dynamics, they said no....medical doctors opposed saying NO!*

*That it is like relegating their job, not even delegating, relegating it to the nurses. That it should be a medical doctor that should do that and that is why Nigeria is using option A. (Participant 27: Procurement and supply expert)*

Participants highlighted how these inter-professional tensions affect decisions made in the proposal phase. Inter-professional conflicts among health workers during the proposal-writing phase were a feature, but according to participants, these conflicts were not as obvious as those seen at the health facilities. This last section sets the scene for what will be discussed in the next chapter.

**Figure 11: Summary of themes in Chapter Six**



## 6.5 Chapter summary

This chapter has presented an analysis of the sub-themes originating from the data in relation to professional influences and proposal writing processes. In this regard, it was seen that the one over-arching professional influence in the proposal writing process was from the medical professional group. Specifically, this influence goes beyond the Global Fund proposal writing process but also spreads throughout the entire Nigerian health system. The reason for this professional monopoly was attributed to some societal factors such as the perception of society about the superior role of medical doctors above other health professionals and the resources to back their biomedical views through research based evidence. Agential factors such as the use of scientific language in meeting proceedings and out-numbering of other occupations were some of the resources mobilised by medical professionals. These findings are similar to the results in Chapter Five but Chapter Six presents a more in-depth picture of the system wide factors that enable the medical professional monopoly in both the Nigerian health system and the proposal writing process of the Global Fund grant. These factors have led to an increasing trend whereby doctors are being pulled to the developmental area of the health system, fuelling a dominant biomedical discourse and weakening contextualisation of the proposals. The first section was able to explore the role of professional monopoly on the various proposal-writing processes, identify medical professionals as the dominant interest group, and explain system-wide consequences of medical dominance in the Nigerian health system.

Further analysis of the other interest groups neglected in the proposal process, was presented under the theme of interdisciplinary systems thinking and participation of repressed interests. This theme is a reflection of participants' views about how field workers possess the potential to improve community contextualisation of the proposal.

Secondarily, the struggle to balance the dominant biomedical discourse with social science knowledge in order to achieve hybridisation of ideas and strategies was linked to the insufficient in-cooperation of non-clinical experts in the proposal writing team. Finally, a case was made for making patients' interests central in the proposal process, which has been neglected in previous grant writing proceedings.

Participation emerged as a significant theme because it showed the kind of interaction among delegates during deliberations in proposal writing meetings. It emerged that low level of engagement by other relevant professionals has created an environment where medical professionals from the influential NGOs and government agencies control meeting proceedings. The second section identified the repressed interests in the study and explained how medical monopoly has marginalised these repressed interests, leading to a circle of lack of commitment and poor participation.

Finally, the critical area of professional conflicts emerged from the data, reflecting the subtle forms of inter-professional rivalry in organisations involved in the proposal writing process. At the top level of management and proposal writing, the conflicts seen were primarily among medical doctors and pharmacists, but were subdued in NGO-like organisations compared to the public sector.

In relation to the forms of power described in the literature review, occupational hierarchies can be as a result of the structural power of the biomedical discourse that *'allocates differential capacities, and typically differential advantages, to different positions'* (Barnett & Duvall 2005). In addition, the productive power of the biomedical discourse, in the form of the dominant biomedical language used during meeting proceedings, has allowed medical professionals to exploit this form of power to exclude other actors from the deliberative process. This appears to contribute towards poorer participation and a certain level of disinterest in the process from the repressed groups,

thereby reducing the variety and quality of participation. Furthermore, the productive power of the biomedical discourse is evident by how it is reproduced by actors involved in the proposal writing process in such a way that they find it difficult to conceptualise alternative health strategies, even when they have evidence to show that current strategies in use are not as effective as they should be. This will be discussed in more detail in the discussion chapter.

In summary, the chapter has explored the influence of medical doctors in the proposal writing process of the Global Fund grant. In the process, the chapter sought to give evidence for this influence, reasons for the influence, and consequent effects of these on the proposal and the health system. Crucial solutions for this dominance were identified, such as: equal participation from other non-medical professionals and an integration of repressed interest groups into the process. The conflicts created by this medical influence with other health occupations featured strongly in the data and this theme will be explored in more detail in the next chapter.



## **Chapter 7**

### **Interactions among health professionals and the Global Fund programme during implementation**

#### **7.1 Introduction**

The purpose of this chapter is to explore the role of medical doctors in implementing the Global Fund programme. In further examination of professional influence on the proposal writing process, it is apparent that there is a growing class of professional experts involved in most decision-making processes in HIV/AIDS programmes in Nigeria spearheaded by medical professionals. The findings reveal the positional power medical professionals possess in the proposal writing process and how the dominant biomedical discourse helps in creating and maintaining this positional power. As a result, these findings about biomedical dominance and a growing focus on NPM among the local epistemic elite in the policy writing process will be explored further in this chapter to see how these patterns influence implementation processes.

This chapter will begin by discussing findings from the interview data concerning the implementation of the Global Fund programme. This will be followed by an exploration of how the Global Fund programme shapes inter-professional roles and relationships at the implementation stage. As part of this, findings about how participants view the roles and attitudes of medical professionals in relation to other health occupations, specifically during the programme implementation phase, will be presented. This discussion will be placed in the context of the broader manifestation of these interactions in the health system.

Thus, it will be argued that there is a difference between medical professional influence in the proposal writing process and the implementation phase. This is because there is

greater interaction between health workers during implementation, and management changes mainly affect the frontline health workers. Firstly, the next section will focus on the role of medical professionals during implementation.

## **7.2 Street level bureaucrats: Frontline medical professionals' as facilitators**

All participants referred to the implementation phase as the phase after the grant approval. This is also the stage where the implementing partners of the Global Fund use the released funds to carry out activities. In order to characterise the frontline medical professionals, the concept of street-level bureaucrats has been adopted in this section. According to Michael Lipsky (1980), *'Public service workers who interact directly with citizens in the course of their jobs, and who have substantial discretion in the execution of their work are called street-level bureaucrats'* (Lipsky 1980:3). This description captures the role frontline medical professionals occupy at the implementation stage from the findings, and for this reason, this term is used to refer to them in this chapter and discussion chapter. However, it is important to state here that this picture was mainly drawn from the accounts of participants who are stationed at the national level (meso level i.e. programme management) and who in some cases have risen through the ranks and were formerly at the implementation level. Only two participants (a doctor and non-doctor) held a dual role of being programme managers and also functioning as portfolio managers for implementation sites. Usually in most organisations there is a clear distinction between these roles. During analysis it was therefore assumed that a majority of the accounts by participants about the implementation process were based on recollections.

### 7.2.1 Medical professionals in implementation

Synthesising the participants' reflections on medical professional's role in the implementation phase suggests a categorisation of frontline medical professionals into two broad groups: those who run the system at the regional state ministry level and those who work in the regional offices of NGOs and similar private organisations. These groups of frontline medical professionals are similar to the frontline medical professionals described in the literature. These medical professionals at the state/regional level provide technical assistance to the facilities, supervise, and make sure activities go according to the national country's policies and guidelines. The elite group of medical professionals at the country/national level provide the technical lead at the country office that helps strategize and support the state frontline staff:

*In the field we actually have, we use a variety of staff, like I said earlier most of our support staff are usually doctors, we also have nurses who work right in the field working with the local government (LG) level. Doctors are usually more at the state level or zonal office level where they provide support to those at the LG. (Participant 6: Medical Doctor)*

There was a general agreement by most participants that medical professionals were heavily involved in the implementation of the programme usually in a supervisory role in both public and private institutions at the state level. These frontline medical professionals have less input and control on the proposal writing stage but in the following sub-sections, similarities in their characteristics with street-level bureaucrats will be drawn.

### 7.2.1.1 Medical professionals as portfolio staff in private and public organisations

The data shows that at the facility level the medical professionals are the head of the clinical and management team while other health occupations cushion the managerial duties of the medical professionals. The portfolio staff are hired by private and public Global Fund implementers with the sole responsibility of overseeing the implementation of the grant at the regional and state level. The statement below emphasises the influence of medical professionals over other health occupations at the lower level of the health system. The document extracts that follows this statement shows the uneven distribution of health workers in the Nigerian health sector:

*The doctors have been recruited to also look at the process, the programme process and identify key areas of challenges. So with the medical background and their public health background, they should be able to say, okay, this is why the programme (is facing challenges). They may not be able to render solution to everything but they can recommend possible experts that can be brought on board to remedy some areas of the programme...These portfolio managers are basically medical doctors except a few, and their mandate really is to work closely with selected SRs as they do their implementation in the facilities, to ensure that they (facility staff) adhere to guidelines and ensure that that facility is actually receiving that service. (Participant 23: Medical Doctor)*

*I mean three or four professions they (implementation staff) might be more than one person in each of the professions, the medical doctor, the pharmacists, the lab scientist, and then the nurses and you know any other relevant health worker and the doctors are always the team leader. So given that they are the team*

*leader, I would like to say officially that they (portfolio staff) are the most influential people (Participant 27: Procurement and supply expert)*

*Imbalances in the skill mix and large disparities in the distribution of the health workforce between rural and urban areas...Majority of health workers in PHC facilities across all the states are CHEWs. Doctors, Nurses and Midwives are more available in non-PHC Healthcare Centres (TB AND HIV CONCEPT NOTE Investing for impact against tuberculosis and HIV (CCM Nigeria 2015b:20)*

The medical professionals who work in the public sector are usually stationed at the federal or state facilities, while the PHC (Primary Health Centre) level have just a few medical professionals, reflecting the scarcity of medical professionals in rural areas. Participants referred to medical professionals who work in the public sector of the state health ministry and facilities as gatekeepers of the health facilities. While in the private sector of NGO-like organisations (such as PRs and SRs) the medical professionals are used as portfolio staff during implementation. The role of the portfolio staff in the PRs is to liaise with SRs and see that set out guidelines are followed, while the portfolio staff working for SRs provide oversight services in the selected Global Fund health facilities. This sub-section highlights the important role medical professionals play as portfolio staff in the implementation of the Global Fund programmes for both public and private health organisations. After reviewing the existing literature on HRH, it is clear that the frontline staff in this study have similar characteristics to the ‘street-level bureaucrats’ described by Lipsky (Lipsky 1980) and other empirical studies that explored the role of frontline health workers in LMICs (Erasmus 2014; Walker & Gilson 2004). Because of how the frontline medical professionals link policy and implementation in this study, they have been referred to as street-level bureaucrats throughout this thesis. In both

private and public organisations, these portfolio staff ensure that facility staff adhere to the work plan in the signed grant during implementation.

### **7.2.1.2 Medical professionals with clinical and managerial roles**

In the field, at the health facilities, medical professionals take on the major clinical and administrative roles because the structures in place ensure that medical professionals take the lead in these settings. Medical professionals are not usually trained in handling management positions, so in cases where a medical professional makes a wrong managerial decision it adversely affects the entire programme. In various programme areas, there is a prevailing view among staff that medical professionals possess both clinical and managerial skills but the experiences of participants in other programmes have proved the opposite (captured in the Participant 30's extract below). The Nigerian health system does not rely on hospital administrators in running the administrative side of the health facilities but instead relies on medical professionals to exhibit these managerial skills. Some participants stated that the input of medical professionals in addressing the bottlenecks of programme (usually operational and management) implementation was limited and this was usually the case in both PEPFAR and Global Fund programmes. The statement by a participant below highlights the dual role medical professional are meant to play during implementation in the health facilities:

*What we have seen even before the Global Fund I worked with CDC and so we have seen PEPFAR implementing partners who were implementing HIV/ AIDS for the programme. And what you see is that the fact that you are a physician, a medical professional does not necessarily have the skill set to manage a programme and so we have two different types of skill set. You have the people*

*who could run the clinical part of the programme, see the patient, prescribe the right regiment, understand the purpose, the drugs could be getting toxic, understand how adherence was affecting that, but if you take that same person and say look the patient flow in this hospital is not working well... The person cannot help to think through how to sort that one out. That is a programme management problem and my experience in the field is that most of the bottlenecks we have are programme management type, which is where the health system bit comes in... So it is not the science of delivery or the science behind the medication, it is managing the programme, which is a HSS thing, (Participant 30: Medical Doctor, Female)*

Although the health system has been operating with medical professionals playing the role of facility clinical and administrative heads, the participants have rarely seen individuals who have successfully merged both clinical and managerial skills to positively impact the implementation phase. A former Global Fund staff member below further reiterated this point, showing the rarity of this combination and its potential:

*A rear skill set I have seen is the ability to match technical and managerial skills and admin skill, it is not a very common err.. You do not see it every day. You see people who are great serving in admin or managerial, you see people who are great in technical field but bringing them together is not a skill that is easily out there it is a very strong combo (Participant 30: Medical Doctor)*

This section has identified the role medical professionals have in the implementation of Global Fund grant programmes, namely; the medical professional portfolio staff in private and public implementing organisations and secondly the medical professional at the facility with both clinical and managerial duties. The portfolio staff that carry out major administrative and managerial duties are similar to street-level bureaucrats and because of their professional background, are very influential during implementation. Even though from the data there is little evidence that medical professionals are better suited than other occupations for administrative roles, medical professionals are nevertheless the administrative head of federal and state health facilities. These two categories of frontline medical professionals are vital in the transfer of policy due to the strategic position they occupy in the supply of health services, which will be described in the next sub-section. In connection to the positional power medical professionals possess in the health system, during implementation the medical professionals occupy a strategic position that enables them to influence the implementation of the grant. The next sub-section is going to explore the medical advantage that enables these frontline medical professionals to occupy the position of street level bureaucrats in the implementation stage.

### **7.2.1.3 Medical professionals and their impact on implementation**

Participants stated that the strategic laws that place the credentials of medical professionals above those of other health occupations is a major contributing factor to the existing medical advantage in the health system. Throughout implementation medical professionals are vital to activities relating to treatment and care because of the role they play in diagnosis and initiation of ARV treatment on patients. In addition, in instances where the SOPs (standard operating procedures) are not explicit, medical professionals, due to their medical knowledge, are competent enough to understand and



disseminate this insight to other health occupations. An example of this type of SOP is seen in the extract of a Global Fund document below:

*Program managers and national health programs can refer to this toolkit for information on the options available to develop differentiated care, as observed in different settings. They can support and encourage the use of relevant practices through national guidelines and policies, referring site managers to this toolkit for further information on how to implement the identified practices.*

The document goes further to give specifics on some implementation strategies.

#### **4.4 Initiating implementation**

##### ***Defining eligibility criteria and referral procedures***

*Sites need to define clear criteria that establish which clients can participate in the selected differentiated approaches. For example, the criteria for fast-track drug refills will need adjustment to the local context, but will likely include:*

- *How long the client has been on ART – preferably more than 6-12 months;*
  - *How long the client has been on the current treatment regimen – preferably at least three months;*
  - *Demographics – older than 18 and not pregnant;*
  - *Response to ART – undetectable viral load, if testing is routinely available; alternatively, demonstrated adherence using an objective measure (e.g. pharmacy dispensing record);*
  - *Overall health – no current illness, stable weight/nutritional assessment.*
- (Differentiated Care For HIV and Tuberculosis: A Toolkit for Health Facilities(Global Fund 2015a:36))*

The document above shows how some of the clinical discretion embedded in some of the implementation toolkits can encourage implementing organisations to hire medical doctors as their focal person. This discretion is a defining feature of their professional status. This has led to a general recognition among implementing organisations that getting medical professionals on board in the early stages of implementation has a significant impact to the outcome of the programme because medical professionals are central to the dissemination of directives to the other health occupations. This is captured in the quote below:

*Getting the doctors on board significantly has a good influence on the outcomes of the programmes at the facility level. Simply because like I said earlier by default the doctor heads the team so when you have a doctor, he is probably the one who will give directives or approve what other duties the other cadre of staff are expected to perform (Participant 3: Medical doctor)*

Another argument in favour of medical professionals relates to quality of service and patient care, which most participants believe can only be achieved through the professionalism of medical practise. Therefore, this is used as a justification for the health system's reliance on medical professionals in implementation, which leads to an inevitable influx of medical professionals into the programme as portfolio staff/managers and facility heads. An example of this medical advantage of medical professionals in implementation is the fact that they can combine their medical knowledge in flagging up things such as drug resistance, drug reactions, and their ability to give appropriate feedback on these issues, which are skills lower cadre health occupations lack in Nigeria. In addition, they can also combine their knowledge in looking at guidelines and recommend changes to these guidelines in the field, which

places them in a strategic position to head the health facilities, regardless of their deficiencies in management skills. In essence, the frontline medical professionals benefit from the fact that other health workers perceive there is a benefit of having doctors on board, as a result increasing their status at the implementation level.

Participants appreciate that medical professionals are vital to the interpretation ('deciphering') of the MOUs and their understanding of the desired community impact to be achieved. Because of this they can negotiate or liaise with politicians, local councils, the NGO implementers and their own health workers such as the nurses and CHEWS, forming a bridge between many 'rivers' as described by one participant later in this section. This is similar to Lipsky's description of 'street level bureaucrats' who he described to have a certain level of discretion in their delivery of policy and being the link between the population and the policy (Lipsky 1980). To others in the full circle of supply of health services and demand generation, the medical professional plays a key role in the supply side through treatment and service provision, and if this role is not carried out as expected, this could have negative consequences on demand generation. This point shows how vital medical professionals are in providing access to healthcare at the implementation phase.

*Is like I will give you example with sex workers because I work with them more, if you refer 10 sex workers, they are very impatient that's one thing. Very impatient, their time is, they are in a hurry so if you refer them to a facility and they have to wait, maybe the doctors doesn't come on time or is busy or something, you've lost those 10 if they wait for 10mins and they can't see a doctor. You've lost those 10 because to convince them to go back to that facility will be difficult, they will end up going either go a pharmacy or something to get*

*their drugs without test, no prescription. So they have a high impact on the programme. (Participant 18: Social scientist)*

Some participants also said that medical professionals are able to command the respect of other fellow health workers in the health system, so if medical professionals hand out orders other health occupations are willing to carry out those instructions. This is also a quality of ‘street level bureaucrats’, with the power to give instructions and be a source of social control in regulating the degree of conflict (Lipsky 1980). Participant 25, involved in day-to-day implementation in the field, reiterates this point in the quote below:

*so they serve as the bridge between so many rivers, between the politicians who are the head of the local government, the local council, the people who are coming from outside to implement a programme and as well their own people who they preside over as in the junior health care workers. So they see to it that all the loose ends are neatly tied and they coordinate everything that everything is the way it is supposed to work (Participant 25: Medical Doctor)*

In summary, most participants gave the impression that the positive impact of medical professionals comes from the fact that during the implementation phase they are coming from a place of superior knowledge compared to other health workers.

*Okay, let me give you an example; the SOP states you are supposed to do this and this; now because the doctor, sometimes, the SOP are very bare because of time and everything; the doctors usually went over and beyond. Especially when the staff during training asked questions, they actually went over and beyond to give details; more in-depth explanation on the issues that were troubling the staff, and if possible provided further support after the training. A staff can actually call the doctor, please I saw a patient that has that kind of thing you described, he will actually go over and beyond to provide support to that staff doing the work. (Participant 6: Medical Doctor)*

The acknowledgement that medical professionals are vital to how the programmes run in the field, which is similar to the role of street-level bureaucrats, is testament to the influence of medical professionals during implementation. From the analysis of the documentary and interview data, it can be inferred that the biomedical framing of the guidelines and work plans positions medical professionals as experts during implementation, hence placing them in a position of power (positional power) to influence the implementation process. This sub-section has been able to identify the critical and strategic role medical professionals' play in the Nigerian health system at the level of implementation, which shapes the outcome of programmes. However, medical professionals, due to their low numbers in the rural parts of Nigeria have a relatively reduced presence in these areas. Other health professionals such as the nurses and CHEWS usually fill this gap and findings from this study show that, the use of other occupations to fill this gap through task shifting has increasingly been put at the top of the agenda by most organisations.

## **7.3 Frontline medical professionals' interface with New Public Management**

The dissemination of health services to rural areas has been a major challenge to organisations involved in health development projects in Nigeria. Due to the large land mass and large rural populations, task shifting is proposed as the practical short-to medium-term solution (United States Government Interagency Team 2011). For this reason, we need to explore the role of other occupations in task shifting. This section will look at the interface between these health occupations and medical professionals as it relates to task shifting. Other similar NPM policies of the Global Fund such as the use of performance-based frameworks and incentives will be explored in the process, in order to see their effects on medical professionals and the entire health system.

### **7.3.1 Task-shifting**

Concerning HRH, there is a serious shortage of health staff that can effectively disseminate health services to Nigerian communities. There has been a lot of focus on task shifting roles in LMICs for HIV/AIDS programmes in order to scale-up programmes (Yaya Bocoum et al. 2013). For this reason, this sub-section will explore the Global Fund's rationale for task shifting, the processes involved in its implementation and the effects of task shifting on the health system.

Most participants accepted that the most obvious solution to the HRH crisis in Nigeria is the task shifting of roles to other lower cadre health staff.

*I think that task shifting is very important, especially in the northern zones of Nigeria. You have very few medical officers, you have very few nurses...,and the*

*CHEWs should be given more responsibility, at least to be able to address the burden that people have, so that we are able to have a better impact on the services we are providing to our patients. (Participant 31: Medical doctor)*

The extract from participant 31 shows how strongly some of the stakeholders believe that task shifting is the most obvious solution to bridge the HRH gap. Task shifting was a topic mentioned in most of the interviews and the participants made their views very clear about the effects task shifting has on professionalism. Participants say that even though task shifting has been encouraged by the public sector agencies and ministries, there is greater pressure from GHIs on the rapid adoption of task shifting. This is because task shifting is a vital aspect of health service dissemination, which is central to achieving the short to medium term goals of the Global Fund, captured in both participant extracts and Global Fund guidelines (Global Fund 2015e:13-15).

*Applicants should particularly consider the following when developing quality concept notes for HIV:*

*1. Review the human resource implications of scaling up and demonstrate mechanisms to support the scale up of quality ART programs. This will need to take into account decentralization of services and task shifting of critical services (e.g., ART initiation) to non-physician health workers (e.g. clinical officers, nurses) to ensure an adequate mix of health workforce at peripheral sites in areas with high HIV burden.*

The guideline goes further to stress the importance of task shifting in designing proposals:

*Applicants are strongly encouraged to demonstrate more efficient and sustainable strategies for addressing human resources capacity barriers for example,*

*decentralization to lower levels of care and community care and task shifting. (Scaling Up Antiretroviral Therapy in Global Fund Concept Notes (Global Fund 2015e:13-15))*

Initially, the Global Fund along with other Global health partners operating in Nigeria used the existing health structure of the country, which has the three tiers of health facilities, namely; the tertiary, secondary, and primary facilities in a structured referral system (discussed in Chapter One and Four). The Global Fund positioned most of its services in the secondary and tertiary facilities. They relied on a good referral system that would send patients from the primary facilities to the secondary and tertiary facilities, in order to provide its services to the community. This structure was called the hub and spoke, with the hub being the secondary/tertiary health facility and the spoke representing the various primary facilities in close proximity to the secondary/tertiary facility (National Agency for the Control of AIDS 2012). Gradually the Global Fund and its partners realised they were not achieving their goals due to under-utilisation of its services in the secondary and tertiary facilities and decided on disseminating these services to the community in the primary facilities (National Agency for the Control of AIDS 2012). The decentralisation of service provision from tertiary and secondary facilities to PHCs was a way of reversing the referral system of health care earlier adopted by the programme. This also entailed training of the PHC staff located in the community in an attempt to bring the services closer to the community. This expansion of task shifting takes first point of care services that do not infringe on professional ethical laws closer to the community. Most implementers are now moving their drug distribution channels to these first points of care PHCs.

Decentralisation of services through task shifting can deliver services to ‘hard to reach’ groups such as the MSMs (men who have sex with men). The introduction of a pilot to decentralise HIV/AIDS health services in 2010 by the government and other INGOs is



evidence that it has been considered by most of the influential public health stakeholders (GHAIN 2010). The existing HIV/AIDS service provision model is very expensive and unsustainable compared to the new decentralised model. Task shifting is a tool used to disseminate these services, as described by this participant:

*Certainly, that has been the situation for a period of time now. There has been a lot of focus on task shifting. As a matter of fact, the decentralisation of the prevention of mother to child transmission initiative to the PHCs further led to the expansion of this task-shifting. Because, initially we were of the opinion that only doctors will provide anti-retroviral therapy, but now for pregnant women it is no longer the case, nurses and community health officers are trained to take on that role. Although, like I said, you have supervision from medical doctors and from our own office from time to time. (Participant 24: Medical doctor)*

Drawing from Hood's description of NPM principles in this perspective, emphasis is placed on output and results rather than procedures, and there is a breaking up of centralised bureaucracy personnel management (Hood 1991). Taylor has gone further to explain that in LMICs in the international development sector, objectives have been re-focused on development outcomes relative to investment (Taylor 2013). We can say that the ideology behind the push for task shifting from international partners such as the Global Fund is similar to the NPM doctrine of 'results rather than existing procedures'. From the documentary evidence and from relevant literature, it can be seen that output-oriented NPM principles have guided decision-making in the Global Fund grant, and this is captured in the documentary evidence below:

*PR and grant performance are measured and rated based on:*

*Programmatic performance, which measures results achieved against, agreed coverage/output indicators contained in the Performance Framework;*

*Performance ratings are key considerations for the CCM and Global Fund in deciding to continue or replace a PR under a new grant.( Guidelines On Implementers Of Global Fund Grants (Global Fund 2015d:5)*

We are going to look at the implications this has for the existing health workforce dynamics and the professionalisation processes already occurring in the health sector. We will start by highlighting, why participants think task shifting is important. This will be followed by a discussion of the barriers to task shifting such as a lack of a policy framework and the consequences such as professional antagonism, concerns around unofficial task shifting and quality of service concerns.

### **7.3.1.1 Importance of task shifting and task sharing**

The lack of the higher cadre of staff such as medical professionals, pharmacists, and nurses in rural communities is the main reason task shifting is advocated, while in urban settings these higher cadres of health workers are overburdened with work. Task shifting became more apparent when implementers were met with the challenge of insufficient laboratory scientists to carry out the simple HIV/AIDS tests. Implementers of HIV/AIDS programmes and the HIV/AIDS expert community in Nigeria in 2010, decided to task shift HIV/AIDS testing to other lower cadres, which led to successful results (GHAIN 2010; National Agency for the Control of AIDS 2012). Implementers riding on this success have now started to encourage task shifting of other activities such as drug refills.

*Those are the direction we are looking at because if we do not go that way now, it will be difficult for us to have this universal access. For everywhere to have access to HIV AID treatment, it will be difficult because you and I know that most of all these rural areas, these our professionals don't want to go there and work, they don't want to go there and work and those who are at the city are over- burdened with so much work. The work-load is too much, client load is too high but then we want to decentralised all these facilities. Definitely, we may have to bend some of those rules where they say okay even though he is not a medical doctor, at least that level (junior cadre) they can do some minor, minor things. If there are complications, they can refer to bigger hospitals where you have these professionals. That is the way am looking at it. In testing also, in the field as far as you are not a medical lab scientist, you cannot test for HIV AIDS. You know those were the songs we were singing but now we realise that if we go that way, there will be many out there who would not be tested. (Participant 16: Logistics and supply chain expert)*

When looking at the task shifting opportunities, it is a useful solution to the HRH problems in Nigeria in terms of achieving health targets. The Northern part of the country with a low number of health personnel, is most in need of task shifting compared to other parts (Mafe 2012). Most participants said in the short term, task shifting could be successful but because of the lack of proper full scale up of task shifting in the country, they could not assess the medium to long-term prospects. The extract below from a programme manager, participant 2, illustrates how central task shifting is to achieving the health targets:

*You know for we on the programme side, we know that without task shifting there is no way we can achieve our objectives and our target. So we on the programme side are always pushing for task shifting because most doctors are in the cities so if you have to work with doctors alone, then a lot of people are not going to have services (Participant 2: Medical doctor)*

Majority of participants discussed task shifting. The sub-section explains some of the reasons behind implementers' argument for task shifting in the Nigerian health system. However, most participants were in support of task shifting, they also voiced their concerns about the barriers to its full scale-up.

