Can NGOs Build States and Citizenship through Service Delivery?
Evidence from HIV/AIDS Programmes in Rural Uganda

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SCHOOL OF ENVIRONMENT AND DEVELOPMENT
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Abstract
The University of Manchester
Badru Bukenya
PhD: Development Policy and Management
2012

Can NGOs Build States and Citizenship through Service Delivery? Evidence from HIV/AIDS Programmes in Rural Uganda

Service delivery NGOs (SD-NGOs) have long been criticised for promoting ‘technocratic’ and ‘depoliticised’ forms of development. However, some commentators have begun to argue that such agencies, and even their ‘technocratic’ interventions, can have positive impacts on political forms and processes. This study investigates these two opposing perspectives through the lens of state building and citizenship formation in the global South. Primary research into the activities of a prominent SD-NGO in Uganda called The AIDS Support Organisation (TASO), through its “mini-TASO Project” (MTP), finds that the project delivered important citizenship gains for People with HIV/AIDS (PWAs). This was visible in four main areas, namely, enhanced ability of PWAs to exercise voice, increased associationalism among previously unorganised and marginalised PWAs, increased voluntarism and more participation of PWAs in political contests. Yet, the project’s state-capacity building effects were more uneven. On the one hand, the programme played an important role in strengthening the bureaucratic ability of targeted hospitals to deliver HIV/AIDS services, enhanced PWAs’ legibility to the state as well as increased state’s embeddedness in society. On the other hand, however, it was less successful in expanding the infrastructural reach of the state in rural Uganda. The overall conclusion is that while SD-NGOs emerge as more political actors than critics claim, their potentially progressive effects are contingent on and remain limited by intervention and contextual factors. While intervention factors encompass issues such as the expertise of SD-NGOs, programme design and funding, the contextual ones include the pre-existing state-society relations, operating environment for civil society, influence of donors, and the character of both formal and informal political institutions, among others.
Declaration

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List of Acronyms

ACP: AIDS Control Programme
AHAP: Arua Hospital HIV/AIDS Project
AIDS: Acquired immunodeficiency syndrome
BUSNET: Busia Network of People Living with HIV/AIDS
CAC(s): Centre Advisory Committee(s)
CSF: Civil Society Fund
DAC(s): District AIDS Coordination Committee(s)
Danida: Danish International Development Agency
DFID: Department for International Development
DHO: District Health Officer
DLG: District Local Government
DP: Democratic Party
FGD(s): Focus Group Discussion(s)
FGDs: Focus group discussions
GFATM: Global Fund to Fight AIDS, Tuberculosis and Malaria
GoU: Government of Uganda
HAU: Hospice Africa Uganda
HIPC II: Enhanced Heavily Indebted Poor Countries initiative
HIV/AIDS: Human immunodeficiency virus and
HSD: Health sub-district
HWCs: Health Watch Committees
IOEs: Islands of excellence
KI: Key informant interviews
KY: Kabaka Yekka
LC(s): Local Council(s)
MACA: Multi-sectoral Approach to the Control of HIV/AIDS
MAP: Multi-Country HIV/AIDS Program
MDGs: Millennium Development Goals
MKSS: Mazdoor Kisan Shakti Sanghatan
MOFPED: Ministry of Finance Planning and Economic Development
MoH: Ministry of Health
MSF: Médecins Sans Frontières
MTP(s): Mini TASO Project(s)
NAADS: National Agricultural Advisory Services
NAFOPHANU: Forum of People Living with HIV/AIDS Network in Uganda
UNASO: Uganda Network of AIDS Service Organisations
NDP: National Development Plan
NGOs: Non Governmental Organisations
NRA/M: National Resistance Army/Movement
NSPs: Non State Providers
NUSAF: Northern Uganda Social Action Fund
OECD: Organisation for Economic Co-operation and Development
OPD: Out-patient department
OPM: Office of the Prime Minister
OVC: Orphans and vulnerable children
PAF: Poverty Action Fund
PDS: Public Distribution System
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<tr>
<td>PEAP</td>
<td>Poverty Eradication Action Plan</td>
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<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
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<td>PRSPs</td>
<td>Poverty Reduction Strategy Papers</td>
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<td>PTA(s)</td>
<td>Parents–Teachers Association(s)</td>
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<td>PWAs</td>
<td>People with HIV/AIDS</td>
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<td>RDC</td>
<td>Resident District Commissioner</td>
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<td>RKS</td>
<td>Rationing Kruti Samiti</td>
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<td>SAPs</td>
<td>Structural Adjustment Programmes</td>
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<td>SD-NGO(s)</td>
<td>Service delivery non-governmental organization(s)</td>
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<td>SSC</td>
<td>Service delivery, state building and citizenship formation</td>
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<td>STF</td>
<td>Straight Talk Foundation</td>
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<td>SWApS</td>
<td>Sector Wide Approaches</td>
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<td>TASO</td>
<td>The AIDS Support Organisation</td>
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<td>UAC</td>
<td>Uganda AIDS Commission</td>
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<td>US</td>
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<td>USAID</td>
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<td>VECs</td>
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Acknowledgements and Dedication

