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TOWARDS
A PRACTICE THEORY OF GOAL-SETTING

Assessing the theoretical goal-setting of
The Leprosy Mission in Nigeria

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Abstract

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Towards A Practice Theory of Goal-setting: Assessing the theoretical goal-setting of The Leprosy Mission in Nigeria

Keywords: Theoretical-goal-setting, Objectives, SMART, Practice-Theory, Leprosy, Nigeria

Goal-setting is indispensable for effective healthcare management. Yet, literature evidence suggests many organisations worldwide do not know how to formulate 'SMART' goals. Evidence of how existing theories work in practice is scarce, and the practices in low-income countries are unknown. Therefore, this research explored how leprosy project goals were formulated to describe the theoretical practice framework of The Leprosy Mission Nigeria (TLMN).

Using a case-study design, ten managers were interviewed individually concerning their goal-setting knowledge, experience and perspective; and documented goals of six projects were reviewed. A five-step constructionist thematic data analysis generated eleven theoretical frameworks from the concepts of the emergent core themes of 'stakeholders', 'strategies' and 'statements.' Further theorisation reduced them to one general framework. This revealed TLMN's goal-setting practice as a four-stage centre-led, top-down, beneficiary-focused and problem-based process. The stages were national preparation, baseline needs-survey, centralised goal formulation and nationalised planning. The outcome was the formulation of assigned, 'non-SMART' objective statements, which are then used for planning projects. Other theoretical models constructed included a Goal Effects Cycle, 'SMARTA' goal attributes and hierarchical criteria for differentiating goal-types.

A theory developed from TLMN goal-setting postulates that: 'Assigned non-SMART goal formulation directly results from centralised goal-setting practice and is the predictor of unrealistic project planning.' Therefore, I propose that goal statements will be 'SMARTA' and plans, more realistic and relevant if goal-setting is done collaboratively by all stakeholders at all stages of the process. Also, 'Change-Beneficiary-Indicator-Target-Timeframe' and 'Change-Beneficiary-Location-Timeframe' frameworks are recommended as templates for writing SMART objectives and aims respectively.

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My study organisation, The Leprosy Mission Nigeria (TLMN), was overly gracious. Their generous support and cooperation enabled the conduct of this research. I appreciate their organisational approval and access to data sources. They also gave logistic assistance during my field visits to leprosy managers in their project locations and to the Annual Country Learning workshops in 2017.

My special thanks to all managers and staff of the TLM Nigeria, especially the former acting National Director (2016-2017), Dr Moses Onoh, and the current National Director Dr Sunday Udoh. Also, thanks to Mrs Jannine Ebenso, Head of Quality Assurance, TLM International, UK.

For their consent and participation in my research, I thank all 10 study participants. For ethical reasons, and as requested by TLMN, they and their assigned leprosy projects are anonymised or pseudonymised in this thesis.

I declare that the TLMN goal-setting practice studied and reported in this thesis describes the knowledge, perspectives and experience of the study participants at the time of their interviews in 2017; and the statement frameworks of goals set in the leprosy project plans for the year 2016. Being a case study, the observations made may not be generalisable beyond the context and timeframe investigated in this doctoral research.

Three peer-reviewed articles on goal-setting were published during this doctoral study, and a fourth is awaiting journal acceptance. Two articles on goal definitions and SMART goal frameworks were published in the British Journal of Healthcare Management and the article on the general concepts of goals was published in the Journal of Management and Organization.

Dedication

To my immediate family members who made every sacrifice and gave me the encouragement necessary to complete this doctoral study programme.

My wife Grace comes first among all.

Of special note is my granddaughter, Irene, who was born, and of whom I was privileged to babysit often during the period of this study.

To my children, Osama, Afe, and Ese, I pass the greatest blessing of my doctoral experience. This thesis is proof that, with divine inspiration, middle age is no barrier to a good education.

Abbreviations

ACL:	Annual Country Learning
AMED:	Allied and Complementary Medicine Database
BSPT:	Behaviour, Support, Performance, Timeframe
CBITT:	Change, Beneficiary, Indicator, Target, Timeframe
CBL:	Change, Beneficiary, Location
CBLT:	Change, Beneficiary, Location, Timeframe
CBTT:	Change, Beneficiary, Target, Timeframe
CCG:	Clinical Commissioning Group
CINAHL:	Cumulative Index to Nursing and Allied Health Literature
CQI:	Continuous Quality Improvement
DAC:	Development Assistance Committee for OECD
DoH:	Department of Health
DRIVE:	Directional, Reasonable, Inspiring, Visible, Eventual
EBSCO:	Elton Bryson Stephens Company
FCT:	Federal Capital Territory
G-AP:	Goal-setting and Action Planning
GTM:	Grounded Theory Method
HFA:	Health For All
HMIC:	Health Management Information Consortium
HRP:	Human Rights Promotion
IIPRT:	Improvement, Indicator, Performer, Results, Time
LCP:	Leprosy Control Programme

M&E:	Monitoring and Evaluation
MBO:	Management By Objectives
NCO:	Nigeria Coordination Office
NHS:	National Health Service
Obj.:	Objective
OECD:	Organisation for Economic Co-operation and Development
OITT:	Outcome, Indicator, Target, Timeframe
Ortho:	Orthopaedic
QA:	Quality Assurance
SED:	Socio-Economic Development
SMART:	Specific, Measurable, Attainable, Realistic and Timed
SMARTA:	Specific, Measurable, Attainable, Realistic, Timed and Agreeable
STBLCO:	State Tuberculosis and Leprosy Control Officer
TA:	Thematic Analysis
TBL:	Tuberculosis and Leprosy
TLMI:	The Leprosy Mission International
TLMN:	The Leprosy Mission Nigeria
TQM:	Total Quality Monitoring
UHBristol:	University Hospital Bristol
UNAIDS:	Joint United Nations Programme on HIV/AIDS
UNDG:	United Nations Development Group
USAID:	United States Agency for International Development
WHO:	World Health Organization

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Chapter 1

INTRODUCTION

“... Specific, difficult goals consistently [lead] to higher performance than urging people to do their best... This is because do-your-best goals have no external referent and thus are defined idiosyncratically”

(Locke and Latham 2002: 706)

1.1 Introduction

This study was an in-depth exploration of the goal-setting practice of The Leprosy Mission Nigeria (TLMN). Overall, the study sought to discover theoretical models or frameworks in the organisation’s practice that illustrate how leprosy goals were formulated for the projects they support in Nigeria. Leprosy project goals in TLMN refer to long-term aims and intermediate objectives in the project plans that link the projects conceptually to the needs of their target beneficiaries as well as the organisational country strategy. These projects, therefore, constitute TLMN’s specific community health and development interventions of the physical and socio-economic problems associated with leprosy disease as a public health burden in Nigeria.

At the end of the study, the identified goal-setting frameworks of these projects were integrated into a more general theoretical framework that was illustrative of TLMN goal-setting practice. From this general framework, a theory of practice for goal-setting that is applicable in the Nigerian context of TLMN was developed. This research makes an original academic contribution to the general epistemology of goal-setting in healthcare delivery settings in low-income countries, where no previous goal-setting research had been reported.

This chapter begins with a basic introduction to my research subject of goals and goal-setting. It also provides a background of my doctoral research journey, the history of goal-setting research and emerging questions that prompted my interest in goal-setting research. In addition, the chapter presents a detailed review report of the problem situation of goal-setting in TLMN as the main

justification for this doctoral research. The chapter ends with a detailed outline of the content of the remaining chapters of this thesis.

1.2 Goals and Goal-setting

As for definition, a goal in this research is the desired result of planned work or project that is expected to be achieved at a specific time in the future (Lock & Latham 2006; Ogbewi 2016). Goals are the necessary building blocks of organisational management (Mullins 1999), which form the logical basis for planning results-oriented services as well as their monitoring and evaluation. This means that goals provide a conceptual structure for developing intervention strategies, as well as for deciding which activities to implement at organisational, programme or project level (Mullins 1999). Thus, significantly, they serve as benchmarks for appraising the extent of implementation and achievement of organisational policies and services, in terms of their related human resource productivity, quality, effectiveness, efficiency and overall success (Shiell 1997; Greenbank 2001; Fitsimmons 2008; Bipp & Kleingeld 2011). They are therefore essential conceptual tools used by organisations and programmes to measure their performances and results in order to show their progress and impact of their work overtime, and their accountability for expended resources (Mullins 1999; Bipp & Kleingeld, 2011). Hence, referring to goals in a healthcare context, Shiell (1997) asserts that, "The success of health service delivery at clinical, planning or system level must be measured against agreed objectives". In agreement, Oracle (2012: 2) speaking from business and industrial contexts, emphatically state that "The organization that makes it a priority to develop quality, effective goals will succeed in its performance management, [and] in its business in general..."

Therefore, goal-setting, the process of formulating goals, has been regarded as a characteristic practice of all results-oriented organisations, programmes, projects, services and individuals in every work sector (Beardshaw & Palfreman 1990; Bratton et al. 2007). Furze (2015: 242) quotes a taxonomical definition of goal-setting accredited to Abraham and Michie (2008: 383), and which describes it in the context of clinical and rehabilitation care of individual patients. According to Furze (2015: 242), in a clinical context, goal-setting includes goal

planning, care planning, and action planning. Specifically, it involves, “detail planning of what the person will *do*, including a definition of the behaviour specifying frequency, intensity or duration, as well as, at least, one context, i.e. where, when, how, or with whom”. However, far beyond “what a person will do” (Abraham & Michie 2008: 383) the general concept of goal-setting in the management of projects and organisations encompasses formulating a statement of *what will be achieved*, a specific destination of service delivery. It outlines the purpose of work being done at every organisational level, whether by a single person, a team or group of individuals or the whole organisation (Oracle 2012). According to Bratton et al. (2007: 6), achieving goals or objectives is the basic expectation of every human activity. So, organisations or individuals working with no goals lack a vital direction for their effort or destination for their journey. They exist functionally with no formal purpose. Thus, goal-setting is, therefore, the essence of all organisations and their intervention programmes (Mullins 1999).

1.3 Doctoral Research Journey

This research study started as a personal journey of discovery to investigate the contemporary goal-setting practice of the National Health Service (NHS) in England. Especially, it sought to assess the extent to which the health goals on which national health services were planned were SMART (Specific, Measurable, Attainable, Realistic and Time-bound) and determined the quality of care delivered and health outcomes. My interest arose from repeated reports that the NHS healthcare institutions suffered from a string of performance challenges that implied poor quality care. The NHS organisation has for a long time called for a fundamental restructuring that would lead to considerable enhancement of its productivity. Statistics published in the Quarterly Monitoring Report for January 2015 (Kingsfund, 2015), reported that up to 60% of NHS Trusts are financially constrained, 49% of them suffer significant low staff morale and unacceptable waiting times – longer than 18 weeks for 54% of outpatients. Hence, the NHS was under immense pressure to improve its effectiveness and efficiency in terms of performance targets and health outcomes (Field et al., 2014). Moreover, a review of NHS websites revealed

that despite the publication of an NHS Outcomes Framework (Department of Health, 2005), the goal-setting practice in most NHS Trusts seemed limited to individual patient improvement targets, rather than set goals achievable at a health service or project level (South Devon NHS, 2012; Derbyshire NHS, 2012). There seemed to be palpable gaps in the goal-setting practice of NHS Trusts, and the effect of the practice at various levels of NHS on health outcomes was largely undocumented. Thus, the study problem then was the perennial reports of poor quality of healthcare services and unacceptable health outcomes at the health service delivery level of the organisation. Goal-setting was therefore considered as a possible remedial intervention to the situation since there was ample empirical theoretical evidence that good goal-setting practice has the potential to motivate task performance towards improved outcomes (Locke and Latham, 2006).

The original research plan was designed to use a research framework that was pragmatic – a mixed-methods paradigm that combined three study methods in the same doctoral study. Formerly, the study methods included a fact-finding descriptive quantitative cross-sectional survey of the structure of NHS health service objectives; a phenomenological exploration of NHS health service managers' essential shared experience of the organisational goal-setting practice; and a quasi-experimental study of the efficacy of using a pre-determined model for formulating SMART objective statements as an intervention for improving healthcare quality and outcomes in the NHS. The study participants would have been managers of locally commissioned services in West Yorkshire NHS health facilities, who were responsible for goal-setting at the service level of NHS.

However, as the preparations for the research progressed, significant changes had to be made in two important areas. First, the study organisation whose goal-setting practice was to be studied was changed from a government-controlled and financed NHS England to a non-governmental and international charity organisation, The Leprosy Mission Nigeria. Secondly, the paradigm or approach of the research was changed from a pragmatic mixed-method to a purely constructivist qualitative study. These changes became necessary after my preliminary contact with the research departments of the Clinical

Commissioning Groups (CCG) in Bradford and Airedale. Our discussions revealed that no health service goal statements were formulated locally by health service managers. Rather, health services were commissioned to local providers who were expected to deliver assigned service targets connected to pre-set health outcomes framework, determined nationally by NHS England. In addition, the many articles written on goal-setting relating to specific disease, disability or rehabilitation services in the UK revealed that the practice occurred only at the patient level: goals were set as individual improvement targets (Furze, 2015). Typically, these were formulated by health professionals collaboratively with the patients and/or their families (Furze, 2015). Thus, the NHS organisation was technically excluded as a useable study organisation for this doctoral research primarily because the individual health managers did not formulate the goals on which their healthcare service delivery was based.

The paradigm shift in the research from mixed methods to qualitative was informed by the insufficient time available to complete all three study methods in the period allotted for my PhD study. For the same reason, a narrower mixed-method framework (with only two study designs) that was also considered at the end of my first year was discarded after the series of meetings with the NHS CCG research officials. The proposed combination of a quantitative descriptive survey of NHS service objectives and outcomes and a qualitative grounded theory method to generate a theoretical goal formulation framework was abandoned in favour of a one study design in one health service. Thus, grounded theory method was the study of choice for studying the goal-setting practice of only leprosy projects in TLMN at the beginning of data collection stage. However, the strict regime of grounded theory method was impracticable in field context of TLMN leprosy managers. It was impossible to carry out a one core question individual interview, theoretical sampling of subsequent interviewees, and collaborative 'going back and forth' data collection and analysis (Creswell 2013: 84). Therefore, a final change was made to use a case study method because of its broader and more flexible application (Creswell 2013).

Nevertheless, all through the doctoral research, a background study of goal-setting as a subject was ongoing based on available literature and a

background desk-review of the TLMN project documents. These led to the publication of three peer-reviewed journal articles (Annexes 1, 2 and 3). The first was a qualitative synthesis of the definitions of goal terms based on searched glossaries and manuals or handbooks of development organisations (Ogbeiwi, 2016). This was followed by a quantitative review of the framework contents of published examples of SMART objective statements recommended or in use by four major international healthcare organisations (Ogbeiwi, 2017). The next was the publication of the narrative literature review of the general concepts of goals and goal-setting (Ogbeiwi, 2018), and the last was a logical framework analysis of the goal statements of leprosy projects of TLMN (Ogbeiwi, in press).

1.4 History of Goal-setting Research

The origin of scientific goal-setting investigation as we know it today can be traced back to Fredrick W. Taylor's (1911) time and motion studies in the early 1900s in which he assigned daily tasks as goals to 'blue-collar workers' (Locke et al. 1981). According to Locke et al. (1981), Pierre Dupont followed up the work of Taylor by testing Taylor's ideas with managers at Dupont Powder Company and General Motors, in collaboration with Donald Brown and Alfred P. Solan. The work of Duport probably formed the basis for Peter Drucker's system of Management By Objectives (MBO) in 1954 (Locke et al. 1981). There was no formal goal-setting theory until Locke and Latham (1990) published their theory that related goal-setting and task performance based on a series of goal-setting empirical experiments. The track records of ad hoc goal-setting studies (not guided by any theories) as outlined by Latham and Locke (2007) include the following timelines:

- | | |
|---------------------------|--|
| Bryan and Hartner (1897): | - Observed the performance of telegraph operators and reported their improvement when assigned specific tasks to accomplish. |
| Taylor (1911): | - Promoted assigning a specific difficult task to each employee to complete to a given amount of quality |

- Wyatt, Frost and Stock (1934): - Reported the reduction of the boredom of factory workers by assigning definite and quantified targets of tasks to complete in a specified period.
- Mace (1935): - A laboratory experiment that showed that setting standards improved performance – only when the person’s ability had grown and increased his confidence that the standard set could be met. Without this, encouraging people to do their best produced the highest performance
- Ryan (1947 & 1970): - Reported the significance of intention in goal attainment
- Meyer, Kay & French. (1965): - Reported goal-setting as a useful tool for performance appraisal of employees

According to Locke and Latham (2002), Mace (1935) was the first to publish any work on the effects of goals on task performance. Locke and Latham (1990) then based their own research work on the previously published works of Atkinson (1958) who reported a curvilinear relationship between effort and task performance, and Ryan (1970) who linked the positive effect of conscious goals on action or behavioural change. From their own work, Locke and Latham concluded that the relationship between specific, difficult goals and task performance is positive and linear. Locke and Latham (1990) aligned their theory with Albert Bandura’s (1986) social cognitive theory of the positive causative effect of motivation and cognition factors within given environments on desired behavioural change (Locke & Latham 2002).

Locke and Latham’s (1990) theory of goal-setting was the product of many empirical studies in cognitive psychology that were conducted over a period of many decades. Their research began with seeking an answer to the question of whether setting a goal influences a person’s task performance or not (Locke 1968). According to Latham and Locke (2007), the goal-setting theory was the theoretical basis of more than 1,000 empirical studies by the beginning of the 21st century. Overall, practically all past goal-setting studies that led to the

development of the goal-setting theory were experimental studies that used goals assigned to the workers whose goal motivated behaviours were observed.

1.5 Emerging Questions

My interest in goal-setting originates from many years of professional work in the management, monitoring and evaluation of anti-leprosy programmes in different countries in Africa. From personal experience, I observed that many leprosy projects were developed on poorly formulated goals that were hardly achievable. Besides, I had a personal stake in the goal-setting practice of The Leprosy Mission International, as a long-standing senior medical staff of almost 19 years (from December 1988 to May 2007). Particularly, I was the national coordinator of TLMN, the country-level executive responsible for developing and resourcing leprosy projects in eight States of Nigeria from 1992 to 1999. Also, I was the Africa regional coordinator of Monitoring and Evaluation (M&E), responsible for assessing the goals, performance and achievements of TLM leprosy projects in African countries from 1999 to 2007. As a scholar-practitioner now, I wondered how leprosy project performance and outcomes may be improved through an academically motivated positive social change, based on empirical research into the way their goals and objectives are constructed.

There is already research-based evidence that good goal-setting practice can promote better performance towards higher effectiveness at the patient, project and organisational levels (Locke and Latham 2006, Furze 2015). Moreover, it is already established that with clearer goal statements that are more specific and measurable, routine monitoring of performance and periodic evaluation of achievements become more meaningful (Beardshaw and Palfreman 1990; Bratton et al. 2007; Day and Tosey 2011). However, research work on goal-setting practice has received less attention in healthcare generally, while being more pronounced in psychology and management sciences, In psychology particularly, goal-setting is an established concept in motivation of human behavioural change towards attainment of desired outcomes (Campbell 1997; Bradley et al. 1999; Locke and Latham 2002).

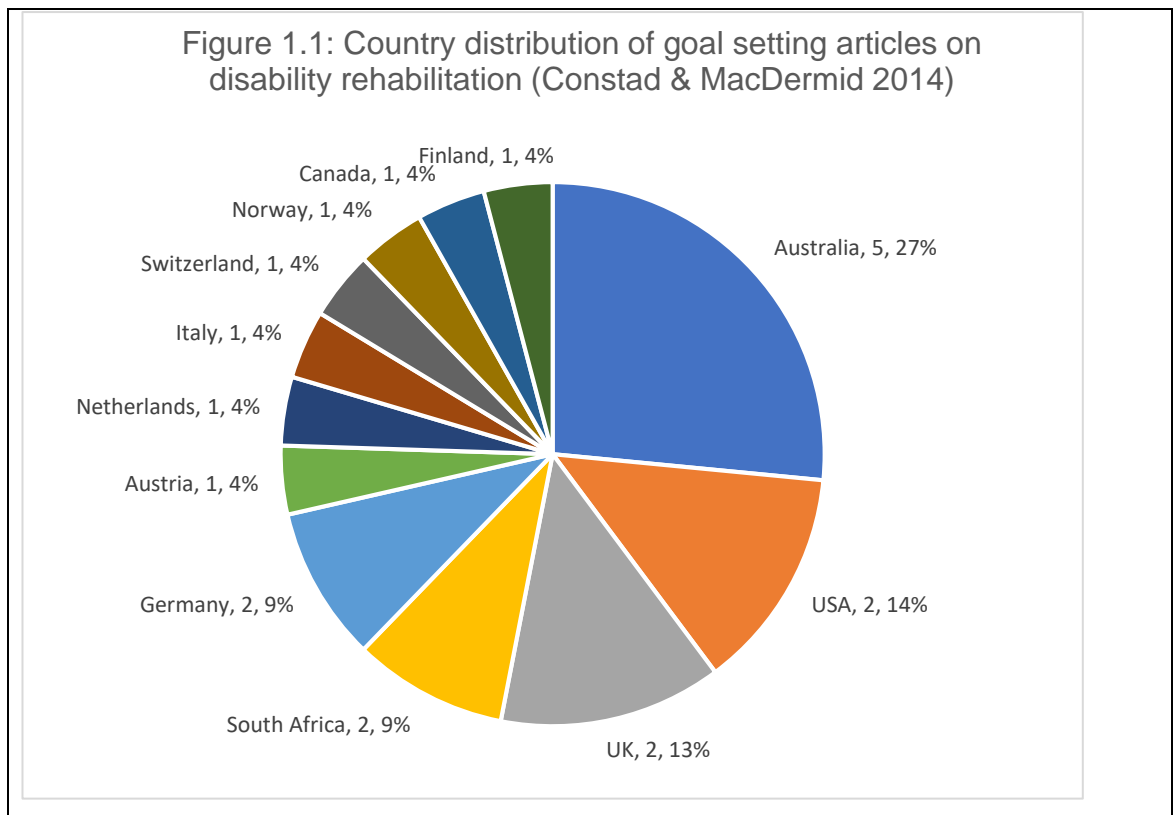
Nevertheless, despite the universal popularity of goals and goal-setting, not every organisation or manager know how to formulate good and effective goals (Platt 2002). Past surveys done at different times in the United Kingdom found that up to 79% of British organisations (Institute of Personnel Management 1992; Yearta, Maitlis & Briner 1995) and 62% of companies use goal-setting as an employee management tool to motivate organisational effectiveness (Baron & Armstrong 2004; Bipp & Kleingeld 2011). Even worse, a qualitative study by Greenbank (2001) involving 58 owner-business managers reported a rather poor goal-setting practice in small-scale businesses in the UK. According to the study, business owners do not set formal goals or write their objectives. This revealed a lack of organised and logical planning based on goals at the micro-level of the British business sector.

Moreover, a similar situation of ineffective goal-setting is reported in other high-income countries such as the USA (Doran 1981). A more recent examination of the framework of 17 published examples of SMART objective statements mostly written by four major international healthcare organisations (Centre for Disease Prevention and Control; National Health Service England, Save the Children, and World Health Organization) found none of them is really SMART. This suggested a possibly universal weakness in goal-setting capacity for formulating SMART healthcare goals (Ogbeiwi 2017).

Moreover, according to reports by Locke and Latham (2006), the empirical evidence for their goal-setting theory came from over 400 laboratory and field studies. These were conducted over 25 years testing more than 88 varied tasks with over 40,000 male and female participants in high-income countries in four continents: Asia, Australia, Europe and North America. However, few studies, if any at all, have explored how goal statements are formulated in practice, or written in a real organisational or project context of any healthcare services. Moreover, no research evidence about goal-setting practices is available for patients, projects or organisation in low-income countries such as Nigeria.

Apparently, no past goal-setting research has been conducted on any aspects of leprosy care either. A preliminary search of PubMed and Medline databases for leprosy research articles produced no result when “Goal-setting and leprosy”

or “Leprosy and Objective-setting” are used as the search key-phrases. While “Leprosy and Goals” produced 43 articles, and “Leprosy and Objectives” yielded 399 articles, none had any relevance to goal-setting in leprosy.



In addition, a literature review of 19 goal-setting articles by Constand and MacDermid (2014) reports a country distribution that suggests that virtually all goal-setting studies in the disability rehabilitation sector have been in high-income countries, and none so far done in low-income countries (Figure 1.1). Hence, so far, low-income countries in general, and Nigeria, in particular, have not yet made any contribution to the current documented knowledge on the goal-setting concept.

1.6 Context of Goal-setting in TLMN

1.6.1 Leprosy: Basic Epidemiological Facts

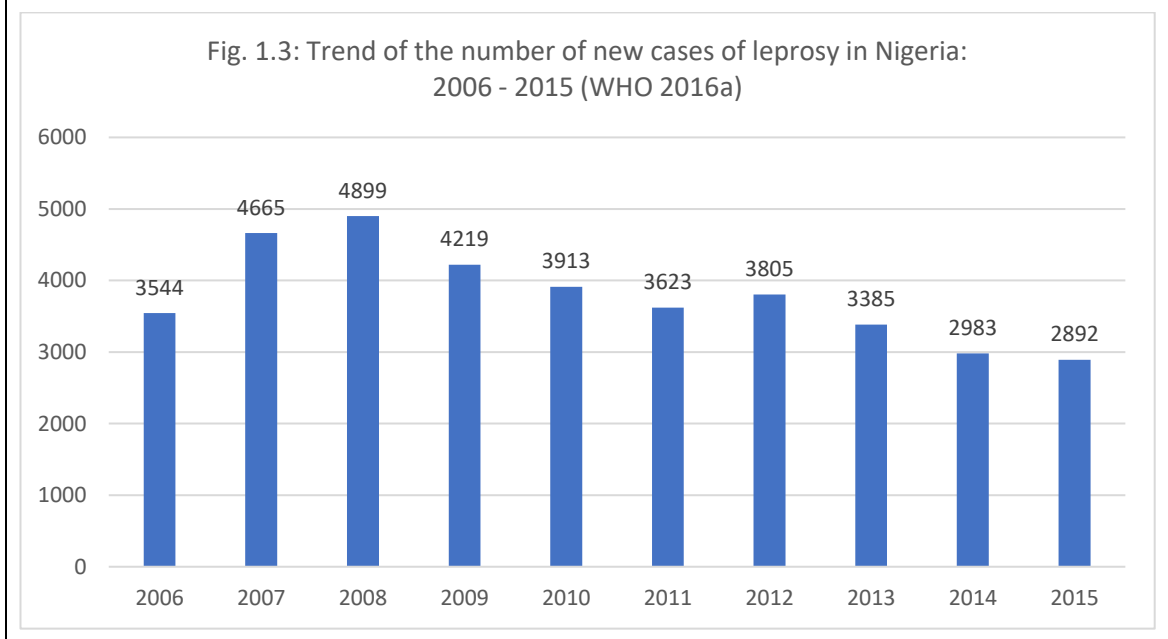
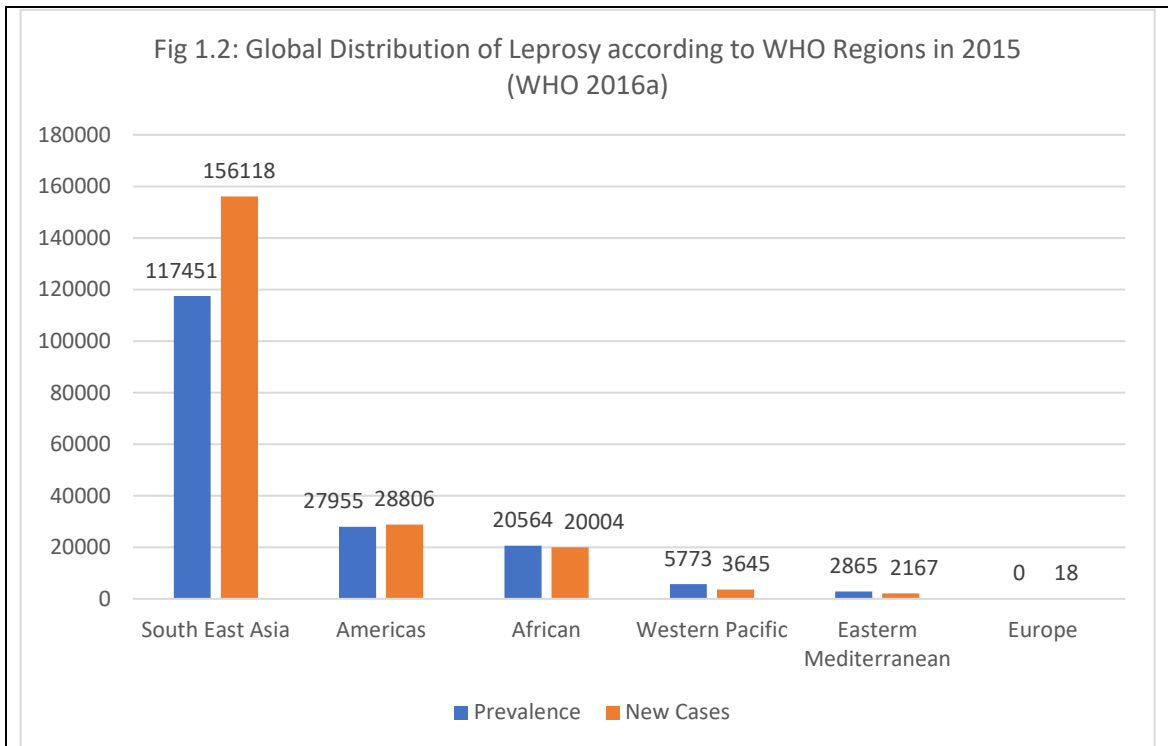
The study context of goal-setting was provided by projects in Nigeria that are helping persons affected by leprosy disease and its complications. Leprosy or Hansen’s disease is a chronic bacterial infection caused by *Mycobacterium*

Leprae, which affects the skin, peripheral nerves and the mucous membranes of the upper respiratory tract and eyes (WHO 2019). The infection is transmitted through contact with the infected and untreated patients and inhalation of the airborne droplets containing the bacteria released from the airways (WHO 2019). However, the disease is contracted by immune-compromised susceptible hosts after prolonged, frequent, and close physical contact (WHO 2019; 2020). The incubation period (the period between infection and onset of symptoms of disease) could be as short as less than one year or as long as 20 years, with an average of five years (WHO 2019; 2020).

People of all ages can be affected by leprosy (WHO 2019), but it tends to affect more males than females, and more people of the lower socio-economic status. The common signs and symptoms include skin lesions – patches or/and nodules and loss of sensation, with or without evidence of peripheral nerve damage. The classification of the disease into paucibacillary (PB) and multibacillary (MB) leprosy is based on the bacterial load in the skin, examined by skin smear test (WHO 2019). The effects of the infiltration of the skin and nerves cause the visible physical disabilities that the society usually associates with leprosy. Based on data reported by 159 countries, the global prevalence of the disease registered for treatment at the end of 2018 was 184,212 (rate of 0.2 per 10,000) and a total 208,619 new cases were detected that year (WHO 2020). The disease is curable with the effective treatment using a combination of three antibiotics (Dapsone, Rifampicine and Clofazimine) introduced by WHO in 1981. Since 1995, this multi-drug therapy (MDT) has been given free of charge to leprosy patients worldwide, courtesy of WHO and her international donors (WHO 2020).

Historically in the 1990s, there was an estimated 15 million cases globally. MDT has resulted in a remarkable global reduction of the prevalence of the disease. The WHO target for global elimination of leprosy (prevalence of less than 1 registered case per 10,000 population) was reached in the year 2000 (WHO 2019). Fifteen years later, regional distribution of leprosy according to data from 138 countries in 2015 (WHO 2016a) revealed that the majority of leprosy cases were in three regions – South-East Asia, Americas and Africa (Figure

1.2). The majority, 67% of prevalence and 74% of new cases of the total 174608 and 210758 respectively were reported in South East Asia region.



The latest WHO (2016a) country data reported that the 2015 leprosy case burden in Nigeria was a prevalence of 3,234 registered patients and 2892 new cases. The new case indicators were: multibacillary rate of 94%, Female proportion of 41%, Child proportion of 9% and Grade 2 disability rate of 15%. Even though the 10-year trend in Figure 1.3 shows a declining trend of leprosy

new cases in Nigeria since 2008, the continuing high case detection indicators suggest there was still an ongoing transmission of the disease. These WHO data in South East Asia and Nigeria indicate leprosy disease is still an important health problem in low-income countries (WHO 2016a).

However, leprosy is not just an epidemiological problem, it is a physical disease that afflicts a holistic damage on the lives of its victims. The major problem is psychosocial: the deep-seated mental self-defeat its diagnosis and social stigma bring on leprosy sufferers (TLMI 2018a). The long-term effect of the social dimensions of the disease is economic, as extreme poverty drags the affected people into a downward vicious spiral of worsening disabilities, societal rejection and greater poverty (TLMI 2018a). Therefore, in addition to WHO's MDT for bacteriological cure, like the many faces of the diseases, intervention of the leprosy problem is multidimensional, combining epidemiological control strategies for early case detection and treatment with prevention of disability, physical rehabilitation, socio-economic development, and development of leprosy communities (WHO 2016a, 2019, 2020). According to The Leprosy Mission in Nigeria, 'Leprosy harm people in multiple ways, and we care about the whole person. We transform people's lives through health and disability care, rehabilitation, education, better livelihood and advocacy for social change' (TLMI 2018b).

1.6.2 A brief background information on TLMN

The study organisation of this research was The Leprosy Mission in Nigeria, which is part of the Global Fellowship of The Leprosy Mission International (TLMI). TLMI is an international conglomerate of national Christian charitable leprosy organisations supporting and / or executing leprosy care projects in low-income countries. The organisation is the oldest and largest leprosy-oriented organisation world-wide, started in 1874 by an Irishman, Wellesley Cosby Bailey (TLMI 2019a). Wellesley worked as a 19th century missionary in India. He was moved by his compassion for the pitiable plight of leprosy sufferers in India. What he started as a tiny ray of hope to Indian leprosy victims grew after 145 years to become a global network of leprosy organisations in 29 countries, all raising support or providing succour for people affected by leprosy worldwide (TLMI 2019a). All are equal partners in the TLM Global Fellowship, with a

shared commitment to achieving a leprosy-free world by transforming the lives of affected people and communities (TLMI 2019a). Today, TLMI supports a wide range of field leprosy projects in 18 of these countries in Africa, Asia and the Pacific, including Nigeria (TLMI 2019b). In these countries, TLM organisations cooperate with national governments, other bilateral agencies, local churches and communities to support the provision of holistic care for people affected by leprosy (TLMI 2019b).

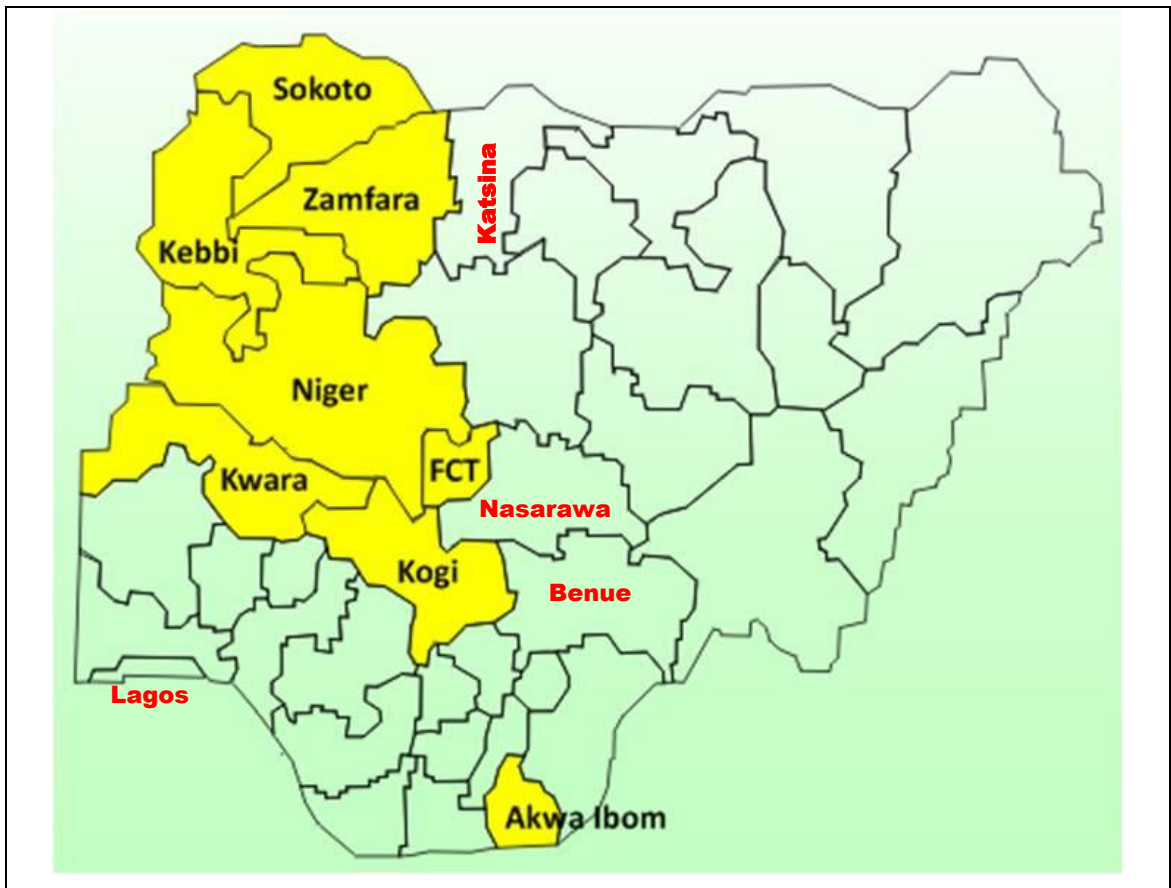


Figure 1.4: Map of Nigeria showing TLMN-supported States (TLMN 2019)

TLMI has supported leprosy projects in Nigeria since the 1920s, now coordinated by TLMN. Despite many decades of leprosy control and care with the enormous contribution made by TLMN and her in-country partners to the National Tuberculosis and Leprosy Control Programme, Nigeria still reports over 3,000 new cases of leprosy every year, with 7% and 15% of them being children and physically disabled respectively (TLMI 2019c). These figures indicate that the leprosy problem persists with ongoing leprosy transmission and

late case detection. Therefore, the present leprosy projects supported by TLMN still aim to find hidden leprosy cases, treat new patients, care for disabled cases, address the social and economic problems of leprosy and develop leprosy-affected communities to become more integrated and habitable (TLMN 2019). The map in Figure 1.4 shows that TLMN mainly supports leprosy projects in eight States in Nigeria. In recent years, however, the 2017 leprosy profile (Annexe 4) shows TLMN also extends her support to leprosy projects in four additional States – Benue, Katsina, Lagos and Nasarawa.

1.6.3 Structure of TLMN Leprosy Project Goals in 2016

Overall, the TLMN fieldwork in Nigeria is implemented in 12 leprosy projects and each is defined by its overall goal, location, funding sources and timeframes. These projects are managed by nine State Leprosy Control Officers and seven Socio-Economic Development (SED) officers. They are centrally coordinated at the head office in Abuja, the country's capital, by TLMN project managers and technical advisors who report to the National Director. A preliminary review of the goal-setting situation of these TLMN leprosy projects I did in 2017 found that only six leprosy projects located in 8 States were actively funded by the organisation in 2016. This was a quantitative document review of the leprosy project plans and annual reports for the year 2016 to investigate the quality of the leprosy goal framework and goal attainability. A customised logical framework matrix was used to analyse the baseline problems of the projects' target populations; the logical linkages between the problems, the long-term goals and the objectives; the constituent lexical components of the goal statements and the extent of attainment of the targets (Ogbeiwi, in press).

Table 1.1 shows the basic details of the six leprosy projects reviewed. They included one State Leprosy Control Programme (LCP), one TLMN-owned orthopaedic workshop and four community-based development projects. The table shows that unlike the State LCP with missing data and the four community-based projects that had a three-year project term each, the orthopaedic workshop project had a five-year term, and the largest budget, leprosy proportion and coverage area.

The community-based projects had low leprosy proportions because the target populations included non-leprosy people with disabilities, women and children.

Table 1.1: TLMN-funded leprosy projects in 2016.

Project Type	Coverage	Target Population	% Leprosy*	Project Term	Annual Budget
Leprosy Control Project	1 State	2,513,469	?	?	£ 274,371
Orthopaedic Workshop	8 States	22,500	40.0%	2014-2018	£ 533,305
Human Rights Promotion	6 communities in 2 States	27,997	3.4%	2014-2016	£ 184,515
Self-Help Project 1	6 communities in 2 States	7,580	11.7%	2015-2017	£ 143,776
Self-Help Project 2	4 communities in 1 State	5,302	12.7%	2015-2017	£ 80,360
Self-Help Project 3	6 communities in 1 State	14,800	1.3%	2016-2018	£ 64,039
Total	8 States	2,591,648			£ 1,280,366

(? = unknown); *Leprosy proportion = percentage of leprosy-affected persons among the total population of project beneficiaries

The reporting year 2016 represented a different stage in the planning cycle of different projects: mid-term for three projects, terminal for one project and the first year for another. All projects except the LCP stated baseline problems in their 2016 project plans. Seven problems were common to all four community-based projects. Apart from high occurrences and low community awareness of diseases, the more common problems were socio-economic – poverty, a begging lifestyle, low literacy, anti-leprosy social stigma, discrimination and exclusion.

All six projects had single aims, but a varying number of objectives. About nine out of every ten objectives were related to the aims. The statements of all six aims specified an expected impact and a target population. Only one aim statement (the ortho workshop) stated impact and a terminal timeframe. The review found the six projects had a total of 19 objectives. Table 1.2 (in Annexe 5, page 328) shows the list of project goals and the percentage of the objectives that had each of the four components (Outcome, Indicator, Target, Timeframe) expected in a SMART statement (Ogbeiwi 2016, 2017). In five projects, the statements had a combination of outcome and timeframe in nine in every ten

objectives. Only one (5.3%) objective (Ortho, Obj. 2) contained all four components.

Moreover, in formulating statements of aim, TLMN mostly writes the expected broad impact without specifying a timeframe. Similarly, in most cases, statements of leprosy objectives used a framework of two components, specifying the desired outcome and a terminal timeframe. The use of long-term timeframes in short-term objective statements may be due to TLMN's practice of multi-year planning of leprosy projects, but this has the negative consequence of making timescales vague. Besides, since the statements were written without specifying the relevant indicators and targets, the objectives lacked the required SMART attribute of measurability and therefore made any evidence-based assessment of goal attainment impossible.

1.6.4 Attainment of Formulated Objectives

Even though the statements of most aims and objectives did not specify indicators and targets, these components were found in the planning framework section of the project plans. In all six plans, there were a total of 42 indicators assigned for the measurement of 18 objectives. There was a mean of seven indicators per project, and a range from one in LCP to 14 in HRP. Of the 42 indicators, 35 (83.3%) were quantitative, and seven (16.7%) qualitative. Relevant baseline and target data were found for only the five indicators of the three orthopaedic project objectives (Table 1.3, page 18). However, Table 1.3 shows that only three indicators of two objectives were quantified, indicating that only 7.1% of the 42 indicators and 10.5% of the total 19 objectives were measurable.

The review also examined the outcome statements in the six project's annual reports for 2016. For 38 (90.5%) indicators, activities accomplished were reported in the place of outcomes achieved. Table 1.3 shows that none of the three quantified targets was achieved. The reason for the non-achievement of the set goals of the orthopaedic project was reported as the rising production cost. This implies that the orthopaedic project objectives were unrealistic in the financial or economic context of TLMN.

1.6.5 Justification for research into TLMN goal-setting practice

The preliminary review of the structure and attainability of leprosy project goals in TLMN found that the written statements of leprosy goals in 2016 did not possess enough components and attributes to make them SMART. Lacking indicators, targets and short-term timeframe most objectives formulated in the TLMN practice were not sufficiently specific, measurable and time-bound.

Table 1.3: Goal attainment by the Orthopaedic Workshop Project by 2016

Objective	Indicator	2014 Baseline	2016 Target	2016 Attainment
Promote functional ability among leprosy-affected persons	User functional ability (Disability Grade 2 among RFT patients) ¹	12%	10%	13%
Promote sustainability of TLMN orthopaedic workshop	% of paying clients	30%	60%	45.30%
	Number of persons reached with free orthopaedic appliances annually	751	1500	616
Strengthen governance structure, systems and capacity for staff performance and quality productivity	Evidence of functional management and advisory committees	Weak	Functional	NS
	Evidence of finance, safety, quality control and human resource manuals	None	Effective utilisation	NS

NS = Not specified in the reporting frameworks.

Even the few measurable objectives were unattainable and unrealistic.

Therefore, the quality of goal statements indicates a formulation problem in TLMN goal-setting practice. My conclusion was that this goal-setting problem in TLMN was not different from the poor state of goal formulation reported in businesses, companies and major health organisations globally by past goal-

¹ TLMN Reviewer's comment:

"The other reason for non-achievement is that this is the wrong indicator for this project. By definition the project will have a large number of clients with irreversible grade 2 [disabilities]. To expect a decrease is not realistic. Giving a prosthesis does not stop the foot being graded WHO 2, but the functional ability has improved with the mobility aid (prosthesis)" (Jannine Ebenso, Head of QA, TLMN, Brentford. UK; 16/08/2019).

setting research (Institute of Personnel Management 1992; Yeara Maitlis & Briner 1995; Greenbank 2001; Bipp & Kleingeld 2011; Ogbeiwi 2017).

Nevertheless, the initial review did not access any in-depth information that could explain how the examined goals were formulated or the perspectives of the managers who formulated them about their experience of TLMN goal-setting practice. Hence, for a clearer understanding of the development of these leprosy project goals formulated in TLMN in order to recommend how to improve the organisational goal-setting practice, a further qualitative investigation of the practice was needed in the field realities of the leprosy managers.

1.7 Purpose of Study

Overall, the purpose of this study was to explore the goal-setting practice that formulated the reviewed goals of the leprosy projects in Nigeria and answer the question of how they were formulated. In this study, despite their international affiliations, TLMN was considered a typical healthcare organisation delivering public health interventions in a low-income country context. My core aim was to systematically investigate how the leprosy project goals and objectives were formulated and written, looking specifically at the process of deciding and constructing their goal statements. The expectation was that an empirical in-depth description of the general pattern of leprosy goal-setting in practice would explain the particular goal-setting culture of TLMN. In turn, this might reveal a clearer understanding of the nature of goals the organisation uses for planning, delivery and assessing leprosy projects in the country.

Setting goals is a global phenomenon and an evidence-based best practice for effective organisational management (Locke and Latham 2002; Locke and Latham 2006). Goal-setting practices have been used as effective interventions to improve project implementation, increase organisational productivity and attain better health outcomes (Greenwood 1981). Therefore, goal-setting is a remarkably common practice in many results-oriented organisations like The Leprosy Mission Nigeria (Locke and Latham, 2006; Bipp and Kleingeld 2011). However, while there is so much information about the theoretical and

experimental dimensions of the goal concept, very little is known about the nature and culture of goal-setting in healthcare organisations working in low-income countries. Primarily, this is because few researchers, if any at all, have explored how goals are formulated and written in practice for field projects intervening tropical diseases like leprosy globally.

Moreover, existing goal-setting theories have originated mainly from deductive behavioural studies conducted under experimental settings (Locke & Latham 2002) or anecdotal reasoning of management consultants (Doran 1981).

Therefore, theoretical frameworks of SMART goals and objectives induced empirically from explorative studies of goal-setting practice in the context of healthcare organisations are uncommon. Instead of using the experimental or scientific approaches of researchers, who themselves are external to the goal-setting environment being studied, my doctoral study followed an alternative pathway. Rather, it was hinged on a relativist, naturalist and constructivist worldview that assumed the presence of multiple realities about goal-setting practice (Denzin and Lincoln 2011; Creswell 2009; Creswell 2014).

I believe these realities should evolve from the actual organisational experience of field project managers who either formulated the goals or were assigned the responsibility for attaining the goals under study. Therefore, the truth of the goal-setting phenomenon in TLMN practice is considered a relative or subjective concept that is only understandable from the way they constructed their goals, and the meanings they gave to their shared experience of the goal-setting process (Charmaz 2008; Denzin and Lincoln 2011; Creswell 2009; Creswell 2014). This study, therefore, provided an opportunity for me, as a researcher, to enter the world of people who set the goals for leprosy care services in TLMN, in order to understand from their perspectives how their project goals were formulated for results-oriented project planning and service delivery.

1.8 Outline of this Thesis

This thesis is an eleven-chapter report of my doctoral research project. This first chapter introduced the entire thesis. It provided the relevant background

information of goals and goal-setting, my doctoral research journey and TLMN as my study organisation. It is, therefore, the rational foundation to the ten chapters that follow it. Chapter two provides details of a robust narrative literature review done through a structured search of literature databases for available knowledge about goals and goal-setting, as well as specific frameworks being used for goal-setting in healthcare and leprosy services. The literature gaps identified provided the basis for the refinement of the research purpose and the study questions. Thus, chapter two ends with the essential framework of this doctoral research, including the research problem, purpose of study, core research questions and the specific objectives achievable at the end of this doctoral study. In particular, the core research question provided the operational guide for the decisions made regarding the methodological framework. These are the philosophical paradigm, study designs and methods of data collection and analysis written in the three chapters – from chapters three to five.

Specifically, chapter three describes my qualitative approach to this research. It provides details such as the criteria for my selection of a qualitative methodology. It also discusses the basis for my choice of case study method, and exclusion of other qualitative study designs (Creswell 2013). Chapter four gives a detailed description of my case study design and the procedural outline of the methods of data collection. This chapter also narrates my framework of three research methods, including the organisation of participant interviews of leprosy managers, unstructured examination of goal statements in project planning documents and direct observation of TLMN goal-setting activities. Chapter five describes my model of qualitative data analysis that combined the typical model of Thematic Analysis according to Braun and Clarke (2006) and Charmaz's (2008) social constructionism. Chapter six reports the initial results of this research. These are narrated as the basic concepts of the three final emergent goal-setting themes and their subsequent integration through hermeneutical theorisation into eleven the frameworks identified in TLMN goal-setting practice.

Chapters seven, eight and nine are the discussion chapters where the theoretical goal-setting frameworks of the three final themes of stakeholders,

strategies and statements respectively are interpreted in relation to current knowledge in literature. In chapter ten, all emergent theoretical frameworks were further reduced and integrated into one general theoretical framework that is illustrative of the TLMN goal-setting practice studied. A theory of practice of goal-setting was then developed from my proposals of the main constructs and relationships observed in the general TLMN practice framework. The final chapter, chapter eleven, contains the overall summary of my thesis, my conclusions of the practice theory of goal-setting, and the key recommendations of this doctoral research project. The chapter ends with an evaluation of the extent of accomplishment of my three study objectives outlined in chapter two.

1.9 Summary of this Chapter

This introduction chapter presented the basic information of the goal concepts, my research journey, the history of goal-setting research and the questions that persist in the knowledge and practice of goal-setting. Overall, the existing goal-setting theories evolved from either experimental psychological studies or anecdotal constructions of SMART goal frameworks in management sciences. Goal-setting is a universally popular concept, but there is empirical evidence that many managers rarely know how to formulate SMART goal statements. Therefore, the extent to which the prevalent goal-setting theories are workable in the real practice of organisations and their managers who set goals is questionable. So far, no research evidence is available on how goals are formulated in practice and virtually all goal-setting studies have been conducted in high-income countries. So how is the practice of goal-setting in low-income countries?

Therefore, a leprosy organisation in Nigeria, TLMN, was selected as my study organisation in this doctoral goal-setting research. Background information on TLMN and the leprosy projects they fund in Nigeria was outlined in detailed. The chapter ends with a background report of the review of the quality of TLMN leprosy project goals formulated for the year 2016. The incomplete components of the goal statements and the economic context of TLMN revealed that the leprosy goals formulated by TLMN practice were not SMART. While this aligns with the universal problem of poor goal-setting, it provides a justification for

further explorative research to investigate how the leprosy project goals were formulated in TLMN's practice context in a low-income country.

The next chapter (Chapter two) is the report of the literature review using a generalist narrative approach. It critically analyses existing goal-setting concepts in academic literature and identifies knowledge gaps that provided the basis for the refinement of the study purpose and questions addressed in this research. That chapter ended with the outline of the research questions and study objectives that were the strategic pointers to the qualitative methodology and case study design employed in this doctoral research.

Chapter 2

NARRATIVE REVIEW OF LITERATURE

“So long as a person is committed to the goal, has the requisite ability to attain it and does not have conflicting goals, there is a positive linear relationship between goal difficulty and task performance”

(Locke & Latham 2006: 265).

2.1 Introduction

This chapter presents a narrative literature review of the subject matter of my research: goals and goal-setting, as available in contemporary databases, especially in the healthcare sector. It specifically describes the search strategy used for obtaining the literature sources reviewed and reports the findings in six main sections. These include terminological definitions, classifications, philosophy of goal-setting, goal-setting frameworks, writing SMART goal statements and goal-setting in healthcare. At the end of the review, the gaps in literature are summarised and discussed; and conclusions are made on the implications of the gaps for this goal-setting research. The chapter ends with an outline of my research questions and objectives which were based on the key knowledge gaps in literature on goal-setting in health generally and leprosy care specifically.

This chapter reports the narrative review of the 70 literature materials obtained from the earlier phase of literature review for this doctoral research. It was updated during a later phase of literature search that was done after compilation of my research findings for more current literature evidence with which to compare and discuss my research findings. The search in the latter phase was substantially a review of goal-setting frameworks in healthcare projects as guided by the key themes of the theoretical frameworks that emerged from the goal-setting practice of TLMN. Hence, in view of the qualitative methodology of this research, the findings in literature from the initial phase of review was preliminary. It served the essential purpose of providing background information that was enough to understand the available knowledge of the subject of goal-setting at the time of conceptualising my research framework. In particular, the

literature gaps helped to refine the research questions applicable to the exploration of goal-setting for the leprosy projects in TLM Nigeria.

2.2 Purpose of Review

The place of literature review in qualitative research is a contested matter (Creswell 2014). Most proponents of constructivist paradigm argue that because of its exploratory and naturalist approach to the discovery of reality and truth, a literature review should not be done before the field data collection and analysis stages of the research. According to them, literature review that is done before a qualitative study may be obstructive to the process of inductive inquiry (Glaser 1978). A constructivist and naturalist researcher should enter the world of study participants with as much an open and clear mind as possible (Glaser, 1978; Bryant & Charmaz 2007b). They believe that any pre-existing knowledge of the subject matter being researched is likely to bias the primary data collection. This supposedly ensures that the research findings are unprejudiced by any pre-determined impressions that could corrupt the knowledge and meanings of the researched topic that may exist in the natural state of study participants (Bryant & Charmaz 2007b). Therefore, to this school of thought, it would seem more acceptable and sensible for investigative field research that a literature review becomes relevant at a later stage when the knowledge deductible from any previous academic work can be compared with the findings that emerged inductively from the research data (Creswell 2014). Yet, other qualitative researchers believe that a detailed pre-study knowledge of the subject being researched may be helpful for the development of data collection tools, analytical templates and hermeneutical lens needed to make sense of massive qualitative data collected (Strauss & Corbin 1998).

Nevertheless, it is also acceptable that in all research inquiries, whether deductive or inductive, literature review may be done to better refine the research problem, identify gaps and streamline the study questions on which the study design is developed (Creswell 2014). This was the approach adopted for this research. Rather than using the findings of this pre-study literature review of previous goal-setting works to develop a data collection template or

hermeneutical lens to analyse the results, as some renown authors suggest (Strauss & Corbin 1998), goal-setting evidence gathered from this literature review in this chapter was used to identify gaps in the current knowledge of goal-setting generally and healthcare sector specifically.

Therefore, the objective of this literature review was primarily to gain insight into my research topic. This was achieved by summarising and critically analysing existing empirical evidence of goals and goal-setting practices in academic literature, authored in as many work settings as available at the time of the searches. As my study explored the frameworks used in the formulation of leprosy goals, it was reasonable that the focus of literature review should be the current knowledge of goals generally and goal formulation in the healthcare sector specifically. So, to guide the literature review, the general questions at this stage were: What is a goal? Why and how are goals formulated generally? What specific frameworks are used in the formulation of goals in modern day healthcare setting?

2.3 Literature Review Method

This was an objective process of reviewing many sources of available research and non-research literature written on goal-setting to retrieve useful, credible information of the current knowledge and practices in relation to the guiding review questions (Cronin et al. 2008). A narrative approach recommended by Cronin et al. (2008) for a traditional literature review methodology was used. This was because it enabled a broader and more general search, for literature materials than the systematic approach. An initial search for textbooks and articles about goals and goal-setting in the libraries of the University of Bradford yielded scanty results. Goal-setting was therefore considered a relatively rare topic in academic literature, and a wider extensive search was therefore necessary to find the literature materials needed to build an evidence base for my research. Besides, it was considered enough to summarise and synthesise available data on goal-setting and find answers to the general questions projected for the review. The more rigorous systematic literature review approach that involves a stepwise, reductive and intensive search for more specifically relevant published literature was not done. Thus, it was not the

purpose of this literature review to create a pre-determined and prescriptive conceptual framework as a theoretical or interpretative lens for examining or analysing the goal-setting practice of TLMN's leprosy projects (Creswell 2014).

2.4 Literature Search Strategy

Initially, a broad search for academic goal-setting articles was done through three databases. Two of them were accessed through the University of Bradford library search sites and the third was Google scholar search engine. The university library databases were Health Management Information Consortium (HMIC) accessed via the links to Health Studies databases, and Emerald database accessed via links to Management databases. These databases were selected because of their wide collection of peer-reviewed journals relating to healthcare and management research. At all three databases, keywords were used for the literature searches. These were "goal-setting", "objective setting", "framework for setting objectives", and "management by objectives". No timeframe was used in the search through Google scholar. Similarly, no timeframe was initially specified in the searches of the HMIC and Emerald databases, but to find more recent studies that were not older than 10 years they were later restricted to the period from 2005 to November 2015 (when the first searches were done). Using objective setting, for example, a total of 38,844 was generated by the HMIC database. The Emerald management database generated 81,608 articles for goal-setting, 51,053 for framework for setting objectives and 97,212 for management by objectives.

Also done was a second, follow-up more restricted but multiple database searches in 2016 that connected six databases in the same key-phrase search and limiting the duration to a ten-year period from 2006 to 2016. The databases included CINAHL, EBSCOhost (eBook collection), Medline, PsycARTICLES, Psychology & Behavioural Sciences and Psych.INFO. The key phrases were 'Goal-setting', 'Framework or model or theory', and 'Health'. When the three phrases or words were searched with "AND", 2,617 articles were generated. This number was reduced to 1,944, when the dates of publication were limited to 2006 to 2016. In addition to searching databases, some secondary sources, such as the paper by Doran (1981), cited in these articles were traced through

links in the references in the primary sources, in a way that describes snowballing technique. These articles were traced through using either google or google scholar search engines. Textbooks available to the researcher, including dictionaries, books and articles relating to organisational management with indexed materials on “goals”, “objectives” or “goal-setting” were also included in the review as sources. Also added were more recent articles including the ones written by the researcher.

Overall, 70 literature materials were selected for review, including 18 abstracts of journal articles, 36 full-text journal articles, five book articles (edited by Locke and Latham), six textbooks, two each of factsheets and toolkits and one glossary. Thus, a total of 59 (84.3%) out of the 70 literature materials reviewed for the initial and follow-up review were related to academic articles, and 54 (91.2%) of them are peer-reviewed journal materials. While the initial and follow-up database searches were done to generally explore current knowledge and studies in goal-setting, identify literature gaps and finetune my research questions, later searches were done continuously after the data collection and analysis stages of this doctoral research. These were specific searches of Medline, PubMed, AMED and the University of Bradford Library search engine for academic literature evidence that related to the three final themes that evolved from the thematic analysis of collected data – including goal-setting stakeholders, goal-setting strategies and goal statements. In these later searches, the duration was more flexible and expanded to include the recent years up to 2019. The evidence gathered from all three phases of literature search were used to discuss the results of this research written in chapters seven, eight, and nine.

2.5 Selection Criteria for Reviewed Literature

The key criteria used for selecting literature material for review were relevance, year of publication, quality of written material, and the availability of the article for review. In all phases of literature searches, the direct relevance of an article to the research topic and the review questions was determined by the inclusion of the goal-setting terms in its title. Initially, the year of publication was not important during the first phase when a broad net was needed to gather as

many goal-setting-related articles as possible. In the later searches, a timeframe of 5-10 years was used to refine the search for current and contemporary articles. So, all articles that reported any work that was not connected directly to goal-setting studies were excluded. On the quality of literature, this was ensured by limiting searches to credible academic sources or published articles relating to original empirical research work. Thus, all literature whose sources could not be traced to academic journals, institutions or formal textbooks were excluded. Thus, a lot of online blogs and personal discussion papers such as the extensive online write-ups by Kellock (2012), RapidBi (2007) and Funds for NGOs (2013) were excluded based on this criterion. Many goal-setting research articles were also excluded for lack of definitions of goal terms.

Similarly, all review articles reporting secondary or tertiary level analysis or synthesis of the research works of other authors were excluded. Availability of the article depended on online access to the full text. Therefore, even though some relevant articles available only as abstracts were selected in the earlier phases, they were excluded in the later phases, when only full-text articles that could be downloaded or printed for review were selected and studied.

2.6 Literature Data Collection Technique

All literature materials selected for review were examined for information relevant to the concepts of goals and goal-setting, and the review questions. The examination of the articles was done using the technique of document examination or desk review with information extracted with the aid of a literature review template or checklist or grid. Table 2.1 shows the headings of the template:

Table 2.1: Template used for initial review of literature materials

Details* of literature	Paradigmatic issues or debates	Methodology	Areas of goal-setting covered	Country of origin	Key findings	Conclusions

*Basic details: type of material, author(s), title, year of publication, journal, publishers

Before the grid was filled, the article was first browsed through to confirm further relevance to the study topic. The findings extracted from the 70 literature materials were synthesised into six main headings reported in this chapter (Table 2.2, Annexe 5, page 330). These included terminological definitions (16), Classification (13), Theory and philosophy (20), goal-setting frameworks (18), writing goal statements (17) and goal-setting in healthcare (20). So far at this stage, relatively few empirical articles were related to the goal-setting framework or goal formulation in healthcare. No articles were found that reported goal-setting practices of organisation in any low-income country. None were found for leprosy goal-setting either.

2.7 What is a Goal?

The Collins English dictionary defines a goal simply as an 'aim or purpose' (Collins 2006: 363). Oxford Social Care dictionary defines it as 'an end result' that a piece of work is specifically performed to achieve (Harris and White 2013). Hence, popular goal-setting theorists render the meaning of the term as the 'object or aim of an action' (Locke and Latham 2002: 705), 'future valued outcomes' (Locke and Latham 2006:265), or generally, 'that which one wants to accomplish, a valued future end state' (Lee et al. 1989; Stretcher et al. 1995). Accordingly, more contemporary researchers like Fitsimmons (2008), Day and Tosey (2011) and Nanji et al. (2013) use the term respectively as 'a desirable end'; 'a description of an intended future state' and 'an envisioned future'. In addition, authors in the field of organisational management define 'goal' as, 'Something the organisation is striving to accomplish' at a future time frame (Mullins 1999: 116) or 'The immediate or ultimate objectives' that the work of employees is directed at achieving (Bratton et al. 2007: 250).

Moreover, the definition by Bratton et al. (2007) shows the term 'objective' is also defined synonymously as 'goal'. According to Beardshaw and Palfreman (1990: 31), objectives are 'Statements of what an organisation is aiming to achieve.' Mullins (1999:123) also equates 'objectives' etymologically to terms such as 'goals', 'aims' or 'end-result' – that an organisation expects to achieve at a set time. Seemingly, this author asserts that both goals and objectives have similar typologies. For example, according to the author, goal types range from

a broad 'overall purpose' of an organisation to 'a more specific desired accomplishment' (Mullins 1999:116), while types of objective also vary from 'general objectives' formulated at the top management structure of organisations to 'specific objectives' formulated regarding particular achievements expected of sub-organisational work areas and definite timeframes where they should apply (Mullins 1999:124).

As goals and objectives, other terms like 'target' and 'aim' have been used interchangeably as their synonyms in goal-setting literature. Even though Day and Tosey (2011) recognise Jones and Duckett's (2004) distinction of targets and goals as 'short-term' and 'longer-term' aims respectively, they still prefer to use the terms interchangeably in their article. This suggests that the differentiation of the meanings of the goal concepts may be terminologically hazy in the academic arena. These goal terms are part of the universal terminological confusion already reported since the turn of the 21st century in the development sector (DAC-OECD 2002; Ogbeiwi 2016). Several attempts have therefore been made in this sector to hermeneutically distinguish them in glossaries of unified definitions that are agreeable across different disciplines, organisations and countries (DAC-OECD 2002). However, definitions in literature from the development sector differentiate a goal from an objective. Typically in this sector, a goal is defined as either a higher-order objective or a development objective – in the sense that a goal is a longer-term objective or improvement, change, outcome or impact (DAC-OECD 2002; Mackay 2007; SIDA 2007; UNIADS 2008, 2010; D'Agnes & Slater 2009; USAID 2009; UNDG 2011). Whilst the meaning of the term goal seems to have a rather generic cover for all types and levels of desired achievements in the health sector, the understanding differs in other sectors. Definitions in the healthcare literature were prone to define a long-term goal as an aim and a short-term goal as an objective (Save the Children 2003; UHBristol NHS Trust 2009; Victorian DoH, 2010; WHO 2016).

Therefore, from recent definitions in health, one can infer that goals express the expected results or desired effects of a planned action or work, but can differ in type, meaning and structural formulation, depending on the level of organisation or programme or intervention at which they are set. As this research was done

in a healthcare context, the understanding and use of the different goal terms complied with the definitions published in the healthcare sector (Save the Children 2003; UHBristol NHS Trust 2009; USAID 2009; WHO 2016; UNDG 2011). They also aligned with the definitions I proposed following my integration of the different definitions I found in the literature materials sourced from different sectors (Ogbeiwi 2016). According to my propositions, the use of the term 'goal' in a development context is synonymous to an aim, which means a 'long-term goal' in a healthcare context (Save the children 2003). An objective is a short-term goal, achievable as an intermediate milestone towards attaining the overall aim (USAID 2009; UHBristol 2009; UNDG 2011). As illustrated in Figure 2.1, Ogbeiwi (2016) views objectives as the direct results of the outputs of interventions implemented, whereas aims are the ultimate effects of the objectives attained.

Therefore, aims, objectives and targets are considered different types of goal rather than synonyms. According to Ogbeiwi (2016), each goal term has a distinctive conceptual framework differentiable by a set of seven themes: object, scope, hierarchy, timeframe, measurability, significance, expression (Ogbeiwi 2016).

Thus, an aim has a framework that is definable by its object of impact, broad overall scope, terminal hierarchy, long-term time-frame, poor measurability, significance of purpose and success, and expression as a qualitative statement that generally specifies an expected Impact and a long-term time frame (Figure 2.1, page 33). On the other hand, an objective has a framework with an object of outcome, specific scope, intermediate hierarchy, medium or short-term time frame, quantifiable measurability, significance of effectiveness and expression as a SMART goal statement (Ogbeiwi 2016). SMART is the acronym given to the five criteria for setting effective goals, which was first published by George Doran (1981). However, it is considered an anecdotal management principle, because the original paper was not based on any research evidence. According to Hartigan (2012a) this acronym was first introduced into rehabilitation goal-setting by Schut and Stam (1994). Concerning target, it is universally accepted as a key part of the composite structure of an objective statement. It is therefore structurally different from an objective. In an objective, it represents a desired

level of the indicator to be achieved with the specified time frame (UNAIDS 2008, 2010; USAID, 2009; UNDG, 2011; Ogbeiwi 2016).

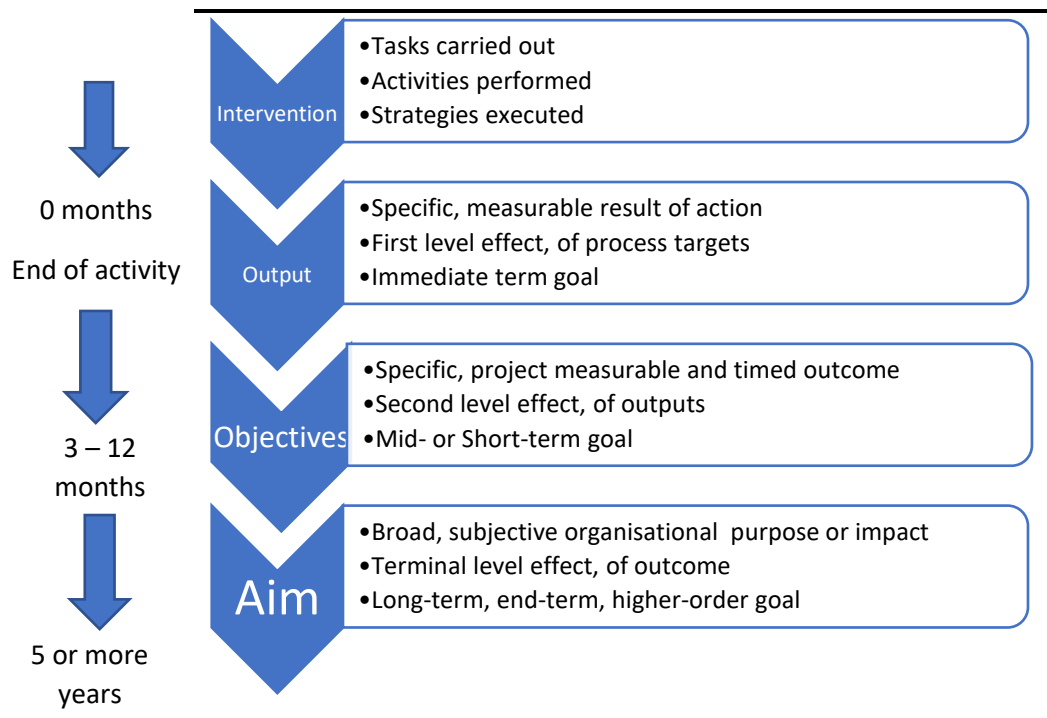


Figure 2.1: The Linear direction of intervention effects and goals

2.8 Classification of Goals

A goal statement is written in different forms and types. Bratton et al. (2007) differentiate immediate and ultimate goals, and Mullins (1999), broad purpose goals and specific accomplishment goals, or general and specific objectives. Mullins (1999: 119-120) gives two different classifications of goals. The first differentiates goals into three types according to the concept of 'power and compliance' – including *order goals* (to restrain workers), *economic goals* (to set profit margins) and *cultural goals* (social needs of workers). The second classification differentiates goals according to the type of organisational system results they represent: including *consumer goals* (e.g. consumer satisfaction targets), *product goals* (service/goods objectives), *operational goals* (performance targets) and *secondary goals* (sub-goals linked to the overall organisational aim).

Moreover, in any service delivery system, goals are classified hierarchically, as they differ according to different organisational structural levels and timeframes

for their attainment. Accordingly, they cascade structurally downwards from the broad general goals to specific goals, and temporally upward from immediate to short-term or intermediate to long-term goals (Bradley et al. 1999). A general goal is a broad aim or statement of the expected long-term impact of an intervention, a futuristic vision or an overall purpose of an organisation. Conversely, a specific goal is either the immediate output or intermediate (medium-term or short-term) outcome. While output is the specific result of a completed task or activity, an outcome is the specific result of a strategic work executed by a team, project, programme or organisation (DAC-OECD 2002; Ogbeiwi 2016).

Some researchers like Whitehead (1998) differentiated the two goal types of general and specific simply as symbolic and action-oriented targets. From her description, symbolic targets are broad and unmeasurable goals stated at a higher organisational or national level intended to inspire and motivate the workers. Action-oriented targets are specific goals with an amount of targeted change to be achieved at a local level in a given population. They are stated with a measurement indicator and by a given time frame (Whitehead, 1998). Some researchers have used other terms, such as distal and proximal goals to differentiate general and specific goals in line with their respective distant and near timeframes for achievement (Yearta Maitlis & Briner 1995; Ginsburg 2001). Clearly, therefore, alternative terms for proximal and distal goals are short-term and long-term goals (Kerr & LePelley, 2013). This supports the impression that goals within an organisation can be hierarchical both temporally (in time) and structurally (in authority and responsibility levels).

In addition to general versus specific goals or long-term versus short-term goals, other binary classifications of goals have been widely studied. Some of these include quantitative versus qualitative, assigned versus participative, conscious versus subconscious, micro versus macro, difficult versus easy, explicit versus vague, and performance versus learning (Erez & Earley 1987; Yearta Maitlis & Briner 1995; Ginsburg 2001; Locke & Latham 2006; Ker & LePelley 2013). Similarly, the different levels of learning goals have been popularized by Bloom's taxonomy of goals (Forehand 2005). Clearly, the concept of assigned and participative goals indicates that goals are also

classified in literature by the process that produced them. Busse and Wismar (2002a) describe an analytical model with two political coordinates of goal-setting. On this model, goals can be either technocratic or participative. *Technocratic* goals are those set through prescriptive, assigned, non-consultative or top-down approach, while *participative* goals are agreed goals that emerge from an all-stakeholder-inclusive bottom-up approach. In an organisational context, the assigned goals are formulated unilaterally by top management and delivered to employees who then carry out activities or services towards achieving them. On the other hand, participative goal-setting begins with the collaboration and consultation of all relevant stakeholders at the grassroots level (Busse & Wismar 2002b). Hence participative goals are jointly set and agreed by all, involving both the employees and the management of the organisation (Locke & Latham 2002).

Accordingly, most proponents of the goal-setting theory define the three goal-setting approaches as sources of goals in work performance settings. In addition to assigned and participative goals, they add that a goal can be 'self-set' (Locke & Latham 2013). Unlike the assigned goals, self-goals are set by the individual employees as the targets or outcomes they desire to achieve for either themselves or the project or the organisation (Locke & Latham 2002). The experience of self-set business versus personal objectives in British micro-businesses was studied by Greenbank (2001).

In summary, goals differ according to their contextual, structural and functional characteristics. Contextual characteristics refer to differences in the goal-setting process or *how they are set*, especially the different sources and approaches that differentiate self-set, assigned and participative goals. Structural characteristics refer to the differences in the content of their statements or *what goal framework with which they are formulated*. This differentiates goals according to their different hierarchies of specificity, clarity, measurability, timeframe, and attainability; such as the frameworks that distinguish general and specific goals; or immediate, short-term and long-term; or micro and macro goals. Functional characteristics refer to the different goal purposes or uses, or *why they are set or which aspects or changes in the organisation they are expected to measure*. These functional attributes differentiate performance and

learning goals or symbolic and action-oriented goals. This observation is compatible with the Locke and Latham's (2002) description of core goal attributes in their goal-setting theory, which differentiated goals according to their content and intensity; and defined goal content further by the goal specificity, clarity and difficulty.

The goal classifications have major implication on planning in organisational settings, where goals can be set for the desired effect of performance at each of three temporal levels of immediate, intermediate or mid-term and terminal, as well as for the structural levels of individual, team, departmental and organisational (Locke & Latham, 2006; Fitsimmons, 2008). According to Fitsimmons (2008), an effort is made during planning to logically link or align the lower-level goals with the higher goals, also referred to as macro-level or cooperative goals, to ensure goal relevance at all levels (Yearta Maitlis & Briner 1995; Locke and Latham 2006).

2.9 Philosophy and Theory of Goal-setting

Inherent in every goal statement is the expression of both a *dissatisfaction* with the current situation and a *desire* for change to a better future state (Locke & Latham, 2006; Day & Tosey, 2011). Yearta, Maitlis and Briner (1995) connected desired goals with the needs the people who set them have. Fitsimmons (2008) also asserts that every goal is set to express the change or effect that the planned work or intervention is expected to impact on the problem situation of a target population or organisation. Therefore, the traditional approach to goal-setting is problem based (Locke & Latham 2002; van Herten & Gunning-Schapers 2000b, Fitsimmons 2008). However, the main philosophical reasoning behind goal-setting is that a well-formulated goal can motivate a positive change in a person's behaviour that would improve his or her performance of tasks relevant to achieving the desired result or reward (Locke & Latham 2006). This reasoning underscores the theory of goal-setting theory and task performance postulated by Locke and Latham in 1990.

The goal-setting theory was based on massive research evidence obtained from over 400 empirical studies done in over four decades (Locke & Latham 2006). According to Locke and Latham (2006), the experiments spanned from

one minute to 25 years and involved over 40,000 participants in at least eight countries in four continents (Asia, Australia, Europe and North America). The tests included more than 100 various tasks in both field and laboratory settings (Locke & Latham 2002, 2006). Simply put, the goal-setting theory states that setting specific and difficult or challenging goals will motivate higher task performance than ambiguous, vague or easy-to-reach goals (Locke and Latham, 2006). This theory also links specific and difficult goals indirectly with other independent variables such as higher levels of individual satisfaction or better outcomes as consequences of improved individual task performance (Locke & Latham 2002).

Thus, the theory shows that setting a goal statement that has the two attributes of specificity and difficulty has primary and secondary benefits. The primary effect is improving task performance and the secondary effect is enhancing satisfaction when the desired outcomes are achieved (figure 2.2).

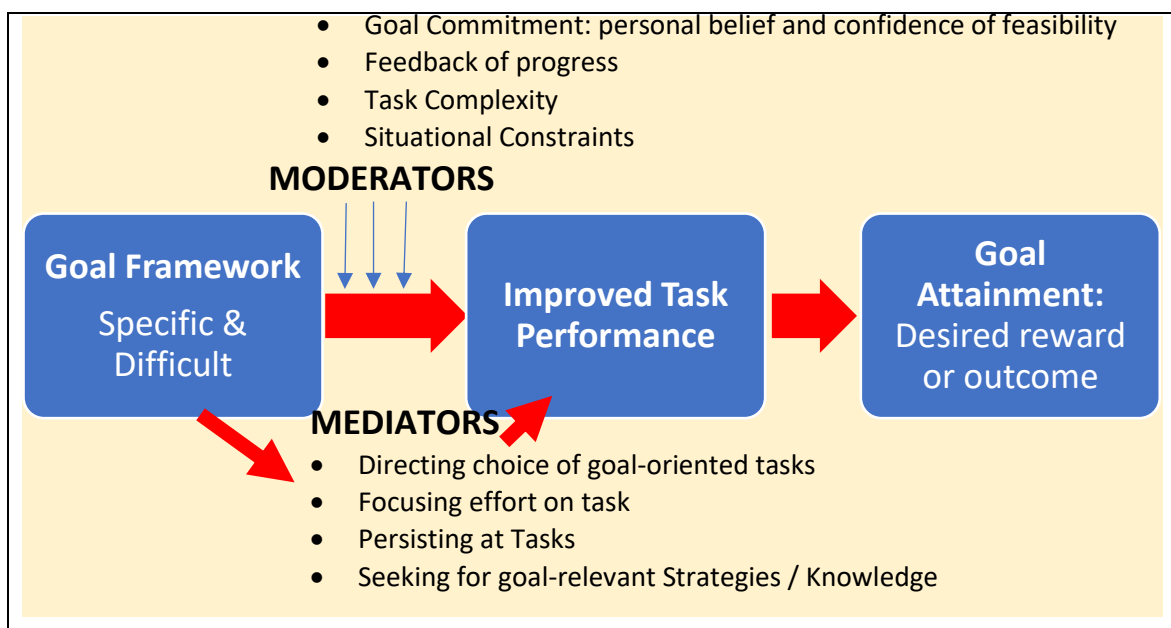


Figure 2.2: Locke and Latham's (2002) Goal-setting Theory

Many further empirical studies based on the goal-setting theory such as the ones by Campion and Lord (1982), Matsui, Okada and Inoshita (1983), Wood, Mento and Locke (1987); Yearta, Maitlis and Briner (1995), Seijts and Latham (2000a, 2000b); Brown, Jones and Leigh (2005), and Locke and Latham (2002, 2006, 2013) attempted to explore why and how goal-setting produces these effects on task performance and subsequent outcomes. They all concluded that

certain mediating and moderating factors must prevail in the individual worker and his or her organisational environment for goal-setting to be effective (figure 2.2, page 37). The mediators are the four mechanisms of the goal effects on task performance. According to Locke and Latham, specific and difficult goals motivate higher task performance by *directing* individual employees to perform activities that are relevant to the goal, *inspiring* them to focus, increase and persist on efforts at attaining the goal, and *changing* their behaviours towards using or seeking the capacity (knowledge and skills) required to perform the goal-related tasks.

Thus, it is gathered from their work that goals effectively influence task performance outcomes through four different functions, including *directing action*, *energizing effort*, *persisting on task* and strategizing *cognition* (Locke & Latham, 2013). Citing from the work of other authors, Locke and Latham (2002, 2006) reported that these mediators are in turn controlled positively by four moderators, which influence the outcome of the goal-setting process. The key moderators include: the workers' *commitment* to the goal, which is determined by their personal *belief* of the importance or seriousness of the goal and self-efficacy or their personal *confidence* that the goal is attainable (Seijts & Latham, 2000a); presence of *feedback* on the progress of their performance and results (Matsui, Okada & Inoshita, 1983); the *complexity* of the task to be performed in order to attain the goal (Wood, Mento & Locke, 1987) and the situational *constraints* (Brown, Jones & Leigh, 2005). On the whole Locke and Latham restated their theory thus: "So long as a person is committed to the goal, has the requisite ability to attain it and does not have conflicting goals, there is a positive linear relationship between goal difficulty and task performance" (Locke & Latham 2006: 265).

Since Locke and Latham formulated their theory of goal-setting, several studies have been done to verify the theory through application in field situations in many sectors. Medlin and Green (2009) expanded the theory when they conducted a descriptive survey of 426 full time and part-time employees conveniently sampled in Southern USA to test three new goal-setting hypotheses – that there are two additional predictor constructs in the relationship between goal-setting and individual task performance. These are

employee engagement (full involvement and enthusiasm in the job) and workplace optimism (unwavering belief in the “best possible outcome”).

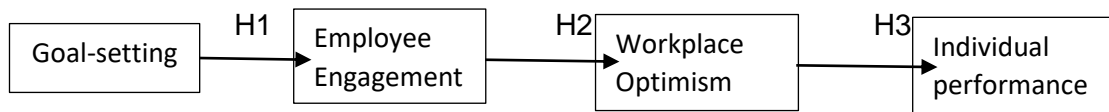


Figure 2.3: Medlin and Green’s (2009) Structural Model of goal-setting theory

Based on their findings, they hypothesized that organizational goal-setting is a positive predictor of employee engagement (H1), which in turn is a positive predictor of workplace optimism (H2), and which in turn is a positive predictor of individual performance (H3) (Figure 2.3). However, an attempt by Yearta, Maitlis and Briner (1995) to replicate the relationships in Locke and Latham’s goal-setting theory under a non-controlled real-life organisational setting found reversed relationships between the key constructs of specific, difficult goals and task performance. Instead of reproducing the theory, that harder goals motivate higher performance and satisfaction (figure 2.2, page 37), Yearta, Maitlis and Briner (1995) discovered that the harder the goal in a normal organizational context, the lower the task performance. This suggests a negative relationship between difficult goals and higher task performance. They also found that participative goal-setting significantly improves task performance contrary to the no-effect reported by Locke and Latham (2002). Caution was therefore advised in the use of hard goals in goal-setting practice within non-experimental settings, even though they entertained suspicion that their contrary findings could also be caused by methodological artefacts and other limitations (Yearta, Maitlis and Briner, 1995).

Similarly, two other studies, Erez and Earley (1987) and Boyce et al. (2001) tested the goal-setting theory against three goal-setting approaches (self-set, assigned and do-your-best) to determine their effect on the task performance in different contexts. Erez & Earley (1987) worked with three cultural groups of 180 American and Israeli participants and Boyce et al. (2001) tested the task of tennis serving with 157 college students after giving them nine tennis classes with goal-setting. Similar to Locke and Latham (1990, 2002, 2006) theory,

Boyce et al. (2001) reported that performance was better in the groups with specific goals, whether instructor set (assigned) or self-set, than in the group with 'do-your-best' goals. However, contrary to Locke and Latham's (2002, 2006) hypothesis that goal sources have no effect on outcome, both studies reported significant differences in outcomes with the different goal-setting approaches. Erez and Earley (1987) found that participative goal-setting produced higher levels of goal acceptance and performance than the assigned approach, with no significant cultural difference; while Boyce et al. (2001) reported that performance was better in the assigned goal group than the self-set goal group.