#### **7.3.1.2 Lack of policy documents on task shifting**

This sub-section is going to aggregate the views of the participants about the major obstacle to the scale up of task shifting; lack of government legislation. The results show that for task shifting to be operational and effective there needs to be government legislation to empower and enforce it. This is informed by experiences from similar schemes in the past that failed due to lack of proper legislation such as the midwives scheme introduced in 2009 by the government to task shift child birth from doctors and nurses to skilled birth attendants (Okeke et al. 2015). From the data, participants sense that a good task shifting policy will strengthen the health system by improving referral linkages, leading to a reduction in the number of patients lost to traditional healers. Secondly, participant believe that proper legislation can play a role in mitigating against health professionals' resistance of task shifting in a bid to protect their professional territory. Because an absence of legislative backing will leave implementation at the discretion of health workers to decide whether to introduce it or resist, thereby leading to conflicts between occupations in different facilities. The quote

below from participant 13 who comprehends that in order to have a country wide implementation of task shifting, it would need some form of government legislation, so that there can be uniform acceptance of the policy:

*Task shifting really, for me I think it is because there is not being a clear definition or laid down rules as to task shifting. If we had guidelines regarding task shifting or laid down regulations this will not be a problem. But because there is no spelt out regulations regarding task shifting, I think that's what causes a lot of disparities and conflicts within facilities, between different cadres of staff. It is not really cadre let me say between professions, whether it's the medical doctors, or the nurses, the lab; right now we are having more problems between the lab and the rest of the nurses and the doctors in the facility. (Participant 13: Medical doctor)*

However, some participants said the task shifting policy has been adopted by the country's highest decision-making body for health but has not been approved by lawmakers because of opposition from professional bodies, leading to delays in signing a new health bill. In addition to this, the findings also tell us that the FMOH has not lived up to its leadership role in trying to force through implementation of policies and guidelines, and in educating health professionals about the task shifting policies and its advantages. The CCM as a body has lobbied for task shifting because they see it as one of their biggest challenges and this is evident from the extracts below from participants 13 and 10:

*Policy wise, no policy backing for that (task shifting), but we are, as CCM, as an organization, advocating for that to happen soon. Because one of the biggest challenges we are experiencing so far is attrition, inadequate HR at the facility and that is leading to a lot of shortcomings in implementation and then it is affecting quality of service (Participant 10: Management expert)*

During an interview a participant said, a policy framework that has the backing of law also protects workers who have accepted the jobs task shifted to them. He also went further to explain how a legal framework protects them from litigation and legal issues if a problem should arise. A legal framework will also be able to address the standardisation of remuneration packages for workers that donors can abide by, because at present different donors have different packages for multi-tasking health workers. This is captured in the extract below from participant 30:

*Because sometimes we say something like nurse-initiated ARVs, and we go to a primary health Centre, she is like “fine I can give the patient ARV oh but if something happens, I am not covered because am not supposed to”.... That is the issue there has to be policy framework that protects those that are receiving new briefs, new roles. Are they covered, if there is litigation around it? (Participant 30: Medical Doctor)*

In the TB grant, this limitation has already been seen to reduce detection levels because the CHEWS who detect a case of childhood TB cannot report this because the national guideline only recognises a case when diagnosed by a medical professional. For task

shifting to succeed, it needs to be captured in the core training of health workers for them to be able to carry out roles task shifted to them, and in a legally recognised curriculum so that quality of service can be protected. In summary, the state has a major role to play in making task shifting operational through laws and legislation because of the existing professional hierarchies' resistance to task shifting. Even though the state's role is necessary, it would need more collaboration from key influential actors such as GHIs.

### **7.3.1.3 Professional antagonism**

From the data, some participants' accounts show how professional antagonism is the biggest threat to task shifting. Task shifting challenges the existing structure that assigns recognition to certain academic qualifications and this has been the basis for jurisdictional control by health workers. In the context of Nigeria, task shifting has led to a heightened awareness among health professionals about their professional boundaries and this reaction is not limited to the medical professionals. Participant 22 cited how the national body of lab technologists have been fighting hard to oppose the task shifting of HIV/AIDS testing and social workers have attempted to limit HIV/AIDS counselling to themselves, making the whole task shifting dynamic very complex. This was the view shared by the participant 22 in the extract below, illustrating this complex dynamic:

*Nigerian Medical and Dental Council will tell “you do not task-shift or task-share what the medical doctor is doing with a JCHEW, it is unethical”. The nurses will tell you “do not task-shift or task-share our duties with a JCHEW, it is unethical”. Pharmacists will tell you “do not task-shift or task-share our*

*duties with pharmacy technicians”. So (this is) professional antagonism (Participant 22: Medical Doctor)*

From the data in this study, decades of oppression from the higher cadre of health workers towards other lower cadre health workers has led to revolts, in the form of strikes. In addition, other health workers look down on the CHEWS because unlike the other health occupations they lack formal training. Participants’ accounts emphasise how the absence of a policy or legislation on task shifting lets professional antagonism fester. This is predominantly seen in the tertiary and secondary facilities where all the health occupations’ roles intersect. This was the impression participant 3 reiterated in his interview:

*Now while that is happening at the field, you have the big players at the national level kicking against various policies simply because everyone wants to ensure their dominance and control of the health sector. Like a doctor will tell you for example “if you allow a CHEW to do this much, then why they don’t just enrol to medical school and get the full training” (Participant 3: Medical doctor, Female)*

Participant 3 went further to express how, in the community PHCs, clashes are seen between the nurses and CHEWS in a struggle for superiority, with the CHEWS claiming the health facility is meant to be headed by CHEWS.



Another example shows how antagonism from medical professionals has seen the whole country adopt an alternative drug therapy for PMTCT, even with contrary evidence to its implementation feasibility. When it comes to training, because of cadre issues some implementers prefer to make medical professionals lead trainings sessions because they would rather medical professionals mentor themselves. Even with WHO documents on the positives of task shifting, it is still a struggle to get the medical professionals approval. Participant 27 shared this view and further expressed his frustration about working in an environment of professional antagonism:

*So it has been a challenge because people oppose that even the issue of the issuance of the triple combination (HIV/AIDS treatment), people oppose that even medical doctors oppose that saying, 'No!' That it is like relegating your job delegating your job not even delegating, relegating it to the nurses that it should have been a medical doctor that should do that ... So it has been a challenge (Participant 27: Procurement and supply expert)*

The struggle by Global Fund implementers to achieve goals and targets set by the Global Fund has left them with no option but to roll out the projects, while encouraging task shifting of roles in the rural facilities. This was termed as unofficial task shifting by participants. The decision on decentralisation of their services from secondary and tertiary institutions has resulted in unofficial task shifting, because task shifting is essential to the decentralisation of services. Participant 22 explains unofficial task shifting in the extract below:

*I will support my reasons; everybody is saying do not task-shift. Task shifting is going on. Task-shifting, task sharing is going on particularly in the rural areas and under-served areas, where doctors will not go, where nurses and midwives will not go; but you find the CHOs or JCHEWs being the head of those facilities. Are you telling me when there is need for IV (intra-venous medication); the JCHEW or the CHEW will not give IV? When there is need to take delivery JCHEW or CHEW will not take delivery? So task shifting is going on, all we need to do now is to formalise it (Participant 22: Medical Doctor)*

Collectively, these findings show us how this dynamic of professional dominance, professional antagonism and a push for rolling out of services by the Global Fund through task shifting can lead to unforeseen outcomes such as unofficial task shifting, hence creating two parallel systems in the health system. These illegal activities of unofficial task shifting by Global Fund implementers have resulted in heightened tension among health occupations and have further worsened the ongoing inter-professional conflicts. As explained earlier, without a good legal framework or policy on task shifting there will be concerns on the quality of service without proper regulation and training to those required to take up new roles.

Another major concern with task shifting is the quality of service and the poor referral linkages. Participant 18 highlighted how some health workers who are given new roles through task shifting try to offer services beyond their level of expertise or training and sometimes mis-manage patients. He further explained that before task shifting is fully implemented a focus on efficiency of services should be done so that the quality of service been rolled out by the lower cadre can be efficient:

*Referral processes between the two linkages is not so strong. Yes some of them they can do test, they can give drugs but when they see the case getting bad instead of referring to a higher place, they prefer to treat the case on their own until it gets really bad then they refer (Participant 18: Social scientist)*

In summary, this section has shown how Global Fund implementers have made a strong case for task shifting during programme implementation. This is driven by the urgent need felt by the Global Fund (and other partners such as PEPFAR) to achieve short and medium term targets in the quickest and most efficient way. Poor government legislation has made the enforcement of task shifting difficult to implement, leading to the practice of unofficial task shifting in rural communities. This has resulted in resistance from other health workers who are concerned about the encroachment of their occupational boundaries by lower cadre health workers. This section has shown how a policy of the Global Fund, shaped by NPM principles, has led to unforeseen negative consequences of professional antagonism and conflicts, which can have long-term structural effects on the inter-professional dynamic in the context of Nigeria.

### **7.3.2 Performance Based Framework**

Performance based system, Performance-based payments or Performance-based contracting have been advocated as the new approach to improve performance of health systems of LMICs by Global health actors (Eldridge & Palmer 2009). During the analysis of the data from the interviews, most referred to Performance-Based Framework in various forms such as Performance Based System, Performance-Based Payments or Performance-Based Contracting, but all had a similar meaning. The

documentary evidence shows that Performance-Based Funding is one of the core principles the Global Fund encourages its implementers to use in achieving its targets, a pattern that is similar to NPM core principles.

#### *Managing Performance of Implementers*

*28. Performance-based funding is one of the core principles of the Global Fund. It promotes accountability and provides an incentive for implementers to use funding as efficiently as possible. (Guidelines On Implementers Of Global Fund Grants(Global Fund 2015d:5))*

From the interview data, organisations that use PBF were more target-oriented than the bureaucratic government agencies. According to the data in this study, as illustrated below, bureaucratic government agencies are indifferent towards achieving short and medium term health targets. Moreover, according to participants, government agencies lack a performance-based framework, which allows staff to embark on unproductive activities such as inter-professional conflicts and strikes without severe repercussions for their actions. Participant 22 highlights how PBF works in private organisations and why a lack of PBF in government organisations allows professionals to carry out counter-productive activities.

*Private organisations are target-oriented unlike the public where in the government you hit target or you don't hit target you are going to get a salary at the end of the month...But in government sector...it is not performance based, that's why people have time to be doing all these kind of things. I have my deliverables for today, before I came to the office today, I have written everything I was going to do for the day, which included that I was going to*

*meet with you. I needed to create that time, I know this time I am meeting with you, which outside of my job schedule, from when I resume to when I will meet with you, I will have covered what I need to cover even within the time I will spend with you, and when we finish I go and do the rest (Participant 22: Medical Doctor)*

Private NGOs have orientation programmes for their implementation staff on guidelines and job descriptions of each member of the team. Job descriptions reduce power play in the work place by health workers because roles and descriptions are clearly defined, which limits domination by one group of professionals. In the Nigerian public institutions, occupational hierarchies insist on the roles to be share based on professional status. Job descriptions that form part of PBF can help to reduce overlapping of roles and to position people in their area of competence. This consequently improves performance in organisations that adopt NPM principles. An absence of robust job descriptions and career pathways in the public sector is an obstacle and some feel a re-orientation to clarify responsibilities, career pathways, and justification for remunerations pathways maybe a solution. A solution to this obstacle is in-service orientation, which most implementing organisations outside the public sector have started using in refocusing the mind-set of health workers towards remuneration based on performance and output, instead of professional background. A re-orientation is needed because most of the health workers in these organisations were recruited from the public sector. The extract below illustrates the type of re-orientation given to staff in these Global Fund partner organisations:

*So usually, a job description is developed for each and every position, all the whatever needs to be done for each position is identified and they should match the needs of the programme, and the expected outputs, and then skills are identified, competencies are identified, and those things are used to guide whosoever is coming on board. In fact, it starts from the job description, so that it is used to recruit the right people, and then when they come on board. This is what is used to guide in executing their jobs, and this is also what is used by the organisation in assessing them at the end of the day, may be through appraisals, to measure how they have performed on the job (Participant 19: Non- Doctor M&E expert)*

In contrast, some participants are not confident this system of motivation and improving performance should be used as a long-term solution. Some have concerns about the unfair system of PBF, because incentives are tied to performance and output; therefore, it is easier for some health workers to reach their targets in high-density urban areas than others in low-density rural areas. PBF further lets health workers focus on their immediate targets and forget about primary professional obligations as health workers. A participant believes that the ideas of a performance based management system to augment the already existing system should be considered in addition to the existing traditional system of trust and altruistic occupational qualities. The extract below explains how performance based framework should be applied to existing contexts in the Nigerian health system:

*I think performance based health work force management or as they call it these days performance based finance. Where you pay by performance, helps in a system where you need to really stimulate performance again but having said that I don't think its replaces the traditional system of trust and providing the right incentives based on the context.... So there is a base system where you have performance management, where somebody takes responsibility for being the manager, ensures that people are at work when they should be at work and all that and then you can use performance based incentives to basically improve on productivity. But performance base system has always being my argument cannot be an absolute system, it can't be a de novo system whereby that's all you run. Then it also creates a perverse incentive, because if I know that my targets are met, then I do not need to do anything else. Where is the conscience part of being a health worker? So for me, it's an add- on, it's something you bring in to tweak (Participant 33: Health economist)*

This type of incentives in the PBF is similar to what is described in the literature (Hood 1991).The extract above from participant 33, highlights the dangers of a purely performance based system which uses a lot of incentives to motivate professionals. The extract is a contrast from the views of other participants, in the sense that Participant 33 highlights the limitations of a pure PBF, and goes further to suggest a hybrid of both the traditional system of motivation and the new system of incentives.

In summary, this sub-section has explored the PBF principle of NPM and explained its application in the Global Fund implementation process. This section has argued that PBF has assisted some Global Fund implementers in improving worker performance and reduced workplace inter-professional conflicts, thereby reducing professional

monopolistic powers. However, an intended consequence of this new system is that it may re-orient health workers to formal rationalisation and reduce altruistic professionalism.

### **7.3.3 Incentives and motivation**

This sub-section aims to explore participants' views about the effects of incentives on the health system. We would focus on the effects incentives have on the motivation of staff and the sustainability of an incentive culture in the health development sector. Following the argument from participant 33 in the previous sub-section, there is some recognition that a faulty system of incentives erodes the altruist work attitudes of saving lives, on which health workers pride themselves. Incentives were mentioned by many of the participants in various contexts, with reference to its effects on professionalism.

Most implementers at the national level have agreed that cash incentives should be discouraged at the facility level for both the Global Fund projects and similar projects. This is because public health experts are concerned about sustainability of this practice when donors leave the country. The argument they make to support this is that, by discouraging incentives expectations of remuneration among staff at facilities will decrease and they would not demand remuneration for services they would have performed normally. Having said this, there are observations that public service health workers in Nigeria are not well paid compared to other neighbouring countries. This is the reason foreign partners use incentives as a strategy to attract and retain their staff. Most core staff of implementation agencies are well paid and compensated for the work they do, while field health workers or workers in facilities that are being used by implementers are given incentives in the form of per diem and training incentives. Participant 32 in the extract below explains why it would be difficult not to give incentives to health professionals such as medical doctors because the poor



remuneration structure in the country is the reason why there is a migration of medical doctors to the cities and eventually to western countries:

*If you are a medical doctor, here in Ghana today and you are posted to a medical health facility or a PHC, first there is a car to you, second there is a house attached to it, third they form what they call the community health management committee. You are in charge...So in that case, you are not even interested in going to the city, it becomes life made easier for you there. You manage every resources...but here (Nigeria) every doctor (plans to migrate to) specialist (facility) and FMC (Federal Medical Centre) they want to go especially to FMCs, national hospital (and then) from there UK and all (Participant 32: Non-doctor public health expert)*

For the Global Fund grant, there is a mutual understanding that the Global Fund will fund provision of capacity building, equipment, and medicine, while the Nigerian government provides the infrastructure and staff. Therefore, the grant does not pay the staff but gives them some allowances to carry out some activities. These allowances differ from grant to grant and most people prefer the PEPFAR projects because the allowances and incentives are a lot better than the Global Fund grants.

Some participants are of the opinion that there is a cultural issue in the Nigerian context concerning incentives and participation both in implementation and proposal writing, whereby health workers expect incentives regardless of the programme or grant. Health workers always expect incentives when they attend meetings and trainings, and due to their large number, this has huge financial implications for the Global Fund. The extract

from this participant explains the incentives culture in Nigeria:

*If you look at it within cultural contexts what is defined as incentive within some culture, probably we (Nigerians) see now as a normal occurrence. Not doing do it (giving incentives) is going to be seen as culture shock and so we need to look at that strictly... So that has affected the staff attitude to Global Fund project relatively to how they will react to other project where they get incentives...if one partner is just like we said before is paying you more, your allegiance will be to that partner and so people will talk about you should look at your professional ethics. "Forget about professional ethics!"...some people will always tell you "will ethics pay my bills, will ethics pay my children, pay my house rent?" And are these are realities, these are economic realities on ground so when a particular grant pays more, people gravitate towards that end and show their allegiance. (Participant 11: Non-doctor Public health expert)*

To some this culture of incentives has now been embedded in the health development sector in Nigeria in a way that not doing it is a culture shock. Some participants have linked this incentive culture to foreign donors who have used incentives as a tool to motivate health workers in order to realise programme goals. Some of these incentive practices are similar to the literature on New Public Management, which explains how incentive structures are used to boost performance in public institutions (Hood 1991). The material incentives by donors is the commonest type of incentive used to motivate health workers, which participants believe, is fuelling this culture of incentives in the country. Material incentive is a similar approach used in NPM and this has been

criticised by some because it ‘downgrades other reward and incentive measures that may be just as important’ (Bertucci 2006:177). In the next sub-section participants describe in better detail how material incentive influence programme implementation. The documentary evidence below shows how central the PBF framework of the Global Fund is to decision making in the disbursements of funds to implementers and which in turn shapes programmatic activity.

*The Global Fund makes funding decisions based on performance to ensure that investments are made where impact in alleviating the burden of HIV/AIDS, tuberculosis and malaria can be achieved. For this purpose, the Global Fund initially approves grant proposals for two years and decides on continued funding based on performance. During the grant period, the Global Fund links disbursements of tranches of the grant to periodic demonstrations of programmatic progress and financial accountability.*

*The Global Fund’s system for Performance Based Funding is designed to:*

- i. Provide **incentives to encourage grant recipients to focus on results rather than on inputs**;*
- ii. Serve as a management tool for Principal Recipients (PRs) of grants to identify early opportunities to expand effective efforts and to address potential issues;*
- iii. Furnish the Global Fund with the necessary performance information to decide on further disbursements of funds;(Emphasis added: Guidelines for Performance Based Funding (Global Fund 2003:1))*

This section aims to explain the incentive culture in the health development field and explores how incentives have made health workers focus on monetary remuneration.

Due to contextual economic realities in the country, health workers are motivated by financial incentives. The implication of this incentive culture is that it raises questions about the sustainability of rising costs of health worker remuneration. Secondly, an incentive culture creates competition between public health facilities and private foreign donor led programmes, resulting in health worker migration from the public facilities. This incentive culture is not unique only to the Global Fund programme and the next sub-section will examine the implications of incentives to the Global Fund programme and other Global health partners.

### **7.3.3.1 Incentives and competition between donor partners**

Participants compared the incentives of the Global Fund to that of PEPFAR and alluded to some level of competition between the two key Global Health actors in the country. We will now examine the data to identify whether different incentive structures can affect the performance of the Global Fund programme.

Participants stated that at the national level staff working in organisations under the Global Fund grant were not paid as much as staff in USAID grants. In most aspects regarding incentives, the Global Fund pays a lot less than USAID funds. Even though PRs and SRs have different salary structures for their staff, notwithstanding, there is an agreement that the Global Fund incentives are a lot lower than USAID incentives. This is because in the Global Fund proposal it is the responsibility of the recipient country to provide incentives, therefore, within the Global Fund grant there is less provision for incentives. Unlike the Global Fund grant, the PEPFAR programmes are flexible and provide everything needed to execute their programmes such as equipment, employment of staff, contact tracing, and supporting groups. This has made Global Fund health facility sites unpopular among health workers. The lower incentives of the Global Fund have affected the dedication and attitude of the staff working in their sites.

This has caused a migration of health workers from the Global Fund programmes to other GHIs that have better financial incentives, thereby affecting the service provisions and quality of service in the Global Fund sites.

Secondly, the Nigerian government introduced a rationalisation system in order to mitigate the competition among foreign donors for health facilities. In the process, some facility sites were rationalised to the Global Fund that were formerly under PEPFAR programme. This has led to complaints from health workers who were formerly under the PEPFAR grant about the lack of incentives under the Global Fund grant, which they used to benefit from under PEPFAR such as transportation, administration, communication, and training allowances. The organisational structure of PEPFAR's implementing partners gives them the flexibility and autonomy to provide these incentives, however this does not apply to the Global Fund implementing partners because most times approval for incentives has to come from the Global Fund head office in Geneva. In addition, facilities that do not have the capacity to hire extra staff to cope with the workload of the Global Fund programmes are left handicapped leading to poor performances in those sites. Consequently, most doctors and health workers do not want to be working on Global Fund sites because they can get better pay from PEPFAR sites. The extract below is illustrative of the interplay between lower incentives in the Global Fund programme and health professionals' motivation/performance:

*But I have to say at this point, that is the challenge we really faced when we went to our facilities on Global Fund. Because before we went there PEPFAR was supporting them and giving them really large incentives in financial terms, so it was a really great challenge for us to change their attitude towards being rewarded in monetary terms, towards them thinking of themselves as health*

*professionals, as that was what they are supposed to do in the first instance. So that was a challenge actually (Participant 13: Medical doctor)*

Some workers have been known to bribe in order to be posted to PEPFAR sites or outright try to reject Global Fund projects in their sites. At the national level, incentives for working in PEPFAR programmes range from the overall general take home pay to even travelling privileges such as getting US VISAS, which they do not get while working for the Global Fund. Apart from the pay incentives, the flexibility of the PEPFAR grant makes it more appealing to people working in the field and implementing their programmes. During an interview with participant 8, he explained how the health workers react when Global Fund projects are been implemented in their health facility:

*It affected the grant anyway and it is still affecting the grant as we speak. Because if you look at now they are trying to do some form of better coordination and harmonisation; but as I speak to you, if you go the field, people will tell you “we will like working with the PEPFAR grants (more) than the Global Fund”; Why? (Because) The PEPFAR grants are more flexible. Apart from the flexibility, the pay is better. So to that extent, you will see those... and it affects the implementation of the grant, no two ways (no doubt) about that (Participant 8: Non-doctor Public health expert)*

*But if you are (on a) Global Fund site, it is a big disadvantage. So you get to see the data entry clerks screaming and complaining “you are giving job you are not paying me”...so whenever there is posting, all of them will go and bribe so*

*that they will be posted to those USG sites so that those incentives could come  
(Participant 32: Non-doctor, public health expert)*

The Global Fund leans towards more sustainability in its aims while the PEPFAR programmes lean towards programme execution. Recently, the Global Fund has been forced to abandon its initial principles and it now focuses on incentives in order to compete with other GHIs. This is captured in more of the recent Global Fund documents, whereby they acknowledge that incentives are seen by the Global Fund as short-term, but still encourage proposals to incorporate incentives into the design of programmes:

*Furthermore, while concept notes include incentive strategies to improve retention, often these are not evidence based and sustainable. It is well known that monetary incentives alone have a short-term impact on motivation.*

The document goes further to show the support the Global Fund has for the use of incentives in programme design:

*“Results-based financing” (RBF) “refers to any program that rewards the delivery of one or more outputs or outcomes by one or more incentives, financial or otherwise.” ... Payments or other rewards are not made unless and until results of performance are satisfactory and independently validated.*

*RBF is gaining support within the Global Fund as a new program financing modality geared toward:*

- *Driving better program results and rewarding good performers to incentivize value for money and maximize impact*

- *Simplifying grant management processes, consequently reducing transaction costs to the Global Fund while still achieving its objectives and achieving impact*
- *Facilitating improvements in health system functionality with greater national ownership*

*it is important that programmatic as well as financial arrangements for RBF are technically sound and appropriate(Report of the technical review panel on the concept notes submitted in the third and fourth windows of the funding model(Global Fund 2014:55))*

However, even with this recent push by the Global Fund, encouraging the use of incentives during implementation, they are still unable to match that of PEPFAR, leading to operational difficulties. There are concerns about the sustainability of this practice and the competition among health donors and organisations. The evidence from this sub-section shows the effects that competition (which is encouraged by NPM principles) can have on the health system and the Global Fund.

#### **7.3.4 Spread of NPM principles in the Nigerian health system**

This sub-section will explore the potential spread of NPM in the Nigerian health system. The interview data illustrates the role of the Global Fund's implementing partners in the spread of New Public Management at the facility level.

Theoretically, the Global Fund does not interfere with the existing management structures of the health system but from the interview data, this was not always the case. A participant cited the active efforts made by Global Fund implementers in changing the management culture of public facilities and institutions to reflect the management principles of private NGO type organisations:



*I think with the trend (of) programme management, the non-medical will be stronger in this area. Even for us, you realise that between the last projects, we have engaged a co-partner with the project that looks at institutional management and then strengthens institutional financial strengthening. So it's not just about service delivery that we did before.... so one of the partners that we engaged, they are organizational development specialists and they are working with us at the state level to make sure that while we the technical people are doing the technical thing, they work on the institutional and financial strengthening of the state's capacity to manage the resources (Participant 12: Medical doctor)*

Apparent in the extract above is the influence implementers have in changing the management principles in the public sector towards a more New Public Management type system. In this case, there is attention gradually being drawn towards improving management of projects and outsourcing of this to third parties by Global Fund implementing partners. This attention to new management processes in health is also influencing some government agencies to adopt this new trend. The rationale cited was that these new management skills would increase the efficacy of the entire health system. Outsourced organisations are now taking these new management principles of finance, human resources, and institutional management to state agencies.

There is a culture of using private sector management practices to increase productivity, and an example is the use of performance-based frameworks. The majority of this section has provided some examples of what can be described as interaction between

health professionals and NPM principles such as job descriptions linked to pay for performance and incentives in the Global Fund programme. The findings indicate that within the health development field, this interaction with the health professionals - most especially the medical professionals - can reduce emphasis on traditional professional hierarchies for some GHIs. These processes limit professional dominance in some instances during implementation and give room for the spread of NPM principles in the Nigerian health system. Frontline health workers are usually more affected by NPM type policies of GHIs, while the top-level management are less affected.

### **7.3 Jurisdictional conflicts**

This section looks at the effects of medical professional monopoly and dominance under the theme of jurisdictional conflicts. Due to the lack of harmony in the sector, there have been strikes by other non-medical professionals seeking for recognition in the sector. The government's inability to use its powers appropriately to curb these sporadic strikes has fuelled the situation as well, which was captured in some interviews and documentary evidence:

*Industrial actions (labour strikes) by various cadres of health care worker continue to limit access to services for both diseases. Some of these actions last for several months at a time, compromising the ability of patients to access anything but emergency services(TB AND HIV CONCEPT NOTE Investing for impact against tuberculosis and HIV (CCM Nigeria 2015b:31))*

The extract by Participant 14 captures the non-medical professionals' frustrations:

*If you eventually get to the root of it, it's not that they (non-doctor health workers) just want to be a chief medical director, which is not the root cause.*

*Get to the root cause of the problem, they feel oppressed, and they feel irrelevant... (Participant 14: Medical doctor)*

Spillover effects from the public sector tensions created by the medical professionals' oppression of other health workers have led to conflicts within the Global Fund grant. Some are of the opinion that as long as Global Fund projects are meant to use government facilities to carry out their activities, these conflicts will continue to occur in the facilities between medical professionals, lab scientist and nurses.