I am greatly indebted to many people whose invaluable contributions in terms of knowledge, inspiration, guidance, support and love, judiciously combined to simplify for me the seemingly insurmountable task of producing a PhD thesis. The following list is obviously not exhaustive and it comes in no specific order.

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Most importantly, my wonderful family, wifey Sylvia and sons Matthew and Shawn, thank you for the love, patience and encouragement throughout the research period. For my extended family, in-laws and friends, your guidance and moral support throughout the research period kept me in high spirits. And for my mother, Ms Resty Nakawungu, who sacrificed enormously to lay a firm foundation for my education, no words can express my deep gratitude for your input, I can only say thank you.

All my PhD colleagues at IDPM who happily shared their knowledge with me during this course deserve special mention here. The financial contribution by the School of Environment and Development (SED), which covered the full cost of tuition for this programme, is also very much appreciated. In the same vein, this research would not be possible without the management and staff of TASO, HIV/AIDS service users and, in particular, those PWAs in the hospitals of Kamuli, Masafu, Iganga and other ‘Mini TASOs’ across Uganda. Thank you all for generously sharing your experiences with me.

Finally, I would like to dedicate this thesis to my mother, grandparents and all the family members of Mr Paskazio Lubega of Kabuwoko.
The Author

I completed my first degree in Social Work and Social Administration from Makerere University, Uganda, in 2004 with First Class honours. From there I was employed by The AIDS Support Organisation (TASO) where, for four years, I worked as a Project Officer in TASO Tororo. My work at TASO gave me exposure to planning, implementing and evaluating development programmes. It is the desire to augment this experience with further training which motivated me, in 2007, to enrol for a Masters degree in International Development with a focus on Development Management at the University of Manchester. I completed this in 2008 with an overall Merit Class and a Distinction in my dissertation. In 2009, I enrolled for a PhD in Development Policy and Management at the same university. This programme involved fieldwork in Uganda spanning nine months from November 2010 to July 2011.

During the course of my PhD research, I was privileged to work alongside my supervisors with whom we successfully executed close to ten consultancy assignments for influential international development institutions. Notable among these are the following: a World Bank consultancy to examine the role of context in shaping social accountability interventions; an Effective States and Inclusive Development (ESID) research assistance work to generate an annotated bibliography and literature review for the paper entitled “Good governance and development: exploring the impact of the public sector reforms on state capacity in developing countries”; research assistance for assessing DFID’s new approach to ‘Empowerment and Accountability’; and, research assistance work involving literature reviews, bibliographic search and statistical analysis of Uganda’s development for the Chronic Poverty Research Centre (CPRC). These assignments have sharpened by analytical skills in various aspects of development management, especially around the politics of development, theories of change, and social accountability. I am currently preparing a number of papers from this thesis for academic publication.
CHAPTER ONE
Research Background, Aim and Overview

1.1 Introduction
This thesis investigates the role of service delivering Non Governmental Organisations (SD-NGOs) in the political areas of state building and citizenship formation in the global South. Across the world, efforts geared towards state and citizenship building have historically been rife with challenges (Tilly, 1975a). This has been especially so in sub-Saharan African countries where, due to the legacies of colonialism combined with inexperienced leadership in the immediate post-independent period, the state and citizenship building project started from a relatively low base. Moreover, even the limited progress made during the postcolonial period came to a sudden halt with the resurgence of neoliberalism in the 1980s, which was accompanied by unprecedented trimming of state capacity and circumscription of its role in development (Crook, 2010; Mkandawire, 2010). In practical terms, this meant corresponding cutbacks by the state on financing and delivering public services with far-reaching implications for its relationship with citizens (Haque, 2008; MacLean, 2011; Vom Hau, 2012). However, by the close of the 1990s, the importance of the state had been re-acknowledged by the key actors in international development (World Bank, 1997), while service delivery also gained centre position as the main avenue to fighting poverty and achieving the Millennium Development Goals (MDGs) (World Bank, 2004).