Like Yeararta, Maitlis and Briner (1995), other more recent authors such as Kramer, Thayer, & Salas (2013) and Ordonez et al. (2009) have asserted that the Locke and Latham's goal-setting theory might not apply in every organisational context. Yeararta, Maitlis and Briner (1995) concluded in their study that the theory does not consider organisational or work settings with multiple goals. Kramer, Thayer, & Salas (2013) infer that the key factors in the goal-setting theory involving single goals are different from the factors that prevail when goals are set for enhancing team or group performance. According to them, this is because team goals bring a social dimension, with its social dynamics and a multi-level concept of individual, team and organisational goals, into goal-setting. These same factors, according to Locke & Latham (2006), also inherently introduce into goal-setting the problem of goal conflict (where individual personal goals conflict with group or organizational goals), which was found by the Seijts & Latham (2000b) study to hamper group performance. Lastly, Ordonez et al. (2009: 3) in their working paper warned that Locke & Latham's theory of goal-setting and task performance should not be seen as a halcyon pill or panacea for motivating employee for better performance because of the experience of adverse organisational side effects of goal-setting reported by organisations such as Sears, Roebuck and Co. (Dishneau, 1992), Enron (Ackman, 2002) and Ford Motor Company. Ordonez et al. (2009) surmised that in organisational settings, where goals are too specific, too narrow-focused, too many, too time inappropriate, and/or too challenging, they might encourage harmful riskier and unethical behaviour by employees in response to the goal

drive to improve performance and achieve promised rewards. In their response, Locke and Latham admitted the presence of gaps in the goal-setting theory, which makes it a continuously evolving theory that is always open for further research (Locke & Latham 2006, 2013).

Nevertheless, there is agreement among a wider range of goal-setting researchers on the general usefulness of goals as a motivational and inspirational management tool that helps employers and employees to be focused on increasing the tasks, effort and capacity needed to achieve the desired outcomes (Bradley et al. 1999; Locke & Latham, 2002; Yearta, Maitlis & Briner 1995; Saari, 2013, Fulop & Hunter, 2000; Kerr & LePelley, 2013, Medlin & Green, 2009, Ginsburg, 2001). In fact, Nanji et al. (2013) assert that goals inspire, motivate and stimulate progress, and, uniquely in their grand purpose, and is pivotal for the forming of a team spirit. The goal-setting theory received full support from a 'real-life case' study conducted over 11 years and reported by Saari (2013: 262). The case study was IBM, a multinational IT company whose failing business, plagued by huge economic woes, in the 1990s was transformed by Gerstener who used his self-set *stretch* goals to change the business direction of the whole company. He did this by aligning the business goals through a *cascading* goal-setting process to every level of its organisational structure from top to the bottom, where they were translated into specific and quantifiable performance objectives for the job of every employee worldwide (Saari, 2013). Despite the methodological weakness inherent in case studies (as they cannot infer causation), the IBM case study, therefore, showcases the possibility of using goal-setting practice and stretch goals as effective tools to change an unproductive conservative organisational culture to achieve an across-the-board transformation and success (Saari, 2013).

The paper by Kerr and LePelley (2013) define stretch goals as goals purposely set at visibly impossible high levels, and so are therefore meant to drive employees and management of organisations to their maximum limit of performance towards achieving them. They reported how the concept of stretch goals was popularized worldwide as a major innovation to goal-setting in General Electric (GE) by Jack Welch in the 1980s and 1990s which 'forced' the improvement of products and services to enable a massive savings of \$12

billion in a 4-year period (Kerr and LePelley, 2013). Other mega-companies that positively transformed their business outcomes through emulating GE's stretch goal-setting included Commonwealth Health Corporation (CHC) in 1988 and Toyota Motors between 1997 and 2001 (Kerr and LePelley, 2013). However, Nanji et al. (2013) reviewed the use of organisational 'BHAGs' (Big Hairy Audacious Goals), which are considered a bolder type of stretch goals that require extraordinary effort to be achieved. According to them, BHAGs are overarching long-term goals with a timeframe of 10-30 years but have a 50%-70% chance of attainment. They, therefore, cautioned that despite their popularity, only 38% of organisations were successful to a full or limited extent.

On the whole, even though few studies suggest otherwise, there is sufficient evidence in the literature that convincingly show that the positive directional relationships between goal-setting and outcome, as the independent and dependent constructs respectively, in Locke and Latham's goal-setting motivation theory works. At least, it works at the individual performance level and more applicable to work situations with single goals. This means that under the environmental conditions of goal effect moderators and mediators in a work setting, setting specific and challenging goals will be a predictor to achieving the immediate and remote outcomes of higher task performance and satisfaction respectively in a positive linear relationship (Locke & Latham 1990, 2002, 2006). The background assumption in the goal-setting theory as a social cognitive motivational theory is that it is possible to influence human behaviour in work settings to improve the performance and productivity of workers by using goals purposely set to be specific and difficult. Therefore, a practical supposition underlying the theory is that every goal statement needs a clear and challenging framework to enhance the chance of attaining the goal.

2.10 Goal-setting Frameworks

Many authors regard the use of specific and practical frameworks as a crucial tool for effective goal-setting because they enable the formulation of good goal statements in programmes and organisations (Oracle 2012). Historically, popular goal-setting models such as the management by objectives (MBO) recommended by Drucker (1955) has been known since the 1950s. The MBO

model has been used extensively since the 1970s in America and Japan, but currently, it has depreciated both in value, popularity and usefulness as a credible framework for goal-setting by organisations worldwide (van Herten & Gunning-Schapers 2000b; Dahlsten, Styhre & Williander 2005; Bipp & Kleingeld 2011). Dahlsten, Styhre and Williander (2005) and Lindberg and Wilson (2011) who studied the experience of MBO in Sweden in 1990s, described how the model was used to introduce participatory objective setting to organisations, and how specific, precise and measurable objectives were set for every organisational level. Furthermore, through the MBO process, overall organisational or corporate objectives were translated into shorter-term objectives. Thus, using the MBO framework, organisations were able to formulate sub-goals for all their work levels and units in a way that motivates workers and managers to control, monitor and reward the progress of work (Dahlsten, Styhre & Williander 2005; Lindberg & Wilson 2011).

According to Bipp & Kleingeld (2011), several other effective goal-setting frameworks have been developed over the past 20 years, including the balanced scorecard approach by Kaplan and Norton (1996) and the productivity measurement and enhancement system by Pritchard et al. (2008). Some authors have examined how goal-setting-based models are used in different sectors, such as the use of Object/Objective-Oriented Maintenance Management (OOMM) in the field of engineering reported by Zhu et al. (2002). Bipp and Kleingeld (2011) assessed the goal-setting practice in a German company that used an un-named goal-setting framework in their annual planning cycle for more than a decade. Their goal-setting approach was top-down. That means their goals were formulated by the top management and cascaded through all organizational levels to individual employees. The goal-setting procedure involved reviewing the results of the goals for the past year before new goals for the next year was set, and the goal attainment of individual employees was linked to performance-based rewards. However, the article does not mention the kinds of goal statements set by the case company. So, it could not be ascertained whether the goals formulated through the reported process had the required specific and challenging attributes for good motivational goals.

In healthcare, there is evidence that many national governments traditionally use different goal-setting frameworks and approaches to provide leadership, guidance and strategic direction for their national healthcare delivery system (van Herten & Gunning-Schapers, 2000a). In this regard, the use of the model of Health Policy Development Cycle (HPDC) has played a major role (van Herten and Gunning-Schapers 2000b). Busse and Wismar (2002a, 2002b) from their review of policy documents of goals-based health programmes in high-income countries, including countries in the European Union, Australia, Canada, New Zealand and the USA, argue that many national health programmes have failed because of the kind of goal-setting process employed. According to them, in most of the countries, nationalised goal-setting was mostly the non-participative, technocratic approach and, health targets focused on intervention areas outside the health sector. In their papers, therefore for a successful goal-setting in healthcare delivery systems, they advocate for an integrated and balanced approach that incorporates both top-down and bottom-up approaches (Busse & Wismar 2002a, 2002b).

Furthermore, Langford et al. (2007) reviewed the effectiveness of the framework of Self-Management Goal Cycle (SMGC) as a goal-setting model for diabetic care in the USA. They concluded that collaborative goal-setting with diabetes patients is effective in enhancing their self-management skills. Scobbie et al. (2013) reported that both patients and health professionals found the Goal-setting and Action Planning (G-AP) model beneficial and acceptable in stroke rehabilitation. Some studies report the use of WHO's International Classification of Function, Disability and Health (ICDH or ICF) framework along with Talking Mats as coded guides for setting goals and planning behavioural change actions with patients with special communication and rehabilitation needs (Bornman & Murphy 2006; Murphy & Boa 2012). The other two goal-setting frameworks reportedly used in healthcare for improvement planning are the Total Quality Management (TQM) and Continuous Quality Improvement (CQI) initiatives (Ginsburg, 2001; Parker et al. 2003; Medlin & Green, 2009). These frameworks provide practical guides or steps for the process of setting goals. However, none of these goal-setting frameworks guides organisational healthcare managers or goal-setting therapists in clinical and rehabilitation

settings on how to formulate goal statements that possess the theoretical core goal attributes inherent in the goal-setting theory.

2.11 Writing SMART Goal Statements

According to Locke and Latham (2013), for goal statements to have a specific and difficult framework, goal-setters should pay attention to two areas: goal content and goal intensity. On goal content, the goal statement must specify the quantifiable performance result to be achieved. For goal intensity, the goal-setting practice must include the mediating and moderating factors, such as individual goal-setting effort, goal commitment, and the goal hierarchy. Yearta, Maitlis and Briner (1995) simply explain the goal content as the components in the goal statement that makes the desired result specific and difficult. They agreed that the goal intensity refers to the goal commitment and the other factors of goal-setting practices needed to achieve the goal. Authors like Bipp and Kleingeld (2011) adapted Locke and Latham's goal attributes to their local cultural contexts in Germany in their study of employee perceptions of goal-setting theory-based practices. In their study, the descriptive attributes of goal content included goal clarity, and absence of goal conflict, goal stress and dysfunctional goal effects (Bipp & Kleingeld, 2011). However, these attributes of goal content and goal intensity do not explain clearly, in a straight-forward manner useable by goal setters in the field, how ideal goal statements should be formulated and written.

So, how are goal statements formulated? Doubtlessly, one of the most popular developments on the Locke and Latham's goal-setting theory that has generated a lot of research interests over the years is George T. Doran's (1981) set of five SMART criteria published in his management paper. Originally, the SMART acronym spells out the attributes of an ideal objective statement as Specific, Measurable, Assignable, Realistic and Time-related. According to these criteria, Doran (1981: 36) recommends that statements of effective objectives should ideally be:

- SPECIFIC – they 'target a specific area for **improvement**'
- MEASURABLE – they 'quantify or suggest an **indicator** of

progress'

- ASSIGNABLE – they 'specify **who** will do it'
- REALISTIC – they 'state what **results** can be realistically achieved with available resources
- TIME-RELATED – they 'specify **when** the result can be achieved'

Thus, unlike other goal-setting frameworks that outline the goal-setting process, the SMART criteria prescribe the attributes of five structural components that a specific objective statement should contain. According to Doran's explication, these components are an area of improvement, a quantifiable progress indicator, the assigned performer, the realistic result and a timeframe.

According to Bipp and Kleingeld (2011: 308), the SMART framework sets out criteria for the "effective use of goals in performance management or appraisal". Oracle (2012) assert the SMART framework is the gold standard for writing any goal statement. However, SMART framework as originally proposed by Doran (1981) and supported by the Oracle (2012) and Bipp and Kleingeld (2011) was based completely on anecdotal observations: they were not based on empirical research evidence.

However, Day and Tosey (2011) consider SMART criteria inadequate for formulating learning goals. Instead, they recommend Zimmerman's (2008) eight criteria for setting appropriate learning goals. Zimmerman's criteria evolved from a combination of both Locke and Latham's goal-setting theory and Bandura's social cognitive theory. They propose that appropriate learning goals must be specific, challenging, proximal, hierarchical, conscious, self-set, performance or process-related, and congruent to self and others' goals (Day & Tosey, 2011). Day and Tosey assert that the SMART criteria draw upon the principles of Locke and Latham's goal-setting theory to produce goals that are specific and challenging, but it may not produce learning goals that are attainable on a short-term and engage the student's commitment to learning. However, unlike Doran's SMART criteria, Zimmerman's criteria do not provide any clarity of what components should be in a goal statement to make it possess all eight attributes. Hence, Day and Tosey (2011) attempted to fill this gap by proposing

a five-component ‘*POWER*’ framework for writing educational goal statements that they claim satisfies Zimmerman’s criteria. The *POWER* acronym means stating: **P**ositive outcome desired, **O**wn role, **W**hat task to be done (with dates), **E**vidence of accomplishment and **R**elationships required.

Table 2.3: Definitions of the SMART acronym in journal articles

Author (s)	Context	Acronym	S	M	A	R	T	Additions
Doran (1981)	Management	SMART	Specific	Measurable	Assignable	Realistic	Time-related	-
van Herten & Gunning-Schapers (2000a)	Health Policy	SMART	Specific	Measurable	Achievable	Realistic	Time-bound	-
Platt (2002)	Training	SMART	Specific	Measurable	Achievable	Relevant	Time-based	-
Jung (2007)	Exceptional Children	SMART	Specific	Measurable	Attainable	Routines-based	Tied to a functional priority	-
Bovend’Eerd, Botell & Wade (2009)	Rehabilitation	SMART	Specific	Measurable	Achievable	Realistic/ Relevant	Timed	-
Clarke, et al. (2009)	Mental Health	SMART	Specific	Measurable	Agreed	Realistic	Timely	-
Lee (2010)	Education	SMART	Specific	Measurable	Attainable/ Achievable	Relevant/ Realistic	Time bound	-
Day & Tosey (2012)	Education	SMART	Specific	Measurable	Achievable / Agreed	Realistic	Time-based	-
MacLeod (2012)	HCOs	SMARTER	Specific	Measurable	Achievable / Agreed	Realistic	Time-bound	Engaging, Rewarding
Hersh et al. (2012)	Aphasia Rehabilitation	SMARTER	Shared	Monitored	Accessible	Relevant	Transparent	Evolving, Relationship-centred

Therefore, it appears the perceived inadequacy in the original SMART criteria made recent authors amend its attributes and acronym. Table 2.3 shows the definitions of SMART found in ten journal articles, including Doran’s, and reveals that most revisions retained the first two criteria of specific and measurable, but changed the remaining three by substituting or adding other attributes the proponents considered more appropriate. Two of the most recent articles even proposed a SMARTER acronym, while one, Hersh et al. (2012), has a completely different set of attributes.

Less orthodox sources reveal that the desire for revision of Doran’s SMART criteria is widespread. For example, the white paper by Oracle (2012) exchanged Doran’s ‘assignable’ with ‘attainable’, ‘realistic’ with ‘relevant’ and ‘time-related’ with ‘timely’; and report other authors’ attempts to lengthen the acronym with various new attributes. The revised acronyms in Oracle (2012)

include 'SMART-ER' (engaging, rewarding), 'SMART-C' (challenging or collaborative), 'SMART-S' (stretch, sustainable, significant), and 'SMA-A-RT' (actionable). Similarly, toolkits of some popular health organisations recommend the revised SMART criteria. In addition to specific and measurable, Save the Children's (2003: 254) claim SMART acronym includes "Achievable, Relevant and Time-bound". Even different departments within Centre for Disease Control and Prevention proffer differing meanings, adding "Achievable, Realistic and Time-phased" (CDC, 2009: 1) or "Attainable/Achievable, Relevant and Time-bound" (CDC-DHDS, 2017: 3) to Specific, and measurable.

Therefore, with few exceptions like Jung (2007) and Hersh et al. (2012), there is more agreement among recent authors with the Doran's SMART criteria of 'specific' and 'measurable' as acceptable attributes of an ideal goal statement, than with 'assignable', 'realistic' and 'time-based'. While the exclusion of assignable in a statement is probably understandable, it is not clear if there is any hermeneutical justification for the widespread disagreement over the two attributes of realistic and timed. Accordingly, Oracle (2012: 10) outline that in writing a SMART objective, the statement should only specify the 'outcomes to be delivered', a means of measurement that 'can be objectively assessed' and a 'delivery date or schedule'. The component of 'performer assigned' is not specified. Rather than refer to components written in the goal statement, the remaining two Oracle criteria – attainable and relevant, are attributes that are considered during formulation of the goal statement. According to Oracle (2012), to be attainable, the employee should have access to all resources needed to achieve it, and to be relevant, the objective should be aligned with other goals of every management level of the organisation.

Accordingly, in a published review, Ogbewi (2016) reduces Doran's original five goal components of Improvement, Indicator, Performer, Result, and Timeframe (IIPRT) for writing a SMART statement to four components: Outcome, Indicator, Target, Timeframe (OITT) illustrated in Figure 2.4. In this new OITT framework, improvement is replaced by outcome as its synonym, and the performer is excluded entirely because it is thought that the person assigned the goal does not have to be specified in the statement. Still, examples of a SMART goal or objective statement that possesses all four OITT components are rare to find in

published articles on SMART goal-setting (Ogbeiwi 2017). Moreover, most academic articles on goal-setting and framework attributes are silent about the extent to which actual goals formulated in real-life service or organisational practices are truly specific, measurable, attainable, realistic and timed.

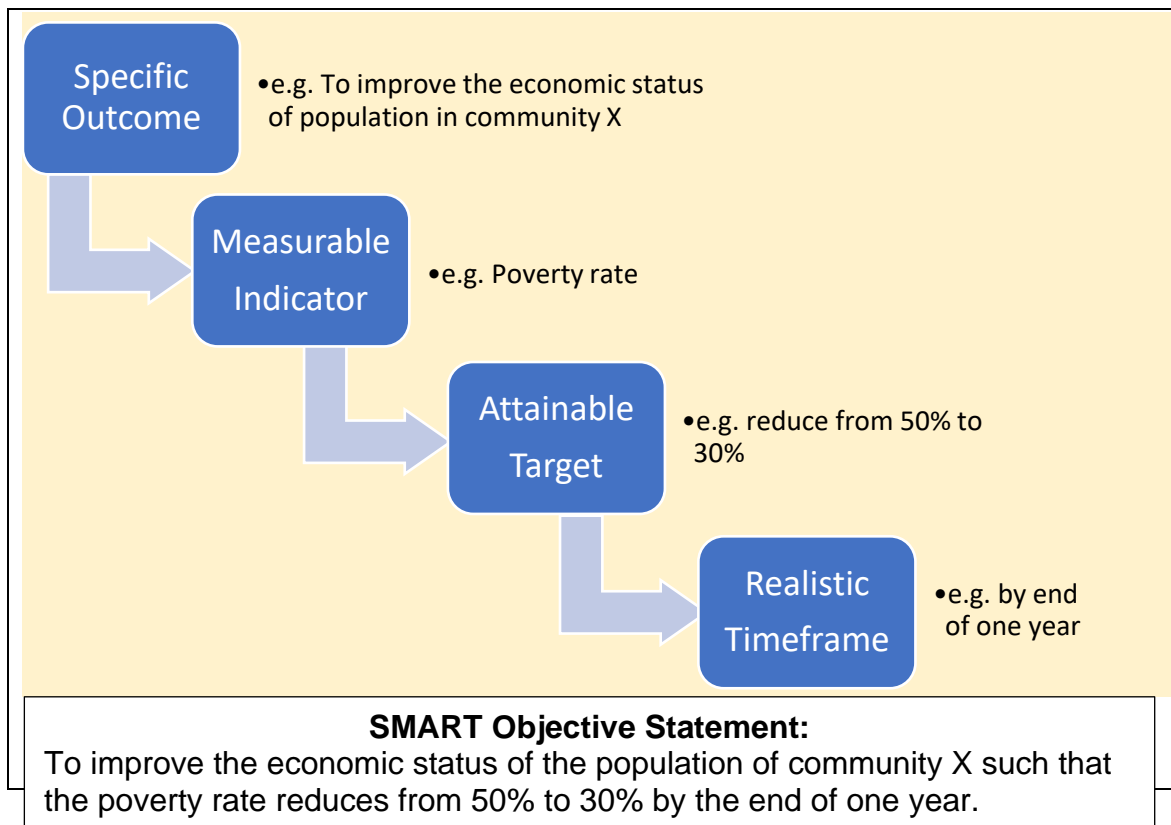


Figure 2.4: OITT Framework of a SMART objective statement (Ogbeiwi 2016)

Therefore, the study by Platt (2002: 25) is exceptional when it assessed the smartness of 11 objectives against a template of his version of the SMART criteria (Specific, Measurable, Achievable, Relevant and Time-based). He found only two objectives to be SMART. According to Platt (2002: 25), the two SMART objective statements are,

- “To have agreed, set and recorded 3 performance targets with each member of staff by the end of June 2003.”
- “To achieve [a] 500% reduction over previous year on transport costs (end of this week).”

However, an attempt to fit the statement components of these objectives into the OITT framework in Figure 2.4 (page 46) shows none of them contains a complete set to be considered truly SMART. The first objective is a task-oriented objective. It specifies only a target ('3 performance targets') and timeframe ('end of June 2003'), but lacks a specific outcome or desired improvement and measurement indicator. The second objective states a quantifiable indicator ('transport costs'), target ('500% reduction') and timeframe ('end of this week'), but lacks a specified outcome. Ogbeiwi (2017) conducted a similar review of 17 published examples of SMART objectives in literature and found that none possessed a complete set of the four OITT components. Hence, there is an apparent lack of capacity to formulate of SMART objectives with all attributes required for effective goal-setting.

2.12 Goal-setting in Healthcare

Many authors in literature like Liss (2003), have over the years advocated for a more effective goal component in the concept of healthcare delivery that matches and clarifies the priorities and outcomes of the healthcare delivery system. According to Liss, this would enable planning of relevant health actions to meet the needs of the target population. Evidence of different goal-setting frameworks and approaches traditionally used by different countries of the world to deliver health care at all levels of their national health system has been discussed in section 2.10 under goal-setting frameworks (page 40). McGlynn (2003) reported the recommendation of the Strategic Framework Board in USA for the formulation and use of 'national goals for quality improvement' to bring to the fore the extreme seriousness of the challenges of poor quality in the American health care delivery system.

Also, Parker et al. (2003) reported the use of a clinical governance programme based on a RAID model of Continuous Quality Improvement framework to transform the poor quality of patient care and low staff morale situation in a 25-bed acute psychiatric adult ward in London. The RAID model involved working with all stakeholders to: *Review* the prevailing problem situation, *Agree on* solutions with setting high goals on a short and long-term, *Implement* solutions according to the clinical governance guidelines to beat deadlines, *Demonstrate*

and *Develop* on changes by accurately measuring outcomes. All goal statements in the paper referred to as aims are shown to be desired qualitative changes in the problem situation of the psychiatric admission ward. Parker et al. (2003) expressed these as broad expectations based on the team leaders' vision of the ward's future, and these included:

“...to provide a comprehensive specialised service that addressed and rectified the negative perceptions of acute inpatient care described in numerous studies and articles.”

“... to provide a service in which our clients would receive the optimum standard of care in a ward of which we clinicians could be proud.”

“...to bring clinical governance to life at ward level and develop a new modern acute inpatient service.” (Parker et al. 2003)

However, these *aims* are too activity-oriented, too broad, too qualitative and therefore too subjective to fit into any SMART goal framework.

Basic historical data to outline the trend of development of goal-setting practice in healthcare was found in four articles reviewed: van Herten (2000); van Herten and Gunning-Schapers (2000a); Gunning-Schapers (2000) and Ritsatallis (2000). The available information suggests that the application of Peter Drucker's (1954) management by objectives may be the first goal-setting model to be applied to health policy (van Herten & Gunning-Schapers, 2000a). MBO was made popular in the 1980s when World Health Organization (WHO) adopted target setting using the approach as a key intervention in the implementation of Health for All (HFA) by the year 2000 in 1984 (van Herten, 2000). Also, in the 1980s, according to Gunning-Schapers (2000), target setting was introduced into epidemiology as a re-discovered practice by health policymakers in Europe. In 1998, WHO adopted new health targets, when the Health for All by 2000 strategy was revised (van Herten & Gunning-Schapers, 2000a). By the year 2000 the WHO European Region had had 20 years of experience of target setting at the national level in more than half of the 51 countries in the region (Ritsatallis, 2000). Thus, there is evidence in literature

that WHO and her high-income member countries have used target setting in the formulation of health policies for planning health interventions at national and interventional levels.

Only a few of the academic articles in the preliminary literature review were recent empirical research that focused on the effectiveness of either goal-setting practice or goal-setting-based planning tools in different aspects of health care delivery. There were research articles found for each of hospital clinical care (Walston & Chou, 2006; Castro, Dorgan & Richardson, 2008), rehabilitation services (Holliday, Ballinger & Playford, 2007; Kolehmainen et al. 2012; Scobbie et al., 2013), institutional and home-based long-term continuing care (Bravo, 2005; Parsons, 2012; Tang Yan et al. 2014; van Soest-Poortvliet et al. 2015); and primary health care (Naik et al., 2011; Ivers et al. 2013). In their methodologies, health goal-setting articles reported randomized experimental trials (Naik et al., 2011; Parsons, 2012; Bravo, 2005; Ivers et al. 2013), quantitative surveys (Castro, Dorgan & Richardson, 2008; Walston & Chou, 2006; van Soest-Poortvliet et al. 2015), mixed methods (Kolehmainen et al. 2012; Scobbie et al. 2013; Tang Yan et al. 2014) and qualitative (Holliday, Ballinger & Playford, 2007).

Overall, most of the articles reported a positive effect of goal-setting practice in either improving the quality of health care or in the attainment of desired patient or service outcomes. These were one each of hospital (Castro, Dorgan & Richardson, 2008), PHC diabetes management (Naik et al., 2011), rehabilitation (Scobbie et al. 2013) and home-based continuing care (Parson 2012). Naik et al. 2011 found that using a structured goal-setting approach improves blood sugar levels in self-management PHC-based diabetic care. Parsons (2012) reports that the use of a goal-setting facilitation tool improved the health-related quality of care in home-based care services. Castro, Dorgan & Richardson (2008) report that better target setting led to lower hospital infection, reduced readmission rates and improved patient satisfaction with care. Lastly, Scobbie et al. (2013) report that both patients and health professionals found the Goal-setting and Action Planning (G-AP) model beneficial and acceptable in stroke rehabilitation.

The other articles mostly report unsatisfactory results from their goal-setting research. Remarkably, Bravo (2005) claims that achieving the patient goals set in institution-based long-term care services did not translate into the desired improvement of quality of care. Walston and Chou (2006) report that employees and managers had different perceptions of change outcomes expected. Hence, there was no alignment of perceptions in the hierarchical goal-setting structure of hospital services. Holliday, Ballinger and Playford (2007) report a poor patient understanding of goal-setting as practised in the rehabilitation services they studied. A deeper critical analysis of the contexts of these pieces of literature evidence was required to determine the specific reasons for the failure of the application of the goal-setting practices they reported. Therefore, there is conflicting evidence among authors regarding the efficacy of goal-setting in producing the expected health outcomes.

2.13 Literature Gaps and Implications for Future Research

The findings of this narrative review outlined the spectra of definitions and classifications of goals. It also described the empirically tested theoretical foundation of the goal-setting practices in many organisations and different sectors in developed countries. Also described is the range of goal-setting frameworks for formulating goals generally and particularly in healthcare. However, this review also found gaps in the terminological definitions of the goal concepts. This revealed a universal confusion in the understanding of goals as well as a need for synthesis and harmonisation of the goal term definitions. There was no report of past research into the frameworks for formulating or writing goal statements universally. Of significance was the complete absence of past empirical research into goal-setting in developing countries. Hence, this study's research questions, methodology and design of this research helped to explore these gaps in the context of TLM Nigeria. Table 2.4 summarises the findings of research evidence in reviewed literature and the implications for future research.

Table 2.4 Summary of findings of Literature Review

Past Research Emphasis	Future Research needs
<p>Goal-setting theory, mediators and moderators of goal effect on task performance and outcome.</p> <p>(Locke & Latham, 1990, 2002, 2006, 2013; Campion & Lord, 1982; Matsui, Okada & Inoshita, 1983; Wood, Mento & Locke 1987; Yeara, Maitlis & Briner 1995; Seijts & Latham 2000a, 2000b; Brown, Jones & Leigh 2005; Medlin & Green 2009; Bradley et al. 1999; Saari 2013; Fulop & Hunter 2000; Kerr & Le Pelley 2013; Ginsburg 2001)</p>	<p>Universal confusion of goal terminology. Academic harmonisation and differentiation of goal terms (Ogbeiwi 2016)</p> <p>The constructs of goal-setting theory are still theoretical, deductive and based on studies done in experimental settings. Does the goal-setting theory work in the actual practice of non-controlled settings of live or real projects?</p>
<p>Caution on goal-setting theory, alternative goal-setting theories (Erez & Earley 1987; Boyce et al. 2001; Kramer, Thayer, & Salas 2013; Ordonez et al 2009; Nanji et al. 2013)</p>	<p>All goal-setting research done in high-income countries. The state of goal-setting practice in low-income countries unknown</p>
<p>Problem-based goal-setting approach (van Herten & Gunning-Schapers 2000b; Fitsimmons 2008; Parker et al. 2003)</p>	
<p>Management By Objectives (MBO) model for objective setting (Dahlsten, Styre & Williander 2005; Bipp & Kleingeld 2011; Lindberg & Wilson 2011)</p>	
<p>Goal frameworks in healthcare: Health Policy Development Cycle (van Herten & Kleingeld 2000b);</p> <p>Total Quality Monitoring/ Continuous Quality Improvement (Ginsburg 2001; Parker et al. 2003; Medlin & Green 2009)</p> <p>Self-management Goal Cycle in diabetes (Langford et al. 2007);</p> <p>Goal-setting and Action Planning (Scobbie et al. 2013)</p> <p>ICF Framework (Bornman & Murphy 2006; Murphy & Boa 2012)</p> <p>RAID model of Continuous Quality Improvement of hospital psychiatric wards (Parker et al. 2003)</p>	<p>All frameworks outline the process for goal-setting and action planning and monitoring. None studied or reported on a framework for formulating, constructing or writing goal statements in practice.</p>
<p>SMART acronyms for writing goal statements (Doran 1981; Oracle 2012)</p> <p>SMART inadequate for educational goals (Day & Tosey 2011)</p>	<p>Numerous SMART acronyms, no universal agreements. All SMART acronyms – based on anecdotal observations and impressions of George Doran. No empirical research evidence basis. How true are the SMART criteria and what is the efficacy of the proposed framework for writing objective statements?</p>
<p>The extent of SMART objective statements (Platt 2002; Ogbeiwi 2017).</p> <p>Use of O.I.T.T. components for constructing a SMART framework of an objective statement and I.T. for aim statement (Ogbeiwi 2016, 2017)</p>	<p>Poor quality of goal statements. Few SMART goal statements. Universal lack of capacity for setting good goal statements No empirical research developed a framework for constructing or writing goal statements</p>

Past Research Emphasis	Future Research needs
Testing or investigation of the effectiveness of goal-setting in specific healthcare services: Hospital clinical care (Walston & Chou, 2006; Castro, Dorgan & Richardson, 2008), Rehabilitation services (Holliday, Ballinger & Playford, 2007; Scobbie et al., 2013), Institutional and home-based long-term continuing care (Bravo, 2005; Parsons, 2012); PHC diabetes management (Naik et al., 2011)	Conflicting evidence of the workability of the goal-setting theory or SMART criteria in actual healthcare settings. No goal-setting studies in a leprosy care service
Goal-setting for development and outcomes of health services, projects and programmes: Clinical governance programme of psychiatric hospital wards (Parker et al. 2003)	No empirical evidence of goal-setting practices for health or disease intervention at service, project, programmes, or organizational level especially in public health and community-based development sector.

There is evidence that goal-setting has been widely adopted as best practice in healthcare. Especially abundant is the evidence of testing of the theoretical constructs of the goal-setting theory and the SMART criteria, in most experimental settings. However, Table 2.4 shows that almost all goal-setting frameworks found relate to processes or cycles of goal-setting in specific health services or individual patient contexts. So far, no literature reported any research on the specific structure of the actual goal-setting practices or goal-setting in the public health sector. None have inductively studied how the goal-setting theories are applied in practice. Moreover, no studies have outlined, through empirical descriptive and critical analyses, the array of existing health goals at the different levels of health care delivery in any organisation in a way that enables a clear understanding of their framework for formulating the goal statements.

In addition, no published research articles explored or analysed the efficacy of any goal-setting frameworks or templates used for writing of the statements of health objectives. A few review studies have assessed the extent to which health goal statements used in practice satisfy Doran's (1981) criteria for SMART goals, but they were not properly structured quantitative design that would enable generalisation of the extent to which formulated goals are SMART and aligned at the various hierarchical levels across the health service delivery system. Therefore, many questions relating to goal-setting frameworks and how

goals are formulated in practice remained unanswered, despite the long history of goal-setting research.

Therefore, according to the summary in Table 2.4, it was considered necessary to design further research that is capable to answer questions of whether healthcare goal statements formulated in practice can improve project planning and performance towards attaining desired health outcomes. This will require first to investigate how health goals are formulated in practice and the extent to which the existing theoretical approaches and models of goal-setting are used to write SMART goal statements. Follow-up studies may then investigate how the quality of goal statements formulated in actual practices of health organisations and their projects determine their health outcomes. These are some of the critical questions that must be answered as health care delivery systems worldwide struggle to search for solutions to improve the quality standards at all levels.

The large collection of literature sources found and reviewed shows the massive and extensive work that had been done already in goal-setting research. However, past studies have been limited to the setting of high-income countries. So far, no goal-setting studies were found done in low-income countries. Moreover, the reviewed literature sources certainly indicate that there was significantly more research work on theoretical goal-setting in the sectors of behavioural psychology and motivational management sciences than in healthcare. So, the evidence gathered from this literature review indicate that a goal-setting research enquiry into how theory-based practices formulate healthcare goals will be a novel contribution to health management in low-income countries particularly.

The fundamental practical implication of the goal-setting theory of Locke and Latham (1990) and the battery of existing theoretical models and frameworks developed from them is this: that to motivate improvement of task performance and goal attainment, goal statements should be formulated with a structure or framework or outline that gives them the necessary goal attributes (Locke & Latham 2006). Hence, the goal-setting theory and the SMART criteria provide only theoretical constructs in the relationship between goal-setting framework

and goal attainment. While the theoretical relationships between the two have been tested to some extent in many clinical and rehabilitation settings in healthcare, not every researcher agrees that these theories are workable in practice. Besides, the workability of these theories is yet to be explored in any leprosy care goal-setting practice settings. However, the evidence of poorly formulated goal statements globally suggests that the constructs of the current theoretical goal-setting models may not be adequately translated into practice.

Thus, in addition to the critical loopholes in the theory and SMART frameworks already reported by many studies such as the works of Yeara Maitlis and Briner (1995), Erez & Earley (1987), Kramer, Thayer and Salas (2013), Boyce et al (2001) and Ordonez et al. (2009), this literature review found that so far, no research inquiry evaluating these theories has empirically generated a structural framework that explains or addresses the practical discrepancies found in goal-setting practice. This provided an academic justification for further research to explore an ongoing organisational goal-setting practice in order to describe how goal statements are formulated and inductively generate a practice theory of goal-setting.

2.14 Research Problem

There is an existing goal-setting theory, which explains the relationships between a specific and difficult goal as the independent variable and improved task performance as the dependent or outcome variable (Locke and Latham, 1990). There is also a set of published criteria that provides the basis for writing SMART goals (Doran 1981). According to these theoretical generalizations, a challenging goal that has a SMART framework is more likely to motivate higher task performance towards achieving desired outcomes, than an easy unstructured goal with a vague or ambiguous framework, (Locke & Latham 2002, 2006; Doran 1981). Thus, a SMART framework is a structure required of an ideal objective statement. According to existing literature from studies done in high-income countries, an objective should be formulated to be specific, measurable, attainable, relevant or realistic and time-bound (Doran 1981). To possess these theoretical attributes, the objective statement should contain at

least four conceptual components, including a specific outcome, a measurable indicator, an attainable target-level and a realistic timeframe (Ogbeiwi 2016).

Many goal effectiveness studies have already tested the workability of these existing theoretical models, though with conflicting findings. Many have reviewed the efficacy of using goal-setting generally to improve individual patient management in health care settings. However, the few studies and reviews that have been done on the quality of goals suggest there is a universal problem of poor goal formulation, as most goals formulated in practice are not entirely SMART (Platt 2002; Ogbeiwi 2017). Besides, no past goal-setting research has explored how health goals and the related statements are formulated in an actual organisational practice based on these popular theoretical goal-setting frameworks. Thus, the findings of this literature review revealed there is no practice theory that describes, illustrates or explains how these theoretical models prescribed universally as standard for goal-setting are applied for goal formulation in practice.

This study, therefore, investigated the theoretical frameworks in the organisational goal-setting practice of TLMN in Nigeria as a typical low-income country. The research neither tested the application or workability of the prevalent theoretical models for leprosy goal-setting nor evaluated the effectiveness of TLMN's goal-setting practice in the light of the theoretical ideals. It was an exploratory inductive inquiry done to generate a theoretical framework from the practice of TLMN that was descriptive in-depth of how a leprosy healthcare organisation in a low-income country context formulated and wrote their leprosy goal statements. Understanding the theoretical frameworks in the goal-setting practice of TLMN provided a missing piece of information about goal-setting in a low-income country context as well as explain the difficulty of translating the theoretical frameworks of the goal-setting and SMART criteria into ideal goals in practice.

2.15 Research Questions

The study questions answered by this research had a direct bearing with the research problems narrated in the previous section (2.14). Especially, the questions addressed the problem of the relative paucity of goal-setting research

in the healthcare sector and low-income countries, and the situation where the existing theoretical goal-setting models deducted from the goal-setting theory and the SMART criteria are not translated into good practice. They are also related to my research purpose and justification written in chapter 1 and the literature gaps identified in this chapter. These all together gave credence to the conduct of this research that explored the theoretical framework of the goal-setting practice of TLMN in the Nigerian context. The study questions defined the direction of my research and formed the basis for my qualitative methodological framework on which the case study design strategies and procedures of the study are based (Creswell 2013).

Specifically, out of the many questions that emerged from the results of the literature review, two needed to be answered by this research: a central, core question and its related sub-question. The core study question indicated the central or overall objective the research was expected to achieve at its end. It indicated that my doctoral research was an exploratory journey of discovery into the goal-setting practice in TLM Nigeria (Creswell 2014).

2.15.1 Core study question

How are leprosy project goals formulated in the practice of The Leprosy Mission Nigeria?

Most evidence of goal-setting in healthcare settings related to setting personal behavioural change goals and treatment targets. These have been essentially limited to therapist-led goal setting in the management of individual patients in clinical and rehabilitation settings. Before the onset of my research, there was no literature evidence of research that investigated the process of formulating leprosy goals in any low-income country. This core question demanded exploring the general theoretical framework of the process of project-level leprosy goal-setting in TLMN's practice context. This question required identification of key conceptual themes in TLMN goal-setting practice that were the theoretical constructs or the building blocks of the general framework of leprosy goal formulation.

2.15.2 Sub-question

How are statements of leprosy project objectives framed or constructed? In other words, what are the thematic components of the statement of leprosy project goal objectives?

Doran's (1981) set of theoretical criteria of SMART attributes of objectives is already popular universally. According to available evidence, it is in common use in goal-setting practices of many organisations in different work settings. However, the criteria have been subjected to varied interpretations by individual goal-setting practitioners. As a result, the current goal setters in healthcare lacked clarity about which components in the framework of an objective statement really make it specific, measurable, attainable, relevant or realistic and timed. This question, therefore, led me to explore the lexical structure or framework used in the construction of objective statements in TLMN's leprosy project context.

2.16 Study Objectives

To answer these two study questions in section 2.15, the three specific objectives of this research were:

Objective 1: To explore the conceptual framework of TLMN's goal-setting practice for leprosy projects in Nigeria.

Objective 2: To describe how the universal theoretical principles for formulating effective objectives were translated into practice in TLMN leprosy project goal-setting.

Objective 3: To develop a practice theory for goal-setting in the low-income country context of TLMN.

Towards accomplishing these three study objectives, the research strategy was to understand how the aims and objectives for leprosy intervention were formulated in TLMN's leprosy projects generally. Specifically, the study would inductively construct the theoretical goal-setting framework inherent in TLMN's practice, according to the experience of leprosy managers and evidence of organisational leprosy goal formulation. In the end, a theory of practice would

be postulated from the most abstract concepts or constructs in the emergent theoretical goal-setting framework of TLMN practice.

2.17 Summary of the chapter

This chapter outlined the methodology and findings of a narrative literature review of academic articles and other literature sources available in specific databases. The databases were searched using key phrases relevant to the subject of goal-setting and the purpose of my doctoral research. The findings included the general concepts and philosophies of goal-setting and the current knowledge about frameworks used for goal formulation as available in current literature. The literature sources reviewed provided the required basic background knowledge of the concepts of goals and goal-setting that guided both my preparation to conduct this doctoral research and my discussion of the research findings in chapters seven, eight and nine of this thesis. More significantly, the review enabled identification of the literature gaps in the knowledge about goal-setting definitions, theory, and frameworks.

Overall, this review finds that available literature sources provided evidence of theory-based research relating to the motivational goal-setting theory, management by objectives and the SMART criteria for good goal formulation. However, these were developed based on mainly quantitative deductive research and circumstantial management reports. There is also literature evidence of goal-setting processes and frameworks in use in health care, but they are restricted essentially to national health systems and individual patient goal-setting in clinical and rehabilitative settings in high-income countries.

Generally, there was inadequate research evidence in the reviewed corpus of published goal-setting literature of how the current universally established theories and models are used in actual goal-setting practice. This is the main problem that gave justification for another research on the topic of goal-setting. There was a lack of published research on the goal-setting frameworks of any specific health care settings that generally illustrate how health goals are formulated in practice. So far, to my knowledge, this doctoral study is the first goal-setting research done in public health and leprosy care specifically and in

low-income countries generally. These identified literature gaps became the basis of the research questions and objectives outlined.

The next chapter, chapter three, presents my philosophical approach of qualitative research inquiry, which I used to find answers empirically to the research questions of how goals of leprosy projects are formulated in the practice context of TLMN organisation.

Chapter 3

QUALITATIVE RESEARCH METHODOLOGY

“...There is no single reality about goal-setting in the TLMN context of leprosy managers. Their realities [therefore] can only be known from their individual experiences, perspectives and interpretation of the organisational practice.”

(Section 3.7, page 76)

3.1 Introduction

The central phenomenon explored in this doctoral research was the theoretical framework of the goal-setting practice of TLMN in Nigeria. Specifically, I sought to identify the framework of how the goals of leprosy projects supported by the organisation were formulated, and how their goal statements were written.

Therefore, the organisation of TLMN served as the field context from where empirical information was gathered to answer the core study question of ‘*How are leprosy project goals formulated in TLMN?*’ and the sub-question of ‘*How are the statements of leprosy project objectives framed or constructed?*’

Generally, these research questions indicated that my research inquiry should discover the framework that describes the organisational process for setting leprosy goals. Therefore, an in-depth field investigation was required to find out what general themes in the organisational goal-setting practice defined the theoretical framework used in the formulation of leprosy goals. These research questions relating to ‘*How?*’ required an explanatory inquiry of the phenomenon of leprosy goal-setting framework as practised by TLMN (Creswell 2013).

Besides, the active verbs in the three study objectives in section 2.16 are to “explore” (objective 1), to “describe” (objective 2) and to “develop”. Due to the exploratory and constructivist natures of the study objectives, I chose a qualitative approach of research as the fundamental methodological paradigm for my doctoral research (Denzin and Lincoln 2011; Creswell 2013).

This chapter, therefore, describes details of the philosophy, rationale and selection criteria of my chosen qualitative methodology and defends it as the most appropriate research approach for answering my study questions. Clearly, it was the only approach that could provide the interpretivist and constructivist

framework of inquiry that I required to effectively accomplish my study objectives at the end of the research process (Denzin and Lincoln 2011).

In addition, this chapter appraises the five options of qualitative study designs as outlined by Creswell (2014). It provides argument for my eventual selection of case study as a more applicable base qualitative design to study the theoretical framework of TLMN goal-setting practice. However, case study was only considered after my attempt to implement the field procedures of grounded theory method became impossible in the context of leprosy projects in Nigeria. This chapter also discusses my present location as a researcher who was also an active interactional participant in the naturalist premise of this research. The ethical implications of my previous engagement with TLMN and steps taken to ensure the trustworthiness of the results of this research are also discussed. In my reflexivity, I acknowledged that there were certainly methodological and ethical issues that needed to be considered and managed in order to minimise potential researcher or observer bias from my strong pre-study experience and knowledge base with the subject matter of goal-setting, the context of TLMN organisation, and the leprosy managers as my study participants.

3.2 Rationale for a Qualitative Approach

My choice of qualitative research inquiry was based on my belief that to understand the truth of an organisation's goal-setting culture I needed to gain in-depth knowledge about the theoretical pattern of its practice which could only be constructed through a naturalistic and interactional investigation. This is contrary to the preference of positivist and post-positivist schools of thought for a more objective, scientifically testable and quantifiable inquiry for empirical research (Denzin and Lincoln 2011). Only a qualitative methodology allows the participation of study persons in the elaborate review of their relative realities and perceptions, and the meanings they give to their experience (Lincoln et al. 2011).

In my understanding, therefore, a qualitative approach alone was enough to answer the two study questions in this research and accomplish the three study objectives. The two open-ended study questions revealed my overall desire to find out the theoretical framework in TLMN's goal-setting practice that

describes, illustrates or explains *how* leprosy goals and objectives were formulated and constructed in a Nigerian context. According to Creswell (2014), such a research question that begins with an explorative word such as 'how' or 'what' is best investigated with a social constructivist and inductivist paradigm. A qualitative worldview requires that the researcher enters the natural settings of the people being researched to explore their multiple realities. So, a qualitative mode of inquiry was necessary for me to experience the field context of TLMN and the leprosy managers in order to fully explore and understand how they construct their leprosy project goals.

As explicated by Denzin and Lincoln (2011: 3), only the interpretive naturalistic premise of qualitative research 'locates the observer in the world' of the people being observed 'where [their] individual belief and action intersect with culture', as the researcher seeks to interpret the meanings they give to their experience of reality. Moreover, rather than test or validate the known and already established goal-setting theories, which is normative in the premise of post-positivist paradigm of quantitative enquiry (Creswell 2013; Creswell 2014), the active word 'how' in my research questions indicated that I sought to know the conceptual pattern of leprosy goal-setting process that would enable me to inductively develop or reconstruct an emergent framework that is illustrative of the goal-setting practice in the context of TLMN. This was in line with Denzin and Lincoln's (2011: 8) description of qualitative research as an approach of inquiry 'that places emphasis on the quality of entities and on processes and meanings that are not experimentally examined or measured' in search for a 'socially constructed nature of reality.'

3.3 Constructivist-Interpretivist Paradigm

This research sought to discover the theoretical pattern of the practice of formulating leprosy goals in TLMN and therefore used the qualitative paradigms of interpretivism and naturalism that employ a social constructivist worldview (Denzin & Lincoln 2011; Creswell 2014). This means that I followed the general approach of discovering and constructing the truth about the goal-setting phenomenon in the natural social setting of leprosy managers in TLMN. Also, I aimed to interpret their practice according to the meanings they accorded to it.

Due to these philosophical premises, my research process was shaped by the specific theoretical assumptions and beliefs of constructivism. These were defined by the *ontological*, *epistemological* and *methodological* realities in the world of leprosy managers who were my study participants (Denzin & Lincoln 2011). According to Denzin and Lincoln (2011: 13) and Lincoln et al. (2011: 98), constructivist philosophical assumptions include a combination of a relativist ontology (reality), subjectivist epistemology (knowledge) and a naturalistic methodology (approach). Thus, in line with constructivist ontological relativism, I believed that the social reality of leprosy goal-setting was not a single absolute in the context of TLMN's projects. Multiple truths or realities existed that must be constructed according to the unique perspectives and specific organisational settings of the leprosy managers (Lincoln et al. 2011: 102).

In particular, Guba and Lincoln (2005: 27) assert that a constructivist ontology also assumes that these truths or realities in the real world can be co-constructed by both the researcher and the researched through a joint, participative and interactive interpretation framework. This position is also held by Lincoln et al. (2011: 102) that, '...As researchers, we must participate in the research process with our subjects to ensure we are producing knowledge that is reflective of their reality.' This was in line with my research's constructivist epistemology that how we know the truth about goal-setting is fundamentally both subjective and transactional. This is according to the social paradigm theory that people's understanding of reality is constructed in line with their own meaning (Lincoln et al. 2011; Guba & Lincoln 1985). This position is well supported by Guba and Lincoln's (1985: 80) claim that 'Social reality is a construction based upon the actor's frame of reference within the setting.' Thus, in constructivist research such as mine, the process involved a close linkage between the 'inquirer and the inquired into' or me as the researcher and leprosy managers as the researched in an interactive collaboration towards a co-creation of the findings or realities in the latter's context (Guba 1990: 27).

To achieve this goal of constructivism, it was imperative that the methodology or the process of my research inquiry be naturalistic, hermeneutical and dialectic. Naturalism describes the approach of my research which was characterised by a field setting and use of a holistic and localised method of information

gathering (Lincoln et al. 2011: 105; Angen 2000). Describing the interpretive process of abstraction, Guba (1990: 27) asserts that, 'individual constructions are elicited and refined hermeneutically, and compared and contrasted dialectically, with the aim of generating one or a few constructions on which there is substantial consensus.' This was the approach adopted in this study for the development of a theory of goal-setting practice in TLMN context. Consensus with the themes and frameworks of the goal-setting practice of TLMN developed in this research was reached through the feedback of the findings and interpretations made by the researcher to the study participants, particularly the leprosy managers at the national level. At the completion of the thesis, the full draft document with the final theory, conclusions and recommendations was disseminated electronically to all respondent managers, both field and national, and the organisation's research ethics committee. All comments and corrections were addressed in the final document.

3.4 Criteria for a Qualitative Methodology

There were criteria that my chosen research methodology had to fulfil for it to be acceptable as a truly qualitative approach. These criteria typically distinguished it from quantitative methodology and made it the appropriate model for accomplishing my research purpose. Denzin and Lincoln (2011) described a model of four criteria which they assert are characteristically descriptive of a well-designed qualitative research process. A fifth was added based on the view of Creswell (2013: 17). These criteria include the:

- Reflexivity of the researcher
- Theoretical paradigms
- Research strategies of inquiry;
- Methods/procedures of data collection and analysis;
- Interpretation and evaluation of data quality

3.4.1 The researcher's reflexivity

Reflexivity refers to the researcher's ongoing personal reflections on the process of study, including his or her location in the study and a pre-declaration

of any possible conflicts of interest that might introduce observer bias into the research findings (Creswell 2014). This also includes a holistic declaration of the role of the researcher as an instrument in the research. Occasionally, it also declares his or her role as a participant that contributes to observation and interpretation of data in the study (Creswell 2014). It is generally agreed that no researcher enters any research process blank. As Creswell (2013: 15) states, 'Whether we are aware of it or not, we always bring certain beliefs and philosophical assumptions to our research. Sometimes these are deeply ingrained views about the types of problem that we need to study, what research questions to ask or how we go about gathering data.'

Denzin and Lincoln (2011: 11) describes the researcher as a 'gendered multiculturally situated' subject who enters the world of his or her study participants already with pre-conceptions of ideas (theory, ontology), questions (epistemology) and specific examinations (methodology). As Charmaz (2008: 402-403) puts it, reflexivity is focal to social constructionism, as 'Social constructionists disavow the idea that researchers can or will begin their studies without prior knowledge and theories about their topics'.

Therefore, into my research, I brought many years of management experience with leprosy projects in Nigeria and professional knowledge of the subject matter of goal-setting as a practising monitoring and evaluation (M&E) consultant. Besides, the detailed narrative literature review in chapter two shows the elaborate knowledge of goal-setting studies, theories and frameworks I already acquired before the data collection phase of my doctoral journey. Doubtlessly, these constitute my personal preconceptions and values that, as a researcher, I brought into the research process. My roles are described further in the reflexivity section (section 3.6, page 70).

3.4.2 Theoretical paradigms and perspectives

There are several defining philosophical beliefs that are typical of qualitative research, which in the context of this research are characteristic of interpretive, inductive and constructivist paradigms. These include assumptions of qualitative researchers about reality as defined by the *relativist ontology* (the existence of multiple realities), and *subjectivist and transactional epistemology*

(that knowledge and experience of reality are individualistic, subjective and requires a close relationship between the researcher and study participants). Others are *value-laden axiology* (that the researcher is not value-free, but is located in the study in a way that reality is co-created) and *inductive naturalistic methodology* (inductive logic, reality emerges from research procedures conducted in the real world of the study participants) (Denzin & Lincoln 2011; Lincoln et al. 2011; Creswell 2013). The inductive nature of qualitative research means that the process of discovering reality is evolutionary. According to Creswell (2013: 22), inductivism is also 'shaped by the researcher's experience in collecting and analysing data.'

All four assumptions were the foundational principles of my doctoral research. Thus, using the same philosophies of Charmaz's (2008: 402) constructionism, the exercise of my goal-setting research rested solidly on the beliefs that there is more than one reality of goal-setting approaches and meanings in the context of TLMN. These realities were inductively co-constructed through a subjectivist, transactional and interactive research process, which involved me (the researcher) being a hermeneutical part of the field setting of TLMN that fully acknowledges the reflexive positions of both the researcher and the researched.

3.4.3 Research strategies

These include a wide range of qualitative study methods or designs, which indicate the variety of options possible for investigating research participants' reality using an inductive and naturalistic methodology. These key options are discussed in the next section (3.4.4). However, the one considered relevant to the interpretive constructivist philosophy of my research, and which aims at inductively constructing the theoretical goal-setting framework of TLMN practice using an in-depth, robust, extensive, and contextually flexible design was the exploratory case study method.

3.4.4 Methods of data collection and analysis

These are the qualitative techniques for collection and analysis of textual or non-numeric data from study participants in their natural setting. Qualitative methods typically use multiple sources of data, inductive textual analysis

(Creswell 2014). The qualitative analysis essentially derives participants' meanings for data interpretation and uses an emergent design with many levels of categorisation and abstraction for the construction of conceptual themes and theories (Creswell 2014). Out of the long list of research processes framed by Denzin and Lincoln (2011: 12), a combination of at least three techniques common with qualitative research was most relevant to my research: in-depth open-ended interviews; direct observation and written documents review.

Qualitative interviews of individual study subjects or key informants use open-ended questions administered with semi-structured or unstructured interview tools. Data is collected in a narrative, quotation or conversational text form relating to participants' individual experiences, opinions, and feelings about the subject under study (Patton 2002; Creswell 2014). According to Warren (2001: 83), unlike quantitative survey interviews, qualitative interviews are epistemologically 'More constructionist than positivist. Interview participants are more likely to be viewed as meaning makers, not passive conduits for retrieving information from an existing vessel of answers.'

In the same vein, qualitative observations make possible first-hand unstructured field observation, of directly visible behaviours, activities and interactions of people or events, as may be relevant to research's subject matter (Creswell 2013). The document reviews collect information on the study subject from relevant written documents for thematic analysis (Patton 2002). Although listed among qualitative data collection methods (Creswell 2013), focus group discussion was not practicable in this case study research because of the project context of TLMN in which study participants worked in isolated locations. Focus group discussions require special arrangements and skills for data collection from specifically different groups of study participants who are the key sources of information relevant to the subject under study (Creswell 2013). In addition, in my research, individual key informant interview of leprosy managers was preferred to focus group discussion for the collection of individual or personal experiences, opinions and knowledge of TLMN goal-setting practice.

Unlike in quantitative surveys and experiments, the output of qualitative data collection is the creation of field notes with massive raw text data, which is then

subjected to a systematic process of textual content analysis to organise data into themes and categories of findings. The results are reported with narrative descriptions, and illustrative case examples and flow charts (Patton 2002). According to Patton (2002: 5), rather than numeric results of statistically significant data, 'The themes, patterns, understandings and insights that emerge from fieldwork and subsequent analysis are the fruit of qualitative inquiry.' In generating a grounded theory, Charmaz (2011: 360-361) asserts that there is a systematic inductive analytic logic that is characteristic of a social constructionist data analysis. This is typically collaborative, comparative and iterative, as the researcher in order to construct 'middle-range theories' from study participants' data is made 'To go back and forth between analysis and data collection because each informs and advances the other.' However, as already explained a number of times before, the practicality of going back and forth between data collection and data analysis simultaneously during fieldwork was not realistic in the project setting of TLMN. Hence, the more direct approach of serial thematic analysis (Braun & Clarke 2006) was used for managing the qualitative data obtained from my research.

3.4.5 Interpretation and evaluation

Patton (2002: 5) asserts that 'The quality of qualitative data depends to a great extent on the methodological skill, sensitivity and integrity of the researcher.' According to Denzin and Lincoln (2011: 13), the quality of the qualitative constructivist approach is verifiable based on five data quality criteria of trustworthiness, dependability, credibility, transferability and confirmability of the qualitative data collected, and the interpretation given to it by the researcher. In their view, these values are considered more relevant to qualitative research. Contrarily, valuation of quantitative research is based on the criteria of reliability, objectivity, replicability and internal and external validity (Denzin and Lincoln 2011).

In general, despite the berated subjectivist epistemology of qualitative research, the data quality can be improved through the researcher's reflexivity and ensuring consistency of the research process across different researchers and studies (Gibbs 2007; Creswell 2014). The validity of qualitative results is ensured through several strategies, such as triangulation of procedures (use of

different methods of data collection to verify the same findings), peer checking, peer debriefing, and participant feedback. Others are prolonged and persistent field engagement or observation with the study participants and phenomenon and review of findings and interpretation by an external auditor (Creswell 2014). Clearly external validity or generalizability of research findings is not considered a strong data validity criterion of qualitative research (Gibbs 2007; Creswell 2014).

3.5 Selection of a Qualitative Design

All inductive, constructionist qualitative inquiries such as my research are characterized by an interpretative and naturalistic design (Creswell 2013). In this, the researcher is reflexively located in the systematic and evolutionary exploration of the abstract knowledge about the real world of the study participants, the social phenomena in which they live and the meanings they give to their experiences in their natural settings (Denzin and Lincoln 2011; Creswell 2013). To answer the study questions and accomplish the purposes of qualitative research, a variety of contextually applicable strategies of inquiry are used as study designs (Denzin and Lincoln 2011; Creswell 2013). The study designs outline the particular frameworks of the different qualitative research processes (Bryman 2016). As defined by Bryman (2016: 39), every research design is a 'Framework for the generation of evidence that is chosen to answer the research question in which the investigator is interested.' While there is a myriad of qualitative designs in literature, most authors such as Creswell (2013, 2014), describe five designs that are in prominent and common use. These, namely, are narrative study, ethnographical study, grounded theory method, phenomenological study and case study: each having its distinct focus of the qualitative investigation process.

Broadly, the narrative design includes historical or biographical studies that focus on exploring the remarkable turning points in the individual stories of 'lived and told experiences' of a single or few study participants (Creswell, 2013: 70). These are then retold by researchers in chronological order of biographical or life-historical or ethnographical events (Creswell, 2013). While phenomenological studies also explore lived experiences of individual respondents, the focus is identifying the common or essential meanings they

give to the phenomenon whose experience they shared in the past, such as success, disease or rejection (Creswell, 2013). Grounded theory method studies seek to generate or develop a theory or provide a theoretical explanation for the process, practice, action, interactions or a shared phenomenon, experienced in the past by individual respondent. Its typical design 'grounds' the research findings on the raw data collected by conducting both data collection and analysis as a joint or combined process during the fieldwork stage of the research (Creswell, 2013: 84). The data collection is therefore rigorous, and the data analysis uses a stepwise thematic analysis approach (Creswell, 2013).

Ethnographical studies also seek to evolve theories about the pattern of a shared culture of a group of people being studied. The researcher interacts actively and closely with the study participants through in-depth participant observation of the way they currently live for a significant period of time and in the same physical, social, work or ethnic settings (Creswell, 2013). Like ethnographical designs, a case study design focuses on evolving in-depth, non-historical, and contemporary knowledge about a single 'case' being studied, which can be either a person, a group of persons, an organisation, an issue, a problem or a subject (Creswell, 2013: 97). Typically, the case study investigator seeks to define the case and its intrinsic context in great detail using multiple in-depth study methods and data sources (Creswell, 2013: 97).

A broad comparison of these five qualitative designs shows that the one most descriptive of the in-depth and elaborate multi-method exploration of the theoretical framework of leprosy goal-setting, as a contemporary case within the TLMN context is case study design. Therefore, in relation to my research, the narrative, phenomenological and grounded theory designs are considered unsuitable because they explore past experiences of individuals, which are either non-contemporary or historical or retrospective in nature. Although like case study designs, the three designs also examine single or a small number of study participants, unlike ethnographical studies that study communities. Despite my research also seeking to explore the organisational goal-setting culture of TLMN, the organisation does not exist naturally as a community of people with shared socio-cultural and geo-ethnographical settings as would be

expected for a typical ethnographical study (Creswell 2013). Besides, my research had a time constraint that made any prolonged in-depth field-based interactive participant observation of the organisational goal-setting culture impossible during my research process.

Many authors like Creswell (2013) and Charmaz (2008) consider the grounded theory method the best design for any qualitative research seeking to generate a theory or conceptual themes for the development of a theoretical framework or process like my research did. However, as explained before, the rigorous field-based collaborative 'going back and forth' from data collection to data analysis (Charmaz 2011) was not possible because of the logistical challenge faced in travelling around TLMN's leprosy projects in Nigeria. Similarly, this organisational context made selection of relevant interview respondents based on theoretical sampling impossible as eligible leprosy managers were spread out geographically in isolated locations across eight States of the country.

3.6 Reflexivity: Location of Researcher and Ethical Issues

I was the country representative in Nigeria for The Leprosy Mission International for almost seven years from October 1992 to June 1999. I had responsibility as the National Coordinator for developing and executing the country-level strategy for assisted leprosy projects in Nigeria at all levels. I was responsible for providing both technical and administrative leadership for the leprosy project managers nationally and liaising with communities and governments on behalf of The Leprosy Mission. Besides, I was still responsible for the monitoring and evaluation of these projects, and periodically assessing their goal-based performance, after I left the position and served for the next eight years (from July 1999 to May 2007) as the regional monitoring and evaluation coordinator for Africa. Therefore, my knowledge of leprosy disease, the study leprosy projects, their managers and the subject of goal-setting were a practical advantage for the conduct of this research project.

However, I had a position of 'power' over the organisation and study participants from my previous management responsibilities, which could have influenced the way they consented and responded to the data collection processes of this research. So, the strength of my previous long-term work

experience with TLM Nigeria could also be the biggest threat to the credibility of this research. It was therefore important that my involvement and interest in, and understanding of, the past goal-setting practices of TLM Nigeria be declared beforehand. However, it was also important that I set them aside or 'bracketed' all through data collection and analysis of the primary data about the current goal-setting practices (Creswell 2014). According to Tufford and Newman (2010), bracketing is particularly important in phenomenological research and there is no uniformity in its definitions, the research stages when it is done and the methods to effectively suspend or isolate the researcher's presuppositions, knowledge and experience from the evolving essence of the phenomenon under study. Practically, in my case study research, bracketing commenced with my self-awareness during the conceptualisation stage when I declared my pre-existing position and experience in relation to the subject of goal setting and the TLMN organisation. I approached the interviews of leprosy managers only as a research student with an open mind to learn from their current goal-setting experience, unbiased by my preconceptions. Leprosy managers were not forced or coerced to consent or participate in the study against their will. Participation in the study was voluntary and leprosy managers gave their opinions and perspectives to the interview questions freely.

Moreover, I wrote a running commentary or a series of memos on interview process and data as they evolved. This enabled me to reflect on the emerging issues of the current goal setting practice of TLMN and identify areas of researcher bias. To ensure that only the collected field data was analysed, I made verbatim recording and transcription of the leprosy managers' interview responses, and coded goal setting themes from these transcripts. Besides, following the fieldwork, I gave written feedback of the research findings as they developed through the data analysis, interpretation and report writing to the interviewed managers and received their confirmation that the data, themes and the frameworks developed from them aligned with their interview responses.

However, my established popularity with the organisation and national staff helped in securing organisational approval and volunteer support for this research, my familiarity with the study participants might have made it difficult for them to refuse my invitation to participate, or freely answer interview

question. Nevertheless, for ethical correctness of my sampling strategy, My professional location in the qualitative study design was simply as a community health practitioner who was already conversant with the concept of leprosy goal-setting that was being explored by the research. Most of my public health work experience was in Africa, particularly Nigeria, where I had carried out evaluation of some of these projects in the past. This doctoral research, therefore, had a fair leaning on my past and current goal-setting experience, on which my impression that leprosy goals were mostly not properly formulated was partially based. So far, from my narrative literature review and articles published before the field stage of this research, I already generated knowledge of goal-setting theories and frameworks. I developed goal-setting models which were published in my first two articles for defining and formulating goals for healthcare settings, such as the leprosy projects I intended to study (Ogbeiwi 2016, 2017). Therefore, I acknowledge that I already had pre-study perspectives and notions of what standard goal-setting practice should be.

So, the above posed a strong risk of researcher bias in my observations and interpretation of goal-setting practices of TLMN. Therefore, as much as possible, the effort was made before the interview to put the respondents at ease and clear any misunderstanding they may have had about purpose of the study and my role in the process. In particular, the organisation was assured that the research was entirely an academic exercise. The participants were assured that the exercise was not in any way a professional evaluation of their leprosy projects and the results would not affect the jobs of the managers. Moreover, to minimise bias in data analysis, the verbatim views of the study participants formed the main database for constructing the theoretical framework of TLMN goal-setting practice.

3.7 Summary of this chapter

This chapter discussed the criteria for my choice of an inductive, interpretive and constructivist qualitative methodology as the paradigm of my doctoral research. Instead of the positivist quantitative or the pragmatic mixed methods approaches, the qualitative was considered best suited for answering the explorative study questions of how leprosy goals were formulated in TLMN's

practice and what theory of practice could be generated from the theoretical goal-setting frameworks. Three basic philosophical assumptions underpin my selection of a qualitative paradigm: the principles of relativist ontology, transactional epistemology and methodological naturalism. This means that my research study is based on a belief that there is no single reality about goal-setting in the TLMN context of leprosy managers. Their realities can only be known from their individual experiences, perspectives and interpretation of the organisation practice. The theoretical goal-setting framework of the leprosy projects can only be constructed inductively through a transactional interaction of the researcher and the researched with the data collected in the field context where leprosy managers work and live. These assumptions are the basis of five criteria that typically differentiate qualitative research from other approaches. In this chapter, these were discussed as the reflexivity and location of the researcher in the study, the probing and inductive field research strategies or study designs, the flexible and evolving methods of collection of textual data and constructionist stepwise thematic analysis, and the steps of triangulation, feedback and reviews of the findings, which are taken to ensure the data validity.

Five qualitative study designs according to Creswell (2013) were compared for relevance to this goal-setting research. Narrative, ethnographic and phenomenological studies were excluded because of their different interpretive focus. However, rather than use the grounded theory method that is the design of choice for empirical theory generation, a more pluralistic and flexible design of case study method was used as my research framework because of practical challenges faced during fieldwork with the rigorous regime of ground theory method. With my robust pre-study knowledge and experience of goal-setting and my possible influence on leprosy managers as a past TLMN leader, my location as both an instrument, and co-participant in this qualitative study is declared in this chapter. The possibility of unintended bias through my involvement in the inductive analytic process is also acknowledged.

The next chapter (chapter four) describes in detail my qualitative case study design and the data collection procedures conducted during the fieldwork stage of this doctoral research.

Chapter 4

CASE STUDY DESIGN AND PROCEDURES

'We may not always appreciate the nature and significance of a case until we have subjected it to detailed scrutiny.'
(Bryman 2016:64)

4.1 Introduction

Bryman (2016: 40) defines research design as 'A framework for the collection and analysis of data.' The perspective of Yin (2014: 26) is that the design is 'The logic that links data to be collected (and the conclusions to be drawn from them) to the initial questions of study.' As the research framework, it is actually 'a logical plan' of the study process that conveys the researcher 'from here to there' or from the study questions to the answers being sought by the research inquiry (Yin 2014:28). According to Yin (2014:29) any explicit research design should be a 'blueprint' that provides details about the research questions, the relevant data to collect, the data collection methods or techniques and data analysis.

In qualitative research such as my leprosy goal-setting study, this research framework or logic was selected based on the need to intensively explore the knowledge, understanding and meaning of the goal-setting phenomenon in the organisation context of TLMN. The impracticability of the strict ground theory regime in this context gave credibility to a case study design. This then provided the research framework required for collecting and analysing textual data to answer my study questions of how leprosy project goals were formulated, and how a practice theory of goal-setting could be constructed from the identified framework of TLMN practice. Specifically, case study provided the essential structure used for exploring the leprosy managers knowledge, experiences and perspectives of the goal-setting process of leprosy projects and discovering the thematic components of their goal frameworks.

This chapter defines and describes case study design as it was applied in my research process. It also discusses its strengths and weaknesses as well as the implications these had for the reliability and validity of the data, findings and

conclusions that evolved using this qualitative research. In addition, in describing my case study design, this chapter also discusses the definitions of the 'case' in my doctoral research, as well as its context and sources of information. The actual procedures and strategies of data collection that outline the framework of the three study methods employed are also described here. My research collected textual qualitative data relating to the goal-setting practice of TLMN leprosy projects. The procedural outline in this chapter gives a stepwise description of the criteria for selecting study participants, and the data collection techniques, sources, and instruments used. It also outlines the process of the fieldwork activities performed during the field data collection exercise. The chapter ends with a detailed outline of steps taken to fulfil the ethical requirements for credible conduct of this research.

4.2 Rationale for Case Study Design

In Yin's (2014: 4) perspective, a case study method is strongly indicated where an in-depth understanding of a 'complex social phenomenon' through focusing on a single case is required to derive 'a holistic and real-world perspective.' In most instances, to achieve this objective, most researchers have used a case study method in the preliminary or exploratory stage of their inquiries. However, Yin (2014) disagrees with this practice because it places case study in the lowest rung of the hierarchy of research methods. Moreover, Yin (2014:8) believes that while any research design could be framed to serve exploratory, descriptive or explanatory purposes, the selection of any study design should be based on three parameters. These are the type of research question, the extent of researcher's control of the events under study, and the extent to which it focuses on a contemporary event (Yin 2014: 9). Accordingly, case study is best indicated in a research set to answer questions of 'how' and 'why'; where the researcher has 'little or no control over the phenomenon being examined; and the object of study is contemporary (Yin 2014: 29).

The applicability of research questions to case studies implies the design can be an appropriate framework for investigative studies that are either exploratory as in any qualitative research or deterministic and explanatory as in most causally controlled analytic or experimental surveys associated with quantitative

research (Creswell 2014; Yin 2014). However, case study design may not be suitable for controlled or randomised studies where the research settings of the study participants are formalised and scientifically arranged to enable observation of some pre-determined variables of interest to the researcher. In the same vein, since it examines contemporary events, a case study is an inappropriate design for examining the development of a historical phenomenon, which is a common feature of retrospective longitudinal surveys, comparative case-control, narrative biographical studies, phenomenological or grounded theory studies that analyse participants reflections on their shared past lived experiences (Creswell 2013).

Thus, case study was therefore considered the best framework for my doctoral research because its framework fulfilled all Yin's three indications: it sought to answer research questions of 'How' leprosy goals are formulated using a purely exploratory, qualitative approach, in which I was not in control of the contextual settings of TLMN and where the leprosy goal-setting practice explored is a current or ongoing organisational phenomenon.

4.3 What is a Case Study Research?

Case study research is defined according to two dimensions of its strategy of inquiry: the *number* of cases examined and the *depth* of information gathered about them – based on a theoretical assumption that 'Other things being equal, the fewer the cases investigated, the more information that can be collected on each of them' (Hammersley & Gomm 2000: 2). Case study strategies therefore typically enable the intensive collection of a lot of information on a single case or very few cases across many dimensions as possible within the context of the case or cases (Hammersley & Gomm 2000, Yin 2014). Thus, as defined by Hammersley and Gomm (2000: 3), a case study is a 'research that investigates a few cases, often just one, in considerable depth,' with an aim 'to capture cases in their uniqueness rather than use them for wider generalization or for theoretical reference of some kind.' According to Bryman (2016: 60), a case study permits a 'detail and intensive analysis of a single case' and focuses on the 'complexity and particular nature of the case in question.'

In defining a case study, Yin (2014) believes the two concepts that need to be considered should be the case and triangulation. The case is 'a contemporary phenomenon' in a natural context with which it shares a boundary that 'may not be clearly evident' (Yin 2014: 2). Triangulation is the data collection approach of using as many methods and data sources as may be necessary to 'address the distinctive technical condition whereby a case study will have more variables of interest than data points' (Yin 2014: 17). Thus, Yin (2014: 16) defines a case study method as 'An empirical inquiry that investigates a contemporary phenomenon in-depth and with a real-world context ... especially the boundaries between the phenomenon and the context may not be clearly evident.' Therefore, in describing the framework of my case study research, it is imperative that the outline of the case, context, and the triangulated in-depth study methods for data collection and analysis need to be explicitly spelt out.

4.4 Strengths and Weaknesses of Case Study Design

The main strength of a case study design is its popularity of use across many disciplines. According to Yin (2014: 4), case study finds its main relevance where there is the need to understand complex social phenomena by focusing on a single case in order to discover a 'holistic and real-world perspective.' it is a common research design in the fields of 'psychology, sociology, political science, anthropology, social work, business, education, nursing and community planning, economic work, etc.' Case study design allows collection of comprehensive information on a wide range of dimensions about each case under study. The design is, therefore, an effective tool for examining individual study subjects in great depth in order to show their complexity, uniqueness and particularity in their specific contexts (Hammersley & Gomm 2000: 2-3; Bryman 2016: 60-61). As thought by Bryman (2016:64), 'We may not always appreciate the nature and significance of a case until we have subjected it to detailed scrutiny.' Case study researchers, therefore, define their cases for study from a natural phenomenon (Hammersley & Gomm 2000). Whereas most case study researchers use the design for qualitative exploration, authors such as Yin (2014) and Bryman (2016) believe it has a wider application in social scientific research, covering both quantitative and qualitative approaches: deductive as

well as inductive ontologies, and for purposes of both theory testing and generation.

In Stake's (2000: 19) view, case studies are 'down-to-earth and attention-holding.' Case study researchers believe that though the design lacks the advantage of generalisation, case studies 'have intrinsic value for a target audience' and therefore 'can provide an effective basis for readers themselves to draw conclusions about other cases' (Gomm, Hammersley & Foster 2000: 99, 100).

On the other hand, the main criticism of the case study design is the fact that despite the in-depth examination of single or few cases in its or their own context(s), the findings cannot be generalised to the wider population to which the phenomenon belongs, on the grounds of poor representativeness of the extremely small sample size investigated. Hence, as applicable to all qualitative studies, its external validity cannot be verified (Bryman 2016: 64). This practically limits the scope of the usefulness of case study research (Bryman 2016: 399). Therefore, according to Yin (2014: 2), a case study has been popularly referred to as a 'soft form of research'; and considered a 'less desirable form of enquiry than experimental or a survey' as many believe it is not 'rigorous enough' (Yin, 2014: 19). It is therefore not the right study design for any research that seeks to generalise observations and conclusions from a study sample of any size. Thus, for most case study researchers, the essence is not the generalisations as much as 'how well the researcher generates theory out of the findings' (Bryman 2016: 64). However, authors such as Stake (2000: 19) believe naturalistic generalisation is still possible when utility of the findings of a case study is left to the experiential judgement of individual readers of the case study report.

Similarly, establishing a causal conclusion is difficult from just examining a single case. However, some authors such as Hammersley and Gomm (2000) do not agree, as they claim causal analysis become possible when cases are examined in-depth and over time. Other weaknesses of case study research, according to Yin (2014: 21) includes its common confusion with educational

case studies, its requirement for significant effort to manage a large amount of data materials generated, and its 'unclear comparative advantage'.

4.5 Type of Case Study

The case study design I used for my research was a cross-sectional single-case study, in which the case is a contemporary phenomenon of leprosy goal-setting definable by the current organisational context of TLMN. Yin (2014: 51) describes five types of single-case study based on the different rationale for the study: including critical, unusual or unique, common or typical, longitudinal and revelatory case study. From the way these case study types are described by Yin (2014), the critical, unusual, typical and longitudinal case study types seem related more to study populations examined in quantitative studies, and therefore do not describe the type of case in my study.

According to Yin (2014) and Bryman (2016), a critical case is selected because it enables understanding of a predetermined theory. The unusual case, common with clinical or experimental studies, is chosen for empirical examination because of its known unique or extreme features. Conversely, the common or typical case is selected for its representativeness: it possesses known features of 'an everyday situation' that exemplify the typical characteristics of the group it naturally belongs. By these rationales, my case of leprosy goal-setting phenomenon in TLMN is *not* considered representative or typical of any natural group, and therefore the findings of my case study research may not be externally generalisable to the goal-setting practice of other leprosy projects or health organisations universally. Lastly, the longitudinal case is chosen because of the possibility of being studied over time or many times during a period, as is necessary for causal and intervention studies, or historical and ethnographical research (Creswell 2014). Hence, my case is not longitudinal either. Therefore, the case phenomenon of goal-setting in this study is considered a revelatory case, that is studied because of its capacity to make known a previously hidden or undiscovered truth. Hence, despite being a popular subject of many contemporary studies, leprosy goal-setting has never been researched before.

Furthermore, Yin (2014: 26) also classifies case study types into four using a 2 x 2 matrix that plots the number of cases against the number of units of analysis (Table 4.1). In the first group, studies are differentiated as single-case or multiple-case studies, and in the second group, differentiated as holistic (single unit of analysis) or embedded (examines multiple units of analysis).

With this matrix of four types according to Yin (2014: 50), my case study could be described as a single-case holistic case study. It was single-case study because it studied only one phenomenon - leprosy goal-setting in TLMN, of which the framework described by the process or pattern served as the only unit of analysis.

Table 4.1: A matrix of four types of case study design (Yin, 2014)

	Single Case	Multiple cases
Single unit of analysis (Holistic)	Single Case / Single Unit of analysis	Multiple Cases / Single Unit of analysis
Multiple units of analysis (Embedded)	Single Case / Multiple units of analysis	Multiple Cases / Multiple units of analysis

It is holistic because it examined the universal or organisation-wide practice: the focus of my research was organisational rather than the practice of individual leprosy projects as operational sub-units of the organisation. Thus, the case study was not a single-case embedded study since the study did not explore the nuances in the TLMN goal-setting practice according to the different management units or projects of the organisation.

4.6 Defining the “Case”

Generally, authors of literature on research methods agree that a case in any case study could be a person, a community, an organization or a whole national entity (Hammersley and Gomm 2000, Bryman 2016: 60 - 61). A case could also be an event, an issue or a phenomenon of interest to the researcher (Bryman 2016: 60 - 61). According to Yin (2014: 2) a case could be single or multiple. Bryman (2016: 60) believes the term ‘case’ connects the research design to the study location, such as a community or an organisation that gives it a definable setting or context as well as a ‘unit of analysis’, while the ‘case’ is the ‘object of

interest' that the researcher seeks to explore its unique features in detail and depth. In the sense of these definitions, the 'case' studied in my research was the phenomenon of TLMN's goal-setting for leprosy projects in Nigeria and the uniqueness of the practice was defined by its location in Nigeria or setting provided by TLMN.

The goal-setting case for this study was definable as the organisational process and pattern of goal formulation for leprosy projects in TLMN. To answer my study questions, the case study explored TLMN's goal-setting process with a mind to discover the conceptual or theoretical themes that constituted the framework by which the statements of leprosy goals were constructed. Thus, according to this general definition the three specific issues concerning the goal-setting phenomenon in TLMN context were:

- Conceptual framework of TLMN goal-setting practice for leprosy projects (see objective 1 in Chapter 2, section 2.16, page 57).
- Translation of universal goal-setting theories into practice of TLMN goal formulation (see objective 2 in Chapter 2, section 2.16, page 57).
- Theory of goal-setting practice in TLMN context (see objective 3 in Chapter 2, section 2.16, page 57).

Other interests also explored by this case study were goal-setting issues related to the human capacity for goal-setting in TLMN – in terms of the presence of general knowledge about goals, understanding of the importance of goals, skills for formulating goals.

In this case study, the framework of TLMN goal-setting practice referred to the process and pattern of goal-setting discoverable thematically in the individual experience, knowledge and perception of individual managers of TLMN leprosy projects. The translation of universal theories of effective goal-setting into practice referred to the extent the theoretical attributes of SMART goals are reflected in the structural components of goal statements formulated in TLMN practice. The theory of goal-setting practice refers to the proposition or hypothesis that could be constructed from the main abstract constructs and their relations in the general goal-setting framework of TLMN practice. Although

not related to the study questions, it is considered interesting to know what knowledge and understanding of goals and goal-setting process already existed in TLMN.

Furthermore, Yin (2014) recommends what he terms 'bounding the case' in which the boundaries of the scope of the case are defined. The scope of goal-setting phenomenon studied was restricted to only project level goals that were directly connected to current leprosy projects of TLMN. This boundary excluded organisational and administrative goals at any other level. It also excludes goals of past or completed leprosy projects. In addition, only goals formulated for TLMN's leprosy projects were included in the case study. This therefore excluded goals formulated for non-leprosy services.

4.7 Context of Case Study

The context of a case study provides the field setting and boundaries for the operational definition of the case under study (Yin, 2014). The context was the organisational settings of TLMN, a nationalised leprosy charity in Nigeria and a member of an international fellowship of leprosy organisations spread across about 19 countries. Structurally, TLMN is constituted by the National Office in Abuja, the capital city of Nigeria, and up to 16 leprosy projects spread geographically in at least eight States of Nigeria. Organisationally, there is a hierarchy of official responsibilities. The National Director is at the head of the organogram, directing the management and operations of the organisation's projects according to a country strategic plan. National management of leprosy projects is done by a team of three managers in the country office, an operations manager, a project development officer and business and finance manager. At the field level, there are State managers and project managers responsible for the direct field management of the leprosy projects that are funded and/or managed centrally by the TLMN national office.

TLMN has a long history of goal-setting, dating back to the early 1990s when I was the national coordinator of the organisation. Then the goals of the leprosy projects were developed annually. Project-specific plans were built on leprosy project's broad terminal goals and specific annual objectives. These were aligned with national and international leprosy control targets. Thus, the study

context of TLMN was selected purposively based on my past familiarity with the organisation and its known long-term practice of goal-setting and planning for leprosy projects.

4.8 Sources of Information

In line with the requirement of triangulation or use of multiple study sources methods in case studies, the main sources of information were leprosy project managers at the national office and field projects who were the study participants of this research. Leprosy managers were used as study participants because they were the key informants of the goal-setting subject of my research. They were the only ones who had the knowledge and could narrate their experience of TLMN practice of setting goals for their leprosy projects. Another source of information was the set of project documents or plans that were reviewed. Additionally, the annual project planning event of TLMN was included as sources of information that could be collected through direct observation.

The total population of study participants were 18 leprosy managers. They included two national managers and 16 field project managers. The field managers included nine State Leprosy Control Officers and seven Socio-Economic Development (SED) Officers. The project documents reviewable were the project plans of all 16 TLMN leprosy projects in the country, but only six projects were active and had goals attainable by the year 2016. The year 2016 was selected because it was the last annual reporting year, before the year 2017 when the field data collection stage of this research was implemented. The only country-wide planning event organised by TLMN involving all funded leprosy projects is the Annual Country Learning (ACL) workshop that holds in November every year. The ACL workshop I attended for direct observation of goal-setting activities was the one that held from 6th to 10th November 2017.