*To the extent that the Global Fund uses the public sector and some private sector organisation health facility in the community in Nigeria, if any friction exists there, you imagine that there will be a spill over...like I said really, once you are using our own public health facility, whatever system operates they (inter-professional conflicts) will affect it. Whether it's a Global Fund project or PEPFAR project (Participant 1: Medical doctor)*

*You are right, they exist. In fact, now that I am thinking about my organisation, I am remembering all those kind of tensions between the lab scientists and the doctors; between the pharmacists and the doctors. They are very real tensions, and it is like "don't encroach on my territory!". Even within the same organisation, working on the same Global Fund programme. I can remember mails and I was like seriously are we going to do this? Yeah, yeah, they exist (Participant 14: Medical doctor)*

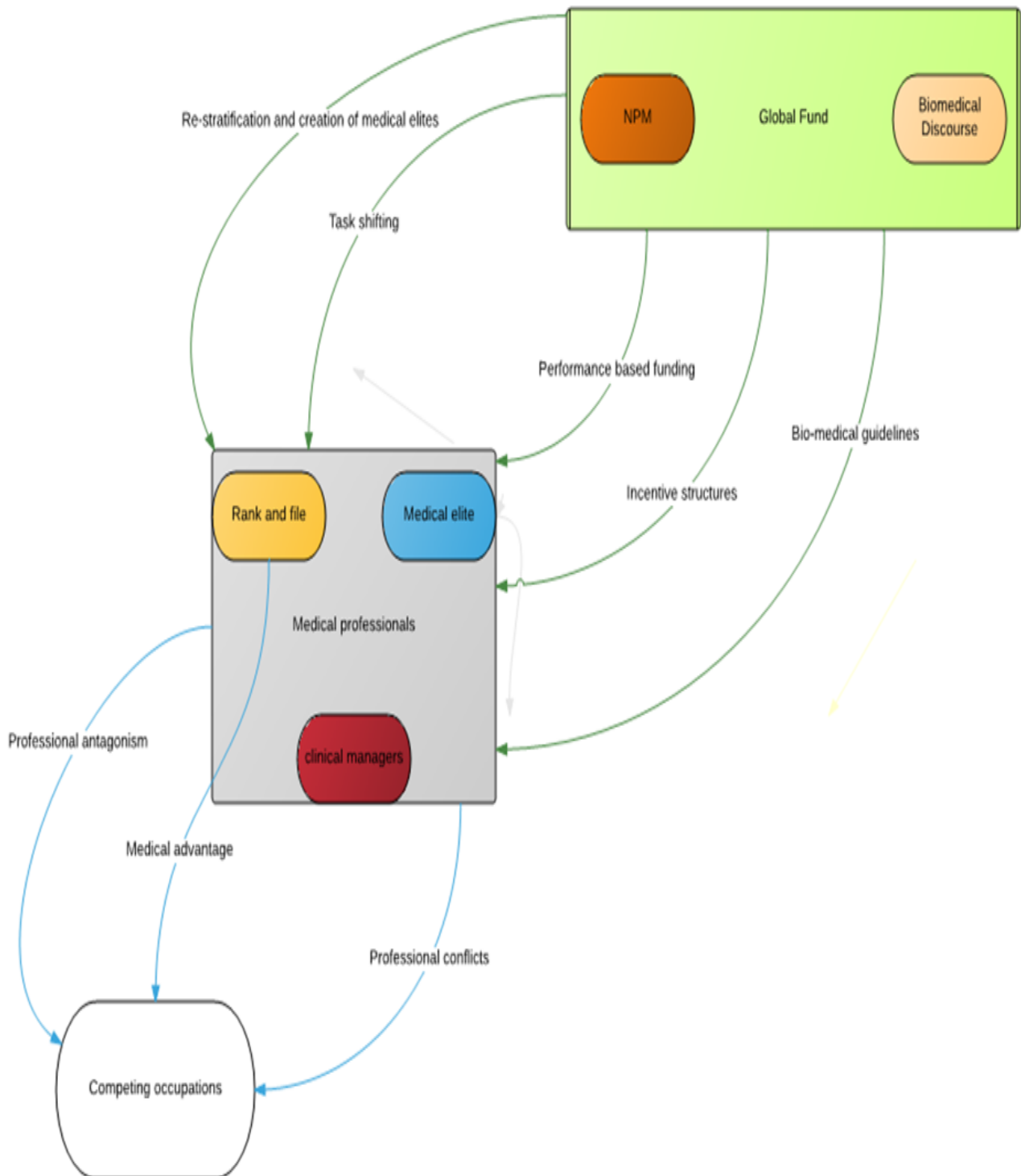
*Yes. That is very, very; it is something that happens all the time, something that happens all the time. There is the particular clinic now different from the one I talked about earlier; we call for lab trainings and the ART coordinator, for example, sent a doctor and the guys in the lab did not find it funny. They think it is just not fair, they think the doctors are taking over everything, so there is this tension everywhere; whether it be PEPFAR site or Global Fund or strictly Government of Nigeria supported site, that tension exists. There is usually that tension between the clinicians and non-clinicians (Participant 7: M&E expert)*

We have observed from the data how accounts about the implementation phase showed there is a strong influence of the medical professionals but also identified some inter-professional conflicts within the Global Fund programme, mainly between doctors and other health occupations. At the national and state level in these NGO type organisations there were more quotes recollecting conflicts between medical doctors and other health professionals such as pharmacists and less so with nurses. They said this was because at the national and state level (which was mainly administrative), there were fewer nurses compared to the facility level that had more nurses. In contrast, at the health facility level (which was mainly clinical) they described conflicts between medical doctors and nurses in the tertiary and secondary health facilities.

The common denominator in the data was the central role medical professional monopoly has in the inter-professional tensions. For instance, there was an impression that doctors dominated all areas of management and clinical duties, even though some of the roles doctors played were unrelated to their training. These tensions may not have

been investigated in-depth but the findings point towards the existence of these undocumented inter-professional tensions within the Global Fund grant.

**Figure 12: Summary of themes in Chapter Seven**



## 7.4 Chapter summary

In this chapter, the findings reveal the street-level bureaucrat status of medical doctors and their importance in linking policy documents and processes during implementation. In contrast to Chapter Five and Six whereby medical professionals were seen as monopolists of the proposal process, during implementation they were seen as facilitators who had a positive impact on implementation. However, unlike the elite group of medical professionals, these frontline medical professionals are more prone to the deprofessionalising effects of NPM such as task shifting, performance based frameworks and job descriptions. Nonetheless, participants highlighted positives of task shifting, stating it as a necessary health strategy needing proper legal status. Furthermore, we identified how some of these NPM principles deprofessionalise medical professionals; for example, the re-focusing of roles based on job descriptions, which replace occupational hierarchies, can gradually reduce the administrative dependence on medical professionals. In addition, it is also effective in reducing inter-professional conflicts.

On the other hand, externalities to the health system such as an unsustainable incentive culture are some of the undesirable consequences of these interactions. The Global Fund and other GHIs have produced an incentive culture among health professionals that has replaced the traditional incentive structure of the health sector. This has resulted in competition between the Global Fund and foreign donors such as PEPFAR, with the Global Fund at the losing end of the struggle for the services of health workers. In summary, the findings reflect the complex nature of the interaction between NPM and medical professionals.

In relation to the forms of power, the strategic position which frontline medical professionals occupy is a result of the structural power of the biomedical discourse in

the health system that makes medical professionals better qualified to occupy those positions during implementation. The power of the biomedical discourse is also in the form of both institutional and productive power at the implementation phase. The dominant biomedical discourse's productive power at the proposal writing stage leads to the creation of the implementation guidelines and work plans. The biomedical discourse has been adopted and institutionalised within work plans, and we can say this is the manifestation of the institutional power of the biomedical discourse. As discussed in the literature review, '*Institutional power is actors' control of others in indirect ways...through the rules and procedures*' (Barnett & Duvall 2005:51). At the implementation phase, it can be said that the medical professionals use these guidelines and principles as a source of power in order to have indirect control over other occupations. For example the option A ARV adopted at the national level (discussed in section 6.4) makes the medical professional at the implementation level have power over other health professionals at the lower level. This is an example of how the power of '*institutions enable some actors to shape the behavior or circumstances of socially distant others*' (Barnett & Duvall 2005:51). Chapter Eight will draw on the findings from Chapters Five, Six, and Seven in order to link these with the literature discussed in Chapter Two, and draw out the major messages from the study.

## **Chapter 8**

### **Discussion**

#### **8.1. Introduction**

This thesis has presented a body of evidence on the interactions between dominant medical professionals and the Global Fund and it has highlighted some of the consequent emergent effects these interactions have had on the Nigerian health system. Chapter Two explored the key features of medical professionals and their evolution in society through a literature review focused on medical sociology and its implications for GHIs and country health systems. This included an exploration of the literature on professional monopoly theories and various structural factors that influence such monopolies. Also, covered in the literature review chapter were deprofessionalisation theories and the biomedical and NPM discourses that underpin GHIs. These three main areas reviewed were important in framing and formulating the research questions and helped in understanding issues of professional influence, power, and conflict in the empirical chapters.

Bearing in mind the contrasting ideas on medical dominance, as well as the gaps in the literature pertaining to LMIC settings, the overall aim of the study was to investigate the interactions of medical professionals with GHIs in a LMIC and to explore the resultant effects on the country's health system. Specifically, this involved exploring the role of medical professionals in the Global Fund health initiative in Nigeria through primary data collection. The main approach to understanding the interactions was to explore the changing roles of medical professionals in the proposal writing and implementation phases of the Global Fund grant, in relation to their professional dominance in the health system. The second approach was to explore the dominant paradigms underlying



the Global Fund grant, in order to better understand how these paradigms affect professional monopoly. Since its inception, the Global Fund has become a major actor interacting with various parts of LMIC health systems, including that of Nigeria. The study helps to explain how GHIs such as the Global Fund influence medical professionals and the health system.

Interestingly, in this study, responses were not divided along professional lines, meaning both medical and non-medical participants concurred in their assessment of the interaction between medical professionals and the various components of the health system. This lack of conflict in the responses did not permit for making distinctions along professional lines when referring to the quotes from participants during data analysis. On the other hand, the level of insight from the responses of participants was related to their level of involvement and position in the Global Fund grant. Participants holding executive positions provided broad insightful responses with few in-depth examples of experiences, while participants holding mid-level management positions gave responses, which were more focused on particular issues, with in-depth explanations related to their personal experience with the Global Fund grant.

The three results chapters describe the empirical findings regarding the Global Fund's organisational structure (Chapter Five), professional influence in proposal writing (Chapter Six) and professional influence in implementation (Chapter Seven). This chapter seeks to bring these findings together and discusses the key professional and organisational factors that interact to have effects on the Nigerian health system. This chapter begins by reflecting on the influence medical professionals have in the Nigerian health system and considers the extent to which medical professionals' influence is relevant in the Global Fund's policy processes. As part of this, the arguments concerning deprofessionalisation are explored to discuss whether GHIs have any

influence on the monopoly of Nigerian medical professionals in the health system. Furthermore, the discourses in GHIs are linked to the influence medical professionals possess in the Global Fund policy process. Finally, the chapter draws on the three main areas discussed to give a holistic picture of the various interactions between medical professionals and GHIs in a causal loop diagram.

## **8.2 Professional monopoly**

This study provides a rich understanding of the dynamic interactions between medical professionals and policy processes in the context of Nigeria and explains the experiences and practices of health professionals at the policy and implementation level of the health system. The influence of medical professionals goes beyond shaping the implementation of health policies, to also altering the policy content and process (Koon & Mayhew 2013), which makes the study of medical professionals important in understanding health systems and policy in LMIC. Currently health systems are multi-disciplinary and involve various actors that interact with the health system in complex ways and sometimes in opposition to each other (Koon & Mayhew 2013). However, most health system strategies in LMICs are guided by biomedical and clinical research because the *'dominant group of actors (in terms of both volume and influence) are those involved in the delivery of health services, primarily medical professionals'* (Sheikh et al. 2011:4).

This study shows that there is evidence of medical dominance in the Nigerian health system. It also goes further, by showing evidence of other features such as professional antagonism and professional conflict: important dynamics in the health system with known side effects on service delivery. Firstly, the results in this study highlight features consistent with the literature and add substantially to the sociology of professions in relation to medical professionals' dominance in the health sector through

occupational boundaries and hierarchies (Crook 2008). Friedson and other authors studied the medical profession in Western developed settings to describe features of medical dominance in the health sector (Davies 1996; Timmermans & Oh 2010; Freidson 2001; Mechanic 1991), but these patterns have not been explored in detail in Sub-Saharan African contexts. In Chapter Six, the discursive frequency with which participants mentioned medical professionals' dominant influence in the proposal writing processes suggests that medical doctors continue to maintain a professional monopoly. The characterisation of medical professionals as 'drivers' of the process by participants, implies an active participation by medical doctors in the policy processes. This active participation can be regarded as an 'unequal influence' in agenda setting and an ability to spread this influence into other thematic areas, which are not medical or clinical. An example of these thematic areas is seen in Chapter Six (section 6.2.1), where medical professionals at the national level dominate the policy and management thematic areas of government agencies, which in turn enables them to control policymaking, policy review, and implementation.

In the literature on professions, Larson argues that professional monopoly is achieved through either monopolisation of the production of knowledge and practice, occupational hierarchy or both (Larson 1977). This 'actions model' explains the active processes used by medical professionals in maintaining their monopoly of a privileged status in the health sector. The data from Chapters Five, Six and Seven highlight this occupational hierarchy in all parts of the policy process, from policy formulation to implementation. Chapter Six clearly illustrated the role of occupational hierarchy in the Nigerian health system. Occupational hierarchy places medical professionals as the head of health units in the public sector, which other health occupations have internalised as the norm. Based on this, their influence in public-private partnerships such as Global Fund's health initiative is a result of a diffusion of their public sector

influence (and in part their privileged social status) into the policy process of the Global Fund. Occupational hierarchy in the literature is a unique feature of a professional bureaucracy which has with it specific accompanying characteristics such as technical autonomy and professional privileges (Larson 1977). In the context of the post-colonial states, it has been suggested in the literature that the professional bureaucrat model of medical professionals was inherited from the colonial regimes (Johnson 1973). In Chapter Six, a participant described some of the professional bureaucrat qualities of the Nigerian medical professional:

*Right, for example, TB is a thematic area, you have about six, seven thematic areas; you have DOT expansion; who else does expansion in the ministry, is a doctor; you look at PPM, who else does PPM in the ministry, is a doctor; you look at TB/HIV. Except areas that really require other expertise like may be lab scientist, logistics and community; apart from that, you have doctors heading all other areas, and that makes them more in number and that's why (Participant 2: Medical doctor)*

According to the accounts of participants, medical professionals have a strong professional monopoly in the Nigerian health system and have the autonomy of professional bureaucrats, similar to the description in the literature. Aside from occupational hierarchy, another professional bureaucratic quality medical professionals possess is their workplace autonomy at the implementation phase. In most government agencies and health facilities, the job descriptions are very general which allows medical professionals to maintain both clinical and administrative roles, even though

through experience they lack management skills to cope. This vague delineation of roles provides medical professionals with authority over other health occupations and in addition the power of self-regulation. This is illustrated in the Chapter Seven (section 7.2.1.3):

*Because like I said earlier by default the doctor heads the team so when you have a doctor, he is probably the one who will give directives or approve what other duties the other cadre of staff are expected to perform (Participant 3: Medical doctor)*

At the implementation stage, this level of authority is similar to the description of the authority of professional bureaucrats, discussed in Chapter Two. The introduction of detailed job descriptions by the Global Fund partners, is also an indication of external actors' realisation of the professional powers that medical professionals have in the workplace and of their attempts at limiting medical professional bureaucratic powers.

Building on this, it is also apparent that the professional influence medical professionals possess in Nigeria is not similar to the current influence medical professionals possess in Western countries. These findings highlight one of the weaknesses in the universal model of the structuralist approach in studying medical professionals, whereby professionals were studied in Western contexts and the findings were generalised to other contexts (Wilensky 1964). This led to calls for more studies in different contexts regarding professional monopoly (Johnson 1982). In Chapter Six, the description of a powerful professional influence in the health sector in Nigeria is different from the current influence of medical professionals in countries such as the UK and France

(Bezes et al. 2012). For example, in England, clinical managers use guidelines and policies set by the politicians, while in Nigeria the medical professionals have more self-regulating powers to design health policies. Chapter Six (section 6.4) illustrates how this power of self-regulation has been used to create policies that favour medical professionals:

*In fact that is one of the reasons in Nigeria we are using option A at the PHCs because in option B you do not need any decision (from the doctor to prescribe ARVs)...but because of those (inter-professional) dynamics, they said no....medical doctors opposed saying NO! That it is like relegating their job (that is prescribing ARVs), not even delegating, relegating it to the nurses. That it should be a medical doctor that should do that (prescribing ARVs) and that is why Nigeria is using option A. (Participant 27: Procurement and supply expert)*

However, results from empirical studies in similar settings such as Zimbabwe and Tanzania (Mutizwa-Mangiza 1999; Harrington 1999), point to strong medical professional self-regulating powers, similar to those found in this study. For example, in terms of licensing autonomy in Zimbabwe, at the time of the study, medical professionals possessed significant autonomy in medical education (Mutizwa-Mangiza 1999). This is similar to the situation in Nigeria and Chapter Six (section 6.2.2.1) illustrates this licensing autonomy in the health education sector by Nigerian medical professionals. While the literature on the monopolistic qualities of medical professionals in Western countries is well developed, in contrast, the sociology of medical professionals in African contexts is poorly researched. This study addresses this research gap in an African context and in addition compares the known monopolistic

qualities of medical professionals in different contexts and the monopolistic qualities of Nigerian medical professionals.

Another manifestation of professional monopoly can be seen in the implementation phase whereby it was found that it is common practice for medical doctors to be involved in the rolling out of the Global Fund's projects at community and facility level. In other words, the street-level bureaucrat role medical doctors occupy in the implementation phase, makes them both crucial and influential in linking health policy and implementation. The professional monopoly described in Chapter Seven focuses on these 'street-level bureaucrat' roles played by medical professionals during implementation. The medical professionals' claim of superior knowledge was indeed the main reason highlighted in the findings for their competence in handling this role. This, according to the results of this study, can be linked to their autonomy in health education licensure and the control of division of labour in the Nigerian context. Importantly, this is similar to Friedson's description of medical professionals in the early 20th century Western contexts (Freidson 2001). In this study, street-level bureaucrats were mainly frontline medical professionals whose influence was limited to the regional and health facility level. Further discussions in this chapter describe other similarities and differences to give an overall picture of the parallels between medical professionals in Nigerian and other contexts.

Although medical professionals as street-level bureaucrats dominate other health occupations, reflections from participants also point to the positive influence these frontline medical professionals have during implementation. A recent systematic review of policy formulation and adoption in LMICs affirms the importance of street-level bureaucrats such as medical professionals, who due to their discretionary role make decisions that impact on the diffusion of policy objectives in the implementation phase

(Berlan et al. 2014). Similarly, this study has identified medical professionals as street-level bureaucrats who use their medical dominance to facilitate smooth implementation of the Global Fund grant. In a similar setting to Nigeria, a study in South Africa shows how street-level bureaucrats play an influential role in the rationalisation that takes place at the implementation phase, which is vital to the success of health programmes (Walker & Gilson 2004). Most health systems research studies that use the theory of street-level bureaucrats in LMICs have been criticised for not identifying the intersection between the street-level bureaucrat theory and other theories (Erasmus 2014). This study, in addition to identifying medical professionals as street-level bureaucrats, uses the theory of professional monopoly to explain how medical professionals have come to occupy this position, identified the medical professional group that occupies this position and the structures that help maintain their jurisdictional dominance. This study has also acknowledged the fact that the theory of street-level bureaucrats is not generalisable to all the sub-groups of medical professionals (elite group and frontline) in the Nigeria health system because of the different roles played by them. From this study one might speculate that professional monopoly by frontline street-level bureaucrat doctors has a positive influence on the Global Fund grant in Nigeria.

As discussed in Chapter Two, the interactionist approaches of the ‘actions model’ and ‘power model’ explore the concept of professionalisation through the investigation of the interfaces between the structures in society and medical professionals (Macdonald 1999). They argue that there is a pattern of intersection between professionals, events, and structures specific to a particular context that confers on professionals autonomy and monopoly (Daniel 1990). They further explain that professional monopolies are not static but monopolies are maintained by a process of domination and influence on societal structures such as the state that help in maintaining this monopoly (Berlant



1975). For this reason, exploring societal structures and agential factors that influence professional monopolies using an interactionist approach serves to provide a deeper understanding of the unique medical professionalisation process in Nigeria. In addition, this professionalisation process is not static but an ongoing process of events and actions to attain and maintain professional autonomy and power, similar to descriptions in the literature (Larson 1977).

### **8.2.1 Structural and agential factors of medical monopoly**

This research identifies some of the contextual and agential factors responsible for medical professional dominance in Nigeria, such as perceived superiority within society, the influx and influence of doctors in policy spaces (Chapter Six) and the predominant use of the biomedical language in discourses about health policy (Chapter Six). The policy process gives an idea of how contextual factors instil a unilateral professional dominance; for example, societal privileges given to medical doctors, as illustrated in Chapter Six (section 6.2.2.1). Health workers in Nigeria have internalised the power that society has allocated to medical professionals, to such an extent that other non-doctor occupations consider this to be the norm. The findings explain how the historical origins of the medical profession as the most established health occupation with autonomy in most parts of the health system, has given them a competitive advantage over other health occupations. According to the literature, this can be traced to the adoption of a Western style health system inherited from the colonial years (Harrison et al. 2009; Cunningham & Andrews 1997; Schram 1971; Arnold 1996; Arnold 1988). In addition, this study illustrates the importance of studying cultural factors that are relevant to this medical dominance through ethnography, historiography, and other methods that were beyond the scope of this study.

The national culture is the *'mental programming that shapes the values, attitudes, competences, behaviours, and perceptions of priority of that nationality'* (Morden 1999:19). The multiple cultural layers in Nigeria such as the pre-colonial cultural structure, which places emphasis on respect for authority, in addition to the post-colonial and post-independence military regime that placed emphasis on hierarchy, contribute to the national culture (Ekeke 2015). The result is an inheritance of some of these values into organisational culture and practices (Hofstede 1997). This is illustrated in the literature review in Chapter Two, which highlighted the historical colonial roots of cultural factors responsible for medical dominance. The evidence in Chapter Six (section 6.2.2.1) that illustrated organisational cultural factors such as respect for hierarchy, which predominate in the Nigerian context have been found to contribute to maintaining the existing occupational hierarchies. This evidence supports and adds to the existing literature.

The scientific community's wider preference for biomedical strategies in disease prevention (Lee 2009a), creates an environment where donors favour proposals in which medical doctors take the lead (Wolffers 2000b). This global structural advantage positions medical professionals as public health experts and as Diane Stone (2002) argues, the reputation of experts in society positions them as filters and interpreters of information, thereby giving them power over others in policy making spaces (Stone 2002). The local (national) and global structural advantage medical professionals possess strategically positions medical doctors in government agencies and other influential stakeholder partners. The observational field notes in Chapter 6 (section 6.3.5.1) and Chapter 5 (section 5.2.2), illustrate how participation barriers such as the invitation process and the positioning of medical elites as representatives of influential organisations, can be a structural advantage in favour of medical monopoly. During implementation, this structural advantage is further illustrated in Chapter 7 (section

7.2.1.3), which shows how medical doctors are seen as the professionals with the training to best conceptualise public health programmes.

Agential factors come into play with regards to the influx of medical professionals into public health programme management positions, leaving their traditional clinical roles in health facilities, the 'repackaging' of doctors into public health experts by acquiring public health postgraduate degrees, and the use of biomedical language in proposal writing processes. In Chapter Six (section 6.2.2.2), the findings illustrate how the use of biomedical language by the medical professionals during meetings helps to maintain their dominance in the policy process. This is aided by the strong biomedical paradigm kept in place by the Global Fund through their guidelines, summarised in Chapter Five (section 5.2). Research in global health and health systems informs us about how GHIs have led to the internal migration of health workers from public facilities to well-paid donor programmes in Nigeria (Chima & Homedes 2015). In this study a combination of the pull factors of a well-paid management jobs in Global Fund implementing organisations and the individual doctors' career decisions (for example training in Public Health in order to gain more influence, described in Chapter Six) work as 'agential' factors in favour of medical dominance. These are some of the agential factors responsible for this professional dominance in policy processes in the Nigerian health system. Colin Hay explains how understanding relationships between structure and agency are helpful in conceptualising the dynamics of influence in various contexts (Hay 2002b). It appears from the findings of this study that medical professionals use their status in society, professional language, and numerical advantage in the health system to influence policy-making decisions. According to the findings, these factors have a limiting influence on a more trans-disciplinary approach towards systems thinking in health policy development.

In this study, we were able to identify some of the agential and structural factors in the health system that would likely give the medical profession advantage in decision-making and agenda setting in the proposal writing process, thereby, shaping the perceptions and preferences of the other non-medical participants. The effect of this is that other professions cannot easily imagine alternative solutions, ideas or concepts (Hay 2002b). Hay explains that context-shaping is a form of this domination whereby a group has the ability to shape the context which defines the range of possibilities perceived by others (Hay 2002b). Foucault's power-knowledge theory sheds light on this too, by explaining that domination can be exercised when subjects are guided by rules and laws which they in turn internalise, so they submit to their position in the system; this is one of the forms in which power manifests itself (Foucault 1981). The finding in Chapter Six (section 6.2.2.1) is an example of participants' internalisation of the superior status of medical professionals, in the context of which they see the contesting of biomedical knowledge as risky. This form of power will be discussed in later parts of this chapter.

### **8.2.2 Dynamics in jurisdictional interactions with other health occupations**

Alford's classical theory on structural interests in healthcare categorises interests into: dominant interest (professional monopoly), challenging interests and repressed interests (Alford 1975). This structuralist approach, which brings out the contours of interactions among formal and informal networks of interests in the health system, has been applied by some researchers in various contexts such the UK and South Korea (Cho 2000; Buse et al. 2012; Lewis 2006; Harrison & Ahmad 2000). Dominant interests are the various health occupations within the health sectors' structures, and within this group lay the medical professional monopoly (Alford 1975). The empirical evidence from this study in Chapters Six and Seven classifies medical professionals as an occupation in this

dominant interest group, in addition to being the only occupation in the health sector that possesses professional monopoly. Although the dominant interest group is heterogeneous, representing most health workers, medical doctors in private and public institutions holding various levels of positions, have interests into monopolising autonomy and power in the health sector (Alford 1975). Captured in Chapter Five, is evidence of how medical professionals from both public and private health organisations dominate policy spaces, thereby possessing professional monopoly of the dominant interest. This dominant interest is also seen, at the implementation phase in Chapter Seven, where the frontline medical professionals dominate as portfolio staff and are regarded as street-level bureaucrats.

Similar to other researchers that use Alford's theory; medical professionals were referred to as the dominant interest even though other health occupations exist within this group. This is because *'Battles occur, to be sure, between segments of those who possess such a monopoly, but these are conflicts of interest within a dominant structural interest. None of the conflicts of this type challenges the principle of professional monopoly – just who is going to have it'* (Alford 1975:14). For this reason, medical professionals in this study are the dominant interest because they are the health professionals who possess the professional monopoly in the Nigerian context. The findings in Chapter Six and Seven highlight the jurisdictional conflicts Alford describes but the findings suggest that medical professionals still maintain professional monopoly, therefore medical professionals are the dominant interest. The two sub-groups of elite and frontline medical professionals in this study possess this type of professional monopoly.