Under the ‘new development architecture’, embodied by the 1999 Comprehensive Development Framework (CDF) of the World Bank, developing countries were under obligation to increase spending on public services and programmes with potential to directly inflict a dent on poverty (Pender, 2001). To guarantee this ‘pro-poor’ development stance, a broad-based participatory process of writing and implementing rolling Poverty Reduction Strategy Papers (PRSPs), which became poor countries’ overarching development frameworks, became a requirement to qualify for debt forgiveness (Booth, 2005; Dijkstra, 2010; Komives and Dijkstra, 2011). Whether or not these reforms managed to usher the state back into the driver’s seat in the formulation

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1 In this thesis, politics means “the process of struggle concerning how society should be organized” (Hickey, 2009b:148).
and implementation of national development policies is a contested issue, not least because the World Bank and other International Financial Institutions (IFIs) still influence development policy content and direction in most countries of the South (Craig and Porter, 2003; Hickey and Mohan, 2008). However, there is some consensus that, as illustrated by the emphasis on consultation and participation in PRSPs, development was henceforth to be steered in a partnership arrangement between the state and other societal actors (Batley and Rose, 2011; Lange, 2008; Lochoro et al., 2006; Pender, 2001). This research is interested in exploring the varied ways through which NGOs, as one of the key non-state actors, impact on state capacity and the practice of citizenship under such development arrangements.

1.2 The making of Service Delivery NGOs
Within the ‘new development architecture’, donors, academics as well as some NGO actors themselves have since categorised NGOs into two broad types: service delivery NGOs (henceforth SD-NGOs) and advocacy NGOs, each with different roles. Here, whereas the former are to be contracted to provide public services on behalf of the state (Lister and Nyamugasira, 2003; World Bank, 2004), the latter are envisaged to be critical in counterbalancing state powers by monitoring its policies and holding it to account on behalf of citizens (Hulme and Edwards, 1997a; Komives, 2011; Lister and Nyamugasira, 2003). Although some question this view, arguing that the distinction between SD-NGOs and advocacy NGOs is blurred since some NGOs combine activities that can be associated with either category (Chhotray, 2008; Lister and Nyamugasira, 2003), this categorisation remains predominant and some even believe that it is heuristically important. Based on the normative assumption that it is advocacy-oriented NGOs that engage in politically relevant activities, however, most analyses about the role of NGOs and civil society in development have focused on this category at the expense of its SD-NGO counterpart (e.g. Hulme and Edwards, 1997a; Kabeer, 2003a; Mitlin et al., 2007; Robinson and Friedman, 2007).

2 Although the PRSP experiment has lost momentum in some countries (Hickey, 2011), its principles and procedures underpin the main international arrangements for delivering aid to developing countries such as the 2005 Paris Declaration and the 2008 Accra Agenda for Action (Dijkstra and Komives, 2011; Komives and Dijkstra, 2011).
SD-NGOs are largely sidelined from serious political analysis with exceptions coming in instances where they are reprimanded for replacing or encouraging the state to abdicate its responsibilities of providing for citizens (Collier, 2000; Wood, 1997). It is claimed that when SD-NGOs “deliver goods and services – which government should be delivering but is not – the population reduce its expectations of what ... government can or should be doing for it” (Collier, 2000:120). SD-NGOs also fit those development agencies which Ferguson (1990) chides for being ‘anti-politics machines’ because they promote depoliticised interventions that, predictably, fail to steer development but yet produce ‘instrument-effects’ or ‘side effects’ of expanding and entrenching bureaucratic state power to the detriment of citizens. Similarly, Bebbington and colleagues indicate that SD-NGOs promote ‘bid D’ Development or ‘reformist’ strategies that fail to contribute to “alternative ways of organising the economy, politics and social relationships in society” (2008:5). The impact of such stinging criticisms was to relegate SD-NGOs to a residual category of development actors and this, for a while, limited the interest of political analysts in investigating them.

However, more recently, two arguments about the politics of development that appear to challenge the ‘anti-politics machine’ thesis have been fronted by some analysts. The first argument, associated with Corbridge and colleagues, is that the development interventions of such agencies have potential for yielding practical political solutions to longstanding challenges concerning state-society relations (Corbridge, 2007; Corbridge et al., 2005). According to Corbridge (2007:201):

> good practical (indeed political) arguments can be made in favour of particular development policies that might seem reformist or hopelessly pragmatic by the light of the depoliticization thesis. It partly depends on how we think about political strategy and tactics. If we assume: (a) that the world is not perfect or perfectible, (b) that what is called ‘development’ comes in many versions and (c) that pro-poor political coalitions are not easily built..., then it is not clear that reformist modes of engagement ... are uncalled for.