4.9 Sampling and Selection Criteria

All 16 TLMN leprosy managers were not assessable during the field stage of this research. Therefore, a purposive sampling technique was used to select

information sources based on a set of eligibility criteria. According to these criteria, only TLMN related leprosy project managers and their project documents were eligible as data sources, and non-leprosy projects were excluded. The original (pre-data collection) eligibility criteria considered for the recruitment of study participants and selection of project documents were:

- Organisational approval of TLMN received in writing for the participation of the leprosy project managers in this doctoral research.
- Personal consent received of each leprosy manager to participate in all data collection processes of this research.
- Leprosy project manager responsible for setting goals for leprosy projects and monitoring their attainment.
- Leprosy project manager experienced setting goals and monitoring outcomes of his or her project.
- The leprosy project manager who could be accessed through telephone and electronic communication facilities.
- Leprosy project manager available for interview and annual project proposal had goals and objectives to be achieved by the end of the immediate past project year (2016).
- Leprosy project managed by the project manager has available for review, annual project report with outcomes of objectives for the end of the immediate past project year (2016).
- The leprosy project manager who possessed enough capacity of the English language to communicate effectively and discuss his or her goal-setting practice in relation to the project objectives.

However, only those who accepted my invitation to voluntarily participate in all processes of this research were assessed for eligibility; and only leprosy managers who voluntarily gave consent to be interviewed participated in the study. Those who did not consent or could not be reached during the field data collection exercise were excluded. The final number of study participants

included in my research sample was 10 leprosy managers. Nevertheless, the project documents for all six active projects in 2016 were included in the study.

4.10 Study Participants

Ten leprosy project managers, two national and eight field managers, participated in this study. Three leprosy managers were employees of TLMN (two national managers and one field). The remaining seven field managers were State government employed. By gender, the study participants were eight males and two females. No age data was collected.

4.11 Study Methods

A triangulation strategy that involved the use of three methods was used for the collection of in-depth textual descriptive data, in order to improve the trustworthiness of the qualitative data. These data collection procedures were conducted in the following steps:

1. Open-ended question individual interviews of 10 leprosy managers as study participants and key informants of goal-setting in leprosy projects using an interview guide. These interviews were conducted during the period from 3rd April to 18th June 2017.
2. Participant observation of planning activities by TLMN stakeholders during the Annual Country Learning workshops that held from 6th to 10th November 2017.
3. A qualitative review of the goal statements in project documents – annual project proposals or plans was completed in January 2018.

4.11.1 Individual interview of study participants

Individual key informant interviews were the first study method used in this research. It was the main study method of the case study as it accounted for most of the qualitative data collected in order to answer my research questions. It was a scheduled open-ended interview of individual leprosy managers who gave their consent to participate in the research. The purpose was to collect in-depth qualitative description of their goal-setting process and formulated goal statements. The interviews were done using an interview guide containing

open-ended questions (Annexe 6). The qualitative interviews were done using a face-to-face contact with nine study participants in their usual field locations: their offices in the State Ministries of Health or TLMN national office. Only one interview, the interview of one of the two national managers, was electronic. This interview was conducted through skype.

4.11.2 Participant observation of goal-setting activities

This was the second study method used and it was an unstructured direct participant observation of planning processes during the ACL workshop I attended on the invitation of the TLMN national office. My hope was to identify the goal formulation activities performed by TLMN organisation that produced the goal statements in the leprosy project plans. The ACL workshop was a five-day TLMN stakeholders' forum in which TLMN management staff discussed project development and country strategy with local leprosy project managers and technical consultants from overseas. However, no goal formulation activities were observed during this ACL workshop. This was due to an organisational revision of its goal-setting strategy, which is now done on a project-by-project basis, rather than the group approached I used previously during my time in the leadership of TLMN. Previously, the goals of all projects were formulated annually during the annual project planning meetings held in the middle of the year. Hence this study method did not contribute any data to my research.

4.11.3 Document review of written goal statements

The third study method was a qualitative document review of the leprosy projects' annual plans and reports for 2016, which were received from the TLMN national office. Approval for access to documents was obtained nationally from TLMN. This involved an unstructured review of the lexical components of goal statements in the annual plans and the outcome statements in the annual reports of six leprosy projects. It was unstructured because no checklist or data collection tool was used. The goal-setting process and the structure of goal statements (including long-term, short-term and immediate goals, or aims, objectives and outputs) of each leprosy project were reviewed simply to isolate the goal statements in the plans and to identify the specific thematic concepts or components in the constructs of the goal

formulations. Table 4.2 shows the basic project data extracted from the six pairs project plans and reports covering implementation for the previous reporting year 2016 were received from the national office of TLM Nigeria for review of the statements project goals. For confidentiality of the projects, project codes instead of project names or titles have been used.

Table 4.2: Details of Leprosy Projects whose documents were reviewed

Project Code	State Location	Target Communities	# Aims	# Objs.
SED 1	Niger	Kuta, Sarkin Pawa, Zanchita, Chanchaga, Dakoko and Kudami (6)	1	3
HRP	FCT & Kogi	FCT - Dakwa & Yangoji (2); Kogi - Etutekpe, Kabawa, Owalla & Oyi (4)	1	4
SED 2	Kwara	Okegbala, Elehin, Offa & Patigi (4)	1	3
SED 3	Kebbi & Sokoto	Kebbi - Argungu, Shanga, Kalgo, & Zuru (4); Sokoto - Amanawa & Kara (2)	1	4
LCP	Nasarawa	State-wide	1	2
Ortho	Niger	Nation-wide	1	3
	7 States	22 Communities	6	19

Table 4.2 shows that TLMN projects in 2016 included 4 community-based socio-economic intervention (SED or HRP), a State-wide leprosy control programme (LCP) and an orthopaedic appliance-making workshop with national outreach. Each project had a single long-term aim and between 2 and 4 statements of objectives. While no statement of actual achievements was found in the LCP report, the orthopaedic project had 4 statements and the community-based projects had between 14 to 31 statements. In total, 6 aim statements, 19 objective statements and 98 attainment statements were retrieved from the documents for review and thematic analysis.

4.12 Procedure of Data Collection

The first step in the data collection phase of this research was an application for ethical approval by the University's research ethics committee. This stage involved my completion of the research protocol, consent form for volunteers (Annexe 6), information sheet (Annexe 7) and data collection tool (interview guide, Annexe 9). The university's ethical application form was then filled, and

the feedback questions of the committee were promptly addressed. This process was started in August 2016 and ended in February 2017, when the ethical approval letter (Annexe 8) was received.

The second step was an application for organisational approval from TLM Nigeria country office through a letter of invitation to participate in the study (Annexe 10). This stage started informally in October 2016 and was completed in February 2017. In the letter the organisation was asked to assist with identification of leprosy managers who qualified to be volunteer study participants in my research, using the set of selection criteria I gave along with the invitation letter. The organisation also received copies of the study documents, including the interview guide, information sheet, Participant Consent Form, and the study protocol. The organisation communicated their approval by sending a list of volunteers and their contact details as acceptance of my invitation and a pair of annual project plan and report for each of the six leprosy projects they funded in Nigeria (see TLMN communications in Annexe 13).

Next, as the third step, individual volunteer leprosy managers were contacted through electronic mail in February 2017 to invite their participation and asked to fill and return the personal consent of acceptance. Contacted volunteers were sent copies of study information sheet, the participant consent form and the interview guide for their full information on the study and the data collection process they were expected to participate in. Each volunteer indicated his or her informed consent by returning a signed or initialled consent form (see a signed consent form in Annexe 12). All volunteers who accepted to participate were then screened for participation in the data collection exercise – through direct telephone or electronic communication. To become a study participant, the consented volunteer was screened on the eligibility criteria. In the original research plan, only those who returned the signed consent form, submitted the annual project plans and reports for the year 2016, and satisfy the other inclusion criteria should be recruited and registered for individual interview. However, in practice, the study participants interviewed were those who consented to participate voluntarily and were included in the interview itinerary

or the schedule of field visits to leprosy projects prepared by the TLMN national office (Annexe 11).

The fourth step was the stage of the qualitative interview of individual study participants. The first interview was conducted electronically in April 2017, and the subsequent field-based interview of other study participants was conducted according to the booked appointments made, and the travel itinerary prepared, by the national office. The interview process included visits to leprosy project locations in four States including Zamfara, Sokoto, Kebbi, and Niger. While the TLMN leprosy projects were in seven States, only four States could be visited during my field visits to Nigeria. The additional three States where no field interviews were done were Kwara, Kogi and Nasarawa. In total, ten interviews were conducted in the National Office and the four States visited. Except for the one interview conducted electronically using Skype, interviews were conducted face-to-face in the respondents' field locations in Nigeria. The travel itinerary began from the national office and ended in Niger State.

Before each interview, each participant was assured of data confidentiality and asked to verbally consent to be interviewed and have his or her responses recorded. I administered the interview guide myself using a probing, in-depth and open-ended question interviewing technique. The 10 interviews were recorded using the audio recording application on my phone and/or I-pad. After the interviews, the audio files were transferred for storage into secured folders in both my personal laptop and the university desktop – in preparation for transcription and data analysis.

The fifth step was the visit to the TLM Nigeria annual planning or country strategy review meeting to observe the goal-setting process. This was done in November 2017, but no goal-setting activities were seen being carried out during the annual meeting. The last and sixth planned step of data collection was the qualitative review of the statements of aims and objectives in the project plans. This was started in July 2017 and completed in December 2017. Even though the study participants interviewed were in four States, the plans reviewed were those of all six projects funded by TLMN in seven States active in 2017. The document review was unstructured, but the data search was

guided by the research question to explore how the goal statements were formulated for the leprosy projects.

4.13 Itinerary and Observations of Field-Visits

This section outlines the itinerary or schedule of interview of all ten study participants, my observations of non-verbal communications and gaps that led to the continuous evolution of the interview guide and the data collected from the interview process. The outline shows that all ten individual interviews of study participants were completed in a total of 7 days during the three-month period from April to June 2017. See the field visit itinerary in Annexe 11.

4.13.1 Day one: 05/04/2017

The process began with the first Interview: of a national manager of TLMN using an electronic medium – a Skype video interview. The manager was at the National Coordination Office (NCO) of TLMN, in Abuja, Nigeria, at the time of the interview. The manager spent a good part of the interview time giving background information on the management structure of TLMN national office, and the responsibilities of the management staff of the office. The manager showed confidence and evidence of good knowledge of the organisational goal-setting practice of TLMN. Initially, he seemed evasive of any knowledge or responsibility for goal-setting in TLMN, and repeatedly deferred the sole responsibility for goal-setting to another national manager, code named Mr B.

4.13.2 Day two: 05/06/2017

The second interview was that of the national manager code-named 'Mr B.' It was physically conducted at the National Coordination Office (NCO). The respondent was confident but also seemed defensive. The manager repeatedly attempted to ascribe the conduct of goal-setting activities to a consultative committee, even though the responsibility and authority for goal-setting and project design possessed in the TLMN organisation seemed obvious. However, a detailed description of the goal-setting practice was obtained from this manager's interview. Nevertheless, after this interview, I still felt there was a gap in the interview data collected. The interview data lacked the respondent's verbal examples of objective statements, which I felt was needed to validate the

frameworks of the goals written in the leprosy project plans. After this interview, we travelled to Gusau, Zamfara.

4.13.3 Day three: 06/06/2017

Two interviews were conducted in Gusau city, Zamfara State, 274 miles (441 Km) road travel from Abuja where the TLMN national office is located. The two leprosy managers interviewed were coded named manager 1 and manager 2. The new information gathered from their interviews were their recommendations for NCO to involve field officers at every stage of the goal-setting process. Both respondents were assertive about their claims of non-involvement of field officers in NCO goal-setting. The manager 2 seemed regretful about a lack of government participation in funding leprosy projects. As I originally considered using ground theory data analysis during data collection, I was unable to follow through with theoretical sampling of study participants and the definite steps of field collaborative data collection and analysis required of grounded theory method. It was at this point that I considered thematic analysis as a better option to analysing my accumulating qualitative research data.

4.13.4 Day four: 07/06/2017

Two leprosy managers were also interviewed in Sokoto City, Sokoto, that is 129 miles (207 Km) road drive from Gusau. They were also coded manager 1 and manager 2. The manager 2 was interviewed first. The manager was detailed in the responses but seemed to misunderstand almost every question. The answers the manager gave were mostly non-related to the questions asked and seemed unintentionally evasive. Manager 1 was sincere but did not seem aware of the current goal-setting practice in TLMN, because of a change of policy that excluded the manager's project from direct TLMN financial support. The manager 1 reported that no goal-setting or planning had happened in the project for some years now because of the shifted responsibility for funding from TLMN to the State government many years ago.

I decided to add the respondent's recommendation to TLMN goal-setting as a new question in the interview guide because it also spontaneously came up in yesterday's interviews at Gusau. Much the same information was obtained from the two interviews in Sokoto. The field staff were apparently not involved in

TLMN goal-setting. Responsibility for initiating and finalising formulation of project goals and objectives is domiciled at NCO. It emerged that field staff may be consulted for inputs, information and confirmation or agreement, but they never participated in the actual formulation or writing of the goal statements.

The manager 1's participation in goal-setting seemed an experience that was in the past, not present. So, no knowledge of objectives for 2016, since the project had no leprosy plan. No comments about formulating objectives for project either. So, this leprosy manager, even though supported by TLMN technically, did not qualify as a study participant according to the study's selection criteria. On reflection, gaps existed in the interview data still: data collected so far lacked any information about why TLMN goal-setting is centralised at the NCO. Why are field officers not involved in the formulation and construction of the statements of goals and objectives for their own project?

4.13.5 Day five: 08/06/2017

Another two interviews were conducted in Birnin-Kebbi city in Kebbi State, about 99 miles (159 km) road drive from Sokoto. The two leprosy managers interviewed were also coded manager 1 and manager 2. Manager 1 was eager to answer questions but acknowledged his knowledge was only of the past goal-setting of TLMN, as his project also was no longer directly funded by TLMN. The manager 2 lacked confidence and seemed unaware of current TLMN goal-setting practice and, therefore mostly gave irrelevant responses. So, the interview was terminated mid-way. This second interview in Kebbi was particularly difficult because of poor capacity of manager 2. The manager had limited understanding of goals and the goal-setting process despite having been manager of the project for three years. Thus, the capacity of the manager 2 for goal-setting was, therefore, a major concern. It necessitated my need to use good communication and interview skills to obtain qualitative information from respondents with limited technical capacity of the subject.

The main observation today was the effect of the shift protocol signed by TLMN with the various State governments, which transferred financial responsibility for some field projects to the governments, while TLMN retained responsibility for technical support. On reflection, it appears the shift protocol eroded any past

TLMN structure for planning of and goal-setting for some programmes. What was apparent was what seemed like an abandonment by both the State government and project staff of the affected projects.

4.13.6 Day six: 09/09/2017

Today was a travel day, as we journeyed from Birnin-Kebbi in far northwest Nigeria to Minna, Niger State in the Northcentral. The journey covered 601 miles (968 Km), passing the longer route through Sokoto, Gusau and Kaduna because the direct route through Kontagora was unmotorable. We left early in the morning and arrived in the evening, right inside a very heavy rain!

4.13.7 Day seven: 10/06/2017

This was Saturday and I conducted two interviews, of the two leprosy managers also coded manager 1 and manager 2. The interviews today were not well recorded. The interviews were conducted outside the TLMN office in Minna, Niger State. There was disturbing background noise, and birds chirping. The manager 1 was confident and very knowledgeable of current TLMN goal-setting practice. On the other hand, manager 2 was soft-speaking and elaborate, but capacity and understanding of the goal-setting topic seemed limited.

Nevertheless, the pattern of goal-setting in TLMN was already apparent: Goal-setting was done when individual projects were planned, initiated by the NCO. NCO contacted and embarked on field visits for needs analysis. Project managers were involved during the needs analysis events. The NCO manager returned to the office to formulate the goals and objectives and prepare the project plans. Project managers were not involved in the actual formulation of the goals and objectives, so most could not or did not know how the goals and objectives were formulated. Generally, they agreed with the goals and plans communicated to them at a later stage by the NCO manager. Most of the field leprosy managers say they are "goal implementers" and not "goal setters". All knew the importance of goals to projects and appreciated the factors that helped their projects achieve the assigned goals.

They recommended more field participation in the actual setting or formulation of goals, e.g. in a planning meeting - according to the staff - like it used to be in the past. Yet there were still gaps in the interview data collected. A more

detailed description of the examples of project objectives and the components of their statements, if known, was still lacking. Only very few leprosy managers were able to describe the structure of their objective statements.

4.14 Summary of the Interview Process

Table 4.3 shows a summary of the individual interview process, including the list of the 10 study participants interviewed in the respective States where their projects were located. Thus, the field setting required for a qualitative research inquiry was fulfilled. All were face-to-face interviews except the first that was interviewed electronically, using Skype video facility. The interview duration ranged from about 15 mins for the shortest, and more than one hour for the longest. While up to 6 interviews were less than 30 mins, all 10 were conducted within the ethically approved duration of about one hour, and without unduly stressing the study participants.

Table 4.3: Schedule of Individual Interviews of study participants

Interview #	State	Venue	Mode	Length
1. Manager 1	Abuja	The interviewee was at NCO, Abuja. The interviewer was in the UK.	Skype Video	63:25
2. Mr B.	Abuja	NCO, Abuja	Face-to-Face	44.35
3. Manger 1	Zamfara	Ministry of Health, Gusau	Face-to-Face	27.37.
4. Manager 2	Zamfara	Ministry of Health, Gusau	Face-to-Face	24.02
5. Manager 2	Sokoto	Sokoto Inn, Training Venue	Face-to-Face	41.40
6. Manager 1	Sokoto	Ministry of Health, Sokoto	Face-to-Face	18:20
7. Manager 1	Kebbi	TBL Office, Birnin-Kebbi	Face-to-Face	28.56
8. Manager 2	Kebbi	Ministry of Women Affairs, Birnin-Kebbi	Face-to-Face	15.07
9. Manager 1	Niger	TLMN Office Annexe, Minna	Face-to-Face	22.52
10. Manager 2	Niger	TLMN Office Annexe, Minna	Face-to-Face	33:60

The shortest interview lasted for 15 mins because of the difficulty of eliciting and probing in-depth information from the interviewee (see day 5 in Table 4.3). The longest interview barely exceeded one hour because the respondent gave extensive background information on the organisational structure of TLMN's current project and management operations in the national office (see day 1 in Table 4.3). The disadvantage of the electronic interview for this study participant was the inability to observe any non-verbal communications from the interviewee, including unspoken responses and expressions that would have probably helped to further aid my understanding of his verbal answers. Table 4.3 also shows the itinerary and observations of the process made during the interviews of the 10 study participants. The observations show the use of open-ended questions in a way that made the interviews developmental, as the gaps and lessons learnt from first set of interviews provided basis for the inclusion of new questions in subsequent interviews.

4.15 Data Trustworthiness Procedures

Initial two interviews were done in March 2017 and these were used to determine the internal consistency of the qualitative interview guide. According to Creswell (2014), internal consistency of a data collection tool means the interviewees' responses to questions asked are consistent across different constructs or interviewees. These first interviews involved two the leprosy managers located in Zamfara and Sokoto States. These were done electronically in the first week of March 2017. A skype audio medium was used in the interviews with the original version of the interview guide. However, the audio quality was poor, and the responses recorded manually were scanty because it was interrupted frequently by internet connection problems in Nigeria. Furthermore, as post-interview feedback, written in-depth answers which they gave to the open-ended questions in the interview guide were requested from these two interviewees. The responses gathered through both ways indicated a poor understanding of most of the open-ended questions in the interview guide.

Data from these interviews were not included in transcribed interview data analysed for this research. But the experience gained was used to revise and improve the clarity of the open-ended questions in the interview guide, and strategic adjustment to the interview process. Hence by the time of the first interview in April 2017, some adjustment had been done to the interview guide and the technique of recording the audio responses. While this interview was also on Skype, the audio recording was done successfully using an I-pad. However, I became convinced that a field-based face-to-face interview was unavoidable if my interview data would be credible. Moreover, with an emerging qualitative data collection process, the interview guide was continuously adjusted during subsequent field interviews. So, the qualitative data collected evolved as the data needs and gaps changed over time.

Even though the initial two leprosy managers interviewed in March 2017 were interviewed a second time during the later field work in June 2017, no test-retest correlations were done to check that the same responses were given to same questions. This was because the questions in the interview guide had been amended using the lessons learnt after their first interviews. Besides, the data reliability test of test-retest correlations, in which the consistency of quantitative scores awarded to responses given to the same questions by the same respondents at different times is compared, seemed less applicable to the subjective open-ended in-depth interview process used in this qualitative study (Creswell 2014).

In addition, a purposeful effort was made to improve the qualitative data integrity in terms of completeness, accuracy, timeliness and consistency of the collected data. This was achieved in this research through triangulation of data collection by using three different collection methods to collect the same information (Creswell 2013). During the individual interviews, I gave verbal feedback to study participants of their responses to confirm the opinions and perceptions they expressed, as a data validation strategy. The transcript of recorded interviews and results of the thematic analysis – the emergent themes were also sent to study participants at the NCO, as additional feedback for their confirmation of the responses before and after the data was analysed.

Moreover, this thesis document was peer-reviewed for validity of my research findings, thematic theorisation and interpretations of the emergent goal-setting themes after completion of the first draft. It was reviewed by a post-doctoral colleague and lecturer at the University of Bristol, Dr Oghale Ayetuoma, and the Head of Quality Assurance at TLM International Office, Mrs Jannine Ebenso. For organisational review and feedback, the draft thesis was also proof-read by the TLMN research ethics committee and their official response was written by the country director TLMN, Dr Sunday Udo, Lastly, as promised to them, the draft thesis was also disseminated to all study participants in this study for their feedback. This thesis was then finalised with the comments, corrections and cautions received from the reviewers of the draft document.

4.16 Ethical Considerations

Ethical issues in my research included protection of the right of my research participants to participate or not in the study, protection of their personal data and confidentiality, and protection from stress during their participation in the data collection process. It was important that no participant was coerced to participate or give any information against his or her will. Particularly, it was vital that their participation was free from pressure either from the TLMN national office or me (the researcher), especially since I was the national leader of TLMN 18 years previously. Moreover, the research proposal and data collection documents were assessed for the extent to which they met the research standards of the university. They were duly approved by the university's research ethical committee (See Approval letter in Annexe 8). In addition, an official invitation to participate in the research was sent and the organisational consent was requested in writing before the onset of the study, and their written permission obtained through electronic communications in Annexe 13.

Furthermore, each listed volunteer was contacted directly, with no pressure from the country office, for their eligibility screening and to obtain their free-will consent to participate in all data collection stages of the study. The Consent form in Annexe 6 shows consent was also requested for the collection, recording and use of the participant's responses. The participants were empowered to withdraw their consent and participation at any stage of the data

collection process. In addition, verbal consent of the interviewee was obtained before commencement of each interview. To enable giving of informed consent, each volunteer also received a detail information sheet on the study (Annexe 7), research protocol, and interview guide (Annexe 9) along with the consent form (Annexe 6). The consented participants were assured that his or her participation and the interview would be confidential. The details of the interviewees, such as personal information and the designated projects, that could identify respondents after the interviews were not collected.

The existing power of influence of the researcher's long-term relationship with the organisation of TLMN, the leprosy projects, and the leprosy managers was duly acknowledged and mitigated as much as possible. This was achieved through creation of appropriate rapport to ensure each respondent was free of intimidation, coercion or inducement. Request or use of favours or threats from past relationships was avoided completely. Every interview was conducted at the free-will of the study participant and at his or her convenience of time, place and comfort. Thus, no participant was forced to participate or to answer questions he or she was not comfortable with. The option of electronic interview was offered to study participants who might have felt pressured or intimidated by the physical presence of the known researcher. Every consented interviewee was thanked profusely for their time at the end of the interview. No financial remuneration or motivation was offered for participation in the data collection exercise. However, the researcher facilitated a training session on goal-setting at the ACL Workshop of TLMN after the data collection was completed and, thus, contributed to the capacity building of all leprosy managers in TLMN, whether they participated in the study or not.

No personal or confidential data that would identify the study respondents after the research process was collected. The recorded interviews saved in the phones and computers will be deleted at the end of my study, according to the research policies of the University of Bradford. The files with the written transcripts were stored securely in my personal pass-worded laptop computer and would be kept for the next 12 months after graduation. They would be securely disposed afterwards. The analysed data in this PhD thesis does not report any identity data of study participants. The PhD thesis after graduation

would be shared with relevant stakeholders in the TLMN organisation and the leprosy managers who participated in the study. The original thesis would be submitted to the University, but the data in the thesis and the right to publish its content would remain my property as the researcher.

4.17 Summary of the Chapter

This chapter has described the framework of case study as the chosen design for my PhD research. It included the specific definition the case and its context as well as the data issues and boundaries of the case phenomenon explored. Also described is the outline of the triangulated study methods of interview of individual study participants in their field contexts, observation of planning activities at the TLMN's ACL workshop and the document review of leprosy project plans. Moreover, details of the data collection procedures that outline how data on how goal-setting was practised in TLMN were provided in this chapter. Overall, using the appropriate qualitative study design and methods, textual data were collected from ten leprosy managers in their project locations in four States and the project plans of six leprosy projects in seven States of Nigeria.

The next chapter (chapter five) describes the steps of thematic analysis of the raw textual data collected from study participants and their project documents. The data analysis was done after completion of the data collection phase of my research. The conceptual themes of the goal-setting process and pattern that emerged from the thematic analysis became the base constructs used in later stages for the development of theoretical frameworks of TLMN goal-setting practice.

Chapter 5

THEMATIC DATA ANALYSIS

‘... [the researcher] always plays a role in identifying patterns and themes, selecting which ones are of interest and reporting on them to the readers.’ ‘... A researcher’s judgement is necessary to determine what a theme is’

(Braun & Clarke 2006: 7, 10)

5.1 Introduction

This chapter describes the details and procedures of my thematic data analysis based on Charmaz’s (2006) social constructionist approach. The chapter begins with basic information about thematic analysis (TA) method according to Braun and Clark (2006) and Clark and Braun (2017). The qualitative data analysis method used in this research integrated the Braun and Clarke’s (2006) six-step model of TA with the Charmaz’s (2006) steps of serial inductive constructionist theme development. It provides a summary of the codes, categories and themes that were generated at each stage of the analytical process. The chapter describes how I analysed and synthesised the qualitative data I collected from study participants and the leprosy project documents. This emergent themes from the analytic process enabled me to develop the theoretical framework of TLMN goal-setting practice I needed to answer my core research questions of how leprosy goals were formulated for leprosy projects.

5.2 Braun and Clarke’s Thematic Analysis

Thematic Analysis (TA) is defined by Clark and Braun (2017: 297) as “A method of identifying, analysing and interpreting patterns of meaning (themes)” within qualitative data. Typically, TA develops thematic patterns from across an entire data set. In a case study, this includes the full range of data collected from all data sources and through all study methods of the research, rather than the analysis of single respondent data, as in narrative or biographical studies. It uses a system of coding concepts in the raw data that are identified as relevant to the research question(s) of the researcher, and then step-wisely developing larger and increasing abstract or general themes. So, like most inductive

constructionist qualitative data analysis techniques, such as grounded theory methods, TA involves the active participation of the researcher in the theme development and the hermeneutical theorisation process (Clark & Braun 2017). Even though TA is as systematic as other qualitative data analysis methods, it is often regarded as the most flexible and accessible. This is because TA procedures are “unbounded by theoretical commitments” to methodological rules such as those that govern Interpretative Phenomenological Analysis (IPA), Grounded Theory Method (GTM), or thematic Discourse Analysis (DA) (Clarke & Braun 2017:297). TA’s elasticity gives it wide applicability across research paradigms because of its flexible aspects of theme and meaning development, research question, sample size and constitution, and even data collection methods and approaches (Clarke & Braun 2017). Thus, according to Braun and Clarke (2006, 2013, 2017), TA has a range of variants as it is the model of choice for data analysis applicable across many theoretical frameworks of qualitative and other research paradigms.

A code, according to Clarke and Braun (2017), is “the smallest unit of analysis that captures interesting features of the data (potentially relevant to the research)”. Codes are used as “building blocks” to develop conceptual themes from data collected from study participants. Themes, on the other hand, are described as “(Larger) patterns of meaning, underpinned by a central organising concept” normally the core phenomenon defined by the core question of the research (Clarke & Braun 2017: 297). They are the key features in the entire corpus of research data that are identified and interpreted systematically in order to answer the research question (Clarke & Braun 2017: 297). In conducting TA, Braun and Clarke (2006: 7) insist that the researcher “always plays a role in identifying patterns and themes, selecting which ones are of interest and reporting on them to the readers.” They assert that “A researcher’s judgement is necessary to determine what a theme is” (Braun & Clarke 2006:10). The flexibility of TA allows the researcher to develop themes in many ways, but constancy of the theme identification approach is crucial (Braun & Clarke 2006: 11). Hence TA is criticised for eventually losing the “voice” of the study participants in the collected data through the analytic process (Braun & Clarke 2006: 7).

However, in this both GTM and TA are similar as GTM also seeks to generate a theory that explains and predicts a phenomenon based directly on themes developed from raw data collected. However, TA is not considered bound to fulfil all conditions that are required for generating a data grounded theory, such as theoretical sampling and sensitivity, and the typical going back and forth between data analysis and data collection until theoretical saturation is reached (Braun & Clarke 2006). Braun and Clarke (2006:8) argue that “TA researchers need not subscribe to the implicit theoretical commitment of grounded theory *if they do not wish to produce a fully worked up grounded theory analysis.*”

Also, discourse analysis as a ‘pattern-type analysis’ is like the social constructionist variant of TA (Braun & Clarke 2006: 8). However, it is mainly indicated when a discursive content analysis that identifies and theorises patterns or themes regarding meanings of language, attitudes etc in the data is required (Braun & Clarke 2006; Titscher et al. 2000). In further contrast, TA does not use any pre-existing theoretical analytic framework as is often used in GTM and IPA. Hence, in the view of Braun and Clarke (2006: 9) TA’s non-requirement of much technical theoretical knowledge makes it a more accessible qualitative analytic tool useable even by researchers with limited research experience.

Philosophically, TA is used in a range of models with two extreme frameworks of essentialism or realism at one end and constructionism at the other, with critical realism or contextualism in the middle (Braun & Clarke 2006: 9). According to Braun and Clarke (2006: 9), essentialist and realist TA analyses the real experiences, knowledge and meanings of study participants, while constructionist TA explores how the events, experiences and realities are “the effects of a range of discourses operating within society.” According to them, critical realism analyses how the individual meaning of the experiences of study participants are influenced by their real social contexts (Braun & Clarke 2006). Whichever side of the spectrum they may be, TA analytic frameworks can be both deductive and inductive, depending on whether the theme identification and development are based on the background research theory or the raw research data (Braun & Clarke 2006:12). Like all inductive qualitative analysis, inductive TA described as “Bottom-up” works from data to develop themes or

patterns of issues related to the research question, while deductive TA works from the research's theoretical framework to develop themes into which the patterns or frequencies of issues in the collected data are fit. Thus, according to Braun and Clarke (2006: 12) inductive TA is "Data-driven" and not "Theory driven". Therefore, they are described as "a process of coding data without trying to fit it into a pre-existing coding frame or researcher's analytical pre-conceptions."

In addition, Braun and Clarke (2006) describe the importance of the level of theme identification in TA. They assert that while there are two levels possible - "semantic" and "latent", TA characteristically uses only one level throughout the process of serial build-up from initial codes to themes or patterns of the phenomenon being explored (Braun and Clarke, 2006:13). According to them at the semantic level, themes are 'Identified within the explicit or surface meanings of the data ... and the analyst is not looking for anything beyond what a participant has said or what has been written' (Braun and Clarke, 2006:13). In this sense semantic themes are literal or superficial. So, their analytical development is progressive from an ordinary description of the identified patterns of the literal contents of the qualitative data to interpretation by theoretical explanation of the importance and implications of the patterns in the light of the research questions. At the latent level, the analyst searches deeper for the "underlying ideas, assumptions, and conceptualisation ... and ideologies" in the data that theoretically explain, determine or enlighten the semantic contents (Braun and Clarke, 2006:13).

However, whichever level of thematic development is used, the steps of TA are inherently hermeneutical and thus produce results that are both descriptive and theoretical of the patterns of the central phenomenon being studied (Braun and Clarke, 2006). In this way, the Braun and Clarke idea of TA is like the inductive constructionist framework proposed by Charmaz for thematic analysis of qualitative data collected using grounded theory methodology. According to Braun and Clarke (2006: 13), "Thematic Analysis conducted within a constructionist framework ... seeks to theorise the socio-cultural contexts and structural conditions that enable the individual accounts that are provided."

The Braun and Clarke (2006) model of TA uses six steps of data analysis that begins with the transcription of the original form of collected data to written text. Then pre-coding, the researcher reads and re-reads the entire qualitative dataset to become conversant with the text and general ideas in the data. The second step is initial coding, which according to Braun and Clarke (2006: 16) produces “general initial list of ideas about what is in the data” that is related to the research question. The third step is theme identification that involves sorting the initial general codes into different groups or categories of probable themes. In the fourth step, the themes are developed into “candidate themes” through reviewing and refining the theme categories in a way that each is clearly demarcated. The fifth step is labelling, in which the refined categories or themes are labelled or assigned a general title. The final step is when the themes identified and developed as “fully worked-out themes” are used to write the research report Braun and Clarke (2006: 16).

5.3 Process of Inductive Thematic Analysis

An initial informal analysis of my collected data was commenced at the same time as data collection. This was done through my reflection on the emerging pattern of goal-setting issues as the data collection process progressed (see section 4.13, Chapter 4). The detailed thematic analysis was done after all 10 interviews had been completed, the verbal recorded data transcribed into written transcripts and verified through participant feedback. I then subjected the raw research data to thematic analysis according to the systematic steps theorised by both Braun and Clarke (2006) and Charmaz (2006).

Overall, the serial constructionist thematic analysis used involved initial textual coding of concepts identified in data and categorisation of codes into sub-themes. The sub-themes were then integrated into main themes. Ongoing reflective refining and interpretation of the main themes were then used to construct the theoretical goal-setting frameworks. This analytic process followed the recommendations of Braun and Clarke (2006:16) and Charmaz (2006: 11) for inductively constructing theories based on the semantic themes that directly or literally emerged from collected data. This detailed procedure of analysing the collected qualitative data in this study are further elaborated in these steps:

5.3.1 Step 1: Clarification of research questions

According to Charmaz (2006), the constructionist data analysis process begins with clarifying the research problem and the research questions. So, in this study, the research problem, according to the identified gaps in the literature review, was that the goal-setting practices of healthcare delivery systems in low-income countries, such as Nigeria, was generally unreported, undocumented and therefore empirically unknown. Specifically, it was reported that most managers and planners in many organisations globally lack the capacity to translate the theoretical principles of existing goal-setting theories and SMART models into practice of formulating SMART and attainable goals. Most goal-setting studies in healthcare in high-income countries focused on the efficacy of goal-setting as recommended concept for patient self-management in clinical therapy and rehabilitation. However, the processes and frameworks for formulating goals and writing statements of objectives for health projects had never been explored in any academic research setting. Most of my pre-doctoral healthcare work experience was related to TLMN leprosy care in Nigeria, faced with the same goal-setting problem situation. Hence the core research question for my study was: How were TLMN leprosy project goals formulated in Nigeria? and a sub-question of: How are the statements of leprosy project objectives framed or constructed?

5.3.2 Step 2: Reading and re-reading

This stage involved a detailed study of the text data in the ten transcripts and goal statements that were printed into paper transcripts. During the first reading, important gaps or missing data in the written conversions and responses were noted and corrected as much as was possible by repeatedly listening to the audio-recordings. Where the audio recordings were poor, the gaps were, as necessary, followed-up by email to the respondents concerned for their confirmation or correction. In the second or third reading, the main issues in the responses to each interview question were noted by labelling or writing comments directly on the printed transcripts. The transcripts were then stored in ringed files after data analysis.

5.3.3 Step 3: Open codification

The next step in Charmaz's (2006) process is the initial coding of the raw textual data collected. Open codification involved identifying and highlighting the specific terms and phrases in the transcribed data related to my research questions – at a semantic level. Literal themes were built from the specific primary or initial conceptual codes into categories of general themes (Braun and Clarke, 2006; Charmaz 2006). In my TA, this meant coding the qualitative data in the transcripts of all ten interviews with leprosy project managers who participated in my research and the written goal statements in the same step. According to Charmaz (2006: 11), knowing the research problem and questions enables theoretical sensitization that is needed to identify the relevant concepts in the raw data, which are then grouped together and labelled as primary or initial codes. Using the theoretical sensitivity guided by the research questions, a manual line-by-line and word-by-word review of transcribed data was done for identification of relevant concepts as codes, without use of any pre-determined coding formula, template or computer application. The interview responses in each transcript were simply read and scanned for terms and phrases related to the research questions. These were circled or underlined or highlighted in the text and labelled with a related heading in the margins of the script.

These primary labels, written mostly as phrases, and were then transferred to a separate word document as the primary codes extracted directly from the managers' responses. Alongside these primary codes were written the corresponding respondents' quotations extracted verbatim from the transcripts. The quotes were written in parentheses and enclosed by quotation marks. Following that, the primary code and its related quotation were numbered serially. Each serial primary code number had 3 figures separated by dots (e.g. 1.2.3): the first figure represented the interviewee number or interview number assigned on the transcript (in order of interview), the second figure represented the transcript response number, and the third figure was the quote number in the order it appeared in the response paragraph in the transcript. So, it may be easy to trace which interviewee said what through the code numbers.

Subsequently, the phrase of each primary code was then examined and keywords in them highlighted in yellow colour. The highlighted words in each primary code were then used to create a second-level label or a secondary code highlighted in light blue colour. The secondary coding involved a response by response sorting and grouping of primary codes *within* individual interview transcripts. To do this, similar primary codes were aggregated into categories according to the sameness of the concepts they portrayed.

5.3.4 Step 4: Selective codification and theoretical integration

This is the stage during which the initial codes are grouped and labelled to create higher conceptual categories. It used a category building process that involved a comparison of the initial codes and grouping them together by their similarities or differences into broader, general, or mega-themes. In the first instance, the secondary codes (representing categories of the initial primary codes) were theoretically integrated into major categories. In this, similar secondary codes were sorted and aggregated *across* the entire data set of 10 interviews. These created major categories of secondary codes with their corresponding primary codes and quotes. These major categories were given either the same label as the secondary codes or revised to match the new concept that emerged after the integration. In the revision process, some labels were fine-tuned to ensure their exact resemblance to the codes and quotations.

This was followed by multiple levels of progressive categorisation of the initial and secondary themes to reveal higher levels of meanings, interpretations, and to evolve final mega-concepts or themes. In this research, this process involved further levels of repeated sorting, grouping and categorisation and labelling of the initial codes and labels across all interviews, in addition to codes imported from the statements of objectives obtained from the review of project documents.

Overall, this process produced 5 stages of categorisation in which the number of conceptual headings, thematic labels or themes were reduced progressively as the analysis moved from initial codes (primary codes, coloured yellow) to sub-categories (aggregated secondary codes, coloured blue), to categories (sub-themes, coloured green), to main themes (major themes, coloured purple)

and finally to final or general themes that were descriptive of the different aspects of the goal-setting practice of TLMN organisation. Dissimilar codes or themes that did not fall into any categories were not forced to belong to existing groups, but were placed separately into their own separate or category labels.

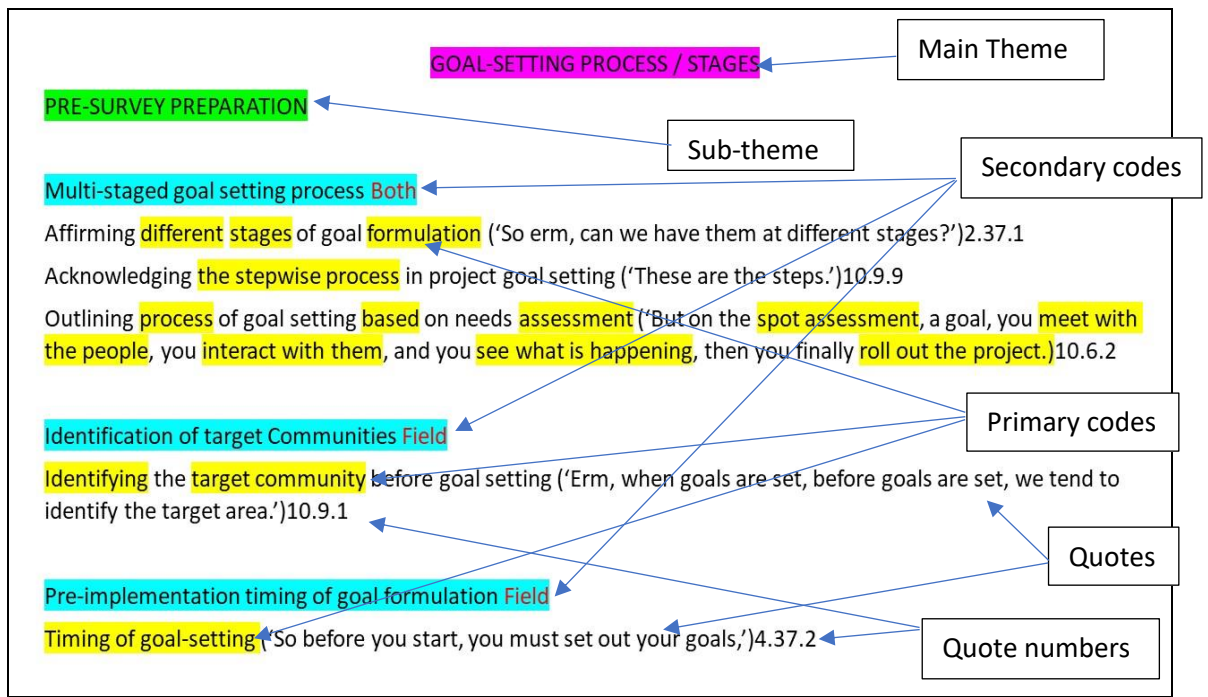


Figure 5.1: Extract of a coded transcript showing the coding levels of themes

Table 5.1: Numbers of primary and secondary codes identified in each interview transcripts

Interview no.	Primary codes	Secondary codes
#1	118	55
#2	200	81
#3	89	50
#4	104	59
#5	111	95
#6	42	21
#7	62	43
#8	26	15
#9	69	44
#10	39	22
Total	860	485

The number of primary codes and secondary codes identified in each interview transcript through this process is shown in Table 5.1. Thus, the analysis generated totals of 860 primary codes and 485 secondary codes from the 10

interview transcripts. These interview themes were then integrated with themes of goal statements collected from the reviewed project documents. These themes at different levels were continuously refined throughout the period of thematic analysis.

Table 5.2 shows that at the end of the integration and refinement process, the results of the thematic analysis were 607 initial codes, 242 sub-categories, 54 categories, 15 main themes and 5 final general themes. The five final themes that emerged from the serial thematic analysis were goal-setting stakeholders, goal-setting strategies, goal statement framework, goal attainment and goal utilization.

Table 5.2: Stages of progressive thematic integration

Stage I: # Primary Codes	Stage II: # Secondary codes	Stage III: # Sub- themes	Stage IV: Main Themes	Stage V: Final Themes
109	62	16	Goal-setting roles	Goal-setting Stakeholders
			Goal beliefs	
			Goal-setting experience	
			Goal-setting ability	
164	65	18	Goal-setting stages	Goal-setting Strategies
			Goal formulation patterns	
193	50	7	Goal Composition	Goal Statements
			Goal construction criteria	
			Goal Structure	
72	28	5	Goal achievement level	Goal attainability
			Goal attainment basis	
			Goal attainment effect	
			Goal attainment factors	
69	37	8	Goal uses	Goal Utilization
			Project development	
607	242	54	15	5

5.3.5 Step 5: Axial codification

This was the interpretative reflection on the emergent themes in order to identify any inter-thematic associations and generate theoretical explanations of the goal-setting concepts that were coded in the research data. This stage, therefore, involved further studying, reflecting and interpreting or theorising the themes. This led to the emergence of patterns of interactions of the concepts relating to final emergent themes that illustrated the way goals were formulated

and stated in the TLMN leprosy project context. In the end, the characteristic quotations that supported any theoretical concepts of these core emergent themes were identified and used as the evidence of the theoretical frameworks generated by this study (see tables in Annexe 5).

5.4 Emergent Goal-setting Themes

5.4.1 Main themes of goal-setting stakeholders

The final theme of goal-setting stakeholders emerged from four main themes that included goal-setting roles, goal beliefs, goal-setting approach and goal ability (Table 5.2, page 113). 'Goal-setting roles' was the category label of five sub-themes developed from 18 secondary codes (Table 5.3 in Annexe 5, page 334). These role concepts described three groups of goal-setting related project tasks implemented by national and field managers - shared, joint or separate responsibilities. 'Goal beliefs' was the thematic label of six sub-themes that emerged from 28 secondary codes. The goal beliefs sub-themes or concepts included the definitions, types, effects, and benefits of goals as well as the effects of goal-lessness and illogical goal-setting (Table 5.4 in Annexe 5, page 334). 'Goal-setting approach' was the label of three sub-themes that evolved from 12 secondary codes, including assigned goals, field recommendations and collaborative goal-setting (Table 5.5, Annexe 5, page 335). Lastly, Table 5.6 (Annexe 5, page 336) shows the main theme of 'goal-setting ability' that was the thematic label for the sole sub-theme of goal-setting competence that emerged from three secondary codes.

5.4.2 Main Themes of Goal-setting Strategies

The final theme of goal-setting strategies emerged from two main themes, namely goal-setting stages and goal formulation patterns. There were ten sub-themes under the label of 'goal-setting stages', which emerged from a total of 30 secondary codes. These stages include pre-survey preparation, baseline survey and a string of eight post-survey goal formulation and project planning stages (Table 5.7 Annexe 5, Page 336). The 'goal formulation' pattern was the label for seven sub-themes generated from 31 secondary codes. The sub-themes or concepts of goal formulation pattern included the types and timeframes of goals, goal differentiation criteria, the logical formulation linkages,

target setting, goal formulation approach and leprosy control goal-setting (Table 5.8 Annexe 5, page 338).

5.4.3 Main themes of Goal Statements

This final theme was developed from three main themes that included goal composition, goal construction criteria and goal structure. The first, 'goal composition' labelled two sub-themes: statement contents and content combinations that emerged from 11 secondary codes (Table 5.9 Annexe 5, page 340). The second thematic label of 'goal construction criteria' was assigned solely to good goal attributes developed from nine secondary codes (Table 5.10 Annexe 5, page 341). The third main theme of 'goal structure' was a label for four sub-themes generated from 29 secondary codes. These sub-themes included the statement construction approach (Table 5.11, page 342), the statement frameworks of verbalised objectives (Tables 5.12, page 342) and written aims and objectives, (Tables 5.13 and 5.14 Annexe 5, page 343).

5.4.4 Main themes of Goal attainability

As outlined in table 5.2, this theme emerged from four main themes: goal achievement level, goal attainment basis, goal attainment effect and goal attainment factors. The main theme of goal achievement was a label for the sole sub-theme of 'extent of achievement of 2016 objectives', which described three secondary codes: achievement type, quantified goal attainment and qualified goal attainment (Table 5.15, page 345). Achievement type described only the multi-year attainment structure of the leprosy project objectives. Quantified goal attainment described the statistical figures of achievement, which the leprosy managers stated as percentages that they believed their projects achieved in 2016. Table 5.15 shows that while some managers felt they achieved less than 100%, many more of them felt they achieved 100% or higher. Qualified goal attainment emerged from the leprosy managers' expression of the extent of their project achievements using qualitative or descriptive terms such as reasonable, very well, all, half-way or not at all.

The main theme of goal attainment basis also emerged from a single sub-theme of goal assessment approaches that described four secondary codes or concepts. The most popular concept was assessment of goal attainment based

on implementation of project activities (Table 5.16, page 345). Similarly, the main theme of goal attainment effect was described by a single sub-thematic label - the leprosy managers' perspectives of the connection between goals and the achievements of their projects. Table 5.17 (page 346) shows this sub-theme emerged from three secondary codes or concepts that described the connection and relevance of achievements to goal setting, and the effects of goal attainment. Table 5:18 (page 346) shows the main theme of goal attainment factors evolved from two sub-themes, including enhancers and risk factors of goal attainment. 'Goal effect enhancers' was the label for 14 secondary codes. In the experience of the leprosy managers, the enhancers of goal attainment constituted mainly availability of resources, nature of partnerships and the project management approaches (Table 5.18). The sub-thematic label of risk factors described four secondary codes that included field personnel, funding, community attitudes and incidental economic and political changes.

5.4.5 Main themes of Goal Utilization

The two main themes that generated the final theme of goal utilization were goal uses and project development. Table 5.19 (page 347) shows the four sub-themes or categories under goal uses, including planning, implementation, progress measurement and evaluation of achievements. The planning sub-theme emerged from the secondary codes or concepts of planning the project's future, resources, and implementation. The implementation sub-theme covered the concepts of using goals for determining timeframes, deciding action and managing implementation. While the sub-theme of progress measurement sub-theme included using goals for monitoring project changes and tracking project goals, the evaluating achievements sub-theme covered using goals to set evaluation timeframes and enabling assessment of project's achievements. The second main theme of project development emerged from a group of four sub-themes or categories also including project planning, implementation, achievement assessment and goal measurement approach (Table 5.20, 348). There were seven concepts that described the project planning sub-theme, namely central location of project design, planning cycle, duration, focus and size of projects and organising workshop meetings as forum for involving stakeholders in the process. The sub-theme of project implementation was the

label of the category of implementing and organising activities, collaboration with government and community stakeholders in implementing and monitoring activities and the challenge of changing needs of beneficiaries during project implementation. The third sub-theme of implementation assessment described eight secondary codes. These are shown in table 5.20 to be mainly timeframes of project reviews, including mid-term reviews, frequency of reviews, project goal setting cycle, the periodic field reporting to the centre and the multi-year planning strategy. The fourth sub-theme - measurement approaches described six secondary codes that included a varied list of project evaluation concepts.

5.5 Selection of Goal Setting Themes

Overall the study objectives were to discover the theoretical goal-setting frameworks that illustrate the organisational goal setting practice, assess the extent to which the existing universal goal setting theories and models are translated into practice and generate inductively from the emergent theoretical goal-setting framework a practice theory that describes, explains and predicts the general process and structure of the TLMN goal setting practice. Out of the 15 main themes in table 5.2 that emerged as the findings of the thematic analysis research and from which the core 5 final themes evolved, only the top 9 are theoretically connected to the process and structure of TLMN goal-setting. These 9 themes generated the three final themes of goal-setting stakeholders, goal-setting strategies and goal statements. Thus for the next stages of the research process, including interpretation, theorisation and discussion of the emergent goal setting concepts done for the generation of the general theoretical framework of TLMN goal-setting towards the construction of a practice theory, the main themes of goal-attainability and goal utilization were excluded. Thus, their constituent four main themes and concepts were not discussed further because they essentially described the level, basis, effect and factors of goal attainment. They thus do not describe or contribute to answer the core research questions of how the goals of TLMN's leprosy projects were formulated and written. Therefore, the fourth and fifth final themes of goal attainment and goal utilization (Table 5.2) were considered outside the scope of my research.

5.6 Summary of this chapter

This chapter described the process and the emergent themes that resulted from the thematic analysis (TA) of my research data. The technique used for analysing the qualitative data collected from the study participants and the project documents in this research. The TA used was the basic systematic model proposed by Braun and Clark (2006) and Clarke and Braun (2017) as well as the social constructionist model proposed by Charmaz (2006). The amalgamation of the two models in this research produced the five-step procedure of inductive constructionist data analysis done. Essentially analysis began with transcription of interview and document data in the written form for analysis. Transcribed data were read and re-read before the primary coding of words or phrases related to the research question of how goals are formulated in TLMN. Secondary coding was the stage of aggregation of similar primary codes into groups of concepts or themes. The primary and secondary coding was done on each of the 10 transcripts. The next stage of theoretical integration and categorisation of grouped and refined the secondary codes across all 10 transcripts into sub-themes or general categories of goal-setting concepts.

Further grouping and integration of the sub-themes produced the main themes or thematic labels. From the main themes emerged five final themes as the overall results of the thematic analysis. However only three final themes were directly related to the core research question of how goals are formulated, and how the goal statements are constructed in TLMN. In the final analysis, these three final themes - goal-setting stakeholders, goal-setting strategies and goal statement - emerged from 9 main themes, 39 sub-themes and 171 secondary codes. The flow chart in Figure 5.2 (next page) illustrates the categorisation of sub-themes or concepts into main themes and final themes.

The next chapter, chapter six, is the narration of my research findings: the products of the theoretical construction of goal-setting concepts identified from thematic analysis into theoretical goal-setting frameworks. It discusses in detail the goal-setting concepts of each of the core three emergent themes and the theoretical frameworks constructed hermeneutically from them.

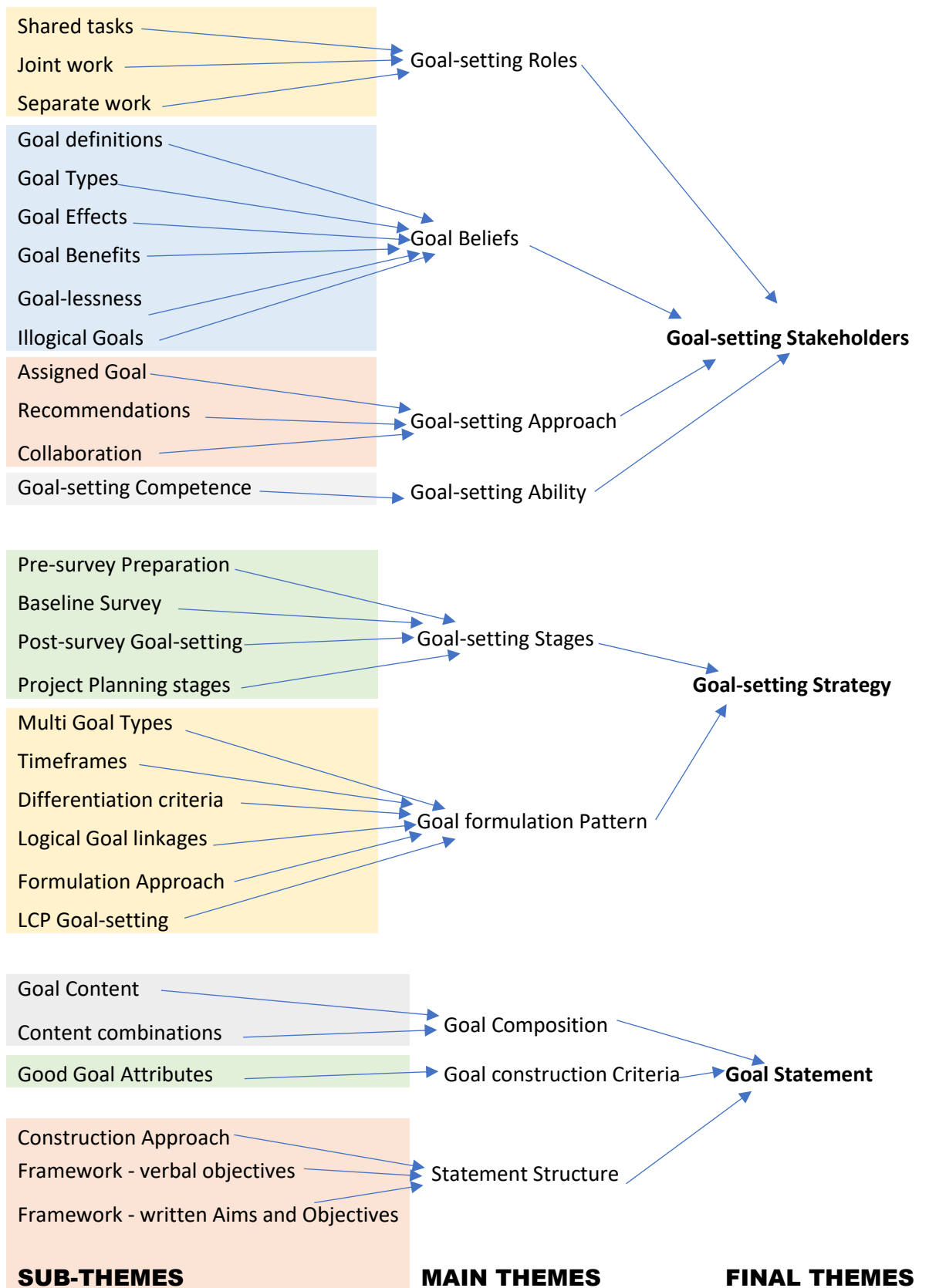


Figure 5.2: Flow Chart illustrating the Inductive thematic integration process

Chapter 6

THEORISATION OF GOAL-SETTING FRAMEWORKS

'We are not part of the committee, ... programme managers ...' (4.18.1), and, *'... they will insist they design it and we are only implementers'* (4.22.5).

(A field leprosy manager)

6.1 Introduction

This chapter reports the findings of this research. It explains the theorisation process by which the original theoretical frameworks identified in TLMN goal-setting practice were developed from the concepts of the three final emergent themes, including goal-setting stakeholders, goal-setting strategies, goal statement, goal attainability, and goal utilisation (Table 5.2, page 113). Thus, this chapter presents only the goal-setting concepts of goal-setting stakeholders and strategies, and goal statements, as well as the 11 theoretical goal-setting frameworks constructed hermeneutically from them. The chapter ends with a summary list of the 11 theoretical frameworks that evolved from TLMN goal-setting practice.

6.2 Thematic Theorisation Process

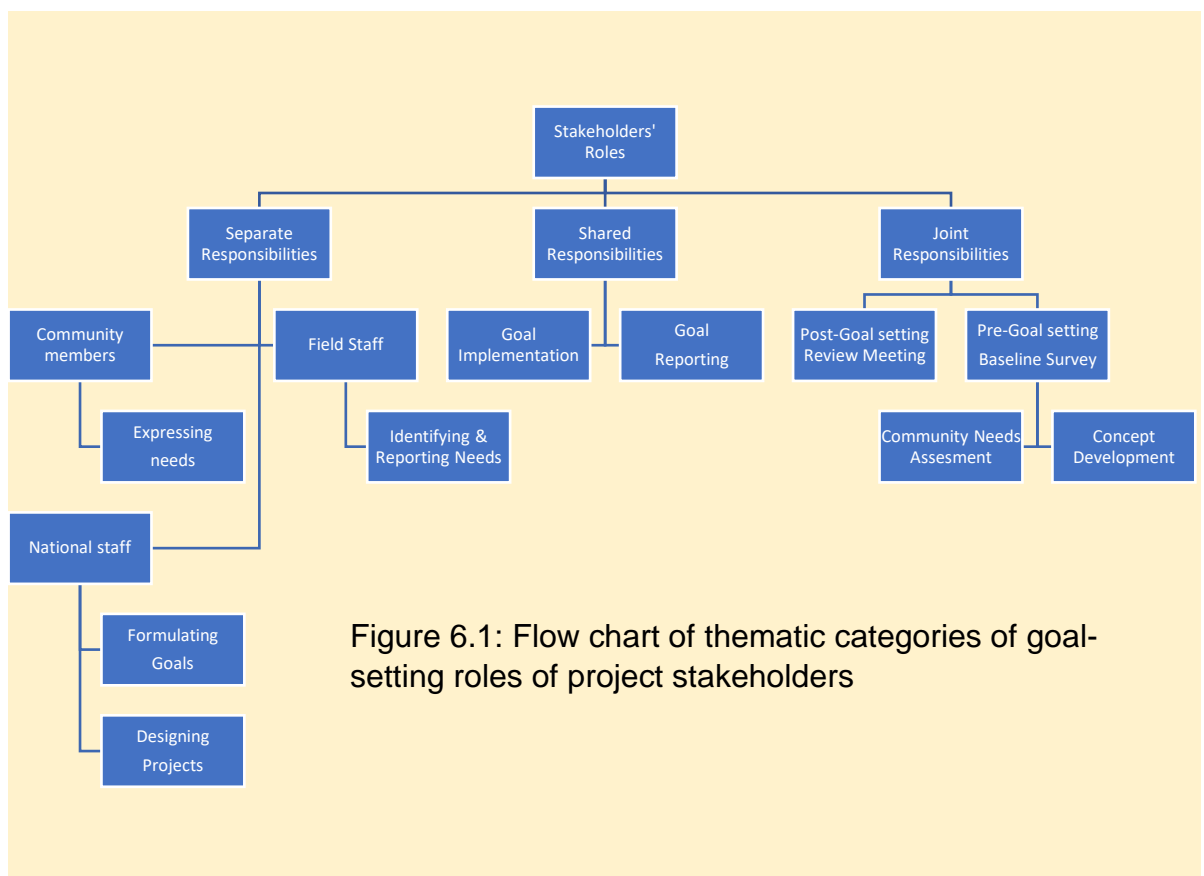
In this research, the theorisation process was fundamentally the axial codification of the emergent themes that evolved from thematic data analysis into theoretical frameworks that describe the core theoretical constructs and relationships in the goal-setting practice of TLMN. During the theorisation process, conceptual frameworks were developed from the study participants' meanings and the researcher's inferences drawn on the inter-thematic relationships. In this process, each final theme was further explored for axial relationships that existed or could exist between the component themes and categories. The inferences were based on consideration of both the quoted perspectives of study participants and the researcher's reflective interpretation.

6.3 Themes of Goal-setting Stakeholders

The main themes labelled ‘goal-setting stakeholders’ included stakeholders’ goal-setting roles, beliefs, experience and ability. The responses of study participants revealed that project stakeholders operate at three levels of the TLMN project concept – community beneficiaries, field managers and national managers.

6.3.1 Theme one: Goal-setting roles

The goal-setting roles of national, field and community stakeholders evolved from three categories of stakeholders’ goal-setting roles that are shared, separate and joint responsibilities according to Table 5.3 (Annexe 5, page 334). Figure 6.1 illustrates the thematic organization of the categories of stakeholders’ roles as described by the leprosy managers.



Shared Responsibilities

The shared responsibilities were those project activities in which the national and field managers did different tasks involved in performing goal implementation and reporting. This concept emerged from one national

manager's explanation that there was a division of labour by field and national stakeholders in implementing the same activities. In implementing goals, the field managers implement project and community activities, while the national managers implement project activities allocated to the national office in the project plan. In reporting on goals, the field managers prepared the field reports, which were later finalized by the national managers.

Separate Responsibilities

The separate responsibilities were those goal-setting responsibilities that were performed separately by stakeholders at different levels. According to the illustration in Figure 6.1, the community stakeholders expressed their needs, the field managers identified and reported the needs to NCO, and the national managers used the reported needs to formulate the goals and plan for the projects. According to a national manager, it was the point of expression of needs that the process of goal-setting began from. He said,

- *'Now, but in terms of formulating the goals, it usually, the goals primarily start from the change expressed, the required change expressed by the beneficiaries' (2.28.4).*

Concerning field managers' separate roles, a national manager said,

- *'Primarily, TLM staff in the field identify the needs and then notify us at the country office' (2.38.18).*

On the other hand, there was a claim by both national and field managers that field managers were excluded from the goal formulation process. Confirming his exclusion, one field manager said,

- *'We are not part of the committee, ... programme managers ...' (4.18.1)*
- *'... they will insist they design it and we are only implementers' (4.22.5).*

The roles that were separate to national managers were descriptive of their project planning responsibilities in which proposal development and the related goal formulation were centralised functions of one staff at the national office. Referring to Mr B, the other national manager claimed,

- *'So, the aspect of goal, developing a goal, the objectives and all the expected outcomes actually falls fully on his table'* (1.1.13).

An elaborate description was received of the role of Mr B. in the entire goal-setting process:

- Initiating the process: *'Because for example, when a project ends, and we now want to develop another project to run for say 3 years, he is responsible for spearheading that'* (1.1.6)
- Conducting the field gap analysis: *'Mr B will visit the field'* (1.3.3) and *'Mr B. to come and say okay where are the gaps'* (1.1.24)
- Conceptualising projects: *'he is responsible for ensuring that project ideas from the concept engagement in the field'* (1.1.3)
- Facilitating the goal-setting discussions: *'Mr B. facilitates that process ...'* (1.16.3)
- Consultation and Feedback: *'But in the process of developing those proposals, there are different points in time when he meets with us to say this how far I have gone'* (1.1.15)
- Finalising the process: *'At the end of the day, he is the one that finalises our line of thought...'* (1.16.4)
- Developing proposals: *'Now the sole, it is on his desk, in this unit that everything that has to do with the development of project proposal'* (1.1.2)

From the above responses, a role pattern emerged that showed theoretically a six-step process of how Mr B. performed his goal-setting responsibilities in the national office (Figure 6.2).

Joint Responsibilities

The joint responsibilities were three roles shown in Table 5.3 (Annexe 5, page 334) that were performed together or collaboratively by national and field managers. While collaborative project conceptualisation and collaborative

proposal review meetings were the opinions of one national manager, a collaborative baseline survey was the opinion of both national and field managers.

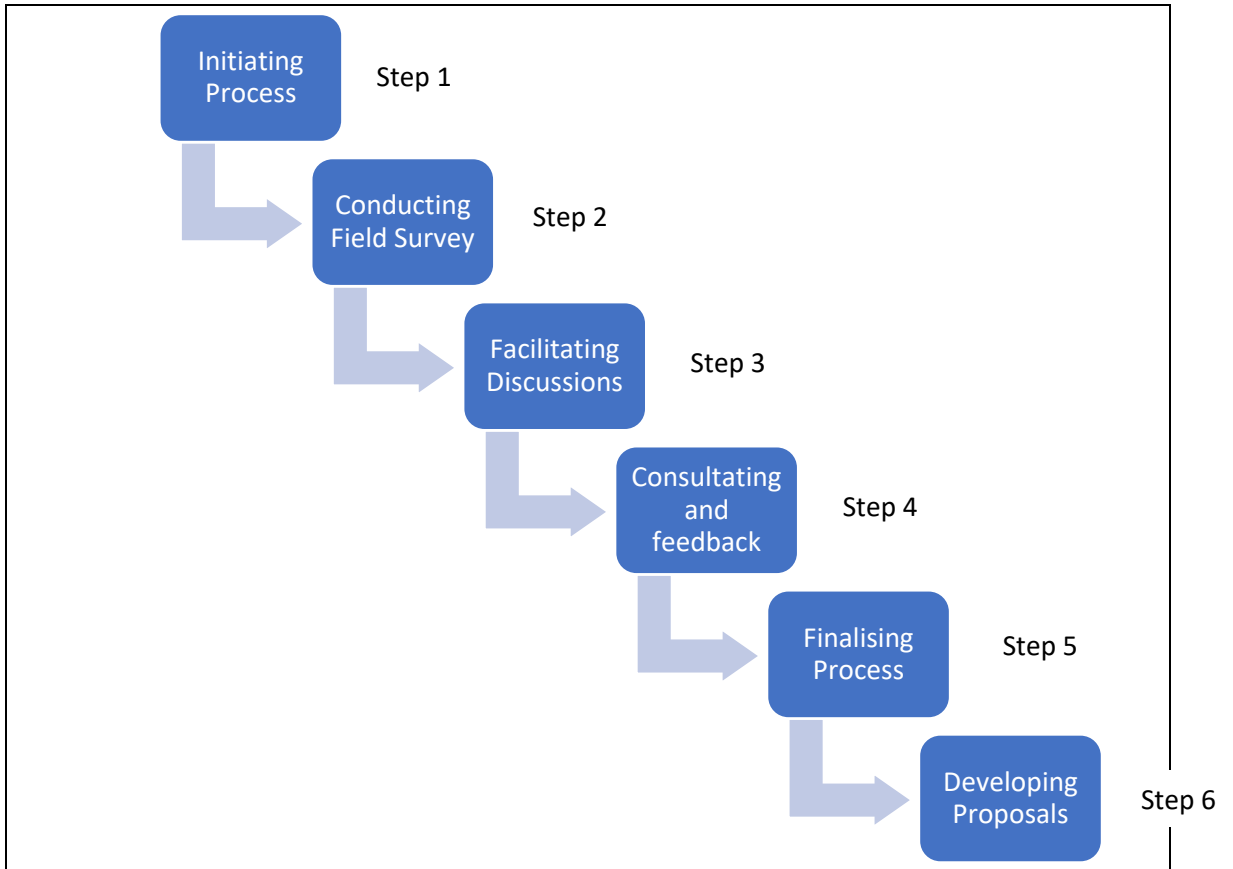


Figure 6.2: Step-wise theoretical linkages of Mr B.’s national goal-setting responsibilities

6.3.2 Theme two: Stakeholders’ goal beliefs

These were leprosy managers’ beliefs about goals described by six conceptual categories including goal definitions, goal types, goal effects, goal benefit, effects of goalless-ness and illogical goal-setting (Table 5.4 Annexe 5, page 334).

Goal Definitions

The concept of goal definitions described seven views leprosy managers held of what a goal is (Figure 6.3). The common beliefs were that a goal could be a target, an end-result or the desired achievement.



Figure 6.3: Seven perspectives of the meaning of a goal according to managers

Defining a goal as a terminal target, a field manager said,

- *'A goal is a targeted, ...it is like a target which a project is meant, a project is meant to achieve at the end of the project' (5.4.1).*

Some managers thought a goal is a change that occurs either temporally on a long-term and as a vision, or spatially at the community level. Only one manager defined goal as the 'desired height', which is a level of achievement chosen for the project.

Goal Types

The concept of goal types emerged from leprosy managers' description of five kinds of goals. The most popular was the long-term goal. The description of long-term goal came from the responses of a national and a field manager. To the national manager, a long-term goal is a statement of long-term change, while to the field manager, a long-term change is an expected impact.

According to them:

- *'The longer-term goals are usually a bit, they are statements of change in the long-term' (2.10.1),*

- ‘Well, a long-term is something that is expected impact, something you want to articulate, it takes time’ (6.10.1).

The other goal types described by leprosy managers included an overall goal, also thought of as an overall change (2.7.7), mid-term goal as a mid-way accomplishment (6.10.2), the short-term goal as activities (4.14.1) and outputs as the end-result of the activities (5.17.1).

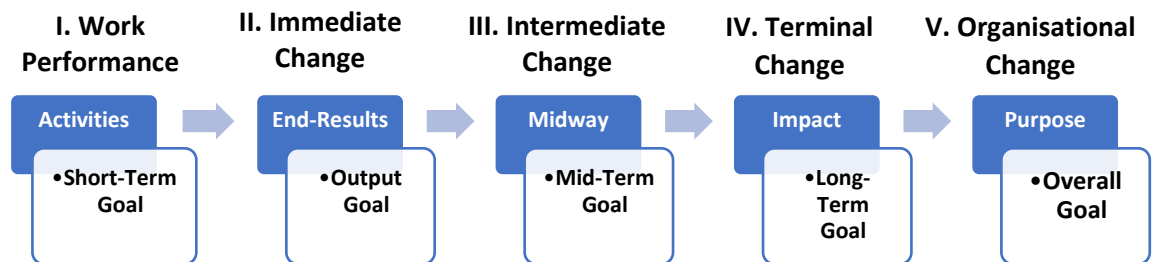


Figure 6.4: Temporal hierarchy of five goal types according to leprosy managers' perspectives

My reflection on the possible relationship between these goal types generated a hierarchical arrangement along a timed direction that flows from activities (short-term goals) to outputs, then through to mid-term goal, to a long-term goal and, finally to the overall goal. The flow diagram in Figure 6.4 illustrates this linkage in line with the descriptions given by leprosy managers and my reflections. I re-labelled the sub-category of overall change that described overall goal as ‘purpose.’

All stages of the goal typology over time were also labelled according to the level of change that the goal type expresses according to the views of the leprosy managers. Hence the first stage of activities that describes the level of a short-term goal is labelled work performance. The subsequent stages of output, mid-term goal, Long-term goal and overall goal are respectively labelled immediate, intermediate, terminal and organisational level changes.

Goal Effects

The third category of goal effects is the label that described the seven perspectives respondents had about the effects of goal-setting on their project. The most common opinion held by both national and field managers was that goals give direction and define the destination of the project. According to a field manager,

- *'Because as I said earlier, goals and objectives are the ones giving you direction of where you want to go, where to go there and how to go there'* (3.69.2).

Another two popular viewpoints, but less common than the first, were that goals give knowledge of expected achievements and aid definition of scopes or operational boundaries for the project. Even less common was the views that goals motivate achievements, enable focusing on expected achievements and increase project effort towards achieving them. The least common was the idea that goals give a project its meaning or sense of purpose. The exact quotes that are typical of these beliefs are:

- Knowing achievement: *'Because ...unless you set goals you may not know what you want to reach'* (6.4.1)
- Focusing on achievement: *'We were able to achieve that because we were focused on that'* (6.19.2)
- Defining scope: *'So it actually put us, it created that boundary or scope or focus'* (1.20.5)
- Motivating achievement: *'I personally feel goals are meant ..., like they are like a driving force to achieve the essence of what the project is all about.'* (5.8.1)
- Increasing effort towards achievement: *'...And because we know this is what we want to do, efforts we made were directed to doing that.'* (6.19.1)
- Giving meaning: *'It gives a sense of meaning for something we are working towards.'* (1.10.10)

On reflection, Figure 6.5 shows the order of popularity of the goal effects among the leprosy managers according to their responses. The most popular effect placed closest to the base of the pyramid is direction and destination, and the least, closest to the apex is sense of meaning or purpose. How are these concepts of goal effects related? On reflection on the relationships that could exist between the emergent goal effects, it seemed to me that any connection

that may exist begins and ends with the knowledge of expected achievement that set goals give to the project managers (Figure 6.6).



Figure 6.5: Goal effects according to the level of popularity among respondents

In the beginning, knowing the set goals gives awareness of the achievements expected from the project implementation, which in turn creates awareness of the project's direction and destination. According to a national manager,

- *'When we set goals for a project it gives a clear picture of the anticipated result or destination'* (1.10.1).
- *'Something that gives a picture of a final destination.'* (1.11.3).

To a field manager,

- *'Because ...unless you set goals you may not know what you want to reach.'* (6.4.1).

Thus, by enabling an understanding of the direction and destination, a goal also creates a sense of meaning or purpose. A national manager connected direction and purpose by saying,

- *'It gives a sense of purpose and direction'* (1.10.3)
- *'A sense of meaning for something we are working towards'* (1.10.10).

Next, it seems the awareness of direction and destination or meaning and purpose motivates implementation towards achievement. According to a field manager, aspiration or dreaming is inherent to good goal-setting,

- *'But if you want a good goal or a good objective you have to dream. You need to know where you are going'* (7.10.3).

Thus, the concept of a goal as a dreamed direction and destination may lead to motivation of the 'dreamer' to achieve it. A field manager believes a goal works

- *'Like a driving force to achieve the essence of what the project is all about'* (5.8.1)

And a national manager declared personally,

- *'And as for me, it helps to motivate'* (1.10.9).

Yet, on another level, knowing the direction and destination also helps to define the scope of project implementation, which in turn helps you to narrow the focus on the work that needs to be done to achieve the goal. As a national manager put it,

- *'It streamlines the scope or boundary of operation'* (1.10.4)

And according to a field manager,

- *'We were able to achieve that because we were focused on that.'* (6.19.2).

Next, it appeared the effects of motivation, scope definition and focusing is an increase or a concentration or an intensification of effort made on doing the work towards achieving the goal. According to a national manager,

- *'So that we can direct our energy, and our effort'* (1.10.6)

And a field manager,

- ‘So these goals come in and you work towards the goal for them [the beneficiaries] to be able to achieve, to be able to be on their own and achieve the development that is so desirable.’ (5.8.6).

From another field manager’s view, an increase of effort may also directly result from knowing the desired achievement. According to him,

- ‘And because we know this is what we want to do, efforts we made were directed to doing that.’ (6.19.1).

At the end of the project, knowing the expected achievement helps in the assessment of the impact that the project has made. As a field manager puts it,

- ‘Well to know the impact of the project, whether it has impacted the right people at the right time and at the right venue that you worked, that you target.’ (4.7.1).

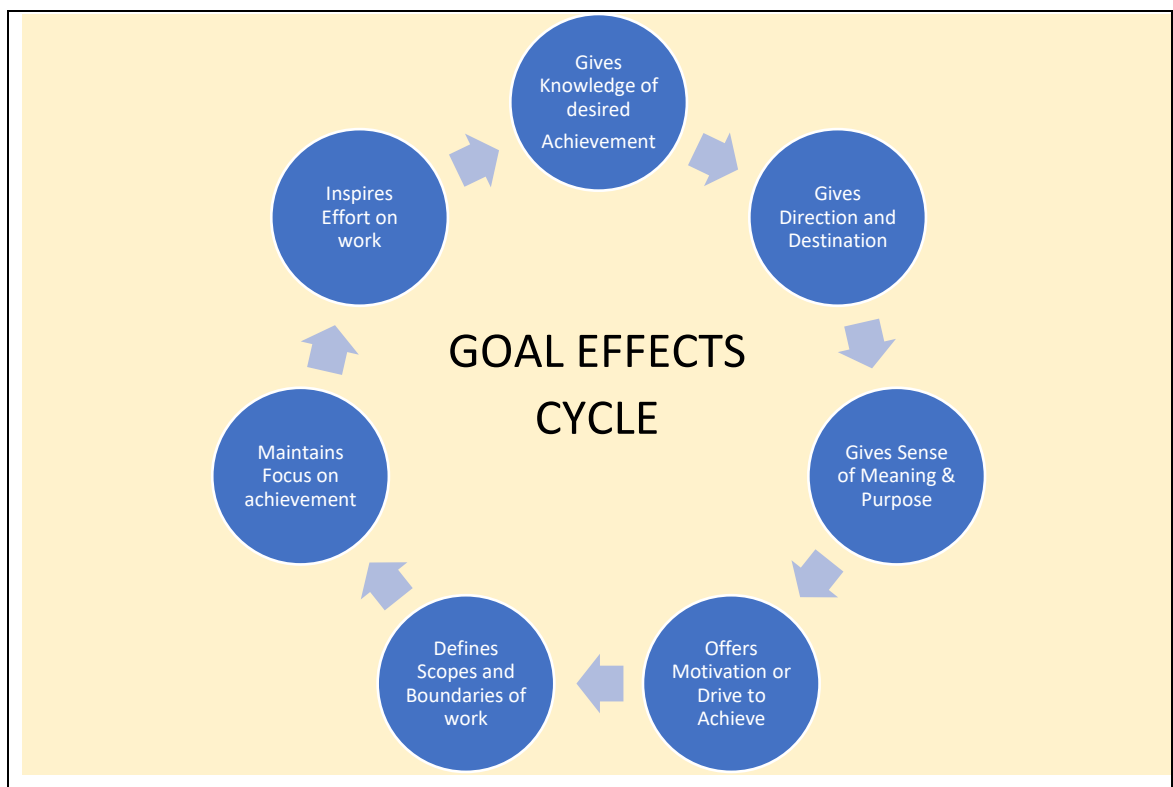


Figure 6.6: A theoretical Goal Effects Cycle based on the researcher’s reflections on leprosy managers’ beliefs.

Speaking specifically of the rationale of knowing the desired objectives at the project’s end, another field manager said,

- *'Because it's the objective is the one who will tell you whether you have gone in achieving what you intended to achieve or not' (7.46.1).*

Thus, the theoretical linkage of goal effects according to leprosy manager's beliefs shows the pivotal location of the goal effect of knowledge of achievement in relations to the other effects. This evolved a cycle of goal effects on projects as illustrated in Figure 6.6.

Goal Benefits

The concept of goal benefits described the life-changing impact of goal-setting on the project's target population. The leprosy managers believed goal-setting enables positive changes at community level. According to one of them, good goals are:

'Goals that are beneficial to the people. Goals that can improve the lives of leprosy-affected persons. Goals that can also improve those who are disabled, who have disability or whatever. This goal can be able to bring out something that they will benefit from.' (9.13.2).

Effect of No goals and Poor goals

The last two concepts included the effects of lack of goals (planning projects without goals) and illogical goal-setting (formulating bad goals). The common belief of both national and field managers was that lack of goal-setting leads to loss of direction and destination. The effect of Illogical goal-setting was described by some field managers who believed that goals formulated based on assumption and those improperly formulated produced projects that are either irrelevant to the needs of target population or doomed to fail.

6.3.3 Theme three: Goal-setting ability

The theme of stakeholders' goal-setting ability described the perceived goal-setting competence based on leprosy managers' views of their goal-setting capacity and experience, and awareness of TLM goal-setting practice (Table 5.4, Annexe 5, page 322).

Goal-setting Experience and Capacity

The common impression given was the claim of ignorance of TLM current goal-setting practice of some field managers: three of the State Leprosy Control Officers who managed leprosy control programmes that were no longer directly supported by TLM Nigeria and one SED officer who despite three years' project experience still claimed ignorance of how TLMN organisation set goals.

According to one of the State Leprosy Control Officers,

- *'Actually, previously I know. But now, I don't know'* (7.30.1).

A detailed description of the current goal-setting experience of stakeholders and their view on the related goal-setting practice in TLM Nigeria emerged under the next theme. Goal-setting capacity described the views of a national and a field manager that acknowledged the presence of goal-setting capacity in the relevant stakeholder, Mr B. Goal-setting experience emerged from the responses of only field managers, in which leprosy control officers referred to their past goal-setting experience and a SED manager who claimed to have no experience of TLM goal-setting (Table 5.4, Annexe 5, page 334).

6.3.4 Theme four: experience with TLMN goals

The separate theme of goal-setting experience evolved from the field managers' description of their experience with the assigned goals, their recommendation of a collaborative goal-setting and its perceived benefit as an alternative goal-setting approach (Table 5.5, Annexe 5, page 335).

Field Experience with Assigned Goals

The field managers' views about assigned goals emerged from their perception that the assigned goals were well-formulated and relevant, but difficult to implement in field settings because the expected targets were not attainable. Concerning the goal statements, one field manager held the opinion that the statements formulated by TLMN were based on local situation and understandable. According to him,

- *'The statement is based on what is on the ground'* (9.32.1); and *'I think the statements are straight-forward'* (9.32.2).

Another manager observed the TLMN goals were concise, complete and time-specific:

- 'What I usually observe is that it is usually brief and all-encompassing to a particular focus at that point in time' (10.14.1).

Concerning the field implementation of the goals, one field manager believed they were statements of what the national stakeholders wanted and doubted whether they were realistic in his project setting. According to him,

- *'Because sometimes they will just say something they want to achieve, you know maybe it's not achievable'* (4.22.4);
- *'Because they don't know what is really on the ground, and they have formulated these goals and it's not realistic maybe to us at the grassroots'* (4.22.7).

This view conflicts with the earlier opinion of another field manager who believed the assigned goals were formulated based on local situation or needs: *'The statement is based on what is on the ground'* (9.32.1). Nevertheless, the same field manager still agreed with the other colleague that the assigned goals formulated by stakeholders at the national level may be difficult to implement:

- *'Because there are some things that if they had involved us before setting those targets or goals, it would have been better done. ... If you do things this way, it will be more difficult.'* (4.36.2)
- *'When you plan it from up and say go and implement it, it will be difficult because what is in the field is different from what is in the office.'* (9.47.4)

Field Recommendations for TLMN Goal-setting Approach

The field managers' recommendations represent their proposals to the TLMN organisation. The most common one was that goal-setting and project development should be collaborative with the involvement of project and community stakeholders from the grassroots.

- *'Well, like I said, the advice they should be involving the people at the grassroots level like the programme managers, this local government TBL supervisors and leprosy supervisors, and then even the officers, general health care workers.'* (4.39.1)

The field manager's responses below show their argument for their involvement:

- *'That whosoever is implementing an activity should as well be involved.'* (5.46.1)
- *'My recommendation is whosoever, the field officer of whatever project, everybody should be part of the formulation of goals.'* (5.46.2)
- *'I think there is a need for key stakeholders to come together, not just one side. The key stakeholders should come together and with control officers and formulate goals and objectives for their projects.'* (6.25.1).

The next recommendation requested a change of goal-setting approach to a bottom-up approach, with an indication that the current approach is top-down. According to a lone voice,

- *'I will also want them to improve in our close relationship so that before any plan [it should be] from down up, it should not be from up down.'* (9.47.2).

Table 5.5 (Annexe 5, page 335) shows that while two of the remaining three recommendations asked for change of priorities or strategies, the third recommended maintenance of the status quo. The field manager who wanted change of priorities recommended a re-prioritisation of leprosy control programme that TLMN had been shifted to the State government. The field manager, a State Leprosy Control Officer said,

- *'I think the notion that because we have reached the elimination target and that [the disease] slows down. I still think we need to prioritise because leprosy is not gone'* (6.14.2).