Dominant interests are held together by the *'existing social, economic, and political structures'* (Lewis 2006:2126), while challenging interests are corporate rationalists such

as the state and corporations who try to encourage more rational planning and efficiency in professional domains such as the hospitals and ‘*organisations (even non-profit ones)*’ (Alford 1975:193). According to Alford, challenging interests such as corporate rationalisers can ally themselves with the professional monopolists in order to have control over the health system domain, while professionals are satisfied with the status quo, as long as health reforms do not threaten their powers (Alford 1975). The empirical evidence in Chapter Six and Seven show the existence of this symbiotic relationship of dominant interests (medical professionals) and challenging interests (private and public organisations), which is in contrast to the current situation in Western contexts such as the UK (Nancarrow & Borthwick 2005). A combination of factors in this study shows this symbiotic relationship between the dominant and challenging interests. For example, in Chapter Six, the Global Fund biomedical agenda is strengthened by medical professionals during proposal writing, resulting in a trend of more medical professionals attaining management positions in Global Fund implementing organisations (Chapter Six section 6.2.5). Understanding this dynamic is important because, as Kuhlmann and Saks (2008) state ‘*the triangle comprising health professions, the state and the public must be understood as a dynamic relationship that allows for various ways to model and remodel power relations in health care systems*’ (Kuhlmann & Saks 2008:47). This power dynamic of the biomedical paradigm in both global actors and medical professionals will be picked on in later parts of this chapter.

Osman (2002) using Alford’s structural theory, refers to other health occupations as repressed interest groups because they do not have social institutions that ensure their interests are served and they are heterogeneous with numerous health sector interests (Osman 2002). The lack of collective interests makes the system unresponsive to their demands. Health occupations such as community based organisations and patients groups fall into this category. From the data in Chapters Six and Seven, in addition to

the patient groups and CBOs, other groups such as the non-clinical occupations and CHEWS fall into this category. This is because the interests of this repressed group are in the opposite direction to those of the dominant interest. There is no structural platform to put their interests in the forefront of agenda setting, even though dominant and challenging interests claim to have their concerns in mind. In Chapter 6 (section 6.3), during proposal writing repressed interests have little influence, even though both dominant and challenging interests have acknowledged their importance in the policy process. This study has identified this repressed interest group and linked their lack of active participation as a likely reason for the poor contextualisation of Global Fund proposals in Nigeria. Inter-disciplinary systems' thinking is important to better health strategies (Adam & de Savigny 2012) and the findings in this study illustrates the importance of this claim. The lack of participation of repressed interest groups cannot be isolated from the structural barriers put in place by dominant and challenging interests that make exclusion from proposal writing possible in the Nigerian context.

In Alford's theory, the dominant interest is contented if its jurisdiction is not encroached upon, but if this stability is challenged it instigates an action in response (Alford 1975). From the data in Chapter Seven (section 7.3.1.3 and section 7.3), appears to suggest that professional antagonism and professional conflicts have been instigated by the Global Fund's grant through its policies such as task shifting. Empirical data from South Korea points to this type of feud between medical doctors and pharmacists on the jurisdiction of prescriptions (Cho 2000). Conway (1990) explains how dominated professionals can evolve to share a certain identity and mobilise in resistance when opportunities in the policy spaces arise (Conway 1990). For example in Chapter Seven (section 7.3.1.3), task shifting has triggered professional antagonism among various health occupations, forcing them to use strategies to protect their professional boundaries, in an attempt to maintain their relevance in the health sector. This cascade of jurisdictional conflicts has

seen health occupations such as the laboratory scientists (Chapter Six section 6.4) attempt to expand their boundaries to dominate more work sites at the detriment of the overall health system. This is similar to the ‘professionalisation’ attempts by other health occupations seen during the industrial era in some Western countries (Abbott 1991).

Medical professionals on the other hand, are aware of the threat of encroachment posed by task shifting to their monopoly and have reacted by protecting their boundaries, illustrated in Chapter Seven (section 7.3.1.3). The current situation in Nigeria, where other health occupations such as the pharmacists, nurses, laboratory scientists, and midwives have formed a union in resistance to the medical profession leading to violent clashes in some cases is a reflection of the deep-seated professional conflict in the Nigerian health system (NMA-FCT 2015). Task shifting in the context of Nigeria, highlights the effects GHI policies have on HRH inter-relations. Task shifting according to most participants in this study has many positives towards the scale-up of medical services to rural areas, in addition to the performance-based framework, which makes health workers focus on efficiency rather than occupational hierarchy in the health system. However, the principles of task shifting have a negative effect on the dominance enjoyed by medical professionals. This presents a double-edged sword dilemma for medical professionals in the policy process because even though medical professionals accept there are benefits to task shifting (such as most of the medical doctors in this study), they still reinforce strategies that frustrate the implementation of task shifting. Thus although the GHIs (challenging interests) may be acting as a powerful lever to encourage task shifting through their policy documents, the existing professional structures in the form of dominant interests within the GHIs and the medical association appear to be the major obstacle to its legalisation in the Nigerian



health system. This is the nature of the complex and interesting interaction between medical professionals and GHIs.

In other words, health systems neoliberal management philosophies similar to those used by GHIs tend to create pressure on professional boundaries (Nancarrow & Borthwick 2005). On the other hand, rarely has the sociology of professions been used to explain these interesting behavioural patterns of human resources for health in LMICs. This study is a good example of how social science can bring to light interactions of central actors in the health system by studying a small segment of the health sector.

### **8.2.3 Consequential effects on the health system**

Non-clinical occupations can play a unique role in providing valuable contributions about the effects of culture on health behaviour in policy processes proceedings (Walt & Gilson 1994). Though this has been argued for some time, participants in this research have been very open about how important social science input is, and how lacking it is in the current process. Even though there were some non-clinical occupations amongst the decision makers in the CCM, most participants felt the non-clinical contributors were limited in their opportunities to contribute and offer their conceptualisation of the community and health in the Nigerian context. In addition, in an environment where quick fix technical evidence-based medicine solutions are preferred in policy processes, there is a struggle in balancing social science-based, people-centred strategies with biomedical strategies. The Health Systems Global conference in 2014 was themed ‘people-centred health systems’ because of this concern. Participants’ reflections on past Global Fund proposals suggest a need for a more transdisciplinary approach to policy decision-making in order to identify health gaps. On the other hand, some doctors have criticised the poor quality of participation and low levels of dedication by

social scientists involved in the proposal writing process, even though the empirical evidence points towards structural barriers that tend to limit participation from the non-doctor experts.

Empirical evidence from LMICs has highlighted the importance of diversifying stakeholder participation in the policy process of GHIs (Biesma et al. 2009; Spicer et al. 2010; Kapilashrami & O'Brien 2012). Biesma et al (2009) report that GHIs have been effective in the diversification of participation through the compulsory involvement of NGOs and CBOs in government-dominated CCMs (Biesma et al. 2009). Although GHIs have widened the participation of stakeholders, Spicer et al (2010) report that the quality of participation in CCMs has been an issue due to poor co-ordination structures, lack of CSO capacity, limited financial resources of stakeholders and '*insufficient time to contribute to proposals with tight submission deadlines*' (Spicer et al. 2010:10). The empirical evidence in Chapter Six highlights concerns similar to those reported by Spicer et al (2010) about the quality of participation of CSOs in the decision making process due to lack of capacity in relation to experts in the CSOs. This study also confirms findings from previous studies about the increase in the involvement of multiple stakeholders in the Global Fund's old and new funding model, however it argues that this does not usually translate into effective multi-disciplinary participation due mostly likely to medical dominance. Therefore, in the case study setting, an underlying medical professional dominance still exists in the CCM policy processes, which probably undermines the effort by the Global Fund to encourage broad stakeholder participation. This is exacerbated by the CSOs' lack of capacity to engage in meaningful participation with experts from powerful organisations such as INGOs and government agencies.

Multi-disciplinary collaboration is one of the tools for strengthening health systems thinking in LMICs (Adam & de Savigny 2012). Adam and de Savigny (2012) argue that due to the complexity of health systems, a paradigm shift from predominant biomedical approaches to a holistic perspective can help in addressing contextual challenges (de Savigny & Adam 2009; Adam & de Savigny 2012). In this study, another challenge to multi-disciplinary team participation was the preference for evidence-based medical guidelines on the part of the Global Fund, and this eventually led to a CCM proposal with an interdisciplinary approach but with a predominant biomedical paradigm. This is illustrated in Chapter 5 (section 5.3.1), where participants point to the prescriptive guidelines of the Global Fund that limit health strategies to fixed WHO and UN guidelines. Due to the biomedical nature of these guidelines, stakeholders are therefore limited in their alternatives to contextualise the proposal. This type of environment encourages medical leadership in proposal writing while other disciplines are confined to the biomedical way of thinking and this can further aggravate the already existing biomedically dominated policy space in the Nigerian health system.

Kapilashrami and O'Brien (2012) state that the Global Fund has instilled a competitive environment through its performance-based grant writing system, which makes actors with economic means focused on acquiring the best technical experts to acquire more funds under the Global Fund grant (Kapilashrami & McPake 2012; Kapilashrami & O'Brien 2012). In this study, this competitive environment of the Global Fund has led to an influx of medical professionals into INGOs and well-funded state agencies as managers, compounding the internal brain drain of rural to urban migration of medical professionals. Secondly, Chapter Six further tells us that the ratio of medical professionals to other occupations favours medical professionals, thereby giving them a numerical advantage in setting a biomedical agenda. Although, the exact numbers were not available, an extract from a participant expresses this point:

*if you go to APIN (AIDS Prevention Initiative in Nigeria), APIN has almost 91% of doctors there, and IHVN (Institute for Human Virology in Nigeria) almost have 98% doctors there. Almost everybody is a medical doctor. I do not know whether it is stated in their policy before they came to Nigeria or sometimes...it is only a few that do not have medical doctors there. (Participant 32: Non-doctor public health expert)*

Helga Nowotny et al (2013) state that the prominence of a biomedical discourse in policy processes can shape how we conceptualise particular problems and that the lack of non-biomedical input in these processes may lead to poor contextualisation of policy agendas (Nowotny et al. 2013). This was indeed the case, as explored in Chapter Six, where the restrictive and rigid approach of medical professionals meant that the grant focused on scaling up of ARTs on the supply side and neglected demand side factors, leading ultimately to unintended consequences including waste in ARTs and financial resources. Another important finding in this study in relation to the monopoly of medical professionals is the fact that both medical and non-medical participants were in agreement in their conclusions, that medical professional monopoly had negative effects to the policymaking processes.

In summary, the findings from this study emphasise the importance of locating the key points of interaction between local and global actors that lead to shaping of health policies in LMICs. The findings reinforce Alford's theory, used in identifying dominant, challenging, and repressed interests, which improves our understanding of the interactions that influence health policy processes (Alford 1975). This thesis has presented empirical evidence, identifying medical professionals as the dominant interest group and other occupations as the repressed interest group in the context of the Nigerian health system. The interactions between medical professionals' monopoly, the

challenging interests, and repressed interests (which are usually opposing) have system-wide effects. The findings reiterate Haynes's (2003) explanation that health systems are complex adaptive systems with a dynamic environment characterised by soft boundaries, which prompts key actors to respond in unpredictable ways (Haynes 2003a). This means in understanding the effects of GHIs on health professionals and on health systems we need to shift our attention from *'things to processes; from entities to interactions'* (Haynes 2003:28). This study findings in identifying the processes and dynamics of these interactions is very important to the global health field (Ooms 2015).

The next section discusses the findings related to the debate about the adaptive changing roles of medical professionals in the health system and the factors that affect their relevance in the policy process. The next section draws upon concepts from the deprofessionalisation theories and compares them with the empirical evidence from this study.

### **8.3 Deprofessionalisation and boundary conflicts**

This section discusses factors related to the neoliberal principles of the GHIs and how they are seen to impinge on the medical professional monopoly. In this regard, the GHI's activities that can lead to deprofessionalisation of medical professionals will be discussed by drawing on areas where medical professionals' monopoly is contested. As discussed in the themes in Chapter Five, Six and Seven, the themes identified in this regard will be classified into two broad categories: NPM strategies (performance based framework, incentives, task shifting) and Re-stratification (composition of CCM, doctors in implementation, trend of doctors' dominance)

### 8.3.1 NPM strategies

As discussed in Chapter Two, the dominant ideology of management disseminated through global development networks such as GHIs is based on NPM principles (Hansen et al. 2002). The Global Fund uses management tools similar to the NPM principles used in Western countries in the early 1980s, which led to the ‘deprofessionalisation’ of medical professionals. Out of the numerous NPM principles highlighted in the literature, those that were relevant to the findings of this study include performance-based frameworks, incentives, and task shifting.

As highlighted in Chapter Seven, performance-based frameworks have become a common work principle among the health occupations involved in GHI activities. A performance based framework involves the *‘transfer of money or material goods conditional upon taking a measurable action or achieving a predetermined performance target’* (Eichler 2006:5). The Global Fund uses this framework in evaluating programme performance in the 130 countries in which it operates. Two arguments have been made in support of PBF, one of which is that it is able to counter the complex nature of public state bureaucracy, which allows professionals, and interest groups to channel resources into activities for their own benefit (Haynes 2003a). As discussed in Chapter Five, in ensuring that funds are used strictly for programme outputs, a rigid system of PBF is created to guarantee accountability but this has also led to a lack of flexibility in implementation. Job descriptions incorporated into the PBF have led to a more focused workforce in Global Fund implementing agencies and have reduced boundary conflicts. The second argument in support of PBF, says that it can be used to encourage community participation through the incorporation of accountability measures specific to communities, thereby making implementing organisations more sensitive to patient satisfaction (Gilson & Mills 1995). There is little evidence from this

study to show the effect of PBF on provider accountability to communities but rather PBF ensures more accountability to the Global Fund (purchaser) through the LFA. The use of accounting firms as the LFA forces countries to conform to accountability measures of the Global Fund and restricts flexibility during implementation, as is captured in Chapter Four (section 4.1.2.2). This is also captured in some of the documents of the Global Fund:

*The key features of the Organization for Economic Cooperation and Development (OECD) Development Assistance Committee (DAC) Task Force on Donor Practices Good Practice Reference Paper on Reporting on Financial Aspects and Auditing **form the foundation of the Global Fund's policy framework for annual audits. While applicable international audit standards should be used for conducting the audit, national standards are acceptable where these are consistent with the international standards in all material respects.** (Guidelines for Performance Based Funding (Global Fund 2003)Emphasis added)*

Competition driven by incentive structures is a key component of NPM (De Vries & Nemeč 2013). The neo-liberal approach observed in this study showed that PBF has created a level of competition among providers and improved their focus on health outputs, which is an improvement from previous grant rounds. In regards to PBF and health workers, the top-level effect of PBF has trickled down to individual health workers in the form of job descriptions. This has replaced the occupational hierarchies at the work place, thereby reducing professional powers. Job descriptions are a product of formal rationalisation of health activities, whereby pressure on providers compels health workers to be more efficient (through job descriptions) and this consequently leads to the deprofessionalisation of medical professionals (Malin 2000; Ritzer & Walczak 1988). In this study, job descriptions seem to be replacing occupational

hierarchies in Global Fund implementing organisations and a further sensitisation in public institutions about the benefits of job descriptions is taking place through the interactions of the Global Fund and public institutions. Examples of this can be seen in Chapter Seven (section 7.3.4), where Global Fund implementing partners actively teach public facilities and agencies new management principles in a bid to replace the traditional bureaucratic culture of public institutions, so that they are more sensitive to new management principles. Re-orientation programmes designed to align newly recruited staff to job descriptions, can reduce the emphasis on occupational hierarchies in the Global Fund implementing partners, as captured in Chapter Seven (section 7.3.2). In addition, job descriptions can remove the power over divisions of labour possessed by medical professionals, which suggests its an indication of the erosion of medical monopoly.

Central to a professional bureaucracy are the professional privileges and autonomy maintained through the occupational hierarchy in health institutions (Dent & Whitehead 2002). In the short-term, job descriptions help in limiting professional powers and participants in this study argue that it makes the system more efficient. However, there is a risk of having two parallel systems in the health sector, whereby in GHIs programmes there is no occupational hierarchy, and in public institutions, a professional hierarchy exists. According to some participants, job descriptions that are in place are meant to be for emergency epidemic situations but in the long-term most positions should align to the existing occupational hierarchies in the system. This statement echoes the growing literature about the parallel systems that GHIs introduce into national health systems (England 2007; Marchal et al. 2009; Balabanova et al. 2010; Spicer et al. 2010; Cavalli et al. 2010). Parallel systems, in this context, appear to create occupational hierarchies that are adhered to in non-Global Fund programmes of government organisations and another system that is less sensitive to occupational



hierarchies in Global Fund programmes, further worsening the existing fragmentation in the health system. This is in addition to the parallel system of referrals created with the unofficial task shifting taking place in GHI programmes in Nigeria. This outcome contradicts the health systems strengthening goal the Global Fund claims they support.

Another concern raised about PBF is the fear of an unfair playing field (Low-Beer et al. 2007). In reference to PBF and the individual health worker, Chapter Seven shows how PBF favours health workers working in densely populated geographical regions, giving them a strategic advantage over other health workers, and PBF is not flexible to adapt to some of these context-specific situations. Consequently, there is a fear that PBF could erode the classical reward system that encourages altruistic moral values, by replacing it with a system that only rewards efficiency and meeting targets (Salskov-Iversen et al. 2000). This concern is reflected in Chapter Seven (section 7.3.2), where participants believe PBF tends to erode altruistic professionalism.

Claims to a basis of altruism have always been central to the medical professionals' argument for justifying their high status compared to other occupations. A system that puts altruistic values as secondary to quantifiable outputs can weaken the altruistic argument that supports professional autonomy. Evidence from participants in this study indicates that the spread of the GHI job description tools into the public health sector has the potential to deprofessionalise medical professionals. This pattern has been identified by other researchers: *'One should not be surprised at this, as the introduction of performance-related pay is a known tool to deprofessionalise professional groups...Performance-related pay replaces professionals' intrinsic satisfaction with a system of externally driven rewards and at the same time allows management to divide-and-conquer'* (Lorenz 2012:613).

*'Market systems can lead to perverse incentives and displacements where the underlying social problem is too complex and multi-dimensional for simple market structures to deal with issues satisfactorily. In these situations, a clearly focused, targeted approach in one agency can lead to problems in other parts of the public sector.'* (Haynes 2003:15). The new incentives-driven culture introduced into the Nigerian health system by GHIs appears to have resulted in the emergence of various parallel lines of incentives in the health system, with health workers gravitating towards programmes with higher incentives. In this study the parallel lines are between the government's incentive structure that uses *'low-powered incentives (incentives that are not related to output)'* and GHIs' incentive structures that use *'high-powered incentives (high financial incentive proportions given to expand output and motivate staff)'* (Hanson 2012:107). The unintended consequence is a high-powered incentive culture leading to competition for health workers between the various GHIs. The Global Fund has lower financial incentives compared to other GHIs, and has also struggled to attract health workers to their health facilities. Chapter 5 (section 5.3.4) shows how duplication of activities can occur when various GHIs are in competition with each other. In addition, incentives might have affected dedication to work from all occupations in the health system. Furthermore, the expensive foreign incentive culture introduced by GHIs is unsustainable by the Nigerian government in the long-term, which raises similar concerns to those shared by others in studies from other countries (Hanefeld & Musheke 2009; Eichler 2006).

A review of the empirical evidence concerning 'pay for performance' incentives by GHIs, showed that incentives had negative effects on the professionalism of health workers in general, leading to a *'focus only on achieving the explicit targets that are being rewarded at the expense of other important but unmeasured tasks'* (Eichler 2006:23). Theories from the literature review on professionalism show that

organisational professionalism, which is centred on target setting and performance, is gradually replacing the occupational professionalism described in Durkheim's model of altruistic occupational communities (Bezes et al. 2012). Incentives have the potential to instil this organisational professionalism, which is a threat to the altruistic values of all health occupations and deprofessionalises medical professionals. However, in the literature there is no evidence that NPM's organisational professionalism can stop medical professionals from using '*traditional exclusionary tactics*' (Kuhlmann & Saks 2008:7). Some researchers claim that replacing occupational professionalism with organisational professionalism through health reforms such as NPM create '*redundant tensions*' in the health system (Southon & Braithwaite 1998:27). The evidence in this research echoes most of the concerns aired in recent research about the negative effects PBF and incentives have on professionalism of health workers and the potential these have for escalating inter-professional conflicts deeply seated in the health system, which is captured in Chapter Six and Seven.

Evidence about task shifting in this study highlights a range of concerns about GHI policies in national health systems. By challenging professional monopoly, task shifting has instigated a cascade of professional antagonism among the Nigerian health occupations due to the re-definition of occupational jurisdictions within GHI programmes, with consequent occupational rivalry in the public sector. Empirical evidence from other studies in LMICs have shown intense professional antagonism among rival occupations when GHIs introduce task shifting policies (Cailhol et al. 2013), which supports the findings in this study elaborated in Chapter Seven (section 7.3.1.3).

The scale up of health service provision in LMICs is very important in successful policy implementation and critical to this is task shifting (Fulton et al. 2011). The results in Chapter Seven show evidence for the positive impact of task shifting. However GHIs, in

a desperate need to attain their set targets, encourage the use of unofficial task shifting in the health system, circumventing the existing occupational structures in place. The potential danger of circumventing professional structures is that it has an unintended consequence of fuelling the ongoing professional rivalry highlighted in this study. In a systematic review of task shifting in LMICs by Fulton et al (2011), the results showed that task shifting was an instigator of professional antagonism and institutional resistance (Fulton et al. 2011). Abbott and Alford's professional theories of professional jurisdiction (Alford 1975; Abbott 1988) and evidence from the empirical literature (Fulton et al. 2011; Cailhol et al. 2013; Temido & Dussault 2015) have shown that encroachment of occupational jurisdictions and boundaries can cause professional antagonism. Similarly, in this study, short-term approaches of GHIs such as task shifting have indicated that alterations to professional boundaries affect inter-health worker relationships and can have a resultant negative effect on the health system.

### **8.3.2 Re-stratification**

A major theme in Chapter Five relates to the composition of the CCM and the Resource Mobilisation Committee (RMC) of the Global Fund in Nigeria. This unique system appears to give power to those who are involved in the two structures of the Global Fund, especially in proposal writing and agenda setting. Although the RMC is answerable to the CCM board, in reality, the RMC is a group of elite experts who develop strategies for the CCM; from the interview data in most cases they have the final say in the overall proposal writing process. The empirical evidence captured in Chapter Five (section 5.2.2), illustrates that the RMC has an overwhelming majority of medical professionals who usually form the core of the committee. Secondly, the influx of medical professionals into managerial positions in most Global Fund implementing organisations (with head offices mostly in the capital city), has perhaps

contributed to a growing number of top managerial medical elites at the meso level, illustrated in Chapter Six (section 6.2.5). Re-stratification in the literature has been identified as part of the ongoing medical professional evolution, with researchers relating this to corporatisation of health, globalisation, and increasing neo-liberal capitalism of the health sector (Tousijn 2002).

The empirical evidence on re-stratification of medical professionals in Western countries similarly highlights how new health reforms in the form of NPM have fragmented the medical profession (McDonald et al. 2009; Pickard 2009). However, not all re-stratification processes are similar. For example, the UK has started to experience a horizontal stratification within a sub-group along technical lines (Sheaff et al. 2003), while the empirical evidence in this data illustrates mainly a vertical stratification within the Global Fund initiative, illustrated in Chapters Five, Six and Seven. The vertical stratification in this study into RMC and managerial elites and frontline medical doctors at the implementation stage is similar to the picture arising from Freidson's re-stratification theory (Freidson 1983). Barnett et al, in their study of the New Zealand medical professionals, argued that it was the frontline doctors who felt the effects of deprofessionalisation (Barnett et al. 1998). Similarly, in this study, it is the frontline doctors who are faced with the task shifting agenda at the micro level that are threatened with the loss of autonomy. Similarly, the internal re-stratification that appears to create these elite doctor managers in this study, is similar to findings in the study by Lewis (Lewis 2006). The study by Lewis (2006), in exploring the power of medical professionals in the Australian health policy process, concluded that there is a distinct difference between the powers of medical elites and frontline medical professionals due to re-stratification (Lewis 2006). This study is in agreement with the evidence from the study by Lewis (2006), because recent re-stratification in the Nigerian health system has divided the medical profession into two distinct categories. The first is the network of

elite medical professionals at the head offices of health organisations and agencies involved in proposal writing and policy decision making; the second is the body of frontline medical professionals at the implementation stage involved in the coordination and execution of activities at the state, regional and facility level.

The major argument about the re-stratification process centres on whether the medical elites are expanding their boundaries, in a bid to expand their medical monopoly by colonising management roles or whether they are being used as agents of challenging interests to reduce the professional powers of frontline professionals (Freidson 1983; Ferlie & Geraghty 2005). The latter argument claims that the state and corporations, through external control, use medical elites to control frontline doctors in order to reduce medical professional power (Coburn et al. 1997; Harrison & Dowswell 2002; Weisz 2006). Internal doctor migration from facilities to managerial roles and the acquisition of Masters in Public Health degrees by doctors illustrates the active efforts by medical professionals to acquire additional occupational jurisdiction, which supports the former argument. Toth (2015) reports a similar trend in Italy *'The processes of corporatisation and politicisation of the Italian healthcare service risk diminishing the ability of physicians to influence strategic decisions in the healthcare sector. To avoid losing their traditional influence, physicians have counterattacked by trying to gain managerial positions and purely political positions. Starting from the early nineties, political offices held by physicians seems to have increased'* (Toth 2015:134). This pattern in the Italian study is very similar to the pattern seen in this study. In addition, the medical elites at the national level are less vulnerable and are able to maintain their dominance and boundaries. In contrast, evidence from this study (Chapter Seven section 7.3) shows that the frontline medical professionals are most at risk of being deprofessionalised because most of the NPM strategies such as job descriptions and task shifting are directed at the implementation stage. These findings show some similarities

with research about how NPM has reduced professional autonomy and power of frontline staff in the UK while sparing to some extent the medical elites' power (Ferlie & Geraghty 2005).

In summary, from this small case study it is hard to determine the extent of the consequences that re-stratification has on the Nigerian health system; however, there is enough evidence to show that there is some level of re-stratification associated with the Global Fund initiative. The findings in this study show the importance of examining GHIs in connection with the concept of 'glocalisation' of health policies (Kickbusch 1999). By exploring professionalisation (professional monopoly) and deprofessionalisation (declining monopoly) concurrently, we are able to observe the two processes in action. This adds to our knowledge of the changing power dynamics and roles of medical professionals, rather than trying to establish either side of the argument conclusively. Identifying these key areas of interaction is vital in understanding the complexity of the health system and the adaptive nature of medical professionals in their changing environment.

The next section discusses the findings related to the underlying discourses in GHIs that are seen to influence professional monopoly and deprofessionalisation of medical doctors. The concept of epistemic communities and knowledge/power discourse will be explored drawing from the empirical evidence.

#### **8.4 NPM and biomedical epistemic networks in GHIs**

As noted in earlier chapters, the concept of a transnational discourse community or epistemic community is relevant in this study. These communities are located within the public space where the shaping of how society conceptualises a particular problem is done (Stone 2002). Epistemic communities are an elite group of professionals and

experts with shared; causal and effect beliefs, professional judgements and sense of collective identity (Hansen et al. 2002; Nowotny et al. 2013; Stone 2002). This concept of epistemic communities is relevant to the findings in this study, as outlined below.

During the development of previous proposals in the old Round Based Funding model, a group of professionals mostly from the medical profession, appear to control the direction of the proceedings and set the agenda in meetings. This is captured in Chapter Six page 211: *'we are all the same set of people that have been running this process in the past years so nothing is going to change'*. This gives an impression of a group of 'HIV/AIDS professionals' who are part of a global epistemic community in the local context of Nigeria, that are able to create a professional system that assembles, orders and institutionalises the priorities and processes of HIV/AIDS programming (Adam 2011). Haas's concept of epistemic communities explains how a group either by design or through unconscious creation, can grow and become very influential in a sector of society (Haas 2004). These local and international knowledge elites, with collective shared identities, network through international documents, international conferences and other avenues, which is made possible by globalisation (Tomlinson 1999; Hansen et al. 2002). In this study, the influence of external consultants, INGOs, and medical professional local governing elites is an example of this global HIV/AIDS epistemic community, as was illustrated in Chapter Five. Members of this group have a global outlook on health issues rather than a focus on national interests in agenda setting and decision-making (Hansen et al. 2002:109). Their ability at the local level to set the predominant discourse, through the use of language, problem definition and policy solutions (Nustad & Sending 2000) such as ART procurement, creates a boundary of exclusion to those who are not experts in the biomedical paradigm. Maciocco and Stefanini (2007) regard the Global Fund as an influential institution in this community (Maciocco & Stefanini 2007) and in this study, the influence their prescriptive



guidelines have in making the biomedical discourse predominant is evident through the narratives of the participants. Harvey (1996) argues that a predominant discourse has the ability to affect the way we talk about, write and represent issues (Harvey 1996), while Mameli (2000) explains that some of these declarations, guidelines and reports set by transnational coalition communities can legitimise policy choices at the national level (Mameli 2000). This perspective is supported by the accounts given by participants in this study, describing their inability to generate context-specific solutions and community based interventions because other professionals and the patient population are not organised, co-ordinated, or knowledgeable enough to participate in skilled debates at the national level.