This view is taken up by Cammett and MacLean (2011) who insist that it is difficult to know ex ante that activities of certain development agencies will always produce negative political outcomes as Ferguson (1990) and others appear to suggest.
Coming from a different analytical angle, the second group posit that in societies where the state and the basis for citizenship are weak, it might be possible to reconstitute both through planned service delivery. Although this view has various versions to it, for now, we restrict the discussion to just two. One of its main strands comes from the World Bank which, particularly, in its 2004 World Development Report (WDR) admits that public services have failed poor people in the South (World Bank, 2004). The Bank then goes ahead to identify two broad sets of interventions through which development agencies can intervene to ‘make services work for poor people’, namely, a) implementing supply side reforms within the public sector, and/or b) placing citizens “more firmly at the center of service delivery” (World Bank, 2004:75). Thus, according to the Bank, state-capacity building and empowerment of citizens can not only be engineered by development agencies, but also these can accomplish this task by choosing to work either on the ‘supply’ or ‘demand’ side. Some, like Gaventa (2002; 2004), support the Bank’s proposals with minor concerns regarding the separation of demand and supply side interventions. It is argued that building responsive states requires working on ‘both sides of the equation’ simultaneously; this is simply because if states have no capacity to deliver no value is gained in empowering citizens to make demands on them (ibid). Although insightful, some argue that frameworks like Gaventa’s miss the political forces, such as the unequal power relations coupled with pervasive inequalities in education, class and ethnicity among others, that shape state-citizen relations in Southern countries (Hickey, 2007; 2009b). This begs the question: can NGOs effectively balance this so-called state-citizenship building equation?

The second strand of the politics of service delivery argument is that the process of service delivery itself has ‘feedback effects’ relating to state-citizen relations. Research, mostly focusing on the welfare systems of the West, reveals that service delivery can affect citizens’ levels of trust, self-confidence, and participation in civic and political activities (see Chapter Two). Relatedly, the recent international focus on conflict and fragile states has stimulated interest on the possibility that service provision affects state legitimacy and other dimensions of state capacity (Brinkerhoff et al., 2012; Eldon et al., 2008; Van de Walle and Scott, 2009). Therefore, specific evidence relating to how activities of SD-NGOs might affect the political outcomes of service delivery programmes here is needed.
In view of these observations, the central question for the current research is: can SD-NGOs work in ways that enhance simultaneous improvement in the capabilities of the state and citizens? To investigate this theme, the study draws on the work of a prominent SD-NGO in Uganda called The AIDS Support Organisation Uganda limited (henceforth TASO). Before outlining the specific questions for this study the chapter will first elaborate the key debates relating to the political role of SD-NGOs.

1.3 The contested role of SD-NGOs in state and citizenship building

The debate around the political role of SD-NGOs in development, generally, can analytically be conceived as lying on a continuum. On one side are sceptics pressing the case that such NGOs do not have serious positive contribution while on the other extreme are optimists insisting that even seemingly technocratic-cum-apolitical programmes have potential for a positive political contribution. In the discussion that follows the key points of contention fronted by sceptics regarding the limitations of SD-NGOs in building states and citizenship are explored together with the responses by optimists.

1.3.1 The challenge of being ‘non-political’

Sceptics categorise service delivery NGOs as representing what Korten (1987) calls “the first generation of NGOs” that focus on meeting immediate needs, mostly appropriate during emergencies, but “[contribute] little or nothing to the ability of the poor, whether countries or individuals, to meet their own needs on a sustained basis” (1987:148). SD-NGOs deal in relief and social welfare activities which are said to be non-political. Many charge that ‘apolitical’ development strategies of SD-NGOs are more likely to undermine rather than support processes of state building and citizenship formation (c.f. Gideon, 1998, Manji and Coill, 2002, Hearn, 2007). This view is poignantly articulated by Dicklitch:

> Because they do not challenge the state, because they do not go beyond simple service provision and because they apply a band-aid solution to the problem rather than petitioning for reform, their ability to link the empowerment of the powerless with the development of a democratic society and polity is limited ... (1998:19).