The field manager who recommended a return to past planning strategy was also a State Leprosy Control Officer. According to him,

- *‘Actually, my full advice is that those activities have to come back as we did before’ (7.60.1).*

However, two SED managers wanted the status quo maintained. While one just wanted TLMN to continue doing what they are doing, the other specifically recommended sustenance of needs assessment as the basis for goal-setting.

Benefit of Collaboration

This last category described the benefit of collaborative goal-setting which was recommended by most field managers. Table 5.5 (Annexe 5, page 335) shows the three benefits the field managers believed TLMN goal-setting would gain if a collaborative approach is adopted. According to these benefits, collaborative goal setting was considered a robust approach for formulating goals, which educates project workers and contributes to ensuring the effectiveness of the project.

6.4 Themes of Goal-setting Strategy

This second theme emerged from the two main themes of goal-setting stages and pattern of the TLMN practice. Both themes described activities that were performed in the process of formulating project goals and objectives and designing the related project plans. The process is theoretical because the specific activities were identified and coded from leprosy managers responses explaining how leprosy goals were formulated. The coded themes were then linked in a general sequence or pattern.

6.4.1 Theme one: Stages of goal-setting process

The theme evolved from 10 sub-themes that described the stages of the goal-setting process and the secondary codes that described the concepts of tasks associated with each stage (Table 5.6, Annexe 5, page 336). Emerging from responses obtained from both national and field managers, the themes and codes revealed that the process of goal-setting in TLMN followed a stepwise multi-staged approach. When asked how goals are set in the organisation, a national manager asked,

- *‘So erm, can we have them at different stages?’ (2.37.1).* A field manager confirmed, *‘These are the steps’ (10.9.9).*

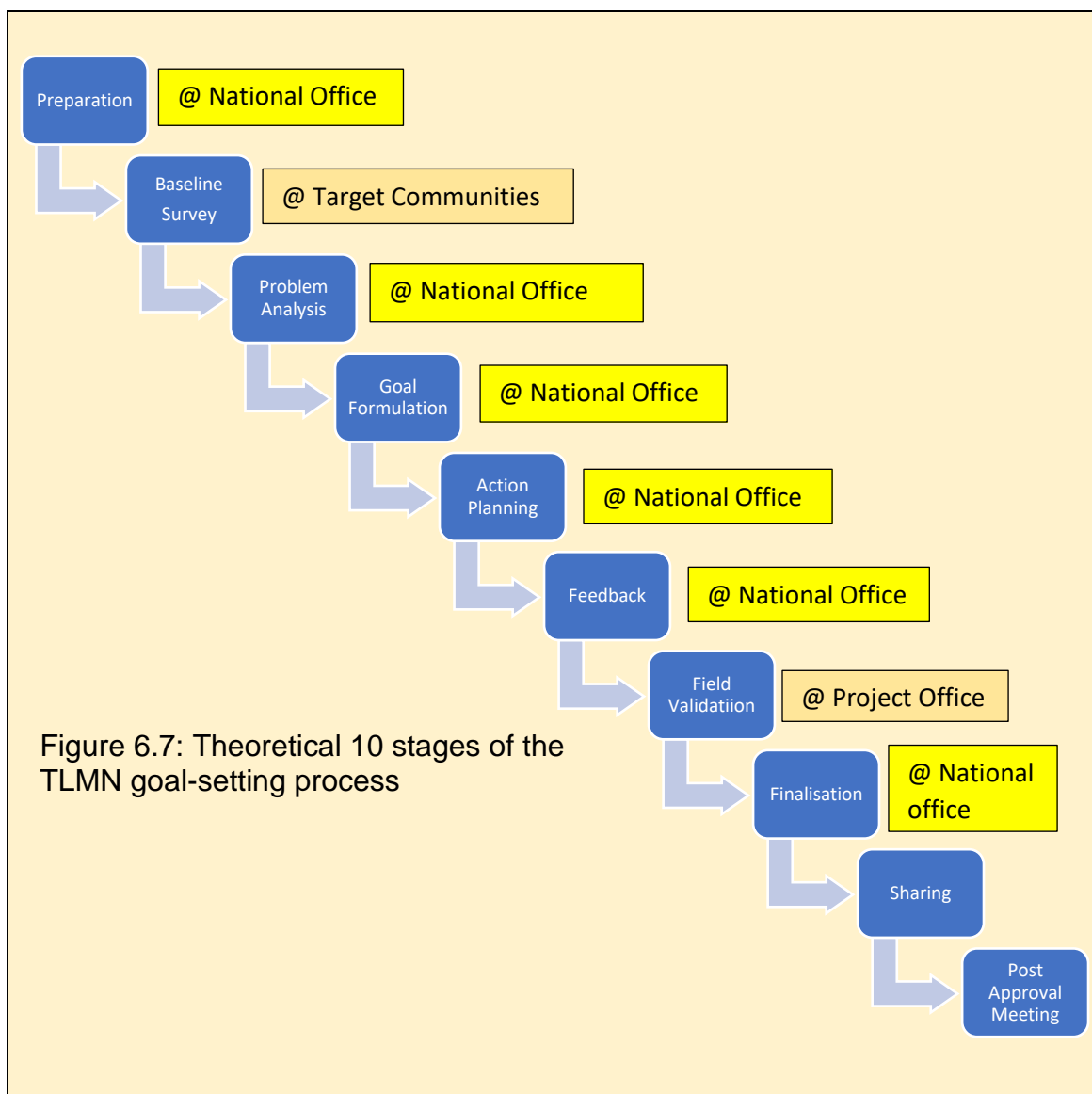


Figure 6.7 illustrates the theoretical sequence of the stages according to the responses of leprosy managers. The stages in Figure 6.7 show the process of goal-setting in TLMN begins from a pre-survey preparation and ends at the post-approval meeting with field managers of the projects after project planning. It also shows that few activities were performed at field venues (project office and target communities), compared to those performed at the national office. In summary, the goal-setting process began and ended at the national office.

Stage 1: Pre-survey Preparation

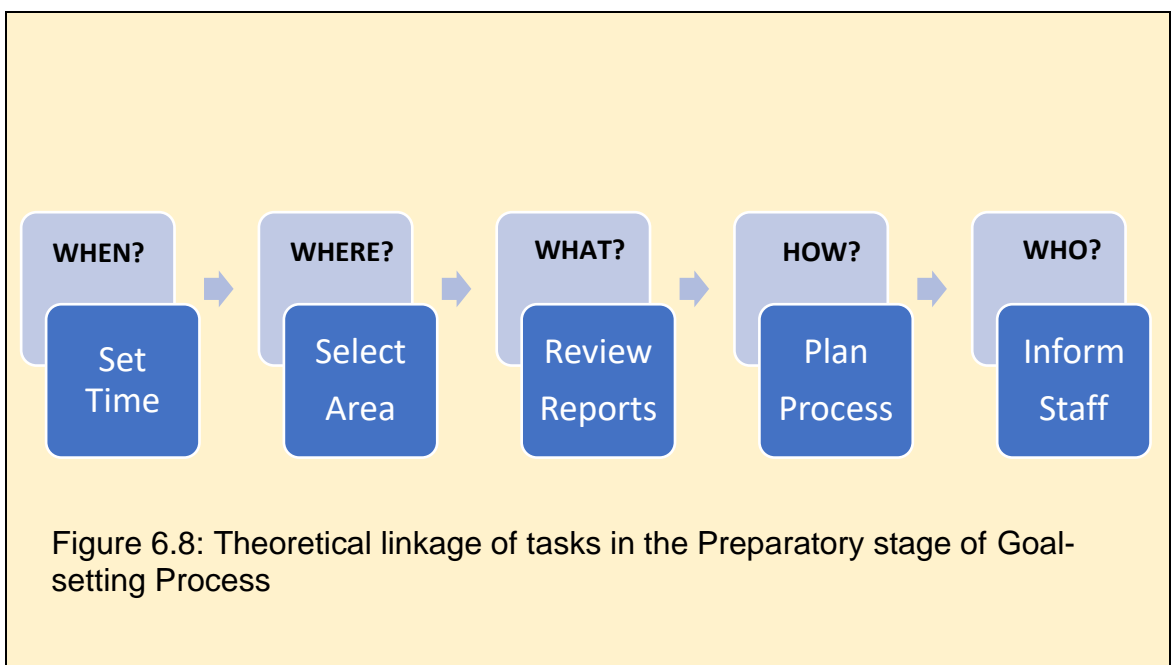
According to Table 5.7 (Annexe 5, page 336), this was the first main step of the goal-setting process and it involved five preparatory events. Of these, the

commonest task done is collation and review of project reports sent in by the field managers to the national office. This was the perspective of only field managers, who were also SED officers. According to one of them,

- *'I am sure the only pattern is, they rely on the annual reports we are sending and the assessment, need assessment we had.'* (3.44.1).

The tasks of identifying the target community and the timing of the goal-setting before project implementation were regarded as the planning activities done during this preparatory stage. The national communication to field officers was considered the later task done at the end of this stage. According to a field manager (SED officer), the purpose of this communication was to inform them of the details of an intended field visit. In his words,

- *'Okay, the best information I have is the project, the fund development officer, Mr B. an informed email will be sent, or by information, trying to develop a proposal, a mail will be sent that he will be visiting the project to have discussion with you, the team and the community.'* (5.23.1).



Based on the researcher's reflection on the possible relationship between these preparatory tasks, figure 6.8 shows the theoretical sequence of the five events

mentioned by leprosy managers that may be linked to this initial stage of the goal-setting process.

Stage 2: Baseline Survey

The baseline survey stage emerged from leprosy managers' responses describing five field-based activities of the goal-setting process. These included field visit, data collection about community needs, needs identification with community involvement, data analysis and preliminary discussion of what should be in the project proposals (Table 5.7, Annexe 5, page 336). Responses of both national and field managers specifically mentioned that Mr B embarks on field visits to identify gaps and assess the needs of the target communities. A national manager confirmed,

- *'He goes into the field'* (1.1.7)
- *'Concept engagement in the field to find out what the current gaps are'* (1.1.4).

A field manager also said,

- *'The planning process, first and foremost, there is more like, there should be a survey, a survey must be carried out'* (5.9.2).

However, in Mr B's own words, *'We sometimes go to the field to meet with the focus groups'* (2.38.21), suggesting that making field visits for community needs survey was not always done.

During data collection, focus group discussions with community people were conducted at the community level. This was the opinion of the two national managers and one field manager. According to a national manager,

- *'They now go to the communities and have focus group discussion'* (1.3.5).

Mr B. himself explained that focus group discussion is a tool to engage the beneficiaries at the community, with a purpose *'to meet with the focus groups'* (2.38.22). According to him,

- *'And in terms of discussing with community members, there are also other tools, the focus group discussion is one approach, transact walk through the community, especially to locate where some of the resources are.'* (2.40.10).

Needs assessment referred to the focus group discussions with community beneficiaries. The discussions served as a forum for identifying and assessing the needs of the beneficiaries. According to the responses of some field managers:

- *'You hear from them, what do they want, this is what we want, this is what we want to achieve'* (5.9.4)
- *'We visit that place, look at Assess... for health and hygiene, for empowerment, sit with them, discuss with them we begin to identify together with them. What is their needs assessment, you know?'* (10.9.3)
- *'The process is to look into the field, look at leprosy-affected persons, look at the communities. What are their immediate needs?'* (9.19.2)

Survey data analysis emerged from responses that indicated some data analysis and interpretation was done by Mr B at the end of the field survey. According to a national manager,

- *'Then it is out of the results of that survey that he now begins to make sense of those things'* (1.11.11; 1.1.12).

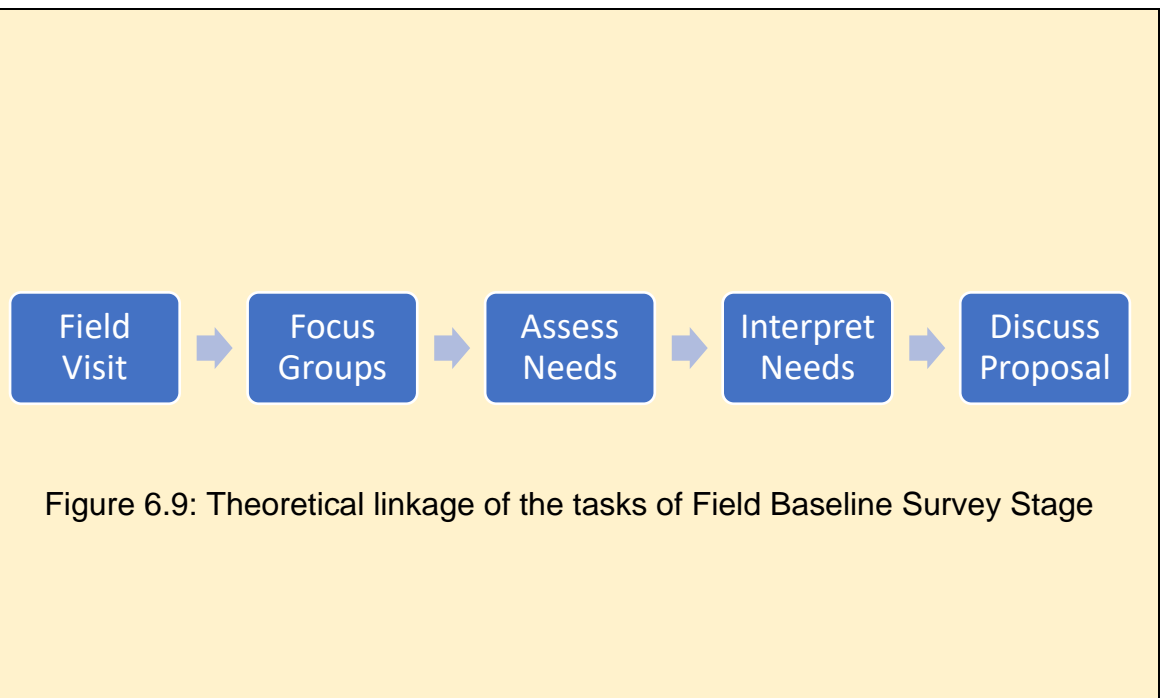
A field manager added that some harmonising and blending of data given by the community and those of the field officers were done:

- *'We get to the community, the information gathered from the community and the one we give will be filtered, and say, okay, how do we now blend both information to suit into ...'* (5.23.9).

Preliminary discussion of the proposed project plan was also done during the survey according to the responses of a national manager and some field managers. According to the following quotes, it was at this stage that the field officers were able to make inputs to goal-setting. In the survey, it was the time of deliberations on the organisational goal, the desires of the community

members, and the goals and feasibility of the proposed project. A response of a national manager also indicated this is the stage at which the kinds of projects were decided. According to the leprosy managers:

- *'We used to gather all this information and then we sit together with TLM and bring out the objectives and the activities'* (9.19.3)
- *'... And then when we decide to have those kinds of projects'* (2.38.23)



A reflection on how the tasks of this baseline survey stage were connected resulted in a theoretical linkage that begins with field visit by Mr B. and ends with the field proposal discussion, as illustrated in Figure 6.9.

Stage 3: Post Survey Problem Analysis

This problem analysis stage emerged from two sub-themes that described Mr B's return to the national office from the field and start of the task of formulating goals and designing the plans of the projects (Table 5.6, page 336). In a field manager's own words,

- *'What happens after that is they will go back to the office.'* (5.24.1).

According to a national manager,

- *‘So, from the information Mr B is able to gather, he returns back to the head office’ (1.3.6).*
- *‘Some of the sessions that we hold with him before he goes on to do the bulk of the work’ (1.15.2).*

The national manager’s response indicates Mr B held some consultation with national office staff on return from the baseline survey. The problem tree analysis of the needs identified during the survey represents the main task performed according to the responses of one of the national managers:

- *‘Some of the sessions that we hold with him Is the process where we do sort of the problem tree where in that process, we now clearly look into some of the concerns raised.’ (1.15.4).*

And the analysis continues until, *‘Until we begin to arrive at what needs to be done and address them.’ (1.15.6).*

Stage 4: Goal Formulation

The goal formulation stage was when goal statements were constructed and written (Table 5.7, Annexe 5, page 336). Both national and field managers mentioned that goal formulation was done at a national consultative event in the NCO facilitated by Mr B. According to some field managers,

- *‘Well, most of the goals that we do formulate, they formulate them at the national level’ (4.10.1).*
- *‘Yeah in terms of setting goals for the leprosy project, mostly we the projects, the goals of the project are not being set at the field. They are set done mostly by the national coordinating office’ (5.5.1).*

According to the national managers, a committee or group was used to formulate project goals at the national office. Mr B. said,

- *‘and we have a smaller team which is sometimes headed by me, often times headed by me’ (2.38.27).*

A field manager referred to this group as technical persons or experts. According to her,

- *'After that, the experts do the planning or goal-setting.'* (10.12.2).

The actual work of formulating goals began with a round table discussion, described by Mr B. as stakeholder consultation organised using a participatory workshop approach:

- *'We just sit around the table...'* 1.16.2
- *'...the way that is planned is that you have a consultation with the stakeholders.'* 2.38.2)
- *'So we have that, we do that in a participatory process in a workshop.'* 2.38.9.

According to Mr B., it was this same group at the national office that formulates the goals by converting the desired changes into statements. The second national manager was apparently also involved in this team. He used the 'We' pronoun in his responses that confirmed the goal statements were jointly written by a group at the national office. They said,

- *'And we have a specific group of people who will sit down and pull all of those changes expressed together into statements.'* 2.38.11
- *'Together we begin to try to put in the statement...'* (1.15.9)
- *'We ensure that we begin to scribble down'* (1.17.1).

Also described were three criteria on which the writing of the goal statements was based. These included beneficiaries' needs, stakeholders' agreement and donor interest. On the criterion of beneficiary needs, a field manager said,

- *'Most goals and objectives are targeting the needs of the community. They are targeting the needs of Zamfara State entirely'* (3.49.1).

Concerning stakeholder agreement, another field manager said,

- *'Yeah. Like I said, the objectives most often are written based on whatever has been agreed with the community and the team itself.'* (5.28.1).

The agreement also plays an important role in goal formulation discussion by the small group at the national office. According to a national manager,

- *'... and we all either agree or make some adjustments.'* (1.16.6).

Stage 5: Action Planning

This stage described the organisation of planning meetings and workshops at the National Office for the planning of the project proposals or project designing after goal formulation. According to a national manager (Mr B),

- *'... and we organise project development workshop'* (2.38.24),
- *'... where we bring representatives from the community and other stakeholders'* (2.38.25).

This shows there was a national claim of involvement of project and community stakeholders during the planning of project proposals. The only field manager who reported field contribution to the proposal planning stage said,

- *'And after the annual meetings, we meet with them so that we will form a work plan. So that we will know what and what programme we are to do to achieve our goal'* (8.23.2).

According to two field managers, both of them SED officers, the project planning was based on the needs of the community; guided by the results of the baseline survey and the desires of the majority:

- *'That planning will now be done based on the needs assessment carried out. We plan for 3 years'* (10.9.4)
- *'So, but what most information based on what the majority of the community say they want. Most often you don't get everybody to agree, but what the majority they want that is what we do work with.'* (5.24.7).

Stage 6: Feedback

The feedback label described the communication of formulated goals and plans from the national office to field managers, which was given in two separate events: communicating messages and field meetings. At the time of feedback to field managers, the national managers either requested for additional information needed to complete a project proposal or requested for validation of goals and action plans already decided.

A national manager said concerning Mr B's feedback,

- *'...Then later he gets back to us to say, this is what it appears we are saying, ...'* (1.16.5),

Which Mr B rationalised as,

- *'And after that we send back for validation'* (2.38.29).

The latter was confirmed by field managers, who claimed that,

- *'It is just that they would send to us, and we review and give our recommendations.'* (4.22.2).
- *'Erh, the goals we formulate are centrally being brought by TLM'* (9.14.1).

The codes in Table 5.7 (Annexe 5, page 336) show that organising meetings to give feedback to field officers was less popular than communicating or sending feedback through official messaging means. Especially, the latter was the claim by one field manager that the national office organises feedback meetings in the field. According to him,

- *'After designing the project, definitely they came here with the project document and we go through it from page one to the last page of the project. And now, later on, we start implementing.'* (3.36.1).

Stage 7: Field Validation

The stage of field validation also emerged from two events in which field staff and community-based beneficiaries were said to validate project goals and plans that had been formulated at the national office, and two results of the

validation stage. Responses from both national and field managers indicated that validation of the goals and proposal by field staff was the main event of this stage. A field officer confirmed that,

- *'At the level where they are supplementary, whatever they are called, they have developed whatever, before they print out the final copy they will get to us. We put up our comments before the final production.'* (9.27.1).

The following quotes show that during validation, the field officers examined the proposals that had been prepared by the national office and had the opportunity to express their observations on the achievability and logicity of the goals as well as the feasibility of the project plans:

- *'... We made some observations'* (3.39.1)
- *'where we advise, we now give our inputs.'* (4.17.6)
- *'whether the project will be feasible, or it will be realistic'* (4.17.5)
- *'Yeah, we have that right [to comment]. We do, we do. 'This goal is not achievable.'* (9.24.1)
- *'.... This goal is not achievable or the activities that you outlined for us to achieve, this goal cannot be, be able to ... We can give suggestions to them'* (9.25.1)
- *'but we now look at the goal, and look at the objectives and the activities, is it speaking to the goal?'* (9.26.3)

Only one national manager, Mr B. mentioned validation of goal statements by community beneficiaries, as, *'just to sort of validate if the statements actually express the change they desire.'* (2.38.13). There was, therefore, an indication that as the outcome of the validation stage, the national managers made effort to ensure the field managers agreed and accepted the assigned goals and proposals. Responses from few field managers suggested that the field managers mostly agreed and accepted the assigned proposals because of their alignment to the needs identified during the baseline survey in which they participated. According to some field managers:

- *'We agreed upon it and we start implementing.'* (3.41.7)
- *'Which are mostly not new to me because they are based on the needs assessment.'* (10.12.4)
- *'I wouldn't say that I don't accept it. Why?' 'Because the initial idea was being captured with me. I have never seen anything outside what we captured.'* (10.13.2; 10.13.1).

However, the field managers claimed they were unable to amend, correct or add to the draft goals during the validation stage. According to one of them,

- *'We can't change.'* (3.38.1), *'but what they said, we should reserve it until mid-term.'* (3.39.2).

Nevertheless, the same manager claimed there was usually no need for corrections as the goals and plans reflected the community needs. There were also comments that showed field managers' perceptions of how the national managers used their feedback (Table 5.7, page 336). While one believed the national office used the feedback to review the draft goal statements or to take further action, the other doubted whether the comments were even considered at all. According to the respondents:

- *'... then they look at it and review it if they see it necessary, or they have any other suggestions to guide whatever they are putting down, they get back to us.'* (9.25.2)
- *'At the end of the day, we are not sure whether they use our recommendations or not. But they don't take it too serious, that whatever we say.'* (4.22.3)

Stage 8: Finalisation

The finalisation stage described how the national managers finalised the project goals and plans using a steering committee. According to Mr B.,

- *'And when that is done, the steering committee finalises the statements of _____ at the country level.'* (2.38.14).

And a field manager agreed that,

- ‘They will now go back, ... ‘and sit down and finalise’ (4.17.9; 4.17.10).

Stage 9: Sharing

This stage described how the national managers distributed the finalised project plans which emerged the process, by sharing with stakeholders at the national, project and community levels. The notion that the plans were shared with national stakeholders emerged from Mr B who seemed responsible for the process. According to him:

- ‘...and then I will share that with my other colleagues here at the office.’ (2.41.2)
- ‘I will share that with the potential donor of the project.’ (2.41.5).

The sharing with field officers was the claim of both national and field managers. According to the national manager, sharing with field officers was done electronically, while the field managers simply acknowledged that the final plans were shared with them for implementation purpose only. One of the field officers acknowledged, ‘Then they send their plan for me to execute’ (10.12.3).

The sharing with community members was the claim of Mr B. According to him, this sharing was done by the field managers who had received the documents from the national office before. In his words: ‘Project staff on the field who will also share with the community members.’ (2.41.4).

Stage 10: Post Approval Meeting

This final stage of the emergent goal-setting process was a post-approval meeting that described the event in which the national managers discussed the approved goals and plans with the field officers. One national manager described this stage as the next time the field officers actually heard from Mr B. since the baseline survey.

According to him,

- ‘The next time they hear from him will probably be after the project has been approved’ (1.1.26)

- *'The next time the field officers become fully engaged is after the project has been approved' (1.3.9).*

According to this national manager, it was also the time when the field managers became aware of what goals and objectives they would be expected to achieve:

- *'So largely, that is when they now begin to know, "O this is the goal, O these are the expected objectives, O these are the expected outcomes" (1.3.11).*

According to Mr B., the meetings were also used as a forum to share hard copies of the project plans with those who did not have access to an electronic medium. Few field managers confirmed this stage as the time they found out about their project goals and when the goals and plans are carefully explained by the national managers. According to some field managers:

- *'These are the objectives, these are the objectives, these are the goals, these are the means of our verification, these are the means of we carrying out the evaluation, this is what the project is meant to achieve.'* (5.25.2)
- *'By giving us the objective and then they will breakdown the activities, stage by stage, for proper implementation' 9.31.1).*
- One field manager mentioned that the meeting held at the national office (NCO): *'Okay, if the goals, if the proposal has been written and, erh, maybe the way it's been operated in TLM now; maybe the proposal sailed through, we will be invited to the national office, and we will be briefed' (5.25.1).*

6.4.2 Theme two: Goal formulation pattern

The theme of goal formulation pattern emerged from seven sub-themes that described the different goal types formulated for the leprosy projects, timeframes for formulating leprosy goals, criteria for differentiating the goal-types, logical linkages of the goals, setting targets for leprosy objectives, approaches for formulating leprosy goals, and goal-setting for Leprosy Control Projects (LCP).

Goal Types

Goal types described the formulation of a mix of three types of leprosy goals, including short, medium, and long-term goals; or immediate, mid-term or long-term goals (Table 5.8, Annexe 5, page 338). According to a national manager,

- *‘So, we actually have a mix of all of them’* (1.13.8).
- *‘I know there is the short-term goal, medium-term and long-term’* (1.12.2).

According to Mr B,

- *‘It could be long-term, medium-term and short-term’* (2.2.2).

While a field manager mentioned two types of goal formulated in their project (*‘It might be a short-term, long-term goal you want to achieve.’* 9.7.2), other field managers agreed with the national managers that the leprosy projects were planned on three goal types:

- *‘I will say long-term goals that will turn to mid-term, because there is eh, what do you call it, after long-term, mid-term, and maybe immediate goal.’* (6.8.1)
- *‘In my project, we have about, let’s say three, three types.’* (3.24.1).

However, other goal types were identified and coded from the managers’ responses that suggested the formulation of five goal types, including short term goals, immediate goals, project-specific goals, long-term goals and organisational strategic goals. Mr B. described short-term goals as operation-level goals that were project-specific and possibly expressed the output:

- *‘The short-term ones apart from projects, they are also at operational level’* (2.17.1)
- *‘and then you have another step where you express the output’* (2.40.6).

According to a field manager, most of his project goals were short-term and related to the accomplishment of activities:

- *‘Well most of them are short-term goals’* (4.13.1)

- *‘So, if you achieve those activities, that is the kind of things that you do.’ (4.14.3).*

These two managers also described the intermediate goals, which he equated to mid-term objectives. In the national manager’s own words:

- *‘Intermediate objectives are, that is the medium-term’ (2.40.5).*

Project-specific goals may not be a goal type, but a group of goals that were specific to a project: different from goals that were general to all projects or the TLMN organisation. According to a field manager:

- *‘Even with that national goals and objectives, we have our own State goals and objectives’ (7.14.2).*

Mr B confirmed that *‘And for each project we have specific objectives’ (2.7.3)*, and for each specific goal, *‘So we are looking at a specific issue, we are looking at an issue that needs to be changed’ (2.45.1.)*.

Concerning the long-term goals, there was one long-term goal for each project according to the claim of Mr B, who also referred to it as an overall goal and overall change:

- *‘And in each of those, maybe 3-year plan or projects, there is also an overall goal’ (2.7.5).*
- *‘... the overall change is, that is the long-term goal’ (2.40.4).*

The organisational strategic goals described the long-term goals of the TLMN, which according to Mr B expressed the long-term changes that the organisational strategies were expected to achieve. According to him:

- *‘Long term goals usually, the changes are expressed in objectives of the country strategy’ (2.23.2).*

A field manager described the organisational strategic goal as an expected organisational achievement:

- *‘So most often what we look out for is this... because whatever we do we look at the organisation. What are the goals or what are the goals or what do you want to achieve as an organisation?’ (5.18.4).*

Goal Timeframes

The leprosy managers mentioned time frames for three types of goals. For short-term goals, the codes in Table 5.8 (Annexe 5, page 338) show a range from a month to a year. While different managers gave different timeframes for short-term goals, including a month, a quarter, a half-year and a year, the commonest timeframe mentioned by most of them was a quarter. According to Mr B:

- *'We want to achieve certain things within a short period, within maybe a quarter. What exactly can we achieve in a quarter?'* (2.30.3).

In the view of two field managers, the short-term timeframe could be:

- *'...just for 3 months, 6 months'* (9.15.1);
- *'...maybe in a quarter or in a year'* (4.16.1).

For intermediate, medium or mid-term goals, the timeframe is three years according to the two national managers, but could span the entire project life span according to a field manager:

- *'...the medium term for us will be within 3 years maybe. Three years on the average'* (2.32.3)
- *'The 3-year project as medium'* (1.13.7).
- *'Then for the intermediate-term, we can say, okay, the life span of the project is like 5 years and more than that'* (4.16.2).

For the long-term goal, the codes also show in Table 5.8 (Annexe 5, page 338) that it could range from one year to more than five years according to leprosy managers. The timeframe of five years or more was the report of a national manager, who also linked a long-term goal to a strategic plan. According to Mr B:

- *'The long-term goals do go for 5 years and beyond'* (2.32.2),
- *'And the 5-year as long-term in a sense strategic plan.'* (2.38.1).

It was the report of field managers that the long-term timeframe could span up to five years or longer:

- *'Long term will be a year, 2 years as the case may be. Some may be 5 years'* (9.17.1).
- *'Then for the long term at the end of all the terms'* (4.16.3).

The two quotes in Figure 6.10 summarise the characteristically different views held about timeframes of TLMN goals by national and field managers.

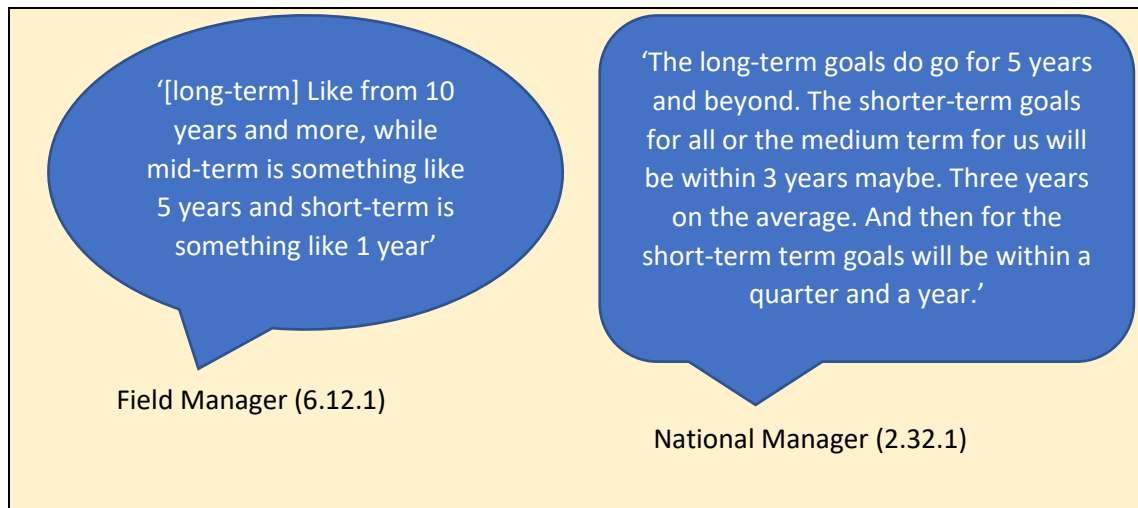


Figure 6.10: Quotes summarising the timeframes for TLMN goal types according to leprosy managers

Criteria for Differentiating Goal types

These were the criteria for the formulation of different goal types according to leprosy managers. The first of the eight criteria in Table 5.9 (Annexe 5, page 340) was availability of funding. According to a national manager the goals formulated, and the duration of projects depended on funding:

- *'It depends on the available, on the funding opportunity'* (1.13.1)
- *'for example, there are lots of, some of the projects that because of the funding its just 12 months projects, one year.'* (1.13.3).

The second criterion was the timeframe. According to a national manager, *'As for me I know the types in terms of duration'* (1.12.1). Other leprosy managers believed timeframe alone did not determine the goal types formulated, except in combination with other criteria. Mr B named three differentiation criteria, while a field manager named two:

- *'They differ mainly in the stakeholders, the timing and the ways they are stated' (2.22.1),*
- *'Well I think the short term, like I said, the time. The time and the resources' (4.15.1).*

The third criterion of stakeholders was the opinion of only Mr B. According to him, the goal types could be differentiated by the stakeholders who formulate them. In his claim, the community members and staff at the project and national levels were involved in the formulation of short-term goals; project-level stakeholders were involved in formulating medium-term goals and country-level stakeholders formulated the country strategic goals (Table 5.9, Annexe 5, page 328).

The fourth was the type of plan in which the goals are used. Three types of plans were identified from the coded responses in Table 5.9 (page 340): an organizational country strategic plan, project plan and work plan. There was a different type of goal associated with each of them. All responses relating this criterion were those of Mr B alone. According his explanation:

- *'So, we have a strategic objective in the country strategy, we have a medium-term goal in the project plan, and then we have smaller goals or shorter-term goals in the work plans' (2.17.5).*

The fifth criterion of measurement described the differences of goal types according to the organizational level that the goals assessed. The codes in Table 5.9 described three different measurement levels. These were long-term, medium and short-term goals, which were formulated to assess achievements of the organizational country strategy plan, project plan and work plan respectively. According to Mr B:

- *'I described the long-term goals looking at the overall country strategy, and then I described the medium-term goal at the regional projects, short-term goals they are basically in terms of processes.'* (2.21.1).

The sixth criterion differentiates goals formulated according to the nature of the written goal statements. Table 5.10 (Annexe 5, page 329) shows the long-term

goal described as a non-SMART statement of change, and the medium-term as objectives that are SMART statements of outcome. According to Mr B:

- *'Yes. The long-term goals are usually statements of change which are not necessarily SMART. ...The medium-term goals which are expressed as outcome level objectives have, they have to be SMART'* (2.33.1).

The seventh and eighth criteria described the differentiation of goals according to the results they indicate and the activities that are performed to achieve them. Two results levels were identified from Mr B's responses: short-term goals representing operational results at output level and the medium-term goals as project results at outcome level.

Concerning short term results, he said,

- *'Those ones are mainly looking at the output level change or the output level goals, which are managed based on the staff workplans.'* (2.17.4).
- *'Yes, and then output level, which is the short term.'* (2.34.1).

And the medium-term goals:

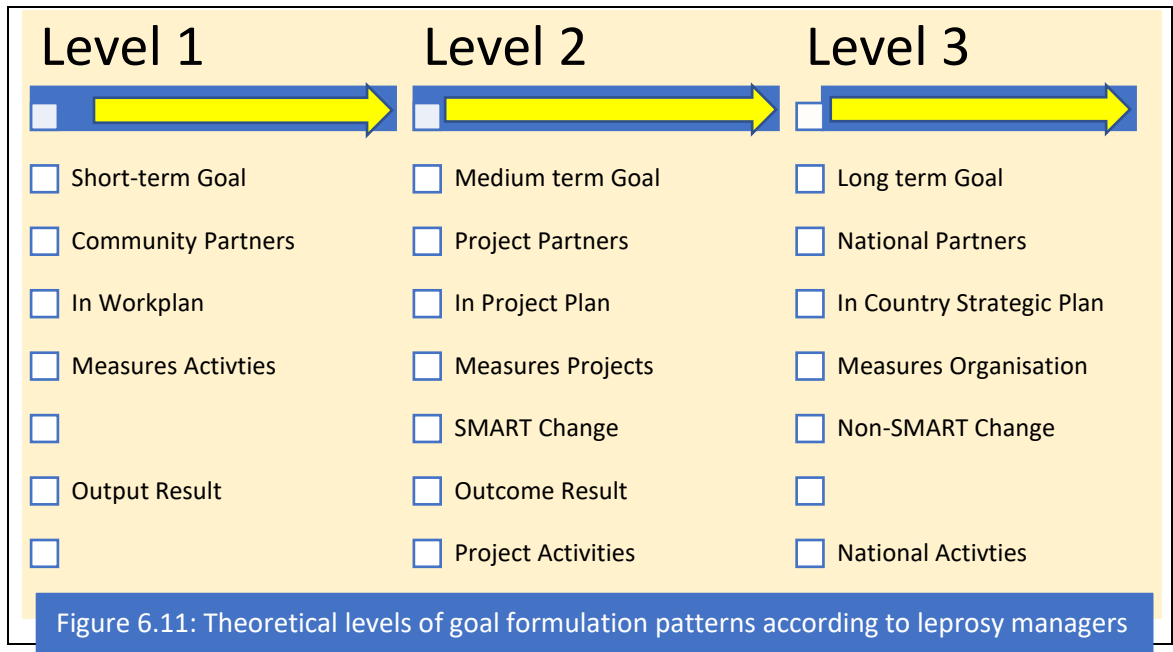
- *'The medium-term goals which are expressed as outcome level objectives'* (2.33.3).

The national and project goals were differentiated based on activities, according to the response of one field manager who said,

- *'But the only thing which makes the difference is in certain activities.'* (7.14.3).

On reflection of the axial connections of the criteria of the goal differences, three distinct levels of differences seemed to exist for each of them, except funding where a hierarchical difference was not obvious. Available funding may have influenced the decision on the goal timeframes and maybe what could be achieved within the assigned timelines. However, it did not seem to bear any relationship with the different goal types. The arrows in Figure 6.11 show the assumed direction of the conceptual linkage of three hierarchical levels of the

criteria for goal differences: from the lower operational goals (Level 1) to the higher strategic or organisational ones. (Level 3).



Logical Linkages

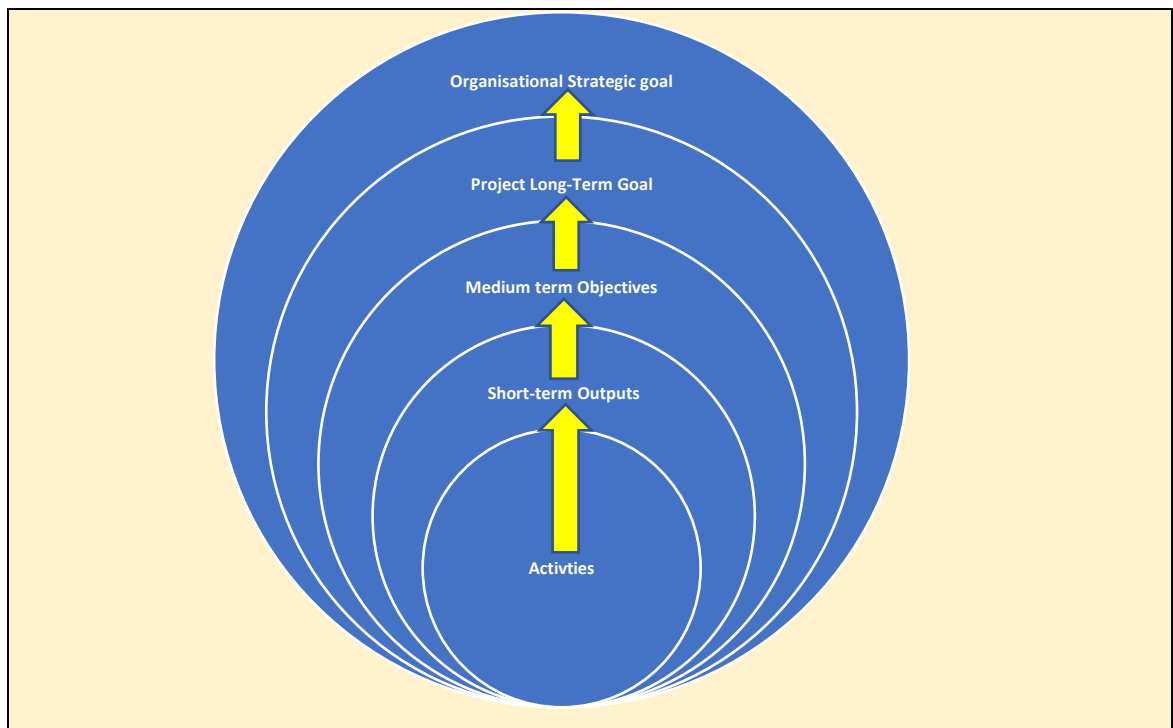


Figure 6.12: Logical linkage of activities and goals to TLMN Country strategy

Logical linkages emerged from five concepts of project planning framework, linkage of long-term goals to organizational strategy, linkage of medium-term objectives to long-term goals, linkage of short-term outputs to medium term objectives and linkage of activities to short-term outputs (Table 5.10, Annexe 5, page 341). The project planning framework describes the TLMN's practice of formulating multiple objectives for each long-term goal and use of a project logic or framework for planning project proposals.

Apparently the remaining four concepts described the different logical linkages used by TLMN in formulating goals and planning projects, which suggested a directional upward conceptual flow of expected project effect from activities implemented through the short-term, medium term and long-term goals of the projects to the organisational strategic goal at the country level (illustrated in Figure 6.12). The related quotes of Mr B and a field manager are as follows:

- *'There is also an overall goal which is more of, which directly contributes to the country strategy' (2.7.6).*
- *'Now they are both ways. The specific objectives are tied to the long-term goal in that project, but also tied to the strategic objectives in our country strategic plan' (2.9.1).*
- *'Yes. Related goals that contribute to the medium-term goals and to the longer-term goals.'* (2.36.1).
- *'What needs to be achieved within a quarter or within a month, within a shorter time that contributes to the project goals or objectives.'* (2.30.7).
- *'But the ones we have been doing, the activities are speaking to objectives, which also brings out the main goal.'* (9.44.2).

Target-Setting

Table 5.11 (Annexe 5, page 342) shows the three factors of resources, desired change and priorities that were considered during setting targets for leprosy goals according to Mr B., the national manager responsible for goal-setting in TLMN. Resources mentioned included available funding and staff in the project. It also includes any contribution possible from the communities. According to Mr B,

- *‘Sometimes we as The Leprosy Mission, already have an idea how much we can commit to the project in terms of money’ (2.47.1).*
- *‘and then we are also looking at what resources the communities have that they can contribute to achieving that.’ (2.47.3).*

Goal Formulation Approach

Goal formulation approach as a theme emerged the number of goals, and the timing, frequency and process of formulating goals (Table 5.11, Annexe 5, page 342). The sub-goal of the number of goals revealed that each project plan contains one long-term goal with multiple objectives, may be up to three or four. The frequency of goal formulation varies with each project, but the timing was always before implementation begins. The same formulation process was followed for all goal types.

Leprosy Control Goal-setting

Table 5.11 shows the two sub-themes of this category that described the current situation of goal-setting specifically for leprosy control programmes (LCP). These emerged from responses obtained from two field managers – State Leprosy Control Officers that revealed the exclusion of leprosy control programmes from the TLMN goal-setting practice. As one of them confirmed,

- *‘Well for now, actually like I said for some years we have not had annual country planning meetings. It is still done for SED, but for leprosy control officers, we no longer do that. And most of our attention has been directed to mostly tuberculosis. It is taking more of our time than leprosy’ (6.14.1).*

The other manager revealed the absence of current goals for his leprosy control:

- *‘No objectives. But still, we use the ones of 2015. We continue with the previous goals we have as I have mentioned’ (7.50.1).*

6.5 Themes of Goal Statements

The final theme of goal statements was the label of three themes that described the concepts of how goal statements were written, including composition, construction criteria and structure of their composition. The researcher’s

reflections on these concepts are summarised in the flow chart illustrations in the figures.

6.5.1 Theme one: Composition of Goal Statements

The composition of goal statements emerged from two categories: namely contents and combinations of the contents of goal statements (Table 5.9, Annexe 5. Page 340).

Contents of Goal Statements

Contents described the concepts of seven components that leprosy managers believed should be contained in a goal statement. An eighth concept referred to their justification for including time and measure as contents or components of a goal statement. Thus, according to leprosy managers, a leprosy goal statement could contain the desired change, a timeframe, a named target population, an indicator, a target level, a baseline level and the strategy for achieving it (Table 5:9, Annexe 5, page 340).

The inclusion of a change in a goal statement was the claim of both national and field managers who described the change component as an expected achievement or accomplishment in relation to the baseline problem analysed. One field manager referred to change as the desired activity to be accomplished (Table 5.9). According to Mr B,

- *'Where we say for example, we want to see a reduction in maybe malnutrition for example. So, I will say 'Malnutrition is reduced' (2.42.3).*

Similarly, the inclusion of a timeframe was a claim of both national and field managers. According to a field manager, timeframe was stated in a goal statement as either a period or a particular year (Table 5.9). The community or people being targeted for intervention was also mentioned as a content in a goal statement, but by fewer leprosy managers than those who mentioned either change or timeframe. Explaining the inclusion of target people, Mr B said,

- *'And then of course, the particular population also has to be considered' (2.46.3).*

Fewer still were the managers who claimed the inclusion of the remaining four contents: target, indicator, strategy and baseline. Relating target to the desired change, a Mr B said,

- *'At what level can we achieve that change'* (2.46.10)
- *'By so so per cent or proportion'* (2.42.8).

Examples of a target that field managers gave included,

- *'...there will be 30% stigma reduction'* (3.53.2) and
- *'...you know you want to see that at least at the end of your project you are able to attend to so, so number of patients'* (6.7.2).

Mr B defined an indicator as a goal measurement tool. According to him,

- *'And there has to be a way of measuring by way of an indicator'* (2.45.3).



Figure 6.13: Components of a goal statement, arranged according to the perceived order of popularity with leprosy managers

The 8th sub-category of contents in Table 5.9 (Annexe 5, page 340) was a field manager's explication of the importance of including timeframe and measure in a goal statement. According to him, they give knowledge of project achievement. Table 5.9 shows the more common contents or components in goal statements were change and timeframe. Less common contents are target and target population. The least mentioned were indicator, baseline level and strategy. Figure 6.13 shows the seven components ordered according to their popularity with leprosy managers.

Combinations of Goal contents

Content combinations emerged from three concepts that described three combinations of components in leprosy project objective statements stated verbally by leprosy managers during interviews (Table 5.12 Annexe 5, page 342). The commonest combination was the one that has two contents of change and timeframe stated by field managers. The other two combinations were less common, stated by one respondent each. They were combinations with either two components of target and timeframe or five components of target population, change, measure, target and timeframe.

6.5.2 Theme two: Goal construction criteria

Attributes of a good goal statement

The theme of criteria for constructing goal statements emerged from a single sub-theme that described nine concepts leprosy managers believed should be the attributes of a good goal statement. The first of the nine concepts suggested a belief in multi-themed attributes. The notion of a themed construction was obtained from a national manager's claim that,

- *'We begin to try to put in the statements that is able to capture that line of thought, ...'* (1.15.10).

However, the notion of each statement being written according to multiple themes evolved from the opinions of field managers, who enumerated mainly three attributes that a good goal statement should possess (Table 5.10, Annexe 5, page 341). According to the field managers,

- *‘Any good objective or goal should entail being real, realistic, then be positive and result-oriented’ (10.5.1)*
- *‘It has to be measurable within your operation project. It has to have time as I said earlier, err... it has to be clear’ (3.17.1).*

Still, different attributes were identified in the combinations mentioned by field managers. There was more agreement among leprosy managers about the concept of multi-themed attributes labelled ‘SMART’ in Table 5.10 (Annexe 5, page 341). ‘SMART’ was a composite of multi-themed attributes of a good goal statement and the individual attributes in the acronym were common knowledge among both national and field managers. According to one of the national managers,

- *‘We do that trying to put at the back of our minds the concept of SMART...’ (1.15.12),*
- *‘We try as much as possible to ensure even as develop goals we try to ask, include that to have SMART goals, SMART objectives and all that’ (1.15.13).*

Explaining the SMART attributes of a good statement, Mr B said,

- *‘... It needs to be specific, ...we need to be able to measure it, it should be attainable, it needs to be realistic, ...and it also needs to be time-bound’ (2.4.2).*

A field manager agreed with this explanation by claiming that,

- *‘It should be specific, it should be measurable, it should be attainable, It should be realistic and it should be time-bounded’ (6.6.2).*

National managers were the only ones who differentiated goal types by their SMART attributes: they claimed that objectives, medium-term and short-term goals have SMART attributes, whereas long-term goals do not (Figure 6.11). According to one of them,

- *‘The medium-term goals which are expressed as outcome level objectives have, they have to be SMART.’ (2.33.4).*

In total, seven individual attributes of a good goal statement emerged from the responses of leprosy managers. Accordingly, a good goal statement should be attainable, specific, time-bound, measurable, realistic, clear and acceptable (Table 5.10, page 341). In the view of leprosy managers, the concept of attainability is the same as achievability and has the additional qualities of being observable and realistic. According to a national manager, objective statements in TLMN were written to be achievable and realistic:

- *'Sometimes we just say to ourselves, can we all scribble down an objective that reflects what we are hoping to achieve' [1.17.2];*
- *'Something you can achieve because we can't set goals that are not realistic. Something that should be achievable, should be realistic.'* [1.11.10]).

Concerning specificity, a specific statement was regarded by leprosy managers as one that lacks vagueness and is understandable. A national manager connecting specificity and vagueness said,

- *'... what that means is that it should be something you can ... that is not vague, which is specific.'* (1.11.9).

The two national managers and one field manager described long-term goals as non-specific because they are vague and broad.

- *'Long-term in terms of something that is broad for us to work towards'* (1.11.2)
- *'The long-term goals in the strategic plan and in the project plan are sometimes a little bit vague'* (2.10.5)
- *'The [long-term] goal is the broad statement: This is what you want to do in general.'* (7.44.2)

Connecting non-specific goals to broad statements leprosy managers implied there is a scope dimension to the concept of specificity of goal statements. Hence according to them, long-term goal statements with a broad scope are not specific and medium-term objectives and short-term outputs with a narrow scope are specific. Thus, specific goals are not vague and not broad.

Similarly, the concept of a statement being time-bound means it is timed.

According to a national manager,

- *'But then that does not mean that to achieve a goal it should take forever – we have to time it, it should be time-bound'* (1.11.11).

Furthermore, measurability was described as a statement being measurable. A national manager explained,

- *'That means we should be able to measure to say this was where we started from and after this period of time with the inputs we made in term of resources, we have been able to arrive'* (1.11.13).

According to the field managers, measurability means

- *'...You should be able to measure whether you have achieved it or not'* (4.8.3), and the statement should possess a measurement tool: *'Eh, it cannot be a good goal when you don't have a measurable standard'* (6.5.5).

Moreover, realistic statements were described by leprosy managers as those that are feasible within the particular contexts of the project, including available resources, real situation, needs and ability of target communities. The resource-limit definition of realistic goal statements is shared by both national and field managers, as the following quotes show:

- *'Yes, and it should also be something that within our resources we can be able to achieve. So even though they say the problem may be among 50% population, but if as an organisation, we are unable to commit sufficient resources to eliminate that problem, up to 100%, then we will just be realistic based on what we can be able to achieve given our resources and time.'* (2.46.1)
- *'Something that you know you can achieve within the bounds of your resources, manpower and other things that are within your limits.'* (4.9.1).

Thus, while realistic statements were connected generally to the achievability of the goal, the leprosy managers also limited them to what is possible within the local context of the project. Also, the attribute of clarity seemed related to

specificity since according to leprosy managers' responses both concepts were connected to the same idea of goal statements being understandable, and not vague. However, clarity as a separate attribute evolved from the opinion of one field manager, who connected good goal statements to being universally understandable:

- 'Yeah, everybody understands what is expected to be achieved, yeah' (3.21.1).

Thus, clarity may seem to be another term for understandable, a concept that is also inherent in the attribute of specificity. The last attribute of acceptability emerged from one field manager's response that described a good goal statement as one agreeable to all stakeholders involved.

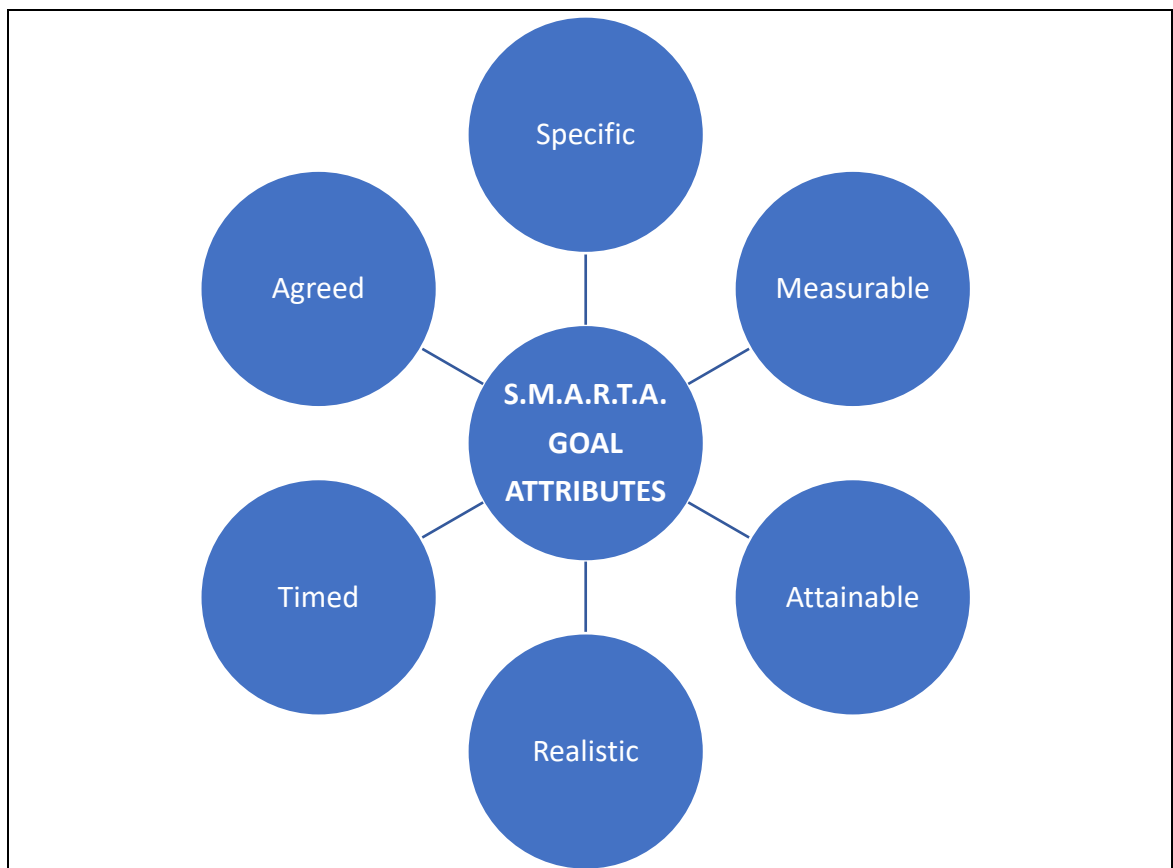


Figure 6.14: SMARTA: Final six attributes of ideal objective statements according to leprosy managers

Figure 6.14 shows a summary of the goal statement attributes to six concepts, in which the two attributes of specificity and clarity are merged. The six attributes are abbreviated to become “SMARTA” acronym, meaning: Specific, Measurable, Attainable, Realistic, Timed and Agreed.

6.5.3 Theme three: Structure of goal statements

This theme was developed from four sub-themes that were identified in both verbal responses of leprosy managers and written goal statements in the plans of six leprosy projects. These include statement construction approach, the framework of verbal objective statements, framework of written aim statements, and framework of written objective statements.

Approaches to Constructing Goal Statements

Statement construction approach evolved from five sub-themes, including: “structured goal formulation”, “using verbs in statements”, “flexible construction”, “using goal-setting frameworks” and “no standard formulation tool” (Table 5.11, Annexe 5, page 342). According to the perspectives of a national manager and some field managers, the concept of a structured goal formulation described how their goal statements were written. The national manager claimed the statements were constructed in a written format, which a field manager described as a sentence structure. Other field respondents believed that a good goal statement is known by its design and that formulating goals randomly actually produces bad goal statements. According to them,

- *‘How do I describe? I do that by writing them out’ (2.43.1).*
- *‘Well, the statements they are just like a sentence. Yeah, maybe a complex sentence’ (4.24.1).*

The second concept described the use of action-words or verbs to indicate the desired achievements or accomplishments in goal statements. This was the opinion of two respondents - a national and a field manager. The national manager’s response indicated that the verbs were written in present tense:

- *‘... And I will try to express this – sometimes we do that in the present tense’ (2.42.2).*

The third concept of flexible construction described the flexibility of the sentence structure and how easy it is for the field officers who implement the project to understand them. According to one of them,

- *'It is flexible in the sense for the implementers ... For us implementing it, to have a full understanding'* (5.31.1).

The remaining two concepts described the use or non-use of any framework templates or guides for goal-setting. While one national manager claims no predetermine or standard template was used, the other national manager (Mr B) and some field managers claimed a planning framework used for preparing the project plans or proposals was also used for goal-setting. According to them:

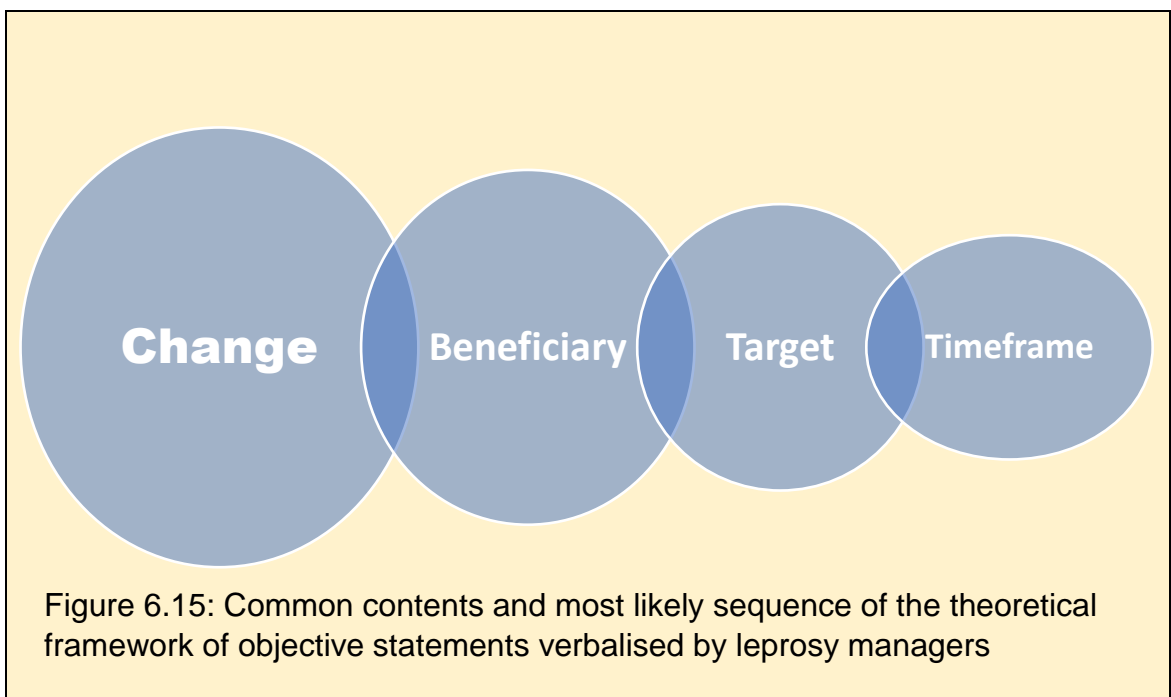
- *'There is the results framework and the ... the one that they say, output, input, output and impact.'* (4.23.2)
- *'An example of one is the project framework,'* (2.40.2)
- *'Where we have to express what the overall change is, that is the long-term goal and what the intermediate objectives are, that is the medium term, and then you have another step where you express the output'* (2.40.3).

The framework of Verbal Objective Statements

A total of 12 objective statements were obtained from the interview responses of leprosy managers. Thematically, nine frameworks were identified according to the sequence of individual goal contents or components found in the objective statements. The goal statement frameworks varied from a one-component structure to a five-component structure (Table 5.12, Annexe 5, page 342). There was only one type of the one-component framework, and it stated only the desired change. The next two frameworks in Table 5.12 had a two-component framework: one that stated change and beneficiaries in the objective, and another, stated change and location. The following two frameworks had a three-component structure. Both frameworks contained beneficiaries and timeframe as contents but mentioned in a different sequence. The third content in one framework was target, while it was 'change' in the other. The next three frameworks were those having a four-component

structure. While all three frameworks had change and timeframe as the first and last content respectively, they had two different contents arranged in different sequences in the middle. Thus, in between change and timeframe, the first framework had beneficiaries and strategy, the second had beneficiaries and target, and the third, baseline and target. The last framework had a five-component structure, in which the sequence began with indicator and ended with baseline level, and in between were beneficiaries, target and timeframe.

Overall, the commonest component in all nine frameworks (present in all except two frameworks) was change, and it was always stated as the first content. Less common than change, but the beneficiary was included in most of the framework, which was mostly stated as the second content. Also present in some frameworks was timeframe, which was mostly the last content in the framework. Next, but less common than timeframe, was target; which was mostly stated as the third content in the frameworks. The three components included in very few frameworks were baseline level, strategy and indicator, and they were stated in different locations in the sequence of the framework. In summary, Figure 6.15 shows the theoretical framework of leprosy objective constructed from statements verbally stated by the leprosy managers, based on the four most common components and the common positions in the sequences.



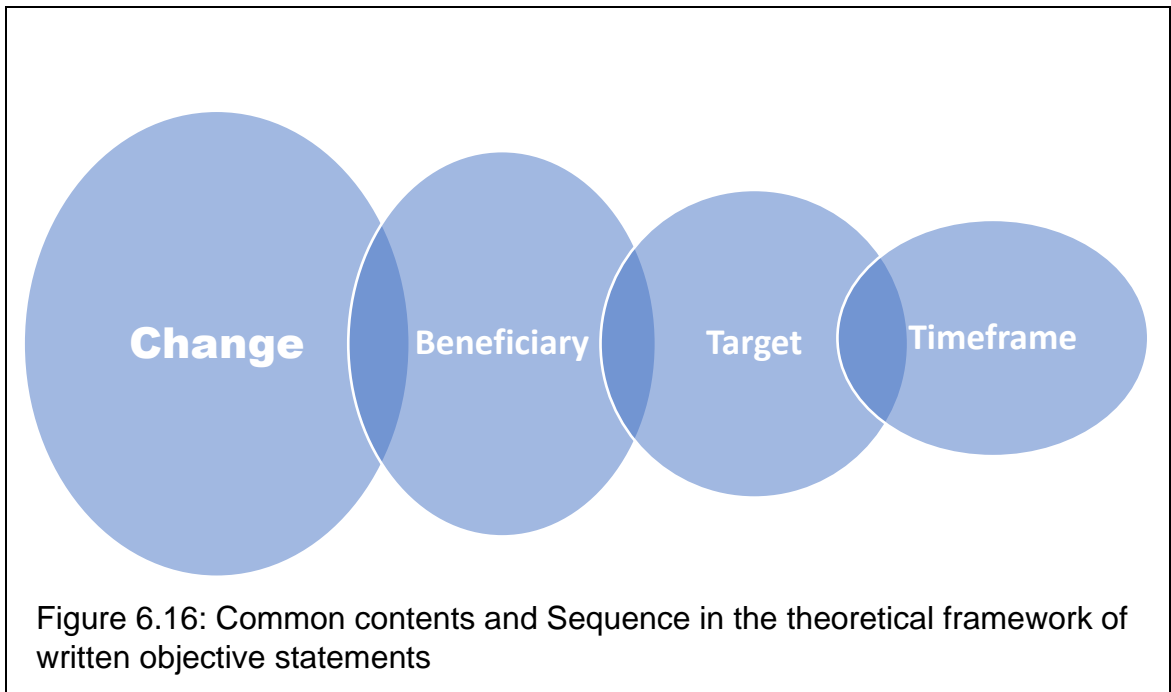
The framework of Written Objective Statements

The sub-theme of the framework of written objectives emerged from ten different frameworks of lexical contents and their sequences identified in the statements of 18 objectives found in the leprosy project plans. The objective statements' frameworks are shown in Table 5.14 (Annexe 5, page 343). They ranged from a two-component to a five-component structure. There were two objectives with a two-component framework (LCP and HRP objectives). Another seven objectives had a three-component framework; six objectives had a four-component framework; and three objectives, a five-component framework. The first component of the two two-component frameworks was similarly 'change', but their second content was different: either beneficiary or timeframe. Likewise, there were two three-component frameworks that each had a different set of contents and sequence. The first of these had a sequence of indicator, target and location; while the second had change, beneficiary and timeframe. In all three four-component frameworks, the sequences ended with timeframe. Two of them either began with change or had beneficiary in the second position or strategy in the third. Target was present as the third component in only one of these four-content frameworks.

Moreover, Table 5.14 (Annexe 5, page 343) shows that all three five-component frameworks had timeframe as their 5th component. All three also had change as a component, but only two positioned it in the first position in the framework sequence. The third framework had it positioned in the fourth position. Also, all three frameworks contained beneficiary, with it positioned second in two frameworks and first in one. In addition, two of the five-component frameworks each contained location in the third position and target in the second and fourth positions. Strategy was positioned fourth in only one framework.

Overall, the most common components in the ten different frameworks of written leprosy project objective statements were change, beneficiary and timeframe. Change was mostly positioned first in the sequence of contents, while beneficiary and timeframe which were mostly positioned as second and last respectively. Much less common than these three, was target whose position varied in the middle of the frameworks. Location and strategy had

about the same rarity in the frameworks as target. Where stated, location was always the third content, while the position of strategy varied in either third or fourth. The rarest content of component in a written objective statement generally was indicator, and it could be positioned in either the first or the third.

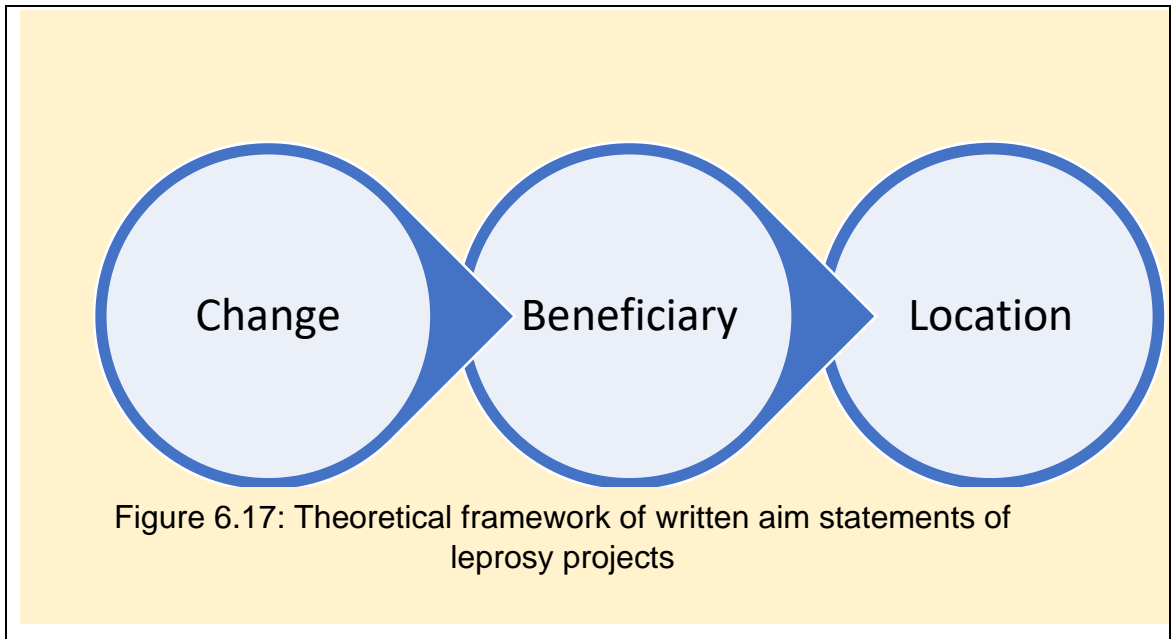


So, based on the common contents and their most likely positions in the sequence of the frameworks, Figure 6.16 shows the common theoretical framework of the written leprosy objectives statements in TLMN project plans. Strategy, location and indicator were omitted because of their rarity and considered occasional components in the statement framework of leprosy project objectives.

Frameworks of Written Aim Statements

Using the same thematic codification process, Table 5.13 (Annexe 5, page 331) shows the four frameworks constructed from the six written statements of aims in the project plans as the structures of long-term leprosy goals. The first three frameworks developed from the aims of LCP, HRP and SHP projects had three components. The fourth from the aim of the orthopaedic workshop project had a four-component framework. The LCP's three-component aim framework stated

change, location and target. However, the target was not quantified. The HRP aim framework stated problem first, change last, and beneficiaries in the middle. In the three SHP aims, the framework typically stated beneficiaries, change and location. The four-component framework of the ortho project's aim statement stated change, beneficiary, timeframe and strategy.



All four aim frameworks had change as a common component, even though it was positioned at different locations in the sequence. Beneficiary was present in three frameworks and positioned mostly as the second content. Location was present in two frameworks. Change and beneficiary were, therefore, less common than the earlier three components. The remaining three contents: problem, target and strategy were the least common, as each was stated in only one aim framework.

Thus, the summarised theoretical framework of aim statements based on the more common contents and sequence would have three components, with a sequence that begins with change, ends with location and beneficiaries in between the two (Figure 6.17).

6.6 Summary of this Chapter

This chapter presented the results of the theorisation of the goal-setting themes that emerged from the thematic analysis of the textual data obtained from 10 leprosy managers and documents of six leprosy projects. The base concepts

that formed the three final themes are described and their axial relationships constructed reflectively to produce theoretical goal-setting frameworks representative of TLMN organisational practice. From the three final themes of goal-setting stakeholders, goal-setting strategies and goal statements, a total of eleven theoretical frameworks possible in the organisations' goal-setting practice were identified. These are:

1. A three-level tripartite organisational framework of *goal-setting activities* (Figure 6.1, page 121).
2. A six-step framework of national *goal-setting responsibilities* (Figure 6.2, page 124).
3. A five-level logical framework of *goal types* (Figure 6.4, page 125).
4. A seven-stage framework of *Goal Effects Cycle* (Figure 6.6, page 130).
5. A ten-stage framework of organisational *goal-setting process* (Figure 6.7, page 136).
6. A five-stage framework of national preparatory *goal-setting tasks* (Figure 6.8, page 137).
7. A five-stage framework of field baseline needs survey tasks (Figure 6.9, page 140).
8. A three-level framework of *goal formulation pattern* (Figure 6.11, page 155).
9. A six-attribute framework of SMARTA *objective statements* (Figure 6.14, 164).
10. A four-component CBTT framework of leprosy *objective statements* (Figures 6.15, page 167; and 6.16, page 169).
11. A three-component CBL framework of leprosy *aim statements* (Figure 6.17, page 170).

These theoretical frameworks were considered the key findings of this research. The implications of each for the theoretical goal-setting of TLMN in the light of available literature evidence were discussed under the relevant theme labels in

the subsequent chapters seven eight and nine. The key concepts in each theoretical framework also provided the keywords for a post-research further literature search to aid the final discussion and conclusions of the emergent theory of goal-setting practice in the final chapters (ten and eleven) of this thesis.

Accordingly, the next chapter (chapter seven), discusses the evidence of theoretical frameworks of goal-setting stakeholders.

Chapter 7

GOAL-SETTING STAKEHOLDER FRAMEWORKS

“...The [TLMI] framework of Goal Effects Cycle signifies leprosy managers’ belief that the concept and practice of goal-setting are indispensable to the success of their field leprosy projects. ...[and] that goal-setting as a management intervention works in healthcare...”

(Section 7.6, last paragraph, page 189)

7.1 Introduction

This chapter discusses the four theoretical frameworks that emerged from the concepts related to the themes of goal-setting stakeholders. In this chapter, the academic implications of these frameworks are discussed in the light of existing published goal-setting literature searched using their related keywords or phrases of: “goal-setting stakeholders”, “organisation of goal-setting activities”, “centralised goal-setting”, “collaborative goal-setting”, “goal types” and “goal effects”. In the beginning, this chapter also discusses the observed conflicts in the perspectives of the national and field managers regarding the key concepts that generated the stakeholder-related frameworks.

7.2 Conflicts in National and Field Perspectives

7.2.1 Goal-setting roles of stakeholders

Responses of national managers gave the notion that national and field managers shared different goal-related roles in implementing and reporting on project performance. Thus, it was their sole opinion that overseeing field officers, working with partners and developing field projects were responsibilities specific to the national managers. It was a national manager’s perspective that goal-setting in the organisation was the sole responsibility of a single individual at the national office – Mr B. Similarly, only national managers gave the impression that there was collaboration of national and field managers in pre-goal-setting conceptualisation of leprosy projects. Also, it was a national opinion that field project officers were invited to a pre-implementation meeting at

the national office where the national managers present the assigned project goals and activities approved for their implementation.

On the other hand, only field managers claimed they were responsible for implementing, monitoring and evaluating their leprosy projects' goals and plans, which were formulated and designed respectively at the national level. They alone claimed explicitly that field officers were excluded from the goal-setting and project design. This confirmed the response of a national respondent that goal-setting and project design were national-based activities of the second national manager. Yet, a response of one field manager specifically mentioned that project planning was done jointly by both national and field managers.

These differing opinions raised the question in my mind of whether goal-setting in TLM Nigeria was strictly a centralised or a collaborative affair. Nevertheless, there was a national response that claimed field managers were invited for pre-implementation discussion of completed project plans, which seemed to support the field managers' claim of exclusion from the actual goal-setting and project design stages. There were also conflicting responses of some field managers that on one hand claimed they had experience of TLM goal-setting, and yet on another hand, some others claimed ignorance of current goal-setting practice in the organisation. Whichever the case, it seemed more likely that the national managers had more experience and responsibility for the goal-setting process than the field managers.

However, responses of both national and field managers suggested there was an agreement of the two, that field staff were involved in needs identification only. Nevertheless, on one hand, the national managers seemed emphatic it was the field manager's role to identify and report the needs of target beneficiaries to the responsible manager at the national office. On the other hand, the field managers simply said they assessed the needs. Despite these differences, both national and field managers apparently agreed that the field staff collaborated with national officers in carrying out field visits to target communities and conducting the baseline survey of their problems and needs. Both national and field responses also showed there was agreement that the beneficiaries identified their own needs at the community level.

This, however, revealed a conflict, a confusion, in the leprosy managers' opinions on who identified the baseline problems and needs on which the goal-setting for leprosy projects was based. Was it the field officers or the target beneficiaries at the community level who reported needs to the national managers? Who voiced the changes in their situation that they desired during the baseline survey? Or did both field officers and community play their needs identification roles for goal-setting at different stages of the project development process? Therefore, while it seemed obvious there was a centralised responsibility for the goal-setting process with the reported exclusion of field managers, the important issue of whose specific responsibility it is for needs identification at the field or peripheral level was unclear in the data collected in this study. I think all three groups of stakeholders – the national managers, the field managers, and the community-level project beneficiaries seemed to collaborate in the baseline survey of needs and problems conducted for project goal-setting and planning, but not in the other goal-setting stages.

7.2.2 Stakeholders' perceptions of goals

The responses of leprosy managers showed that no goal definitions were specific to either national or field managers. It was the perception of both national and field managers that a goal is an expected or desired target, and an aim or a change that is desired in target communities. Similarly, both levels of managers used the word aim to describe a goal. Nevertheless, only field managers defined a goal as an end-result of activities, an expected outcome, the desired achievement, a dream, height or a vision to be attained, while, only the national managers referred to aim as a long-term goal. Concerning goal types, only one national manager defined an overall goal as an overall change, while only field managers defined mid-term goals as mid-way outcomes, short-term goals as intended activities, and outputs as the end-results of activities. However, both national and field managers seemed to share similar understanding of long-term goals, even though they described them differently: they are long-term changes to a national manager and expected impacts to a field manager.

Leprosy managers expressed their views on the effects of both the presence and absence of goal-setting on a project. While both national and field

managers gave their opinions about the usefulness of a project having goals, only field managers described the effects of the absence of goals and their recommendations for improving goal-setting for their projects. However, this was mainly because these issues came up during the interviews conducted at a later stage of the data collection process. Accordingly, it was the perception of a national manager that goals give a project a sense of purpose and meaning, and field managers generally believed that projects without goals are bound to fail, lack knowledge of their achievements, cause confusion and are impossible to evaluate. The field managers also believed goal-setting has a life-changing effect on the project. According to their jointly held views, national and field managers perceived that goals give direction to a project, narrow the focus of implementation, streamline the scope of operation, and motivate effort towards achievements. It was therefore understandable that both levels of leprosy managers held the opinion that absence of goals would mean loss of direction for a project.

Overall, it appears these perceptions showed there was a similarly good awareness about the theoretical concepts of goals among both national and field leprosy managers. Generally, their idea of what a goal is agreed with the essential rendition of pioneer goal-setting researchers such as Locke and Latham (2002) and Erez and Kanker (1983). Erez and Kanker's (1983: 454) reference to a goal as being illustrative of 'an end-state towards which a person strives, and they serve as immediate regulators of action' fits very well with the leprosy managers' perspectives of what a goal is and its effect on project implementation. Rather than indicating different levels of understanding, the managers' different opinions about the definitions, classifications and goal effect appeared to reflect the varying levels of role or experience the national and field managers had in the actual practice of goal formulating and project implementation respectively. For example, the field managers were more likely to define goals operationally - as expected results of activities being implemented, while the national managers seemed to more particularly referred to the overall or long-term nature of change in reference to goals.

Nevertheless, the different definitions and use of terms such as aims, targets of goals displayed by the managers was compatible with the current universal

situation of synonymous rendition of the spectrum of goal terminology (DAC-OECD 2002; Ogbeiwi 2016; 2018). Similarly, their perceptions of the effects of goals on performance and achievements at the project were aligned with Locke and Latham's (2002) mediation effect of the goal mechanism in task motivation and enhancement.

7.2.3 Field managers' views on assigned goals

Concerning the statements of goals formulated, the field managers believed the objectives were well-formulated and relevant to beneficiary needs, but they considered them generally not realistic, difficult to implement and not achievable. For better goal-setting therefore, they recommended involvement of the grassroots or field level stakeholders in goal-setting. While some field managers, specifically Leprosy Control Officers for whose projects TLMN no longer funded, suggested a return to the goal-setting practice of the past, another, a Socio-Economic Development Officer, desired maintenance of the status quo. Yet another recommended a change of goal-setting approach from top-down to bottom-up. Hence even field officers have conflicting views about what goal-setting approach would be the best in the interest of their field projects.

These views indicated the goals of the leprosy projects were assigned goals since they were formulated centrally in the organisation and given to the field managers to deliver project achievements based on them. Latham and Marshall (1982) described assigned goals as goals imposed on employees. Obviously, not all field managers were happy with the organisational assigned goals, apparently being products of a top-down goal-setting practice which, according to some field managers, were not compatible with field realities. Their views on assigned goals were agreeable with the observations made by Hato (2004) of the attainability of the assigned goals of a Japanese English education programme. The goal-setting process was centrally directed by the Ministry of Education of Japan, using a top-down approach. The target levels of proficiency were also found to be not feasible, unrealistic and impractical (Hato 2004). Hence their desire for a bottom-up goal-setting practice that involves the grassroots stakeholders' participation in goal formulation was understandable.

However, this opinion was not held by all field managers as some of them believed the assigned goals were related to the needs in the field. Especially, collaboration with field project and community stakeholders seemed to have been the idea behind the baseline survey to identify the base needs that determined the project goals set. Still, the discordant views of field managers on assigned goals did not support the reports of past experimental goal-setting research that found no difference in goal acceptance and performance irrespective of the goal-setting approach – whether self-set, participatively-set or assigned (Dorsett, Latham & Mitchell, 1979; Latham & Marshall, 1982; Gauggel, Hoop & Werner, 2002). Besides, the complaints of some field manager about the assigned goals in TLMN context actually suggested their non-acceptance of the goals or their apparent imposition for field implementation and attainment.

Therefore, the rationale for the field response to assigned leprosy project goals seems to find accord with the explanation by Erez and Kanker (1983: 455) that 'A goal is more likely be accepted when it is perceived to be under a person's control than when it is perceived as externally imposed.' Furthermore, the view of these authors that participation could be an effective approach to improve goal acceptance supports the field managers' recommendation of collaborative goal-setting as a possible way forward for TLMN's organisational practice (Erez & Kanker, 1983).

7.3 Tripartite Framework of Goal-setting activities

The evidence gathered from leprosy managers suggested their goal-setting roles occurred in TLMN in three dimensions – separate, shared and joint responsibilities (see Figure 6.1, page 121) and performed by three levels of stakeholders – national, field and community. The role themes that emerged from their separate goal-setting responsibilities produced a framework of tripartite organisation of goal-setting activities.

According to this functional hierarchy, the community members expressed their needs and the changes they desire. The field managers identified their project beneficiaries' needs and reported to the national managers. The national managers initiate the goal-setting process, develop the project concept, analyse the problems, formulate the goals and design the project plans. Thus, in

describing how leprosy goals were formulated in TLMN, the original stakeholder roles framework in Figure 6.1 was further reduced to the one illustrated in Figure 7.1.

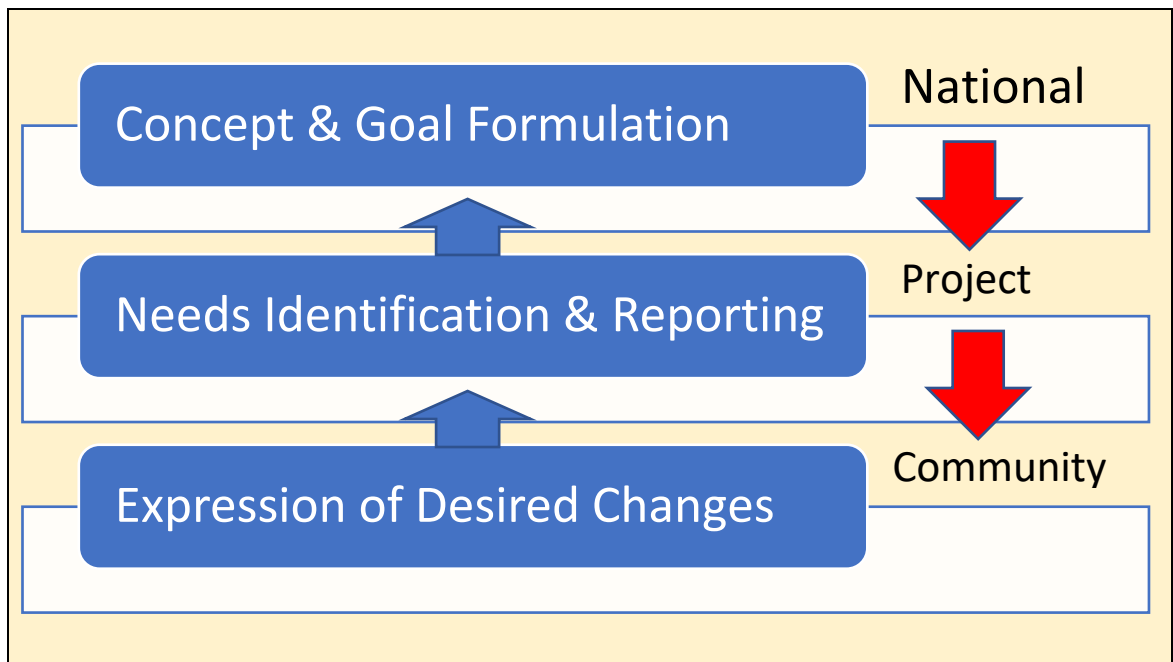


Figure 7.1: Three-level Tripartite Organisational framework of Stakeholder Goal-setting Roles

Reflectively, therefore, as illustrated by the arrows in framework in Figure 7.1, there seems to be a two-directional conceptual flow in the three-level organisation of goal-setting activities in TLMN practice. The downward red arrows show the top-down flow of initiation of the concept, mobilisation for the goal-setting process and assignment of formulated goals from the national level to the field, and then to community levels. This downward flow is supported by the evidence of the national managers' communication with the field managers and exercise of organisational authority over regarding the conduct of field visits, baseline survey and the national dissemination of assigned project goals and plans. The upward blue arrows indicate that the bottom-up flow of information used for goal-setting at the top, which began from the involvement of the communities, through the field project managers to the national managers. Hence the bottom-up information flow or data gathering for goal-setting suggested that the main role of the peripheral stakeholders were

essentially passive: as sources of information used for goal formulation at the national level.