The extent to which the wider global epistemic community influences local epistemic communities is also something to be considered. Tess van der Rijt (2013) describes how local professional systems of the Global South, similar to the one in this study, are greatly influenced by the global health thinkers of the Global North (Rijt & Pang 2013). The research concludes by stating that the Global North's influence diminishes the possibility of incorporating local contexts in national health policy processes and research (Rijt & Pang 2013). In other words, the sharing of knowledge at the global level is replicated locally (Stiglitz 2000). In Chapter Six section 6.2.4, evidence of this fixed universal approach towards health strategies is disclosed by participants and is seen as a symptom of their inability to think beyond the more familiar biomedical model. Chapter Six section 6.3.3, draws attention to the how operational research funding appears to be concentrated in these professional knowledge systems of HIV/AIDS that are biased to the biomedical paradigm and this has contributed to under-development in other knowledge networks (Adam 2011).

#### **8.4.1 Discourse hybrid**

Language discourse is *'the moment for resort to the vast panoply of coded ways available to us for talking about, writing about, and representing the world'* (Harvey 1996:78). By dominating the discursive spaces over time, key actors accept this discourse as fact, leading to a 'discourse structuration' and then 'discourse institutionalisation' is the next step (Hajer 1993). Discourse institutionalisation happens when policies are made based on the ideas and concepts of the dominant discourse (Hajer 1993). The dominant discourse becomes the basis for the language and communication codes used in conceptualising issues, and professionals and experts in this discourse can use this as a platform for obtaining opportunities (Hansen et al. 2002). Harvey explains that the *'effects of truth'* as a dominant discourse can lead to an *'effect of power'* (Harvey 1996:78). In the next sub-section, we will look at the discourses that dominate and give epistemic communities 'epistemic power', as reflected in this study.

##### **8.4.1.1 Biomedical discourse**

This sub-section will explore the synergy between the dominant biomedical discourse in the Global Fund and the HIV/AIDS epistemic community mainly comprised of medical professionals in the context of Nigeria. As discussed earlier, epistemic communities are in a privileged position to advise on ways of approaching national, supranational, and global policy because of their ability to influence the dominant discourse. In addition, the biomedical discourse has been the dominant approach in global health governance over time, because it has been crystallised as the superior approach to health challenges (Kay & Williams 2009). Even with a multidisciplinary group of experts, research has shown there is a continued domination by the biomedical discourse, because other behavioural research initiatives nonetheless conform to biomedical ways of reasoning rather than a hybridisation of discourses (Foster 1987). This has been argued in the

previous sections of this chapter and evidence of this is seen in Chapter Six, where participants say that during proposal writing, they are usually not open to alternative ways of reasoning. This shows that there are discourses that set the agenda in the proposal writing process. Global guidelines and reports developed from these expert networks show the power epistemic communities exercise from a distance on national health systems (Stone 2002). *'The management of the HIV/AIDS pandemic also shows the ways in which low-intensity, international quasi-legal instruments such as non-binding resolutions, declarations, guidelines, and reports (some- times referred to as "soft law") can be deployed creatively by international governmental organizations (IGOs) to attempt to order such change.'* (Mameli 2000:203). The danger of having such global guidelines is that approaches that use these 'gold standard' guidelines are seen as best practice, while those that do not are seen as not being compliant, leaving little room for alternative approaches (Lush et al. 2003).

The field of HIV/AIDS has had two contesting narratives, namely: the biomedical and social narrative. Even though the biomedical narrative is dominant, the social narrative has made a case for collective interventions that focus on communities (Kippax & Stephenson 2012; Lee 2009a). On the other hand, great appeal (by donors and national governments) for a treatment strategy that involves less interaction with complex social structures, has led to vertical single line disease programmes by the Global Fund and Gates Foundation (Williams & Rushton 2009; Kippax & Stephenson 2012; Lee 2009a). The findings in Chapter Six explain how the preference for a biomedical model that focuses on medications and test kits has dedicated funds towards supply of health services, while neglecting the social science narrative of demand creation. In addition, the strategic framework of the Global Fund seems to indicate its preference for the biomedical narrative, thereby making the biomedical narrative the most dominant discourse in the proposal writing process.

The biomedical discourse has been the major source of knowledge and information about the HIV/AIDS epidemic, and policies have mainly been drawn from the clinical and population studies of biomedical experts (Stone 2002). Experts and think tanks have become very important in this respect and have held considerable power due to their ability to filter and make sense of the evidence presented to policy makers (Stone 2002). The observational field notes in Chapter Six appears to demonstrate how experts use biomedical data in presentations during meetings and participants have given examples of how they use biomedical language to exclude other contesting narratives. This cycle of a dominant biomedical narrative appears to favour medical professionals in the context of Nigeria and positions them in elite positions such as membership of the RMC of the CCM. This study is in agreement with recent research on this theme, and some authors have stated that the authority of biomedical experts at a global level in the field of HIV/AIDS places them in a position of authority, even though there are rival paradigms (Wolffers 2000; Adam 2011; Ingram 2009). This sub-section demonstrates how the biomedical narrative, which is dominant in the Global Fund, encourages medical professional monopoly in the context of Nigeria. These findings cannot be overestimated because it echoes the concerns of HPSR academics that have called for global research, which would reveal the process, and power relations that create and maintain the normative knowledge paradigm (Hanefeld 2016; Ooms 2015).

#### **8.4.1.2 NPM discourse**

This sub-section seeks to describe how NPM has become a dominant discourse in the Global Fund grant. NPM, used as a tool for rationalisation has spread through epistemic communities with the aid of globalisation. In this process, NPM has promoted cost effectiveness and efficiency, while concurrently reducing bureaucracy and occupational hierarchy in public administration (Salskov-Iversen et al. 2000). In recent years, the

NPM discourse has crept into the health reforms of developing countries through the propagation of neoliberalism in global economics (Lee & McInnes 2013).

It has been argued that NPM is one of the key components that developing countries need in implementing health reforms in order to deliver equitable healthcare within limited resources (Russell et al. 1999). The Structural Adjustment Programme (SAP) of the World Bank and IMF was one of the first encounters of developing countries with NPM in healthcare reforms (Hansen et al. 2002; Lee & McInnes 2013). The second and most recent encounter of NPM with developing countries has been through aid agencies and donors, facilitated through knowledge networks such as epistemic communities (Lee & McInnes 2013). The evidence from the data in this study reflects most of the arguments made in recent research, in this respect. Chapter Five illustrates the gradual evolution of the Global Fund grant that was initially country driven, to its current prescriptive approach, which focuses on a rigid system of vertical top-down programming, reflecting NPM principles. Chapter Five section 5.3.2, illustrates the Global Fund's emphasis on strategic targets, value for money and cost effectiveness which are examples of the top-down approach of NPM. A participant (Chapter Five section 5.3.2) described this new approach as the '*micro-managing*' of the grant by the Global Fund. Furthermore, this study gives additional evidence on approximately how Global Fund implementers have facilitated the training of public sector facilities and agencies on similar NPM-style approaches. In summary, in relation to the global health agenda, the NPM narrative has gradually infiltrated national health reform policies, most recently through private-public partnerships such as the Global Fund (Lee & McInnes 2013).

The massive increase in international monetary donations by private-public partnerships (Lee & McInnes 2013), has advanced the use of a more open competitive and market-

oriented approach for better cost-effective use of these resources (Lee & Zwi 1996). In achieving perceived efficiency from health providers, an adoption of performance-based funding, incentive structures, market driven research and vertical approaches has consequently shaped the health market. The findings in Chapter Five (section 5.3), suggests possible ways in which the overall NPM paradigm influences proposals and Chapter Seven (section 7.3) highlights specific vertical NPM strategies such as task shifting, incentives and performance based funding used by Global Fund implementers. Neoliberal values have influenced HIV/AIDS projects in the form of NPM through the international network of donor agencies. A review of the Global Fund's New Funding model concluded that *'The demand for efficiency enhancements, and the drive for managerial logics and technocratic solutions that underpin these, has gained new force in the new strategy. This significantly departs from the human rights focus that the strategy commits to.'* (Kapilashrami & Hanefeld 2014). This sub-section suggests that NPM is a dominant narrative that is used in the framing of proposals and implementation of the Global Fund grant in Nigeria, with potential negative consequences.

#### **8.4.1.3 Hybridisation**

In relation to global health, the HIV/AIDS debate is a good context in which to examine how epistemic communities use the biomedical and NPM discourse in influencing health policy agenda. Biomedical science has benefited from NPM through the amount of funds being channelled to biomedical technologies and institutions for the treatment and prevention of the epidemic by influential actors (Lee & Zwi 1996). In the case of HIV/AIDS, there is a synergistic relationship between the discourse of NPM and the epistemic community of HIV/AIDS, where the biomedical discourse is reinforced through the interaction with international organisations such as OECD, World Bank and

UN agencies. The evidence from this study has shown how INGOs and GHIs have used the dominant biomedical and NPM discourse to create a local epistemic community that are located within strategic health organisations. The hybrid of these discourses in this epistemic community has become the focal point of the power they exert on the Global Fund grant. The Global Fund has further created structures that help maintain the CCMs' adherence to these paradigms such as the LFA, TRP and the confined list of consultants the CCM are allowed to use for their annual performance self-assessments, captured in Chapter Four and Five. This study shows that the power approach used in understanding the monopoly of medical professionals unveils other forms of power such as epistemic power, previously poorly explored in LMICs contexts.

Actors can use the legitimacy of discourses to exert power in a system (Shiffman 2014). Epistemic power is a source of power, and this places a certain group of experts at a level of authority over others, and exploring where it lies is important in mitigating its misuse by actors (Brown 2015). With the biomedical narrative shaping the epistemological foundations of research in health (Kippax & Stephenson 2012), it is important to investigate whether this has an influence on the role and relevance of medical professionals in a local context. Evidence of this epistemic power is presented in this study, with the evidence clarifying its benefits towards the professional monopoly of elite medical professionals. Even though the biomedical narrative favours certain medical professionals, the hybrid of NPM and biomedicine also seems to pose potential threats to the professional power of frontline medical professionals.

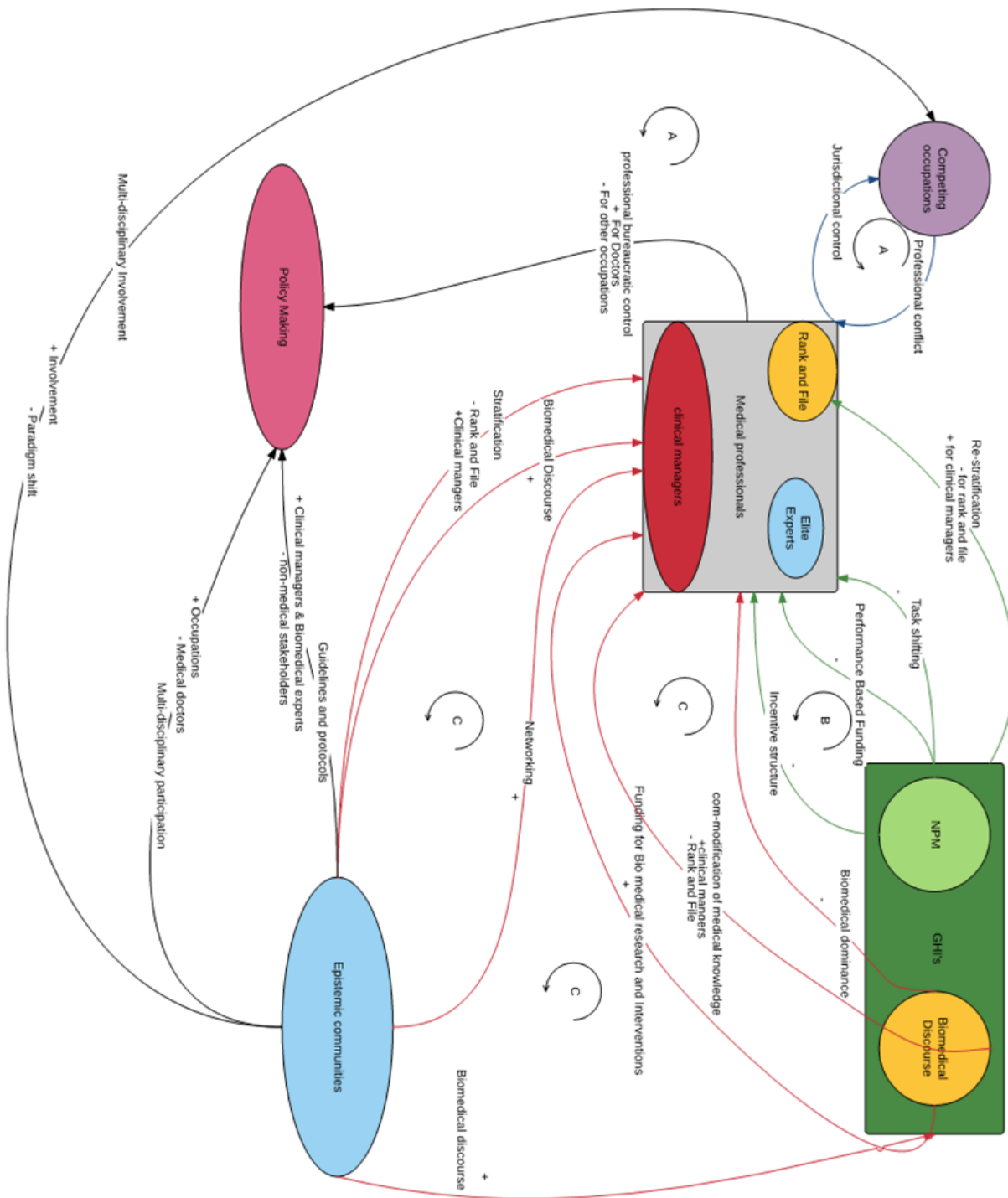
The complex soft boundaries between occupations in the health field have made studying medical professionals complicated. Focusing on purely the normative altruistic arguments or market closure theories neglects the effects that new evolving knowledge networks have on the role medical professionals play in the health field. The economics

of HIV/AIDS prevention and the biomedical model, packaged over the years by global health actors, individualises people in communities into separate units, thereby causing them to make biomedical choices of ‘testing and treatment’ and adopting a biomedical lifestyle (Brown & Bell 2008; Laurier Decoteau 2013). This is one of the potential system-wide consequence of having a hybrid of these two dominant discourses in a health system.

The use of the causal loop diagram (**Figure 13**) below represents the general overview of the interactions within the context of the Nigerian health system. This diagram is an incorporation of the diagrams from the findings chapters in order to give a full picture of the interactions already discussed in the empirical findings chapter and discussion chapter.



**Figure 13: Causal loop diagram illustrating the interactions between actors and structures within the Global Fund grant proposal writing process and implementation**



**KEY**

A= Professional relations

B= NPM Discourse

C= Biomedical Discourse

## 8.5 Relevance to the sociology of professions

Looking back to the origins of the sociology of medical professions, the idea of altruism as a concept used by functionalists focuses on the *'doctor–patient relationship as a social system'* that creates a universal stereotype that legitimises the superior role of medical professionals in society (Bradby 2012:25). By tracing the historical origins of medical professionals in Africa, the increasing medicalisation of society in colonial and post-colonial states saw society defining health as the domain of the medical doctor (Arnold 1988; Arnold 1993). This was because during the colonial period in order for local communities to accept interventions such as vaccination, they had to be convinced about the importance of western medicine (Feierman 1985). *'For the patient, his attempts to dialogue with the professional within the established framework of his cultural outlook are condemned with the well-known paternalism of Western medicine...After all, science — especially Western science— is knowledge par excellence'* (Afolabi 2011:241). The people in the communities were made to believe that even though they did not understand what the medical doctor was doing, his/her actions were ultimately for the good of everyone. Over time this altruistic notion spread through post-colonial societies because it was argued that these altruistic qualities were seen to have a stabilising effect on the health of the community, even though initially Western medicine was met with resistance (Last & Chavunduka 1988). This caused a shift in the conceptualisation of health, whereby in pre-colonial era traditional healers were the divine healers playing the altruistic role, while in post-colonial era they were replaced by medical professionals in a more medicalised African society (Last & Chavunduka 1988).

From this study, the findings tell us that the internalisation of the altruistic qualities of medical professionals still exists, whereby participants see HIV/AIDS as a public health issue and therefore the domain of the medical professional. At the same time, medical

professional participants use the altruistic argument as a reason for their dedication in the policy making process when compared to other non-medical professionals. These findings show that the notion of altruism is still prominent in the Nigerian context. Even though the altruist argument is relevant, it hardly takes into account that society has evolved and the altruist argument does not take into consideration new structural changes to society, including those seen in Nigeria (Brante 1988). This study shows that social relations in Nigeria have changed through the introduction of GHIs and other new stakeholders, which has made the notion of altruism outdated but not completely irrelevant.

The second important body of literature combines the structuralist and interactionist theories of medical professionals by authors such as Wilensky and Abbott (Wilensky 1964; Abbott et al. 2003). These theories expose the structures that place medical professionals in a privileged position. In the professionalisation theories of the structuralist era, a sequence of processes was postulated as the steps necessary for a professional to move up the social ladder. These theories were drawn from mainly European and United States contexts. On the other hand, through examining the history of medical professionals in the African context, we can understand that rather than climbing up the social and professional ladder, medical professionals inherited their professional status post-independence. The health system in newly independent countries (Nigeria included) initially inherited some of the old colonial structures and hierarchies, and retained many aspects of these over time (for example autonomy of training, and certification). This western model of occupational hierarchy, which is dominant, is evident in this thesis. For instance, the existing structuralist literature points us to institutions and structures that instil and maintain this professional status such as an established '*professional association with the formal code of ethics to exclude unqualified competitors*' (Wilensky 1964). In relation to this study, other professionals

have been excluded from being able to train as public health specialists in institutions in the Nigerian education system. However, even though medical professionals have inherited a system that favours their monopoly and autonomy, *'It is also worth mentioning that Western medicine brought about an institutional dislocation in the arena of inter-professional rivalry, an inheritance of Western-style medicine'*(Afolabi 2011:242). This inter-professional rivalry is captured in this thesis under the task-shifting theme. This thesis has explained how the inherited occupational hierarchy in the Nigerian health systems has led to a toxic environment of professional antagonism from other health professionals, which have further resulted in strikes as a form of rebellion towards the existing power structure that favours medical professionals. Hence, the history of the sociology of medicine in African helps us understand some of the findings in this study that the structuralist literature alone would not have fully explained.

According to Freidson, the four areas of medical professional autonomy are the division of labour, control over the labour market, control over occupational training and a distinct professional ideology (Freidson 2001). In relation to the division of labour, from participants' accounts it is evident that at the implementation stage medical professionals are the clinical and management head of the health team who delegate roles to the other health staff. This is possible because in the health system the medical professional is the administrative and clinical lead of every health team. This autonomy over the division of labour, as seen in this study, is also a reflection of what is known in the existing literature about the historical inheritance of both administrative and clinical roles by post-colonial medical professionals, which is still evident from more recent literature (Olumide 1997; Ojo & Akinwumi 2015). Examples of these patterns, in this study, are seen in the way elite medical professionals do retain control over key areas of the division of labour both at the top level of management in the form of TWG and at the lower level as street level bureaucrats in the form of portfolio staff.

In relation to a controlled labour market, in this study the advantage of having a medical degree places medical professionals above other occupations in the health sector labour market, giving the medical professionals a sense of job security or market shelter. An example of this is seen in the way implementing organisations prefer to employ medical professionals rather than other recruits, because they are thought to understand the policies better at the implementation phase. Furthermore, the occupationally-controlled training institutions, which only allow medical professionals to study certain specialities such as public health, control those who would end up being employable in health organisations involved in Global Health Initiatives. This further extends their market shelter beyond the public sector of the Nigerian health system. In contrast, in the UK, public health training and leadership positions are now open to non-doctors, *'from the early 1990s, a number of non-medical public health specialists have sought to persuade the Faculty to broaden its membership to include non-medical specialists'* (Evans & Dowling 2002:745). However, there are still concerns that even with this progressive movement in the UK to open up the public health field to non-medical professionals, some believe that *'non-medical specialists are still some way from equivalence with their medical colleagues'* (Evans & Dowling 2002:747).

In relation to Friedson's fourth point regarding professional ideology, interestingly; 'public health' can be seen as a new medical professional ideology, in the Nigerian context. Although, a similar form of public health has existed in medical training in the form of community medicine, the current form of public health training at master's level is somewhat new to the Nigerian medical education system compared to western contexts (Heller et al. 2007). This is a specialist training that some doctors now take up in order to secure their elite positions. The professional ideology theme was not thoroughly explored in this thesis, but nevertheless, the effort to make public health

exclusively part of the medical professional ideology in the Nigerian context can be seen as similar to Friedson's fourth point about monopoly of professional ideology.

Moving on from Friedson's theories about professional autonomy, theories of professional monopoly have been regarded as the cynical side of the sociology of medical professional argument by some authors (Brante 1988). In fact, these theories that centre on closure of market opportunities to other occupations are supported in this study. For instance, the 'actions' theory that focuses on strategies used by medical professionals is reflected in this study in Chapters Five and Six. Examples of these strategies are seen in this study in the form of migration of medical professionals from health facilities to INGOs, NGOs and similar organisations, otherwise known as internal brain drain in the literature (Chima & Homedes 2015). This large migration of medical professionals enables them to monopolise strategic positions because their large number can crowd out other non-doctor occupations in the more lucrative GHI labour market. Over time this large migration of medical professionals can create a circle of dominance. This is similar to the neo-Weberian theories of social stratification that explain the actions carried out to move up the social ladder (Bradby 2012).

Another example of the 'actions' model is seen in the use of biomedical language by medical professional during meetings as a form of exclusionary tactics, causing further closure of the deliberative space from other non-doctors. In the sociology of medical professions, a look back at history gives us examples of closure and *'history is understood as accumulated chains of closures and reactions to these. What we call social structures and positions are remnants of previous closure and struggles'* (Brante 1988). This is why the actions approach is relevant to this study because even though there are gaps in the literature on medical professionals in the context of Nigeria, this study has highlighted some strategies used by medical professionals that can lead to

closure and monopoly. This can be used as a reference point in future studies in explaining social structures of professional monopoly, through the identification of these remnants of previous closure.

Historically the power given to medical professionals by the state in the form of autonomy of licensure and self-regulation is reflected in this study when the level of medical influence in the whole health system is highlighted in the findings. Example are seen in the occupational hierarchy of the health sector that places medical professionals at the top in the majority of the thematic working groups. In this case study, the positional power they possess enables them to interact with the Global Fund CCM structure in such a way that they are able to influence the direction of policy making proceedings. An example of this extended power is seen in situations whereby the ART protocol adopted by the country was selected so it could favour medical professionals and this can be seen as an expression of their power. Although it is difficult to identify all forms of power in this study, the positional power medical professionals occupy from the proposal writing stage to the implementation phase is very evident. Another form of power is seen in the biomedical discourse theme. There is evidence of the dominance of the biomedical paradigm in the Nigerian health sector institutions, the Global Fund structure, and other influential agencies. This biomedical dominance has been a source of power to medical professionals because they are able to use biomedical language and their position as biomedical experts to exclude other non-doctor participants from the proposal writing process. The theme of power in the form of epistemic power will be discussed in more detail in later parts of this chapter.

These findings are clearly significant within Nigeria, but what implications do they have for other contexts? The findings in this thesis are important because the research draws on most of the theories in the sociology of professions in explaining how medical

professionals interact with the health system in Nigeria. This is important to the field of public health because it creates another avenue to broaden our understanding of HRH. In relation to the transferability of these findings to similar contexts, these findings can be used in similar West African contexts such as Ghana, Togo, and Cameroon that have similar post-colonial histories and have similarities in their health system structures. However, Brante states that '*it is always risky to propose general, trans-historical concepts; too often they entail that historical examples must be forced into the formula in order to save it...such formulae often make it easy to find striking resemblances and dissimilarities between historical events. But too often they are of a very superficial kind, tending to hide more profound factors*' (Brante 1988). Therefore, it is important to note that the findings can only be transferred on a preliminary level in areas such as biomedical dominance in health policy making strategies, the power models of medical professional monopoly and jurisdictional boundaries and professional antagonism. For example, this study suggests some starting points for other investigations, such as research on whether medical professionals in other sub-Saharan contexts use their power and status to resist task shifting in similar ways to patterns in Nigeria. One might expect to find some similar post-colonial patterns where medical professionals possess considerable power in the health policy space. This has a policy implication because task shifting is a strategy that is implemented in several other sub-Saharan contexts. Some lessons can be learnt from this case study about possible outcomes of task shifting in similar contexts, such as strikes and inter-professional conflicts. For example, there is plenty of evidence to show that the boundaries between medicine and other health-related professions and occupations is always a sensitive one, whatever the context. So 'task-shifting', as one feature of an NPM-inspired set of policies, could be predicted to cause friction in any health system. However, the nature and scope of the friction, and its eventual outcome, are much more likely to be specific to the context.



Furthermore, these findings can be transferred to similar contexts to explain how medical professionals use the biomedical discourse in maintaining their professional power. For example, the use of the biomedical language to exclude non-medical professional stakeholders by medical professionals is an area that is unlikely to be unique to only the Nigerian context and can be expected to occur in other settings.

However, deeper contextual generalisations will be risky because Nigeria is a particular Sub-Saharan country, with widespread systemic corruption, a large population compared to other African countries, a good number of medical schools and a fairly good medical doctors per populations ratio compared to other African post-colonial countries (National Population Commission 2013). In addition, Nigeria has one of the highest number of foreign students studying abroad, ranked 8<sup>th</sup> highest in the world, which is more than any other African country (UNESCO 2016), and this can have an effect on the number of medical doctors who leave to acquire Master in Public health degrees. These peculiarities about the Nigerian context are the reason why themes such as the actions model of medical monopoly in Nigeria, trends of medical doctors dominance, agential factors of professional dominance and quality of participation are more difficult to transfer to other LMICS settings.

In summary, this chapter drew on the theories of professionalisation (focusing on professional monopoly) and deprofessionalisation theories (focusing on NPM) from both the discipline of sociology and management in order to explain the findings of this thesis. This section has only focused specifically on the more relevant theories of the sociology of professions in order to link them with the findings of this study and context. The next section will discuss the power theme and explain its relevance to the sociology of professions and global health governance.

## **8.6 Biomedical discourse and Global Health Governance**

This thesis offers a useful case study because it identifies the various forms of biomedical power in the Nigerian health system and how such power is transmitted from the global level into the local or national level. In this section, the various forms of power of the biomedical discourse revealed in the findings chapters will be discussed and then plausible explanations about how power is transmitted, reproduced, and used by actors will also be further discussed. Although, this is not purely a global health research thesis, it is nevertheless important to highlight the relevance of the findings to this growing interdisciplinary field of research. Therefore, this thesis can be viewed as a case study that addresses one of the relevant global health governance research topics that seeks to identify *'the role of... power in global health'* agenda setting (Ooms 2015:641. Emphasis added). Shiffman (2015) has proposed unravelling how the various forms of epistemic power (in this study, in the form of biomedical discourse) are expressed in policy processes : *'Each of these two kinds of assertions—epistemic and normative—invoke both structural and productive power'* (Shiffman 2014:297). For this reason, this thesis will show how such concepts of power supported by Shiffman and Lee (Shiffman 2014; Lee 2015) can be useful in addressing the questions raised by Ooms (2015).