Others show that some NGOs use intervention methods that reproduce patron-client relations in the community (Hickey, 2002; Jellinek, 2003; Miraftab, 1997; Swidler, 2009). Here, NGOs operate in ways that dispossess communities of their agency thereby
fostering a situation of dependency rather than self-reliance (Swidler and Watkins, 2009). Denhardt and Denhardt (2000), who write from a public management perspective, observe that this happens where NGOs embark on “professionalisation” which devalues the input of citizens in favour of expert advice. Such professionalisation shifts NGOs’ approach from an arrangement that Srinivas (2009) calls ‘doers’ with their constituencies to ‘helpers’ and this turns beneficiaries into passive recipients of development assistance (Hickey, 2002). Related to this is the claim that most NGOs are unable to challenge donors’ views even when these undermine communities’ agency (Jellinek, 2003; Swidler and Watkins, 2009). To Swidler and Watkins (2009), whose research focuses on the burgeoning NGO activities in the HIV/AIDS sub-sector in Malawi, these agencies do not empower communities to ask for what they really need, instead, they teach them to ask for things that donors will find appropriate.

In response, optimists have argued that such criticisms are made without due consideration to the political contexts within which NGOs operate. They indicate that activities which critics regard as important, such as direct political activism, are either inappropriate or hampered by historical and structural factors in the South. For instance, Hyden and Lanegran (1993:253) argue that “political activism, other than that directed against foreigners, is regarded inappropriate” in most parts of Africa. It is reported further that even after the opening of political space to multiparty politics, in most African countries, political activities of registered NGOs and other civil society groups are still legally restricted by the state (Cornwall et al., 2011; Dicklitch and Lwanga, 2003; Therklidsen and Semboja, 1995). Most political regimes in Africa insist that voluntary organisations should be both non-profit-making and non-political. Chapter Five, which focuses on Uganda, observes that being outspoken triggers outright harassment from the government, and could risk the very survival of NGOs through deregistration (Batsell, 2005; Grebe and Nattrass, 2009; Lister and Nyamugasira, 2003). According to Grebe and Nattrass’ (2009:12), “there are personal and professional risks to being perceived as critical [of the state] – ranging from exclusion from consultative forums, being cut off from sources of funding and even personal harassment and intimidation”. Consequently, NGOs in most African countries prefer taking quieter routes of political influence – where necessary to lobby government officials ‘behind the scenes’ (Batsell, 2005).
In such political settings, optimists argue, activities aiming at citizens’ transformation like conscientizing citizens about their rights and encouraging them to demand for accountability from authorities might not be carried out in the open. This reading is in line with Fowler (1993) who suggests that NGOs working under such constraints should engage in the ‘onion strategy’, which is underpinned by ‘transformation by stealth’. The onion strategy is characterised by political activities and methods that are camouflaged by welfare-oriented activities to cloud their actual intent. The “outer layer of welfare-oriented activity”, Fowler argues, “protects inner layers of material service delivery that acts as nuclei for a core strategy dedicated to transformation” (1993:335). Thus, NGOs would outwardly appear engaged in Korten’s ‘first generation’ welfarist activities, which are allegedly politically neutral in the eyes of state functionaries, but when inwardly they are implementing transformation-oriented activities. Organisations that are ‘transformative’ are change driven and challenge the status quo in that their work goes beyond service provision that merely maintains people’s well-being in response to state and/or market failure to that which attempts to empower people to change the structure of these institutions (Fowler, 2010; Gaventa and McGee, 2010).

Therefore, optimistic scholars challenge us to go beyond conventional measures of NGOs project impacts which fail to recognise the indirect “qualitative effects that [service delivery] might be engendering” (Charlton and May, 1995:240). Indeed, as argued in Chapter Two, analysts working from the experience of the welfare state in industrialised countries have long argued that citizenship building can be nurtured (or undermined) by the design and quality of service delivery. Thus service delivery, optimists insist, should not be marginalized as merely an “adjunct to activities… arbitrarily defined as ‘more’ political; nor should it be dismissed as a distraction from these more important ‘political’ missions” (Charlton and May, 1995:241). This conclusion is supported by Chhotray (2008) who, as observed earlier, challenges the artificial demarcation between SD-NGOs and advocacy or political ones.