Generally, the evidence gathered from this research shows that goal-setting in TLMN was executed through the sole responsibility of a national manager, Mr B as the main active stakeholder; who seemed to facilitate the entire process. Goal-setting was initiated, facilitated and completed by him at the national level of the organisation. The process is regarded as *centralised* because of the national location of Mr B in the process and the exclusion of the peripheral field managers from the goal formulation activities. Nevertheless, even though the project implementers – the field managers – were excluded, it was observable that in the centralised framework of TLMN goal-setting, the national processes that led to the finalisation of goal formulation by Mr B., were also participative. This was because of the use of a multi-sector stakeholder committee-based approach for problem analysis and goal formulation. Moreover, the three-level organisational framework indicates the field-based project managers and community stakeholders also participated at the peripheral level of goal-setting activities (the baseline need-identification stage), howbeit passively. Thus, while the TLMN goal-setting practice was *national manager-led* and the end-product were essentially assigned goals, there was evidence of multi-layer stakeholder participation or involvement in the centralised TLMN goal-setting process.

With this *centralised model with some participative elements*, TLMN goal-setting practice is comparable to the therapist-led goal-setting in clinical rehabilitation. In this sector, Plant and Tyson (2018) found in a multicentre mixed-methods study in the UK that there are varying degrees of stakeholder involvement at different stages of a multi-level process of setting goals related to behavioural change of stroke inpatients. In this study of the practice of 13 therapists, while less than half (five) set patients goals alone (fully centralised goal-setting), a remarkable 10 (77%) claimed they set patient goals participatively, with the involvement of patients, their families or a multi-disciplinary team (Plant & Tyson, 2018). Therapist-led, collaborative patient or client-centred goal-setting practice seems to be the norm for clinical and rehabilitation interventions in the healthcare sector of high-income countries. It emphasises active participation of

the patients or clients, or families (in the case of paediatric rehabilitation) whose goals are being formulated in the process (Øien, Fallang & Østensjø, 2010).

According to Aston and Sheehan (2010), and supported by other authors (Pimentel 2008; Murphy & Boa, 2012), patient participation in setting their goals is a key approach to the implementation of the UK's Department of Health (2005) standard guidelines for patient involvement in treatment decisions outlined in the National Service Framework for Long-term conditions. Pimentel (2008: 493) described this participation as a "partnership between the client and the rehabilitation team." Similar reports of statutory collaborative or shared patient-therapist participation in goal-setting in high-income countries was made in the USA (Schulman-Green et al., 2006; Brown, Bartholomew & Naik, 2007; Lafata et al. 2013; Sleath et al., 2014), Canada (Peng et al., 2014), the Netherlands (Vermunt et al., 2007; Friessen-storms et al., 2018), Australia (Fernandez et al. 2012) and New Zealand (Levarik et al., 2011). However, as reported by Plant and Tyson (2018) for stroke patients and Sleath et al. (2014) for glaucoma patients, collaborative goal-setting involving patients do not always follow the standard guidelines. In some instances, it does not happen at all (Sleath et al., 2014). Hence, Vermunt et al. (2007) in their systematic review of collaborative goal-setting for geriatric patients assert that this concept where health professionals and their patients cooperate and share knowledge and information leading to mutually agreed goals is still premature within the framework of decision making.

Nevertheless, compared to the goal-setting approach in rehabilitation and clinical healthcare in high-income countries that is statutorily therapist-controlled, patient-centred and yet collaborative in its prescribed formulation of patient health goals, the multi-level tri-partite framework of the organisation of TLMN goal-setting shows a practice that was similarly organisation-controlled and community beneficiary-centred. However, the TLMN practice was different in its centralised, non-collaborative formulation of leprosy project goals by national stakeholders. This is reminiscent of a typical top-down goal-setting approach (Hato, 2004), which is contrasted from the bottom-up approach in which the peripheral stakeholders are actively engaged, not only in the discussion and identification of their needs and desired improvements but also

as equal partners in the actual formulation of the project goals (Fraser et al., 2006; El Asmar, Ebohon & Taaki, 2012). According to Fraser et al. (2006), even though the actively participatory bottom-up process may be more time-consuming and resource-intensive, and the resulting goals less standardised and comparable across project areas, the approach has the advantage of ensuring ownership and local relevance of the goals and preventing alienation and disempowerment of local stakeholders from the organisational goal-setting practice.

Overall, even though Peng et al. (2014) describe a patient self-management goal-setting by community-based therapists working in the setting of home-care of people with chronic conditions, no previous research has reported any evidence of organisational framework of stakeholders' goal-setting roles for field-based public health interventions like TLMN leprosy projects. Definitely, no past goal-setting study has reported a tripartite stakeholder involvement in a healthcare goal-setting practice.

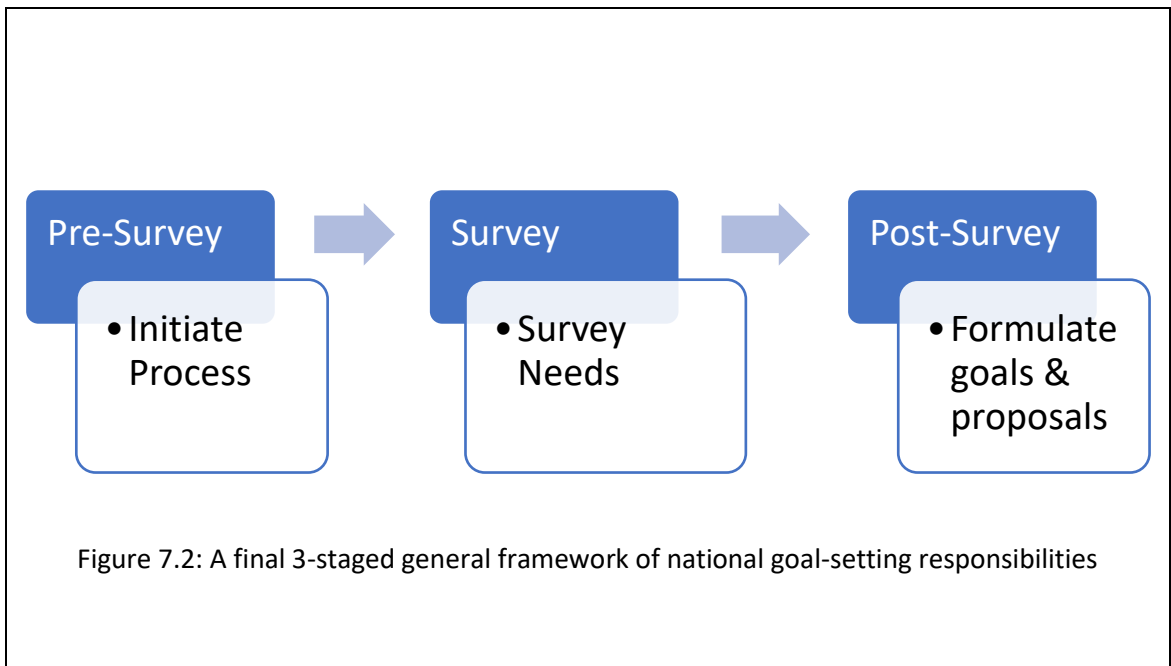
7.4 Framework of National Goal-setting Responsibilities

This framework illustrated in Figure 6.2 on page 114 shows the theoretical six-step implementation of the national goal-setting responsibilities of Mr B. This framework revealed that TLMN goal-setting process began with Mr B. initiating preparation for the baseline survey and ended with him developing project proposals. This shows goal-setting in TLMN was an integral part of its centrally controlled organisational process of project conceptualisation, planning and development. Reflexively, the six national responsibilities of Mr B in this framework could be further reduced into three stages around the baseline survey which was the only activity that may be done outside of the national office (Figure 7.2). These stages of goal-setting responsibilities indicate that the national manager was involved and in control of the entire organisational process.

The pre-survey responsibilities were those of initiating the goal-setting process, essentially the development of a project concept and preparation for the baseline needs-survey. The steps where specific goal formulation processes were done, included discussions, consultation and finalisation. These were

facilitated centrally post-survey by Mr B., based on the analysis of the results of the needs survey (Figure 6.2, page 124).

Thus, this theoretical framework adds to the evidence that goal-setting in the organisational context of TLM Nigeria was a highly centralised process, initiated, facilitated and completed by a single national manager. According to Vitez (2019), a centralised organisational goal-setting structure is popular with small businesses, where the business owner is solely responsible for setting the vision, mission, values, and goals as well as making all the decisions that guide all organisational operations. Regarding decision making, centralisation of responsibility in a single person might mean decisions are made quicker and more efficient.



Thus, this theoretical framework adds to the evidence that goal-setting in the organisational context of TLM Nigeria was a highly centralised process, initiated, facilitated and completed by a single national manager. According to Vitez (2019), a centralised organisational goal-setting structure is popular with small businesses, where the business owner is solely responsible for setting the vision, mission, values, and goals as well as making all the decisions that guide all organisational operations. Regarding decision making, centralisation of responsibility in a single person might mean decisions are made quicker and

more efficient. However, as the organisation gets larger and the organogram gets wider, it develops many structural levels that tend to lengthen the distance between the sole decision-maker at the top and the peripheral front-line operational managers. The bureaucracy introduced inevitably and invariably slows down both the management and operations of the organisation (Vitez, 2019). Past research rarely reported any centralised framework of goal-setting activities, if any at all. Lozano, Villa and Adenso-Diaz (2004) describe a centralised target setting process by a regional authority in Spain for some decision-making units (DMUs) using a mathematical goal programming model called Data Envelopment Analysis (DEA). While the stages of the process are not clear and the preparatory initiation activities not reported, they specifically show that the first step was information gathering about the DMUs, much like the baseline needs survey done by TLMN.

7.5 Framework of Goal Types

The leprosy managers gave seven basic definitions of a goal that generally implied that a goal is a targeted change or improvement that is stated with temporal and spatial dimensions. On its temporal dimension, the expected achievement of the planned change is time-specific, defined by a spectrum of timeframes that ranged from immediate, short-term, intermediate to long-term (Figure 6.4, page 126). Similarly, on its spatial dimension, there is evidence that goals are also stated according to three organisational hierarchies or levels, where their achievements are expected, such as workers' activity-level, project-level, and country-level (Figure 6.11, page 155). These two dimensions formed the bases for the framework and differentiation of five types of goals (Figure 6.4). According to this framework, leprosy managers believed that *different goals* were formulated to target *specific changes in beneficiaries*, which were expected to result from project implementation at *different organisational timelines and levels*. In this understanding, a short-term goal was related to the accomplishment of activities. In this goal type framework, it is the first goal type and level to be achieved in the temporal and spatial spectra of goals. In their perspective, the other types were immediate, intermediate or mid-term, long-term and overall strategic goals.

Ordinarily, it is confusing how a short-term goal is achieved before an immediate goal as described by the leprosy managers. Unlike Ogbeiwi's (2016, 2017) definition of short-term goals as annual outcomes that are expressed as the specific desired changes in project-level objectives, the view of leprosy managers reveals short-term goals in TLM Nigeria projects were related to performance targets of planned activities. However, their description of immediate goals, as the results of the activities or outputs, that are achieved immediately after they are completed, agrees with the DAC-OECD (2002) definition of outputs in the development sector (Ogbeiwi, 2016). Hence, their understanding of immediate goals aligned with the universal understanding of immediate results or outputs. However, their perspective of short-term goals as expressing the accomplishment of activities temporally put short-term goals before immediate goals in TLMN's project context. Nevertheless, the intermediate/mid-term and long-term goals tally with the general definitions of project objective and aim respectively in similar healthcare settings (Save our children 2003, Ogbeiwi 2016, 2018). Though, in TLMN context, both objectives and aims essentially had a longer timeframe than what is reported in published literature (Ogbeiwi 2016, 2018). Moreover, the project long-term goals were differentiated from overall strategic goals only because the former was limited by the projects' end-term, while the latter referred to the country-level organisational goals that the project goals were expected to contribute to ultimately.

Clearly, the leprosy managers' perspectives of the goal definition which were related to a desired change temporally and spatially aligned with the terminological definitions by mainstream goal-setting researchers found in reviewed academic articles in Chapter 2 (Locke & Latham, 2002, 2006; Lee et al, 1989; Stretcher et al. 1995; Fitsimmons 2008; Lee, 2010; Day & Tosey 2011; Nanji et al 2013; Mullins 1999; Bratton et al., 2007). The same change-related definitions hold sway in rehabilitative healthcare, which according to Meester et al. (2013: 888) is "an intended future state of functioning and therefore implies a change that is established by the planned actions ...". In particular, Wade (2009: 291) agrees that the goal definition typically describes two components of "end state" and "an effort to reach that state". This, therefore, implies that

goals specify a desired “change from the current situation” as well as the “intended consequence of actions undertaken” (Wade 2009: 291). Similarly, the temporal and spatial dimensions discovered in the goal definitions by leprosy managers are also agreeable with the assertion by Wade (2009: 293) that “goals are hierarchical in at least two ways”: time and conceptual levels. Like the leprosy managers, Wade (2009) also believes that the time axis of goals enables the differentiative definitions of long-term goals, medium-term goals and short-term goals; since the goal types are expected to be achieved at different timeframes of the planned intervention.

However, unlike the synonymous use of different goal terms in academic literature (Collins, 2007; Beardshaw & Palfreman, 1990; Mullins 1999), the leprosy managers’ perspective of different goal typologies rhymes with the understanding and classification of goal types in the health sector (Ogbeiwi, 2016). In addition, the leprosy goal typology evident from the temporal hierarchical framework of five types illustrated in Figure 6.4 (Chapter 6, page 126) appears to be unique to TLMN organisation as it is different from the binary goal classifications reported by many goal-setting authors in the articles reviewed in Chapter 2. Thus, according to the goal type framework in TLMN organisation, leprosy goals were not simply immediate and ultimate (Bratton et al., 2007), or general and specific (Bradley et al. 1999; Mullins, 1999), or symbolic and action-oriented (Whitehead 1998), or distal and proximal (Yearta Maitlis & Briner 1995; Ginsburg 2001; Locke & Latham, 2006), or short-term and long-term (Kerr & LePelley, 2013); but a wider range from short-term goals of activity performance through the immediate (output), intermediate (medium-term) and terminal (long-term) goals of project-level results to the overall organisational strategic or purpose goals.

7.6 Framework of The Goal Effect Cycle

This framework illustrates the theoretical relationship between the seven-goal effects that evolved from the beliefs of leprosy managers about goals.

According to the goal effects cycle in Figure 6.6 (page 130), the expression of desired change in a goal statement enabled at the start of a project the knowledge of expected accomplishment or achievement. The direct effect of

this knowledge of goals was believed by leprosy managers to be a definition of the direction and destination of the project or organisation. In turn, the project's direction and destination were believed to give its sense of meaning and purpose. Apparently, the project's meaning and purpose motivate the project staff to make the needed effort towards achieving the targeted changes. However, the motivation to achieve the goal, presumably, would lead the staff to refine and limit the scope of work to those that are relevant to the goals. This then enabled a keener focus of attention on the expected achievements during project implementation, which in turn would inspire the exertion of purposeful effort on task performance. At the end of the project term, the cycle suggests that with increasing effort on task performance, the goals enabled knowledge of the expected targets and levels of change desired *ab initio*. This would enable monitoring of the progress being made during project implementation and evaluation of what was accomplished at the end. With this chain of effects, it is understandable why leprosy managers believed that goal-setting enables the project to make positive changes in the target population. Therefore, also appreciated is their view that lack of or illogical goal-setting in a project most likely results in loss of direction, development of irrelevant activity planning or ultimately, failure of the project altogether.

While Locke and Latham (1990, 2002, 2006) did not construct a cyclical order of the motivational goal mechanisms in their goal-setting theory (Figure 2.1, page 33), the goal effects identified in the leprosy managers' beliefs are in harmony with theoretical mediators or predictors between goals and task performance. Besides, the leprosy managers may not have been aware of the independent, predictor and dependent constructs in Locke and Latham's (1990) goal-setting theory. However, the cascade of effects in the goal effects cycle - from knowledge of the expected achievements specified in goal statements to increased effort on project performance - mirrored the various ways by which goals in experimental settings reportedly motivated changes of workers' behaviour towards goal attainment.

Accordingly, Locke and Latham (2002) and Bipp and Kleingeld (2008) seem to agree with the goal effect cycle, in their assertion that the knowledge of assigned or own goals primarily directs workers' *choice* of goal-relevant tasks,

enhances their *focus* and attention on what needs to be achieved, boosts their *persistence* of effort at what needs to be done and encourages their search for the *capacities* they need to do well on the goal-oriented tasks (Figure 2.2, page 37). Clare et al. (2011: 220) clarify these goal effects by stating that, 'Working towards identified goals directs attention and effort towards relevant activities and away from irrelevant ones, leads to greater and more prolonged effort and facilitates the identification of assistive strategies.' However, Locke and Latham's (1990) goal-setting theory proposes that these goal effects only happen when the goals are stated in a specific and challenging format, and, when certain moderating environmental factors or contextual conditions are fulfilled in the project or organisation (Locke & Latham, 2002, 2006, 2013; Seijts & Latham, 2000a; Matsui, Okada & Inoshita, 1983; Wood, Mento & Locke 1987; Brown, Jones & Leigh, 2005). These goal moderators were not mentioned or suggested by the leprosy managers as conditions in the theoretical relationship between goal setting and improved project performance in the TLMN context.

Without doubt, the evidence of these goal effects provides the rationale for the universal recommendation and practice of goal-setting as a best practice and an effective patient management strategy in healthcare settings (Bornman & Murphy, 2006; Aston & Sheehan, 2010; Sugavanam et al. 2013; Clare et al. 2011; Scobbie et al. 2013), because of its association with motivation of change in health-related behaviours (Wade, 2009; Ries et al. 2014). In healthcare goal-setting articles, authors generally assert that introducing goal-setting into the clinical or rehabilitative care of individual patients enhances patient motivation, compliance, autonomy, health outcomes and satisfaction (Basset & Petrie, 1999; Clare et al. 2011; Constand & MacDermid, 2014; Sugavanam et al. 2013; Scobbie et al., 2013). It is also considered beneficial to both the therapist and patient (Hartigan 2012b) as it enhances the measurement of the effectiveness of therapeutic programs (Clare et al. 2011) and improves multidisciplinary team collaboration (Holliday, Ballinger & Playford, 2007). While there is a vast corpus of empirical evidence of the various dimensions of goal effects inpatient care, none is yet reported for public health interventions such as field leprosy projects. Certainly, none has proposed any possible way these individual goal effects may be related, as illustrated in the goal effects cycle.

Overall, the framework of goal effects cycle signifies leprosy managers' belief that the concept and practice of goal-setting are indispensable to the success of their field leprosy projects. Possibly, it also indicates their belief that goal-setting as a management intervention works in healthcare and has the power to motivate changes in their project towards improving implementation and therefore enhance their chance of goal attainability. These beliefs, therefore, should constitute a strong positive motivation for TLMN to adopt stakeholders' active participation at all levels of the TLMN organisational goal-setting practice.

7.7 Summary of this Chapter

This chapter discussed the structures and implications of the four frameworks that emerged from the themes of goal-setting stakeholders against published evidence in the available literature. The first tripartite framework of stakeholder roles indicated that there were three organisational levels of stakeholders' involvement in goal-setting activities. A top-down structure of TLMN goal-setting was revealed, especially by the passivity of the roles of field staff and community members in information gathering, their exclusion from the goal formulation activities at the top or national level, and the assigned project goals delivered to field managers from the top. The second framework of national goal-setting responsibilities showed the presence of a typical centralised structure with one national manager being responsible for the entire process of three general stages: pre-survey, baseline and post-survey. While virtually every literature evidence reports a therapist-led, patient-centred, and collaboration-based goal-setting. Which produces participative-set patient goals, as standard for clinical and rehabilitative healthcare programmes, the TLMN structure discovered was an organisation-led, project beneficiary need-centred and centralised goal-setting practice that produced assigned leprosy goals for field managers' implementation.

The third framework of goal types led to a literature-based discussion of the leprosy managers' beliefs about the definitions and classifications of goals. This revealed a framework of a range of five types of leprosy project goals differentiated according to their temporal and spatial hierarchies in the TLMN organisational structure. Lastly, the fourth framework relates to the theorisation

of a goal effects cycle based on leprosy managers perspectives and the possible theoretical linkages of the effects of goals. These were shown to clearly aligned with conceptual mediators that, according to Locke and Latham (2002), are evidence-based goal effect predictors in the goal-setting theory. These goal effects gave credence to the universal acceptance and application of goal-setting as an effective health behaviour change strategy in individual patient clinical and rehabilitative care. However, there is no evidence of past goal-setting research found to ratify this confidence in goal effects in any field of public health or leprosy intervention projects.

The next chapter (chapter 8) discusses the implications of the four theoretical frameworks that emerged from the final themes of goal-setting strategy in the TLM organisational practice.

Chapter 8

GOAL-SETTING STRATEGY FRAMEWORKS

“...Leprosy project goal formulation in TLMN is beneficiary need-oriented, problem-based and foundational to the development of project plans...”
(Section 8.6, last paragraph, page 209)

8.1 Introduction

This chapter discusses the four theoretical frameworks that emerged from the concepts of the second core theme of goal-setting strategy. These concepts generally describe the process of goal-setting and the pattern of goal formulation in TLMN. The steps of each framework are described in detail before their key concepts and implications are discussed later in the light of current knowledge in available goal-setting literature. The source literature materials were searched using five keywords or phrases of “goal-setting strategies”, “organisational goal-setting process”, “preparatory process for goal-setting”, “baseline needs survey for goal-setting” and “goal hierarchies”.

Like in the previous chapter, this chapter begins with a discussion of the conflicts found in the perspectives of the national and field leprosy managers regarding the concepts from which these goal-setting strategy frameworks were developed.

8.2 Conflicts in opinions of National and Field managers

8.2.1 Goal-setting process

It was entirely a national opinion that a problem tree analysis of the findings of the baseline needs survey was done at the national office. This involved a process of discussing the needs of project beneficiaries and making conclusions about the project problems that would be addressed during the goal formulation stage. Similarly, it was the opinion of national managers that project and community-based stakeholders validated the assigned leprosy goals before the goals were finalised and approved for implementation at the national office. It was also their opinion that the finalised project goals and plans were shared with stakeholders at NCO, donors and the target communities. However, there

were a lot more of the perspectives that were specifically those of only field-based managers than those that were of only national managers.

Clearly, it was a field opinion that the national managers identified the community areas targeted for intervention before goal-setting; goals were formulated before project implementation; information in their project reports was used for needs assessment and goal-setting. Also it was a field opinion that they were sent an electronic communication from the national manager responsible for goal-setting, Mr B., to inform them about his intended field visit for baseline survey. Likewise, the notion that a community needs assessment was done during the baseline survey was strictly that of field-based managers, who also claimed that the goal formulation and the subsequent project planning done at the national office used the results of the baseline needs assessment. Furthermore, the opinions about what happens during and after the field validation of project goal statements and plans post-design were those of field managers alone.

However, there were more areas where the national and field managers had the same opinions or similar perspectives. First of these was the notion that there is a multi-staged goal-setting process. The national managers particularly used the phrase “different stages”, and the field managers referred to them as the “steps” followed. Secondly both levels of managers agreed that the project concept was developed during the national manager’s field visits to the targeted beneficiaries and their communities. Thirdly, the perceptive of a baseline survey was held by both categories of managers as well. Both agreed that the community members were the primary sources of needs data used for goal-setting and, that, the field survey was the first real step of the goal-setting process. However, the opinion that the baseline survey was done before project implementation was obtained from the field-based managers, just as the opinion that focus group discussions with beneficiaries were conducted during baseline survey belonged to only the national managers. Fourthly, both levels of managers also agreed that some initial data analysis was done during the field survey. A field manager described this as filtering community information, while to a national manager, it was making sense of survey data.

Fifthly, both levels of managers shared the view that the initial project planning discussion was done during the survey. Yet, they differed on what was discussed in the field. While the national managers mentioned discussing the country strategy and deciding the type of project suitable for the communities, the field managers specified discussions of the project objectives and activities, which covered issues such as the desires of the communities and the feasibility of the proposals. Sixthly, the opinion that the goal formulation stage occurred at the national office was held by both national and field managers. According to the national managers, goals were formulated at the national office using participatory round-table teamwork headed by Mr B. The field managers were definite that all goals were formulated by TLMN technical persons without the involvement of field project staff. Lastly, both field and national managers agree that the goal statements were written at the national office. The national managers gave the information that the statements were written collaboratively with a small group at the office.

Differences in perspectives between people who formulate goals and those for whom goals are assigned have been reported by past research, such as the qualitative study of patient and professional perspectives of patient-centred goal-setting by van Seben, Smorenburg and Buurman (2019). This study done in The Netherlands reported the different ideas about the goals formulated for patients and different expectations therapists and their patients have from the goal-setting process (van Seben, Smorenburg & Buurman, 2019). Despite the areas of conflicts and agreements in opinions of national and field managers in this research, the four frameworks discussed in this chapter evolved from themes developed from all responses relating to the goal-setting strategies in TLMN organisational practice, irrespective of whether the respondents were national or field leprosy managers.

Overall, the areas of conflict indicate the national managers were exclusively knowledgeable of the centralised goal formulation processes that happened in the national office. On the other hand, the field managers were particularly aware of the community-based components of the process, especially the needs assessment activities done during the baseline survey stage. Likewise, the areas of shared perspectives indicated that both national and field

managers were agreed on the general goal-setting strategy of TLMN, the field process of the baseline survey and the central location of the goal formulation process. On the whole, the areas of both conflict and agreement suggest there was consensus among the leprosy managers that field-based managers participated at the baseline survey stage, but were excluded from the post-survey stages when goal formulation and project planning were done.

8.2.2 Goal formulation pattern

The concept that TLMN formulated a goal mix was mostly the opinion of national managers. They specifically mentioned that the mix of goal types for leprosy projects included short-term, medium-term and long-term goals. Few field managers also mentioned short-term and long-term goals but stated “mid-term” in place of “medium-term” goals. While both levels of managers explained the meanings of the goal types, short-term goals were defined particularly by national managers as expressions of project-specific outputs and operational level goals. The field managers believed most of their goals were short-term and which are activity performance goals. The terms ‘intermediate goals’ were used by both national and field managers. While both levels of managers believed projects had long-term goals, national managers alone specifically described them as the overall goals of the projects.

Responses from both national and field managers suggested the formulation of project-specific goals, specific objectives were mentioned by national managers. Similarly, organisational goals were mentioned by both as the strategic goals of TLMN organisation. As put by a field manager, they are ‘What ... you want to achieve as an organisation’. That the goals were timed also was the impression of both levels of managers. However, but they differed regarding the timeframes specified for each goal type. National managers believed short-term timeframes that ranged from three to 12 months, medium goal was three years and long-term goal was five years or more. The field managers also gave a range from a quarter to one year for short term goals, but one of them stated they could have a timeframe as short as one month. Field managers generally gave longer timeframes for intermediate and long-term goals than the national managers. To the field managers the timeframe in an intermediate goal could be as long as 5 years, and the long-term goals could be up to 5 years, 10 years

and more. I believe since the goals were formulated by the national managers, they, therefore, knew the goal constructs and contents better than the field managers who merely implemented activities to achieve the assigned goals.

In addition, it was a field perspective that project goals were linked to national goals and objectives. There was also the observation that multiple goals were formulated for each project. Nevertheless, it was the opinions of field managers that the frequency of goal-setting was determined by the duration of the projects and that goal-setting occurred before the commencement of the projects. These field opinions gave the understanding that goal-setting of their leprosy projects in TLMN practice was not an annual event, but one that depended on the cycle of each project. Also notable was the report by field managers who were leprosy control officers that no TLMN goal-setting is done for their leprosy control projects because they were excluded from the project planning activities of TLMN altogether. Without doubt, there was paucity of views on goal formulation pattern specific to the national managers, principally because of the few numbers interviewed and their interviews happened earlier during the data collection process. Thus, while signifying a weakness of the evolving nature of the qualitative data collection process used, the situation indicates that a preponderance of field managers' perspectives produced the conceptual themes from which the frameworks of goal statements were generated in this research.

8.2.3 Differences in Goal Types

Both national and field managers shared the opinion that goal types can be differentiated according to the timeframe. There was also agreement between the managers that the goal types differed according to the written statements, but the notion that long-term goals were non-SMART statements of change while medium-term goals were SMART outcome level objectives was a national perspective. Specific to field managers was the perspective that goal types can be differentiated according to the desired accomplishment, and the activities to be done. Conversely, only national managers perceived that their goal types were differentiated according to available funding, measurement of the goals, the type result expected to be achieved (whether outputs of the short-term goals or outcomes of the medium-term goals), the level of stakeholders involved in

the goal formulation, and the level of the plans in which the goal statements are written. Hence, it was a national impression that strategic objectives were written in the plan of country strategy, medium-term goals were in the project plan, and the short-term goals were in the operational work plans. Similarly, national managers had the notion that the projects long-term goals were linked to the organisational strategic plan. Thus, it would seem obvious that the different opinions of field and national managers could be explained by their different responsibilities as shareholders in the implementation and assessment of the leprosy projects (see the framework of stakeholders' roles in Figure 7.1, page 179). Therefore, the field-specific perspectives show their statutory operational connection with implementing and accomplishing activities, while those specific to national managers show their association with resources, goal formulation process, project monitoring and achievements at the organisational level.

However, both national and field managers shared the perspective that there is a logical linkage of the goals formulated for leprosy projects. However, the formulation of different objectives under one long-term goal was a field perspective, while the use of a project framework and project logic in formulating project goals and activities to create this logical linkage was national. In addition, both levels of managers shared the impression that project implementation of activities was linked to the achievement of project goals, and project objectives were connected to the strategic areas of the TLMN organisational plan. But it was entirely a national perspective that the shorter-term goals and medium-term objectives were linked to the overall or long-term goals, and the overall goals were linked to the country strategy. Nevertheless, the field managers also believed that attaining the mid-term goals contributed to achieving the long-term goals. A field manager particularly stated that project goals, objectives and activities should be "speaking together".

Hence, the national opinion of the linkage of project activities and goals was supported by the field perspective that activities in the project plan were derived from objectives, and at the same time, the short-term goals were formulated based on the activities. Thus, it was the understanding of field managers that the outline of activities in the project plans was planned based on the expected

outcomes and impacts expressed in the objectives and long-term goals respectively. However, the culmination of both shared and different opinions of field and national managers show there was a consensus that there is a linear, progressive, hierarchical and logical linkage in the relationship between formulated goals and the activities planned and implemented to achieve them (Figure 8.1).

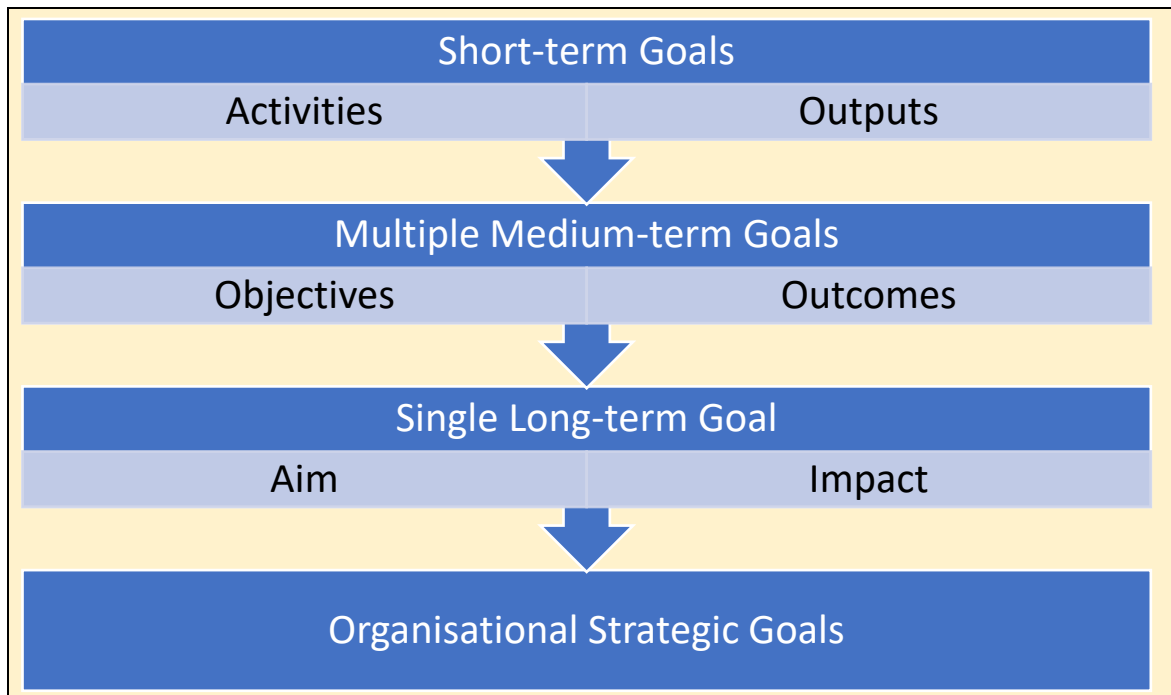


Figure 8.1 Logical and hierarchical linkage of activities and goals in TLMN

8.3 Framework of Goal-setting Process

According to the concepts identified from leprosy managers' responses, TLMN used a 10-staged process for goal-setting. The first four stages in Figure 6.7 (page 136) suggest the goal-setting process began with preparation at the national office before the baseline survey of beneficiaries' needs in project communities. The process then continued with problem analysis and formulation of goal statements in the national office. The next stage was when the formulated goal statements were utilised for planning project activities and the related work plans, also at the national office. Subsequently, the responsible national manager executed the stages of feedback and validation of the drafted project goals and plans. These are the times when he consulted with the peripheral stakeholders to seek their agreement with centrally formulated goals

and plans of their leprosy project before they were finalised and approved for implementation. The last two stages of sharing and meetings with field officers were essentially when the project plans were disseminated after organisational approval.

A reflection on these 10 stages and their component activities enabled further integration of the goal-setting process into four general stages (Figure 8.2). This reduced framework indicates that, overall, the goal-setting process begins from the preparation at the national office and progresses through the field-based survey to goal formulation activities at the national office. All other stages after goal formulation were considered part of the project planning process and so put under the same heading (Figure 8.2).

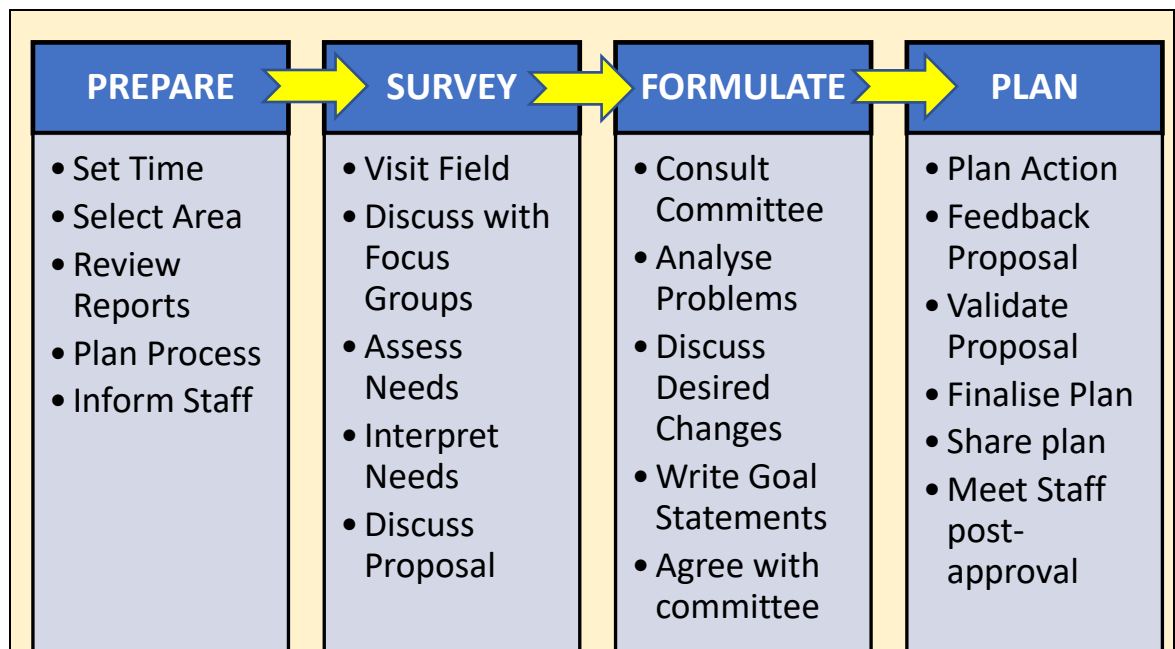


Figure 8.2 A general framework of stages of the goal-setting process of TLMN

This shows that the entire goal-setting process aligns with the three-staged framework of national goal-setting responsibilities of Mr B, except for the fourth stage that was essentially the planning component of his post-survey responsibilities (Figure 8.2). The integrated framework (in Figure 8.2) also indicates that the next two frameworks of national preparation and field baseline survey activities correspond to the first two stages that preceded the goal formulation stage in the general goal-setting process. Most published articles on goal-setting do not describe the framework or the process of the goal-setting

practice studied. Specific empirical research on the goal-setting process is rare. One published goal-setting model with a four-stage process (like the TLMN's in Figure 8.2) is the Goal-setting and Action Planning (G-AP) Framework. This was developed with the guidance of the Medical Research Council (UK) and recommended for collaborative goal-setting in clinical patient rehabilitation programmes (Scobbie et al. 2013).

This originally evolved from the study by Scobbie, Dixon and Wyke (2011) that used causal modelling to map out the process of goal-setting and planning for goal attainment from behavioural change theories. The G-AP framework includes goal negotiation, goal-setting, action planning, and appraisal and feedback (Scobbie, Dixon & Wyke, 2011; Scobbie et al., 2013). According to Scobbie et al. (2013: 4), the stage of goal negotiation involves “identifying general problem areas and goals” of the patient with the participation of the patients in the process. The goals negotiated at this stage are usually the changes expected by the patients, therapists, families and the multidisciplinary team. Thus, this initial stage in the G-AP framework seems like the baseline needs survey, done at the second stage of the general TLMN goal-setting process (Figure 8.2).

Likewise, the second goal-setting stage in the G-AP framework, when the identified general problems and goals are refined and formulated into specific problems and goals (Scobbie et al. 2013), is similar to the TLMN's third stage goal formulation stage, shown in Figure 8.2 to involve problem analysis and formulation of goal statements. According Scobbie et al. (2013), the third G-AP stage of Action planning is when “... a series of ‘stepping stones’ or ‘targets’” is set as activities to be performed as “a manageable route to achieving specific goals.” This stage clearly also aligns with the fourth stage of project proposal planning, validation and finalisation in the TLMN process (Figure 8.2). However, the G-AP framework is different from the TLMN process by the inclusion of another stage of appraisal and feedback when both therapists and patients monitor the progress of the patients on the goals agreed (Scobbie et al. 2013). In contrast, Lenzen et al. (2017) identified a five-stage process from their scoping review of research literature on self-management goal-setting and action planning. Even though the framework has the same concept as the

Scobbie et al.'s (2013) G-AP framework, the divisions and nomenclature of the main steps of the process identified by Lenzen et al. (2017) bear little resemblance with the four steps of the former. Instead of beginning with goal negotiation and going through goal-setting and action-planning to end in goal-appraisal and feedback (Scobbie et al. 2013), the five steps identified by Lenzen et al. (2017) include preparation, goal formulation, action plan formulation, coping planning and follow-up. Nevertheless, the two G-AP frameworks are similar in their component activities. The preparatory activities in Lenzen et al.'s (2017) framework that includes patient education and goal identification seem to align well with Scobbie et al.'s (2013) goal negotiation stage. While their second and last steps of goal-setting and appraisal/feedback/follow-up respectively are essentially the same, the separate stages of action planning and coping planning in Lenzen et al.'s process are seemingly combined in Scobbie et al.'s action planning step.

On the other hand, Conneeley (2004), Leach et al. (2010), Hartigan (2012a) and Furze (2015) describe a three-stage goal-setting process for collaborative goal-setting during patient-oriented rehabilitation. Citing Conneeley (2004), Hartigan (2012a), outlines this process as generally including goal identification, goal assessment and goal agreement, in which the first two stages conform with the goal negotiation stage of the G-AP framework and the third stage seems aligned with G-AP's goal-setting or formulation stage (Scobbie et al., 2013; Lenzen et al., 2017). Hartigan (2012a: 67) explains that it is during the third period, about 2 weeks after the initial assessment that "the therapist, patient and relative met to discuss and agree on goals." Thus, the three-stage framework identified by Hartigan (2012a) from the study by Conneeley (2004) lacks the post-goal setting stages identified by Scobbie et al. (2013) and Lenzen et al. (2017) as planning action and coping strategies and appraisal, feedback or follow-up stages of G-AP frameworks. These missing stages are probably what Furze (2015) incorporated in her three essential steps for a person-centred goal-setting. The stages according to Furze include goal identification, goal-setting and goal monitoring, feedback and reinforcement, based on the motivational behaviour change goal-setting theory (Locke & Latham 2002).

However, in a later review of published literature on goal-setting processes in stroke rehabilitation, Hartigan (2012b), identified a different process for the three goal-setting approaches of therapist-controlled, therapist-led and patient-centred, ascribed to the earlier studies by Leach et al. (2010) and Law et al. (1990). While the processes of the therapist-controlled and therapist-led approaches involved some form of assessments of patients' impairments and problems before a later goal-setting stage (Leach et al 2010; Hartigan, 2012b), the patient-centred process as reported by Law et al. (1990) and Hartigan (2012b) uses a structured template, the Canadian Occupational Measure (COPM), to produce patient goals which are then discussed with the patients and their families at a goal negotiation stage. Leach et al.'s (2010) own report of the three approaches, outlines only the process of the therapist-controlled goal-setting as having three stages of impairment-based assessment, problem identification and goal-setting. Contrarily, the processes of the other two approaches (therapist-led and patient-centred) have more stages: at least five.

Also, differing from Law et al. (1990), the patient-centred process reported by Leach et al. (2010), has the impairment-based assessment activity in its third stage. This is after the therapist's description of the goal-setting procedures to the patient and the patient's goal identification in the first and second stages respectively. The assessment stage is before the stage of collaborative goal-setting, when both therapist and patient work together to agree on realistic and measurable goals, in the fourth stage (Leach et al. 2010). Another goal-setting process framework is described by Friesen-Storms et al. (2018) as a four-stage iterative and developmental process that includes problem identification, 'identification' of overall objectives, intervention planning or design, and pretesting and adapting the intervention. In a way, these four stages appear similar to goal negotiation, goal-setting, action planning and appraisal stages of the G-AP framework by Scobbie et al. (2013). Hence there are many, and conflicting process frameworks being used for goal-setting in patient-centred care, but most have similar component activities in different steps and headings.

Nevertheless, the TLMN organisational four-stage process framework of goal-setting for leprosy projects is considered conceptually different from these

myriads of frameworks already existing for the patient-oriented goal-setting practices of clinical and rehabilitative healthcare programmes. Furthermore, TLMN's four-stage goal-setting process is different from the three-stepped process of organisational goal-setting reported by Cyert and March (1963) and cited in Kotlar and De Massis (2013) as a popular framework applicable in the business sector. According to these authors, the steps of goal-setting in an organisational context begins with the stage of coalition formation, when coalition goals are formulated; before the stage when goals are made realistic and aligned with the organisational control systems; and ends with the stage when the organisational goals are updated according to experience gained during their implementation (Kotlar & De Massis, 2013). Thus, the TLMN goal-setting practice uses a framework that is unique and not previously reported in empirical goal-setting research.

8.4 Framework for Goal-setting Preparation Process

This framework is an elaboration of the first of the four general stages identified in TLMN organisational goal-setting process. The flow chart in Figure 6.8 (page 137) shows the framework is a series of five national tasks or activities that are preparatory steps for the conduct of the field baseline survey and planning of the entire goal-setting process. Theoretically, the framework illustrates that preparation for goal-setting and project planning begins with determining a timeframe for conducting the exercise and defining a project area. The project area constitutes the beneficiaries and their communities targeted by the intervention being conceptualised. The next stage could be best described as a desk review or gathering of background documentary information on the project area. This information enables the next stage of planning the specific activities of the goal-setting process, the result of which is then communicated to stakeholders who will be involved in the goal-setting process (Figure 6.8).

A further reflection of these five preparatory steps led to the combination of the first two under one general heading of "Concept Development" in terms of time and place of the proposed intervention. The next three steps could be re-labelled with the headings of "Desk Review" or "Information gathering", "Process Planning" and "Stakeholder Communication". Figure 8.3 shows these

general four steps of the preparation stage of TLMN's goal-setting process based on these revised headings. This general framework suggests that preparation for goal-setting begins from conceptualisation, and ends with communication, with background review and planning of the process in between.

Description of a preparation stage in a goal-setting process in previous empirical research work is rare. Evidently, neither the G-AP process originated by Scobbie et al. (2013) nor the three approaches identified by Leach et al. (2010) and Hartigan (2012a and 2012b) nor the essential steps by Furze (2015) nor the iterative process outlined by Friesen-Storms et al. (2018) mentioned an initial preparatory stage done as part of a goal-setting process framework, which was identified as the first stage in the TLMN practice. However, the editorial by Wade (2009: 293) describes the initial step of patient goal identification and assessment of goal feasibility in a formal therapist-led goal-setting process as the preparatory stage. According to Wade, this preparatory stage comes before the later stages of information sharing and goal negotiation, and goal documentation for progress evaluation.

Still, what Wade describes as a preparatory stage does not fit the definition of a preparation stage in the context of TLMN organisational goal-setting practice. Talking about preparation process in terms buyer's goal orientation and practice in the business sector, Schoenherr and Mabert (2014: 384) assert that "information search" and "extent of analysis" are the two most frequent activities that define the preparatory stage. Accordingly, Schoenherr and Mabert (2014: 384) refers to "the effort expended to search for information in preparation for negotiations" and "the amount of effort invested in the examination and evaluation of the collected information" as preparatory events for goal-setting. While these definitions aptly fit the description of the review of background information of target communities in the TLMN goal-setting preparation process, the extent to which information search and review are done in Wade's (2009) therapist-led goal-setting process is unremarkable.



Figure 8.3: General theoretical steps of the preparation process for goal-setting

Nevertheless, it is notable that the five-stage goal-setting process identified by Lenzen et al. (2017) is the only framework that specifically delineates a preparation phase as its first or initial stage. In their scoping review of literature on the goal-setting process, these authors identified a preparation phase in the process described by the majority (85%) of the 58 articles reviewed. While this may imply that a preparation stage is commonly reported in literature contrary to my earlier statement, the three-component activities or steps in the preparation phase identified in reviewed literature by Lenzen et al. (2017) are clearly different from the four general preparation steps in TLMN framework (Figure 8.3). The preparatory activities and steps evidenced in literature include patient education, patient reflection and identification of goal-setting topics (Lenzen et al. 2017).

8.5 Framework of Baseline Survey

This framework is also an expansion of the second stage of the goal-setting process framework in TLMN practice (Figure 8.2). The component steps are

five survey activities illustrated in Figure 6.9 (chapter 6, page 140), which illustrate the process of problem identification for goal-setting. The survey process also implies that the problems on which leprosy project goals were based emerged from a structured procedure of investigation of the perceived or expressed needs of the community-based beneficiaries. The framework of survey activities shows the process begins with the national manager making a field visit, and then conducting focus group discussions with community beneficiaries in the target project area. It continues with assessment and interpretation of their expressed needs, before the discussion of proposed changes or problems for intervention at the end. A further reflection on these steps enables reduction of the steps into three broad stages of field exploration, needs assessment, and problem identification (Figure 8.4).

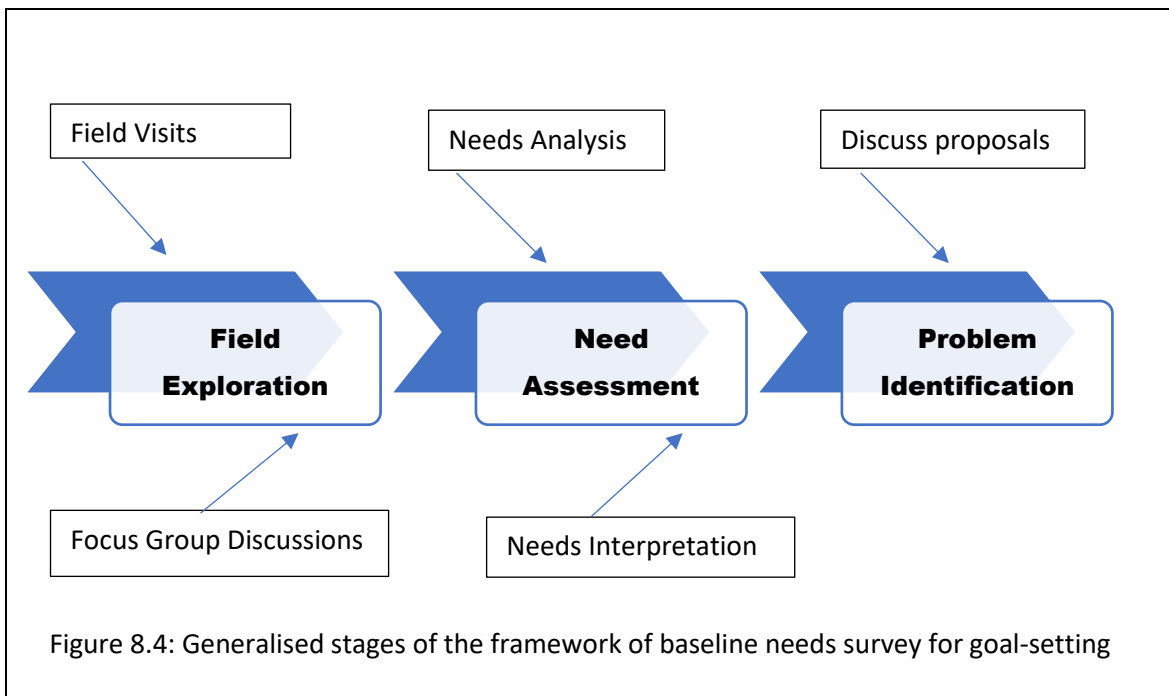


Figure 8.4 shows the first and second steps of field visits and focus group discussions could be categorised under the first general heading of field exploration. The third and fourth steps could be categorised into the second general heading of Needs Assessment and the fifth step re-labelled as problem identification. Practically, no previous empirical research or ad-hoc report on goal-setting has described a specific event of field-based baseline survey as a separate stage of the process. This could be because almost all articles on the goal-setting process in health care report the patient needs assessment as an

integral part of the goal negotiation stage as practised in clinical and rehabilitation settings.

Nevertheless, the goal-setting framework of baseline survey indicates that goal formulation in the TLMN organisational practice is a problem-based approach. This seems to be the common approach inherent in the processes of many frameworks already recommended in healthcare goal-setting generally. Identifying problems from patient needs or impairment assessment is one of the activities done during the first stage of the iterative development process (Friesen-Storms et al. 2018); therapist controlled or therapist-led processes (Leach et al. 2010; Hartigan 2012a;), goal-setting and action planning (G-AP) practice framework (Scobbie, Dixon & Wyke 2011; Scobbie et al., 2013), and the RAID model of continuous quality improvement framework (Parker et al. 2003).

A postal survey of goal-setting methods in rehabilitation by Holliday, Antoun and Playford (2005) found that most commonly, the patient goal-setting approach is oriented towards identifying and addressing patients' problems and needs. Hence, these authors inferred that there is a connection between a problem-orientated goal-setting approach and assigned goals given by therapists to the patient (Holliday, Antoun & Playford 2005). But the proposed linkage might not hold true for TLMN's situation of top-down goal-setting approach and the assigned goals that it produced, because the baseline survey of needs and problems was done collaboratively with project and community stakeholders. Nevertheless, despite the popularity of need-based and problem-oriented goal-setting, Nijhuis et al. (2008) still found that just about half of the 95 rehabilitation goal constructs formulated for children with cerebral palsy had any relationship with the needs or problems of the patient. Similarly, in a multicentre study of 351 documented goals in inpatient stroke rehabilitation conducted by Plant and Tyson (2018), while most goals are patient disability-related, a significant proportion of them is non-patient directed, but rather oriented towards the requirements of staff and families.

8.6 Goal Formulation Process

In the TLMN general goal-setting process framework (Figure 8.2), goal formulation activities were done during the third stage by a steering committee of national stakeholders. They analysed the baseline problems of target communities, using a problem-tree approach, and translated them into goal statements for leprosy projects. The responses of the core national manager indicated that constructing and writing the goal statements at this stage was based on consultation and agreement with this national committee. Hence, even though no further reduced framework could be developed for this stage, the process of leprosy goal formulation has two main component activities that illustrate a centralised multi-sectoral committee team goal-setting approach like the professional multidisciplinary team goal-setting reported in most clinical and rehabilitation healthcare settings. According to Kramer, Thayer and Salas (2013: 287), a team is a 'Distinguishable set of two or more people who interact dynamically, interdependently and adaptively towards a common valued goal/objective/mission and who have been assigned specific roles or functions to perform and who have a limited lifespan or membership.' Research in goal-setting indicates there is a substantial difference between team goal-setting and individual goal-setting, mainly because the team approach enables different members to discuss and contribute to the formulation of goals at different levels of the organisation, and members suppressing their personal goals in favour of the joint or cooperative goals of the team (Weldon, Jehn & Pradham 1991; Kramer, Thayer & Salas 2013).

However, in TLMN organisational practice, the goals set by the goal-setting committee members at the national level cannot be said to be cooperative goals because the field project managers, the end-users of the assigned goals, were excluded from the goal-setting committee. The TLMN practice of team goal-setting appears similar to the multidisciplinary goal-setting in acute rehabilitation setting described by Thomson and Black (2008: 423) as a process in which a group of therapists "meet together ... to discuss and set joint goals *for* patients once their individual assessments have been completed." They contrasted this from uni-disciplinary goal-setting in which individual therapists formulate their separate goals for a patient, who then ends up having several individual goals

from different therapists. Nevertheless, many goal-setting authors assert that there are many advantages of team, group or multidisciplinary goal-setting over individual goal-setting. Thomson and Black (2008) found that multidisciplinary goals were significantly more specific, measurable, realistic and timely than the uni-disciplinary ones. According to Kramer, Thayer and Salas (2013), team goals motivate goal commitment (a combination of individual belief of goal importance and self-efficacy or goal achievability), interdependence and collaboration.

Similarly, Plant and Tyson (2018) believe team goal-setting improves multidisciplinary communication and collaboration. In Yu et al.'s (2015) view, the process of interprofessional team goal-setting aids shared decision-making. Agreeing from goal-setting in a sports setting, Arraya, Pellissier and Preto (2015) assert that team goal-setting aids group goal orientation, collectivism (preference for collective goal over individual or personal goals) and group motivation towards performance and goal attainment. Therefore, inherent in the definition of multidisciplinary goal-setting process is collective decision making (Rosewilliams, Roskell & Pandyan, 2011) through brainstorming about the current and desired states (Friesen-Storms et al. 2018). It enhances change through team effort and functioning (Meesters et al., 2013). Arraya, Pellisa and Preto (2015) and Groen (2018) stress that participation of all goal stakeholders in the process of formulating the goal is the vital factor that inspires goal commitment, ownership, and collaboration by a team. According to Groen (2018:10), participatively set goals "increase self-efficacy by stimulating information exchange between employees and their superiors."

Therefore, even though they collaborate with Mr B. during the baseline survey stage, the exclusion of field leprosy managers from the national goal-setting committee means the TLMN leprosy goal formulation process is not sufficiently participatory. Thus, the team goal-setting in TLMN's context may not have created the social dynamics leading to collectivism, commitment, ownership and collaboration theoretically associated with multidisciplinary team goal-setting (Arraya, Pellisa and Preto 2015; Groen, 2018; Rosewilliams, Roskell & Pandyan, 2011; Yu et al., 2015; Kramer, Thayer & Salas, 2013; Plant & Tyson, 2018). However, despite its advantages, Wade (2009) asserts that

multidisciplinary goalsetting is only indicated where a patient's problem is too complicated and diverse to be handled by a single therapist. How far does this opinion support the centralisation of goal-setting in TLMN practice?

However, the six activities categorised by the fourth stage of planning in TLMN organisational goal-setting framework indicates the national attempt to involve field leprosy managers in the later stage of the goal-setting process. Apparently, while the project planning based on formulated goals is still done nationally, the post-planning steps, when national managers give feedback to the field managers in order to validate the proposed plans with their comments, may represent an effort to secure their agreement with the project goals and plans assigned. Thus, inherent in TLMN's goal-setting and action planning framework is a conscious intention to produce agreed goals and plans from a process that involved national and field stakeholders at different stages. According to Kotlar and De Massis (2013: 1265), it is essential to involve stakeholders at different levels of an organisation in formulating organisational goals in order to prevent a flawed implementation.

Overall, the organisational goal-setting framework reveals that leprosy project goal formulation in TLM Nigeria is beneficiary need-oriented, problem-based and foundational to the development of project plans. This also directly means that the project plans developed for leprosy projects following this process are *goal-based*. Even though the goal formulation is nationalised or centralised, there seemed to be episodes of collaboration and consultation with national and field leprosy managers at other stages in the goal-setting process.

Nevertheless, the goal statements that are the products of this framework were typically assigned goals, because of the exclusion of field managers from participation in the steering committee that formulated their project goals.

8.7 Framework of Goal Formulation Pattern

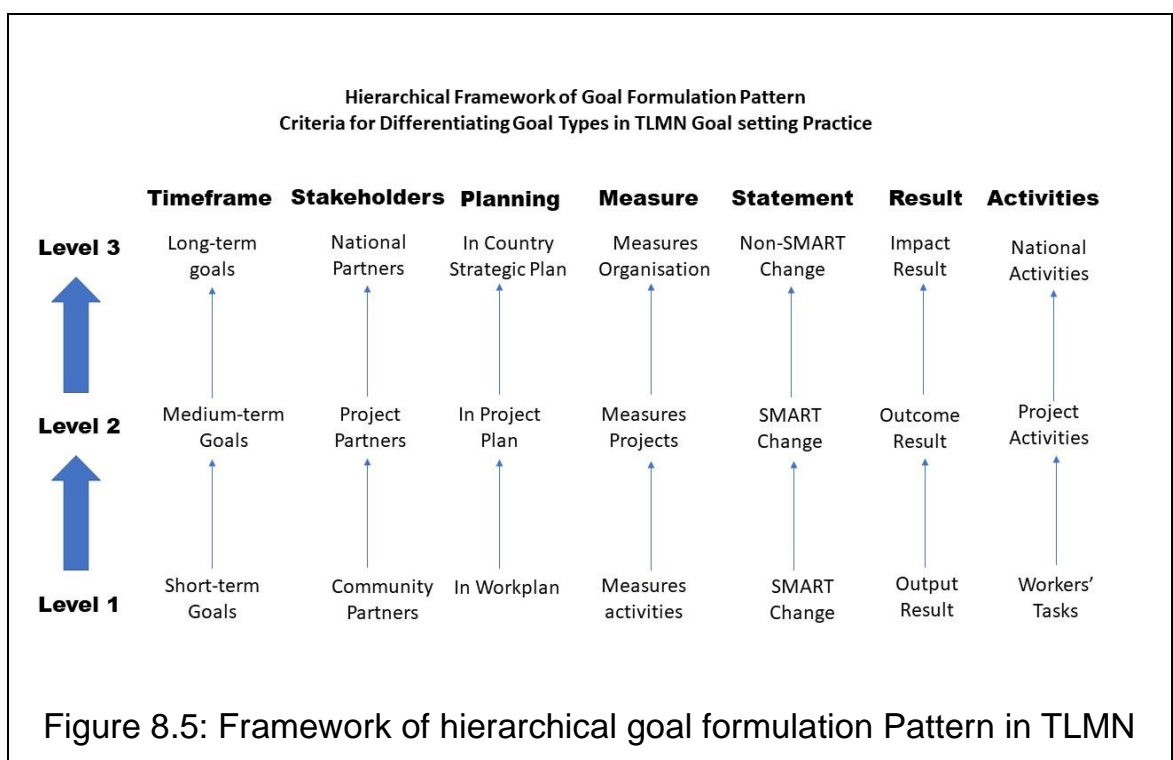
The framework in Figure 6.11 (Chapter 6, page 155) illustrates the pattern of goal formulation in TLMN practice according to seven concepts, including goal types, goal timeframes, goal differences, goal linkages, target setting, goal formulation and leprosy control goal-setting. Most of these illustrate a

hierarchical pattern of the leprosy project goals formulated in TLMN practice. This framework shows there is generally a mix of three types of goals formulated in the plans for project implementation: short-term, medium-term and long-term. This conflicts with the framework of five goal types discussed in chapter 6 (section 6.4.2) and which were evolved from leprosy managers' general perspective and knowledge of goal types. The three general goal types evolved from the category building of goal-setting pattern from the leprosy managers' description of the actual goal-setting practice of TLMN organisation for their leprosy projects. Therefore, there seems to be a discrepancy in the goal types developed from the leprosy managers' descriptions. However, the range of three goal types evolved from a further integrative reduction of goal types from the original five. Apparent in this integration, the short-term activity goal type was grouped with the immediate output of activities in the staff's workplans as this seemed to align with the perspectives of the national managers. Similarly, the project's overall terminal goal was aligned with the organisational strategic goal, because both are conceptually linked to a long-term timeframe. However, the medium-term goal type still relates to the intermediate outcomes, which in both frameworks refer to the project-level specific objectives.

Clearly, the three general goal types in the goal formulation pattern appear related to a three-level hierarchy of goal timeframes associated with different set durations for achieving each goal type. While a difference in opinion between the national and field managers emerged, the general perspective is it takes about three months to achieve a short-term goal, three years for a medium-term goal and at least five years for a long-term goal. In addition, the framework indicates that the three types of goal and timeframes are directly linked to three levels of goal-setting stakeholders, organisational planning, measurement, type of statement, type of results, and implementation (Figure 8.5).

Overall, based on the hierarchical pattern of TLMN goals illustrated in the framework in Figure 8.5, three propositions could be made. First, the short-term goals achievable in about three months are theoretically related to the involvement of community stakeholders, planning of work plans, measurement

of activities, and output results. Secondly, at a higher level, the medium-term goals achievable in about three years may be related to involvement of project stakeholders, planning of project plan, measurement of the project-level achievements, formulation as SMART change, outcome-level results and implementation of project activities. Thirdly, the long-term goals achievable in five years or more could be related to involvement of national stakeholders, planning organisational strategic plan, measurement of organisation-level achievements, formulation as non-SMART goals, and implementation of national activities.



Although not in the original framework (Figure 6.11, page 155), as shown in Figure 8.5, some organisations and goal-setting authors have associated output related goals with formulation as SMART change, work plans with implementation of individual workers' tasks and long-term goals with expression of impact-level results (Save the Children 2003; Ogbeiwi 2016). Therefore, besides funding availability claimed by national managers to determine the project duration, the concepts in this framework of hierarchical goal pattern provides a three-level theoretical model of seven thematic criteria that could be used for differentiating the three goal types in the TLMN goal-setting practice,

including the spatial and temporal dimensions revealed in the framework of goal types in section 6.4.2.

This framework of TLMN goal-setting pattern is supported by Playford et al. (2009: 338) who assert that “Goals can be classified across many hierarchies covering different time scales, different organisational levels for interactions (e.g. from whole organisations to single individuals), different aspects of an illness, and different contexts...” and by Ogbeiwi (2018) who reports that types of goals differ according to their different levels of measurement, goal-setting approaches, cognition, localisation, target, clarity and purpose. Playford et al. (2009) and Ogbeiwi (2018) also agree with the three-level pattern of goals set along different scales, which essentially differentiates long-term goals, intermediate goals and short-term goals. Ogbeiwi (2018) asserts that “Goals are differentiated on a linear directional framework into three levels of work results,” including output as immediate goal, outcome as intermediate goal or objectives and impact as terminal goal or aim.

Likewise, Playford et al.’s (2009) definitions of long-term and intermediate goals as aims and objectives respectively agree with the leprosy manager’s explication of these goals in the TLMN goal-setting practice. Also, their rendering of short-term goals as operational targets seems technically similar to TLMN’s understanding of short-term goals as targeted accomplishment of activities within a three-month period. At the same time, Playford et al.’s view of short-term targets may also align with the TLMN definition of outputs and understanding as immediate results of activities in development sector (DAC-OECD 2002). This may indicate there is an interchangeable interpretation of the terms relating to short-term goals and outputs in the article by Playford et al. (2009), as was possibly the understanding among the leprosy managers in TLMN goal-setting practice. In addition, Playford’s conceptual linkage of short-term targets to intermediate objectives, which in turn are linked to long-term aims is in line with the hierarchical linkages between the different goal types in both TLMN goal-setting pattern (Figure 8.5) and the illustration of general concept of goal types in Figure 2.1 (page 33).

The hierarchical pattern of goal types has also been described by other goal-setting studies as discussed in the literature review in Chapter 2. There is therefore abundant evidence to the conclusion that goals differ hierarchically according to the contextual, structural and functional characteristics of the goals (Ogbeiwi 2018). According to Ogbeiwi (2016), these goal characteristics enable the differentiative definition of different goal types using seven conceptual themes: the object (the desired change or effect), scope (extent of specificity), hierarchy (organisational or project level), timeframe, measurability, significance and expression. On these themes, goals with a long-term timeframe also have an object of impact, a broad scope, and overall or terminal hierarchy. Also, they are not measurable quantitatively, they possess the significance of purpose, value or success and are expressed as qualitative non-SMART statements (Ogbeiwi 2016).

These themes also differentiate intermediate level goals as objectives with a short-term timeframe, outcome as the object and specific scope. They are also quantitatively measurable; indicators of effectiveness and expressed as SMART statements. In the same way, outputs are thematically distinct as specific, measurable, immediate-term goals. However, this immediate goal type is not clearly differentiated from level 1 short-term goals in the TLMN's framework of goal-setting pattern illustrated in Figure 8.5. Thus, the theoretical themes by Ogbeiwi (2016) are only partially applicable to the emergent concepts of hierarchical goal pattern discovered in TLMN practice.

Contrarily, TLMN's hierarchical goal-setting pattern appears entirely different from the goal pattern reported in clinical and rehabilitation settings. In the healthcare setting, the hierarchies of goals developed for individual patients are commonly guided by the World Health Organization-recommended international classification of function, disability and health (ICF) (see Figure 8.6) (McLeod & Bleile 2004; Leach et al. 2010; Fernandez et al. 2012; Meesters et al. 2013; Brown & Vickers, 2015; WHO 2016).

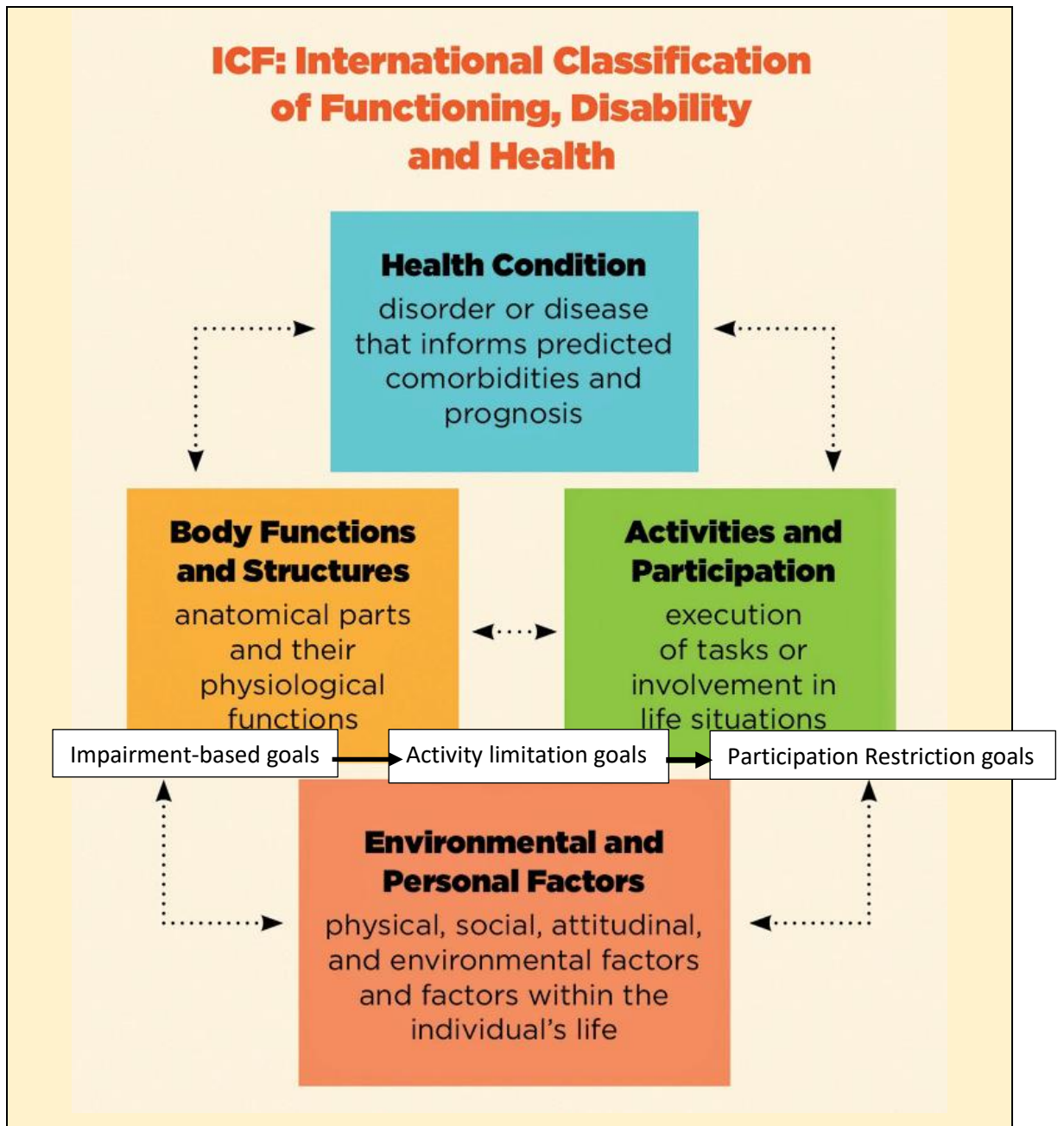


Figure 8.6: ICF Framework used in Clinical and Rehabilitation patient-oriented goal-setting. (Brown and Vickers, 2015)

Generally, similar to the TLMN goal pattern framework, the ICF enables a three-level hierarchical goal-setting pattern, in which improvement goals, whether short-term or long-term or both, are formulated specifically for the different levels of body impairment (abnormality of structure or function), personal activity limitation and social participation restriction (McLeod & Bleile, 2004; Leach et al., 2010; Fernandez et al., 2012; Meesters et al., 2013; Brown & Vickers, 2015). While like in TLMN practice, goal-setting therapists can set long-term

and short- rehabilitation goals (Playford et al. 2009; Fernandez et al. 2012; Brown & Vickers 2015), Brown and Vickers (2015) assert that the ICF framework enables therapists and clinicians to formulate goals that suit the individual unique needs of patients. In fact, McLeod and Bleile (2004: 212) emphasise that “The ICF is a meta-theory that allows for consideration of all possibilities” in patient-oriented goal-setting.

According to Leach et al. (2010), using the ICF framework, therapists focus their goal-setting on the particular disability areas of their specialities. For example, while few goals aim at levels of participation restriction, physiotherapists focus mainly on different levels of impairment goals, occupational therapists focus on levels of activity limitation goals and speech therapists on both impairment and activity limitation goals (Leach et al., 2010). Thus, from his narrative review of goal-setting literature, Ogbeiwi (2018) concludes that the pattern of goals formulated in most sectors in healthcare differs in form and type depending on the organization context of the goal setters.

8.8 Summary of this Chapter

This chapter discussed the different frameworks in the TLMN goal-setting practice associated with the final theme of goal-setting strategy. The findings were further discussed by comparing the further integrated general frameworks in TLM practice with the existing goal-setting frameworks reported in goal-setting literature. In all four frameworks the original components or stages were further reduced to fewer general steps that summarised the process of goal-setting in TLMN organisational practice. Even though no frameworks were originally constructed for the goal formulation and project planning stages, the TLMN practice during these stages were also discussed. On the whole, no previous goal-setting studies in the same health care settings as the field leprosy projects explored in this research has published any framework of goal-setting process and pattern of goal formulation. Most of the materials used to compare my findings in TLMN goal-setting practice were published studies or articles that reported patient-oriented goal-setting processes in the clinical and rehabilitation settings.

The first framework illustrated the entire 10-stage goal-setting process of TLMN practice, but which were reduced to four general steps of preparation, survey, formulation and planning. The activities during these stages revealed a centralised, national manager-led goal-setting process in general, but akin to a top-down decision-making approach. Nevertheless, a national attempt to consult with field stakeholders for some collaboration at the survey and post-planning activities was duly acknowledged. While available goal-setting literature sources describe a number of different process frameworks being used in different healthcare contexts, this TLMN goal-setting process was comparable with the four stages of the Goal-setting and Action Planning (G-AP) framework first described by Scobbie et al. (2011) as a theory-based practice framework. This seemed to provide the most popular base framework for therapist-controlled and therapist-led goal-setting approaches in rehabilitation goal-setting. Like the TLMN goal-setting process, The G-AP is needs and problem focussed. But unlike TLMN process, it lacks a clear description of a preparation stage, which is the major preliminary step in TLMN organisational practice.

The second framework of goal-setting preparation expands the first stage of TLMN goals setting process. It describes the four general preparatory steps of concept development, information review, process planning and stakeholder communication. This framework in TLMN practice was considered unique and elaborate, as it provided a robust and clearer guide than the outline of preparation activities some authors report for the pre-goal negotiation activities in the G-AP framework. The third framework of baseline survey also expatiated the second stage of TLMN goal-setting process and shows its implementation in three general steps of field exploration, need assessment and problem identification. This framework is the evidence of a problem-based approached of TLMN goal-setting and shows similarity to some activities of the goal negotiation stage of the G-AP and the initial stage of a few other goal-setting frameworks reported in current literature.

The activities of the goal formulation and project planning stages revealed TLMN's use of a multi-disciplinary approach to goal formulation and stakeholder consultative approach to project planning. However instead involving the

participation of field managers in goal formulation discussions by the national goal-setting committee, they were consulted after goal formulation and project planning for their validation comments on the assigned project goals and plans. How this TLMN's practice compares with the rehabilitation practice of multi-disciplinary goal-setting reported in the literature was discussed.

The fourth framework described the hierarchical goal formulation pattern of TLMN. This revealed a hierarchy of three general types of goals formulated according to three general timeframe levels of short-term, medium-term or intermediate and long-term. On this framework, in addition to timeframe, these goal types can be differentiated by hierarchies of six other criteria including goal-setting partners, plan, measurement unit, goal quality, project result and responsible worker. Overall, this goal formulation pattern in TLMN practice aligns with the general concept of goal hierarchies reported by some goal-setting researchers. However, it does not describe the immediate goal type generally referred to as output, which is the end-result of activities done, according to definitions in the development sector (DAC-OECD 2002; Playford 2009; Ogbeiwi 2016).

The next chapter (chapter nine) discusses the frameworks related to the third core theme of goal statement developed from the three categories of composition, construction criteria and the structure of goal statements. The product of every goal-setting process is a set of goal statements. Hence these frameworks will outline how TLMN leprosy goals were written generally. Specifically, the chapter will discuss the goal contents that constituted the components of leprosy project goal statements, the basic principles of how the goals were constructed and the lexical structure or sequence of these components.

Chapter 9

GOAL STATEMENT FRAMEWORKS

“...Good goal statements should possess the six attributes of Specific, Measurable, Attainable, Realistic or Relevant, Timed and Agreeable. SMARTA is a new acronym of a set of criteria for formulating ideal objective statements.”
(Section 9.3, first paragraph, page 221)

9.1 Introduction

The third and final theme of the frameworks of leprosy goal statements emerged from three main themes that included composition, construction criteria and the structure of goal statements. This chapter discusses the possible meanings of the three theoretical frameworks generated from the concepts of this final theme. These include the six-attribute framework of SMARTA objective statements (Figure 6.14, page 164), the four-component CBTT (Change, Beneficiaries, Target, Timeframe) framework of leprosy objective statements (Figures 6.15 and 6.16, pages 167 and 169) and the three-component CBL (Change, Beneficiaries, Location) framework of leprosy aim statements (Figure 6.17, page 170).

The chapter begins with a discussion of possible conflicts or agreements in the perspectives of the national and field managers concerning the composition, construction and structure of goal statements. In the subsequent sections, the components or constructs of each theoretical framework are further reviewed and integrated, and their implications discussed in the light of current knowledge about frameworks for writing goal statements in published goal-setting literature.

9.2 Conflicts in National and Field Perspectives

9.2.1 Content of goal statements

Both national and field managers share the same view that leprosy goal statements specified the desired change, timeframe, target population, target level, or a measurement indicator. Concerning change, both agree it is ‘the change you want to see’ (a field manager). They also believed the timeframe in

a goal statement should specify either a period or a particular year when the goal is expected to be achieved. The term 'target population' stated in a goal was explained by both national and field managers to be leprosy-affected persons or their communities who are the primary beneficiaries of the project, while the 'target level' was rendered as a specific quantifiable mark: a percentage, number of patients or a 'level we can achieve' (a national manager). Even though only national managers specifically mentioned measurement indicator as a way of measuring the achievement of the goal, some field managers also stated indicators in the verbal examples of their leprosy goals. However, the inclusion of baseline data (of the indicator) as a content of a goal statement was a view specific to only field managers. It is also a field perspective that a desired accomplishment or change is "What you are expected to do", which seemingly conflicts with its shared definition by national and field managers as what you want to see or achieve. However, only field managers think the change component in a goal statement is what you want to see *at the end of the project*. Concerning including resource as content in goal statements, field managers believed it should be implied but not specifically mentioned in the statement.

Overall, the few differences suggest there was a great extent of agreement between national and field managers on their opinions concerning the content of leprosy goal statements. I can infer that the specific mention of goal indicator as content by national managers could be because they alone had the practical experience and knowledge of the goal formulation process which the field managers were excluded from. On the other hand, the specific mention of baseline data as a goal content by the field managers seemingly reflects their involvement in the baseline survey stage of the process. The additional descriptions of some field managers of change as "what you want to do" and "what you want to see" could simply reflect their different interpretation of goals as activities or tasks to be accomplished and a desired future state. This may also show their unique understanding of the project goals assigned to them by the national managers.

9.2.2 Goal attributes

There seems to be an agreement in the views of leprosy managers that goal statements were formulated to satisfy multiple themes or criteria, among which were all five SMART attributes including, specificity, measurability, attainability, being realistic and being timebound. Both national and field managers share the view that attainable goals should 'address what we want or hope to achieve.' However, while field managers believed attainable goal statements should reflect the project's ability to achieve its targets, only national managers specifically mentioned they should be realistic. The SMART attributes were also popular with national and field managers alike who rendered the definition of the acronym similar to the original definition by Doran (1981). There were certain emergent goal attributes that were specifically field views, such as expressing an achievable dream, clarity in relation to understandability, acceptability as a concept of agreement by all parties or stakeholders and flexibility of the statement. Despite these additional attributes from field managers, the opinions of both levels of managers showed the vast popularity and awareness of the SMART acronym and its definitions prevalent among the leprosy managers in TLMN.

9.2.3 Construction of goal statements

Both national and field managers had the perspective that goal statements should be written in a sentence format. The national managers claimed the verbs should be in present tense. Despite the opinion of some leprosy managers that no goal writing templates were used, both national and field managers were among those who held a contrary view that different frameworks were used in formulating goals. Nevertheless, there was still a conflict in the type of framework mentioned. While a field manager mentioned a results framework, a national manager declared a project planning framework for goal-setting. However, because both results and planning frameworks were different sections of the template used to prepare project proposals, it was therefore evident that no standard goal formulation template was used for constructing the goal statements in TLMN organisational goal-setting practice.

Clearly, the themes identified in the verbal project goals stated by field managers showed that goal statements could be constructed using certain combinations of contents. These included combining target and timeframe or combining change and timeframe or combining accomplishment and target population. These combinations ranged from the one-component change statement to the 5-component framework of indicator, beneficiaries, target, timeframe, and baseline. These frameworks revealed the field impression that leprosy goal statements stated mostly contents such as change, beneficiaries, timeframe, and target; and less of location and baseline. Evidently, field managers only described what they could remember of the leprosy goal statements purely from their second-hand knowledge since they were not part of the committee that discussed the problems and formulated the goal statements at the national level. The lack of national managers' perspectives on goal constructs was only because they were not asked to give examples of leprosy project goal statements during their interviews.

9.3 Framework of SMARTA Attributes of *Objective Statements*

The criteria for the construction of good goal statements according to leprosy managers perspectives are multi-themed attributes. They aligned the criteria with the Doran's (1981) five SMART attributes but include an additional attribute of acceptability or agreeability. So, this SMARTA framework in Figure 6.14 (chapter 6, page 164) implies that good goal statements should possess the six attributes of Specific, Measurable, Attainable, Realistic or Relevant, Timed and Agreeable. SMARTA is a new acronym of a set of criteria for formulating ideal objective statements. However, it is not the first to evolve as an improvement on Doran's (1981) SMART acronym as Table 2.3 (chapter 2, page 47) shows.

SMARTA particularly sounds like the SMARTER framework coined by Hersh et al. (2012: 220) and MacLeod (2012). According to Hersh et al. (2012), SMARTER is "a new framework for conceptualising and structuring collaborative goal-setting in aphasia rehabilitation". In MacLeod's (2012) view, a SMART goal would be SMARTER if it has two additional attributes: Engaging and Rewarding. MacLeod (2012) believes a SMART goal should also engage the stakeholders to encourage acceptance and ownership of the goal. It should

also be linked to specific rewards that can motivate a change of behaviour towards goal attainment. However, rather than being attributes of an ideal objective statement like SMART, SMARTA and MacLeod's (2012) SMARTER, the SMARTER framework by Hersh et al. (2012) prescribes a collaborative goal-setting process that the authors believe should be Shared, Monitored, Accessible, Relevant, Transparent, Evolving and Relationship-centred.

Hence, SMARTA adds to the wide range of SMART-related acronyms that already includes goal agreement as one of the criteria of a good or ideal goal statement. Wade (2009) and Day and Tosey (2011) listed 'Agreed upon' among the possible meanings of the letter 'A' in the SMART acronym, in addition to *attainable* and *achievable*. In the view of Clarke et al. (2009), the letter 'A' in SMART only stands for 'Agreed to'. However, Playford et al. (2009) assert that the letter "A" could mean either 'Ambitious' or 'Achievable'. Hence, like Doran's (1981) SMART goal framework, the new SMARTA acronym offers a set of standard attributes of a well-formulated goal statement. Good goal attributes have been extensively researched or reported over the many years since the Drucker's (1954) concept of Management by Objectives and Locke and Latham's (1990) goal-setting theory (Lee, 2007; Thomson & Black, 2008; Clarke et al. 2009; Playford, 2009; Wade, 2009; Aston & Sheehan, 2010; Lee, 2010; Day & Tosey, 2011; Hartigan, 2012; Hersh et al. 2012; MacLeod, 2012; Meesters et al. 2013; Ogbeiwi, 2016; Ratcliffe, 2016; Bjerke & Renger, 2017; Ogbeiwi 2017; Bexelius, Carlberg & Lowing, 2018; Ogbeiwi 2018; Plant & Tyson, 2018; Sull & Sull, 2018; Swann & Rosenbaum, 2018).