### **8.6.1 Global (macro)**

The GHG literature discusses the dominance of the biomedical discourse and how it shapes decision making in global health, affecting all global health actors (Lee 2015). This global acceptance of the biomedical discourse as an un-contested truth in evidence policy making, reflects the biomedical *'productive power, expressed in "how we create" meaning'* (Lee 2015:257). According to Kelley Lee (2015), this legitimises, *'qualifies'* and reduces *'truth'* *'to quantifiable measures of problems, such as disability-adjusted life years, and their solutions such as randomized control trials and impact evaluations'*

(Lee 2015:258). This is reflected, for example, in how the MDGs (Millennium Developmental Goals) and SDGs (Sustainable Developmental Goals) are designed and communicated (Lee 2015). Therefore, we can infer that the productive power of the biomedical discourse has enabled its 'structuralisation' and 'institutionalisation' into the global health governance architecture; at the global level the biomedical discourse has productive power. Lee (2015) says that the reproduction of the biomedical discourse in the MDG's and then subsequently in the SDG's, shows how at the global levels there is a recycling of the biomedical discourse in various forms without any paradigm shift. Through this reproduction, global health actors become biomedically structured in how they operate, and this allows them to claim that their decisions are a product of evidence based policymaking (Yamey & Feachem 2011). However, Ooms (2015) states that this claim allows global health actors to hide their true intentions under layers of empirical evidence in order to achieve their agendas. But by exposing this productive power we can uncover the *'stealth advocacy'* used by actors *'disguised as the outcome of a logical process that relied entirely on empirical evidence'* (Ooms 2015:642). Charting this path in global health research will expose the vast degree of politics involved in health policymaking, which has remained somewhat under-researched. It is hoped that this will lead to a rise in academic debates that challenge power and *'support empirical research on power'* (Erasmus & Gilson 2008:316), which could be akin to the effect professional monopoly research had on the sociology of professions.

While it is difficult to distinguish between the use of productive and of structural power by global health actors, describing the structural form of power discussed by Shiffman and Lee (Shiffman 2014; Lee 2015) is important because in synergy these two forms of power can explain the dominance of a particular discourse. For instance a global health actor such as the WHO can use productive power to frame our thoughts on issues, while also using structural power in shaping how we operate in relation to each other, such as

providing access to a certain type of researchers (Shiffman 2014). In the Global Fund, the TRP is the technical arm, designed to guide and inform the board during decision making (Kapilashrami & McPake 2012; The Global Fund 2014). Section 4.1.2.1 shows how through the creation of the TRP, the Global Fund has shown its preference for biomedical evidence in decision-making. In addition, this allows the organisation to claim that they are an apolitical organisation that uses superior knowledge in decision making (Brown & Barnes 2011). This important structure in the Global Fund is a source of structural power based on the biomedical discourse because it *'enables certain state and non-state actors in global health development, well-intended or otherwise, to shape the behaviour of aid recipients'* (Lee 2015:257-258). A stakeholder analysis in Tanzania has shown this power in action in the form of technical expertise which was seen as the most important factor in the power dynamic between donor and recipient: *'the major source of power stemmed from technical expertise and evidence'* (Fischer & Strandberg-Larsen 2016:359). The TRP in the Global Fund can be seen as a major way in which structural power is exercised by the donor over the recipient, because in situations of negotiations *'they not only had the money behind them, but also good evidence that theirs was the best for the situation. Hence, a strong argument with robust evidence-based rationale can sway opposing stakeholders'*(Fischer & Strandberg-Larsen 2016:359-360). The TRP, with its biomedical base, uses the structural power of superior evidence to oblige recipient countries to conform to their preferred strategy. From the findings in this study, the TRP has this structural power, because although country proposals are meant to reflect country priorities, stakeholders in the proposal process accept that the TRP is superior in the technical knowledge hierarchy and country stakeholders design their proposals according to evidence that is acceptable to the TRP.

Hence, at the global level we can suggest that we have identified the two forms of biomedical power, both productive and structural, based on reviewing relevant literature, which is central to understanding how the biomedical discourse flows and is diffused to other health systems and networks. However, it is very difficult to explain these forms of power by delineating them into specific categories but describing them together allows the reader to conceptualise how they operate.

### **8.6.2 National (meso)**

In Nigeria, the introduction of the biomedical discourse into the Nigerian society can be traced back from its colonial origins. The literature tells us how a western-health system dominated by the biomedical paradigm was initially developed for the benefit of the colonial army and structure. Post-independence, this paradigm was adopted as the model for health care in Nigeria and it replaced the indigenous traditional medicine (Last & Chavunduka 1988). This can be referred to as the origin of the biomedical discourse in Nigeria and its ability to relegate the other alternative forms of health care shows its productive power. In relation to this study, productive power is seen in the way meetings and deliberative processes are dominated by biomedical language, which also relegates other alternative forms of reasoning. For example, participants complained about their inability to rationalise beyond their biomedical knowledge. In addition, during observation of meetings, the overwhelming number of biomedical presentations is evidence of this biomedical dominance. Interestingly, participants were aware that what they understood to be superior knowledge was not working, but because alternative ways of reasoning have been relegated from the policy processes, the dominant (but underperforming) biomedical paradigm is reproduced in all the grant proposals. This finding is similar to the '*unconscious dogmatism*' described by Ooms (2015) that makes health actors believe that the way they view health is the only way (Ooms 2015:643). However, it is important to note that this productive power of the

biomedical discourse has been exploited by medical professionals in the way they use biomedical language to exclude other non-doctors actors from the policy process (section 6.2.2.2). Therefore, an argument can be made that this is a form of ‘stealth advocacy’ by medical professionals to maintain their relevance in policymaking rather than a form of ‘unconscious dogmatism’, which also benefits the medical professionals.

The structural power of the biomedical discourse can be seen in the way it favours a certain group of actors through the legitimisation of the occupational hierarchy in the health sector: *‘we see structural power at work in the existence of a cadre of individuals’* (Shiffman 2014:297). This is reflected in the literature review (section 2.6.1) and in the interview data whereby medical professionals occupy strategic clinical and administrative positions. They head TWG of government agencies that set the priorities for the health sector because as some of the participants mentioned, medical professionals are perceived in society to possess the superior biomedical knowledge to occupy those positions. From the interview data, this is also seen in other non-government health organisations and agencies leading to an influx of medical professionals into key strategic managerial positions. For example, the government of Nigeria recently appointed heads of the top health agencies in the public sector namely: Nigerian Institute for Medical Research (NIMR), National Agency for the Control of Aids (NACA), National Primary Health Care Development Agency (NPHCDA), Nigerian Centre for Disease Control (CDC) and National Health Insurance Scheme (NHIS). A nephrologist, microbiologist, paediatrician, epidemiologist, and another paediatrician filled these positions respectively. These professionals all have an undergraduate medical professional background and are career specialists in core-biomedical specialities but currently hold management positions in the core policymaking institutions in Nigeria. The appointment of a career paediatrician to head an organisation with predominantly management functions such as the NHIS shows

how management positions in the health sector are exclusively reserved for medical professionals.

The structural power of the biomedical discourse legitimises the positioning of biomedical experts i.e. medical professionals in those strategic positions. In relation to the CCM, the structural power of the biomedical discourse allows the RMC to be the most powerful structure in the CCM. As a result, biomedical experts who already occupy strategic positions in other influential organisations are selected to occupy this power positions, due to their expertise in biomedical knowledge. This uneven distribution of privileges is similar to the description of structural power by Barnett and Duvall (2005). This study shows us how this structural power can be used to dominate proceedings and instil the biomedical paradigm in the policy process. For example, when biomedical experts out-number other non-biomedical professionals it leads to a crowding out of the non-biomedical alternatives in addressing demand creation, seen in both interview and observational data (section 6.2.5). This thesis is important because it has shown how influential position and technical expertise in combination are a form of structural power. This is similar to the findings in a study of power in Tanzania: *'having the greatest amount of power in the agenda-setting process is increased by the ability to somehow combine influential position and technical expertise if you are not the one with the money.'* (Fischer & Strandberg-Larsen 2016:361). In this study, medical professional have been able to do this in the policy making process of the Global Fund, described in section 6.2.3.

Institutional power is seen *'through the rules and procedures that define those institutions'* (Barnett & Duvall 2005:51). Although, not mentioned by Shiffman (Shiffman 2015), institutional power is seen in this study and is a vital link between the global and local contexts during proposal writing. In this study, the prescriptive

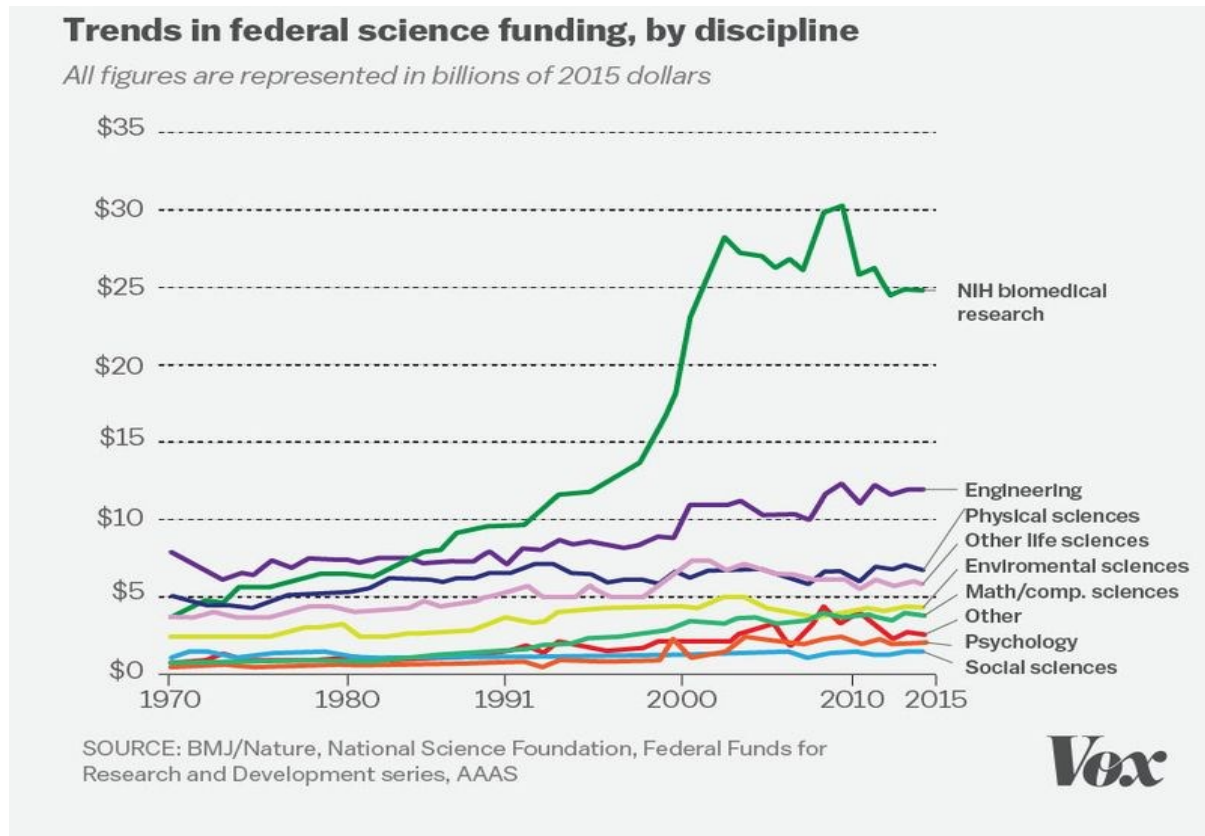
guidelines from the Global Fund and other similar organisations such as the WHO, reveal the institutional power of the biomedical paradigm in the form of guidelines that dictate the proposal writing process. The documentary and interview data highlight how these rigid prescriptive biomedical guidelines have made it difficult for other policy alternatives to be included into proposals, leading to a poor contextualisation of proposals. In addition, medical professionals have used these biomedical documents to argue that they are best qualified to understand the technicalities involved in deciphering the contents of the complex guidelines. Furthermore, medical professionals have used this institutional power in influencing the type of interventions that are selected to subdue other occupations and maintain their dominance in the health system. This is seen in section 6.4. In relation to global health research, Marten (2016) describes this as the use of *'indirect power'* because *'international institutions are designed to favour one actor over another'* (Marten 2016:208).

This relegation of the repressed interests in the processes has led to proposals that are prone to operational difficulties such as wastage of resources, and this can be referred to as an *'implementation gap'*. The *'implementation gap'* in these findings is similar to the findings in a systematic review of interventions in LMICs that identified the lack of contextualisation of interventions as a major cause of *'implementation gap'* (Haines et al. 2004). The paper concluded that for this to be avoided *'the strategy selected must be consistent with the local context and the behaviour to be targeted'* (Haines et al. 2004:729). Strict adherence to biomedical guidelines, as seen in this study, is a major concern to HPSR in LMICS because *'The lack of rigorous evaluations of implementation strategies, particularly in low-income countries, reflects in part the low priority accorded to health and systems research.'* (Haines et al. 2004:728). For example, in the USA biomedical research has the power to attract more research



funding than any other discipline in general (Belluz et al. 2015), which is seen in the table below:

**Figure 14: Showing trends of science funding in the USA (Belluz et al. 2015)**



However, it is important to note that not only medical professionals have been seen to use the institutional power of the biomedical paradigm. For example, studies have shown that corporations also take advantage of this power to influence policy (Buchholz 2005).

In summary, at the national level the biomedical paradigm has been diffused into the Nigerian system historically during colonial years, and is still being transmitted into the Nigerian health system through GHIs such as the Global Fund. The productive power, structural power and institutional power of the biomedical discourse have been found to favour medical professionals thereby ignoring other non-biomedical occupations. This study shows how biomedical power from the global level transmits itself to the local

level and unduly favours a particular profession. Sadly, this is also a reflection of the global level *'In HPSR...the dominant group of actors (in terms of both volume and influence) are those involved in the delivery of health services (primarily medical professionals)* (Sheikh et al. 2011:4).

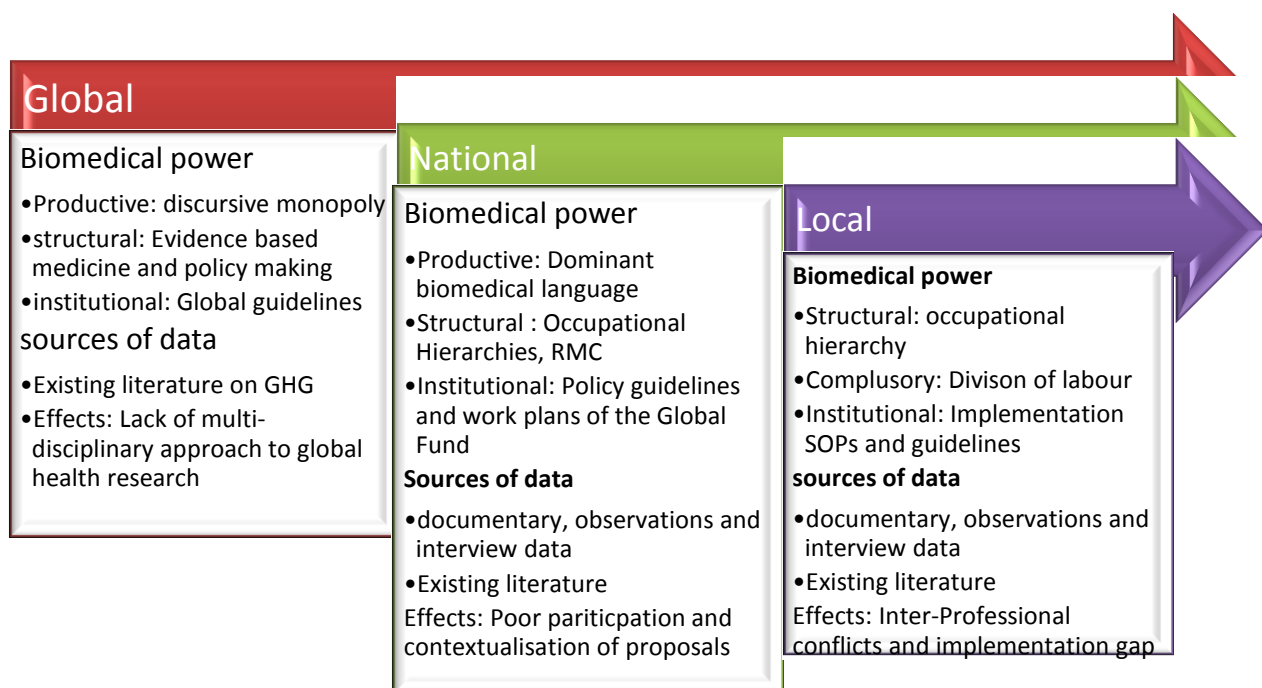
### **8.6.3 Local (micro)**

*'Compulsory power'* can also be seen in the power of division of labour. This is a more direct use of power, and evidence from both the literature and the accounts of participants showed that medical professionals are meant to delegate roles to other health occupations in the Nigerian health system. At the local level of implementation, the structural form of the biomedical discourse is most prominent. However, as discussed earlier, occupational hierarchies are an expression of structural power. Structural power at the implementation stage creates a *'framework of actors and their roles'*(Marten 2016:208) and in this study both public and private sector health organisations have placed medical professionals above other health professionals. This study adopted the 'street level bureaucrat' term to describe medical professionals because in the implementation phase they are the key factor in the dissemination of the programme and hence occupy a strategic position. This dispositional power has allowed them to dictate implementation according to the guidelines and work plans given to them. Participants describe this as a positive impact. Shiffman argues that not all power is negative but identifying power enables us to know when and how it is used and by whom (Shiffman 2014). However, he further states that *'good intentions and effectiveness are insufficient grounds for considering an actor or decision legitimate'*(Shiffman 2014:498). This point is important because the focus on the success of the programme can blind us to the injustice done to other health workers. The fact that medical professionals are able to understand the guidelines better than other

health workers does not make their monopoly of these strategic positions of structural power legitimate.

The unfair exclusion of other health workers from certain benefits enjoyed by medical professionals has been identified in this study as one of the major reasons for inter-professional conflicts. However, by tracing the structural power of the biomedical discourse from the global to the national and then local, these unequal distribution of power at the local level do not occur in isolation from other factors. The interaction of the global and national institutions that control the implementation phase involves a diffusion of biomedical power through the productive, structural and institutional forms of power, which favours medical professionals in the Nigerian context. This is captured in the diagram below. Therefore, this study reveals that *'participation is limited'* in the Global Fund policy process due to the various forms of biomedical power and this questions the fairness of the use of this power by medical professionals because *'legitimacy in the exercise of power comes from the consent of those subject to it'* (Bump 2015:395).

**Figure 15: Flow of the biomedical discourse from Global to Local**



An alternative way of understanding epistemic power in global health is by using Pierre Bourdieu's theory of forms of capital (Hanefeld & Walt 2015). Bourdieu argues that power can be derived from different sources in society in the form of economic, social, cultural, and symbolic capital (Bourdieu 1986). As it relates to this study, foreign donors through the Global Fund possess economic capital, while the biomedical epistemic community members possess cultural capital due to their academic qualifications. According to Hanefeld and Walt (2015), those who have knowledge and experience in a particular discipline possess cultural capital, which can be used by those with economic capital to produce '*evidence-based research translated into policy solutions*' (Hanefeld & Walt 2015:120). Although there are similarities that can be

drawn from Bourdieu's forms of capital in this study, and the forms of power, highlighting the forms of capital was beyond the scope of this thesis. Hence, Foucault's knowledge/power theory was preferred due to its focus on the relationship between discourse and power, which was explored in order to reveal its various forms. Future research, drawing on this study, can go further to explore the various forms of capital that contribute to the epistemic power revealed in this study.

## **8.7 Study limitations**

This section focuses on the efforts made to overcome the methodological challenges and limitations of this study. During the course of this study, some challenges and limitations were encountered which is common in most studies. The challenges encountered were due to the numerous uncertainties about the CCM context and processes, which were linked to the new Global Fund reforms of the proposal writing process.

A further revalidation of these interactions is necessary through a participatory process with stakeholders from this study to determine enforcing and re-enforcing loops of interactions. However, this can be a follow-up to the findings of this research and form the basis for further research.

Tracking participants and setting up interviews was the most time consuming effort during data collection. Before the field visit, this challenge was not envisioned. This resulted in appointment clashes and missed opportunities due to short interview notices. As I grew to understand the study environment mid-way into data collection, I was able to overcome this challenge through better negotiation skills in booking appointments, the use of intermediaries in setting up meetings and attending open door meetings in an attempt to meet prospective participants. In addition, during the pre-field visit planning

stage, an extra 1 month was added to the time on the field to mitigate for such time challenges.

Even though, the period of data collection coincided with a fresh proposal writing process, some participants at the start of interviews were wary about the objectives of the study. Although, it was made clear to the participants that this was an independent study, some participants were scared that information they divulged might be used against their organisation during the proposal writing process. During the course of the interviews upon realisation that no sensitive or damaging information was required, they began to express their views and not feel restrained. Nonetheless, obtaining minutes of meetings proved difficult because they felt some potentially damaging information contained in the meetings would expose some individuals and organisations to public scrutiny. This was even after repeated attempts to reassure them about confidentiality of the data management process employed in this thesis. Despite this limitation, the information from other online data sources such as past evaluations of the Nigerian CCM was robust enough to reduce the limitation of access to CCM meetings. In summary, despite the limitations discussed above, this study is robust and results are of a high quality and relevant.

## **8.8 Chapter summary**

This chapter, has discussed the research findings as they relate to the proposal writing process and implementation of the Global Fund grant in Nigeria. This thesis gives an in-depth exploration of the Nigerian setting by using multiple theories in studying the interaction between medical professionals and the Global Fund grant in Nigeria. In the process of exploring this interaction, relevant theories were used to identify the key actors in the Global Fund grant policy process and the type of interactions they have with each other. Alford's ideas about classifying actors into structural interests, aided in

identifying key actors in the Global Fund grant policy process. Medical professionals were identified as the dominant interest group due to their professional monopoly in the CCM, which is strongly linked to their established dominance over other health occupations in the Nigerian health system. Challenging interests were identified as the Global Fund and its other implementing partners. This is in agreement with Alford's theory about challenging interests, mainly because challenging interests use corporate rationalisation principles such as NPM that are in conflict with '*fundamental interests of professional monopolies*' (Alford 1975:13). The last group of key actors identified were the repressed structural interest category. This group is composed of non-clinical occupations, the patient population, and the CBOs, who are relegated to the background in the proposal writing process due to structural barriers that limit their participation, while protecting the interests of the dominant group. Furthermore, in the process of classifying the structural interests, it appears that dominant and challenging interests were interacting in synergy with the challenging interests using the dominant interests as drivers of the policy process, while favouring the dominant interests, to the detriment of repressed interests. This is crucial because it highlights some of the interests and power relationships between key health systems actors and further research from the perspective of political science and global health may be needed to determine ways in which repressed interests can become active participants of the policy process.

In turn, the work begins to reflect on the role medical professionals (dominant interest) play in the proposal writing and implementation of the Global Fund grant. The concepts of professional monopoly and street level bureaucrats were vital in exploring the role of medical professionals, and the flexibility of the HPSR approach accommodates the merging of these concepts from different disciplines. Professional monopoly theories help in explaining the reasons why medical professionals occupy an elite position in the health system. Various structural and agential factors specific to the Nigerian context

are key in maintaining this professional monopoly and these factors have limited the opportunities for other health occupations' rise up the social status ladder. The superior role medical professionals possess in the Nigerian health system makes them elites in the health policy process of the Global Fund, while the frontline medical professionals are positioned as street level bureaucrats. Professional monopoly by medical professionals has led to conflicts with other health occupations who attempt to expand their professional boundaries and encroach on the jurisdiction of medical professionals. Some of these encroachments seem to be aided by the influence of challenging interests such as the Global Fund due to their NPM strategies that attempt to motivate the efficiency of health workers and scale up health interventions in rural communities.

In light of this, it was possible to explore the contributions of medical professionals to the Global Fund policy development process. Theories on medical professional monopoly facilitated the examining of the strategic position medical professionals occupy in the Nigerian health system. The findings concur with the literature that medical professionals possess a monopoly, which makes them the main stakeholder driving the policy process. This was demonstrated in the proposal writing process, whereby medical professionals preferred biomedical strategies that seem to focus on supply strategies. This research was able to show that medical monopoly is related to biomedical dominance in the policy process. This effect of medical monopoly places more emphasis on biomedical strategies, thereby limiting the contextualisation of demand strategies in proposals. It appeared that medical professional monopoly at the proposal writing process had negative effects for the contextualisation of community demand strategies, while during implementation medical professionals had a positive influence as facilitators of the smooth running of the grant. Biomedical dominance of health strategies under the Global Fund grant seems to give medical professionals



epistemic power, which is a focus of some of their professional power in the policy process.

The findings from this study suggest that technical specifications and institutional procedures influence the opportunities medical professionals' have in participating, constructing proposals, and implementing the Global Fund grant. These technical specifications and institutional procedures are a result of dominant discourses within the Global Fund's structure, culminating in a hybrid of the biomedical and NPM discourse. The biomedical discourse amplifies the existing medical monopoly, whilst the NPM discourse retains the neo-liberal values of challenging interests. The subsequent effect of this hybrid is the creation of a local epistemic community of elite medical professionals who dominate the health policy space in the health system and epistemic power has been found to be central to their medical dominance. On the other hand, the NPM principles of the challenging interests have the potential to deprofessionalise the frontline medical professionals and reduce professional power at the implementation phase, while creating prestigious managerial roles for medical elites. Although NPM, through its job descriptions, appears to facilitate a reduction in occupational hierarchy in the health system, there are potential long-term destabilising implications to the health system from high-powered incentive structures and unofficial task shifting. Having presented the findings in the empirical chapters and having linked these to the wider existing literature in the discussion chapter, the following chapter provides a reflection upon the implications of this study for policy, practice, and future research. In addition, it provides some conclusions about my own thoughts on the process of carrying out this study.

## **Chapter 9**

### **Conclusions**

#### **9.1. Introduction**

The aim of this chapter is to present potential contributions this thesis makes to the academic body of literature and to the policies of Human Resources for Health. In the previous chapter, empirical findings of the research were aggregated and discussed according to themes, and linked to key topics within the existing literature. This chapter provides a reflective account of the findings, and the implications they have on policy and the wider literature.

Much of this thesis has focused on how NPM reduces the excessive powers of some medical professionals; on the other hand, a more serious issue highlighted is the negative effect these neo-liberal policies have on the Nigerian health system. On a more global scale, much of the literature has focused on how neoliberal policies have dominated the political and economic discourse leading to inequality and lack of accountability of big corporations (Rapley 2004). This study indicates that NPM principles have a similar effect in the Nigerian context because it appears that more power is given to top elites, which has increased the inequality between the elite and frontline medical professionals. Furthermore, this approach has fragmented the health system: the interests of the GHIs take precedence over other interests, leading to illegal practices such as unofficial task shifting which likely weaken the government's control of the health system. Furthermore, these activities show how GHIs have a lack of accountability to the local context and would rather focus on the accountability measures created by global actors. Findings in this thesis are a reflection of some of

what is happening in the wider international political economy, whereby global actions and actors influence local contexts.

In light of this argument, going forward, there needs to be recognition of the positives and negatives of NPM by all stakeholders in the Nigerian health system, in order to develop the positive purposes such as the accountability measure of job descriptions and diminish the more negatives ones such as incentives and PBF. The following sections highlight the careful considerations and possible policy options that would strengthen future HRH policies in Nigeria.