1.3.2 Saboteurs of state capacity and legitimacy?
There are also raging debates around NGOs’ impact on state legitimacy. Sceptics argue that when NGOs excel in service provision, in effect, they bring unfavourable comparisons that make services from government facilities look poor in comparison (Edwards and
Hulme, 1996; White, 1999). Other scholars have argued that using SD-NGOs might cause variations in the quality and quantity of services that citizens in the different regions receive since few SD-NGOs cover whole countries let alone regions (Bebbington, 2004). When this happens, the state loses legitimacy as people in the under-served regions become dissatisfied with government (Brinkerhoff et al., 2012; White, 1999). Related arguments have been advanced by claims that NGOs greatly undermine local governments when they “set up parallel systems alongside a weak and under-funded local government system” (Mohan, 2002:146). Such claims tend to corroborate White’s conclusion that “the rise of NGOs as the agents of development per excellence has been achieved at the cost of the legitimacy of the state” (1999:308). Other NGOs practices like luring good staff from the civil service also greatly impair the full development of the governments’ own bureaucratic capacity (Cannon, 2000; Fritz and Menocal, 2007; Ghani et al., 2006; Mercer, 2002).

Whereas such criticisms are sobering for even NGO sympathisers, some optimists have challenged the view that SD-NGOs always undermine state legitimacy. According to Batley and Mcloughlin (2010:132), the tension between state building and service delivery manifested in using “state avoidance strategies” can be resolved when the state is allowed to perform ‘stewardship’ roles. Such roles include policy making, managing contracts, and regulating and monitoring services. This view is supported by Parkhurst’s (2005) analysis of the Ugandan response to HIV where, even though most service delivery was done by NGOs, the central government took lead on policy formulation and regulation. Contrary to the popular negative sentiments, Parkhurst (2005) claims, service delivery by NGOs boosted state legitimacy and at the same time created room for the state to develop its bureaucratic capacity for policy formulation and co-ordination. In relation to this, some argue, when the government takes on policy setting and other oversight functions it “can establish itself as responsible for and organizing the (well executed) contributions of other actors” (Brinkerhoff et al., 2012:276).

Brass (2010a) provides another good example that challenges the legitimacy erosion thesis. Basing on evidence from Kenya, she claims, NGO-provisioning seemed to improve overall citizens’ support for the state:
While scholarship has suggested that African states make a social contract with their citizens in which the state gives services and people give the state loyalty, it seems that in fact the people give loyalty [to the state] regardless of who gives services (Brass, 2010a:17).

This observation is supported by Cammett and MacLean with a disclaimer that whether or not provision by non-state actors affects state legitimacy is “context specific and depends on the particular relationship between the state and NSPs [Non-State Providers]” (2011:8). Also Tsai (2011), drawing on evidence from local governments in China, shows that state legitimacy could be boosted if non-state actors promote ‘co-production’—delivery arrangements where both the state and communities contribute to the production process. This is because, in part, co-production increases face-to-face interactions between state and non-state actors and encourages local officials to build better relationships with citizens (ibid).

1.3.3 Too close for comfort?

Some sceptics insist that in order for NGOs to engage in genuine empowerment activities, such as demonstrations, petitioning and litigation, they need to maintain their ‘autonomy’ in relation to the state and international donors. To the chagrin of sceptics, however, SD-NGOs normally work in close contact with the state, to levels that even NGO sympathisers acknowledge could be ‘too close for comfort’ (Hulme and Edwards, 1997c).

However, optimistic analysts have watered down such criticisms by suggesting that working in close collaboration with the state should be interpreted as part of NGOs’ political strategising. For instance, being close could actually allow NGOs to gain access and influence things from inside the state itself (Batley, 2011; Charlton and May, 1995; Chhotray, 2008; Clark, 1997; Lavalle et al., 2005). Batley makes this point more explicit: “by comparison with the blunt view of much of the literature—that collaboration in service delivery undermines NGOs’ freedom to undertake advocacy—our evidence supports the view ... that it affects how, not whether, they influence policy and its implementation” (2011:316). Many NGOs now consider non-cooperation with the government “as an outdated attitude that represents a politics of self-exclusion” (Miraftab, 1997:366). Moreover, other analysts have argued that in contexts where state agencies genuinely lack the capacity to respond to their citizens, political activism yields
limited positive outcomes other than driving the state on the defensive (Goetz and Gaventa, 2001b; Mitlin, 2008; Posner, 2004; Satterthwaite, 2008). Illustrating this point, with evidence from Mexico, Miraftab indicates that “the demand-making mechanisms that were effective in the miracle years ... the 1960s and 1970s, are increasingly ineffective with regard to making a government that in the last decade has twice declared bankrupt” (1997:366). Such circumstances, it is argued, call for approaches that aim at (re)building the capacity of the state to function before demands could be made on it by citizens (Gaventa, 2002; 2004; Golooba-Mutebi, 2005; Posner, 2004).