Thus, there is ample evidence in goal-setting literature that goals formulated using the guidance of SMART-based frameworks like SMARTA are high-quality goals (Bexelius, Carlberg & Lowing, 2018), identifiable by their timeframe-based hierarchical typology (Aston & Sheehan 2010). Also, they enable quantitative expression of desired patient behavioural changes (Playford et al. 2009), while helping therapists and project managers to focus on what is "achievable and relevant" (Thomson & Black 2008). They are also effective aids to sensible planning, monitoring and evaluation of programmes (Meesters et al. 2013), as well as objective and realistic completion of tasks or projects (Ratcliffe 2016).

However, the opponents of the SMART framework assert that caution is required in the application of the acronym for good goal formulation as a “One size fits all approach” (Bjerke & Renger 2017: 125). Some believe not every goal formulated for every organisational level can satisfy all SMART attributes (Wade 2009) Other authors like Ratcliffe (2016) believe that some of the SMART attributes, such as realistic and time-bound, actually limit the development of the project or organisation, as the employees only formulate achievable goals and never challenging goals that will stretch them to perform beyond what is realistically possible within their work contexts. Still some authors identify the moral and practical abuses in the use of the SMART framework and suggest alternatives which they believe can genuinely motivate real improvement and achieve desired outcomes. In place of SMART, authors such as Day and Tosey (2011) propose the POWER (Positive outcome, Owned role, What tasks will be done, Evidence of accomplishment, and Relationships required) framework for formulating educational goals. Also, Sull and Sull (2018) recommend FAST (Frequently discussed, Ambitious, Specific, and Transparent) framework. Hence, the universal acceptance and generalisation of the application of the new SMARTA framework that emerged from the TLMN organisational practice for goal-setting in other contexts is not guaranteed.

Nevertheless, I agree with Bjerke and Renger (2017: 125) that:

‘The proliferation of the SMART method in evaluation and non-profit organization guidance supports the contention that SMART is now a mainstream method for developing program goals and objectives.’

‘...Many mainstream program evaluation guides present the SMART criteria without an explanation as to *why* or *how* they should be applied. Thus, users may [be] blindly following the recipe-like method to develop SMART objectives without understanding the underlying reasons for applying each SMART criterion’

Therefore, I acknowledge that introducing SMARTA to goal setters generally may add to the confusion already created by the myriads of guided goal-setting frameworks and the multiple constellations of acronyms, as each claims to be *THE* ideal criteria for formulating good quality effective goal statements based

on best practice. Without doubt, the only advantage the framework of SMARTA criteria has over the other frameworks is the spatial separation of the two alternative meanings of the letter 'A' – attainable and agreeable – in the same SMART acronym.

9.4 Frameworks for Constructing Goal Statements

A list of seven leprosy goal contents evolved from the thematic analysis of both the leprosy managers' verbal goal statements and the written statements in the project plans. Overall, these contents emerged as the desired change, followed in order of popularity by timeframe, target population (beneficiaries), measurement or progress indicator, target level, baseline data and strategy for achieving or accomplishing the goal. From these contents, the integration process and theoretical sequence of the commoner ones produced two final combinations as the structural frameworks of the components of goal statements. There was one each for objectives (medium-term or intermediate goals) and aims (long-term, overall goals), as illustrated in Figures 6.16 (chapter 6, page 169) and 6.17 (chapter 6, page 170) respectively.

However, empirical research on the framework components for constructing goal statements is rare, since despite the universal popularity of goal-setting and the use of the SMART criteria to guide goal formulation, most published academic goal-setting articles do not proffer any framework of goal components that may be used as a template for actually writing a goal statement. The best available in the articles of some authors is a recommendation to use the individual SMART attributes or their definitions as a guide to decide the lexical contents or components of the goal statement construction. For example the originator of the SMART criteria, Doran (1981: 36) indicates that the 'specific' goal attribute means stating a 'specific area of improvement', 'measurable' means stating 'an indicator of process', 'assignable' means stating (the person or performer) 'who will do it', 'realistic' means the expected 'results achievable with available resources' and 'time-related' means a (timeframe) "when results can be achieved." Hence even though not specified by Doran (1981) in his management paper that was not research evidence-based, one may therefore suppose that in writing a goal statement that satisfies all five SMART criteria in

Doran's original view, the five components of the objective statement would be the Improvement desired (I), Indicator of progress (I), Performer (P), Result-level (R) and Timeframe (T). In effect, therefore, the goal writing template deducible from Doran's original SMART goal formulation framework could be represented by the acronym 'IIPRT'.

However, the only published goal-setting article found that specifically identified a set of goal components for writing a SMART goal, besides the publications by Ogbeiwi (2016, 2017, 2018), was a practical guide written by Bovend'Eerd, Botell and Wade (2009) for individual patient rehabilitation. According to these authors, a rehabilitation goal statement that is specific, measurable, achievable, realistic/relevant and timed (SMART) should specify four components: 'target activity (or behaviour)', 'support needed', a quantified performance and 'time period to achieve the desired state'. (Bovend'Eerd, Botell & Wade, 2009: 354). Compared to the components of the IIPRT from Doran's (1981) SMART definitions, the target activity or behaviour (B) in Bovend'Eerd, Botell and Wade's (2009) framework seemingly relates to the desired improvement (I), while the quantified performance (P) and time period (T) aligns with the result-level (R) and timeframe (T) respectively. However, both SMART goal frameworks are conceptually different because while the Doran's IIPRT framework requires additional specification of a measurement indicator (I) and the person assigned the task or goal (P), the goal statement framework based on Bovend'Eerd, Botell and Wade's (2009) perspective of SMART criteria demands the additional components of support needed (S) but without a specified measurement indicator.

In practice, neither the Doran's IIPRT (improvement, indicator, performer, results and time) components nor the Bovend'Eerd, Botell and Wade's (2009) BSPT (Behaviour, Support, Performance and Time) components are used entirely in TLMN project goal formulation in Nigeria. My research findings of leprosy goal statement components discovered in TLMN practice provided a rational basis for my inference of the presence of two new general conceptual frameworks theoretically used for constructing leprosy goal statements. These included the Change, Beneficiaries, Target, and Timeframe (CBTT) framework

for the writing statements of objectives; and Change, Beneficiaries, and Location (CBL) framework for writing aims.

9.4.1 CBTT framework of objective statements

CBTT is the acronym for Change, Beneficiaries, Target and Timeframe. Theoretically, this framework represents the general lexical structure of leprosy objective statements with the conceptual components constituted by the four most common goal contents arranged in a sequence from the most frequent to the least. The CBTT framework was the final framework for statements of leprosy project objectives that evolved inductively from the original nine frameworks generated from the 12 verbal objective statements and 11 frameworks generated from the 18 written objective statements. The change component in the context of TLMN practice, and according to Ratcliffe (2016), represents a specific statement of the desired outcome or the improvement expected to result from project implementation. Beneficiaries represent the target population. Target refers to the particular quantified level of performance, while the timeframe is the time limit or period by which the target is expected to be achieved. Thus, according to this CBTT framework illustrated in Figure 6.16 (page 163), the sequence of goal components shows the desired Change (C) is specified first in the objective statement, then Beneficiaries (B), Target (T) and lastly the Timeframe (T). Generally, the CBTT framework revealed the theoretical structure for writing leprosy objective statement in TLMN organisational goal-setting practice.

Despite the popularity of the SMART criteria and acronym as goal-setting guide in published literature, research-based evidence of frameworks that specify individual concepts or components for constructing statements of objectives is sparse. However, the IIPRT framework I deduced from Doran's (1981) definitions of the SMART acronym is comparable to TLMN's CBTT framework being similar in three components. Conceptually, the Change (C), Target-level (T) and Timeframe (T) components in the CBTT framework are considered synonymous to the Improvement (I), Result-level (R) and Timeframe (T) components respectively of the IIPRT framework. Also, the TLMN's CBTT also shares similar components with the Bovend'Eerd, Botell and Wade's (2009)

BSPT framework, since the components of desired Behaviour (B), Performance-level (P) and Timeframe (T) are synonymous with desired Change (C), Target (T) and Timeframe (T). Likewise, the Change, Target and Timeframe components in TLMN's CBTT framework are synonymous to the Outcome, Target and Timeframe in the OITT framework by Ogbeiwi (2016; 2017; 2018).

Nevertheless, TLMN's CBTT framework of leprosy objectives is remarkably different from these three SMART-based frameworks reported in the literature in its non-specification of the components of Indicator, Performer and Support needed. It seems clearly understandable from the evidence of this research why the resources, whether performer or other support, needed to achieve the leprosy goal were not included in TLMN's CBTT framework. Apparently, this is in line with the argument of some field leprosy managers and some goal-setting authors that, even though the resources needed should be considered as a contextual criterion for the formulation of *realistic* objectives, it should not be specified as a separate component in the goal statements (Lee, 2010; Ratcliffe 2016; Bjerke & Renger 2017). But the reason for the omission of the measurement component of indicator from the statement framework of most leprosy objectives formulated in TLMN practice is not so clear.

The OITT framework illustrated in Figure 2.4 (page 49) suggests that every SMART objective statement should be written with four components that include a specific outcome, a measurable indicator, an attainable target and a realistic timeframe (Ogbeiwi 2017). Like the CBTT framework, IIPRT and BSPT frameworks essentially share the same components of change, target and timeframe with the OITT framework. All three are clearly different from the OITT framework by the inclusion of Beneficiary (CBTT, Performer (IIPRT) and Support (BSPT) components. In addition, the CBTT and BSPT frameworks are different from the IIPRT and OITT frameworks by the exclusion of the Indicator (I) as an essential component from their frameworks. Theoretically, the lack of a specified indicator in CBTT and BSPT frameworks implies that any objective statement formulated through the goal-setting practices in TLMN and clinical rehabilitation respectively may not be measurable empirically, even though a quantified target may be stated. Without specifying an indicator component, the

objective statement would lack a clear expression of how progress towards achieving the goal would be measured (Doran 1981; Lee, 2007; Lee, 2010; Oracle 2012; Ogbeiwi 2016; Ogbeiwi 2017).

Moreover, like the BSPT framework for rehabilitation goal-setting, the emergent CBTT framework in TLMN practice implies stating a target-level for an objective, but without stating an indicator that is conceptually the scale of measurement on which the expected attainable target is set (Ogbeiwi 2016). As shown in Figure 2.4 (page 49), the target of an objective statement is essentially a specific quantifiable level of its stated indicator. Therefore, simply stating a target level without the relevant indicator will be both conceptually baseless and meaningless, since its measurement will be impossible. Hence, though the emergent CBTT framework may enable a clear specification of the desired change and the beneficiaries, the target-level specified would be immeasurable by the defined timeframe. Thus, based on the CBTT framework, the leprosy project objective statements formulated by the organisation's practice lacked one of the vital SMART attributes.

Of what use is the beneficiary component in the CBTT framework? The significance of the other components (change, target and timeframe) is amply evidenced in the literature. It is believed that the presence of the change and timeframe components in a goal statement enables goal setters to specify respectively a clear outcome that the project will achieve and a fixed timeline or deadline for achieving this result (Lee 2010; Aston & Sheehan, 2010; Ratcliffe 2016). While the indicator component enables the quantification of the desired outcome so it can be objectively measured, on its own, the target signifies the level of "goal performance" that can realistically be achieved on that indicator (Playford et al. 2009; Lee, 2010; Aston & Sheehan 2010; Ratcliffe, 2016). What advantage does specification of the target population that beneficiaries represent confer on the objective statement?

While the perspectives of the leprosy managers on the rationale for writing each goal component in the objective statement was not explored in this research, I think that the relevance of the beneficiary component is linked to the change component, about which the additional detail of beneficiaries provides greater

specificity and clarity in terms of the direction of the desired change (Lee, 2010; Aston & Sheehan, 2010). With more details come higher goal specificity, which helps all stakeholders of the project to gain better awareness and understanding of what they are expected to achieve (Lee 2007; Bjerke & Renger 2017). Thus, the beneficiaries are not just the target population of the project, they are specifically the beneficiary of the change component in the goal statement. Therefore, while the beneficiary component is missing in other objective statement frameworks, the CBTT framework highlights the importance of including this component in a goal statement, at least in the goal-setting practice context of TLMN organisation.

9.4.2 CBL framework of leprosy aim statements

CBL framework represents the general structure of leprosy aim statements containing three components of Change (C), Beneficiaries (B) and Location (L). This framework evolved from the four different frameworks generated thematically from six written aim (long-term goal) statements in the leprosy project plans. Figure 6.17 (page 170) illustrated this framework as the structure of three general contents that were found to be the commonest themes or concepts in the six aim statements. They were also linked in the order of their commonness – from the most common component, Change, followed by Beneficiaries then to Location. In the context of leprosy projects and according to MacLeod (2012), the change component of this framework represents the long-term broad impact desired at the end of the project. The beneficiary component represents the target leprosy or non-leprosy population who were the recipients of the intended project intervention and therefore the people on which the project impact is expected. The location component represents the community or place where the target beneficiaries live. Overall, this framework, therefore, revealed that in the TLMN organisational practice, a long-term goal was generally written as a statement which specifies the expected Change, Beneficiaries and Location.

Even though long-term goals are popular goal types in goal-setting literature, evidence of any framework for formulating aims based on empirical research is scarce. Although not based on any empirical research, the article by Stein

(2013) advanced a five-component framework with the acronym “DRIVE” meaning Directional, Reasonable, Inspiring, Visible and Eventual. However, from his explanation of this framework, the components are more of his perspective of the attributes of a long-term goal, rather than the components or goal contents for formulating an aim statement. Speaking from a farming business setting, Stein (2013) asserts that long-term goals formulated to have the “DRIVE” components will specify the general direction of the business. Also, it will be achievable and challenging or motivational. DRIVE goals that are visible are those that have the relevant measures to assess the progress being made towards the goal, and eventual goals specify a timeframe (Stein 2013). Even though Stein (2013) defines a long-term goal as a general goal, he asserts that any goal statement formulated based on the DRIVE framework must be achievable, monitorable or measurable, mostly likely possessing a measurement indicator and time-bound like a SMART goal. Hence Stein’s (2013) DRIVE framework sounds like a tool for formulating objectives and not long-term aims. Nevertheless, it defers conceptually from TLMN’s CBL framework, especially because of its possession of five components and its use to specify indicator and timeframe as components of a long-term goal statement. These components are lacking in TLMN’s CBL framework.

On the other hand, another published long-term goal formulation framework is the “IT” framework recommended by Ogbeiw (2016; 2017) and structurally contains two components of Impact (I) and Timeframe (T) which are proposed as the two basic contents to be included in the composition of an aim statement. According to Ogbeiw (2016), the IT framework was proposed based on the seven basic themes he identified through a thematic analysis of published definitions of a long-term goal. These themes differentiated aims from objectives. Accordingly, every aim statement is formulated to specify the goal object of impact, broad scope, terminal hierarchy, long-term timeframe, immeasurability, significance of overall purpose and expression as qualitative non-SMART statement (MacLeod 2012; Ogbeiw 2016). Based on the IT framework, these themes imply that while a long-term goal statement may specify a broad overall impact on the target beneficiaries (MacLeod 2012), it should also specify the timeframe that defines when the impact or change will

be achieved. Therefore, the change component in the CBL framework is synonymous with the impact component in the IT framework. However, the CBL framework is conceptually different from IT framework with its specification of the target beneficiaries and location and the non-specification of a long-term timeframe.

Thus, this emergent CBL framework for writing long-term goals in TLMN context lacks the vital component of timeframe, which is the content that should clearly identify the aim statement as a long-term goal type (Playford et al., 2009; Wade 2009; Aston & Sheehan 2010). Thus, when using this CBL framework for long-term goal formulation, the aimed change could be expressed in a broad futuristic scope and the absence of indicator and target component would give an attribute of immeasurability (MacLeod 2012, Ogbeiwi 2016). However, lacking a timeframe component, the statement would lack the quality of time-limitedness that is required for all goals (Doran 1981; Ogbeiwi, 2016; Bexelius, Carlberg & Loring, 2018). The goal definitions by Lee, Locke and Latham (1989), Stretcher et al. (1995), Locke and Latham (2002, 2006) and Fitsimmons (2008) all stress the accomplishment of a desired change “at a particular time in the future” (Ogbeiwi, 2018: 4). Of what significance are the two components of beneficiaries and location in an aim statement? This study did not explore why each goal content was written in the aim statement. However, as explained for the CBTT framework, the inclusion of beneficiaries and location in leprosy project aim statements possibly helps to clarify the recipients of the expected project impact, since both components have descriptive and defining references to the target population of the leprosy projects.

9.5 Summary of this Chapter

This chapter discussed the implication of the three goal-setting frameworks related to the construction of leprosy goal statements in the context of TLMN organisational goal-setting practice. There was an impressive agreement between the national and field managers regarding the base themes and concepts from which the three frameworks were generated. The concepts that evolved from the opinions of only field managers were related to their later

interviews compared to the earlier interviews of national managers during the data collection phase of this research.

The first framework illustrates the SMARTA attributes of good or ideal goals as perceived by leprosy managers. SMARTA contained attributes already associated with the different variants of the SMART acronym promulgated by Doran (1981), which provides standard criteria for the formulation of effective and well-defined goal statements. SMARTA constructed from leprosy managers' perspectives mean that good leprosy goals should be stated in a format that makes them not only Specific, Measurable, Attainable, Realistic and Time-bound (SMART), but also Agreeable or acceptable to all stakeholders. The last attribute of Agreeability or acceptability is particularly vital in TLMN organisational goal-setting practice context because of the exclusion of the field managers from the statement formulation stage of the goal-setting process, even though they were the workers assigned the responsibility for achieving the leprosy project goals. While there are variants of the SMART acronym that include Agreed or Agreeable among the list of possible meanings the letter "A", the SMARTA acronym generated through this explorative research was the first to separate the attribute Agreeable from the popular attributes of Attainable or Achievable in the SMART acronym.

This separation highlights the importance of goal agreement through the participation of field leprosy manager in the multi-sectoral committee discussions at the TLMN national office during goal-setting. Moreover, the separate mention of the attribute of agreeability or acceptability among the ideal goal criteria emphasises the need for agreeable goals to be placed on the same level of significance and relevance with goals that satisfy other SMART attributes. Thus, while the concepts inherent in SMARTA goal criteria framework is not new, the acronym introduces a new understanding and appreciation of collaborative or participative goal-setting process as a smarter way to formulate good quality goal statements that are potentially able to motivate goal implementers further towards achieving project goals.

The second framework was the CBTT framework that has four components of change, beneficiaries, target and timeframe. These components were

sequenced in the framework in the order of their frequency, beginning from 'change' as the most frequent goal content. It is proposed that CBTT represents the general structure with which most leprosy objectives were formulated in the TLMN organisational goal-setting practice. In specifying change, target and timeframe components, the TLMN's CBTT is like the few objective setting frameworks found in published literature, such as IIPRT, BSPT, and OITT frameworks. However, the TLMN's framework is different, particularly because it lacks an indicator component that would make the objective statement formulated with it measurable. This finding conforms with the conclusions of the initial review of leprosy project objectives reported in Chapter 1 of this thesis. That review concluded that the leprosy project objectives reviewed did not contain enough components in its structure to give them have the SMART attributes.

The third framework is the CBL framework developed thematically from the six aim (long term goal) statements in the leprosy project plans. The components: change, beneficiaries and location represent the most common themes in the statements of leprosy project aims. Generally, therefore, it is proposed that most leprosy aim statements were formulated in TLMN organisation practice with these three components specified and linked in this framework. Besides the DRIVE framework reported by Stein (2013) and the IT framework by Ogbeiwi (2016), no framework for formulating long-term goals were found published in literature.

Moreover, the DRIVE framework does not specify the components of an aim statement either. However, the change component in the TLMN's CBL framework would be synonymous with the Impact component in the 'IT' framework. But without a timeframe, the CBL framework lacks the component that typically would identify any goal statement formulated with it as a long-term goal on a temporal scale. Nevertheless, the CBL is unique in its inclusion of beneficiaries and location in the aim statement. It is considered that stating beneficiaries and their location in the CBL framework probably served to provide further specification of the expected recipients of the impact stated in the aim statement.

The next chapter, chapter 10, is the chapter that presents the final general theoretical goal-setting framework of TLMN. It was generated through further reflective integration of all eleven theoretical goal-setting frameworks discovered in the TLMN organisational goal-setting practice. Also discussed there are the key proposals identified in this general framework and from which the theory of goal-setting practice in TLMN context was developed.

Chapter 10

A PRACTICE THEORY OF GOAL-SETTING

“Assigned non-SMART goal formulation is the direct consequence of a centralised non-participative goal-setting process and is the predictor of assigned unrealistic project planning.”
(Section 10.4, 2nd paragraph, page 244)

10.1 Introduction

This qualitative case study research was an in-depth exploration of the theoretical frameworks for setting goals of leprosy projects in the TLMN organisational practice. It had a broad aim of discovering how leprosy goals were formulated in order to assess how the prevalent universal theoretical models of the motivational goal-setting theory and SMART criteria for goal statement formulation are translated into practice in a Nigerian context. Textual data were collected through open-ended individual interviews of 10 leprosy managers (two in the national office and eight in the field project locations) and structural review of goal statements in the 2016 plans of the six leprosy projects in TLMN.

A combination of inductive thematic analysis and transactional constructionism was used to identify relevant goal-setting concepts in the interview and documentary data collected. These concepts were coded, categorised and integrated into general theoretical themes and frameworks. Guided by the research questions and objectives, the serial analytic process produced three final emergent themes of goal-setting stakeholders, goal-setting strategy and goal statements and a total of 11 associated theoretical goal-setting frameworks. The theoretical framework construction process involved a series of reflective integration, axial association and increasing level of abstraction of the related emergent themes. The initial theoretical goal-setting frameworks generated were four stakeholder frameworks, four strategy frameworks and three statement frameworks. In this chapter, all 11 frameworks were integrated into one general theoretical framework that is illustrative of the overall organisational goal-setting practice. This final theoretical framework of goal-

setting practice is one which potentially explains the general thematic constructs identified in the practice of TLMN.

Therefore, this chapter finalises the theorisation process in this research. It describes the main constructs of the single general theoretical framework of TLMN goal-setting practice in a way that clearly answered my core research question of how leprosy goals were formulated in TLMN's Nigerian context. Eventually, from the general framework, propositions are made from the directional relationships between the independent, predictor and dependent constructs in TLMN goal-setting. These constructs gave rise to the postulation of a theory of goal-setting practice.

The chapter begins with a summary of the research problem outlined in chapters 1 and 2, and the lessons learnt from the field, according to implications of the 11 goal-setting theoretical frameworks discussed in chapters 7, 8 and 9. This is followed by a hermeneutical assessment of the main constructs of TLMN goal-setting, as proposed from the final general theoretical framework. These constructs are considered illustrative of the theoretical goal-setting practice of TLMN. The chapter concludes with the sections on the proposed practice-based theory and the limitations of this research.

10.2 Recap of the Research Problems

The key problem that justified the conduct of this research was the empirical evidence of the inadequate capacity of managers and organisations to set good goals. This problem was considered universal with a suspected prevalence of poorly formulated goal statements being used by health organisations to develop their projects globally. An initial assessment of leprosy project goals suggested that the quality of goal-setting in TLMN organisation was not different from the worldwide situation. Already, there are theoretical frameworks popular universally to guide good goal formulation, such as the experiment-based deductive motivational goal-setting theory of Locke and Latham (1990) which encourages goal setters to formulate specific and challenging goals to achieve higher task performance and better outcomes. Over the years, anecdotal models have been published with the plausible intention of improving both the goal-setting process and the framework for formulating goal statements. The

more popular models included Drucker's (1953) Management by Objectives (MBO) for multi-level organisational goal-setting and Doran's (1981) SMART criteria for formulating specific, measurable, attainable, assignable, realistic and timed goal statements. The universal popularity of these theoretical precepts for goal-setting is evidenced especially by the myriad of studies done and articles published that support the effectiveness of goal-setting in high-income countries. However, none of them reports any evidence-based goal formulation frameworks that show how their theories are translated into standard practice for constructing and writing good goal statements. To my knowledge, no past goal-setting studies have investigated how goal statements are formulated in a real practice context of healthcare organisations. While a lot of articles have been written on the recommended process and frameworks for formulating individual patient or client improvement goals in clinical and rehabilitation care setting, empirical research inquiry into how public health organisations formulate their health intervention or development goals is unreported. Moreover, virtually all goal-setting studies have been done in high-income countries. Hence, the nature of goal-setting practices in low-income countries is also unknown.

10.3 Lessons Learnt from TLMN Goal-setting

This research set out to discover the theoretical framework that is descriptive of the goal-setting practice of TLMN. The core study question was 'How are leprosy project goals formulated in TLMN in Nigeria?' The associated sub-question was 'How are statements of leprosy project objectives framed or constructed?' To answer these questions, the research had three objectives to explore the conceptual framework of TLMN goal-setting practice, describe how the universal theoretical principles were translated into practice in TLMN and develop a practice theory for goal-setting in TLMN's low-income country context. Towards accomplishing these objectives this research identified 11 theoretical frameworks that were related to the three final emergent goal-setting themes.

The four theoretical stakeholder frameworks revealed a three-level tripartite organisation of different stakeholders' goal-setting roles, a nationalised

responsibility for the entire goal-setting process, the leprosy managers' perception of five logically connected goal types and a goal effects cycle that evolved from their beliefs in seven effects of goal-setting. Interpreted in the context of my research question, the tripartite framework suggested a general structure of goal-setting activities that involved stakeholders at national, project and community levels. There was a top-down flow of communication and authority from the national to the field, and bottom-up flow of information generated from the field to the national level. A multi-sectoral committee, from which the field stakeholders were excluded, formulated the leprosy goals at the national office. The national responsibilities indicated the process was an entirely centre-led, organisationally directed goal-setting in which the field stakeholders played a passive role as information sources. However, despite the national prominence in the initiation and leadership of the process, the information collected for goal-setting is focused on the needs of project beneficiaries. Thus, according to the stakeholders' frameworks, the TLMN organisational goal-setting could be, fundamentally, a hierarchical multi-stakeholder, beneficiary-focused centralised practice that operates through an organisationally controlled top-down approach.

The involvement of a multi-sectoral goal-setting committee shows there was an attempt at using a collaborative team effort at a national level in formulating leprosy project goals. However, with the non-inclusion of the field goal implementers, the leprosy goals produced by the TLMN goal-setting practice could not be described as participative, but rather as non-cooperative and assigned. These qualities show that TLMN practice has a technocratic goal-setting that is reportedly typical in government and non-government organisations with top-level goal-setting (Busse & Wismar (2002a)).

Similarly, the frameworks of goal types and effects suggested the leprosy managers' perceptions of goal-setting aligned with the general understanding among goal-setting theorists of the definitions, typology of goals and the relationship between goals and project performance. Figure 10.1 shows the final general theoretical framework of leprosy managers' understanding of goal types. The goal definition in Figure 10.1 summarises their general understanding of what a goal is and the two dimensions on which their

classifications were based. Both dimensions illustrate that the leprosy managers believed there is a hierarchical structure of goal types: three levels of the spatial dimension and five levels of the temporal dimension, and a logical linkage of goals from the lowest to the highest. Therefore, these frameworks revealed an immense awareness of the popular theoretical concepts of goal-setting among the leprosy managers in TLMN.

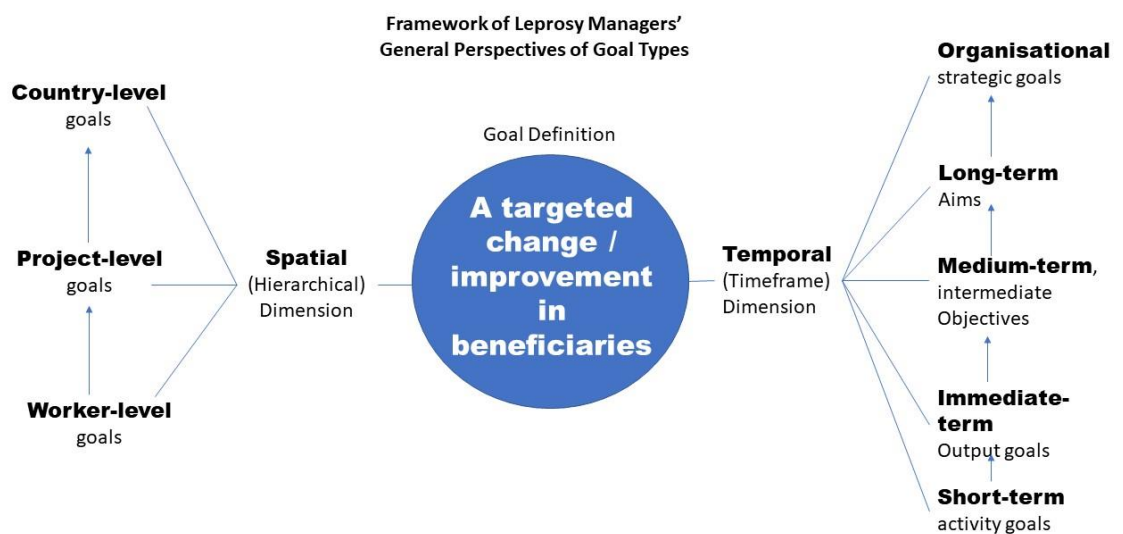


Figure 10.1 Stakeholders' General Perspectives of Goal Definition, Classifications and Types

Apart from the three-level framework of hierarchical goal formulation pattern, the theoretical frameworks of goal-setting strategies illustrate the 10 stages and key steps of the goal-setting process in TLMN practice. This framework was further integrated and reduced to four general stages: including preparation; baseline needs survey; goal formulation; and project planning (Figure 8.1, page 185). During the goal formulation stage, a national committee used the data from the needs survey to analyse beneficiary problems and write goal statements. During the project planning stage, the formulated goals were used to design the plans of the proposed projects. The project proposals were then sent as feedback to field managers for their validation. I think the later field validation of assigned goals and plans could be the attempts of national stakeholders to solicit the participation of field stakeholders in the goal

formulation and planning process. Lastly, the theoretical framework of goal formulation pattern illustrated leprosy managers' ideas of formulating leprosy goal types of long-term aims, medium-term objectives and short-term activity outputs differentiated hierarchically by seven criteria (Figure 8.4, page 205).

The three frameworks of goal statements outlined the good goal attributes according to leprosy managers' perspectives and the structural components of the statements of the aims and objectives formulated by the TLMN for leprosy projects. The good goal attributes were summarised by the SMARTA acronym meaning *specific, measurable, attainable, realistic, timed and agreeable* (Figure 6.14, page 164). Though not a new concept, this new acronym indicates an impressive good level of awareness of the universally popular Doran's (1981) SMART criteria for writing effective goal statements. In addition, the inclusion of agreeable as an additional attribute to SMART may have been necessitated by the field managers' exclusion from goal formulation stage of TLMN goal-setting process. This may have also justified their recommendation that TLMN's goal-setting approach needs to be more collaborative and participative. Moreover, the emergent CBTT and CBL frameworks represent respectively the general components of the statements of leprosy objectives and aims respectively.

Theoretically, the CBTT framework means the leprosy objectives were commonly written with specific Change, Beneficiaries, Target and Timeframe as the general components of their statements. This framework means that the specification of a measurement indicator was uncommon in the leprosy objectives. Similarly, the CBL framework signifies the common inclusion of overall Change, Beneficiaries and Location in the statements of leprosy aims or long-term goals. Thus, aim statements were mostly without the specification of a timeframe. Without specifying an indicator as an essential component, the objectives formulated in TLMN practice were not in line with the theoretical SMART principles (Doran 1981), since they would not be measurable. Similarly, without a specified timeframe, the aim statements were in line with the general goal definition by goal-setting theorists (Locke and Latham 2006), since they would not be time-bound and not distinguishable as long-time goals (Playford et al. 2009; Wade 2009). Thus, despite the excellent awareness of the universal theoretical models, criteria and definitions, the emergent frameworks of leprosy

goal statements revealed these theories were only partially translated into practice in the TLMN goal-setting context.

Overall, Figure 10.2 shows the single final general framework that resulted from the thematic integration of all 11 theoretical frameworks discovered in TLMN goal-setting practice. This final framework illustrates the theoretical relationships between the abstract themes or general constructs in the process and structure of TLMN goal-setting. It also summarises the five key lessons induced from the TLMN goal-setting practice through this explorative case study research.

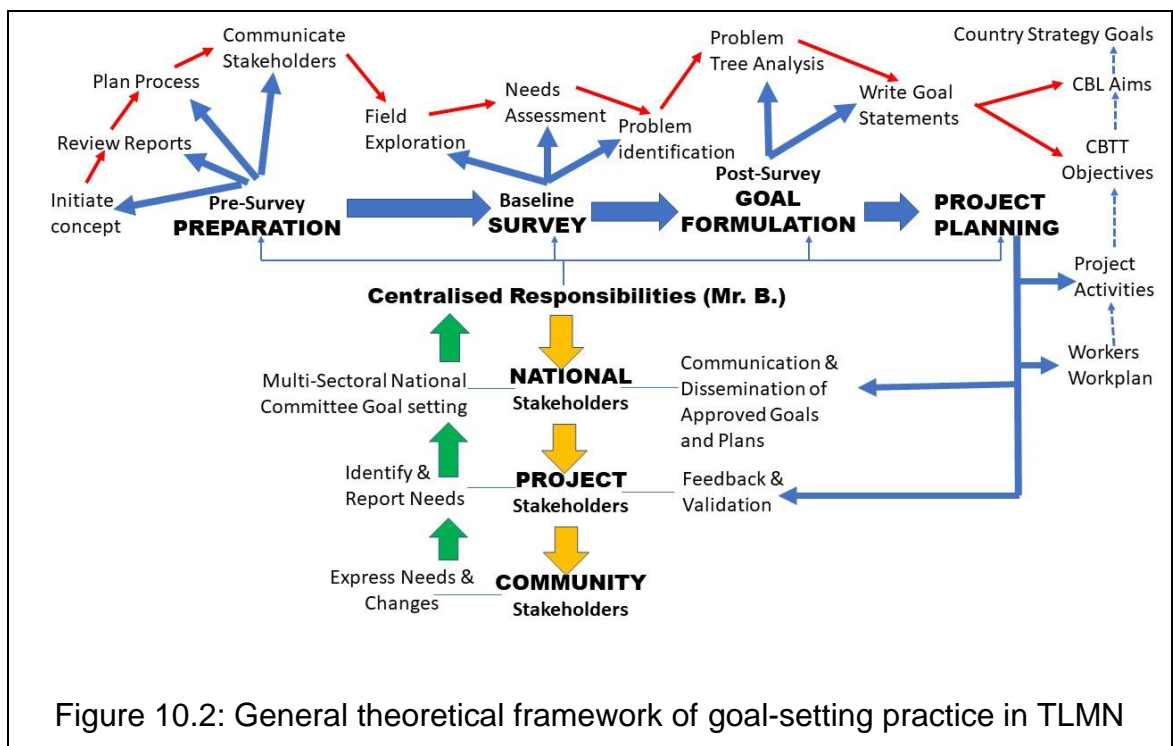


Figure 10.2: General theoretical framework of goal-setting practice in TLMN

First, there are four general stages of activities in the centralised goal-setting process. This infers that TLMN goal-setting was a linear, multi-stage, centre-driven process in which goal formulation was dependent on the conduct of a baseline problem survey and was the precursor or predictor of project planning (broad blue horizontal arrows in Figure 10.2). Secondly, the goal-setting process resulted in the formulation of written statements of leprosy objectives and aims with CBTT and CBL components respectively (narrow red arrows in Figure 10.2). Thus, the leprosy objectives statements formulated through the goal-setting process were not likely to be measurable since they mostly did not

specify an indicator component. So CBTT objective statements were not entirely SMART. Also, the leprosy aims formulated could not be distinguishable as long-term goals since they mostly did not state a timeframe component. Nevertheless, thirdly, the goals formulated were both hierarchical and logical. Conceptually, there was an upward sequential linkage over five levels of goals from work-plan based short-term operational targets to immediate outputs or results of activities, to intermediate objectives, to long-term aims, and finally to the overall organisational strategic goals (narrow broken upward blue arrows in Figure 10.2). This indicates that the attainment of the formulated leprosy project goals was dependent on the performance of activities in the project plans and was predictor of the overall achievement of the organisational goals in the country strategic plan.

Fourthly, the structure of TLMN goal-setting process was top-down. It originated from the national level responsibilities of Mr B to the peripheral stakeholders at the project and community levels (broad brown downward arrows in Figure 10.2). This structure illustrates top-down communication at the initiation of the process and the top-down dissemination of assigned goals at the end of the process. Fifthly, there was a bottom-up flow of information about the needs and problems of beneficiaries that emanated from the community and project stakeholders to the multi-sectoral committee, the national stakeholders responsible for the goal formulation stage at the national office (broad green upward arrows in Figure 10.2). While this reflects the information used for goal-setting is *beneficiary-focused or -centred*, it also illustrates the centralisation of goal-setting at the national level, based on a *team consultative approach*, and the exclusion of the peripheral stakeholders from the goal formulation stage. Hence, the overall framework shows the goal-setting process began and ended at the centre of the organisation.

10.4 Theory Based on TLMN Goal-setting Practice

Overall, based on the five key lessons learnt from the final general theoretical goal-setting framework in Figure 10.2, I can propose the following four submissions about the TLMN organisational goal-setting practice. First, it could be generally described as *a linear multi-staged centralised and top-down*

process in which field stakeholders play a passive role, but typically uses *problem-based, beneficiary-focused, and national team-consultative approaches*. Secondly, the process is directly the determinant of the formulation of *written, hierarchical and logical assigned project goals*, but whose statements are generally *non-SMART*. Thirdly, the formulated project goals are foundational to the planning of assigned project plans. Lastly, the achievements of the project goals produced by the process are logically dependent on the performance of planned activities and predictor to the attainment of organisational strategic goals.

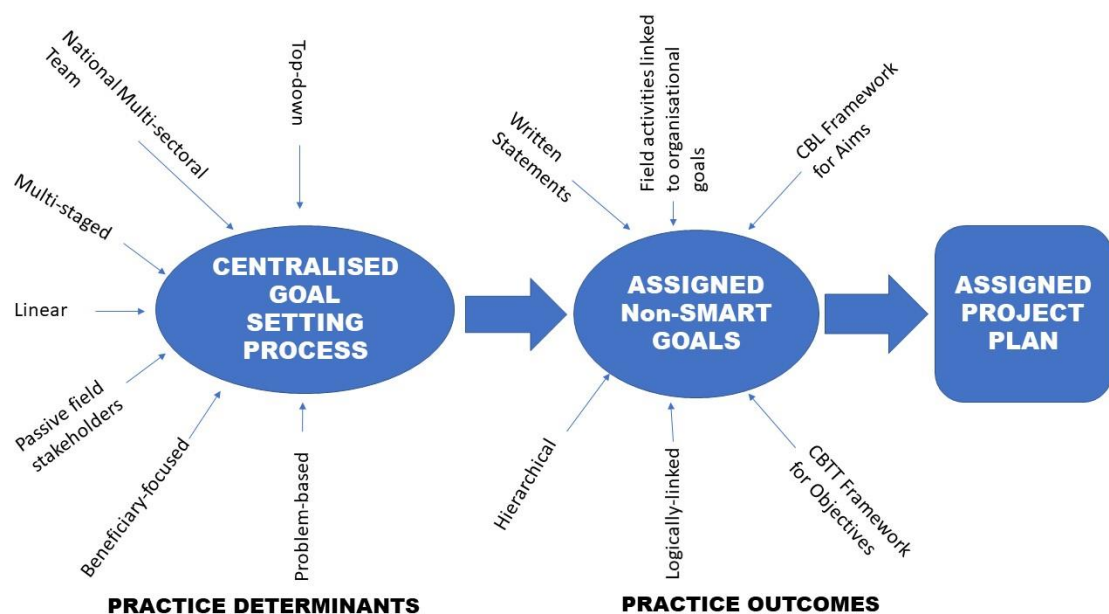


Figure 10.3: Theory of TLMN Organisational Goal-setting Practice

As illustrated in Figure 10.3, I wish to infer from these submissions that there are three linearly related general constructs in the theory that explains TLMN's goal-setting practice: the centralised top-down goal-setting process, logical non-SMART assigned goal formulation and project planning. Generally, the framework of this theory suggests that the centralised goal-setting process and its typical attributes are the determinants of the goal-setting practice. Similarly, the formulation of non-SMART assigned goals, which follows from the goal-setting process, and its defining attributes, are the immediate outcomes of the goal-setting practice outcomes. The remote outcome of the goal-setting process

is the project plan, which is directly dependent on the quality of goals formulated (Figure 10.3). Invariably, therefore, I can postulate a theory based on these assumptions from TLMN goal-setting practice that: *Assigned non-SMART goal formulation is the direct consequence of a centralised non-participative goal-setting process and the predictor of assigned unrealistic project planning* (Figure 10.3). This is, therefore, the theory of practice for goal-setting in the context of TLMN organisation.

Overall, this emergent theory of practice describes the theoretical relationship between the goal-setting process and the formulated goals; and forecasts the relationship between goal formulation and project planning in TLMN's goal-setting practice. The immediate implication is an assumption that any changes made in the conceptual attributes of the goal-setting process could directly change the defining attributes of the formulated goals (Figure 10.3) and ultimately change the quality of project plans also. Hence, looked at positively, any improvement in the quality or concepts of the goal-setting process would improve the quality of formulated goals and should lead to better quality of the project planning of these leprosy projects. Therefore, based on the evidence of this research, the theory of practice that proposes participatory goal-setting practice is recommended. This would propose a collaborative process in place of the centralised one as the independent construct of the recommended goal-setting practice, and the formulation of SMARTA goals in place of assigned non-SMART goals as the immediate outcome construct (Figure 10.4).

According to the recommended theory of participatory goal-setting practice, formulated project goal statements will be SMARTA (specific, measurable, attainable, realistic, timed and agreeable) and project plans will therefore be realistic and relevant, if the goal-setting process is collaboratively performed at all stages of the practice by all relevant project stakeholders (Figure 10.4). As listed in section 6.3 and illustrated in figures 6.1 (page 121) and 7.1 (page 179), the project stakeholders include leprosy managers at the national and project levels of TLMN organisation, as well as project beneficiaries at the community level. Implementing the recommended collaborative goal-setting practice in the TLMN context means including capable representatives of all three levels in the national goal setting committees as active participants in the discussions of

problem tree analysis, goal formulation and design of the project of which they are direct stakeholders.

Figure 10.4 compares this recommended theory of participatory practice with the centralised practice in TLMN and the already prevalent deductive goal-setting theories according to Locke and Latham (1990) and Doran (1981). Clearly, it shows the evidence that since the TLMN goal-setting practice did not produce SMART goal statements, the deductive theories that prescribe SMART goal formulation were not translated into practice.

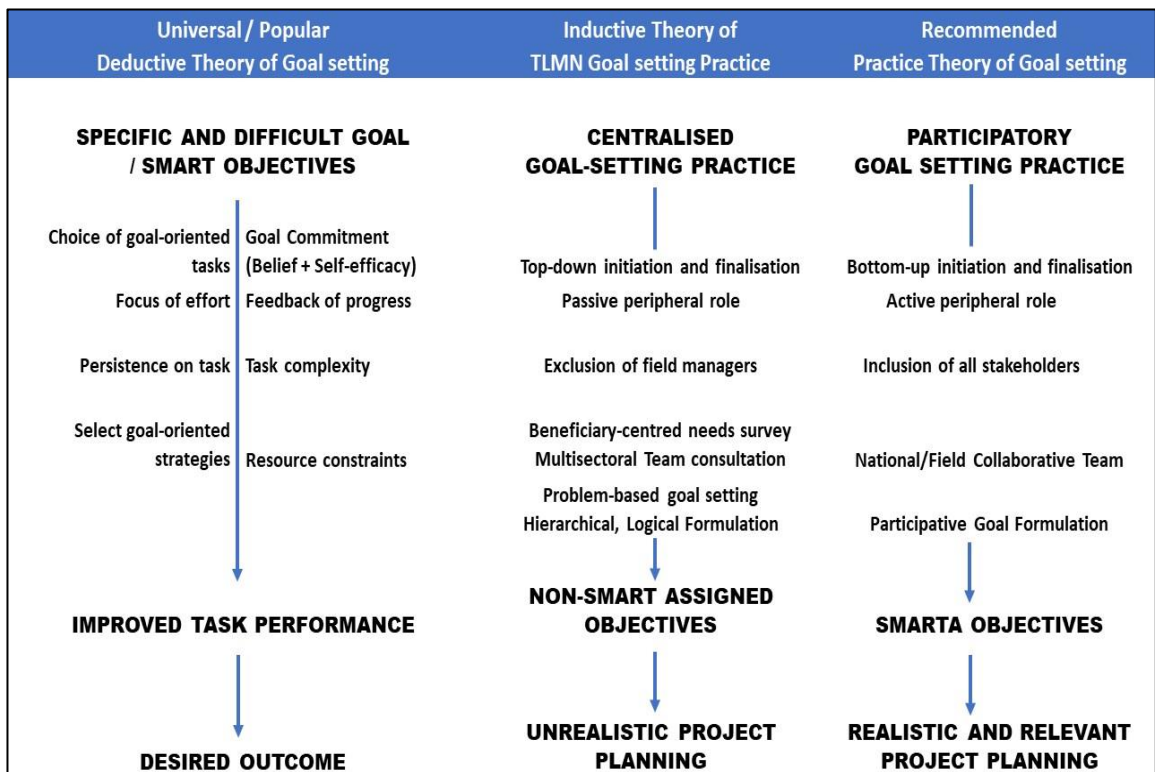


Figure 10.4: Comparing the inductive theory of goal-setting practice and the prevalent deductive theory by Locke and Latham (1990)

Therefore, theoretically, with the current CBTT and CBL framework of leprosy goals, the theoretical goal effects of improved task performance and goal attainment may not happen in the context of TLMN leprosy projects, despite the impressive awareness of these concepts of among leprosy managers. Moreover, the assumed overall complication of centralised goal-setting is unrealistic project planning, which the field leprosy managers themselves believed is a key factor in project failure. While the quality of leprosy project

planning was not explored in this research, the recommended theory of participatory goal-setting practice illustrates that the direct benefit of the SMARTA goals formulated will be realistic and relevant project plans. To my knowledge, this theory is the first theory of goal-setting practice to evolve from empirical research. However, like all inductive theories, it is open for verification (Locke & Latham 2006) and will need further inductive research such as the grounded theory method to be conducted in the same or other leprosy organisational contexts. Also, deductive surveys and experimental studies will be useful to test its workability and prove its generalisability.

10.5 Limitations of the Study

Most importantly, according to popular knowledge, a grounded theory method would have been a more appropriate qualitative study design for generating theories or theoretical process frameworks that are grounded on the raw data collected from study participants (Charmaz 2006; Creswell 2013). It is therefore considered a major methodological limitation of this research that an exploratory case study design was used. So, the theoretical frameworks of the goal-setting practice in TLMN organisation and the final theory of practice constructed from it may not technically be considered grounded theories, since the typical procedures for the theory generation required for a proper constructionist grounded theory methodology were not followed in this research. Therefore, there may be doubt of the workability and applicability of the theories and proposals that emerged from this research in the actual goal-setting practice in the context of TLMN or other organisations. Besides, despite the extensive triangulated examination of a single case phenomena possible with case study research, the design has a poor reputation for exploration of generalisable relationships of the case under study (Creswell 2013; Yin 2014). As already argued by Hammersley and Gomm (2000), the causality in the relationships between centralised goal-setting process, non-SMART goals and unrealistic project planning cannot be established or generalised from the practice of a single organisation of TLMN studied in this research. Thus, in the view of Bryman (2016), the scope of the usefulness of my qualitative case study findings is further limited by their external validity that cannot be verified. Yet, as

advised by Stake (2000) a naturalistic and theoretical generalisation may still be possible when the findings are left to the individual judgement of readers of my thesis, as to whether the theoretical concepts generated by this research may be applicable to their specific goal-setting contexts or not.

Moreover, the general subjectivity of qualitative research (Creswell 2013) may have been further increased by the flexible theorisation process permitted by the combination of thematic analysis models of Charmaz (2006, 2008) and Braun and Clark (2006). The generation of all theoretical goal-setting frameworks from TLMN practice involved my reflective interpretation of the emergent goal-setting themes and my continuous interaction with the research data throughout the data analysis and interpretation stage of my study. This means that all theoretical frameworks and theories did not evolve purely from the perspectives of the leprosy managers based on data collected, but also from the researcher's reflective interaction with the emergent empirical themes and concepts of TLMN goal-setting practice. While this process is in line with the subjectivist nature of qualitative methodology and the flexible social constructionist approach (Creswell 2013; Charmaz 2006), the possibility of unintentional researcher bias getting into the theorisation process from the strong background of my past association with the goal-setting practices of TLMN Nigeria is a technical limitation. It was expected as in most qualitative research for me to minimise any researcher bias by bracketing (excluding) my pre-existing knowledge and personal opinions from the empirical observations of the goal-setting practice. However, the relativist ontology and transactional epistemology of the methodology required that I participated in the process of co-constructing reality with the leprosy managers as my study participants (Charmaz 2008).

Moreover, it is ethical for a pure qualitative researcher to evolve his understanding of his or her study subject, from the meanings and perceptions that the study participants have concerning the studied phenomenon in their own natural state. However, for this doctoral research study, it was not possible for me to enter the world of leprosy managers without a robust and critical review of literature on the current knowledge of goal-setting concepts or a detail pre-study analysis of the leprosy projects and their goals. Before the field data

collection stage of this research, I already published two peer-reviewed articles on the frameworks for defining and writing goals in development and health contexts. Hence, I did not enter the fieldwork stage of my research with a blank sheet as typical for a qualitative study (Creswell 2013).

10.6 Summary of this Chapter

This chapter discussed the final stages of the process of theory development in this research. In the beginning, it provided summaries of the research problems and the findings of theoretical goal-setting frameworks that emerged from the analysis of research data. All eleven theoretical frameworks constructed from the concepts of the three final themes of goal-setting stakeholders, goal-setting strategies and goal statements were integrated into one general theoretical framework of TLMN goal-setting practice. A theory of TLMN goal-setting practice was evolved from the theoretical submissions made from the final general framework. According to this framework (Figure 10.3) and theory (Figure 10.4), TLMN goal-setting practice is composed by a multi-stage centralised process with a top-down structure because of the localisation of goal-setting at the national level of TLMN and the passive role of field and community stakeholders at the periphery.

This centralised process was a determinant factor that led to the formulation of assigned hierarchical, logical goals according to the CBL and CBTT frameworks of the statements of aims and objectives respectively. The theory of practice from TLMN's context suggests a direct linear relationship between the three general constructs of the centralised goal-setting process, the formulation of non-SMART goals and the planning of unrealistic project plans. A participatory goal-setting process that theoretically produces SMARTA goals and more realistic and relevant project plans is therefore recommended. The chapter ended with the key methodological limitations associated with my use of case study design and thematic analysis as the study design for the generation of the goal-setting theoretical frameworks and the theory of practice. These methodological limitations should be considered when interpreting the applicability of the evidence of theoretical goal-setting frameworks from this research to settings other than TLMN leprosy projects in Nigeria.

The next chapter (chapter 11) reports the final conclusions of this doctoral thesis generally and specifically discusses participative goal-setting practice as the main recommendation of my doctoral research and the way forward for the goal-setting practice of TLMN organisation in Nigeria in the future.

Chapter 11

CONCLUSIONS

'Goal statements will be 'SMARTA' and work plans will, in turn, be realistic and relevant, if goal-setting is done collaboratively by all stakeholders at all stages of the process.'
(Section 11.2, page 251, 2nd paragraph)

11.1 Introduction

This final chapter presents the final conclusions of my research and discusses participatory goal-setting practice as a key recommendation. The conclusions and recommendations are directly related to the theory of practice that was developed from the final emergent general framework that is illustrative of TLMN goal-setting practice in the previous chapter. In my final submissions, the evidence of theoretical frameworks and the theory of practice for goal-setting are used to address the purpose of the research in chapter 1, and the knowledge gaps identified in the review of literature goal-setting in chapter 2. In particular, the research evidence is also used to answer the two study answers stated at the end of chapter 2.

In addition, this chapter outlines the contribution of my research findings to academic knowledge about the subject of goal-setting and discusses the implications of the research evidence for future research on the theory of goal-setting practice. Based on the evidence that emerged from this research, my post-study recommendations are listed for the improvement of goal-setting practice in healthcare organisations specifically, and low-income countries in general. In the final section of the chapter, the extent of my accomplishment of the three study objectives outlined in chapter 2 is evaluated. In this, the study objectives are assessed as my final validation and valuation of this doctoral research project.

11.2 Final Submissions

This study was primarily necessitated by the evidenced low goal-setting capacity of managers and healthcare organisations, despite the widespread knowledge and argument for the practice of goal-setting as an effective

management intervention to improve work performance and outcomes (Locke & Latham 2002, 2006; Boyce et al., 2001). Even a pre-study review of the leprosy goals formulated in TLMN organisation found the structure of goal statements on which the leprosy projects were planned and delivered could not be measurable, attainable or realistic. Yet, while many previous studies conducted in both field and experimental settings supported the theoretical workability of the goal-setting theory (Locke & Latham 1990) and the SMART criteria for good goals (Doran's 1981), the literature gaps revealed there was no empirical evidence of goal-setting frameworks that show how these universal theoretical concepts were translated into practice, especially in healthcare and in low-income countries. Hence, this case study qualitatively explored the theoretical frameworks of the goal-setting practice of TLMN to illustrate generally how leprosy goals were formulated for field leprosy projects according to the experience of leprosy managers and actual goal statements in their project documents.

Guided by the core research question of how leprosy goals were formulated in TLMN organisation, a final general theoretical goal-setting framework was constructed from the emergent themes and theoretical frameworks about the process and structure of goal-setting identified in the research data. The goal-setting process had four general centralised stages that included national preparation, field baseline needs survey, goal formulation and project planning. The process was top-down, centre-led, beneficiary-focused and involved field stakeholders as passive participants. The goal formulation was problem-based and consultative of a national multi-sectoral team that excluded the participation of field stakeholders. Hence the goals formulated were assigned and had non-SMART goal statements, but which were foundational to the design of project plans. The project goals were theoretically linked to planned activities, as well as to the overall organisational strategic goals. Based on these empirical observations, a theory of goal-setting practice in the TLMN context was postulated, that: *'Assigned non-SMART goal formulation is the direct consequence of a centralised non-participative goal-setting process and the predictor of assigned unrealistic project planning.'*

According to the theoretical elements or constructs of the theory of TLMN goal-setting practice, the centralised linear multi-stage goal-setting process is regarded as the determinant variable of the goal-setting practice, while the formulation of the assigned non-SMART goals is the outcome variable. In turn the project planning done at the end is dependent on the non-SMART goal statements formulated. As a way forward for the goal-setting practice of TLMN, it is assumed that any change or improvement of the goal-setting process will invariably change or improve both the quality of goals formulated and the project plans developed on them. So, my final proposal and key recommendation of this research is participatory goal-setting practice, which according to the perspectives of the leprosy managers assumes that, *Goal statements would be 'SMARTA' and work plans will, in turn, be realistic and relevant, if goal-setting is done collaboratively by all stakeholders at all stages of the process.* Therefore, a participatory goal-setting practice is more likely to produce goals that are specific, measurable, attainable, realistic, timed and agreeable (SMARTA) according to the leprosy managers' beliefs of the qualities of good goals. Also inherent in this recommended practice theory is the assumption that SMARTA goal statements are more likely to enable project plans that are realistic and relevant to the desired achievements. However, whether this new theory of goal-setting practice would work true or false in TLMN organisation or organisation working in other settings needs to be tested and verified through further research with the appropriate inductive or deductive methodology.

11.3 Research's Contribution to Goal-setting Knowledge

To the best of my knowledge, the theory of TLM goal-setting practice developed through this exploratory research is the only practice-based theory known to describe goal-setting in any setting. Besides, this research is the first to be conducted about setting goals in leprosy care and in a low-income country such as Nigeria. In addition to the emergent theories, this research generated some theoretical goal-setting frameworks that illustrate how leprosy goals were generally formulated in the TLMN organisational context. More specifically, some key goal-setting frameworks were discovered by this research, such as

the top-down structure of goal-setting stakeholders' roles, the four-stages centralised goal-setting process, the three-level hierarchy pattern of goal types, the seven criteria differentiating goals, and the two frameworks, CBL and CBTT, for constructing or writing leprosy aims and objectives. With the exception of the four-stage goal-setting process that seemed comparable to some goal-setting process frameworks already reported in literature, like Scobbie et al.'s (2013) G-AP framework, these frameworks represent new organisational goal-setting tools not yet reported in any published goal-setting literature.

The subjectivity of my qualitative paradigm and the particularity of my case study design might make any generalisation of these findings in TLMN goal-setting context to other project or organisational settings unreasonable. However, theoretically, the frameworks may be found to be useful practical goal-setting guides by individual goal setters in any contexts – healthcare settings or even beyond. In this regard, I present the CBTT and CBL frameworks as possible templates for writing statements of leprosy project objectives and aims respectively. However, two adjustments are necessary for the future use of these frameworks for formulating effective goal statements. First, to improve the measurability of the CBTT objective statements and make the goal fully SMART, a progress indicator should be specified as an additional component in the framework. This would then revise the functional acronym to CBITT. (Change, Beneficiaries, Indicator, Target and Timeframe). Second, to retain the identity of the aim as a long-term goal type, it is essential to set a fixed long-term time or period in the statement. So, to do this, a CBL framed aim statement would require timeframe as an additional component in the framework. This would also revise the functional acronym to CBLT (Change, Beneficiaries, Location and Timeframe).

However, many of the goal-setting concepts generated from the TLMN practice are not entirely new or innovative additions to the existing general knowledge of goal-setting. Chapter 2 reports the abundant evidence gathered from the past goal-setting studies reviewed. Particularly, while the framework of the SMARTA goal criteria represents a new acronym for the set of attributes of an ideal objective statement, there is already a myriad of similar SMART-related acronyms and criteria that possess the same letters and meanings. Likewise,

the proposed Goal Effect Cycle (GEC) is an innovative proposal of the cyclical relationships between the individual goal effects mentioned by leprosy managers, but the concept of mediators in the goal mechanism is already an integral part of Locke and Latham's (1990, 2002, 2006) goal-setting theory. Thus, apart from the frameworks of assigned non-SMART goals formulated, there is some alignment of the theoretical themes in TLMN goal-setting practice with the universally popular theoretical models for goal-setting.

Nevertheless, in line with the knowledge gaps identified from the narrative review of goal-setting literature in chapter 2, the findings of this research have addressed to a reasonable extent the lack of research-based evidence of goal-setting practice frameworks that illustrate how health goals are formulated. Therefore, I propose that the final general theoretical goal-setting framework (Figure 10.2, page 241) illustrates how goal-setting was practised for leprosy projects in TLMN using an overall centralised process and a top-down structure. The theory of TLMN practice for goal-setting (Figure 10.3, page 243) explains how the key variables in a centralised goal-setting process may influence the formulation of assigned non-SMART goals. They also explain why a participatory goal-setting practice could be the way forward to improve goal-setting at project or organisational level.

11.4 Implications for Further Research

Due to the methodological weakness of using a case study design for the generation of a theory of goal-setting practice in this research, it is important that the next stage of theory verification research should use a grounded theory method in settings where the rigorous study design procedures are practicable (Glaser & Strauss 1967; Glaser 1978; Glaser 2003). This will be a further inductive study that will verify whether this practice theory of goal-setting works in the reality of leprosy managers' experience in TLMN goal-setting practice. According to Glaser (1978), that a theory works means it *explains* what happens, *predict* what will happen and *interpret* what is happening in an area of substantive or formal inquiry. Kearney (2007: 128) adds that a theory's generalizations of the relationships and influences of its constructs must be *acceptable*. Also, in Stern's (2007) view, it must be *sensible*, emerge directly

from data and have all its components in *harmony* with one another. Therefore, even though my theory evolved inductively from both experiential and documentary data relating directly to the TLMN goal-setting practice, it still requires an evaluative verification of its workability and relevance to research data. To what extent is my practice theory of goal setting grounded on the TLMN goal setting practice data? Only a future verification grounded theory research can show whether a theory generated from a case study can possess the standard features of a well-generated theory.

Clearly, a theory verification research is necessary because the theory of goal-setting practice that emerged from this doctoral study cannot be said to be a 'grounded' theory since it did not evolve out of a systematic theorisation process. The typical design of a well-planned grounded theory method involves a theoretical sampling (selection) of study participants, theoretical sensitivity of conceptual codification and integration, theoretical saturation of data collection, and simultaneous collaborative data collection and analysis (Glaser & Strauss 1967; Glaser, 1978; Patton 2002; Charmaz 2006; Corbin & Strauss 2007; Bryant & Charmaz 2007a; Bryant & Charmaz 2007b).

Moreover, it will be necessary to deductively test the hypothesis that stakeholder collaboration in all stages of the goal-setting process would improve the quality of goal statements and plans developed on them. According to Creswell (2013), testing a hypothesis requires a post-positivist research paradigm that is philosophically deductive and quantitative. I, therefore, recommend a post-doctoral quasi-experimental randomised controlled trial. This could be designed to test the efficacy of the model of participatory goal-setting practice using the CBITT and CBLT frameworks to formulate SMARTA healthcare service goals as a goal-setting intervention in TLMN or other organisational contexts (Creswell 2009, 2014). This will answer the vital question of whether a SMARTA goal-based participatory goal-setting approach works in an organisational practice of a similar setting as TLMN. The study could also be done a different setting, for example a healthcare delivery system or programme in a high-income country such as the NHS healthcare services, where this doctoral research was originally intended. The proposed NHS goal setting study could compare the quality of project goals and plans formulated by

two study groups: an intervention group and a control group using the study framework outlined in Table 11.1.

Table 11.1: Research framework of proposed quasi-experimental trial

Headings	Details
Study Design	A prospective cluster, randomised, controlled quasi-experimental trial
Target population	Locally Commissioned NHS Health service units or programmes – trusts, practices and health projects at primary, secondary and tertiary tiers of health care delivery in England.
Sampling	Stratified sampling - A random selection of locally commissioned NHS services from the three tiers of healthcare delivery (primary, secondary care hospitals, specialist care hospital into study sample. All locally commissioned services in the study areas will be invited to participate
	Sample size: All NHS service units that consent to participation in the study will be recruited for data collection.
	Selection of services into intervention and control groups will be randomised in a single-blind manner – the researcher will allocate services into groups , but the participating services will be ‘blind’ concerning the group that are assigned.
Study Groups	<u>Intervention group</u> : NHS service units given an active intervention of workshop training of participants on SMARTA participatory goal setting
	<u>Control group</u> : NHS services, not given the intervention but given only a general capacity building of NHS goal setting and planning framework enough to prepare quality health service plan aligned to the current NHS goal setting practice.
Participants	Health Planners, managers, monitoring and evaluation officers of selected NHS services or programmes
Variables	Determinants of goal-setting practice <ul style="list-style-type: none"> • Process / stages / activities of goal-setting • Stakeholders – National, Local Commissioners, Managers and Providers of commissioned services, patients, families etc • Approach – Participatory or Non-participatory / Current • Sources / Focus of goal setting data
	Outcomes of Goal-setting Practice <ul style="list-style-type: none"> • SMARTA / Framework / components of goal statements • Logical framework of planned service plan: Linkage of problems/aims/objectives/outputs/strategies/activities • Goal attainability
Study methods and Tools	Structured document review / examination of NHS service plans and periodic reports using a structured checklist
	Structured questionnaire interview
Procedure	Baseline data collected during capacity building and annual planning event
	Follow-up data collected quarterly at 3 rd month, 6 th month, 9 th month and finally at the 12 th month
Data Analysis	Quantitative analysis of data collected at baseline and quarterly during the one year period.
Ethical consideration	It is important that every consenting NHS service is given an equal chance of being selected into the intervention group

11.5 Key Recommendations

The main recommendation based on the evidence of this research is the adoption of participative goal-setting practice as the framework for formulating SMARTA goal statements and developing realistic and relevant project plans. Adopting a participatory goal-setting practice would mean organisations such as TLMN use a more inclusive goal-setting approach that has a bottom-up structure and a collaborative process that involves both central and peripheral project stakeholders at all stages of goal formulation. In TLM's context, this means both the national and field managers play active roles in formulating agreed, participative or cooperative goals. This is in line with the field leprosy managers desire for a revision of TLMN's top-down goal-setting, to a bottom-up approach. This would essentially transform the TLMN organisational practice from their current centralised one in which the field leprosy managers and community beneficiaries are passive participants.

Also recommended is the modification of the two general frameworks for constructing the statements of aims and objectives as already outlined in section 11.3. As proposed by this research, the more effective goal writing templates could be a four-component CBLT framework for aim statements and a five-component CBITT framework for objective statements. As highlighted in section 11.3 earlier, the inclusion of a timeframe (T) component would identify the written aim statement as a long-term goal (Playford et al. 2009). Similarly, including a quantifiable indicator will make the objective statement measurable and completely SMART (Doran 1981; Ogbeiwi 2017).

11.6 Application of the Theoretical Frameworks for Goal-setting

As discussed in the previous section, this research ended with the generation of main theoretical frameworks for goal setting, including the theory of participatory goal setting practice and the CBITT and CBLT frameworks for constructing goal statements and the SMARTA criteria for formulating good goals. Despite the literature-based caution against generalization of the findings of a case study research, the universal situation of poor goal-setting skills gives the indication of a plausible applicability of these theoretical frameworks to improve the quality of

goal-setting practices in different work sectors in both high-income and low-income countries.

11.6.1 Participatory Practice Theory of Goal-setting

The theory of participatory goal-setting practice relates three constructs of a goal setting practice – the participatory process, the SMARTA statement formulation and the relevant project or action planning. Therefore, translating the practice theory into actual practice requires that goal setters first design the goal setting process in which all designated stakeholders, including service providers or implementers, beneficiaries, managers, and regulators collaborate in the execution of all four stages of preparation, needs survey, goal formulation and action planning.

In the practice context of TLMN, collaboration during the preparation stage would mean the national managers consult and work with the field managers and beneficiaries as much as practically and technically feasible in the four tasks of conceptualising, reviewing information, planning the process and communication. There was already a passive collaboration by the three levels of stakeholders during the needs survey stage. Future collaboration at this stage would mean the field managers and representatives of beneficiaries become active participants in the survey data collection team and be involved in the three tasks of field exploration, needs assessment and problem identification. At the goal formulation stage, collaboration would mean the project's field managers and the representatives of beneficiaries who are technically capable participate in the consultative goal-setting committee responsible for the three tasks of performing the problem-tree analysis, discussing the desired changes and writing goal statements. Similarly, collaborative project planning in the last stage would mean that the responsible national manager (Mr. B.) works alongside the field managers to design the goal-related action plans.

This proposed TLMN collaborative goal-setting approach for field leprosy projects is considered equally applicable or adaptable to the settings of other public health intervention projects in low and high-income countries. Applying the four-staged collaborative goal-setting practice to setting goals for the

individual locally commissioned health services of the NHS England would require a strategic policy change at the national level. A new policy is required that would empower the local commissioners and the managers of the commissioned services to collaborate through all four stages of the goal setting process. Collaborative goal setting is already a statutory requirement for the process of the therapist-led, client-centred goal-setting for individual patients and clients in clinical therapy and rehabilitation in high-income countries (Department of Health, 2005; Schulman-Green et al., 2006; Brown, Bartholomew & Naik, 2007; Vermunt et al., 2007; Pimentel 2008; Aston and Sheehan 2010; Øien, Fallang & Østensjø, 2010; Levark et al., 2011; Fernandez et al. 2012; Murphy & Boa, 2012; Lafata et al. 2013; Sleath et al., 2014; Peng et al., 2014; Friessen-storms et al., 2018; Plant & Tyson 2018). Applying the four-stage collaborative goal setting process that emerged from this research to clinical and rehabilitative goal-setting practice would mean that patients or clients or family members participate actively with their therapists at all stages from preparation to action planning (Øien, Fallang & Østensjø, 2010).

11.6.2 SMARTA criteria for Good Goal Formulation

The SMART criteria is already a popular concept for formulating standard goal statements. Similarly, the SMARTA criteria could be used for assessing the quality of stated objectives – simply by asking the following six key questions:

- Is the desired change SPECIFIC?
- Is the indicator MEASURABLE?
- Is the target ATTAINABLE
- Are the target and timeframe REALISTIC using available resources?
- Is the TIMEFRAME a fixed term?
- Are the change, indicator, target, and timeframe AGREEABLE to all stakeholders?

I propose that statements of objectives formulated using a collaborative goal-setting process should fulfil all six criteria of the SMARTA framework. This is relevant not only for health service objectives as formulated in the leprosy project practice of TLMN or service objectives of other organisations delivering healthcare services worldwide, but also for assessing the quality of goal

statements formulated for the monitoring of individual patient or client improvement in clinical and rehabilitative medicine.

11.6.3 CBITT and CBLT Frameworks for Writing Goal Statements

The CBITT and CBLT frameworks for formulating mid-term objectives and long-term aims proposed at the end of this research are more elaborate than the OITT and IT frameworks derived during the literature review stage. Using the CBITT and CBLT for constructing statements of objectives and aims requires the specification of additional components than are needed for OITT and IT. For writing an objective, in addition to stating the mid-term Change (C) or Outcome (O), Indicator (I), Target (T) and Timeframe (T), the CBITT framework also states the Beneficiaries (B) of the service or project. For writing an aim, in addition to stating the long-term Change (C) or Impact (I) and Timeframe (T), the CBLT framework also states the Beneficiaries (B) and their Location (L). Just as I have recommended for the complete the framework of goal statements in TLMN practice, I propose the CBITT and CBLT could be used as templates for writing service or intervention objectives and aims respectively generally. Thus they could be particularly useful in improving the quality of goal statements writing for public health projects managed by organisations in low-income countries or for healthcare services commissioned and deliver by systems in high-income countries such as the NHS in England.

11.7 Evaluation of Research Objectives

11.7.1 Objective 1

The first objective of this research was to explore the conceptual or theoretical framework of TLMN's goal-setting practice that describes how goals are formulated for leprosy projects in Nigeria. In the final analysis, this research developed a general theoretical framework of TLMN's goal-setting practice from the initial 11 frameworks related to the final emergent themes of stakeholders, strategies and statements. According to the theoretical evidence of this research, the key strength of TLMN general goal-setting framework was the multi-stage problem-based goal formulation that was the rational basis of their leprosy project planning. Even though the overall process was centralised and not completely collaborative, it was also an advantage that the information used for problem

analysis and goal formulation was beneficiary focused. This potentially makes the leprosy goals and the intervention plans relevant to the needs of the target population of the leprosy project in the long run. Additional strengths were the use of national-based multi-sectoral team consultation for goal formulation and the post-planning feedback to field leprosy managers for their validation of formulated goals and plans.

However, according to the perspectives of field managers, the key weaknesses of TLMN goal-setting framework were the passiveness of field-based stakeholders and their exclusion from the goal formulation stage that occurred at the national level. As a result, the organisation formulated assigned goals and plans with theoretical possibility of delivery of an unrealistic intervention despite the beneficiary need-oriented goal-setting. Moreover, the evidence of CBL and CBTT statement frameworks for formulated aims and objectives supported the conclusion that the formulated goals were not entirely SMART. Overall, the research was successful in identifying the general theoretical framework inherent in TLMN's goal-setting practice for leprosy projects in Nigeria. While the practice shows a systematic approach, theoretically, it is assumed that the assigned non-SMART goal formulation is a consequence of the centralised non-participative top-down process and a possible determinant of unrealistic project planning.

11.7.2 Objective 2:

The second study objective was to assess the extent to which the universal theoretical concepts for formulating objectives were implemented in the practice context of TLMN. Without doubt, several of the theoretical goal-setting frameworks generated from the goal perspectives of leprosy managers indicated a reasonably good awareness of the universal theoretical concepts of goals and effective goal-setting. Particularly, the frameworks of goal definitions, the Goal Effects Cycle, the hierarchical goal classifications and differentiation, and the SMARTA attributes of ideal goal statements were enough evidence of the theoretically strong knowledge base of the TLMN goal-setting practice. However, this research concludes that these theoretical concepts were only partially translated into practice. This was primarily because of the evidence of the incomplete components in the CBL and CBTT frameworks of the statements

of formulated aims and objectives respectively. Therefore, it is considered essential that additional components of indicator and timeframe are required in the formulation of leprosy goal statements to make them really SMART.

11.7.3 Objective 3

The third objective was to develop a practice theory for goal-setting in a low-income country context. Like all qualitative studies should (Creswell 2013), this study ended with a theory of goal-setting practice that emerged inductively from the general theoretical framework in TLMN's context. This theory postulates that assigned non-SMART goal formulation is the direct consequence of a centralised non-participative goal-setting process. It is also the predictor of assigned unrealistic project planning. Based on the lessons learnt from TLMN goal-setting practice, participatory goal-setting is recommended for effective and realistic goal-setting and planning. This proposal suggests that goal statements would be 'SMARTA' (specific, measurable, attainable, realistic and agreeable) and work plans would, in turn, be realistic and relevant if goal-setting is done collaboratively by all stakeholders at all stages of the process.

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ANNEXEES

Annexe 1: Published Article #1

Defining Goal Terms in Development and Health

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ABSTRACT

Introduction:

Most academic literature uses 'goal', 'aim', 'objective' and 'target' as synonymous terms, but development and healthcare sectors define them as distinct etymological entities with varied and confusing interpretations. This review sought to constructively harmonise and differentiate each definition using a thematic framework.

Method:

An inductive synthesis of definitions of the goal terms collected from 22 literature sources selected through a systematic internet search. Thirty-three specific definitions were reduced through serial category-building to single general definitions, and a set of theoretical themes generated as characteristic framework of each goal.

Results:

Seven conceptual themes evolved from the synthesis, including the object, scope, hierarchy, timeframe, measurability, significance and expression of each goal term. Two terms, 'goal' and 'aim' are thematically similar as broad objects of immeasurable terminal impact, with a long-term timeframe. They signify organisational success, expressed as general-purpose statements. 'Objective' is differentiated as a specific object of measurable intermediate outcome, with short-term timeframe. It signifies intervention effectiveness, expressed as a SMART statement. 'Target' is simply a specific quantifiable level of an indicator.

Conclusions:

Goal, aim, objective and target are conceptually different. New frameworks for writing complete goal statements are proposed, including impact and timeframe; and outcome, indicator and timeframe frameworks for aim and objective respectively.

Key Words: Definitions • Goals • Aims • Objectives • Targets • Intervention

Introduction

Most goal-setting articles use the terms goal, aim, objective and target interchangeably as similar in the concept of a goal (Locke et al, 1981; Locke and Latham, 2002; Day and Tosey, 2011), which Lee et al (1989) defined as 'that which one wants to accomplish ... concerns a valued future end state'. A preliminary review by the author of 50 goal-setting articles published from 1982 to 2013, found the majority—30 (60%)—use the term goal, 17 (34%) target, and seven (14%), objective, but all used the terms synonymously in the different contexts of their studies. However, relatively few articles—seven (30.4%)—provide a definition of the term used (Yearita Maitlis & Briner 1995; Locke and Latham, 2002; 2006; 2013; Fitsimmons, 2008; Day and Tosey, 2011; Nanji et al, 2013). In the same definition, Locke and Latham (2006) describe a goal as an expected 'object or outcome', 'the aim of an action' and 'the level of performance to be attained', which have interpretative references to 'objective',

'aim' and 'target' respectively. In fact, Locke et al (1981: 126) assert that a goal means the same as an objective, being 'the ultimate aim of an action'. Apparently, the synonymous usage of these terms are supported by the Collins English Dictionary (2006), in which aim is an 'intention or purpose'; goal and objective are similarly 'an aim or purpose'; and target is 'a fixed goal or objective'. Even though Day and Tosey (2011) recognise Jones and Duckett's (2004) distinction of targets and goals as 'short-term' and 'longer-term' aims respectively, they still prefer to use the terms interchangeably in their article. However, Mullins (1999: 115) in a textbook on management and organisational behaviour separates goal from objective. According to Mullins (1999: 115), 'Goals are translated into objectives'. This indicates that, hierarchically, a goal is conceptually higher than an objective.

Nevertheless, Mullins also interlaces their meanings by stating that, while goal could vary in meaning, from a broad organisational purpose to a specific measured achievement (Mullins, 1999: 116), objectives could be specific organisational goals as well as the 'aims to be achieved and the desired end-results' (Mullins, 1999: 123). The academic sector seems to confuse the distinction of the goal terms, which are undoubtedly the key conceptual pillars on which every effective goalsetting practice should rest. Understandably, a situation of terminological confusion was declared in the development sector since early 21st century with respect to the diverse understanding of core technical terms in popular usage (Organisation for Economic Cooperation and Development (OECD), 2002). This, according to Niels Dabelstein of OECD, predicated the publication of numerous glossaries aimed at standardising definitions in the sector (OECD, 2002). However, the author's preliminary review of glossaries of development organisations revealed a lack of coherence on how each term is defined and stated is still prevalent in the sector, despite seeming agreement on the differentiation of goals, aims, objectives and targets as nonsynonymous entities (OECD, 2002; Save the Children, 2003; UNFPA, 2004; UNDG, 2011). It is the purpose of this article to review the range of definitions of these four goal terms in contemporary development and healthcare literature with a mind to constructively harmonise them for a uniform application by goal-setting practitioners. This review hopes to address a basic question in goal-setting: how do we clearly define and state goals, aims, objectives and targets?

Methods

A systematic search for credible literature sources with definitions of the four goal terms began with browsing standard electronic health and health management databases using key phrases. Initially, PubMed, MEDLINE, Health Management Information Consortium and Google scholar databases were searched with the phrase: 'Definition of goal, aim, objective and target in health management and development.' When no relevant results were obtained, the search terms were pruned, first to 'definition of goal, aim, objective and target in health management,' then later to 'Goal, aim, objective and target in health management.' With no satisfactory results, the search strategy was widened to include Google search engine, using more specific phrases: 'Glossaries of monitoring and evaluation terms' and 'Toolkits for monitoring and evaluation'. A final search was done with the phrase 'Goal-setting in the NHS.' The main inclusion criteria for relevant literature included availability of definitions of at least one of the four terms, publication date after the year 2000 (21st century) and credible institutional association. On the last criterion, many internet blogs and personal opinion materials were excluded, such as the extensive online write-ups by Kellock (2012), RapidBi (2007) and Funds for NGOs (2013). Many goal-setting research articles were also excluded for lack of definitions.

The searches produced 22 usable sources, with 20 (90.1%) published since 2007. They included seven glossaries, four manuals, nine information sheets on goal-setting, and two slide-share presentations. They were from three sectors: 11 (50%) from healthcare, eight (36.4%) from development, and three (13.6%) from universities. A total of 12 definitions of the term 'goal' were found in 19 sources, 14 definitions of 'objective' in 13 sources, five definitions of 'target' in five sources, and two definitions of 'aim' in two sources. The text data of the total 33 definitions were analysed qualitatively through an inductive harmonisation process involving serial category building. With this, the initial list of specific definitions of each term were reduced to primary, secondary and tertiary general categories. The primary categories were formed by grouping together definitions with similar concepts in their statements, and each category labelled with a general descriptive theme. Similar to thematic steps described for grounded theory analysis (Glaser, 1978), successive categories were formed through further identification and comparisons of conceptual themes in the primary categories. In the final stage, a single tertiary definition as well as a characteristic framework of theoretical themes were generated for each goal term. While the reviewed literature documents may be few and the sources less orthodox than academic articles, the collected definitions represent the collaborative products of many sectors, organisations, and professionals in different parts of the world. In particular, the OECD (2002) glossary was adopted by its membership of 34 countries (mostly developed countries) and multi-national, multi-agency organisations. The non-OECD sources also represent the work of several organisations— including non-governmental charities, universities, and healthcare institutions.

Results

What is a goal?

Twelve definitions of goal were reduced to five primary labelled categories, three secondary categories and one tertiary general definitions. The largest primary category with most literature sources relates to OECD (2002: 24) definition of goal as a 'higher order objective' and 'development objective' and the World Health Organization's (WHO) (2016) 'overall objectives'. The other four primary labels show that goals are also 'broad, long-term improvements' or 'broad, long-term outcomes' or 'collective, shared end-results' or 'personal aims'. These categories indicate that while development organisations define goal as a higher type of objective, the NHS healthcare organisations define different types of personal goals that are either short or long term. From the definitions of a goal, the six descriptive themes identified include—its object, scope, hierarchy, timeframe, significance and measurability. A goal's object is identified as outcome, impact, objective or purpose. OECD (2002: 24) describe goal as a development objective, equated to an impact, which they defined as 'positive and negative, primary and secondary long-term effects produced by a development intervention— directly or indirectly, intended or unintended'. The scope is 'broad' (MSU, 2012); 'generic' (UNAIDS, 2008; UNAIDS, 2010), 'common' (D'Agnes and Slater, 2009), or 'overall' (WHO, 2016). Hierarchically, it is an 'end-result' (UNDG, 2011), a 'higher order' (OECD 2002), 'higher-level effect' (USAID, 2009), or a collective result of a set of objectives (Victoria, 2010; Salford, 2011). Derbyshire (2012) treats a goal as a generic term for the entire 'ladder' of achievements with three levels: leading from 'immediate or mini goals' to 'specific goal' to the 'long-term or overall goals.'

In its timeframe, goal is long-term (Chaplowe, 2008; USAID, 2009) or 'far sighted' (D'Agnes and Slater, 2009). According to South-Devon (2012), long-term goal is 'something you want to achieve in the future', and short-term, 'smaller attainable and manageable chunks which will help you achieve a long-term goal.' In its significance, a goal is the basis for assessment of an

organisation’s purpose, vision or aspiration (Lidhiya-babu, 2014), which helps to inspire performance (UNAIDS, 2008, D’Agnes and Slater, 2009; MSU 2012). In measurability, while Lidhiya-babu states that a goal ‘may not be strictly measurable or tangible’ (slide 78), to D’Agnes and Slater (2009), it may be indirectly ‘measurable in terms of the desired changes in the factors you are trying to influence.’

What is an aim?

Table 1: Primary and secondary themes of an aim

Source Definitions	Primary definitive Concepts	Secondary labels or themes
“The broad, long-term goals set for a piece of work, for example to improve the health of children under five in district X. “	A Broad goal	Scope
	Long-term goal	Time frame
	A goal of work	Object
	Standard of success	Significance
	Expresses Organisational mandate, principles, values	Significance
“Relates to agency’s mandate, principles and values = fundamental standards against which the success of the work can be measured” (Save the Children, 2003, p.336)	A hoped achievement	Object
	Overall purpose	Scope
	Purpose of project	Object
	Broad structure	Significance
	Desired result	Object
	Phrased positively	Statement
“What you hope to achieve, i.e., the overall purpose of the project.”		
“Written as a statement of what you want to happen as a result of the audit [or action]. Phrased positively. For example, “To improve the care received by patients who develop leg ulcers”		
Provides a broad structure for your project (UHBristol NHS Trust, 2009)		
Harmonised definition:		
<i>A broad statement of a long-term goal or result desired which expresses the overall purpose of a project or the organisational mandate and serves as the standard of success</i>		

Table 1 shows the primary categories based on two source definitions and the single secondary definition harmonised from them. Five themes are identifiable from the definitions, including the scope, object, timeframe, significance and statement of an aim. The scope of an aim is ‘broad’ (Save the Children, 2003) or ‘overall’ (Bristol, 2009). The object includes ‘goal’ (Save the Children, 2003), ‘hope’, ‘desired result’ or ‘purpose’ (Bristol, 2009). Only Save the Children define the time frame as ‘long-term’. In its significance, an aim provides a ‘broad structure’, for the project (Bristol, 2009), and represents an ‘agency’s mandate, principles and values ... fundamental standards against which the success of the work can be measured’ (Save the Children, 2003). In its statement, an aim should be written as broad statement ‘phrased positively’ (Bristol 2009). Both sources gave examples of aim statements:

- ‘To improve the care received by patients who develop leg ulcers’ (Bristol, 2009)
- ‘To improve the health of children under five in district x’ (Save the Children, 2003: 336).

Both statements include broad achievements, but do not state any time frames.

What is an objective?