## **9.2. Contributions of the thesis to academic literature and research**

The potential contribution of this thesis is its multi-disciplinary approach, using theories and concepts from sociology, management, politics, and public health to explore patterns of professional power and influence in a previously under-researched area. As discussed in Chapter Two, studies have explored in depth professional monopoly in relation to health policy and politics, and how these relate to specific Western contexts, and these have resulted in concepts and ideas that improve our understanding of health professionals in Western settings. Given the poor quality of research on health professionals in LMICs (Chopra et al. 2008), this multi-disciplinary study has exposed potential areas of future research in the various disciplines in LMICs. In addition, this thesis is a practical example of how a multi-disciplinary approach can be used in studying health systems in LMICs. Future research can focus on one of the mechanism identified in various GHIs and government programmes in order to develop further the findings put forward in this thesis. In addition, the importance of issues highlighted in the health system, such as interests and power, can be researched in more detail, which would give more insight as to why many Western-styled health reforms fail in LMICs such as Nigeria (Sheikh & Porter 2010).

The narrative literature review approach, used in this thesis, presented the trends and historical progression of the theories accumulated in the existing literature about professionals. Both local and global contexts are important in modern public health research (McMichael & Beaglehole 2000; Krumeich & Meershoek 2014), which is why this thesis gave an overview of all the concepts and modifications of existing concepts in order to give the reader a deeper understanding of how the relevant concepts have evolved over-time. The benefit of this approach is that it provides the researcher with a range of alternative theories to select from in the initial understanding of the problem. By so doing, this study was able to link the appropriate theories (from the range of existing theories) with the methodology, in order to use a theory-driven approach in analysing the results. The importance of this theory-driven approach to the field of HPSR is that it improves our understanding of existing theories in the context of LMICs, and creates a theoretical platform that can be used to inform further studies in LMICs.

In the study of HRH in LMICs, there are knowledge gaps and the quality of the existing literature has been unable to provide a basis for more in-depth explanations about the HRH deficiencies in these countries (Ranson et al. 2010; Adam & Ghaffar 2011). Most research about HRH in LMICs has not been able to generate research priorities that are of relevance to strengthening HRH, with most of the data coming from developed settings (Ranson et al. 2010). This research has focused on answering questions that are of high research priority to key stakeholders of the health system. The reflexive approach of this thesis enabled a constant review of the literature that was relevant to the themes generated from interviews with the participants.

Finally, because HPSR is a relatively new field compared to other disciplines, innovative ideas are important in encouraging the methodological dialogue in the field of HPSR (Bennett et al. 2011). This study uses a causal loop diagram from systems

thinking, in presenting the conclusions of this study. By so doing, this research has creatively conceptualised the findings, which adds to the ongoing methodological dialogue in the field of HPSR.

### **9.3. Contributions of the thesis to policy and practice**

This section focuses on the implications this thesis has for HRH polices and the wider health systems field. The power of medical professionals in the health system and their ability to control the system is a barrier to the much needed health reforms; therefore, this has implications for policy. The government needs to strengthen its regulatory power in order to promote legislation that would reduce the medical professions' barriers on management positions which has relegated non-doctor health workers to the background in decision-making. The first action needed to tackle this barrier would be to create job descriptions for administrative positions that are reflective of the competences needed in the available roles in the health system. By adopting a culture of good practice and transparency in organisational structures, recruitment and promotion processes via clear job descriptions, the government will be able to create laws that separate clinical and administrative career paths. This will enable other non-doctor occupations to apply for administrative roles through a fair and competitive process rather than the existing occupational hierarchy as seen in other healthcare settings (Paliwal et al. 2015). Clear job descriptions in this type of transparent processes do not necessarily have to be linked to PBF (which is more genuinely a characteristic of NPM thinking).

Furthermore, the government needs to harmonise the task shifting laws used by GHIs and the existing government laws on task shifting. A unified task shifting law with clear algorithms showing alternative pathways for job sharing when facilities are under staffed and during emergencies would make it easy and safe for health workers to

implement (Katende & Donnelly 2016). In order to accomplish this, the task shifting roles should be confined to specific simple roles that are important in improving scale-up of health service dissemination, while being sensitive and fair to all occupational boundaries. Tasks that can be rotated among all the cadres of the health workforce include: rapid screening tests for malaria and HIV, dispensing of ART refills (Fairall et al. 2012), administration of vaccines, diagnosis, and treatment of common illness such as diarrhoea, malnutrition, malaria and family planning activities (Smith et al. 2014). Task shifting should only be implemented during emergencies, whereby there is a shortage of the higher cadre staff in a health facility. The government and GHIs should put in place safeguards such as regular inspections to monitor quality of care and ensure that all health workers are competent in the roles that would be task shifted to them (WHO 2007). This would require the creation of a government-funded agency that would be independent of the politics of the FMOH led by patient groups, CSOs and CBOs, with the sole purpose of inspecting the quality of care in health facilities. They should also be empowered with the authority to impose some form of sanctions on defaulting health centres.

In addition, policy spaces have to be opened up in order to allow active participation of repressed interests that represent both the patient population and other non-clinical professions. This would only be possible by making health policy-making truly multi-sectoral through sensitisation of the non-health sector (UN 2013) and the removal of structural barriers put in place to protect the jurisdiction of dominant professional monopolies (Morgan 1998). Among the possible actions would be to ensure all policy deliberations are advertised well in advance and early invitations are given to relevant stakeholders. Rotation of facilitator and leadership positions during policy-making meetings among all stakeholders will give the non-clinical stakeholders an opportunity to influence proceedings, thereby promoting participation of repressed interests. In

addition, these repressed interests need financial empowerment from both government and non-government bodies, in order to bridge the economic barrier between them and their well-paid medical professional counterparts. One important initial step towards this empowerment identified from the findings would be more investment in social science operational research and this is suggested by other authors (Gilson et al. 2011).

Researchers have suggested a multi-sectoral approach to health planning (Shakarishvili et al. 2011; Booth 2012; Spicer et al. 2010) and some other researchers have recommended an inter-disciplinary approach in research and policy formulation as a means to achieving holistic system-wide health strategies (Ooms 2014; Gilson 2012; World Health Organization 2006; The Joint Learning Initiative 2004; Russell et al. 2014). This approach has been successful in some settings but this was largely due to the system-wide structural reforms put in place by the government (Whitfield 2008). According to Brown (2009), *'However, one consistent critique of the CCM process is that there are few structural safeguards to guarantee that the CCM process is in all cases multi-sectoral'* (Brown 2009:172). This implies that more efforts must be put in place to ensure inter-disciplinary participation because as seen in other contexts, existing hierarchies can capitalise on these multi-sectoral platforms to enhance their influence in the system (Kapilashrami & McPake 2012). Firstly, the Global Fund needs to identify specifically the right mix of professionals that would be representative of the multiple disciplines needed in each committee of the CCM. Secondly, the Global Fund has to ensure that the committees in the CCM are constantly re-constituted with fresh competent members at regular intervals in a manner that would not disrupt the continuity of the aims and objectives, but will ensure an inter-disciplinary participation. This will reduce the powers of a few elite professionals and will make the composition of the committees sensitive to the exact expertise needed at any given point in time. In addition, the Global Fund has to go beyond funding biomedical operational research but

should also fund HPSR that use theoretical and methodological approaches from different fields (Remme et al. 2010). On the part of the government and other global health actors, academic institutions need strengthening so that they can produce context specific and innovative inter-disciplinary HPSR relevant to policy and practice, in order to avoid a biomedical disciplinary capture of the field HPSR (Sheikh et al. 2011).

As evident in this thesis, local epistemic communities can potentially limit the contextualisation of national health policies, thereby making health policies insensitive to existing realities. GHIs and national government need to understand how these epistemic communities operate in order to create safeguards in policy reforms that would ensure multi-sectorial and inter-disciplinary decision-making (S. Dalglish et al. 2015).

New Public Management is a school of thought, which is widely used in Western contexts with countries adopting '*various elements in different ways*' (Pollitt & Bouckaert 2004:3). For this reason, NPM strategies must be incorporated into national health reforms, if not, they could potentially weaken the health system with funds that were allocated to strengthen the health system (Buse & Tanaka 2011). Findings from this study have shown that more studies are needed to focus on the various forms of NPM applicable to the Nigerian context. Most importantly, the government needs to understand the importance of taking up the role of being the sole purchaser of health services on behalf of all GHIs operating in Nigeria. GHIs funds when channelled through the government would be given to providers of healthcare such as NGOs, government agencies and facilities, who will be guided by a uniform set of PBF conditions and incentives (Smith & Hanson 2011). This would stop the parallel incentive structures and competition between GHIs, while still maintaining competition between health service providers. The basket-funding model is now tested in other Sub-



Saharan countries, which Nigerian policy makers can learn from (Hobbs 2001). In addition, a uniform NPM policy applicable to all GHI funds would enable the government and researchers study the impact of NPM on the health system and make appropriate adjustments. This process could lead to the creation of a template for an NPM version that is unique to the Nigerian context. In the current form of parallel and fragmented management styles and duplication, it is difficult to trace the impact of the various interventions.

Significantly, this study presents empirical evidence of some of the qualities medical street-level bureaucrats have in the health system that makes them so important and further research is needed to fully explore this role. With most global health actors focused on decentralisation of care in both LMICs settings, competencies that are unique to the medical professionals that make them effective in carrying out these roles can be introduced into the curriculum of other health professionals. In so doing, GHIs and local governments will not be limited by the lack of availability of medical professionals but will instead create a workforce that can effectively and efficiently compliment medical professionals.

#### **9.4 Concluding reflection on the thesis**

The research question and topic arose from my personal interest in HRH and from my insider experience in both the context of Nigeria and the Global Fund programmes. This is a reflection of how a novice researcher can draw from their background knowledge and position in order to identify a topic of interest.

In relation to my thesis, my personal experience helped in two ways. First, having mapped out the existing literature and gaps in this literature, I was able to use my background knowledge and experience to narrow down research questions and to access how I would be able to accomplish these objectives. Secondly, being new to non-

biomedical research without having any disciplinary preference (aside from my biomedical background), I was able to identify disciplines such as sociology that would help me in exploring the research question. In addition, this enabled me to situate the findings in fields that were relevant to the findings such as global health and HPSR.

As a medical doctor with a biomedical background, I had to unlearn my positivist inclinations to be able to be a critical realist. The context in SchaRR was vital in this process because this type of standpoint is uncommon in the institution in which I was a lecturer. From my experience, the field of public health in Nigeria is dominated by clinical biomedical research while qualitative research is usually relegated to the background; even if qualitative research is used, it is done so in the context of a mixed research methods research design. However, over the years I have come to see more qualitative public health research from Nigerian authors, which may be an indication of a growing acceptance of qualitative social science research in the field of public health in LMICs.

During analysis of the findings due to the detailed and in-depth nature of the evidence from the data, my knowledge and position had little impact on the findings and on discussion or interpretation. This is because in total I spent only 3 years in Nigeria as a medical doctor in a junior position, while I have actually spent more time in the UK post-medical school, as both a Masters and Phd student and then as a junior medical doctor. Even though my position helped in gaining access and shaping my research questions, it had little impact in affecting conclusions made from the findings. My limited exposure to the Nigerian health system as a medical doctor was not as informative, detailed and precise as the evidence acquired from the informant interviews and observations.

Finally, due to the multidisciplinary approach of this study, it was difficult to situate this research using one particular theory or perspective. Hence I attempted to draw on multiple fields such as global health, sociology, management, HPSR and politics (in relation to power). This has exposed me to the difficulties in carrying out and presenting a multi-disciplinary study. However, the pros of this approach far outweigh the difficulties encountered. Perhaps in future studies I would be more inclined to drawing on expertise from a wider multi-disciplinary team, in order to build on the experience gained with my own Phd research.

## **9.5. Concluding remarks**

In this thesis, I have attempted to provide evidence about the interactions of medical professionals and GHIs in the context of a LMIC. This thesis has illustrated how progressive initiatives of private-public partnerships GHIs can interact with a select group of health professionals, leading to a sequence of system-wide effects, which are not easily detected by the regular monitoring and evaluation indices of global health partners. In addition, this study reveals the structural and contextual factors that are specific to Nigeria by providing illustrations of how these interact to cause system-wide effects.

In conclusion, this study contributes to the field of HPSR by highlighting the importance of unearthing country-specific dynamics in LMICs that are relevant to evidence-based policymaking. Furthermore, this study draws attention to the importance of research that investigate theoretical models in various contexts of LMICs, rather than generating universal conclusions drawn from Western developed settings. Transferring Western policy reforms to LMIC contexts can lead to unforeseen challenges and consequences.

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## Appendices

### Appendix 1: Interview guide

Date: \_\_\_\_\_ Interviewer: \_\_\_\_\_ Location: \_\_\_\_\_

Code for Participant: \_\_\_\_\_

#### 1. Background information

- a. What sector does your organization belong to? ( NGO, CSO, Public, Private)
- b. How long have you been in your current position?
- c. What part of the CCM Global Fund project do staffs of your organization undertake in connection with the Global Fund? (proposal writing, evaluation, implementation and decision making)
- d. What types of activities does your organisation do? (proposal writing, evaluation, implementation and decision making)
- e. What is the level of your involvement in the affairs of the Global Fund proposal process and implementation? ( member, principal recipient or sub-recipient)

#### 2. Issues around actors involvement

- a. From which professions do GF programmes draw their workforce?
- b. Can you tell me the types of people involved in the proposal process?
  - i. For example, what mix of professional backgrounds is involved?

- c. Who has most influence in the proposal-writing process?
  - i. Has this been a consistent picture, or have there been changes over time? Please give examples.
- d. Are there any professional groups or individuals who you feel should be included, but who are not involved? Please give examples.
- e. If there are significant differences of opinion, how are these resolved?

### 3. Implementing issues

- a. Who has most influence over the implementation of the grant policies?
- b. How do they exercise their influence?
- c. How do you think this group (or these groups) became influential?
- d. Are there any specific aspects of the policy implementation that they influence?
- e. What part do medical doctors play in implementation?
  - i. Do they favour any particular part of the implementation?
  - ii. Are there any particular reasons for this?
  - iii. What impact do medical doctors have on the effectiveness of the implementation process?

### 4. Looking ahead

- a. Any new possible changes that can affect dominant or less dominant professionals?
- b. Would you like to see the proposal process improved in any way?
- c. If so how can this be achieved?

### 5. Conclusion

- a. Any comments or questions?
- b. Would you like to see the findings of the research?

## Appendix 2: Consent form for Key informant Interviews

Title of Research Project: Exploring the interactions between medical professionals and Global health initiatives in the Nigerian health system: A case study of the Global Fund grant in Nigeria

Name of Researcher:

**Participant Identification Number for this project:**

**Please initial box**

1. I confirm that I have read and understand the information sheet  
dated [            ] explaining the above research project  
and I have had the opportunity to ask questions about the project.

2. I understand that my participation is voluntary and that I am free to withdraw  
at any time within one month of the interview without giving any reason

and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline.

3. I understand that my responses will be kept strictly confidential.

I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.

4. I agree for the data collected from me to be used in future research

5. I agree to take part in the above research project.

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Name of Participant

Date

Signature

*(or legal representative)*

---

Name of person taking consent

Date

Signature

*(if different from lead researcher)*

*To be signed and dated in presence of the participant*

---

Lead Researcher

Date

Signature

*To be signed and dated in presence of the participant*

## **Appendix 3: Information sheet for key informant interviews**

### **Interviews with governmental and non-governmental officials/cadres**

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part. Thank you for reading this.

#### **Research Project Title:**

Exploring the interactions between medical professionals and Global health initiatives in the Nigerian health system: A case study of the Global Fund grant in Nigeria

#### **What is the project's purpose?**

The purpose of this research is to gather an evidence base and provide in-depth understanding of how medical professionals interact with other stakeholders in the proposal writing process of the Global Fund grant. The aim of the study is to understand how key stakeholders are involved in the process in the context of Nigeria. The overall purpose is to develop entry points, policy options, and recommendations for human resources of health system strengthening.

#### **What you will do in this research:**

You are being asked to participate in a semi-structured interview that includes a series of open-ended questions regarding medical professionals in the health system. This will involve the use of questions pertaining to your experience in writing proposals, decision-making, and implementation of the Global Fund grant and your perception of current gaps within the health system.

### **Why have I been chosen?**

You have been chosen because of your active involvement in the policy process of the Global Fund grant and your experience in being a stakeholder in this policy process from proposal writing to the implementation process.

### **What will happen to me if I take part?**

If you wish to take part in the study, you will be interviewed for 40 minutes. This interview will be recorded on an audio recorded which will be totally anonymous and you will be asked a few question about the Global Fund grant.

### **Time required:**

Participation will take up to 40 minutes to complete.

### **Risks:**

There are no anticipated risks associated with participating in this study. All information that can be self-identifiable will be excluded and removed from the study and all interviews are completely anonymous.

### **Benefits:**

At the end of the study, we will provide the results of the study and recommendations. Results will be validated and used to provide further inputs to improve participation and delivery of health services. If you wish to see the results of this study, you may send an email message to Dr Samuel Lassa ([cmp08sl@shef.ac.uk](mailto:cmp08sl@shef.ac.uk)) and a copy of any manuscripts based on the research once completed will be sent to you.

### **Participation and withdrawal**

Your participation in this study is voluntary, and you may withdraw at any time within one month of the interview without penalty. You may withdraw by informing the interviewer that

you no longer wish to participate, and no further questions would be asked. Should you agree to participate, we would like to record the interview and have it transcribed to aid our analysis. However, you are free to indicate that you would prefer the interview not to be recorded, in which case the interviewer will take hand-written notes during the course of the interview.

### **Confidentiality and attribution:**

Access to interview material will be available only to researchers directly involved in the project, Dr Samuel Lassa, Dr Jenny Owen and Dr Julie Balen. All interview material, including recordings, will be destroyed 6 years after the interviews.

We wish to make all information about interviews anonymous; we will ensure that your identity is anonymised by not taking information about your place of work, your name or anyone you maybe referring to in the interview. In the interview, there will be no mention of your name, the organisation you work with or your position in the organisation.

Where necessary, we may ask for links to other groups or members of these groups to be interviewed and these people will be contacted by you and not by any member of the research team. You may choose to render this link available to us or decline.

You may discuss these issues with the interviewer prior to the commencement of the interview, where any questions you have can be answered and your concerns clarified.

### **How will the recorded media be used?**

The audio recordings during this research will be used only for analysis and for illustrations in conference presentations and lectures. No other use will be made of them without your written permission, and no one outside the project will be allowed access to the original recordings.

### **What if I have a complaint?**

If you have a complaint about how the researcher has treated you, a complaint can be made to the lead supervisor through the details below:



Dr Jenny Owen,

School of Health and Related Research (ScHARR)

University of Sheffield

Regent Court

30 Regent Street

Sheffield

S1 4DA

Office: Room 2021, 2nd Floor

Tel: (+44) (0) 114 222 0849

Fax: (+44) (0) 114 222 0749

email : [j.m.owen@sheffield.ac.uk](mailto:j.m.owen@sheffield.ac.uk)

If you feel the above supervisor has not properly handled your complaint, you can further contact the University Registrar or Secretary:

Office of the Registrar and Secretary

Firth Court

Western Bank

Sheffield

S10 2TN

Telephone: 0114 222 1100

Fax: 0114 222 1103

email : [registrar@sheffield.ac.uk](mailto:registrar@sheffield.ac.uk)

### **Who is organising and funding the research?**

No organisation or individual is funding this research. This research is purely for academic purposes and is not obligated to any organisation or institution.

### **Who has ethically reviewed the project?**

This project has been ethically approved via School of Health and Related Research of the University of Sheffield ethics review procedure .The University's Research Ethics Committee

monitors the application and delivery of the University's Ethics Review Procedure across the University.

Ethics approval has also been gained from the Federal Ministry of Health to conduct this study through the University of Jos, Nigeria.

### **Contact for further information**

Dr Samuel Lassa,

School of Health and Related Research (SchARR)

University of Sheffield

Regent Court

30 Regent Street

Sheffield

S1 4DA

Office: Room 2021, 2nd Floor

Tel: (+44) (0) 114 222 6381

Mobile: (+44) (0) 7446891184

Fax: (+44) (0) 114 222 0749

email : [j.m.owen@sheffield.ac.uk](mailto:j.m.owen@sheffield.ac.uk)

*Finally, you will be given a copy of this information sheet and a copy of the signed consent form to keep.*

*Thank you for taking part in this project.*

## Appendix 4: Ethics approval, University of Sheffield



Kirsty Woodhead  
Ethics Committee Administrator

Regent Court  
30 Regent Street  
Sheffield S1 4DA  
Telephone: +44 (0) 114 2225453  
Fax: +44 (0) 114 272 4095 (non confidential)  
Email: k.woodhead@sheffield.ac.uk

Our ref: 0697/KW

3 January 2014

Samuel Lassa  
SchARR

Dear Samuel

**Exploring the interactions between medical professionals and Global health initiatives in the Nigerian health system: A case study of the Health Systems Strengthening (HSS) initiative of the Global Fund in Nigeria.**

Thank you for submitting the above research project for approval by the SchARR Research Ethics Committee. On behalf of the University Chair of Ethics who reviewed your project, I am pleased to inform you that on 03 January 2014 the project was approved on ethics grounds, on the basis that you will adhere to the documents that you submitted for ethics review.

The research must be conducted within the requirements of the hosting/employing organisation or the organisation where the research is being undertaken. You are also required to ensure that you meet any research ethics and governance requirements in the country in which you are researching. It is your responsibility to find out what these are.

If during the course of the project you need to deviate significantly from the documents you submitted for review, please inform me since written approval will be required. Please also inform me should you decide to terminate the project prematurely.

Yours sincerely

A handwritten signature in black ink, appearing to read 'K. Woodhead'.

**Kirsty Woodhead**  
Ethics Committee Administrator

## Appendix 5: Letter of consent and approval from CCM Nigeria to undertake research



Country Coordinating Mechanism (CCM) Nigeria  
Investing in our Future



### The Global Fund To Fight AIDS, Tuberculosis and Malaria

**LOCATION:** Federal Secretariat Complex Phase 1

**OFFICE:** Annex 1A, 2nd Floor, Rooms 2.79-2.85, 2.87-2.93, Shehu Shagari Way, Garki - Abuja, Nigeria

Phone: +234-7098823379, +234-7098823386

e-mail: [ccmnigeria@gmail.com](mailto:ccmnigeria@gmail.com), Website: [www.ccmnigeria.org](http://www.ccmnigeria.org)

31<sup>st</sup> January, 2014

#### TO WHOM IT MAY CONCERN

The bearer is **Dr. Samuel Lassa** a student of the University of Sheffield, UK, undergoing his Ph.D in Public Health and also a Lecturer in the University of Jos, Nigeria, department of Public Health, currently on study leave. He has previously worked with in NACA (National Agency for the Control of AIDS) under the Global Fund Unit as Program Officer for Round 9.

In line with the requirement of his institution, he is embarking on a study 'exploring the interactions between medical professionals and global health initiatives in the Nigerian health system: A case study of the Health Systems Strengthening (HSS) initiative of the Global Fund in Nigeria'.

The study is aimed at generating an improved understanding of the interactions that medical professionals have with others in the proposal writing and implementation of Global Fund Health Systems Strengthening programmes.

The methodology will be interviews, administration of questionnaire and review of records.

In view of the above, you are kindly requested to accord the bearer necessary support.

Please do not hesitate to contact me if you have any question(s) or further clarification.

Yours sincerely,

Dr. FW Bello  
Executive Secretary

## Appendix 6: Summary of themes from interviews and observational data

| Name                                 | Sources | References | Created On          | Created By | Modified On         | Modified By |
|--------------------------------------|---------|------------|---------------------|------------|---------------------|-------------|
| <b>Global Fund Structure And CCM</b> | 0       | 0          | 20/11/2014<br>17:16 | SL         | 24/03/2015<br>14:04 | SL          |
| Composition Of CCM Participants      | 4       | 6          | 20/11/2014<br>17:16 | SL         | 25/03/2015<br>19:16 | SL          |
| CCM Dictates Content Of Proposal     | 4       | 4          | 20/11/2014<br>17:16 | SL         | 25/03/2015<br>19:16 | SL          |
| CCM Roles                            | 3       | 4          | 20/11/2014<br>17:16 | SL         | 25/03/2015<br>19:15 | SL          |
| CCM Secretariat                      | 1       | 1          | 20/11/2014<br>17:16 | SL         | 23/10/2014<br>15:17 | SL          |
| Weak CCM                             | 2       | 4          | 20/11/2014<br>17:16 | SL         | 21/10/2014<br>16:57 | SL          |
| Funding Framework                    | 1       | 1          | 20/11/2014<br>17:16 | SL         | 31/10/2014<br>18:46 | SL          |
| Counterpart Funding                  | 7       | 7          | 20/11/2014<br>17:16 | SL         | 22/10/2014<br>14:49 | SL          |
| GF Funding Gaps                      | 6       | 6          | 20/11/2014<br>17:16 | SL         | 17/10/2014<br>15:16 | SL          |
| Programme Sustainability             | 4       | 5          | 20/11/2014<br>17:16 | SL         | 26/03/2015<br>15:35 | SL          |
| GF Compared To Other                 | 0       | 0          | 20/11/2014          | SL         | 31/10/2014          | SL          |

| Partners                           |    |    | 17:16               |    | 18:52               |    |
|------------------------------------|----|----|---------------------|----|---------------------|----|
| GF Versus PEPFAR Grants            | 10 | 15 | 20/11/2014<br>17:16 | SL | 22/10/2014<br>18:55 | SL |
| PEPFAR Cushioning GF Grants        | 4  | 4  | 20/11/2014<br>17:16 | SL | 23/10/2014<br>15:17 | SL |
| Improve Management At GF Level     | 2  | 3  | 20/11/2014<br>17:16 | SL | 21/10/2014<br>18:51 | SL |
| Rationalization Process            | 4  | 6  | 20/11/2014<br>17:16 | SL | 26/03/2015<br>19:11 | SL |
| Top-Down Approach                  | 2  | 2  | 20/11/2014<br>17:16 | SL | 14/10/2014<br>17:26 | SL |
| Vertical Programming               | 5  | 6  | 20/11/2014<br>17:16 | SL | 03/03/2015<br>18:33 | SL |
| Basket Funding                     | 2  | 2  | 20/11/2014<br>17:16 | SL | 04/11/2014<br>16:53 | SL |
| New Funding Model                  | 5  | 5  | 20/11/2014<br>17:16 | SL | 31/10/2014<br>19:08 | SL |
| Experience From Previous Grants    | 2  | 2  | 08/04/2015<br>15:29 | SL | 16/10/2014<br>18:31 | SL |
| In Country Global Fund Involvement | 1  | 3  | 08/04/2015<br>15:29 | SL | 21/11/2014<br>17:14 | SL |
| More Room For Dialogue With GF     | 8  | 9  | 08/04/2015<br>15:29 | SL | 22/11/2014<br>13:11 | SL |
| Open To Feedback                   | 2  | 2  | 08/04/2015<br>15:29 | SL | 14/10/2014<br>16:18 | SL |
| Prescriptive Process               | 12 | 15 | 20/11/2014<br>17:16 | SL | 20/11/2014<br>18:21 | SL |