1.3.4 The need for further research

Basing on the above observations, two points can be made. One is that it would be unwise to write-off SD-NGOs from the political equation just because they are service delivery agencies. Nonetheless, and this is the second point, there is limited systematic evidence on the political implications of SD-NGO activities particularly in developing countries (Cammett and MacLean, 2011). A critical question, however, as rightly posed by Charlton and May (1995), is how can we understand the role of SD-NGOs whose strategies might be indirect and therefore not amenable to objectively verifiable measures? Some suggest that analysts need to focus on specific activities that such NGOs engage in and interpret their political implications in their own right. For instance, Corbridge et al (2007; 2005) provide an example of an Indian NGO called Mazdoor Kisan Shakti Sanghatan (MKSS) that supplied photocopiers to communities as a form of political empowerment. Such seemingly technocratic intervention had very powerful political outcomes in as far as it helped citizens to access information on state expenditures and thus led to opening up spaces within which people started to exert influence over the state, demanding higher level of responsiveness and accountability, and thus contributed to progressive processes of citizenship formation (Hickey, 2010).

It is from a similar reading that this research draws on the Ugandan SD-NGO called The AIDS Support Organisation (TASO). TASO had a programme called the Mini TASO Project (henceforth MTP) which sought to build the capacity of local governments in the area of HIV/AIDS management while also simultaneously empowering people with HIV/AIDS (PWAs) to make demands on the state for the proper functioning of these services. In this way, the MTP approach resembles what Gaventa (2002; 2004) calls working on ‘both
sides of the equation’ and, as described in more detail in Chapter Five, it seemed to provide a platform for the state and citizens to engage in an “unmediated encounter that offers each party an undistorted [and perhaps improved] sighting of the other” (Corbridge et al., 2005:44). The goal and research questions of this study are explained next.

1.4 Research goal and questions
This study seeks to establish whether SD-NGOs can work in ways that both enhance state capacity and contribute to citizens’ empowerment. To make this broad goal amenable to empirical scrutiny, we formulated two specific questions:

1) In what ways do SD-NGOs impact on the capacity and legitimacy of the state in developing countries?

2) How do SD-NGOs’ interventions influence the condition and practice of citizenship among the users of public social services in developing countries?

Basing on the evidence from Uganda, this research also draws lessons that the activities of SD-NGO offer for development theory, policy and practice.

1.5 Overview of the thesis
Chapter One has set the context for this study by mapping the debates around the role of SD-NGOs in the current international drive for building capable states and citizenship in the global South. The chapter noted that although there are indications that SD-NGOs might have political significance, there is a dearth of empirical work dedicated to settling the debates explored. To this effect, the chapter has delineated two research questions whose answers might contribute towards filling this gap. The rest of this thesis is structured as follows:

Chapter Two concentrates on establishing the theoretical basis for understanding service delivery as an avenue for state building, legitimacy and citizenship formation. This task is done in a phased manner. The chapter starts with a brief elucidation of the key concepts employed in this research including the state, citizenship, service delivery and related concepts. Next, the chapter draws on a wide range of sources to summarise the available evidence about the influence of public service delivery on specific dimensions of state capacity. After that it summarises the evidence of the impact of service delivery on the different aspects of citizenship. Although the chapter observes some consensus on the
political significance of service delivery, it notes that research is currently divided and/or limited on whether service provision must be provided by the state to facilitate positive outcomes on state capacity and citizenship.

Chapter Three introduces and explains the contextual setting of the fieldwork country, Uganda. After dividing the post-independence history of Uganda into four main blocks following the country’s major political leaders, namely, Milton Obote I, Idi Amin, Milton Obote II and Yoweri Museveni, the chapter assesses the main factors that shaped service delivery, state building and citizenship during these respective regimes. In particular, the chapter explains why no government has so far managed to front a lasting solution to Uganda’s challenges such as ethno-religious cleavages, weak bureaucracy and low penetrative reach of the state in the rural areas.

Chapter Four explains the methodology employed to investigate state capacity and citizenship in rural Uganda. It starts by providing the rationale for the case study choices made in terms of Uganda as a country and TASO as a SD-NGO. This is followed by the justification for the research paradigm and research design that were employed in the study. The chapter then describes the main fieldwork sites of Kamuli and Masafu-Busia districts (representing those areas that implemented MTP) and Iganga district that acted as the control site. The chapter emphasises that choosing the appropriate methodology is a messy undertaking that calls for flexibility which in itself requires a high degree of maturity on the part of the researcher to make critical decisions before, during and after fieldwork. Put together, the chapter shows that the research requirements for this study fitted well with the critical realist paradigm (see, Pawson and Tilley, 1997; Sayer, 2000).