A total of 14 definitions were reduced to five primary labelled categories, three secondary definitions and a single tertiary definition. The five primary labels indicate that objectives are 'exact targets', 'measurable results', 'short-term goals', 'desired outcomes' or 'medium term changes'. Overall, seven broad themes—the object, scope, hierarchy, timeframe, measurability, significance and statement of an objective are identified from the definitions. The object includes: exact targets or milestones, measurable sectional results, short-term goals, outcomes and mid-term changes. Most sources give the impression that objective is an outcome, defined by USAID (2009) as 'the results or effects caused by or attributed to the project, programme or policy. Often used to refer to more immediate and intended effects.' Regarding its scope, it is specific or narrow. Hierarchically, they are placed at the intermediate result level, between immediate-level outputs, and terminal-level impact (USAID, 2009; UNDG, 2011); therefore, they are smaller units of, or steps towards, an aim (Bristol, 2009; Victoria, 2010). Accordingly, D'Agnes and Slater (2009) states that an 'Objective is moving you towards your overall aim and provides targets and milestones.' In timeframe, it is short-term (Save the Children, 2003), which could be 3 or 6 months (Barts Health NHS Trust, 2016; WHO, 2016), 12 months (Salford, 2011) or five years (Save the Children, 2003). These figures have a median of 9 months. Barts (2016) assert that a timeframe of 5 years is applicable to long-term goals. In its measurability, objectives must be measurable quantitatively or qualitatively (Murray State University, 2012), 'in terms of quantity, quality, time and money' (Salford, 2011). In significance, it is an essential tool for measuring the effectiveness and efficiency of organisations (Libhiya-babu, 2014).

In objective statements, most sources report they must satisfy the SMART criteria (being Specific, Measurable, Attainable, Realistic and Timed) (Doran, 1981). According to Lidhiyababu (2014: 43), the statement should specify 'what is to be accomplished by when and should be quantified if possible.' For example:

- 'The risk of diarrhea reduced by 50% in the target population in 6 months' (WHO, 2016)
- 'To achieve 80 per cent immunisation coverage in the next 5 years in district X' (Save the children, 2003: 339).

A review of the framework of the first statement by WHO (2016) reveals the specific outcome is 'The risk of diarrhoea reduced,' the target is '50%', and the time frame is '6 months.' This objective does not state how the outcome will be measured. Similarly, the second statement includes a target '80%', the means of measurement 'immunisation coverage' and time frame of the 'next 5 years'. However, it does not specify the specific outcome that the immunisation coverage measures.

What is a target?

Table 2 shows the three labelled primary categories obtained from the five source definitions, and the subsequent reduction to three secondary definitions, and a single tertiary definition. The primary labels reflect that a target is either a 'particular value', 'specific objective' or 'step or milestone' (*Table 2*). The three themes of target are its object, expression, and time frame. The object is either an 'objective' (UNAIDS, 2008; UNAIDS, 2010), 'results' (USAID, 2009: 11), 'rungs on the ladder' (Derbyshire, 2012) or 'The desired value of an indicator' (UNDG, 2011). The object shows its connection to an objective, as well as to the calibration of an indicator, which is defined as a quantitative or qualitative variable that serves as means to measure a desired achievement or change (Chaplowe, 2008). In expression, a target is stated as a numeric value of an indicator, which should be 'realistic, achievable and specific' (Derbyshire, 2012).

In its timeframe, its attainment refers to a particular point in time (UNAIDS 2008; UNAIDS 2010) or ‘a specific date in the future’ (UNDG 2011). In the example given by UNDG (2011), the stated indicator is ‘literacy rate’, the target is ‘85%’ and the time frame, ‘the year 2010.’

Table 2: Reduction of primary definitions of a target in source literature

Primary definitions	Secondary definitions	Tertiary definition
<p>Particular VALUE</p> <p>1. A particular value that an indicator should reach by a specific date in the future. For example, “total literacy rate to reach 85 per cent among groups X and Y by the year 2010 (UNDG, 2011)</p> <p>2. The desired value for an indicator at a particular point in time. (UNAIDS 2008, 2010, P.69)</p>	<p>A particular value of an indicator to be reached at a particular future time frame</p>	<p>A desired result or milestone toward the long term goal expressed as a particular measurable value of an indicator</p>
<p>Specified objective or RESULT</p> <p>3. The objective a program / intervention is working towards expressed as a measurable value. (UNAIDS 2008, 2010, P.69)</p> <p>4. The specified result often expressed by a value of an indicator, that a project, program or policy intends to achieve (USAID, 2009, p.11)</p>	<p>A specified objective or result to be achieved expressed as a measurable value of an indicator</p>	
<p>STEPS or MILESTONES</p> <p>5. Your targets are the rungs on the ladder (towards your long-term goal at the top) (Derbyshire, 2012)</p>	<p>Specific milestones to the long-term goal</p>	

Discussion

The terminological confusion in the definitions of goal, aim, objective and target is universal and understandably justifies the global efforts to unify their meanings through multilateral consultations over the past two decades (OECD, 2002). This review is the first attempt to inductively harmonise their definitions according to a framework of thematic concepts that differentiate them and provide a guide to a constructive formulation of their statements. Despite their non-academic sources, the literature reviewed has sufficient evidence to show that the terms are not synonymous as used in academic literature, but can be differentiated thematically on the bases of their object, scope, hierarchy, timeframe, measurability, significance and expression. Overall, the review finds a difference in understanding of the goal terms between the development and healthcare sectors. In the health sector, the term goal has a generic reference to all types of intervention results, instead of its rendition as a ‘higher order objective’ by development organisations (OECD, 2002). In addition, the shared framework indicates that the term aim is analogous with the non-generic development goal. Thematically, both are similarly objects of impact—broad terminal results with long-term timeframe and poor immeasurability; markers of organisational success, expressed as general purpose statements.

Objectives can be distinctly differentiated by their object of outcome: specific intermediate-level results with short-term timeframes and measurable indicators. They are markers of intervention effectiveness, expressed as milestone statements that satisfy the SMART criteria (Lidhiya-babu, 2014; WHO, 2016). Similarly, a target is definable by its object as a numeric value of an indicator. Moreover, these thematic frameworks also have implication for how the statements of each goal-term are written. For instance, the statement of an aim could be constructed on a lexical structure with at least two basic components—a broad, overall impact and a terminal long-term timeframe. The SMART framework expected for an objective statement necessitates that it is written on a structure that has at least four components — specific intermediate-level outcome, measurable indicator, attainable target and realistic, timely short-term timeframe.

In the final synthesis, some propositions are inducible from this review. First, in healthcare the term goal is generic for all anticipated achievements of an intervention, including aims, objectives and targets. Second, an objective as a sub-goal represents a quantifiable milestone towards an aim as the overall goal (Save theChildren, 2003; Bristol, 2009). Third, writing statements of aims and objectives could be guided by the components of a thematic goal framework. An aim statement should compose of components of the impact and timeframe (IT), while an objective statement could be written with a framework composed of four basic components: outcome, indicator, target and timeframe (OITT). Clearly, the proposed frameworks are not alternative to Doran’s (1981) SMART criteria, rather they provide templates on which SMART goals could be written. Accordingly, the published examples of aims and objectives statements in some reviewed sources are considered incomplete. This reveals a need in organisations to review the construction of statements of their aims and objectives for a more effective goal-setting practice. For example, the Save the Children (2003) aim statement could be re-written on the IT framework as, ‘To improve the health of under-five children (impact) in district X in the next five years (timeframe)’ and the WHO (2016) objectivestatement could be re-phrased on the OITT framework as, ‘To reduce the risk of diarrhoea (outcome) in the target population such that the incidence of diarrhoea (indicator) in the decreases by 50% (target) in 6 months (timeframe).’

Conclusion

The four terms of goal, aim, objective and target are thematically different according to their object, scope, hierarchy, timeframe, measurability, significance and expression. These concepts also provide structural bases for the components of lexical frameworks for writing statements of aims and objectives. In particular, the IT and OITT frameworks are recommended for writing complete aim and objective statements respectively. However, the efficacy of these frameworks to improve the quality of goalsetting practices and motivate better outcomes of interventions needs further research.

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Annexe 2: Published article #2

Why written objectives need to be really SMART

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ABSTRACT

There is general agreement that plans without well-formulated goals lack rationale, strategies lack relevance, actions lack direction, projects lack accountability, and organisations lack purpose (Mullins, 1999; Beardshaw and Palfreman, 1990; Bratton, et al, 2007). Moreover, goals need to be properly constructed to serve as credible and usable benchmarks by which the results can be monitored and evaluated via immediate outputs, intermediate outcomes over the short term or terminal impacts in the long term (Greenbank, 2001; Fitsimmons, 2008; Bipp and Kleingeld, 2011). Thus, it is a basic requirement of effective goal-setting that objective statements are formulated using a clear and logical structure or framework. This article analyses examples of objective statements drawn from the literature and concludes that none of these can be truly described as SMART, posing the risk that organisations using them as guide will fail to attain their goals.

Key Words: SMART1 objectives • Objective statements • Goal-setting • OITT2

1 SMART = *specific, measurable, attainable, realistic, time bound;*

2 OITT = *outcome, indicator, target level, time frame*

INTRODUCTION

Goal-setting is a characteristic practice shared by successful programmes and organisations across every sector of human endeavour; and writing clear and well-structured statements to express objectives in a specific, measurable and achievable format is the norm (Beardshaw and Palfreman 1990; Bratton et al 2007; Day and Tosey 2011). Hence, it is best practice to use a conceptual framework as a tool for setting goals to provide a reliable and logical platform on which work can be planned and assessed (Mullins, 1999). Generically, researchers define a goal as the desired end result of an action that is expected to be achieved at some specified time in the future, and toward which all effort and essential resources are committed to achieving (Locke and Latham, 2002; Locke and Latham, 2006; Fitsimmons, 2008; Day and Tosey, 2011; Nanji et al, 2013).

In this article, the term 'objective' is used to refer to a sub-goal, one that expresses a desired outcome: a short-term effect or change expected to result from the outputs of activities performed (Organisation for Economic, Co-operation and Development (OECD), 2002). In the hierarchy of goals illustrated in *Figure 1*, the effects of the immediate output of an intervention lead to the attainment of the objective in the short term, which in turn over the longer term contributes to achieving the broad or overall aim, described by some organisations as general goal and development, or a higher order objective (OECD, 2002). Besides the levels, *Figure 1* also differentiates outputs, objectives and aims according to the differing time frames for their attainment and goal attributes.

The literature suggests that it may take 3-12 months to achieve a short-term outcome relating to an objective, and at least five years to accomplish a long-term impact relating to an aim.

A synthetic review by Ogbeiwi (2016) identified seven thematic characteristics that distinguish an objective from other goal types, including:

- Its stated object of outcome
- Specific scope
- Mid-level or intermediate hierarchy
- Short-term time frame
- Quantifiable measurability
- Significance of effectiveness
- Expression as a SMART (**s**pecific, **m**easurable, **a**ttainable, **r**ealistic and **t**ime-bound) goal.

Hence, while *Figure 1* shows that an aim is the broad statement of the expected terminal achievement of an intervention, expressing its long-term impact and overall purpose, an objective is a specific statement of time-bound interim accomplishment. The US Centers for Disease Control and Prevention (CDC) defines objectives as ‘annual milestones that the program needs to achieve in order to accomplish its goals by the end of a five-year funding period’ (CDC, 2009).

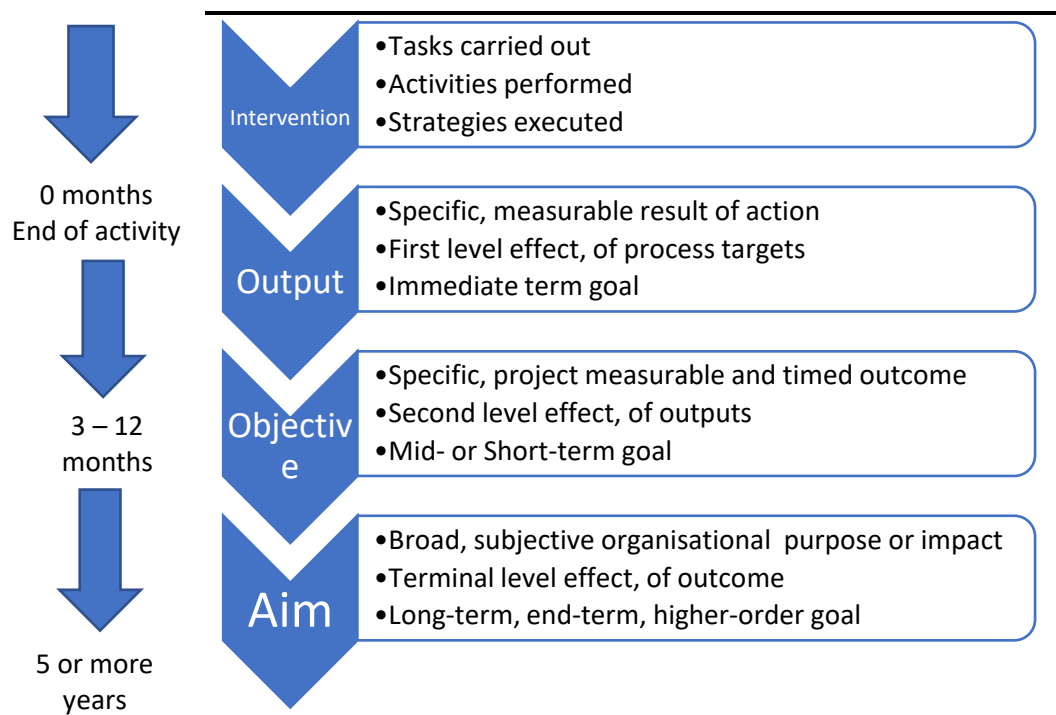


Figure 1. Linear direction of the chain effects of intervention goals

SMART objective setting

Typically, writing objectives as SMART statements is the gold standard for goal-setting, because it gives a clear direction for action planning and implementation (CDC, 2008). The SMART model was originally outlined by George T. Doran in 1981 as the five essential criteria that the statement of every meaningful and effective objective should fulfil (Doran, 1981; CDC, 2008; Day and Tosey, 2011). Many programmes and organisations have since used the SMART acronym as a reliable model to guide formulation of objectives for different intervention levels by simply asking the question: ‘Is the objective SMART?’

Different divisions of the CDC have produced tools such as checklists and templates for SMART objective setting (CDC 2008, 2009; CDC Communities for Public Health (CPH), 2017; CDC

Division for Heart Disease and Stroke Prevention (DHDSP), 2017; CDC Division of TB Elimination (DTBE), 2017). These checklists use the SMART acronym as a base, and goal setters simply answer questions related to each key word on how to make the objective statement SMART. To aid the construction of an objective statement, the CDC DTBE (2007) provides a tabulated template split into seven parts: verb, metric, population, object, baseline measure, goal measure and time frame. Two other CDC divisions provide a template of incomplete statement, with gaps to be filled with expected components (Division of Sexually Transmitted Disease Prevention (DSTDP), 2017; DHDSP, 2017). Thus, there are few tools that offer structural guidance for writing objective statements using a SMART goal framework or templates against which goal setters can compare their formulated goal statements to determine whether they satisfy the SMART criteria.

Goal-setting frameworks

Goal-setting frameworks have been studied extensively since the 1950s. The most popular of these include:

- Management by Objectives (Drucker, 1955; Dahlsten et al, 2005; Bipp and Kleingeld, 2011)
- Balanced Scorecard Approach (Kaplan and Norton, 1996)
- Goal Attainment Scale (Yip et al, 1998)
- Total Quality Management and continuous quality improvement (Ginsburg, 2001; Medlin and Green, 2009).

Other models have included the RAID (**r**eview, **a**gree, **i**mplement, and **d**emonstrate and **d**evelop) model (Parker et al, 2003) and the Productivity Measurement and Enhancement System (Pritchard et al, 2008). Bovend'Eerd et al, (2009) reported the use of WHO International Classification of Functioning, Disability and Health (ICF) as a template for goal-setting, and Scobbie et al (2013) described the G-AP (**g**oal-setting and **a**ction **p**lanning) framework. In the field of engineering, Zhu et al (2002) looked at the use of **o**bject/**o**bjective oriented **m**aintenance **m**anagement (OOMM) as a goal-setting framework.

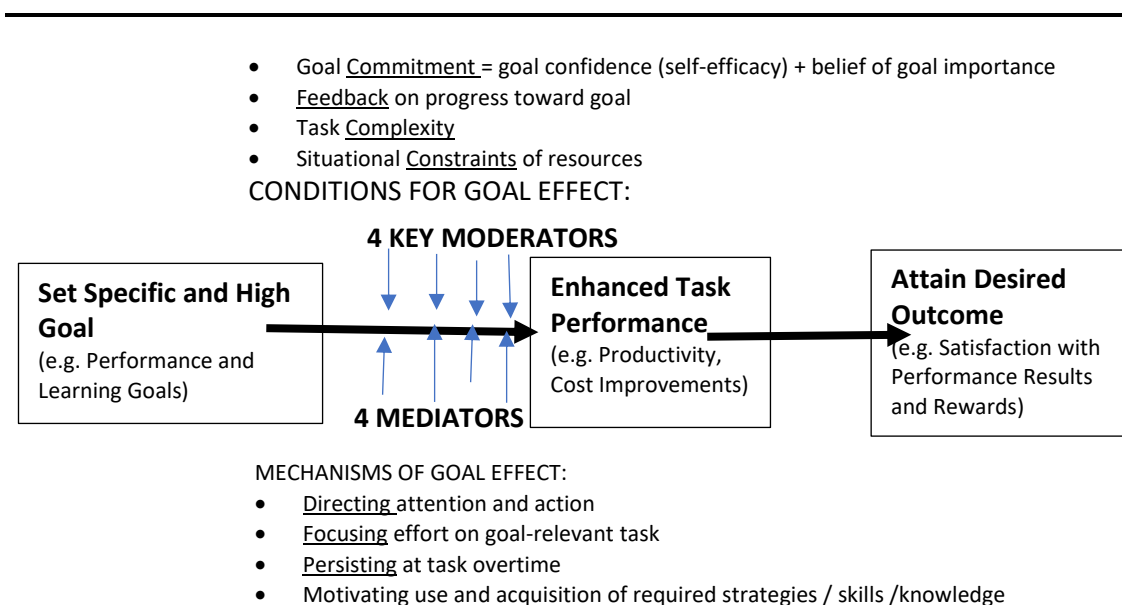


Figure 2. Locke and Latham's goal-setting theory (adapted from Locke and Latham 2002; 2006)

While most of these frameworks are hinged on SMART goal-setting, Day and Tosey (2011) criticised the use of SMART criteria in the education sector, recommending instead as an alternative the use of the 'well-formed outcome' framework for writing learning objectives, based on Zimmerman's (2007) eight criteria for appropriate goals. According to Zimmerman (2007), learning goals must satisfy the conditions of goal specificity, temporal proximity, hierarchical organisation, congruence with self and others' goals, degree of difficulty, self-generation, a level of conscious awareness, and clarity about whether the goal is process or performance related. Day and Tosey's (2011) well-formed outcomes framework requires properly formulated educational objectives to be written on a POWER template, where POWER stands for: **p**ositive outcome, **o**wn role, **w**hat task (with dates), **e**vidence of accomplishment and relationships required. Practically, besides the CDC and the Day and Tosey templates, most frameworks simply outline the process steps that goal setters can follow in practice, rather than offering lexical frameworks for writing SMART objective statements. However, they are largely underpinned by Locke and Latham's (1990) motivational theory of goal-setting and task performance (*Figure 2*). This illustrates how goals formulated with goal attributes of specificity and difficulty, under certain mediating and moderating conditions, result in improvement of task performance, in turn increasing the chance of goal attainment (Locke and Latham, 2002; Locke and Latham, 2006).

Thus, it can be assumed that a specific, challenging, clearly written goal framework is an indirect predictor of goal attainment. However, like the SMART criteria, Locke and Latham's theoretical framework outlines only the goal attributes that effective objectives should have to enable the attainment of the desired goal effect (Locke and Latham 2013); it does not specify the goal contents that give the statements these attributes. Therefore, there is still need for a reliable and practical conceptual guide to aid goal setters in writing objective statements with the right components of a SMART goal framework.

Model framework

Writing SMART objectives

To be SMART and ensure goal clarity, according to Doran's original criteria, and to positively influence goal attainment according to Locke and Latham's (1990) theory, it is essential that every meaningful objective statement should specify:

- The positive change or improvement desired
- The measurable indicator of the change
- The challenging but attainable level of the indicator
- The realistic time frame of when the change can be achieved (Doran 1981, Ogbeiwi 2016).

Therefore, SMART objective statements could be constructed using a model framework that has four components:

- The **o**utcome
- Its **i**ndicator
- **T**arget level and
- **T**ime frame (OITT).

Figure 3 shows an example of an objective statement constructed using the OITT framework. To date, no empirical studies have investigated or reported on the goal frameworks used by goal setters for writing statements of objectives, or assessed the extent to which the objective statements formulated for their development or intervention plans are SMART.

Purpose of review

No empirical goal-setting research has yet been undertaken to investigate the constituent components of goal frameworks used to write a SMART objective statement. This review, therefore, analyses the goal framework of SMART objective statements found in the literature and seeks to determine the extent to which they satisfy the five goal attributes of specificity, measurability, attainability, realisability and time. The review is designed to answer a core question: Are SMART objective statements really specific, measurable, attainable, realistic and time bound? To answer the question, the goal framework of sample SMART objective statements is compared against the OITT components (*Figure 3*) as a standard analytical template.

Method

This review presents a quantitative descriptive analysis of published examples of SMART objective statements obtained through a purposeful search of the literature on SMART goal-setting. It involved online searches of formal academic sources, such as the Health Management Information Consortium and Allied and Complementary Medicine databases, Pubmed, Medline, PsychArticles, CINAHL, and Google scholar, as well as using informal search engines such as Google. The search phrases used were 'writing SMART objectives' and 'goal-setting and framework', 'goal-setting in healthcare' and 'monitoring and evaluation toolkits'. Goal-setting framework articles were generated from these databases, but only those that gave access to full texts were printed for document review. Other materials were obtained through snowballing from the reference lists of accessed articles.

All materials were manually scanned for objective statements given as 'examples of SMART objectives' as the main selection criterion. In line with the chosen definition of an objective, any statements referred to as 'SMART process objectives' were excluded, while 'SMART outcome objectives' were included, even though some of them still described tasks as desired accomplishments. The OITT framework was used as the standard template for determining whether the goal framework of each objective statement was truly SMART or not. Accordingly, to be SMART each objective statement had to be a single sentence specifying a complete set of OITT components (*Figure 3*).

To be an *outcome*, the specified accomplishment needed to be an expected short-term result or change that could be related to the activities of a project, intervention or organisation (OECD, 2002, DSTDP, 2017) as illustrated in *Figure 1*. To be an *indicator*, the specified goal measure needed to be a direct quantifiable variable of the outcome. Usually indicators are expressed in quantitative units of number, percentage or proportion, average, ratio, rates, etc. (DHDS, 2017). To be a *target*, the specified level or quantity needed to be an amount of the indicator stated. *Time frames* had to be specific dates, periods or time frequency.

Notably, no examples of SMART objectives were found in any of academic goal-setting articles reviewed. A total of 17 examples of objective statements (*Table 1*) were collected from Doran (1981) and four major healthcare organisations, including the US CDC (11), Salford Royal NHS Foundation Trust in the UK (3), the World Health Organization (WHO) (1), and Save the Children UK (1). To comply with copyright, written permission was obtained from Salford Royal NHS Foundation Trust for the use its material in the study. The 11 CDC objective statements were published by five divisions of the CDC: the CPH, DHDS, DSTDP, DTBE and Health Youths (CDC, 2009). The CDC are also the publisher of the conference presentation by Carl Osaki (2008). The structural contents of each of the 17 objective statements were analysed descriptively and compared against the components of the OITT framework to determine the degree to which their structures or goal frameworks were SMART. Each statement was assessed by the number of OITT components specified and the percentage completeness of

the four components. For each statement, completeness was assigned as 0% (no components), 25% (one component), 50% (two components), 75% (three components) or 100% (four components). In interpreting whether the structure or framework of an objective statement is SMART or not in this study, the following criteria were applied according to *Figure 3*:

- Specific: it states an outcome
- Measurable: it states an indicator of the outcome
- Attainable: it states an achievable relevant target level of the indicator
- Realistic: the target level can be attained with available resources in a particular time frame
- Time bound: the desired time frame is specified.

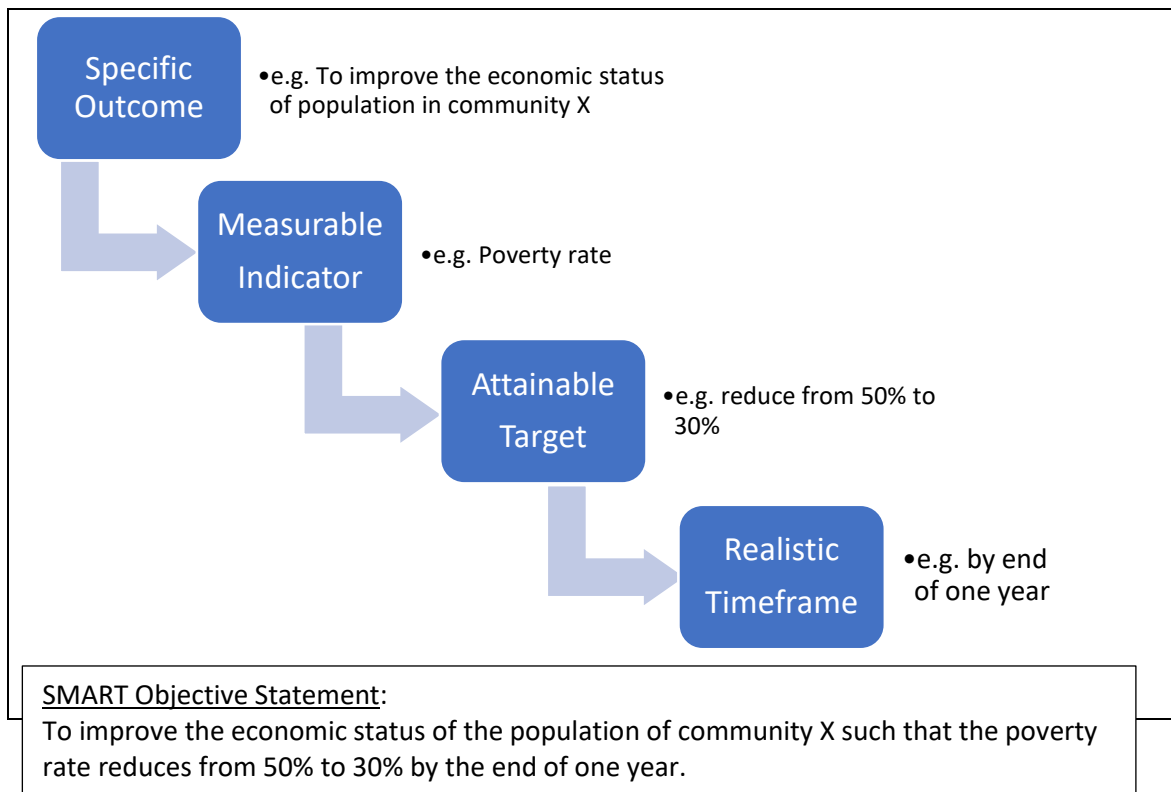


Figure 3. OITT framework of an objective statement

However, the realisability of the objective statements in this study was not assessed because the operational and resource contexts were unknown (the objective statements being published examples only). The StatCalc epidemiologic calculator (part of the Epi-Info software tools, version 7.2.1.0) was used for 2x2 contingency calculation of Chi-square test values for differences in the number of individual components; statistical significance was determined by Mantel Haenszel test results and two-tailed *p*-values of less than 0.05.

Results

Contexts of objectives

Table 1 shows the 17 examples of objective statements taken from 12 project contexts. All are health related, except for the management objective from Doran (1981) and Osaki's (2008) climate change research objective. The hospital and heart disease/stroke projects each yielded three objectives (17.6%); youth health two (11.8%); and the remaining nine — STD, TB, child health, diarrhoea, environmental health, climate change, human resource management, minority communities and management — one each (5.9%). Similarly, the areas of work or care for which the sample objectives were set varied, covering 11 work settings. According to

Table 1, health education and training have three objectives each, while breast surgery and health information system are each linked to two objectives. The remaining seven work settings, with one objective each, range across inventory system, STD treatment, TB case holding, immunisation, diarrhoeal prevention, surgical theatre management and research.

Table 1: Published Examples of SMART Objectives reviewed

{	Objective	Work or care area	Context	Objective Type
1.	To develop and implement by December 31, 198__, an inventory system that will reduce inventory costs by \$1 million with a cost not to exceed 200 work-hours and \$15000 (Doran 1981)	Inventory system	Management	Process
2.	By year two of the project, LEA staff will have trained 75% of health education teachers in the school district on the selected scientifically based health curriculum (CDC 2009: 2)	Health Education	Youth Health	Process
3.	Reduce current operating costs by 5% in breast surgery by March 2012 (Salford NHS 2011)	Breast Surgery	Hospital	Process
4.	Increase the percentage of converted day cases in breast surgery from baseline of 20% to 25% by November 2011 (Salford NHS 2011)	Breast surgery	Hospital	Process
5.	By (month/year), increase the percentage from X% to Y% of providers in county Z that fully adhere to the CDC-STD treatment guidelines for appropriate treatment of gonorrhoea (CDC-DSTDP, 2017).	Treatment	STD	Process
6.	Increase percentage of adult patients with non-resistant TB who completed therapy (within 12 mos.) from 80% to 90% by 2006 (CDC-DTBE, 2017).	Case-holding	TB	Outcome
7.	By June 29 2006, increase the number of training sessions given for HDSP program partners on implementing and evaluating System change from 10 – 14. (CDC-DHDSP 2017: 5).	Training	Heart Disease & Stroke	Process
8.	By February 15 2006, increase by four the number of community health centers in (State) that have incorporated into the clinic system electronic records with reminders of treatment protocols (DHSP 2017: 6)	Health Information System	Heart Disease and Stoke	Process
9.	To achieve 80 per cent immunization coverage in the next 5 years in district X. (Save the Children 2003: 339)	Immunization	Child Health	Outcome
10	By December 31 2009, increase awareness of signs and symptoms of stroke and the importance of calling 9-1-1 among African American men in (State) from 11% to 15%. (CDC-DHDSP 2017: 5).	Health Education	Heart Disease and Stoke	Outcome
11	The risk of diarrhoea is reduced by 50% in the target population in 6 months. (WHO 2016)	Prevention	Diarrhoea	Outcome
12	By the end of the school year, district health educators will have delivered lessons on assertive communication skills to 90% of youth participants in the middle school HIV-prevention curriculum (CDC 2009: 2)	Health education	Youth Health	Process
13	Improve Operating Theatre productivity from 80% to 90% (Salford NHS 2011)	Theatre management	Hospital	Process
14	From August 2008-2009, establish recruitment initiatives at historically Black colleges and other minority institutions in conjunction with the training initiatives of national partner organizations (CDC-CPH, 2017).	Training	Minority communities	Process
15	By December 31 2008, develop an inventory of staff training and competency needs (Osaki 2008)	Training	Human Resource Development	Process
16	By July 31 2008, develop an information management plan that describes how to identify, collect, store, analyse and correct environmental health data (Osaki 2008)	Health information System	Environmental Health	Process
17	By March 1 2008, begin a research project with the local university on impacts of climate change on our community (Osaki 2008)	Research	Climate change	Process

Type of objectives

To be considered an *outcome* objective the desired change should be a short-term *result* of a task, activity or strategy, rather than a change of the level of task performance or indicator. For

example, No 10 (*Table 1*) is an *outcome* objective because raising awareness of stroke in a community is a short-term outcome of project implementation. It does not state accomplishment of particular awareness creation activities as a goal.

No 1 is a *process* objective, because it seeks to develop and implement an inventory system with change in operation costs being the indicator that measures the progress towards or accomplishment of the inventory system. Of the 17 statements, 13 (76.5%) are *process*-oriented objectives that seek targeted accomplishment of tasks or work, and four (23.5%) are *results* or *outcome* oriented. *Table 1* shows that the four work settings and contexts where *outcome* objectives are formulated are case-holding in TB, child immunisation, stroke awareness health education and diarrhoeal prevention.

Basic structure of objective statements

The majority, 11 (64.7%), originate from CDC-related sources. Apart from the CDC DTBE objective, all the CDC objectives are written within a structure that includes the time frame, task or outcome to be accomplished, and the expected change in the measure from baseline to target. Objective No 5 (*Table 1*), relating to an STD treatment goal, is typical of this template for writing objective statements in CDC programmes, which the CDC DHDSP (2017) set out as:

'By ____/____/____, [WHEN—*Time bound*] [WHO/WHAT—*Specific*] from: ____ to: ____ [MEASURE (number, rate, percentage of change and baseline) — *Measurable*]'

The five examples from Salford Royal NHS Foundation Trust, WHO and Save the Children mostly share a similar sequence, stating the desired accomplishment first, and the measure and time frame last.

Frequency of OITT components in objective statements

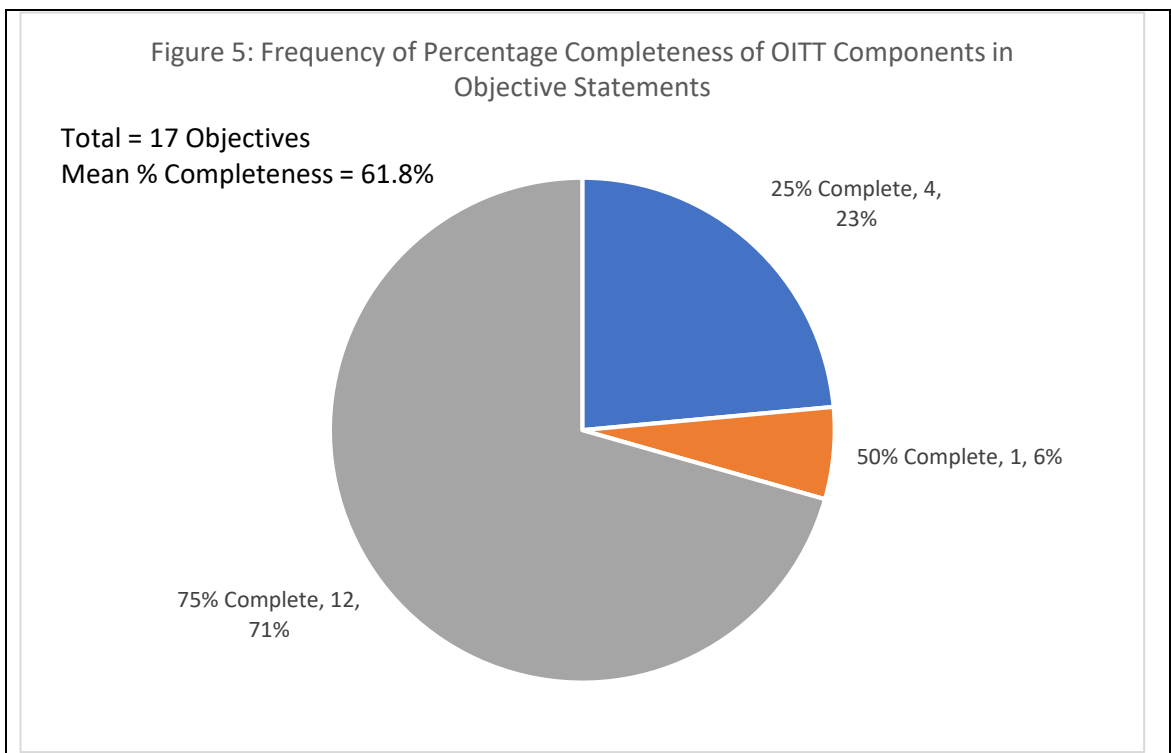
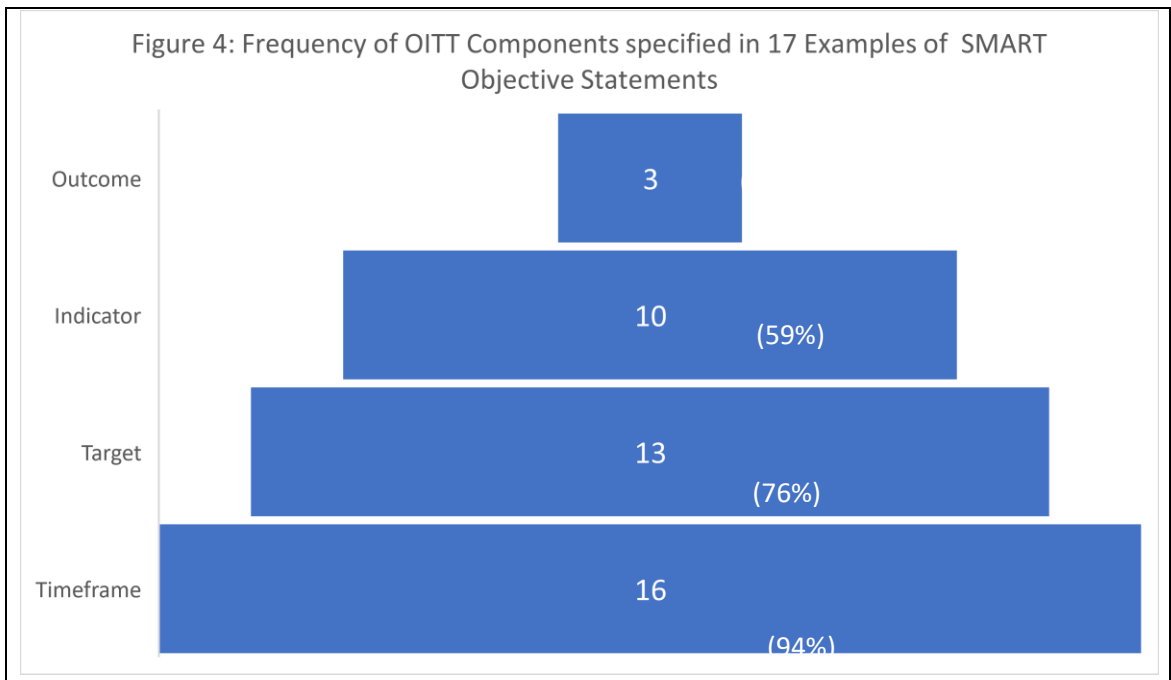
Table 2 and *Figure 4* show the distribution of the four OITT components across the 17 objective statements. The most frequent component is the time frame, specified in 94% of statements. The least frequent component is outcome, specified in 18%. *Figure 4* also shows that, while 59% of statements specify an indicator, 76% specify a target. The Chi-square test values for the observed differences between the number of statements with a specified outcome and the number with each of the other components are:

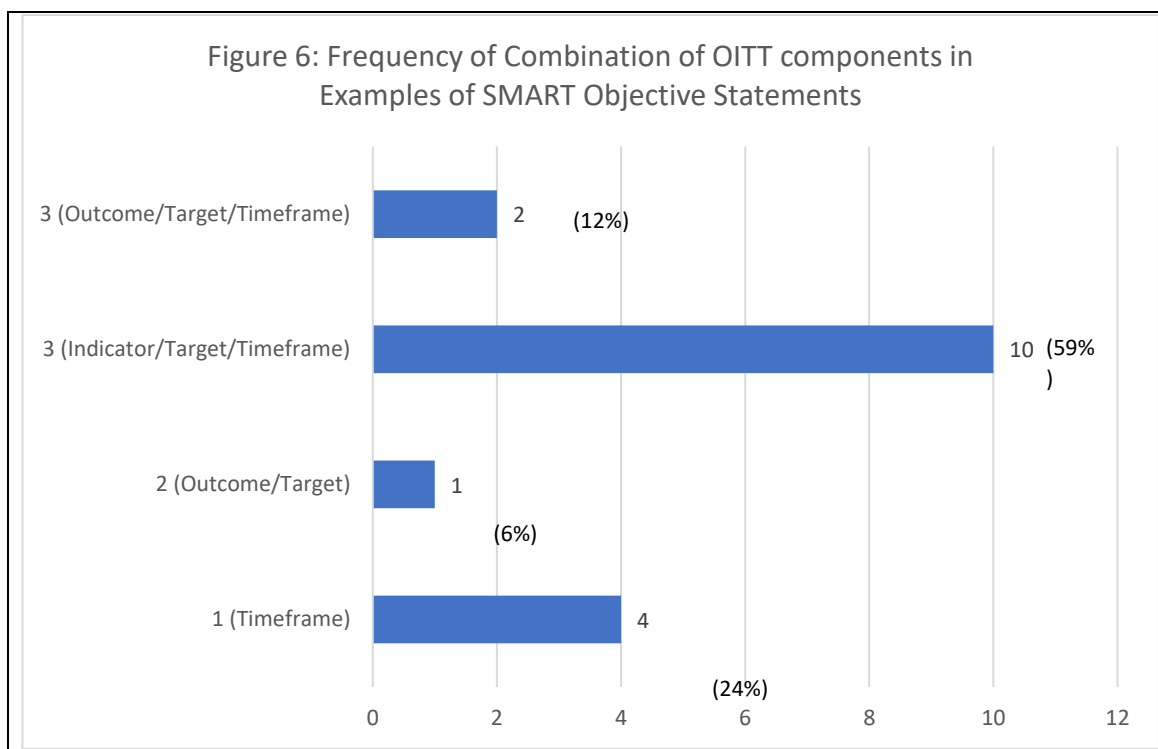
- Indicator ($X^2=5.92$)
- Target ($X^2=11.46$)
- Time frame ($X^2=19.57$).

They are all statistically significant on the Mantel Haenszel test results ($p < 0.05$).

Completeness of the SMART goal framework

Table 2 and *Figure 5* show the number of OITT components in each objective statement, ranging from one (25% completeness) being included in four statements, two (50% completeness) in one statement and three (75% completeness) in 12 statements. The mean of 2.5 components per statement represents an overall 61.8% completeness of the framework of the 17 statements studied. None of the 17 statements contain all four OITT components, and therefore none is SMART (*Table 2*). *Figure 6* shows that the most common combination of components is *indicator/target/time frame*, which is present in 59% of statements. Thus, no statement has a structure with the required combination of OITT components.





Discussion

The objective statements analysed in this study may represent the products of goal-setting practice in multidisciplinary health contexts, but the findings may have wider application beyond healthcare organisations. Clearly, the types of objectives found in the literature suggest that goal-setting in healthcare may be oriented more towards targeted accomplishment of tasks than the achievement of specific levels of desired results or outcomes of services. However, the availability of different template designs for formulating objective statements indicates that there is no unified pattern for writing objective statements across different health organisations, even though the CDC templates represent a commendable attempt to standardise practice across different departments or services within the same organisation. The two template designs used clearly diverge: while the CDC recommends using the *time-accomplishment-target-measure* pattern, the statements of the other organisations refer to *accomplishment-measure-time*. Although using a particular template or pattern may be helpful in writing goals, this review indicates that it is a less useful tool for determining whether the statement produced is SMART, certainly not as important as the goal content or the completeness of the components required for the statement to possess SMART goal attributes.

In terms of completeness, this analysis finds that none of the examples of objective statements sit within a goal framework that encompasses all four OITT components. These examples have, on average, a 62% completeness rate and, on average, each health objective statement contains three OITT components. According to the frequency of components in the statements, these examples suggest that goal setters in health organisations may be more likely to include a time frame in every objective or use a combination of *indicator, target and time frame* than specify an outcome. Rather than being objectives that state a specific outcome — along with the defining components of *indicator, target and time frame* — they are mostly statements of measurable and time-bound indicators, but make no mention of the intended short-term goal. Thus, on the whole, the statements lack clarity and specificity about the result to be accomplished, of which the *indicators, targets and time frames* should be

relevant measures. Therefore, none of the published examples of SMART objectives really are SMART, since they lack the complete goal framework comprising all four OITT components needed to satisfy each of the five SMART criteria.

It is noteworthy that most statements reviewed are process oriented. Even the SMART example published by Doran (1981) — the originator of SMART criteria — states as the objective a task performance, instead of an outcome. While some statements may be acceptable as SMART process targets, without a specific outcome, they do not qualify as SMART objectives if assessed on the OITT framework. Depending on the reliability and external validity of the OITT as an objective setting tool, the inadequate frameworks in the published examples, which span a range of project settings, may suggest that there is a high prevalence of non-SMART objective statements in use in the health sector. This observation primarily questions the motives behind objective-setting practices in the healthcare sector. Should goal setters set them to show the expected changes in task performance (Locke and Latham 2002), or the short-term effect or outcome results they expect from the outputs of implementing planned tasks (OECD 2002; Ogbeiwi 2016)? Should they state specific changes in indicators that are solely statistical measures of the changes towards a goal (OECD 2002), without specifying the goal itself? What expected results should goal setters really specify as outcomes in their objectives statements?

With the confusion surrounding the exact definition of an objective (Ogbeiwi 2016), it appears that the type of accomplishment specified in an objective statement reflects the goal setter's organisational understanding of what an objective is. Hence, organisations that use the term objective as a generic term may also assert that it can be both task (process) and outcome oriented. They may therefore encourage their projects to be formulated using objective statements that show expected accomplishments at different system levels of task, output, outcome and impact (OECD, 2002; DHDS, 2017, DSTDP, 2017).

The immediate implication of the findings of this analysis is that few projects, if evaluated against this new template of the OITT framework, have outcome-oriented objectives that are in reality SMART. However, the current study may have a weakness, in that it looked at only sample objective statements and not objectives developed in real project contexts. Nonetheless, it does reveal the potential risk that projects relying on the use of these examples as objective-setting guides may lack the complete set of components required to formulate a SMART goal framework, including specific *outcome*, *measurable indicator*, *attainable target and realistic time frame* (Doran, 1981; Ogbeiwi, 2016). According to Locke and Latham's goal-setting theory, clear, specific and challenging goals can engender improved performance towards goal attainment (Locke and Latham, 2006). So it is reasonable to assume that projects designed with an incomplete or defective goal framework are less likely to attain their desired outcomes.

Consequently, the possibility that globally many organisations are basing their planning on non-SMART objectives should be a serious concern to all stakeholders in the healthcare sector, since it implies that many healthcare projects with life-saving significance are likely to be built on them. This is worrying because it may mean that many health projects worldwide are implementing health plans with no hope of goal attainment. There is, therefore, a need for projects designed on a framework of objective statements, such as the examples studied, to review the extent to which their objectives really are SMART. Hence, the above implications raise more questions for further research in real field situations. First, to what extent is the goal framework of objective statements of real projects actually SMART? Second, is it more likely that projects planned on the basis of objectives with a complete OITT goal framework

will attain their desired outcomes? These questions should lead to further research to investigate the reliability, validity and efficacy of using the OITT framework as a standard tool for objective setting.

Conclusion

Writing SMART goals is fundamental to planning effective results-oriented action. Even though there are many goal-setting templates and guides, it appears that none currently offers a relevant and complete structural template to aid the construction of written objective statements that satisfy all the criteria for SMART goals. The author proposes that writing objective statements that encompass the four components of the OITT goal framework as a conceptual template might help goal setters to formulate better objectives — SMART in goal attributes and goal content. The objectives analysed in this article may have been drawn from just few examples and skewed toward the goal-setting practice of the CDC, but they provide a credible basis to invite programmes and organisations worldwide to review their SMART objective statements. BJHCM

KEY POINTS

- Projects designed with an incomplete or defective goal framework are less likely to attain their desired outcomes
- There is no single, agreed template or standardised guidance for writing effective goal-setting objectives
- SMART goals are central to planning and attaining effective changes, however, many organisations fail to comply with SMART objectives
- Writing objective statements based on a template that encompasses the concepts of OITT (outcome, indicator, target and time frame) will ensure that organisations work towards specific, attainable
- and measurable aims

Table 2: Analysis of the OITT SMART Components in Objective Statements

Obj. No.	Related Task	OITT Components specified in objective statement				No of OITT components	% Completeness	SMART? Yes/No
		Outcome	Indicator	Target	Timeframe			
1	To develop and implement an inventory system	Unknown	Inventory costs	Reduce by \$1 million with a cost not to exceed 200 work-hours and \$15000	December 31, 198__.	3	75%	No
2	LEA staff will have trained health education teachers	Unknown	% HE Teachers trained	75%	By year two	3	75%	No
3	Reduce current operating costs	Unknown	Operating costs	5%	Mar-12	3	75%	No
4	Increase day cases of breast surgery	Unknown	% Converted day cases	from 20% to 25%	Nov-11	3	75%	No
5	Unknown	Unknown	% Providers that fully adhere to guidelines	from X% to Y%	By (month/year)	3	75%	No
6	Unknown	Unknown	% Adult patients with non-resistant TB who completed therapy	90%	2006 (within 12 mos.)	3	75%	No
7	Increase training sessions given for HDSP program partners	Unknown	Number of training sessions	from 10 – 14.	June 29 2006	3	75%	No

8	Increase community health centers	Unknown	Number of community health centers	Four	February 15 2006	3	75%	No
9	Unknown	Unknown	Immunization coverage	80 per cent	Next 5 years	3	75%	No
10	Unknown	Increase awareness of signs and symptoms	Unknown	from 11% to 15%.	December 31 2009,	3	75%	No
11	Unknown	The risk of diarrhoea is reduced	Unknown	by 50%	6 months.	3	75%	No
12	district health educators will have delivered lessons		% Youth Participants	90%	End of the school year	3	75%	No

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Annexe 3: Published Article #3

General concepts of goals and goal-setting in healthcare: A narrative review

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Abstract

Goal-setting is fundamental to organisational management, yet not every manager knows how to do it well. A narrative literature review was done to explore current knowledge of definitions and classifications of goals, and principles of goal-setting in the healthcare sector. Online databases generated 65 relevant articles. Additional literature sources were snowballed from referenced articles, and textbooks. Most academic authors define 'goal' synonymously as 'aim' or 'objective', but there is evidence of hermeneutical confusion in general literature. Goal classifications are diverse, differing according to their contextual, structural, functional, and temporal characteristics. Many authors agree that goal-setting is problem-based, change-oriented, and can effectively motivate attainment if the goal statement is formulated with a specific and challenging or SMART framework. However, recent authors report varying definitions for SMART, and evidence of past studies that empirically examined the nature and efficacy of frameworks currently used for formulating goal statements for health programmes are lacking.

Keywords: Goals, Objectives, Definitions, Classifications, Goal-setting theory, SMART Framework, Writing Goals

INTRODUCTION

Goal-setting is an immensely popular concept in work planning and assessment, and useful as a fundamental component of organisational management in general. Even though it is a common practice of many organisations in virtually all sectors of human endeavour (Locke & Latham, 2006; Bipp & Kleingeld, 2011), available evidence suggests that not every employee, educator, manager or organisation knows how to do it or do it well (Lee, 2015). Surveys done at different times in the United Kingdom found that up to 79% of British organisations (Institute of Personnel Management, 1992; Yearta, Maitlis, & Briner, 1995) and 62% of companies use goal-setting as employee management tool to motivate organisational effectiveness (Baron & Armstrong, 2004; Bipp & Kleingeld, 2011). While this seems an impressive goal-setting practice in UK companies and organisations, a qualitative study by Greenbank (2001) involving 58 owner-business managers reports a rather poor goal-setting practice in small-scale businesses in the United Kingdom, because any goal-setting they did was informal, and objective statements were not written down. Hence, Platt (2002) in the United Kingdom, believes that very few out of the managers who know the meaning of the SMART acronym, also know how to formulate 'good objectives that comply with all the criteria' (p. 23). Likewise, the ad hoc report of Doran (1981) in the United States that outlines the famous SMART criteria for objective-setting 36 years ago, asserts that formal goal-setting may be absent or at best ineffective in most American companies.

Significantly, goals are the foundational blocks that form the base on which organisations and programmes are built, and good goals are therefore essential management tools that all results oriented organisations must have (Mullins, 1999). Well formulated goals serve three basic functions. First, they provide a conceptual framework for planning strategies and their

component activities that are required to achieve desired results (Mullins, 1999). Second, they are the monitoring benchmarks that enable objective appraisal of the quality and progress of implementation, which is done to determine whether or not the organisation or programme is on its planned course (Mullins, 1999; Bipp & Kleingeld, 2011). Third, they are the rational tools for evaluating the relevance and overall value of policies, services and projects at the end of implementation, which allows empirical judgement of the effectiveness, efficiency and success of work, and demonstration of management accountability for expended resources at all levels (Shiell, 1997; Greenbank, 2001; Fitsimmons, 2008; Bipp & Kleingeld, 2011). Hence, referring to goals in a healthcare context, Shiell (1997) asserts that, 'the success of health service delivery at clinical, planning or system level must be measured against agreed objectives' (Abstract). In agreement, an Oracle white paper (Oracle, 2012) in business and industrial contexts emphatically asserts that, 'the organization that makes it a priority to develop quality, effective goals will succeed in its performance management, [and] in its business in general' (p. 2). Therefore, goal-setting, the process of formulating goals, has been regarded as a characteristic feature of every well-managed organisation (Beardshaw & Palfreman, 1990; Bratton, Callinan, Forshaw, & Sawchuk, 2007).

The origin of scientific goal-setting as we know it today can be traced back to Fredrick W. Taylor's time and motion studies at the beginning of the 20th century, in which he assigned daily tasks as goals to 'blue collar workers' (Locke, Shaw, Saari, & Latham, 1981). Pierre Dupont followed up the work of Taylor by testing Taylor's ideas with managers at Dupont Powder Company and General Motors. The work of Dupont probably formed the basis for Peter Drucker's system of Management by Objectives in 1954 (Locke et al., 1981). According to Locke and Latham (2002), Mace (1935) was the first to publish any work on the effects of goals on task performance; and they then founded their own research work on the published works of researchers such as Atkinson in 1958 who reported a curvilinear relationship between effort and task performance, and Ryan (1970) who linked the positive effect of conscious goals on action or behaviour. However, there was no formal goal-setting theory based on empirical evidence until Locke and Latham published their theory of goal-setting and task performance in 1990. From their own work, Locke and Latham concluded that the relationship between specific and difficult goals and task performance is positive and linear. This they then aligned with Albert Bandura's social cognitive theory of the positive causative effect of motivation and cognition factors within given environments on desired behavioural change (Locke & Latham, 2002). Locke and Latham's theory was the product of many empirical researches in cognitive psychology conducted over a period of many decades, and which began with finding answers to the question of whether goal-setting influences a person's task performance (Locke, 1968). According to Latham and Locke (2007), by the beginning of the 21st century, the goal-setting theory had provided a theoretical framework for more than 1,000 empirical studies.

Purpose of review

This paper is primarily a review of available literature on the concepts of goals and goal-setting, aimed at describing current knowledge and practice and identifying gaps in literature for further explorative research on the subject in healthcare. It specifically reviews the definitions and classifications of goals as well as the philosophy and frameworks of goal-setting practice in a general context.

METHODS

To the large extent, the step by step approach recommended by Cronin, Ryan, and Coughlan (2008) for a traditional or narrative literature review methodology was used because it enables a broad search for relevant materials sufficient to summarise and synthesise available knowledge on the subject. Three phases of organised literature search were done using online

databases accessed through the university of Bradford library search sites, Google and Google scholar. The initial database search included Health Management Information Consortium (HMIC) and Emerald. Both database sources were selected because of their wide collection of peer reviewed journals relating to healthcare and management researches. The key words used were 'goal-setting', 'objective setting', 'framework for setting objectives', and 'management by objectives'. No time frame was used in the search through Google scholar. None was also initially selected for the HMIC and Emerald databases, but the search was later restricted to the period from 2005 to current (January 2016). Using 'objective setting' for example, a total of 38,844 was generated by the HMIC database. The Emerald management database generated 81,608 articles for goalsetting, 51,053 for framework for setting objectives and 97,212 for management by objectives. The search results were scanned for articles with titles that include the terms 'goal-setting' and only sources that gave access to downloading the articles – abstract or full document through the university library web links were printed for review. In this first phase, no article was excluded on the ground of year of publication. The second phase of literature search was more restricted, but included a multiple database search that connected six databases, including CINAHL, EBSCOhost (eBook collection), Medline, PsycARTICLES, Psychology & Behavioural Sciences and Psych.INFO. In the second search, the key phrases used were 'Goal-setting', 'Framework or model or theory', and 'Health'. When the three phrases or words were searched with 'AND' 2,617 articles were generated. This number reduced to 1944 when the dates of publication were limited to the 10 years from 2006 to 2016. The third phase searched for more recent journal articles published during the 5-year period from 2013 to 2018, accessed through the websites of four management journals recommended by a reviewer of this article, using only the broad key words 'Goals, Objectives'. The search through the website of Academy of Management Journal produced a result of 9,993 articles as abstracts, but only four articles were selected for review based on relevance to the goal concept. The search through the website of Journal of Management provided a link to all SAGE journals and a result of 2,231 articles for Health Sciences from which seven relevant articles were selected. The search of Journal of Management and Organisation (Cambridge Core) produced 403 articles because restriction to articles that give open access in the field of Medicine, Life sciences and Nutrition. Only one relevant article was selected. Even though 932 articles were generated through Strategic Management Journal, none were considered relevant.

A total of 65 goal-setting articles found from the database searches as full articles or abstract were selected for review. The oldest article is dated 1982 and the most current are dated 2017. In addition, some secondary sources, such as the paper by Doran (1981), cited in these articles were traced through the links in the references in the primary sources, in a way that describes 'snow-balling' technique, using either google or google scholar search engines. Textbooks, including dictionaries and titles relating to organisational management, available to the author and with indexed materials on goals, objectives and goalsetting, and the recent articles written by the author were also included in the review as sources.

RESULTS

Terminological definitions of a goal

In Collins English Dictionary, a goal is simply 'aim or purpose' (Collins, 2006: 363). Oxford Social Care Dictionary defines it as 'an end result' that work is specifically performed to achieve (Harris & White, 2013: 229). Hence, popular goal-setting theorists render the meaning of the term similarly as the purpose of an action whose end-result is expected to be achieved at a particular time in the future (Lee, Locke, & Latham, 1989; Stretcher et al., 1995; Locke & Latham, 2002, 2006; Fitsimmons, 2008). In addition, some authors in the field of organisational

management defined the term as a timed future accomplishment that the whole organisation is working hard to attain, which could be either the immediate or ultimate objectives to which the effort of employees are directed (Beardshaw & Palfreman, 1990; Mullins, 1999; Bratton et al., 2007). However, other authors in the same sector Mullins (1999) also equates 'objectives' etymologically to terms such as 'goals', 'aims' or 'end-result'. Other related terms such as 'target' have been used interchangeably with goals, aims and objectives as their synonyms in goal-setting literature, which suggests that the distinction of the meanings of the different goal concepts may be terminologically hazy in the academic arena (Ogbeiwi, 2016).

On the contrary, in development and health sectors, while goals generally express the expected results or desired effects of a planned action or work, they can differ in type, meaning and formulation, depending on the level of organisational or programme framework at which they are set (Ogbeiwi, 2016). Accordingly, the use of the term 'goal' in development organisations means a higher-order objective, and has the same meaning as 'aim' or a long-term goal in a healthcare context. To many health organisations, an objective is a short-term goal, achievable as an intermediate milestone on the path towards attaining the overall aim (OECD, 2002; Save the Children, 2003). Therefore, in the typology of goals, the terms 'aims', 'objectives', and 'targets' are considered different types of the generic term 'goal' rather than its synonyms, and each has a distinctive conceptual framework that differentiates it according to a set of seven themes: object, scope, hierarchy, timeframe, measurability, significance, expression (Ogbeiwi, 2016).

Classifications of goals

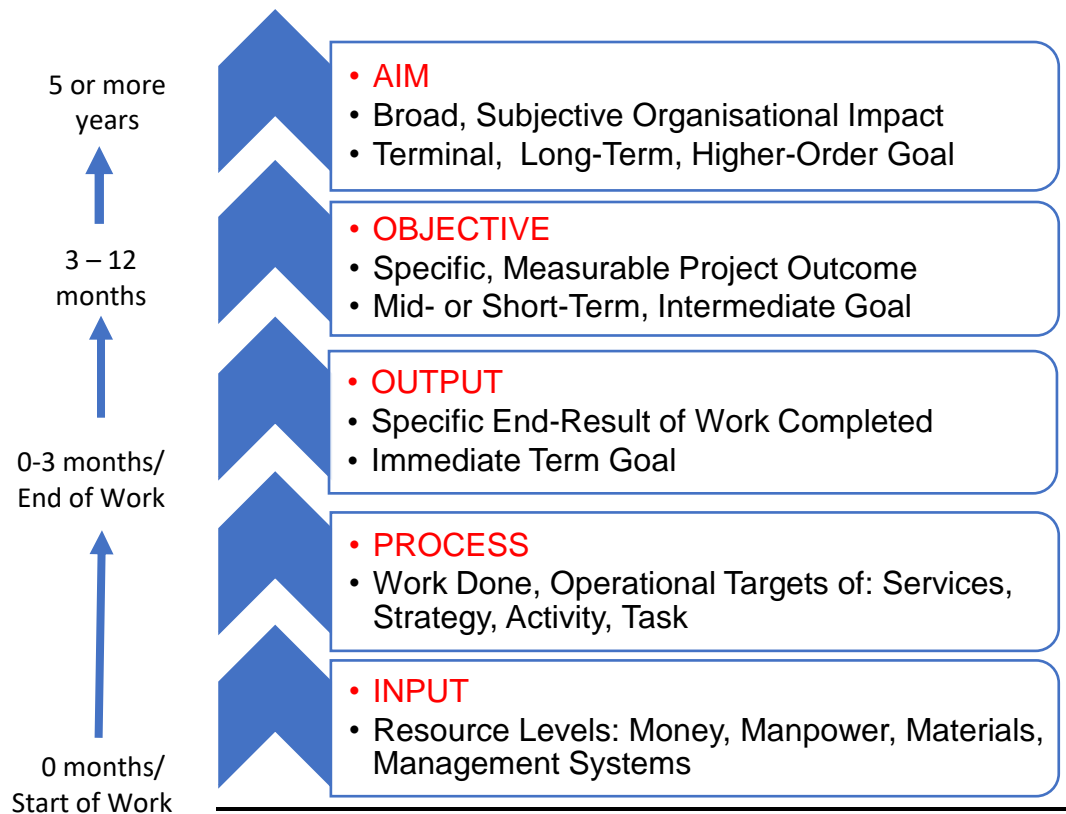
A goal can be formulated and written in different forms and types to suit the organisational context of goal setters. Figure 1 shows the basic typology of goals in a health context (Ogbeiwi, 2016), and illustrates the differentiation of goal types according to a linear directional framework into three levels of results of work: output (immediate goal), outcome expressed as objective (intermediate goal) and impact expressed as aim (terminal goal). Bratton et al. (2007) differentiate two types: immediate and ultimate goals, and Mullins (1999) likewise wrote about broad purpose goals and specific accomplishment goals, or general and specific objectives. However, Mullins (1999: 119–120) also gives two different ways to classify goals types.

The first differentiates goals into three types according to the concept of 'power and compliance' – including order goals (to restrain workers), economic goals (to set profit margins) and cultural goals (to satisfy social needs of workers). The second classification differentiates goals according to the types of organisational system results they represent: including consumer goals (e.g., consumer satisfaction targets), product goals (service/goods objectives), operational goals (performance targets) and secondary goals (sub-goals linked to the overall organisational aim). Thus, in any service delivery system, goals are hierarchical, differing according to their organisational level and expected timeframe for attainment (Figure 1). Accordingly, they cascade both structurally downwards from general goals at the higher management levels to specific goals at the lower operational levels, and temporally upward from immediate goals to long-term goals (Bradley et al., 1999).

General goals are broad aims or statements of expected long-term impact of intervention, futuristic visions and overall purposes of an organisation, while specific goals are either the immediate results of individual task performance or the intermediate or short-term outcomes of performance at team, project or sub-organisational levels. Some researchers like Whitehead (1998) differentiated general and specific goals simply as 'Symbolic' and 'Action-oriented' targets. From her description, symbolic targets are broad and unmeasurable goals stated at a

higher organisational or national level intended to stimulate people to action. Action-oriented targets are specific goals that target a particular change to be achieved in a given population at a local level, with a measurement indicator and by a given time frame (Whitehead, 1998). Some researchers have used other terms, such as ‘distal’ and ‘proximal’ goals to differentiate general and specific goals in line with their respective distant and near timeframes for achievement (Yearta, Maitlis, & Briner, 1995; Ginsburg, 2001).

FIGURE 1. TYPES OF GOALS IN A HEALTHCARE CONTEXT (ADAPTED FROM OGBEIWI, 2017)



Clearly therefore, alternative terms for proximal and distal goals also refer to short-term and long-term goals (Kerr & LePelley, 2013). This supports the impression that goals within an organisation can be hierarchical both temporally (in time) and structurally (in authority and responsibility). Other binary classifications of goals exist in literature, including: quantitative versus qualitative goals, assigned versus participative goals, conscious versus subconscious goals, micro versus macro goals, difficult versus easy goals, specific versus vague goals, performance versus learning goals, and personal versus group goals (Erez & Earley, 1987; Yearta, Maitlis, & Briner, 1995; Ginsburg, 2001; Locke & Latham, 2006; Zhang & Chiu, 2012; Kerr & LePelley, 2013; Sitzmann & Bell, 2015). These different systems of classifications indicate that types of goals are differentiated respectively according to their different properties of measurement, goal-setting approach, cognition, localisation, target, clarity, and purpose.

Elaborating on the different goals-setting approach, Busse and Wismar (2002a) describe an analytical model with two political coordinates of goal-setting. On this model, goals can be either ‘technocratic’ or ‘participative’. Technocratic goals are those set through prescriptive, assigned, non-consultative or top-down approach: they are goals formulated by the top management of an organisation and given to workers to accomplish. This goal type is therefore

extrinsic to those who are expected to deliver them, and therefore may be less inspiring and owned than participative type. On the other hand, participative goals are agreed goals that emerge from a bottom-up consultative approach – begins with the participation and collaboration of all available and relevant stakeholders at the grassroots (Busse & Wismar, 2002b). Locke and Latham (2013) define three goal-setting approaches as the usual sources of goals in work performance settings. In addition to assigned and participative goal categories, they add 'self-set' goals. Unlike assigned or technocratic goals, which are set by others and given to employees, and participative goals, which are produced jointly by the employees and the management, self-set goals are those set by employees themselves, either individually or collaboratively as a team (Locke & Latham, 2002). In healthcare, collaborative goal-setting is the norm for health personnel to work with individual patients to set their personal treatment improvement goals (Morris, Carlyle, & Lafata, 2016). Furthermore, Greenbank's (2001) study of objective-setting by British micro-business owner-managers reports business or organisational goals as different from personal or own goal.

Philosophy of goal-setting

The goal concept encompasses the specific destination of service delivery, which is the purpose of effort being made at every organisational level, whether done by a single employee, a team, a department or the whole organisation (Oracle, 2012). According to Bratton et al. (2007: 6), achieving goals is a basic expectation of every human activity. So, organisations or individuals working with no goals lack vital direction for their effort or destination for their journey. They exist functionally with no formal purpose. Thus, goals and goal-setting are therefore the essence of all organisations and their programmes (Mullins, 1999). Some authors asserted that inherent in every goal statement is an expression of both a dissatisfaction with the current situation and a desire for change to a better future state (Locke & Latham, 2006; Day & Tosey, 2011; Barbic et al., 2017). Barbic et al. (2017) reviewed the short-term goals of 108 acute mental health patients at an emergency department and found the goals were based on their dissatisfaction with their housing, employment and social relationships. Yearta, Maitlis, and Briner (1995) connected desired goals with the needs of people who set them. Hence, irrespective of the goal sources and types, the logical approach to goal-setting is problem-based (van Herten & Gunning-Schapers, 2000a; Locke & Latham, 2002; Fitsimmons, 2008), as goals are set to reflect the desired changes that are expected from the planned intervention of the problem situations affecting a particular population or organisation (Fitsimmons 2008). Accordingly, in the description of a Health Policy Development Cycle by van Herten and Gunning-Schapers (2000a), setting goals begins with problem analysis that helps planners to understand the baseline situation of their target population that needs to change, and then to select a problem-relevant intervention for which related goals and action plans are formulated.

A problem-based goal-setting approach is also illustrated by the four-step RAID model of Continuous Quality Improvement framework reported by Parker et al. (2003), which she used in a clinical governance programme to transform the poor quality of patient care and low staff morale situation in a 25-bed acute psychiatric adult ward in London. The RAID model involved working with all stakeholders to Review the prevailing problem situation, Agree on solutions and setting high goals on a short and longterm, Implement solutions according to the clinical governance guidelines to beat deadlines, and then Demonstrate and Develop on changes by accurately measuring outcomes (Parker et al. 2003). Moreover, the constructs of the goal-setting theory (Figure 2) provide evidence that the key philosophical reasoning behind goal-setting is its power to motivate the behaviour and effort of workers that are required as goal mediators to improve action performance towards achieving the desired changes or outcomes in any work-related setting (Locke & Latham, 2006). The Locke and Latham's (1990) theory indicates that the desired goal effect only occurs when the goal framework is formulated to be

specific and challenging, and where the necessary moderating factors are in place in the practical context of the organisation (Figure 2).

Figure 2: Goal-setting Theory (adapted - from Locke & Latham 2002)



According to Locke and Latham (2006: 265), ‘So long as a person is committed to the goal, has the requisite ability to attain it, and does not have conflicting goals, there is a positive, linear relationship between goal difficulty and task performance’. Thus, Figure 2 shows the theory links goal framework as the independent variable in its theoretical relationship with goal attainment as the dependent or outcome variable and improved task performance as the key predictor variable. The directions of the arrows in Figure 2 show the mediating and moderating factors are also necessary predictors of higher task performance: they facilitate the goal effect by directly influencing improvement of task performance after goals with a specific and challenging framework have been set (Locke & Latham, 2002). Many further empirical researches based on the goal-setting theory, such as the ones by Brown, Jones, and Leigh (2005), Campion and Lord (1982), Matsui, Okada, and Inoshita (1983), Seijts and Latham (2000), Wood, Mento, and Locke (1987), Yearta, Maitlis, and Briner (1995), and Jansen and Paine (2017) have explored the different mediators and moderators in the relationship between goal-setting and task performance and/or goal attainment, and concluded they are indispensable factors that must be present intrinsically in the individual workers and extrinsically in the organisational contexts for a goal-setting practice to be effective.

Particularly, the four mediators in Figure 2 are the mechanisms by which the goal effect on task performance happens. According to Locke and Latham (2002), goals motivate higher task performance by inspiring cognitive change in workers and management towards acquiring goal relevant behaviours, which reveals the directing, energising, persisting and strategising functions of structured goal-setting (Locke & Latham, 2013). Similarly, the four moderators are organisational factors that can have a positive control on the goal effects, when present (Wood, Mento, & Locke, 1987; Seijts & Latham, 2000; Brown, Jones, & Leigh, 2005; Locke & Latham, 2006). The study by Medlin and Green (2009) expand this theory by adding two-employee predictor constructs as hypotheses in the relationship between goal-setting and tasks performance, including employee engagement (full involvement and enthusiasm in the job) and workplace optimism (unwavering belief in the ‘best possible outcome’).

However, an attempt by Yearta, Maitlis, and Briner (1995) to replicate the relationships in Locke and Latham’s theory under non-experimental real-life organisational settings found

reversed relationships between the key constructs of specific, difficult goals and task performance. Yeararta Maitlis and Briner (1995) discovered that the harder the goal in a normal work situation, the lower the task performance. Similarly, two other studies by Boyce et al. (2001) and Erez and Earley (1987) tested the goal-setting theory using three goal-setting approaches (self-set, assigned, and do-your-best) to determine their effect on task performance in different work contexts. Similar to Locke and Latham (1990) theory, Boyce et al. (2001) reported that performance was better in the groups with specific goals, whether instructor set (assigned) or self-set, than in the group with vague 'do-your-best' goals. However, contrary to Locke and Latham's (2002, 2006) hypothesis that goal sources have no effect on outcome, both studies reported significant differences in outcomes with the different goal-setting approaches. Boyce et al. (2001) reported that performance was better in the assigned goal group than the self-set goal group, while Erez and Earley (1987) reported that participative goal-setting produced higher levels of goal acceptance and performance than the assigned approach, but with no significant effect of cultural differences. Hence, like Yeararta, Maitlis, and Briner (1995), more recent authors such as Ordonez, Schweitzer, Galinsky, and Bazerman (2009) and Kramer, Thayer, and Salas (2013) asserted that Locke and Latham's goal-setting theory might not apply in every organisational context. Yeararta, Maitlis, and Briner (1995) concluded in their study that the theory does not consider organisational or work settings with multiple goals. Kramer, Thayer, and Salas (2013) inferred that the key factors in the goal-setting framework involving single goals for improving individual performance are different from the factors that prevail when goals are set for enhancing team or group performance, as team goals bring a social dimension with its social dynamics and a multi-level concept of individual, team and organisational goals to goal-setting. These same factors, according to Locke & Latham (2006), also inherently introduce into goal-setting the problem of goal conflict (where workers' personal goals conflict with group or organisational goals), which Seijts and Latham (2000) found hampers group performance.

Therefore, Ordonez et al. (2009) warned that Locke and Latham's theory of goal-setting and task performance should not be seen as a 'halcyon pill' (p. 3) or panacea for motivating employee for better performance. They supported this by reporting the adverse organisational side effects of goal-setting experienced by organisations such as Sears, Roebuck and Co., Enron and Ford Motor Company. Ordonez et al. (2009) therefore surmised that in organisational settings where goals are too specific, too narrow-focused, too many, too time inappropriate, and/or too challenging, they might encourage harmful, riskier and unethical behaviour of employees in response to the goal drive to improve performance toward winning rewards.

Nevertheless, there is agreement among a wide range of goal-setting researchers that goal-setting is generally useful as a motivational and inspirational management tool that can help employers and employees to become collaboratively focused on increasing the level of task performance, effort and capacity they needed to achieve desired outcomes (Yeararta, Maitlis, & Briner, 1995; Bradley et al 1999; Fulop & Hunter, 2000; Ginsburg, 2001; Locke & Latham, 2002; Medlin & Green, 2009; Kerr & LePelley, 2013; Saari, 2013). In fact, Nanji, Ferris, Torchiana, and Meyer (2013) asserted that goals act as catalysts that inspire, motivate and stimulate progress. The goal-setting theory received full support from the IBM case study reported by Saari (2013), which was conducted for over 11 years, in which Gerstener used self-set stretch goals at every level of the company to transform their failing business. In addition, while defining stretch goals as goals purposely set at visibly impossible high levels, and so are therefore meant to drive employees and management of organisations to their maximum limit of performance, Kerr and LePelley (2013) reported how the concept was popularised world-wide as a major innovation to goal-setting by Jack Welch in General Electric (GE) in the 1980s and 1990s. Using goal-setting, he enforced improvement of products and services to enable a massive savings of

US\$ 12 billion in a 4-year period (Kerr and LePelley, 2013). Other mega companies that positively transformed their business outcomes through emulating GE's stretch goal-setting included Commonwealth Health Corporation (CHC) in 1988 and Toyota Motors between 1997 and 2001 (Kerr & LePelley, 2013).

However, Nanji et al. (2013) reviewed the use of organisational 'Big Hairy Audacious Goals' goals: a bold type of stretch goals, which are overarching long-term goals (10–30 years) that require massive effort and have a 50–70% chance of attainment. They cautioned that despite its popularity, only 38% of organisations were successful to a full or limited extent. This conforms with the assertion by Yang, Gary, and Yetton (2015) from their management simulation experiments that there is no evidence that stretch goals, despite their popular support, actually improve performance at the organisational level. In fact, some recent authors believe that extremely high-performance goals will have negative effects on organisations and agree with Ordonez et al. (2009) that they could create opportunity for corrupt behaviours as employees strive against odds to achieve them (Yang, Gary, & Yetton, 2015; Welsh, Miller, & Cho, 2016).

Goal-setting frameworks

Many authors regard the use of frameworks as crucial concepts for effective goal-setting, because of their theoretical link to improvement of performance and achievement in programmes and organisations (Oracle, 2012). Historically, popular goal-setting models such as Drucker's (1955) management by objectives (MBO) has been known since the 1950s, and used extensively since the 1970s in America and Japan. However, MBO is reported to have depreciated both in its value and use by organisations (van Herten & Gunning-Schapers, 2000b; Dahlsten, Styhre, & Williander, 2005; Bipp & Kleingeld, 2011). Dahlsten, Styhre, and Williander (2005) and Lindberg and Wilson (2011) who studied the experience of MBO in Sweden in the 1990s, described how MBO was used to introduce participatory objective setting to organisations, in which specific, precise and measurable objectives were set for every organisational level. Furthermore, through the MBO process, overall organisational or corporate objectives were translated into shorter term objectives or sub-goals for all work levels and units of the organisation in a way that motivates workers and managers to control, monitor, and reward the progress of their work (Dahlsten, Styhre, & Williander, 2005; Lindberg & Wilson, 2011).

According to Bipp and Kleingeld (2011) and Ogbeiwi (2017), a number of other effective goal-setting frameworks have been developed over the past 20 years, including balanced scorecard approach by Kaplan and Norton (1996) and the productivity measurement and enhancement system by Pritchard, Harrell, DiazGranados, and Guzman (2008). Some authors have examined how goal-setting-based models or frameworks are used in different sectors, such as the use of Object/Objective-Oriented Maintenance Management (OOMM) in the field of engineering reported by Zhu, Gelders, and Pintelon (2002). Bipp and Kleingeld (2011) assessed the goal-setting practice in a German company that used an un-named goal-setting framework in their annual planning cycle for more a decade. Their goal-setting approach was top-down: goals were formulated by the top management and cascaded through all organisational levels to individual employees. The goal-setting procedures involved using interviews to review the results of the goals for the past year before the goals for the next year were set, and the goal attainment of individual employees was linked to rewards. However, the article does not mention the kinds or example of goal statements set by the case company, and so, the extent to which the goals formulated through the reported process satisfy the required goal attributes is unknown.

Particularly in healthcare, there is evidence that goal-setting with different frameworks and approaches are traditionally used by many national governments to provide leadership, guidance, and strategic direction (van Herten & Gunning-Schapers, 2000a). As earlier mentioned, van Herten and Gunning-Schapers (2000b) report the major role the use of a Health Policy Development Cycle has played in this regard. Busse and Wismar (2002a, 2002b) from their review of policy documents of goals-based health programmes in countries in the European Union, Australia, Canada, New Zealand, and United States argued that many health programmes in the developed countries have failed because of the kind of goalsetting process employed and the intervention areas focused by their health targets. According to them goal-setting was mostly the non-participative technocratic approach and, in most of the countries, health targets focused on intervention areas outside the health sector. In their papers, they advocated for an integrated and balanced approach that incorporates both top-down and bottom-up approaches for a successful goal-setting in healthcare delivery systems (Busse & Wismar, 2002a, 2002b).

Furthermore, Langford, Sawyer, Giomo, Brownson, and Toole (2007) reviewed the effectiveness of the Self-Management Goal Cycle framework as a model for diabetic care in the United States and concluded that collaborative goal-setting with diabetes patients is effective for enhancing their self-management skills. Scobbie, McLean, Dixon, Duncan, and Wyke (2013) reported that both patients and health professionals found the Goal-Action Planning model beneficial and acceptable in stroke rehabilitation. Some studies reported the use of WHO's International Classification of Function, Disability and Health and the Talking Mats as coded guides for patient goal-setting and action planning in special communication and rehabilitation need settings (Bornman & Murphy, 2006; Murphy & Boa, 2012); and the use of Goal Attainment Scaling as an effective framework for the evaluation of the achievement of treatment goals (Balkin, 2013; Brady, Busse, & Lopez, 2014). Another two goal-setting frameworks reported in healthcare improvement planning are total quality management and continuous quality improvement initiatives (Ginsburg, 2001; Parker et al. 2003; Medlin & Green, 2009). These frameworks provide practical guides or steps for the process of setting goals (Ogbeiwi, 2017). None, however, is a goal-setting framework that guides how the structure of a goal statement should be formulated or constructed, such that it possesses the theoretical core goal attributes required to motivate task performance and achieve desired outcomes (Ogbeiwi, 2017).

According to Locke and Latham (2013), to have a specific and difficult structure, goal statements must have a framework with two attributes or components: Goal content – that is, it states the specific quantifiable performance result to be achieved, and Goal intensity – that is, the goal-setting practice factors including the mediating goal-setting effort, the moderating individual goal commitment, and the goal hierarchy. Yearta, Maitlis, and Briner (1995) simply explain the goal content as the structure that makes a goal-specific and difficult, while the goal intensity as the needed goal commitment as well as the other factors of goal-setting practices. Authors like Bipp and Kleingeld (2011) adapted the Locke and Latham's goal attributes to their local cultural contexts in Germany in their study of the employee perceptions of the goal-setting theory-based practices. In their study, the descriptive attributes of goal content included goal clarity, and absence of goal conflict, goal stress and dysfunctional goal effects (Bipp & Kleingeld, 2011).

Framework for writing SMART goal statements

Doubtlessly, one of the most popular developments on the Locke and Latham's theoretical goal attributes that has generated a lot of research interests over the years is Doran's (1981) set of five SMART criteria that spell out the attributes of an effective goal statement as

Specific, Measurable, Assignable, Realistic and Time-related. In these criteria, Doran (1981) recommended that SMART objectives should state ‘a specific area for improvement’, ‘an indicator of progress’, ‘who will do it’, ‘what results’ can be accomplished given the resource context of the organisation, and ‘when the result’ (p. 36) will be attained. Unlike other goal-setting frameworks, SMART criteria prescribe the structural components for writing or formulating a goal statement, such that it possesses all five SMART attributes (Oracle, 2012). According to Bipp and Kleingeld (2011), the SMART framework sets out the criteria for the ‘effective use of goals in performance management or appraisal’ (p. 308). Oracle (2012) recommended SMART framework as the gold standard required for writing any goal statement.

However, Day and Tosey (2011) considered SMART criteria inadequate for formulating learning goals and instead recommended Zimmerman’s (2008) eight criteria for appropriate learning goals that evolved from the combination of both Locke and Latham’s goal-setting theory and Bandura’s social cognitive theory to the development of educational goals. On Zimmerman’s criteria, appropriate learning goals must be specific, challenging, proximal, hierarchical, conscious, self-set, performance or process related, and congruent to self and others’ goals (Day & Tosey, 2011). Day and Tosey asserted that the SMART criteria while drawing upon the principles of Locke and Latham’s goal-setting theory to produce learning goals that are specific and challenging, may not produce goals that are attainable on a short-term and can engage the student’s commitment to learn. However, unlike Doran’s SMART criteria, Zimmerman’s criteria do not provide any clarity of what framework components should be in a goal statement to make it fulfil the eight attributes. Hence, Day and Tosey (2011) attempted to fill this gap by proposing a five component ‘P.O.W.E.R.’ framework for writing educational goal statements that they claimed satisfy Zimmerman’s criteria; where the acronym means stating: Positive outcome desired, Own role, What task to be done (with dates), Evidence of accomplishment and Relationships required.

Therefore, it appears the perceived inadequacy in the SMART criteria has made recent authors to amend the original SMART attributes and acronym since Doran first published them in 1981. Table 1 shows the definitions of SMART found in 10 journal articles, including Doran’s, and reveals that most revisions retained the first two criteria of ‘specific’ and ‘measurable’, but changed the remaining three by substituting or adding other attributes that the proponents considered more appropriate. Two of the most recent articles even proposed a SMARTER acronym, while one, Hersh, Worrall, Howe, Sherratt, and Davidson (2012), reported a completely different set of attributes. Less orthodox sources reveal that the revision of Doran’s SMART is widespread. For example, the white paper by Oracle (2012) exchanged Doran’s ‘assignable’ with ‘attainable’, ‘realistic’ with ‘relevant’ and ‘time-related’ with ‘timely’; and reported other authors’ attempts to lengthen the acronym with various new attributes. The revised acronyms in Oracle (2012) include ‘SMART-ER’ (engaging, rewarding), ‘SMART-C’ (challenging or collaborative), ‘SMART-S’ (stretch, sustainable, significant), and ‘SMA-A-RT’ (actionable).