|   |   |    |                     |    |                     |    |
|---|---|----|---------------------|----|---------------------|----|
| Balancing Accountability And Flexibility  | 3 | 3  | 20/11/2014<br>17:16 | SL | 27/03/2015<br>13:31 | SL |
| Becoming More Prescriptive                | 6 | 8  | 20/11/2014<br>17:16 | SL | 24/03/2015<br>19:35 | SL |
| Demand Generation Was Prescriptive        | 1 | 1  | 20/11/2014<br>17:16 | SL | 24/03/2015<br>19:35 | SL |
| Difficult Work plans                      | 2 | 2  | 20/11/2014<br>17:16 | SL | 21/11/2014<br>16:39 | SL |
| Exceptions Made By GF                     | 3 | 5  | 20/11/2014<br>17:16 | SL | 13/10/2014<br>20:07 | SL |
| NGO Rule                                  | 1 | 1  | 20/11/2014<br>17:16 | SL | 13/10/2014<br>20:09 | SL |
| Flexibility In Implementation             | 8 | 11 | 20/11/2014<br>17:16 | SL | 25/03/2015<br>15:18 | SL |
| No Bio-Medical Preference                 | 2 | 3  | 20/11/2014<br>17:16 | SL | 16/10/2014<br>20:31 | SL |
| Prescriptive Guidelines Of WHO And UNAIDS | 2 | 3  | 20/11/2014<br>17:16 | SL | 04/11/2014<br>16:10 | SL |
| Priority Setting                          | 1 | 1  | 20/11/2014<br>17:16 | SL | 08/10/2014<br>15:13 | SL |
| Quantitative Preference                   | 1 | 1  | 20/11/2014<br>17:16 | SL | 23/10/2014<br>18:42 | SL |
| Proposal Process                          | 0 | 0  | 20/11/2014<br>17:16 | SL | 31/10/2014<br>18:59 | SL |
| Adherence To Minimum Service Package      | 3 | 3  | 20/11/2014<br>17:16 | SL | 22/10/2014<br>15:07 | SL |

|   |   |   |                     |    |                     |    |
|---|---|---|---------------------|----|---------------------|----|
| Challenges Of Proposal Writing Schedule           | 5 | 6 | 20/11/2014<br>17:16 | SL | 14/10/2014<br>19:43 | SL |
| Need To Have Proper National Strategic Guidelines | 1 | 1 | 20/11/2014<br>17:16 | SL | 23/10/2014<br>16:49 | SL |
| Politics  | 1 | 1 | 20/11/2014<br>17:16 | SL | 23/10/2014<br>16:52 | SL |
| Short Time For Proposal Process                   | 6 | 7 | 20/11/2014<br>17:16 | SL | 23/10/2014<br>17:39 | SL |
| Unstable Political Environment                    | 1 | 1 | 20/11/2014<br>17:16 | SL | 14/10/2014<br>15:46 | SL |
| Disorganised NACA                                 | 3 | 6 | 20/11/2014<br>17:16 | SL | 21/11/2014<br>14:29 | SL |
| GF Quality Of Service                             | 2 | 2 | 20/11/2014<br>17:16 | SL | 22/10/2014<br>15:22 | SL |
| NACA Influence                                    | 6 | 7 | 20/11/2014<br>17:16 | SL | 21/11/2014<br>14:22 | SL |
| Proposal Writing Done In Stages                   | 1 | 2 | 20/11/2014<br>17:16 | SL | 14/10/2014<br>18:25 | SL |
| Role Of Consultants In Proposal Writing           | 7 | 8 | 20/11/2014<br>17:16 | SL | 21/11/2014<br>12:10 | SL |
| Resource Mobilization Committee                   | 4 | 4 | 20/11/2014<br>17:16 | SL | 21/11/2014<br>17:01 | SL |
| PR Selection                                      | 5 | 5 | 20/11/2014<br>17:16 | SL | 21/11/2014<br>17:01 | SL |
| PR Selection Professionals                        | 1 | 1 | 20/11/2014<br>17:16 | SL | 08/08/2014<br>19:07 | SL |



|                                  |    |    |                     |    |                     |    |
|----------------------------------|----|----|---------------------|----|---------------------|----|
| RMC Attendance                   | 1  | 2  | 20/11/2014<br>17:16 | SL | 08/08/2014<br>19:12 | SL |
| RMC Having Final Say             | 3  | 4  | 20/11/2014<br>17:16 | SL | 21/10/2014<br>19:26 | SL |
| <b>Informant Background</b>      | 0  | 0  | 20/11/2014<br>17:16 | SL | 22/11/2014<br>13:11 | SL |
| Sector Worked In                 | 33 | 35 | 20/11/2014<br>17:16 | SL | 21/11/2014<br>12:28 | SL |
| Level Of Involvement             | 23 | 23 | 20/11/2014<br>17:16 | SL | 23/10/2014<br>16:55 | SL |
| Type Of Activities               | 29 | 32 | 20/11/2014<br>17:16 | SL | 23/10/2014<br>17:54 | SL |
| WHO Not Implementing             | 2  | 3  | 20/11/2014<br>17:16 | SL | 15/08/2014<br>17:23 | SL |
| Work Experience                  | 31 | 33 | 20/11/2014<br>17:16 | SL | 23/10/2014<br>16:55 | SL |
| Staffing                         | 16 | 18 | 20/11/2014<br>17:16 | SL | 23/10/2014<br>16:55 | SL |
| Ideal GF Workforce               | 1  | 1  | 20/11/2014<br>17:16 | SL | 08/10/2014<br>14:32 | SL |
| NACA Growth In Workforce         | 1  | 1  | 20/11/2014<br>17:16 | SL | 08/10/2014<br>14:58 | SL |
| Public Health Background         | 3  | 3  | 20/11/2014<br>17:16 | SL | 16/10/2014<br>14:43 | SL |
| Skill Mix                        | 20 | 23 | 20/11/2014<br>17:16 | SL | 22/11/2014<br>13:10 | SL |
| <b>Professional Dominance In</b> | 26 | 39 | 20/11/2014          | SL | 26/11/2014          | SL |

| <b>Proposal Writing</b>                       |    |    | 17:16               |    | 17:36               |    |
|---|----|----|---------------------|----|---------------------|----|
| Different Perspectives In Proposal Writing    | 0  | 0  | 20/11/2014<br>17:16 | SL | 30/10/2014<br>19:54 | SL |
| Conflicts Caused By Professional Background   | 6  | 8  | 20/11/2014<br>17:16 | SL | 22/10/2014<br>14:46 | SL |
| Different Perspectives In Proposal Writing    | 2  | 2  | 20/11/2014<br>17:16 | SL | 22/10/2014<br>18:37 | SL |
| Influence Based On Area                       | 1  | 1  | 20/11/2014<br>17:16 | SL | 06/10/2014<br>16:08 | SL |
| Professional Conflicts                        | 8  | 8  | 20/11/2014<br>17:16 | SL | 21/10/2014<br>18:42 | SL |
| Team Spirit                                   | 4  | 5  | 20/11/2014<br>17:16 | SL | 22/10/2014<br>17:33 | SL |
| Team Work                                     | 3  | 3  | 20/11/2014<br>17:16 | SL | 15/10/2014<br>19:27 | SL |
| Doctors Influence In Proposal Writing         | 18 | 24 | 20/11/2014<br>17:16 | SL | 19/02/2015<br>18:51 | SL |
| Doctor Dominance In The Overall Health System | 14 | 28 | 20/11/2014<br>17:16 | SL | 26/11/2014<br>16:02 | SL |
| Effects Of Doctor Dominance                   | 20 | 40 | 20/11/2014<br>17:16 | SL | 26/11/2014<br>16:05 | SL |
| Process Driven By Same People                 | 1  | 1  | 20/11/2014<br>17:16 | SL | 21/10/2014<br>17:27 | SL |

|   |    |    |                     |    |                     |    |
|---|----|----|---------------------|----|---------------------|----|
| Reason For Doctor Dominance In Proposal Writing | 21 | 47 | 20/11/2014<br>17:16 | SL | 22/02/2015<br>16:02 | SL |
| Trend Of Doctors Dominance                      | 13 | 21 | 20/11/2014<br>17:16 | SL | 22/02/2015<br>15:40 | SL |
| NGO And CSO Power Play                          | 2  | 2  | 20/11/2014<br>17:16 | SL | 30/10/2014<br>20:02 | SL |
| Inter NGO Conflicts                             | 2  | 4  | 20/11/2014<br>17:16 | SL | 22/10/2014<br>19:12 | SL |
| Need To Build Capacity Of CSO's                 | 1  | 3  | 20/11/2014<br>17:16 | SL | 16/10/2014<br>20:37 | SL |
| NGO's Work As For Profit                        | 1  | 1  | 20/11/2014<br>17:16 | SL | 16/10/2014<br>20:08 | SL |
| Operational Research                            | 2  | 2  | 20/11/2014<br>17:16 | SL | 11/11/2014<br>16:22 | SL |
| Academia Involvement                            | 1  | 1  | 26/11/2014<br>15:11 | SL | 23/10/2014<br>15:25 | SL |
| Behavioural Sciences                            | 4  | 5  | 26/11/2014<br>15:11 | SL | 23/10/2014<br>15:26 | SL |
| Bio-Medical Influence On Research Methods       | 3  | 3  | 26/11/2014<br>15:11 | SL | 23/10/2014<br>18:41 | SL |
| CHAI Did A Good Job                             | 2  | 2  | 26/11/2014<br>15:11 | SL | 23/10/2014<br>18:21 | SL |
| Community Systems Research Needed               | 1  | 1  | 26/11/2014<br>15:11 | SL | 16/10/2014<br>18:18 | SL |
| Definition Of Gap                               | 15 | 16 | 26/11/2014<br>16:04 | SL | 20/11/2014<br>19:30 | SL |

|   |    |    |                     |    |                     |    |
|---|----|----|---------------------|----|---------------------|----|
| Inadequate Trend Analysis                             | 1  | 1  | 26/11/2014<br>15:11 | SL | 23/10/2014<br>18:49 | SL |
| Lack Of Proper Commodity Costing                      | 6  | 7  | 26/11/2014<br>15:11 | SL | 23/10/2014<br>18:35 | SL |
| Need For Contextual Content                           | 1  | 1  | 26/11/2014<br>15:11 | SL | 23/10/2014<br>16:50 | SL |
| Non-Biomedical Approach                               | 3  | 3  | 26/11/2014<br>15:11 | SL | 22/10/2014<br>17:12 | SL |
| Poor Data Sources                                     | 1  | 1  | 26/11/2014<br>15:11 | SL | 17/10/2014<br>18:14 | SL |
| Synergy Between Qualitative And Quantitative Research | 2  | 2  | 26/11/2014<br>15:11 | SL | 16/10/2014<br>19:47 | SL |
| Participation   | 1  | 1  | 20/11/2014<br>17:16 | SL | 20/11/2014<br>19:35 | SL |
| Commitments From Other Professionals                  | 4  | 4  | 20/11/2014<br>17:16 | SL | 20/11/2014<br>19:33 | SL |
| Education Sector Involvement                          | 1  | 1  | 20/11/2014<br>17:16 | SL | 15/08/2014<br>19:31 | SL |
| Inter-Discipline Participation                        | 11 | 21 | 20/11/2014<br>17:16 | SL | 20/11/2014<br>18:32 | SL |
| Sensitization Of Other Stakeholders                   | 1  | 2  | 20/11/2014<br>17:16 | SL | 06/10/2014<br>19:24 | SL |
| Sustaining Broad-Based Participation                  | 2  | 3  | 20/11/2014<br>17:16 | SL | 15/10/2014<br>14:16 | SL |
| Professionals In Proposal Writing                     | 8  | 10 | 20/11/2014<br>17:16 | SL | 04/11/2014<br>15:37 | SL |

|  |          |          |                             |           |                             |           |
|--|----------|----------|-----------------------------|-----------|-----------------------------|-----------|
| Assumed Professionals Involved In Proposal Writing | 7        | 8        | 20/11/2014<br>17:16         | SL        | 20/11/2014<br>17:54         | SL        |
| CBO's Not Heard In Proposal Writing                | 1        | 1        | 20/11/2014<br>17:16         | SL        | 21/10/2014<br>14:22         | SL        |
| Doctors And Social Science Influence               | 1        | 1        | 20/11/2014<br>17:16         | SL        | 06/10/2014<br>18:44         | SL        |
| Lack Of Social Science Input                       | 10       | 13       | 20/11/2014<br>17:16         | SL        | 26/11/2014<br>16:41         | SL        |
| Need More Participation Of Field Workers           | 8        | 15       | 20/11/2014<br>17:16         | SL        | 23/11/2014<br>17:57         | SL        |
| Neglected Non-Doctor Professionals                 | 12       | 22       | 20/11/2014<br>17:16         | SL        | 26/11/2014<br>16:42         | SL        |
| Patient Interests                                  | 5        | 10       | 20/11/2014<br>17:16         | SL        | 22/11/2014<br>14:02         | SL        |
| <b>Professional Influence On Implementation</b>    | <b>0</b> | <b>0</b> | <b>20/11/2014<br/>17:16</b> | <b>SL</b> | <b>22/11/2014<br/>13:11</b> | <b>SL</b> |
| CHEWS Influence                                    | 9        | 16       | 20/11/2014<br>17:16         | SL        | 26/02/2015<br>18:20         | SL        |
| Acceptability And Availability                     | 1        | 1        | 19/02/2015<br>16:25         | SL        | 19/02/2015<br>16:27         | SL        |
| CBO's Influence                                    | 4        | 5        | 20/11/2014<br>17:16         | SL        | 02/03/2015<br>19:02         | SL        |
| CSO's Influence                                    | 2        | 4        | 20/11/2014<br>17:16         | SL        | 03/03/2015<br>18:22         | SL        |

|  |    |    |                     |    |                     |    |
|--|----|----|---------------------|----|---------------------|----|
| CSO's As Watchdogs                         | 3  | 3  | 20/11/2014<br>17:16 | SL | 16/10/2014<br>20:04 | SL |
| Doctors In Implementation                  | 2  | 2  | 20/11/2014<br>17:16 | SL | 19/02/2015<br>19:53 | SL |
| Doctor Medical Advantage                   | 8  | 9  | 20/11/2014<br>17:16 | SL | 22/02/2015<br>14:47 | SL |
| Doctors As Facility Heads                  | 9  | 13 | 20/11/2014<br>17:16 | SL | 22/02/2015<br>18:49 | SL |
| Doctors As Portfolio Managers              | 3  | 6  | 20/11/2014<br>17:16 | SL | 19/02/2015<br>18:50 | SL |
| Doctors More In Facility Oversight         | 3  | 3  | 20/11/2014<br>17:16 | SL | 19/02/2015<br>18:50 | SL |
| Doctors With Clinical And Managerial Roles | 5  | 7  | 20/11/2014<br>17:16 | SL | 22/02/2015<br>14:16 | SL |
| Positive Impact Of Doctors                 | 9  | 13 | 20/11/2014<br>17:16 | SL | 04/03/2015<br>14:26 | SL |
| Incentives And Motivation                  | 7  | 8  | 20/11/2014<br>17:16 | SL | 26/03/2015<br>19:11 | SL |
| GF Grant Not Wanted By Facility Staff      | 6  | 7  | 20/11/2014<br>17:16 | SL | 22/10/2014<br>17:45 | SL |
| Incentives And Performance                 | 4  | 5  | 20/11/2014<br>17:16 | SL | 23/03/2015<br>16:44 | SL |
| Incentives In GF Compared To Others        | 11 | 14 | 20/11/2014<br>17:16 | SL | 23/03/2015<br>16:44 | SL |
| Performance Based Frame Work               | 5  | 9  | 20/11/2014<br>17:16 | SL | 23/02/2015<br>20:26 | SL |

|   |    |    |                     |    |                     |    |
|---|----|----|---------------------|----|---------------------|----|
| Better Job Description                                | 6  | 6  | 20/11/2014<br>17:16 | SL | 21/11/2014<br>15:59 | SL |
| Job Description Not Ideal In Epidemics                | 1  | 1  | 20/11/2014<br>17:16 | SL | 22/10/2014<br>19:09 | SL |
| PBS Concerns  | 1  | 2  | 20/11/2014<br>17:16 | SL | 16/10/2014<br>20:19 | SL |
| PBS Improves Efficiency                               | 6  | 6  | 20/11/2014<br>17:16 | SL | 21/11/2014<br>16:02 | SL |
| Poor Incentives For Nigerian Doctors                  | 2  | 2  | 20/11/2014<br>17:16 | SL | 19/02/2015<br>15:23 | SL |
| Inter-Professional Conflicts                          | 3  | 6  | 20/11/2014<br>17:16 | SL | 26/02/2015<br>18:19 | SL |
| Conflicts Seen More In Secondary And Tertiary Centres | 1  | 1  | 20/11/2014<br>17:16 | SL | 15/10/2014<br>14:14 | SL |
| GF Inter-Professional Interactions                    | 12 | 15 | 20/11/2014<br>17:16 | SL | 03/03/2015<br>18:33 | SL |
| Inter-Professional Respect                            | 3  | 3  | 20/11/2014<br>17:16 | SL | 10/10/2014<br>16:10 | SL |
| Spill Over Of Inter-Professional Tensions             | 5  | 8  | 20/11/2014<br>17:16 | SL | 23/10/2014<br>18:38 | SL |
| Management At Facility Level And Programmer Influence | 0  | 0  | 20/11/2014<br>17:16 | SL | 19/02/2015<br>18:57 | SL |

|  |   |   |                     |    |                     |    |
|--|---|---|---------------------|----|---------------------|----|
| Community Implementer's Influence                    | 1 | 1 | 20/11/2014<br>17:16 | SL | 18/08/2014<br>19:50 | SL |
| Effects Of Good Administrators                       | 3 | 3 | 20/11/2014<br>17:16 | SL | 21/10/2014<br>18:41 | SL |
| Facility Advocacy                                    | 4 | 4 | 20/11/2014<br>17:16 | SL | 17/10/2014<br>15:01 | SL |
| Facility Oversight Assessment                        | 1 | 1 | 20/11/2014<br>17:16 | SL | 14/10/2014<br>15:52 | SL |
| Facility Training                                    | 3 | 3 | 20/11/2014<br>17:16 | SL | 22/10/2014<br>17:39 | SL |
| Improving Programme Management                       | 2 | 3 | 20/11/2014<br>17:16 | SL | 13/03/2015<br>18:39 | SL |
| Institutional And Financial Management Strengthening | 2 | 3 | 20/11/2014<br>17:16 | SL | 15/10/2014<br>14:17 | SL |
| Programmers Influence                                | 1 | 1 | 20/11/2014<br>17:16 | SL | 06/10/2014<br>16:10 | SL |
| Composition Of Programmers                           | 1 | 1 | 20/11/2014<br>17:16 | SL | 06/10/2014<br>16:12 | SL |
| Programmers In Charge Of Accountability              | 1 | 1 | 20/11/2014<br>17:16 | SL | 06/10/2014<br>16:17 | SL |
| Non-Doctor Portfolio Managers                        | 6 | 8 | 20/11/2014<br>17:16 | SL | 19/02/2015<br>18:57 | SL |
| Nurses Influence                                     | 4 | 5 | 20/11/2014<br>17:16 | SL | 19/02/2015<br>18:57 | SL |



|   |    |    |                     |    |                     |    |
|---|----|----|---------------------|----|---------------------|----|
| PR Oversight Function                           | 4  | 4  | 20/11/2014<br>17:16 | SL | 19/02/2015<br>18:57 | SL |
| State And LGA Influence                         | 5  | 6  | 20/11/2014<br>17:16 | SL | 04/03/2015<br>14:25 | SL |
| Task Shifting                                   | 2  | 4  | 20/11/2014<br>17:16 | SL | 31/10/2014<br>16:14 | SL |
| Decentralization And Task Shifting              | 5  | 5  | 20/11/2014<br>17:16 | SL | 06/10/2014<br>19:10 | SL |
| Importance Of Task Shifting And Task Sharing    | 9  | 9  | 20/11/2014<br>17:16 | SL | 05/03/2015<br>17:05 | SL |
| Task Shifting Success                           | 3  | 4  | 20/11/2014<br>17:16 | SL | 05/03/2015<br>15:42 | SL |
| Lack Of Policy Document On Task Shifting        | 9  | 14 | 20/11/2014<br>17:16 | SL | 05/03/2015<br>21:34 | SL |
| Policy Framework To Protect Those Task Shifting | 3  | 3  | 20/11/2014<br>17:16 | SL | 25/02/2015<br>14:48 | SL |
| Task Shifting Curriculum                        | 4  | 4  | 20/11/2014<br>17:16 | SL | 25/02/2015<br>18:18 | SL |
| Professional Antagonism                         | 11 | 24 | 20/11/2014<br>17:16 | SL | 05/03/2015<br>19:56 | SL |
| Doctors Antagonism                              | 8  | 9  | 20/11/2014<br>17:16 | SL | 23/10/2014<br>17:27 | SL |
| Quality Of Service Concerns                     | 5  | 7  | 20/11/2014<br>17:16 | SL | 25/02/2015<br>17:14 | SL |
| Removing Emphasis On                            | 3  | 4  | 20/11/2014<br>17:16 | SL | 06/03/2015<br>19:02 | SL |

|   |    |    |                     |    |                     |    |
|---|----|----|---------------------|----|---------------------|----|
| Professionalism                           |    |    |                     |    |                     |    |
| Task Shifting Overburdened Health Workers | 3  | 4  | 20/11/2014<br>17:16 | SL | 22/10/2014<br>18:55 | SL |
| Unofficial Task Shifting                  | 7  | 8  | 20/11/2014<br>17:16 | SL | 04/11/2014<br>16:05 | SL |
| Private Facilities As Solution To Strikes | 2  | 3  | 20/11/2014<br>17:16 | SL | 17/10/2014<br>19:11 | SL |
| Uneven HRH Distribution                   | 12 | 16 | 20/11/2014<br>17:16 | SL | 26/02/2015<br>15:10 | SL |
| Doctor Transfers                          | 1  | 1  | 20/11/2014<br>17:16 | SL | 15/10/2014<br>21:48 | SL |
| Doctors In South Compared To North        | 1  | 1  | 20/11/2014<br>17:16 | SL | 15/08/2014<br>19:44 | SL |
| Inadequacy Of Doctors In Rural Areas      | 2  | 3  | 20/11/2014<br>17:16 | SL | 26/02/2015<br>18:12 | SL |

## **Appendix 7: William J. Goode(Goode 1960) list of professional traits**

1. Determines its own standards of education and training
2. The student professional goes through a more far-reaching adult socialization experience than the learner in other occupations
3. A form of licensure is used to legally recognized any Professional practice by members
4. Members of the profession operate Licensing and admission boards.
5. Legislation that governs and shapes the profession is developed by the members
6. High income, power, and prestige are sociologically causal and they can demand for a certain calibre of students to enrol into training
7. Members are more strongly identified and affiliated with the profession
8. The practitioner is free from normal evaluation and control
9. The norms of practice enforced by the profession are more stringent than legal controls
10. The profession is more likely to be a terminal occupation

## Appendix 8: Ethics approval, Jos University Teaching Hospital, Jos, Nigeria

# JOS UNIVERSITY TEACHING HOSPITAL JOS, NIGERIA

Phone: 073-450226 - 9  
e-mail: juth@infoweb.abs.net



Cables & Telegram: JUTH  
P.M.B. 2076  
Jos.

JUTH/DCS/ADM/127/XIX/ 5941  
Ref:.....

5<sup>th</sup> May, 2014.

Date:.....

**Dr. Samuel Lassa,**  
Department of Community Medicine,  
Jos University Teaching Hospital,  
Jos-Nigeria.

### RE: ETHICAL CLEARANCE/APPROVAL

I am directed to refer to your application dated 9<sup>th</sup> April, 2014 on the research proposal titled:

**“Exploring the Interactions between Medical Professionals and Global Health Initiatives in the Nigerian Health System: A Case Study of Health Systems Strengthening (HSS) Initiative of the Global Fund in Nigeria ”** and your appearance before the Ethical Committee on 15<sup>th</sup> April, 2014.


Following recommendation from the Institutional Health Research Ethical Committee, I am to inform you that Management has given approval for you to proceed on your research topic as indicated.

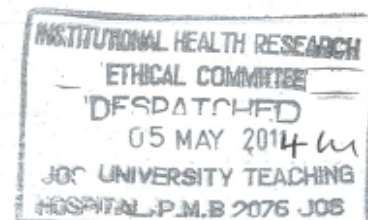
You are however required to obtain a separate approval for use of patients and facilities from the department(s) you intend to use for your research.

The Principal Investigator is required to send a progress report to the Ethical Committee at the expiration of three (3) months after ethical clearance to enable the Committee carry out its oversight function.

Submission of final research work should be made to the Institutional Health Research Ethical Committee through the **Secretary in Room 2, Administration Department**, please.

On behalf of the Management of this Hospital, I wish you a successful research outing.

  
**Hajia R. Danfilo**  
For: Chairman, MAC



Ethical approval from the Jos University Teaching Hospital, Jos was approved during an industrial strike action but the letter was not dispatched till after the strike action.

## Appendix 9: Document list

### *From the CCM website*

1. CCM Nigeria, 2001. *Country proposal – Round 1*,
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2. Global Fund, 2003. *Guidelines for Performance Based Funding*,
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4. Global Fund, 2011b. *The Global Fund's Approach To Health Systems Strengthening ( HSS )*
5. Global Fund, 2013a. *Information Note for Country Dialogue*,
6. Global Fund, 2013b. *The Global Fund's New Funding Model Brochure*.
7. Global Fund, 2014a. *Partnership profile: The Global Fund*.
8. Global Fund, 2014b. *Report of the technical review panel on the concept notes*

*submitted in the third and fourth windows of the funding model,*

9. Global Fund, 2015a. *CCM Guidance Note Annual CCM Eligibility and Performance Assessment,*
10. Global Fund, 2015b. *Differentiated Care For HIV and Tuberculosis: A Toolkit for Health Facilities,*
11. Global Fund, 2015c. *Global Fund Information Note: Strategic Investments for HIV Programs,*
12. Global Fund, 2015d. *Guidelines and Requirements for Country Coordinating Mechanisms,*
13. Global Fund, 2015e. *Guidelines On Implementers Of Global Fund Grants,*
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15. Global Fund, 2015g. *Members - The Global Fund to Fight AIDS, Tuberculosis and Malaria.*
16. Global Fund, 2015h. *Scaling Up Antiretroviral Therapy in Global Fund Concept Notes,*
17. Global Fund, 2015i. *Monitoring and Evaluation Indicator Guidance.*
18. Global Health Workforce Alliance, 2011. *Outcome statement of the Second Global Forum on Human Resources for Health.*

*From organisations related to proposal writing process*

1. Aidspace 2007, Special issue – CCM Governance.
2. GHAIN, 2010. *Ghain support to antiretroviral therapy in Nigeria.*
3. Global Health Workforce Alliance, 2011. *Outcome statement of the Second Global Forum on Human Resources for Health.*
4. Pullen, K. & Garmaise, D., 2014. *A guide to building and running an effective CCM.*

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6. The Joint Learning Initiative, 2004. *Human resources for health: overcoming the crisis*.
7. WHO|UNAIDS, 2011. Technical Guidance Note for Global Fund HIV Proposals Prevention of Mother-To-Child Transmission of HIV. , pp.1–30.
8. World Health Organization, 2007a. *Everybody's business -- strengthening health systems to improve health outcomes : WHO's framework for action*, Geneva, Switzerland.
9. World Health Organization, 2007b. *Treat train retain. Task shifting: Global recommendations and guidelines*, Geneva.
10. World Health Organization, 2011a. *Guidance to develop Global Fund Round 11 proposal for tuberculosis control*,
11. World Health Organization, 2011b. *The Global Fund and Health System Strengthening: How to Make the Case , in a Proposal for Round 8,9,10*,
12. World Health Organization, 2016. WHO | Health Systems Strengthening Glossary.
13. World Health Organization., 2006. *Working together for health*,

*Documents on the Nigerian context*

1. Chankova, S. et al., 2006. *A Situation Assessment of Human Resources in the Public Health Sector in Nigeria: A joint Federal Government of Nigeria (FMOH/NACA) and PHRplus report*.
2. Chirdan, O.O. et al., 2009. Perceptions of working conditions amongst health workers in state-owned facilities in northeastern Nigeria. *Annals of African medicine*, 8(4), pp.243–249.
3. Directory of Health Facilities in Nigeria, 2014a. Federal Ministry of Health Data

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  5. Kombe, G. et al., 2009. Nigeria Health System Assessment.
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  11. National Population Commission 2008, Nigeria Demographic and Health Survey.
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  15. National Technical Working Group, 2009. *Report of the Vision 2020 National Technical Working Group On Health*, Abuja, Nigeria.
  16. Okeke, E.N. et al., 2015. The Better Obstetrics in Rural Nigeria (BORN) Study: Evaluating the Nigerian Midwives Service Scheme, Santa Monica, CA.
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