Table 1: Definitions of the SMART acronym for effective goals in journal articles

Author (s)	Context	Acronym	S	M	A	R	T	Additions
Doran (1981)	Management	SMART	Specific	Measurable	Assignable	Realistic	Time-related	-
van Herten & Gunning-Schapers (2000)	Health Policy	SMART	Specific	Measurable	Achievable	Realistic	Time bound	-
Platt (2002)	Training	SMART	Specific	Measurable	Achievable	Relevant	Time-based	-

Jung (2007)	Exceptional Children	SMART	Specific	Measurable	Attainable	Routine-based	Tied to a functional priority	-
Bovend'Eerd, Botell & Wade (2008)	Rehabilitation	SMART	Specific	Measurable	Achievable	Realistic/Relevant	Timed	-
Clarke, Crowe & Deane (2009)	Mental Health	SMART	Specific	Measurable	Agreed	Realistic	Timely	-
Lee (2010)	Education	SMART	Specific	Measurable	Attainable/Achievable	Relevant/Realistic	Time bound	-
Day & Tosey (2012)	Education	SMART	Specific	Measurable	Achievable / Agreed	Realistic	Time-based	-
Macleod (2012)	HCOs	SMARTER	Specific	Measurable	Achievable / Agreed	Realistic	Time-bound	Engaging, Rewarding
Hersh et al. (2012)	Aphasia Rehabilitation	SMARTER	Shared	Monitored	Accessible	Relevant	Transparent	Evolving, Relationship-centred

In addition, Oracle outlines that in writing a SMART objective, the statement should specify the 'outcomes to be delivered', a means of measurement that 'can be objectively assessed' and a 'delivery date or schedule' (p. 10). Rather than add any structural components to the goal statement, the remaining two Oracle criteria can only be considered during its formulation, that is, to be attainable, the employee should have access to all resources needed to achieve it, and to be relevant the objective should be aligned with other goals of every management level of the organisation. Similarly, the toolkits of some popular health organisations recommend the revised SMART criteria. In addition to specific and measurable, Save the Children's (2003) toolkit claims SMART means 'Achievable, Relevant and Time-bound' (p. 254). Even different departments within Centre for Disease Control and Prevention proffer differing meanings, adding 'Achievable, Realistic and Time-phased' (CDC, 2009: 1) or 'Attainable/Achievable, Relevant and Time-bound' (CDC-DHDSP, 2017: 3) to Specific, and measurable.

Therefore, with few exceptions like Jung (2007) and Hersh et al. (2012), among recent authors, there is more agreement with the Doran's SMART criteria of 'specific' and 'measurable' as acceptable attributes of an effective goal statement, than with 'assignable', 'realistic' and 'time-based'. While the exclusion of assignable in a goal statement is probably understandable, it is not clear if there is any hermeneutical justification for the disagreements over either of the two sets of related terms: attainable, achievable, realistic and relevant, or time-based, time-related, time-bound and timely. Accordingly, in earlier reviews, Ogbeiwi (2016, 2017) reduced Doran's original five-goal components for writing an objective statement to a four-component OITT framework illustrated in Figure 3, which includes specifying outcome, indicator, target and time-frame, and excludes the person to whom the goal is assigned.

Specific

Still, examples of a SMART goal or objective statement that possesses all four framework components required to satisfy the recommended criteria or goal attributes are rare to find in published articles on SMART goal-setting. Thus, indicating that the majority of academic reviews and empirical researches on goal-setting and framework attributes are silent about the extent to which actual goals formulated in real-life management practice are truly specific,

measurable, attainable, realistic or time bound. However, Platt (2002) assessed the smartness of 11 objectives against a template of his SMART criteria of specific, measurable, achievable, relevant and time-based and considered only two as SMART, including: 'To have agreed, set and recorded 3 performance targets with each member of staff by the end of June 2003' and 'To achieve 500% reduction over previous year on transport costs (end of this week)' (p. 25). However, none of these 'SMART' objective statements contain a complete set of SMART components if assessed on the OITT framework in Figure 3. The first example is task-oriented, having a target and timeframe, but lack an outcome and indicator measure. The second example states an indicator (transport cost), target (500% reduction) and timeframe, but lack an outcome. Ogbeiwi (2017) conducted a similar review of 17 published examples of SMART objectives and found that none possessed a complete set of outcome, indicator, target and timeframe. Hence, there is an apparent lack of capacity to formulate statements of SMART goals or objectives with the attributes to be useful as effective goals.

DISCUSSION

Goal-setting has generated a massive research interest in the past 4 decades, as evidenced by the large collection of literature sources found and reviewed. However, we cannot claim that a robust review of contemporary concepts of goals and goal-setting has been done with this narrative review methodology, as it uses a search strategy that is considered less structurally organised than the more empirical systematic review (Cronin, Ryan, & Coughlan, 2008). Nevertheless, ample evidence gathered from the sources reviewed has enabled a reasonable overview of current knowledge of goals and goal-setting that is fundamental to contemporary understanding and application of the management concepts.

This review finds that answering basic questions such as 'What is a goal?' may not be so simple, given the massive haziness and confusion that surround the definitions and differentiation of the related goal terms of goals, objectives, aims, or target in both academic literature. Apparently, the debates on whether they are synonyms or not in management circles is not new (Doran, 1981). While Doran believes that whichever term is used may not be practically relevant in all contexts, Macleod (2012) thinks the confusion is pointless as the understanding the entire concept and theory of goal-setting is still evolving. Both authors, however, assert that a clearer differentiation of each goal term, as a different type of expected results of work done, will enable their better application in organisational goal-setting practices, especially at the executive level. A detailed thematic synthesis to harmonise the definitions and differentiate the meaning of each term was reported by the author (Ogbeiwi, 2016).

Overall, the different classification systems in literature indicate that goals exist as different types, differentiable by their contextual, structural, functional and temporal characteristics. Contextual characteristics refer to goal differences in the goal-setting process or approach: how they are set, for example self-set, assigned and participative goals. Structural characteristics refer to the goal differences in their content or what goal framework with which they are formulated or how they are stated, for example specific, broad, general or vague goals. Functional characteristics refer to the different goal purposes or uses, which goal aspects or changes in the organisation's work they are expected to achieve or why they are set, for example performance and learning goals. Temporal characteristics refer to the different goal timeframes or when they will be achieved, for example immediate-term, short-term or long-term goals. This observation is compatible with the Locke and Latham's (2002) description of core goal attributes in their goal-setting theory, which differentiated goals according to their content and intensity, with goal content further elucidated as the goal specificity, clarity and difficulty. The goal classifications have major implication on planning in

organisational settings, where goals can be set for the desired effect of performance at different levels of individual, team, departmental and organisational tiers (Locke & Latham, 2006; Fitsimmons, 2008). Therefore, like Oracle (2002) and Fitsimmons (2008) advise, effort should be made during planning to logically link or align the lower-level goals with the higher goals, also referred to as micro-level and macro-level respectively by Yearta, Maitlis, and Briner (1995) and Locke and Latham (2006); as well as align personal goals to organisational goals, and vice versa, to ensure goal relevance and goal commitment by employees at all levels (Zhang & Chiu, 2012). However, Zhang and Chiu (2012) assert that alignment of personal goals will only motivate individual employees if the goals are also shared goals at the group level.

The evidence found in articles reviewed shows that research about goals in organisations has been evolving for more than 100 years, and, therefore, the understanding of the goal concept is still emerging. Current knowledge show that the goals underscore the direction and destination of an organisation. So, to be relevant to the needs of the organisation and their target population, they should be formulated using a problem-based approach, to reflect the desired change from a problematic status quo, knowing the power of goals to motivate behavioural change (Locke & Latham, 2006). However, the implication of the goal-setting theory by Locke and Latham (1990) and the battery of models and frameworks that have been developed on it by other authors is this: goals can only motivate improved performance towards achieving the desired change if they are written in a structural framework that makes them specific and challenging, and due attention given to the behavioural mediators in the relationship between goal-setting and task performance, and the employee and organisational moderators of goal effect (Locke & Latham, 2002). Hence, despite the doubts in some authors that the theory may not be replicable or applicable or even generalisable to every work setting (Erez & Earley, 1987; Yearta, Maitlis, & Briner, 1995; Boyce et al., 2001; Ordonez et al., 2009; Kramer, Thayer, & Salas 2013), empirical evidence shows that goal-setting theory provides a formidable framework for understanding and further studying the positive and directional effects of goals (MacLeod, 2012).

Most existing goal-setting frameworks only outline practical steps for setting goals in the different contexts, but do not provide any framework for formulating or writing good goals statements. This apparently informed the universal interest in Doran's SMART criteria and the components they recommend should constitute the framework of an effective goal statement. However, there seems to be controversy over which attributes of the SMART acronym appropriately define a good goal in today's work contexts. The summary of the basic components in Doran's criteria according to literature is: SMART goal statements or objectives must have four basic components, to be specific, measurable, attainable or realistic, relevant and time bound (Ogbeiwi, 2016, 2017).

So far, no literature has been found with written examples of SMART objectives that fully possess all framework components required to write statements with the five attributes of SMART goals. This is compatible with findings made from a recent review by Ogbeiwi (2017). Equally, there is no previous research inquiry found to have examined the process of formulation of SMART goal statements according to these attributes and components in any health service provision contexts. To what extent are the current goals of organisations and programmes in different work sectors SMART? Can the goal framework or way they are formulated and written motivate achievement of their desired outcomes? The answers to these questions are currently unknown. Clearly these are obvious gaps for further research.

CONCLUSIONS

The terminological confusion in the definitions of goal terms in popular usage still prevents a clear understanding of how the goal concepts can be applied effectively in existing organisational goal-setting practices. This review finds that goal types are multifarious, and vary according to the organisational goal-setting contexts as well as the structural, functional, and temporal attributes of the goals set. Locke and Latham's (1990) theory of goal-setting and task performance provides a framework for understanding the philosophy of goals, especially that the goal framework could influence attainment of desired outcomes, under specific individual employee and organisational conditions. However, evidence of research exploring the components of a framework for writing statements of actual goals that the work of organisations and programmes can be logically planned is still lacking.

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DECLARATION

This article is an original work of the author and has not been submitted or published elsewhere and aligns with the scope of this journal by seeking to update the knowledge of the readership with the current concepts of goals and goal-setting. Some materials from the authors previous articles are used in some sections, especially definitions, goal-setting theory and the framework. These are appropriately cited and referenced. There is, however, no conflict of interest as this review was not supported by any external funding or obligations.

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Annexe 4: TLM Nigeria Project Profile 2017

TLMN priority	Project title	Goal	Location	Timeline	2017 Budget (NGN)
Funds Development (1)	Harnessing Local Resources: TLM-Nigeria Fundraising Plan.	Increase TLM-Nigeria funding and resources	FCT, Kogi, Kwara, Niger, Lagos.	Oct 2015 – Sept 2018	9,955,419
Empowerment & Livelihoods (4) Advocacy & Communication	Extension: Promoting human rights protection for people affected by leprosy, people with disabilities and children in 6 Communities in FCT / Kogi	Human rights abuses among people affected by leprosy, people with disabilities and children are reduced in Kogi State and the Federal Capital Territory of Nigeria	FCT / Kogi State	2017	38,309,900
	Yes we Can! Empowering Communities affected by Leprosy and Disabilities to Promote Development	People affected by Leprosy, People with Disabilities and Women are Empowered to take responsibility for their Development in Kebbi and Sokoto States of Nigeria.	Kebbi / Sokoto States	2015-2017	31,234,803
	Empowering people affected by leprosy and disabilities for self-development in Kwara State, Nigeria.	People affected by Leprosy and Disabilities Empowered to take responsibility for their Development in Kwara State, Nigeria	Kwara State	2015 - 2017	20,294,000
	Empowering People affected by Leprosy and disadvantaged Populations for Sustainable Development in Niger State, Nigeria.	People affected by leprosy and disadvantaged populations empowered for sustainable development in Niger	Niger state	2016-2018	26,265,452
Health Promotion & Prevention And Management Of	Integrated NTD Control Programme	Community members have timely and effective NTD prevention, diagnosis and management.	Kwara	2015-2018	21,128,715
	Integrated NTD and Disability Project in Zamfara State, Nigeria.	Reduced burden of leprosy and NTD related disability in communities of high prevalence in Zamfara State	Zamfara State	Jul. 2014 – June, 2019	16,929,052
	Improving PHC and Livelihoods in Leprosy affected communities in Kwara & Niger States	Improve health services (malaria, leprosy, MNCH) in 4 leprosy villages in Kwara.	Kwara & Niger States	2015 – 2017	16,942,299

TLMN priority	Project title	Goal	Location	Timeline	2017 Budget (NGN)
Disabilities (5)	Strengthening Qua Iboe Church Leprosy Hospital Ekpene Obom to Provide Sustained Quality Leprosy Care in Akwa Ibom, Nigeria	Enhanced quality care at QIC Leprosy Hospital	Akwa Ibom	2016 – 2018	24,700,000
	TLM Nigeria Orthopedic Project	TLM Nigeria Orthopaedic workshop is a 30% self-funded vibrant Social Enterprise through delivery of best quality Orthopaedic Devices to leprosy affected persons and people with disabilities by 2018	TLM Orthopedic workshop in Niger State	2014 – 2018	28,595,871
Learning & Education (1)	Improving Access to Quality Education and Sanitation in Owalla Community School, Kogi State.	Improved access to learning condition and sanitation for Owalla school children	Kogi	2017	10,446,000
Build Partnerships To Strengthen Our Work (1)	IDEA Nigeria	Promote inclusion & overcome stigma, discrimination and human rights abuses against people affected by leprosy in Nigeria.	Nationally	2017	7,290,680

Annexe 5: Tables

Table 1.2: Breakdown of the components in the framework of projects' objective statements

	Objective Statement	Framework Components			
		Outcome	Indicator	Target	Time
LCP	Obj. 1: To reduce the prevalence of leprosy to the level at which they no longer constitute public health problems in the State	NS	Prevalence	Level not quantified	NS
	Obj. 2: To prevent and reduce the impairments associated with leprosy as well as provide appropriate rehabilitation for persons affected	To prevent and reduce the impairments and rehabilitate	NS	NS	NS
HRP	Obj. 1: Community members are empowered to mainstream gender and protect the rights of women and people with disabilities by 2016	Community members empowered to protect their rights	NS	NS	2016
	Obj. 2: Increased government legal commitment to protect and defend the rights of leprosy-affected persons, people with disabilities and children put in place by 2016	Increased govt legal commitment to protect and defend the rights	NS	NS	2016
	Obj. 3: Improved social and economic situation of leprosy-affected persons PWD and children in 6 villages by 2016	Improved social and economic situation	NS	NS	2016
	Obj. 4: Increased awareness and community participation in health promotion and prevention of disabilities in ... 2016	Increased awareness and community participation	NS	NS	2016
SHP1	Obj. 1: Increased govt legal commitment to protect the equality of rights for leprosy affected persons in xxx by 2017	Increased govt legal commitment to protect the equality of rights	NS	NS	2017
	Obj. 2: People affected by leprosy, disabilities and women are included in govt programmes through a Rights-Based Approach by 2017	Inclusion in govt programmes	NS	NS	2017
	Obj. 3: People affected by leprosy, disabilities and women in 6 communities have improved livelihoods in XX by 2017	Improved livelihood	NS	NS	2017
	Obj. 4: Community aware and promote healthy living in 6 communities in XX by 2017	Community aware and promote healthy living	NS	NS	2017

	Objective Statement	Framework Components			
		Outcome	Indicator	Target	Time
SHP 2	Obj. 1: Improved community health & prevention of disabilities in 4 communities in XX State by 2017	Improved community health & disability prevention	NS	NS	2017
	Obj. 2: Improved livelihood of people affected by leprosy and disabilities in 4 communities in XX State by 2017	Improved livelihood	NS	NS	2017
	Obj. 3: Promote inclusion of people affected by leprosy, disabilities and women in govt programmes through a Right-based Approach by 2017	Promote inclusion in govt programmes	NS	NS	2017
SHP 3	Obj. 1: Improved community health in 6 communities through safe-hygiene practices in X State by 2018	Improved community health	NS	NS	2018
	Obj. 2: Improved inclusion of people affected by leprosy, ...in X State through a Rights-Based Approach by 2018	Improved inclusion	NS	NS	2018
	Obj. 3: Improved socio-economic situation of people affected by leprosy, ... in 6 communities in Nigeria by 2018	Improved socio-economic situation	NS	NS	2018
Ortho	Obj. 1: Promote functional ability among leprosy-affected persons through access to qualitative assistive devices and essential services by 2018	Promote functional ability	NS	NS	2018
	Obj. 2: Promote sustainability of TLMN Orthopaedic workshop such that paying clients increased by at least 30% by 2018	Promote sustainability	Number of Paying Clients	30% increase	2018
	Obj. 3: Strengthen governance structure, systems and capacity for staff performance and quality productivity at Orthopaedic workshop by 2018	Strengthened governance structure, systems and capacity	NS	NS	2018
Count	19 (100%)	18 (94.7%)	2 (10.5%)	1 (5.3%)	17 (89.5%)

NS = Not Stated or Specified in the statements

Table 2.2 List of Literature Sources Reviewed in Phases 1 and 2

	Authors	Type of Literature	Terminological Definitions	Classification of Goals	Goal-setting Philosophy	Goal-setting frameworks	Writing SMART Goals	Healthcare Goal-setting
1	Boyce et al. (2001)	Journal Abstract			X			
2	Bradley et al. (1999).	Journal Abstract		X	X			
3	Campion & Lord (1982),	Journal Abstract			X			
4	Castro et al. (2008)	Journal Abstract						X
5	Fulop & Hunter, 2000;	Journal Abstract			X			
6	Gunning-Schapers (2000)	Journal Abstract						X
7	Holiday (2007)	Journal Abstract						X
8	Langford et al. (2007)	Journal Abstract				X		X
9	Liss (2003),	Journal Abstract						X
10	McGlynn (2003)	Journal Abstract						X
11	Parson (2012).	Journal Abstract						X
12	Ritsatailis (2000).	Journal Abstract						X
13	Van Herten & Gunning-Schapers (2000a)	Journal Abstract			X	X	X	X
14	Van Herten & Gunning-Schapers (2000b)	Journal Abstract			X	X	X	X
15	van Herten (2000);	Journal Abstract						X
16	Whitehead (1998)	Journal Abstract		X				
17	Busse and Wismar (2002a)	Journal Abstract		X		X		X
18	Busse and Wismar (2002b)	Journal Abstract		X		X		X
19	Bipp & Kleingeld (2011)	Journal Article				X	X	

	Authors	Type of Literature	Terminological Definitions	Classification of Goals	Goal-setting Philosophy	Goal-setting frameworks	Writing SMART Goals	Healthcare Goal-setting
20	Bornman & Murphy (2006)	Journal Article				X		
21	Bovend'Eerd et al. (2008)	Journal Article					X	
22	Bravo (2005)	Journal Article						X
23	Brown et al. (2005)	Journal Article			X			
24	Clarke et al. (2009)	Journal Article					X	
25	Dahlsten et al. (2005)	Journal Article				X		
26	Day and Tosey (2011)	Journal Article	X		X		X	
27	Doran (1981)	Journal Article	X				X	
28	Dorgan and Richardson (2008)	Journal Article						X
29	Erez and Earley (1987)	Journal Article		X	X			
30	Fitsimmons (2008),	Journal Article	X	X	X			
31	Hurn et al. (2006)	Journal Article						
32	Ginsburg 2001).	Journal Article		X		X		
33	Greenbank (2001).	Journal Article		X				
34	Hersh et al. (2012)	Journal Article					X	
35	Jung (2007)	Journal Article					X	
36	Lee (2010)	Journal Article					X	
37	Lindberg and Wilson (2011)	Journal Article				X		
38	Locke and Latham (2002)	Journal Article	X	X	X	X		
39	Locke and Latham (2006)	Journal Article						

	Authors	Type of Literature	Terminological Definitions	Classification of Goals	Goal-setting Philosophy	Goal-setting frameworks	Writing SMART Goals	Healthcare Goal-setting
40	Locke et al. (1980)	Journal Article	X		X			
41	Latham and Locke (2007)	Journal Article	X					
42	Macleod (2012)	Journal Article					X	
43	Medlin and Green (2009)	Journal Article			X	X		
44	Naik et al., 2011;	Journal Article						X
45	Ogbeiw (2016)	Journal Article	X				X	
46	Ordonez et al. (2009)	Journal Article			X			
47	Parker et al. (2003)	Journal Article				X		X
48	Platt (2002)	Journal Article					X	
49	Scobbie et al. (2013)	Journal Article				X		X
50	Seijts & Latham (2000);	Journal Article			X			
51	Stretcher et al. (1995)	Journal Article	X					
52	Walston & Chou (2006),	Journal Article						X
53	Yearta et al. (1995)	Journal Article		X	X	X		
54	Zhu et al. (2002).	Journal Article				X		
55	Kerr and LePelley (2013)	Book Article		X	X			
56	Kramer, Thayer, & Salas (2013)	Book Article			X			
57	Locke and Latham (2013)	Book Article	X					
58	Nanji et al. (2013)	Book Article	X		X			X
59	Saari (2013)	Book Article			X			

	Authors	Type of Literature	Terminological Definitions	Classification of Goals	Goal-setting Philosophy	Goal-setting frameworks	Writing SMART Goals	Healthcare Goal-setting
60	CDC (2009)	Factsheet					X	
61	CDC-DHDSP, (2017)	Factsheet					X	
62	OECD (2002)	Glossary	X					
63	Beardshaw and Palfreman (1990)	Textbook	X					
64	Bratton et al. (2007).	Textbook	X	X				
65	Collins Dictionary (2006)	Textbook	X					
66	Harris and White (2013).	Textbook	X					
67	Mullins (1999)	Textbook	X	X				
68	Murphy and Boa 2012).	Textbook				X		
69	Oracle (2012)	Toolkit				X	X	
70	Save the Children's (2003)	Toolkit					X	
	Total (%)		16 (22.9%)	13 (18.6%)	20 (28.6%)	18 (25.7%)	17 (24.3%)	20 (28.6%)

Table 5.3: Themes of stakeholders' goal-setting *roles* in TLMN

Typical Primary code(s) and Quote #	Secondary codes	Sub-theme
Division of implementation (1.4.1)	Implementing	Shared National & Field Roles
Division of reporting (1.4.2)	Reporting	
Overseeing managers (1.5.1; 1.5.7)	Managing Projects	National responsibilities
Ensuring approved implementation and reporting (1.1.14; 1.5.2)	Implementation	
Keeping partners informed (1.5.6)	Working with Partners	
Developing project proposals (1.1.2)	Project development	
Mr B's sole responsibility for goal-setting, formulating, writing, finalizing (1.1.13; 1.2.1; 1.1.21; 1.15.3; 1.16.4; 2.41.1)	Sole responsibility for goal-formulation	
Designing project centrally at NCO (3.34.1)	Project design by NCO	
Reporting project needs to NCO (2.38.18; 2.38.20)	Project Needs Identification	Field Responsibilities
Managing leprosy control projects (3.1.1.; 4.2.1)	Managing Projects	
Implementing assigned goals (4.10.2; 4.10.4; 5.6.1; 5.7.1)	Implementation	
Evaluating intermediate and short-term goals (4.13.5)	Evaluating project achievement	
Not responsible for the designing of the project (3.27.2; 4.22.5)	Exclusion from project design	
Not part of goal formulation process (3.33.1; 1.3.1; 3.45.1; 6.15.1; 6.15.3; 9.21.1; 4.18.1)	Exclusion from goal formulation	
Expressing desired change (2.28.2; 2.28.4; 2.28.5; 2.39.1)	Needs identification by beneficiaries	Community responsibilities
Conceptualisation (1.1.5; 1.3.2; 1.3.8)	Concept Initiation	Joint Responsibilities
Community needs assessment (1.1.22; 3.35.1; 9.20.1; 10.11.1; 10.11.2; 3.35.3; 3.35.4; 3.41.2)	Baseline Survey	
Reviewing approved project proposals (1.3.10)	Proposal review meetings	

Table 5.4: Themes of the goal belief of leprosy managers

Typical Primary codes (Quote #)	Secondary codes	Sub-themes
A desired, terminal, or problem related target (4.5.1; 4.5.2; 1.9.1; 8.13.1; 5.4.1; 6.3.2; 10.3.1)	A Target	Goal definitions
Long-term change or aim (4.5.4; 4.6.2; 2.2.1; 2.2.4)	Long-term aim	
Societal or Population changes (2.2.3; 2.46.4)	Community-level change	
An attempted, desired end result (3.8.1; 3.11.1; 4.14.5; 10.4.1; 5.18.1)	An expected Result	
A desired or timed achievement (6.3.1; 7.17.1; 7.19.1; 9.7.1; 7.7.3)	A desired achievement	
A focused vision (7.7.1; 7.7.2)	A Vision	
A height to reach (6.3.3)	A desired height	
Overall change (2.7.7)	Overall goal	Goal-type
Long-term change or Expected impact (2.10.1; 2.10.6; 6.10.1; 6.9.1)	Long-term goal	
Mid-way accomplishment (6.10.2)	Mid-term goals	
Activities (4.14.1)	Short-term goal	

Typical Primary codes (Quote #)	Secondary codes	Sub-themes
End-result of activities (5.17.1)	Output	
Showing direction or Defining destination (1.10.3; 3.13.1; 2.5.2; 3.69.2; 7.10.3; 1.10.2; 7.10.3; 4.6.3; 3.13.2; 3.69.2; 1.10.1)	Indication of project direction and destination	Goal Effect
Showing purpose (1.10.2; 1.10.10)	Giving project meaning	
Narrowing attention (1.20.5; 6.19.2)	Enabling project focus	
Setting operational boundaries (1.10.4; 1.20.5, 4.38.5, 5.35.2)	Defining Scope	
Concentrating effort (1.10.6; 6.19.1)	Increasing Effort	
Driving towards the achievement (1.10.9; 5.8.1; 5.8.3)	Motivating achievement	
Enabling knowledge of expected achievement (6.4.1.; 5.8.5; 3.71.1; 4.7.1; 7.46.1)	Knowing achievement	
Impactful, beneficial to people's lives (10.7.1; 6.5.4; 9.13.2)	Life-changing for the target population	
Total collapse (7.9.1), Impossible to run the project (3.69.1)	Project failure	Effect of Goal-lessness
No information about plan or achievement (3.70.2; 3.70.3)	Ignorance of project	
Lost - ignorant of direction; (1.20.4; 5.8.2; 7.9.3; 4.38.1)	Loss of direction / destination	
Lack of order, coordination (4.38.2; 10.23.1)	Confused implementation	
No project to report (9.46.1; 9.46.3; 9.45.1)	No implementation	
Difficult evaluation (9.46.2)	Impossible to evaluate	
Objectives based on assumptions produce projects irrelevant to beneficiaries needs (10.6.4)	Assumption-Based Goal Formulation	Effect of Illogical Goals
Causing project failure (7.46.2)	Effect of improper objective formulation	

Table 5.5: Themes of the goal-setting approach according to leprosy managers

Typical primary codes (Quote #)	Secondary codes	Sub-theme
Statements are straight forward (9.32.2), Brief and all-encompassing (10.14.1)	Well formulated objectives	Assigned Goals
Doubtful achievability of national-set goals (4.22.4), National ignorance of field reality (4.22.7)	Not realistic in field settings	
Field setting different from office settings (9.47.4); Causing problems for field workers (4.22.6)	Difficult to implement	
Grassroot involvement in goal formulation (4.22.8; 4.36.3; 4.39.1)	Grass-root collaboration	Field recommendations
Involve field officers in project planning / goal-setting (10.24.2; 6.25.1; 9.47.1; 5.46.2; 5.46.1)	Project stakeholder collaboration	
Bottom-up, rather than top-down (9.47.2)	Change goal-setting approach	
Re-strategise, re-prioritise leprosy control (6.14.2; 6.19.4)	Change project strategies	
Return to past goal-setting activities (7.60.1)	Return to past planning practice	

Typical primary codes (Quote #)	Secondary codes	Sub-theme
Keep on doing what you are doing (10.24.1, 8.44.1; 8.45.1)	Continuation of status quo	
Views are contained, covers all nooks and crannies (4.39.2; 9.47.3)	Robust goal formulation approach	Collaborative Goal-setting
Enables project achievement (5.46.3)	Project effectiveness	
Gives knowledge about project goals (5.46.4)	Educates field officers	

Table 5.6: Themes of goal-setting ability in TLMN practice

Typical Primary codes and Quote #	Secondary codes	Sub-theme
Hailing Mr B's Expert goal-setting capacity (1.1.20), Having the ability to formulate goals (1.1.20; 7.35.1)	Goal-setting Capacity	Goal-setting competence
Having past experience (7.42.1); Having no experience (8.7.1)	Experience of TLM Goal-setting Practice	
Claiming ignorance of current goal-setting (8.18.1; 8.28.1; 6.18.1; 7.27.1; 7.30.1; 7.31.1)	Non-Awareness of TLM Goal-setting	

Table 5.7: Themes of the goal-setting stages in TLMN practice

Typical Primary codes and Quote #	Secondary codes	Sub-theme
Different, stepwise stages of goal formulation (2.37.1; 10.9.9; 10.6.2)	Multi-staged goal-setting process	Pre-survey preparation
Identify the target area (10.9.1)	Identification of target communities	
Before you start (4.37.2)	Pre-implementation timing	
Field officers sending reports to NCO, NCO Studying field projects (3.34.3; 3.34.5; 3.44.1; 8.27.1, 8.29.1)	Review of project reports	
Receiving communication from M. T. (5.23.1; 5.23.2)	NCO Communication to field officers	
Pre-project Survey Assessment (1.1.7; 1.1.4; 2.38.21; 3.27.3; 3.34.4; 5.9.2; 5.22.1; 9.19.1)	Making Field Visit for needs assessment	Baseline Survey
Focus group discussion with community; Meeting with community members as sources of data (5.9.3; 5.23.9; 5.24.6; 1.1.10; 2.28.1; 2.38.22; 1.1.9; 1.3.5; 2.40.10; 1.1.25; 5.23.8; 5.22.2)	Field survey data collection	
Community members identifying their own needs (10.9.3; 9.19.2; 5.9.4)	Field Needs Assessment	
Interpreting - making sense of survey results (1.1.12; 1.1.11; 5.23.9)	Survey data analysis	
Discussing projects and proposal development (5.23.3; 5.23.5; 5.23.7; 5.23.4; 2.38.23; 5.22.3; 5.22.7; 10.9.2; 9.19.3; 5.23.6)	Field discussion of project proposal	Post-Survey Problem Analysis
Beginning goal-setting process after Mr T's return (1.15.1; 1.15.2; 1.3.7; 3.35.6; 3.41.35.24.1; 1.3.6)	Returning to NCO with survey results	
Examining project issues with problem tree; Deciding project solutions (1.15.4; 1.15.5; 1.15.6)	Problem Tree Analysis at NCO	
Group, joint, collaborative goal formulation at NCO consultation (3.41.4; 3.46.1; 2.38.26; 4.10.1; 4.10.3; 5.5.1; 5.45.1; 9.19.4; 9.26.2; 4.17.2; 4.20.1, 10.10.1;	Goal Formulation at NCO	Goal Formulation

Typical Primary codes and Quote #	Secondary codes	Sub-theme
10.12.2; 5.5.2; 1.1.17; 1.15.2; 1.16.2; 2.38.2; 2.38.11; 2.38.27; 2.38.28; 2.28.9)		
Small group converting desired changes to goal statements together (2.38.28; 2.38.11; 1.15.9; 2.39.2; 7.29.1; 8.27.2; 5.24.2; 8.26.1)	Writing Goal Statements at NCO	
Focused on needs, problems of the target population. Communities (3.27.4; 3.49.1; 3.49.23.40.2; 5.9.5)	Needs-base goal formulation	
Based on survey agreements, Collaboratively agreed goal statements (5.14.3; 5.16.1; 5.28.1; 1.16.6)	Agreement-based goal formulation	
Relating objectives to donors' focus areas (5.28.2)	Donor-based goal formulation	
Field contributing to project planning at annual meetings and project development workshops (2.38.24; 2.38.25; 8.23.2; 8.29.2)	Planning Meetings and workshops	Project Action Planning
Interventions based on needs assessment (5.24.7; 10.9.4)	Planning based on community needs	
Request for more information, Feedback of NCO decisions on goals and plan for validation (5.24.3; 5.24.5; 5.24.8; 5.24.4; 1.16.5; 3.41.1; 2.38.29; 2.47.7; 4.17.4; 4.21.01; 4.17.8; 9.14.1; 4.22.2; 9.22.1; 2.29.3; 2.39.3)	NCO communication to Field Officers	Post Planning Feedback
NCO giving feedback to field officers in the meeting (3.41.5; 3.41.6; 3.36.1)	Field Feedback Meetings	
Validating achievability of goal statements; Reviewing logical connection of goals and activities (2.38.30; 2.39.4; 4.17.6; 9.24.1; 9.25.1; 9.27.1; 3.39.1; 9.26.3; 4.17.5)	Validation by field staff	Field Validation
Validating goal statements' relevance to desired needs (2.38.13)	Validation by beneficiaries	
Joint agreement on goals, Acceptance of goal statements (3.40.1; 3.41.7; 10.13.1; 10.13.2; 10.12.4)	Outcome of field validation	
Field officers unable to amend NCO goal statements (4.22.1; 3.38.1; 3.29.2)		
NCO review of field comments, Doubtful use of field comments (4.17.7; 4.22.3; 9.25.2)	NCO action on field validation	
Finalising goal statements by NCO steering committee (2.38.14; 2.38.31; 4.17.9; 4.17.10)	NCO Finalisation of goals	Finalisation of project plans
NCO sharing goals with office colleagues and donors (2.41.2; 2.41.5)	Sharing with National stakeholders	Sharing approved plans
Sending final plans to field officers (2.38.11; 4.17.11; 10.12.3)	Sharing with field officers	
Project officers sharing goals with the community (2.41.4)	Sharing with community members	
Field officers receiving, engaged after approved plans (1.1.26; 1.3.9; 2.41.1; 2.41.3; 1.3.11; 5.25.1; 5.25.2; 2.38.11; 9.31.1; 5.25.3)	Discussion approved goals and plans with Field officers at NCO	Post Approval Meeting

Table 5.8: Themes of the goal-setting pattern in TLMN practice

Typical Primary codes and Quote #	Secondary codes	Sub-theme
Mixing different types of goals in project plan (1.13.2; 1.13.8); Setting short, medium and long-term goals (1.12.2; 2.2.2; 9.7.2; 9.15.1; 2.6.1; 2.10.3) Three types: long-term, mid-term and immediate goal (6.8.1; 3.24.1)	Project Goal Mix	Project Goal Types / Choice
Expressing outputs as lower-level goals (2.40.6), Project-specific shorter-term goals (2.5.7) Project, operational level goals (2.17.1), Related achieving activities (4.14.3)	Short-term goals	
Medium-term goals (2.40.5; 4.13.2)	Intermediate goals	
Objectives addressing specific project issues (2.7.3; 2.45.1; 7.14.2)	Project-specific goals	
Projects having single long-term goals (4.13.3; 2.5.1), Representing the overall goal of projects (2.7.5), Expressing expected overall change (2.40.4)	Long-term goals	
Long-term goals of TLM country-level strategies (2.5.3; 2.5.5.; 5.18.4) Expressing expected long-term changes from country strategies (2.23.2)	Organisational Strategic goals	
A quarter or a month (2.30.6; 2.30.7); a month, a quarter, a year (2.35.2); a quarter (2.30.3); 3 months, 6 months (9.15.1); between a quarter and a year (2.32.4; 4.16.1; 2.32.1); 12 months (1.13.6)	Short-term timeframes	Goal Timeframes
3 years (1.13.7; 2.13.5; 2.32.3; 2.32.1); A project's life-span, 5 years (4.16.2);	Intermediate / Medium-term Timeframes	
5 years and more (6.12.1; 2.38.1; 2.32.1); a year, 2 years, 5 years, project-dependent (9.17.1); End of all terms (4.16.3)	Long-term time frame	
Available funding, resources (1.13.1; 1.13.3; 4.15.1)	Funding	Goal Differentiation Criteria
Different goal times (1.14.1; 2.32.1; 1.12.1; 4.15.1; 2.22.1)	Timeframes	
Group of stakeholders involved in goal-setting/planning (2.13.1; 2.13.4; 2.13.7; 2.21.3; 2.22.1)	Stakeholders	
<u>Communities</u> involved in short-term goals (2.12.2; 2.31.2) <u>Internal stakeholders</u> , <u>staff</u> involved, formulating in short term goals (2.30.1;2.30.4). Both country and project <u>staff</u> involved in short term goals (2.31.1)		
Country-level stakeholders write country-level goals (2.26.1; 2.25.3)		
Project partners involved in medium-term goals (2.28.3)		
Three plan levels: country strategy, project plan and Workplan (2.17.5)	Plan level	
Strategic objectives in organisational/country plan (2.17.6; 2.38.1)		
Long-term goals in country-level strategic objectives (2.23.1)		
Medium-term goals in project plans (2.17.7)		

Typical Primary codes and Quote #	Secondary codes	Sub-theme	
Short-term goals in operational work plans, project plan (2.17.8; 2.30.2)			
Short-term goals and outputs related in activity plans (2.35.1)			
Long-term goals measuring overall country strategy (2.21.1)	Measurement		
Medium-term goals measuring regional projects (2.21.1)			
Short-term goals measuring activities (2.21.1)			
Long-term goals - statements of change, not SMART (2.33.1)	Statements		
Medium-term goals - outcome level objectives, SMART (2.33.1)			
By the way they are stated, nature (2.22.1)			
Short-term goals as operational outputs (2.17.4; 2.34.1)	Results		
Medium term goals as outcomes (2.19.1; 2.33.3)			
Activities differentiating national and State goals (7.14.3)	Activities		
Linking multiple objectives to single long-term goal (7.15.2; 6.5.2)	Project Planning Framework		Logical Goal Formulation
Using project logic, planning framework (2.40.9)			
Linking project objectives to organisational strategies (2.7.4; 2.5.6; 2.5.8; 2.9.1.; 2.9.2)	Linkage of project long-term goals to organisational strategy		
Project overall goals contributing to country strategy (2.7.6; 5.19.1)			
Deriving project goals from national goals (7.14.1)			
Overall goals as change expected from specific objectives (2.7.8.; 2.9.1.; 2.9.2; 6.5.2; 7.17.2; 7.19.4; 2.40.8)	Linkage of medium-term goals to long-term goals		
Attaining mid-term goals makes achieving long-term goal possible (6.10.3)			
"...Goal and objectives are speaking together" (9.30.1)			
Breaking medium-term goals into short-term goals (2.17.2)	Linkage of short-term to medium		
Short-term outputs contributing to both medium and long-term goals (2.36.1; 2.40.7; 2.30.7)			
Attaining short-term goals makes the mid-term goal possible (6.10.4)			
Planning activities based on objectives (9.33.4)	Linkage of activities to goals		
Breaking down activities to formulate short-term goals (2.30.5)			
Linking activities to the outcome, and then to impact (4.24.6; 4.14.2; 4.5.3; 5.5.4; 9.44.2)			
Defining intermediate goals as the impact of activities (4.14.4)			
"Wrapping" interventions around objectives (1.15.8)			

Typical Primary codes and Quote #	Secondary codes	Sub-theme
Available funds (2.47.1), Available staff (2.47.2) Expected community contribution (2.47.3)	Resources	Target setting
Desired extent of change (2.47.4)	Extent of targeted change	
Priorities (2.47.5)	Organisational priorities	
Multiple goals in the project plan (8.15.1); Four objective statements (5.36.3) Three particular goals (10.8.1)	Number of goals	Goal Formulation Approach
Formulating one project (long-term) goal (7.15.1)		
Project dependent (3.27.1)	Frequency	
Before the inception of the project (3.29.1; 3.30.1)	Timing	
Use similar process for all goal types (2.13.6; 2.15.2; 2.21.2; 2.38.15)	Formulation process	Leprosy Control Goal- setting
We no longer do that. It is done for SED (6.14.1)	Absence of goal-setting for leprosy control projects	
No goals for the previous project year (6.20.1; 7.50.1)		
No project planning documents (6.23.1; 7.48.1)	The rationale for the exclusion of leprosy projects	
The shift of funding focus from leprosy control (7.34.1)		

Table 5.9: Themes of goal statement composition in TLMN practice

Typical Primary codes and Quote #	Secondary codes	Sub-theme
Expressed change, desired, A specific change in an objective statement (2.45.2; 4.24.3) Stating the change in the problem first (2.42.4; 3.51.2)	Desired change or accomplishment	Contents of statements
Stating the desired achievement first (3.51.3; 6.7.3) expected to achieve (2.42.1; 2.42.3; 1.17.5; 2.46.7; 9.35.2; 2.42.6; 6.7.4) expected, desired accomplishment (9.37.2; 5.35.1; 5.36.4; 7.11.1); Desired activity (5.36.1)		
The period and the year (9.37.3)	Timeframe	
State timeframe (1.15.11; 2.42.9; 2.46.11; 3.53.1) State timeframe in an objective statement (1.15.11; 9.35.4; 2.46.2; 7.40.4; 4.24.5; 7.19.3)		
Included the target persons / community in the objective statement (9.33.3; 2.42.7; 2.46.3; 2.46.6; 3.51.4; 3.53.3; 4.24.4)	Target Population	
A measure of change 2.42.8	A Target Level	
An attainable target (2.46.10) The desired target level (3.53.2; 7.40.3; 6.7.2) A targeted achievement (9.35.3)		
Stating the baseline level: e.g. '2010 baseline data' (7.40.5)	Baseline level	
Including strategy in an objective statement (1.17.6)	Strategy	
Including a measure, an indicator in an objective statement (2.45.3; 2.46.8; 7.40.2)	Indicator	
For you to know if you have achieved the goal. (3.19.1)	Reasons for the inclusion of time and measure	
inclusion of measurement and timeframe in an objective statement (9.36.1)	Target and Timeframe	Content Combinations

Typical Primary codes and Quote #	Secondary codes	Sub-theme
what they want to achieve, the timeframe that they want (4.25.1; 4.26.2; 9.37.1; 3.16.1)	accomplishment and Timeframe	
5 contents considered in statement 2.46.5	target population, change, measure, target and timeframe	

Table 5.10: Themes of goal construction criteria in TLMN practice

Typical Primary codes and Quote #	Secondary codes	Sub-Theme
Writing statements according to specific goal-setting themes (1.15.10)	Multi-Themed Attributes	Good goal Attributes
Being realistic, positive and results-oriented (10.5.1); Measurable, timed and clear (3.17.1); Design, implementation, and end-result (5.12.1); Usage of the goals (5.13.1)		
SMART concept (1.15.12; 1.15.13; 1.17.3; 2.4.1; 6.6.1; 6.6.3; 3.55.1; 7.12.1; 1.17.9) specific, measurable, attainable, realistic, time-bound (2.4.2; 4.8.1; 6.6.2) specific, measurable, time-bound, realistic (1.17.8) SMART medium-term goal, Objectives (1.15.13; 2.33.4; 2.10.4) short-term goals: specific, measurable, attainable, realistic, time-bound (2.12.1; 2.10.4)	S.M.A.R.T. Attributes	
Non-SMART quality of long-term goal statements (2.33.2; 2.10.2)		
achievable, something that is achieved (4.8.2; 7.13.1; 9.13.1; 2.46.9; 1.1.18; 1.17.2; 5.9.6; 7.10.1) should be visible, knowable (1.11.12) means realistic (1.11.10)	Achievability / Attainability	
Never vague (1.11.6; 1.11.9); specific (1.11.7); understandable (1.11.8)	Specificity	
Long-term goals ... are sometimes a little bit vague (2.10.5); broad (1.11.2; 7.44.2)		
it will have to be time-bound (1.11.11; 7.13.2)	Time-bound	
a good goal is one that is long term (1.11.1); lack of timeframe for accomplishing a long-term goal (7.19.2)		
measurable you should be able to measure (4.8.3; 1.11.14; 6.5.5.; 6.5.6; 1.11.13)	Measurability	
Something that you know you can achieve within the bounds of your resources (2.4.3; 4.9.1.; 2.31.4; 2.46.1); really realistic (6.5.1); situation-based (9.32.1); real needs of the target people (10.6.3); the ability of the community' (5.9.1); being workable or feasible (6.5.3)	Realistic	
For clear understanding (3.20.1; 3.21.1)	Clarity	
Acceptable by all, by all parties involved (5.10.1)	Acceptability	

Table 5.11: Themes of goal statement construction approach

Typical Primary codes and Quote #	Secondary codes
Writing of various parts out (2.43.1); The statements they are just like a sentence (4.24.1)	Structured Goal Formulation
a good goal [comes from] how the goal is being designed (5.11.1) Setting bad goals randomly (7.10.2)	
Expressing the desired change in present tense (2.42.2) Common verbs used in objective statements (5.36.2)	Using Verbs in statements
Flexible objective statements (5.30.1)	Flexible construction
For us implementing it, to have a full understanding (5.31.1; 3.31.3)	
a variety of goal-setting frameworks, tools (4.23.1; 4.23.3; 2.40.1) There is the results framework (4.23.2); Using Project Framework to formulate three levels of goals (2.40.3; 2.40.2)	Using Goal-setting Frameworks
There is no standard template 1.16.1; 1.16.7	No Standard formulation tool

Table 5.12: Themes of the framework of verbal examples of objectives in TLMN practice

Typical Primary codes and Quote #	Secondary codes
Change: ("To increase access to quality care of leprosy and NTD") 3.24.2; ("to gain government commitment and ownership") 3.24.3	Change structure
Change ("Increase participation") 3.24.5; ("To reduce stigma, or to zero stigma") 3.51.1; ("to reduce the impairment") 9.33.1	Change-Beneficiaries Structure
Beneficiaries ("of people affected by leprosy and NTD") 3.24.5; ("within the community, leprosy-affected and other communities.") 3.51.1; ("among the affected persons") 9.33.1	
Change "to reduce the spread of leprosy" 9.33.1	Change-Location Structure
Location: "in the community" 9.33.1	
Timeframe ("by the end of 2018") 3.53.1	Timeframe-Target-Beneficiaries Structure
"Target ("that there will be 30% stigma reduction") 3.53.1	
Beneficiaries ("in a particular community") 3.53.1	
Change ("to reduce the burden of leprosy or disability") 4.24.2	Change-Beneficiaries-Timeframe Structure
Beneficiaries ("in so, so, so community") 4.24.2	
Timeframe ("within so, so, so years") 4.24.2	
Change ("improve inclusion of") 1.17.4	Change-Beneficiaries-Strategy-Timeframe Structure
Beneficiaries ("people affected by leprosy and women in government programmes") 1.17.4	
Strategy ("through the rights-based approach") 1.17.4	
Timeframe ("by 2020.") 1.17.4	
Change ("Malnutrition is reduced") 2.42.5	Change-Beneficiaries-Target-Timeframe Structure
Beneficiaries ("among so so population") 2.42.5	
Target ("by so so per cent or proportion") 2.42.5	
Timeframe ("by so so time.") 2.42.5	
Change ("To reduce ...the spread of TB") 9.35.1	Change-Baseline-Target-
Baseline ("from this percentage") 9.35.1	

Typical Primary codes and Quote #	Secondary codes
Target (“to this percentage”) 9.35.1	Timeframe Structure
Timeframe (“by the year”) 9.35.1	
Indicator (“To reduce the prevalence of grade 2 disability per 100 population”)7.40.1	Indicator- Beneficiaries- Target- Timeframe- Baseline Structure
Beneficiaries (“people affected by leprosy coming in with”) 7.40.1	
Target (“to 25%”)7.40.1	
Timeframe (“by the end of 2015”) 7.40.1	
Baseline (“compared with 2010 baseline data”) 7.40.1	

Table 5.13: Themes of the framework of written aim statements

Typical Primary codes and Quote #	Secondary codes
Change (“To reduce significantly the burden, socio-economic impact and transmission of leprosy”) LCP	Change-Location- Target structure
Location (“in the State”) LCP	
Target (“in line with the MDG and Stop TB partnership targets”) LCP	
Problem (“Human rights abuses”) HRP	Problem- Beneficiaries-Change Structure
Beneficiaries (“among people affected by leprosy...”) HRP	
Change (... are reduced”) HRP	
Beneficiaries (“People affected by leprosy”) SHP 1; (“People affected by leprosy and disabilities SHP 2; (“People affected by leprosy and disadvantaged populations”) SHP 3	Beneficiaries- Change-Location Structure
Change (“Are empowered to take responsibility for their development”) SHP 1; (“empowered to take responsibility for their development”) SHP 2; (“empowered for sustainable development”) SHP 3	
Location (“... in XX of Nigeria”) SHP 1 Location (“in XX State, Nigeria”) SHP 2	
Location (“in X State, Nigeria”) SHP 3	
Change (“Improved functional ability”) Ortho	Change-Beneficiary- Timeframe-Strategy Structure
Beneficiaries (“of people affected by leprosy and disabilities”) Ortho	
Timeframe (“by 2018”) Ortho	
Strategy (“through a social enterprise model”) Ortho	

Table 5.14: Themes of the framework of written objectives

Typical Primary codes and Quote #	Secondary codes
Change (“To prevent and reduce the impairments associated with leprosy as well as provide appropriate rehabilitation”) LCP	Change- Beneficiaries Structure
Beneficiaries (“for persons affected”) LCP	
Change (“Increased awareness and community participation in health promotion and prevention of disabilities”) HRP	Change- Timeframe Structure
Timeframe (“in ... 2016”) HRP	
Indicator (“To reduce the prevalence of leprosy”) LCP	Indicator-Target- Location Structure
Target (“to the level at which they no longer constitute public health problems”) LCP	
Location (“in the State”) LCP	

Typical Primary codes and Quote #	Secondary codes
Change (“Community members are empowered to mainstream gender and protect the rights”) HRP; (“Strengthen governance structure, systems and capacity for staff performance and quality productivity”) Ortho; (“Increased government legal commitment to protect and defend the rights”) HRP; (“Improved socio-economic situation”) SHP3; (“Improved community health & prevention of disabilities”) SHP2; (“Increased govt legal commitment to protect equality of rights”) SHP1	Change-Beneficiaries-Timeframe structure
Beneficiaries (“of women and people with disabilities”)HRP; (“at Orthopaedic workshop”) Ortho; (“of leprosy-affected persons, people with disabilities and children”) HRP; (“of people affected by leprosy in 6 communities... in Nigeria”) SHP3; (“in 4 communities in XX State”) SHP2; (“for leprosy affected persons in xxx”) SHP1	
Time frame (“by 2016”) HRP; (“by 2018”) Ortho; (“by 2016”) HRP; (“by 2018”) SHP3; (“by 2017”) SHP2; (“by 2017”) SHP1	
Change (“Promote functional ability”) Ortho; (“Promote inclusion in govt programmes”) SHP2	Change-Beneficiaries-Strategy-Timeframe Structure
Beneficiaries (“among leprosy-affected persons”) Ortho; (“of people affected by leprosy, disabilities and women”) SHP2	
Strategy (“through access to qualitative assistive devices and essential services”) Ortho; (“through a Right-based Approach”) SHP2	
Timeframe (“by 2018”) Ortho; (“by 2017”) SHP2	Change-Beneficiaries-Target-Timeframe Structure
Change (“Improved livelihood”) SHP2; (“Improved social and economic situation”) HRP	
Beneficiaries (“of people affected by leprosy and disabilities”) SHP2; (“of leprosy-affected persons PWD and children”) HRP	
Target (“in 4 communities in XX State”) SHP2; (“in 6 villages”) HRP	
Timeframe (“by 2017”) SHP2; (“by 2016”) HRP	Beneficiaries-Change-Strategy-Timeframe Structure
Beneficiaries (“People affected by leprosy, disabilities and women”) SHP1	
Change (“included in govt programmes”) SHP1	
Strategy (“through a Rights-Based Approach”) SHP1	
Timeframe (“by 2017”) SHP1	Change-beneficiaries-Strategy-Timeframe Structure
Change (“Improved community health SHP3	
Beneficiaries (“in 6 communities... in X State”) SHP3	
Strategy (“through safe-hygiene practices”) SHP3	
Timeframe (“by 2018”) SHP3	Change-Beneficiaries-Location-Strategy-Timeframe Structure
Change (“Improved inclusion”) SHP3	
Beneficiaries (“of people affected by leprosy”) SHP3	
Location (“...in X State”) SHP3	
Strategy (“through a Rights-Based Approach”) SHP3	
Timeframe (“by 2018”) SHP3	Beneficiaries-Target-Location-Change-Timeframe Structure
Beneficiaries (“People affected by leprosy, disabilities and women”) SHP1	
Target (“in 6 communities”) SHP1	
Location (“in XX”) SHP1	
Change (“have improved livelihoods”) SHP1	
Timeframe (“by 2017”) SHP1	Change (“Promote sustainability”) Ortho

Typical Primary codes and Quote #	Secondary codes
Beneficiary (“of TLMN Orthopaedic workshop”) Ortho	Change-Beneficiary-Indicator-target-Timeframe Structure
Indicator (“paying clients increased”) Ortho	
Target (“by at least 30%”) Ortho	
Timeframe (“by 2018”) Ortho	

Table 5.15: Themes of Extent of Achievement of 2016 Objectives

Typical Primary codes and Quote #	Secondary codes
Multi-year attainment of project objectives (1.18.1)	Achievement type
100%; to me it is hundred per cent (3.59.1; 4.32.1; 4.32.3)	Quantified goal attainment
Almost 80 per cent of the objectives has been achieved (9.38.1)	
we would not use 100% because it would be difficult to achieve the 100% (1.18.2; 2.48.3)	
we have also achieved 100% in a few cases and exceeded (2.48.4)	
I think we have made <i>reasonable</i> progress (2.48.2)	Qualified goal attainment
I would say that we achieved our objectives <i>very well</i> (2.48.5)	
It was achieved, <i>automatically</i> (3.58.1)	
It was achieved (3.63.1)	
To us, yeah, we have achieved <i>all</i> the objectives (4.29.5). For the short term, we have achieved <i>all</i> our goals (4.32.5)	
objectives were achieved to a <i>large</i> extent; I will not say to a full extent; I will say to a great extent ⁵ . (41.1; 8.41.1; 10.18.1)	
we achieved but it is not as much as what we need (8.45.1)	
It has not yet been achieved (3.66.1)	
It was achieved <i>half-way</i> (3.63.2)	
Difficulty of full goal achievement based on outcome (4.30.1)	

Table 5.16: Themes of Goal Assessment Approaches

Typical Primary codes and Quote #	Secondary codes
Using implemented activities performed (4.29.1; 4.29.3; 4.32.2; 9.7.3; 1.18.5)	Implementation-based achievement
Because there are so many success stories (10.18.2)	Success story-based achievement
Basing attainment on the indicators (2.48.1)	Indicator-based attainment
Not measuring project long-term goals at project level (2.10.7)	Long-term Goal based attainment
We do measure them at country level’ (2.10.8)	
Too early to measure impact (1.18.4)	

Table 5.17: Themes of the Connection between Goals and Project Achievement

Typical Primary codes and Quote #	Secondary codes
Connected (9.43.1; 7.41.1)	Project achievements Connection to goal setting
It has direct bearing with that goal (7.44.1)	
the goals bring about the achievement, the success of the project (5.40.2)	
Goals are basis for project achievement, success or failure (5.40.3; 7.42.1; 7.44.4)	Relevance of Goals to Attainment
Goal-setting contributed 90% to project achievement (4.36.3; 4.36.1)	
the two cannot do without one another. Because if goals are not set, you won't be able to achieve (5.40.1)	
we are now relaxed because we know that we have achieved that goal. (6.19.3)	Effects of Goals after attainment

5.18: Themes of the Goal Attainment Factors

Typical Primary codes and Quote #	Secondary codes
Sub-Theme: Goal Effect Enhancers	
the release of funds. Yes those funds were released; Timely release (1.19.3; 3.67.2)	Funding Availability
Availability of funds for activities (4.34.5; 8.41.1; 9.41.1)	
Helpful transport resources (8.41.1)	
Collaborative Partnership (1.19.1)	Partnership
Commitment of community people (2.49.3)	
Support of government and partners (4.35.5)	
Commitment and cooperation of partners (4.34.4)	
Team work by leprosy and NTD partners (3.60.1)	Human resources for fieldwork
Hardworking of field officers (1.19.4)	
Commitment of employees (4.35.1)	
Availability of human resources (2.49.1; 2.49.2; 2.49.5)	Combination of Factors
Well, there are many factors (4.34.1)	
the human resources, the material resources and the financial resources (4.34.3; 4.35.2); the money are there, the community are there, people are there (3.67.3)	
The planning, human resources, finance, and the communities were informed (9.42.1)	
targeting a particular time, particular community, at the appropriate time. (9.42.2)	
Purpose, well planned, involve the key players, be well implemented, financial backing (9.10.1)	Project monitoring
there is a full monitoring by the NCO; their mentorship and technical assistance (3.67.1; 4.34.6)	
Field officers monitoring of project implementation (10.20.1)	

Typical Primary codes and Quote #	Secondary codes
Involving beneficiaries in project monitoring (1.19.2)	
Accepting responsibility for implementation by field staff and community (5.43.1)	Acceptance of assignments
Knowing assigned responsibility (5.3.2)	Awareness of assignments
Communicating the project plan to the community in local language; information (5.41.3; 5.43.3; 5.43.6)	Community mobilisation
Community members help in the process of mobilising (5.43.5)	
Acceptance by target communities (4.35.3; 5.43.5)	Community acceptance and participation
Commitment of the target communities (4.35.4)	
Because the project itself talk about women, so we engage other women to come and facilitate. (5.43.7)	Gender Balancing implementers
Being considerate about religion (5.43.8)	Being sensitive about the majority religion
TLM Nigeria supportive assistance (8.39.1; 8.40.1)	General TLMN Project Support/Assistance
TLMN guidance (8.42.1)	
Training beneficiaries to perform activities (10.19.1)	Training implementers
Learning from self-reviewing project by community stakeholders (10.21.1)	Self-evaluation
Sub-Theme: Risk Factors preventing goal attainment	
Low management capacity of field personnel (4.34.2)	Personnel factor
Unforeseen reasons for short falls (2.48.6; 2.48.8; 5.41.2; 5.44.1)	Unexpected events
inflation might affect achievement (2.48.7)	
No counterpart government funding (3.65.1)	
the Naira devaluation was not considered (2.48.9)	
Government's non-project priorities (3.68.1)	
Changing attitude of beneficiaries (5.44.2)	Attitude of community
Unchanging behaviour - "They can't stop begging " (8.38.1; 8.38.2)	
sometimes we have struggled to meet 100% project budget needs. (2.49.4; 9.39.1; 9.40.1)	Funding Reasons
Financial constraints of project beneficiaries (5.44.3)	
different field environmental factors (5.45.2)	

5.19: Themes of Goal Uses

Typical Primary codes and Quote #	Secondary codes	SubThemes
Goals helping project planning 3.15.1	Planning the Future	PLANNING
Goals guide resource allocation 1.10.7	Planning inputs	
Planning resources towards achieving desired change 2.3.3		
Planning strategies for achievement of desired change 2.3.2	Planning Implementation	
Goal logically connected to strategies for its achievement 2.3.5		
Defining strategies in relation to processes performed for specific goal attainment 2.3.6		

Typical Primary codes and Quote #	Secondary codes	SubThemes
Knowing the target enables to plan strategies 6.4.2		
Objectives giving knowledge of implementation timeframes 7.17.3	Setting Timeframes	IMPLEMENTATION
Linking project implementation to desired goals 7.44.3	Deciding Action	
Guiding implementation with goals 7.44.5		
Goals helping management of implementation 9.9.1	Managing Project	
Goals helping management of resources 9.9.2		
Organisational reason for goal setting – documenting desired change 2.3.1	Documenting Change	MEASURING PROGRESS
Goals used for project review 1.10.8	Project Monitoring	
Tracking goals during implementation 1.20.1		
Referencing objectives and outcomes in activity reporting (1.20.2); Referencing goals and objectives and outcomes during implementation (1.20.3)		
Project measurable if having goals 3.70.1		
Relating achievement evaluation to the specified timeframe in a goal 4.6.4	Timing of project evaluation	EVALUATING ACHIEVEMENT
Goal setting for project evaluation 4.37.3	Evaluating achievement	
Goal setting enables project measurement (4.37.1); Goals helping to assess achievement 4.38.4); Goals helping evaluation (7.8.1)		
Using goals to evaluate success and achievement 6.4.3; 7.8.2; 4.6.1; 9.8.1		

Table 5.20: Themes of Project Development

Typical Primary codes and Quote #	Secondary codes
Sub-Theme: PROJECT PLANNING	
Designing project centrally at NCO (3.34.1)	Project design by NCO
Confirming duration of project design (5.26.1, 5.27.1)	Length of project design process
Long process of project planning / goal setting (8.21.1)	
Considering the duration of planning process short (9.28.1)	
Project mix depending of time frames (2.7.1)	Project Durations
Duration of organisational plan (2.5.4)	
Commonest duration of projects (2.7.2)	
Formerly focusing on leprosy alone (3.3.1)	Project Focus
Currently combining leprosy with NTD (3.1.2)	
Highlighting interventions (1.15.7)	Project Interventions
Meeting with stakeholders in workshops (2.38.3)	Organising workshop meetings
Holding occasional project development workshop with project-level stakeholders (2.38.16)	
Linking smaller projects to fewer beneficiaries (2.15.3)	Project size and beneficiaries

Typical Primary codes and Quote #	Secondary codes	
Sub-Theme: PROJECT IMPLEMENTATION		
Planning activities to achieve set Goals (5.16.2)	Implementing activities to achieve goals	
Joint advocating for government support (3.35.7)	Collaboration in project implementation	
Involving community and partners in project implementation (5.31.2)		
Defining implementation criteria as implementing activities (5.15.1)	Implementing/ Organising activities	
Connecting activity planning with field agreements (5.15.2)		
Organising implementation of activities (5.16.3)		
Aligning implementation to set goals (5.16.4; 5.20.1; 5.22.6; 5.22.8)		
Discussing implementation of activities with the community (5.16.5)		
Implementing action collaboratively with communities (5.16.7)		
Learning during project implementation (5.22.4)		
Implementing plan (10.9.5)		
Discovering the changing community needs during implementation (5.22.5)		Needs changing during implementation
Monitoring implementation of activities (5.16.6)		Community Monitoring of implementation
Listing the leprosy project activities being performed (4.2.2; 4.29.2; 8.6.1)	Leprosy project activities	
Listing activities to stop begging instead of goal types (8.16.1)		
Sub-Theme: PROJECT ACHIEVEMENT ASSESSMENT		
Reviewing project goals at midterm (3.28.1; 3.32.1)	Mid-term goal reviews	
Field officers reporting on activities implemented to national level (3.34.2; 4.31.2)	Periodic field reporting to NCO	
Assessing the results of activities after implementation (10.9.6)	Project Assessments	
Specifying monitoring and evaluation to review impact and progress made on baseline (10.9.7)		
Conducting terminal evaluation (9.44.3)		
Assessing achievability of short term goals during evaluation (9.18.1)		
Community appreciating achieving their identified needs (5.9.7)	Needs achievement appreciated by community	
Reserving additions to plan until mid-term (3.40.4)	Post-Evaluation Project Amendments	
Reviewing strategies and re-strategising after monitoring and evaluation (10.9.8)		
Quarterly Timing measurement of short-term goals (2.17.3)	Frequency of goal reviews	
Periodic Timing of review of medium-term goals (2.20.1)		
measurement of long-term goals: during reviews (2.10.9)		
Terminal timing of evaluation (4.16.4)		
Measuring outcomes by the end of the project (5.18.2)		
Most 3-year projects (1.13.4)		

Typical Primary codes and Quote #	Secondary codes
Few 5-year projects (1.13.5)	Duration of Project Goal Setting cycle
MYP type of planning (1.3.12)	Project Planning Strategy
Past planning strategy of project leaders meeting (1.3.13)	
Sub-Theme: GOAL MEASUREMENT APPROACH	
Measuring intermediate and long-term goals at the national level 4.32.4; 4.13.4	Evaluating goals at national level
Evaluating project goals at national level 4.31.3	
Field officers not evaluating goals (4.31.1)	
Evaluating targeted achievements during M&E (5.13.2)	Project measurement of targets
Evaluation helping to know improvements (4.14.6)	Evaluation knowledge of improvements
Goal attainment assessed by project outcome and impact (4.29.4)	Attainment based on project results
Measuring linkage of goals and project (5.13.3)	Assessing alignment of goals and project
Focusing on particular results during project assessment (5.18.3)	Evaluation goal themes as outcomes

Annexe 6: Blank Consent Form
**FOR TLM PROJECT MANAGERS
PARTICIPATION IN QUALITATIVE RESEARCH**

PhD Research Title:

Goal-setting in Healthcare:
An Exploration of the Theoretical Framework of Leprosy Project Objectives

Name, position and contact address of Researcher:

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Please tick either 'Yes' or 'No' in response to the following statements

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. I agree to take part in all stages of this study. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. I agree to be interviewed and the interview being recorded. | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. I agree to the use of anonymised quotes in publications | <input type="checkbox"/> | <input type="checkbox"/> |

Name of Participant

Date

Signature

Name of Researcher

Date

Signature

Annexe 7: INFORMATION SHEET

This information sheet is for designated managers of leprosy projects funded by The Leprosy Mission International who are invited to participate in an academic research project with the title:

GOAL-SETTING IN HEALTHCARE: AN EXPLORATION OF THE THEORETICAL FRAMEWORK OF LEPROSY PROJECT OBJECTIVES

Student Researcher:

- Dr. Osahon Jeremie I. Ogbeiwi (PhD Student Researcher)

Academic Supervisors:

- Dr. Bryan McIntosh (Principal Supervisor)
- Dr. Barbara McNamara (Associate Supervisor)

Institution:

- Faculty of Health Studies, University of Bradford, Bradford, West Yorkshire, UK

This information sheet has the aim of providing you with sufficient information about the research to enable you give a full consent to participate in the above research. You will be required to sign the attached Informed Consent Form after you have read and fully understand this information sheet.

Introduction

I am Dr. Osahon Jeremie I. Ogbeiwi, a full-time student of Nigerian-British nationalities, residing locally in Dewsbury Town in Kirklees, West Yorkshire, and studying for a research-based PhD at the University of Bradford in Bradford. I worked for The Leprosy Mission International (TLMI) for more than 18 years from December 1988 to May 2007. For TLMI in Nigeria, I was a resident medical doctor at 2 leprosy hospitals (Ekpene Obom and Okegbala), a hospital and field leprosy project manager in Kwara State, and the National Coordinator and Country Representative supporting leprosy projects in 8 States up till 1999. At Africa level, from 1999 I was the Regional Monitoring & Evaluation Coordinator, organizing staff training and evaluation exercises for more than 30 leprosy projects in 15 countries. At International level, from 2002 I was the International Data Analyst responsible for the annual collation, analysis and reporting of ILEP statistical data of leprosy projects in the three regions of Africa, Asia and South-East Asia / Pacific. After leaving TLMI, from 2011 to 2014 I served as a member of the advisory committee, Project Review Group (PRG), that studied project proposals for funding before TLMI approval. In all these roles, I encountered all stages of TLMI organisational dealings with goal-setting in, including facilitating formulation and assessment of project goals, as well training others to formulate SMART goals for effective project delivery.

This research is a core requirement for obtaining my doctorate degree. You are hereby invited to participate in the research investigating the goal-setting pattern of leprosy projects as an individual key informant.

Before you decide, you may wish to talk to anyone you feel comfortable talking with about the research and take time to reflect on whether you want to participate or not. If you do not understand some of the words or concepts, I will take time to explain them before the start of data collection exercise. You can still ask further questions that you may have at any time during the research process.

Purpose of the research

Healthcare delivery systems in different settings seek for effective strategies to improve the outcomes of their services. There is already established empirical evidence that using a Specific, Measurable, Attainable, Realistic and Timed (SMART) structure for setting goals of projects motivates achievement of desired outcomes. Based on this, my research aims to develop a theoretical framework or a conceptual structure for setting SMART objectives in healthcare, by finding out what themes or concepts in the formulation of health service objectives define the goal-setting framework of leprosy projects. Therefore, the research has been designed to answer one core question: "How do leprosy projects formulate objectives for their services?" Answering this research question requires an in-depth open interview with individual managers of leprosy projects, who are responsible for planning and monitoring their project goals, about the pattern of their goal-setting practice.

Type of Research Intervention

This study requires your participation in an individual interview about your goal-setting practice. The period of your engagement may not exceed 60 minutes. You may however be contacted again with a feedback for confirmation or further clarification as the need may be.

Participant Selection

You have been selected to participate in this research because we believe that your experience as a leprosy project manager will contribute to our knowledge and understanding of the structure of goal-setting practice in healthcare.

Voluntary Participation

Your participation in my research is completely voluntary. Whether you choose to participate or not will have no bearing on your job or job-related evaluations. No person information that identifies you will be collected, and whatever health service information you provide will be used only for the academic purpose of the research. In addition, while your country TLM office may have produced the list of volunteers, the list of managers who participated will not be made known to them. Thus, your participation will be confidential.

If you decide not to take part in this research study after an interview has been completed, you may still ask that your responses to be removed from the research before it is included in the data analysis.

Procedures

If you accept to participate in this research, as much as possible, data collection will be conducted in your usual place of work, such as your office or field project location. When on-site visit is not possible, data collection will be conducted through an official electronic medium, such as telephone call, skype video call, or internet chat facility on a pre-arranged date and time.

Before the interview, you will be asked to:

1. Sign and return or (confirm electronically, e.g. Email) an informed consent form
2. Book an appointment with the researcher for an individual interview
3. Make available for review the annual project plan with your set of goals and objectives for a selected year
4. Make available for review the annual project report with an assessment of your achieved outcomes for the selected year

During the interview, you will be asked to:

5. Be interviewed by the researcher using a questionnaire with a set of opened-ended probing questions about the pattern of your objective setting practice.
6. Confirm your responses through a feedback sent afterwards to validate the results of your interview

The interview questionnaire will be administered by the researcher. Generally, the questions will explore in-depth how you formulate objectives for your leprosy project.

During the interview, you will also be asked to review your actual goals and their outcomes and discuss your personal opinions of:

- How setting goals influence or moderate your project outcomes
- Factors in your organisation that you think mediate, i.e. help or limit this effect.

In addition, your level of goal attainment, expressed as the extent to which your actual annual outcomes represent your desired annual goals will be assessed qualitatively using a 5-point graded ordinal scale as guide:

- | | |
|---------------------------|---------------------|
| ▪ More than 100% achieved | = Excellent Outcome |
| ▪ Exact 100% achieved | = Good outcome |
| ▪ 80% - 99% achieved | = Fair outcome |
| ▪ 60% - 79% achieved | = Poor outcome |
| ▪ Below 60% achieved | = Very poor |

Duration

If you decide to participate in the research, the interview may not exceed 60 minutes. The duration may reach up to 90 minutes if the interview is written through online chat/ messaging route. It is expected that your entire engagement with this research will be one month, including time for interview, document review, feedback and reconciliation of your responses.

Risks

You will not be put at any known risk by your participation in this research, as the interviews will be informal and conducted in a way and in a place that are most convenient and relaxed for you.

Benefits

The benefit of your participation could be an enhanced awareness of the goal-setting practices generally. In addition, it offers you a valuable opportunity to contribute to the body of knowledge in the academic community advancing goal-setting as a motivational management concept in programme and organisational development. Also, the researcher will send a thank you letter to you for your time, and to your organisation gratefully acknowledge your participation in this academic research.

Reimbursements

Hopefully, your participation will not incur any monetary expenses on your part, since the research activities will be done within your official schedule and time.

Confidentiality

This research will not collect any personal information that identifies you. All references will be made to the type of project within the context of your leprosy organisation. However, your responses that you provide during the interview and discussion of the document review may be quoted verbatim in my academic thesis, reports or publication. No material that you

consider confidential to you or your leprosy organisation will be collected or disseminated through any social or public media.

Sharing the Results

The findings of this research will consist of aggregations of themes and their relationships, which will result many stages of building categories from the concepts identified from the interview responses of all study participants. These findings will be reported in my PhD thesis, which is expected to be completed at some time in 2018. They may also be published in academic journals and shared in conferences during or after my study.

Right to Refuse or Withdraw

I wish to reconfirm that your participation is entire voluntary and includes your right to withdraw at any stage during data collection, but before data analysis. It also includes your right to request that your responses should not be included in the data analysis.

Annexe 8: University Ethical Approval for the Study

Approval - Ethics Application E589

Ethics

Mon 27/02/2017 11:49

To: Osahon Ogbeiwi <O.J.I.Ogbeiwi@bradford.ac.uk>; Bryan McIntosh <B.McIntosh1@bradford.ac.uk>

Cc: Ethics <ethics@bradford.ac.uk>; Barbara McNamara <B.McNamara1@bradford.ac.uk>

Dear Osahon and Bryan,

Ethics Application: E589

Title: An Exploration of the Theoretical Framework of Leprosy

Your ethics submission, documents and amendments have now been reviewed by the Chair of the Research Ethics Panel.

I am pleased to inform you that the Chair has confirmed approval of this study, with no further ethical scrutiny required.

NOTE that this approval is for this study only.

Should there be any changes to this study, you must inform ethics@bradford.ac.uk.

Once your changes have been reviewed and you have approval to proceed, only then can you recommence the study.

Failure to do so will render your original approval invalid and withdrawn.

Please add a sentence onto any material you share with participants confirming that ethics approval has been granted by the Chair of the Biomedical, Natural, Physical and Health Sciences Research Ethics Panel at the University of Bradford on 27/02/17.

Thank you

Best Wishes

Deborah

Deborah Hodgson

Research Support Administrator

RKTS, F.24

Ext: 3196

Annexe 9: Interview Guide

Semi-structured questionnaire for in depth interview of individual managers of Leprosy Projects

Organisation: _____ Country: _____ Leprosy Project: _____
Place of interview: _____ Date: _____ Time: _____

Information:

This is an interview to discuss the goals of and the practice of goal-setting for the named leprosy project planned and delivered by your organisation. It is part of the data collection process in my PhD research studying the Goal-setting in healthcare, focusing on the framework of your objective setting. The overall research purpose is to explore the how goal-setting can be used as an effective strategy to improve healthcare outcomes. It will therefore be very helpful if you can give as much details about your goal-setting practice as possible – the more details the better. If you accept to participate in this interview, please give your consent by signing the consent form and appending your initial on the consent statement below.

Respondent's Consent for interview:

I hereby give my consent to participate in this interview process and freely answer the questions to the best of my knowledge of the goal-setting practice in relation to the named leprosy project above. I consent to my responses being recorded using any means at the disposal of the researcher.

Respondent's signature or initials: _____ Date: _____

QUESTIONS:

A. Understanding of Goal-setting

- In your own view, what is a goal?
- What do you think are the purposes of reasons for setting goals for a project?
- What attributes do you think an effective goal should have? What are the characteristics of a good goal?

B. Choice of Goal Types

- What types of goals do you formulate for planning your leprosy project?

C. Goal-setting Approaches

- How would you describe the process for setting objectives for your leprosy project?

D. Goal-setting Templates

- What pattern or outline do you follow for formulating the objectives of your leprosy project?

E. Formats of Goal statements

- How do you write the statement that expresses each objective of your leprosy project?

F. Goal Attainment

- To what extent were the objectives for your last reporting year achieved?
- Which factors do you think essentially influence the chance of your leprosy project achieving its desired objectives?
- Looking at the outcomes of your project in the last reporting year, how would describe the role played by your goal-setting practice?

Annexe 10: TLMN Invitation letter

Dr Osahon Jeremie I.
Ogbeiwi
Faculty of Health Studies
University of Bradford,
Bradford BD7 1DP, UK

15 / 02 / 2017

The Country Director,
National Coordination Office
The Leprosy Mission Nigeria
Abuja Nigeria

Dear Ma / Sir,

**A Doctoral Study of the Goal-setting Practice of Leprosy Projects supported by TLM
INVITATION TO PARTICIPATE**

I wish to invite your participation in the above academic research study being proposed for leprosy projects supported by The Leprosy Mission (TLM). I am Dr. Osahon Jeremie I. Ogbeiwi, a former TLM staff and now a full-time post-graduate research student of the University of Bradford, Bradford. This research is primarily being done to fulfil my requirement for the award of Doctor of Philosophy degree in the Faculty of Health Studies.

However, the research also generally seeks to generate empirical knowledge and deepen understanding of how goals are formulated for healthcare services in order to improve the goal-setting practice in the health sector. Specifically, this research intends to explore the conceptual framework for setting leprosy project objectives. This will be evolved systematically from the interview responses of individual leprosy project managers. It is hoped that your engagement with my research will contribute to enhancing the goal-setting capacity and practice of your leprosy managers.

I shall therefore be grateful for your acceptance of my invitation and your participation through the following areas:

- A compilation of a complete list of leprosy projects and their designated project managers in your country
- An official mobilisation of the leprosy project managers in your TLM country projects to volunteer to participate in the data collection process of this research. Participation is open to all and optional.
- Assistance with recruitment of study participants – by sending to me the names and contact (telephone, email and skype name or link to chat on messenger, Facebook or other social media) of leprosy project managers who voluntarily consent to participate in the data collection process.

The information sheet and consent form for consented leprosy project managers are attached. I most sincerely look forward to your participation, which is considered vital to the success of this research.

Yours sincerely



Dr. Osahon J. I. Ogbeiwi
Doctoral Researcher, University of Bradford

Copy: Mrs Jannine Ebenso, Head of Quality Assurance, The Leprosy Mission International

Annexe 11: Draft Plan for Dr. Osahon Field visit to TLMN Projects

Date	Place	Activity	Time
Monday 5 th	Abuja	Meeting with Management Team	9.00am
		Meeting with Mr B.	9.30 – 11.30am
Tuesday 6 th	Abuja	Depart for Gusau	6.00am
	Gusau	Meet with Manager 1	12.00pm – 1.00pm
		Meet with Manager 2	1.00pm – 2.00pm
Wednesday 7 th	Gusau	Depart for Sokoto	7.00am
	Sokoto	Meet with Manager 1	10.00am – 11.00am
		Meet with Manager 2	11.00am – 12.00pm
Thursday 8 th	Sokoto	Depart for Sokoto	7.00am
	Birnin Kebbi	Meet with Manager 1	10.00am – 11.00am
		Meet with Manager 2	11.00am – 12.00pm
Friday 9 th	Birnin Kebbi	Depart for Minna	7.00am 5.00pm
Saturday 10 th	Minna	Meet with Manager 1	10.00am – 11.00am
		Meet with Manager 2	11.00am – 12.00pm
Sunday 11 th	Minna	Attend Church Service	8.00am
		Depart for Abuja	2.00pm
Monday 12 th	Abuja	Depart for Lokoja	7.00am
		Meet with Manager 1	10.00am – 11.00am
		Meet with Manager 2	11.00am – 12.00pm
	Lokoja	Depart for Ilorin	12.00pm – 6.00pm
Tuesday 13 th	Ilorin	Meet with Manager 1	9.00am – 10.00am
		Meet with Manager 2	10.00am – 11.00am
Wednesday 14 th	Ilorin	Depart for Abuja	7.00am – 4.00pm
Thursday 15 th	Abuja	Meet with Management Team for debriefing	9.00am
Friday 16 th			

(Prepared by TLMN National Office, but actuals names of respondents have been replaced with pseudonyms for ethical reasons)

PARTICIPATION IN QUALITATIVE RESEARCH

Annexe 12: SIGNED CONSENT FORM FOR TLM PROJECT MANAGERS

PhD Research Title:

Goal-Setting in Healthcare:
An Exploration of the Theoretical Framework of Leprosy Project Objectives



Name, position and contact address of Researcher:

Dr. Osahon Jeremie I. Ogbeiwi
Doctoral Researcher, School of Service Development and Improvement,
Faculty of Health Studies, University of Bradford, Bradford
Tel: 07999444545 Email: o.j.i.ogbeiwi@bradford.ac.uk

Please tick either 'Yes' or 'No' in response to the following statements

- | | Yes | No |
|---|-------------------------------------|----|
| 1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. | | |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason. | <input checked="" type="checkbox"/> | |
| 3. I agree to take part in all stages of this study. | <input checked="" type="checkbox"/> | |
| 4. I agree to be interviewed and the interview being recorded. | | |
| 5. I agree to the use of anonymised quotes in publications | <input checked="" type="checkbox"/> | |



	6 th March 2017	
_____ Name of Participant	_____ Date	_____ Signature
Osahon Ogbeiwi		
_____ Name of Researcher	_____ Date	_____ Signature

Annexe 13: Selected Email Communications with TLMN

#1. RE: Invitation to participate in Doctoral Research

Pius Ogbu Sunday < >
Wed 05/04/2017 14:35
To: Osahon Ogbeiwi < >

4 attachments (6 MB)

435E02 - EPALD Annual Report (Kwara) 2016 v1.pdf; 435O03 Orthopaedic Project Annual Report 2016 v1.pdf; 435Z99 Yes We Can Project in Kebbi - Sokoto Annual Report 2016.pdf; 2016-008 EMPALD Annual Project Report Niger State 2016 v1.pdf;

Dear Sir,

It was good speaking with you this morning Sir. Please find attached the 2016 Annual Reports for the following States:

- Kwara SMC
- Niger SMC
- Kebbi/Sokoto
- Orthopaedic Workshop

I had initially sent to you that of FCT/Kogi.

I hope this helps Sir.

Kind regards.

Pius Ogbu Sunday

Operations Manager

Address: C83/C84 Fort Royal Homes Estate - Lugbe, P.M.B. 494, Area 10, Garki, F.C.T. Abuja. | **Email:** | **Skype:** | **Website:** www.leprosymission-nig.org | **Tel:** +234 (80) 55961756, +234 (70) 36694394

#2. Re: Participation in the TLM Nigeria 2018 Project Planning Meeting

Moses Onoh < >
Wed 29/03/2017 21:15
To: Osahon Ogbeiwi < >
Cc: < >; < >; Bryan Mcintosh < >; Barbara Mcnamara < >

Dear Sir,

Thanks for your patience in waiting for responses from volunteering project officers. I am happy to know that you have started interviewing them.

As was the practice during your time, the process of projects' development are largely centralized through the NCO and then the annual reports of the various projects are usually finalized at the NCO. So I believe the bulk of the information that you might need could be provided at NCO level. But let's see how it goes.

Yes, it will be our pleasure to have you participate in our 2018 Annual Country Learning

workshop by His Grace (this review meeting has since 2011 replaced the former Project Leaders Planning meeting and holds in November every year). A learning section on goal-setting could be incorporated in the meeting for you to facilitate. And as you pointed out this will contribute to strengthening the capacity of the various projects/programme officers here.

We appreciate you sir and had been looking forward to receiving you since February as discussed last year.

Best Regards.

Moses Onoh.

(Acting National Director, TLMN)

#3. ARRIVAL TO NIGERIA

TLM NIGERIA ABUJA < >

Fri 27/10/2017 14:07

To: Osahon Ogbeiwi < >

Cc: Moses Onoh < >

Dear Sir,

This is to inform you that one of TLMN Drivers - **SAMAILA TANKO** will pick you at the airport on your arrival on Friday, 3rd November, 2017 at 10.00am.

We have made reservation for you at Hotel De Bently, located at Plot 892, Ngozi Okonjo Iweala Street, Utako District, Abuja, the same venue the Annual Country Learning(ACL) Review is taking place.

We wish you safe flight.

Best regards Sir,

Temitope Ayoola

Administrative Officer

For: The Leprosy Mission, Nigeria, National Coordination Office, Abuja, Nigeria.

Address: 12/14 Kings Drive, Fort Royal Homes Estate - Lugbe, P.M.B. 494, Area 10, Garki, F.C.T. Abuja, Nigeria | **Email:** | **Website:** www.leprosymission-nig.org | **Tel:**

#6. Re: Article on Goal-Setting: Request for permission to publish

Moses Onoh < >

Fri 04/08/2017 19:13

To: Osahon Ogbeiwi < >

Cc:

>

Dear Sir,

Thanks for sharing this very resourceful document with us.

Yes, we will not mind you mentioning it in the article if this would help optimize the quality of your work. In doing this however, kindly consider how this balances with our status as a foremost leprosy organization. As you know, TLM Nigeria is a learning organization, so we have planned to include a session on "Goal-setting" in the 2017 TLM Nigeria Annual Country Learning workshop this November and look forward to you facilitating that for us (thanks in advance!)

I took a quick scan through the document and had so much inspiration from it on goal-setting. Please check more for some typos and consistency in using the number of projects examined as 6 and not 5.

You can go ahead and submit it for publication as this could potentially improve the profile TLMN.

We appreciate your continuous commitment to the growth of our dear organization.

Best Regards,

Moses.

(Ag. National Director, TLMN)