Chapter Five focuses on describing the SD-NGO TASO, its Mini TASO Project (MTP) and how this was introduced in our study sites of Kamuli and Masafu-Busia. It starts by tracing the origin of TASO and locates its development role within the broader context of the Ugandan NGO sector. The chapter shows that MTP was only part of TASO’s core activity focusing on training and capacity building of other organizations. The NGO’s other core activities are medical support, counselling, social support and AIDS education and advocacy. The chapter discusses TASO’s relationship with the state and shows how this might have shaped the structure of MTP. The chapter then analyses the pre-existing
situation before the implementation of MTP in the two study sites to provide the baseline with which to measure the changes in state capacity (Chapter six) and citizenship (Chapter Seven) that the study links to MTP. Lastly, the chapter discusses the project implementation arrangements, as well as how it was wound up.

Chapters Six and Seven focus on the main empirical findings of the study. Chapter Six delineates avenues through which TASO influenced the capacities of local governments where MTP project was implemented. The project’s impact is investigated in four areas. First, is whether and how it influenced the bureaucratic capacity of the state. Second, the chapter investigates MTP’s attempts to facilitate the creation of dense ties with the relevant actors in civil society to bring about “external embeddedness” of the state (Evans, 2011; Vom Hau, 2012). Third, it looks at activities which aimed at enabling the state to reach the peripheries to implement chosen policies, and thus enhance the “infrastructural power” of the state (Soifer and vom Hau, 2008). Fourth, in relation to state legitimacy, the chapter probes the impact of MTP performance on beneficiaries trust in state institutions at different levels (Brinkerhoff et al., 2012; Levi et al., 2009).

For its part, Chapter Seven analyses the ways through which TASO attempted to bring the state more firmly under the gaze and control of PWAs and thus advance processes of citizenship formation. This is done by assessing TASO’s impact on citizenship amongst PWAs in three areas: amplification of voice; civic engagement and participation in direct political contest.

Chapter Eight is the last chapter of the thesis and provides the overall summary of the main findings and conclusions. The chapter starts by analysing the relationship between state building and citizenship formation and this is followed by a summary of the study’s main findings on each research question. It also probes whether the findings of this thesis are specific to the HIV/AIDS sector or could actually have resonance in the wider development field. Lastly, the chapter suggests ways forward for NGOs, donors and other development actors and makes recommendations for further research.
CHAPTER TWO

The Politics of Building States and Citizenship through Service Delivery

2.1 Introduction

Having explored the key debates relating to the contested role of SD-NGOs in the political arena in Chapter One, this chapter focuses the spotlight on the links between service delivery and the political processes of state building and citizenship formation. Although the evidence on these issues is generally limited, since the mid-2000s, there has been heightened interest in theorizing and empirically investigating the so-called “feedback effects of service delivery on politics” (Batley et al., 2012). The central point of departure for studies here is the claim that service delivery programmes are not just outcomes of political action, but that they themselves set political forces in motion and shape political agency of citizens (Pierson, 1993). Specifically, scholars have started interrogating the effects of services on issues such as the legitimacy and stability of the state, the distribution of resources and power between social groups, and accountability of states among others (Brinkerhoff et al., 2012; Devarajan and Widlund, 2007; Van de Walle and Scott, 2011; World Bank, 2004). The aim of this chapter is to summarise this evidence, establish areas of convergence and divergence and identify gaps that require further research. The chapter will also probe what the current literature says about the role of SD-NGOs here. However, before we can engage this discussion, the chapter first describes the central concepts underpinning this thesis. After, it discusses the implications of service delivery for state building. The fourth section analyses the impact of service delivery on citizenship formation. The role of SD-NGOs in state and citizenship building is integrated in the analysis of the foregoing two sections. The fifth section concludes the discussion.

2.2 Definition of key concepts

There are numerous concepts used in this study. However, they mainly revolve around three themes, state building, citizenship formation and service delivery, which are respectively discussed below.
2.2.1 Understanding the “state”

The ‘state’ is an elusive concept which, as stipulated by Young (1994:25), cannot fit a “single, well-tuned phrase”. And with Chabal (1994) noting that the ‘state’ is one of the most “abused notions”, the researcher refrains from providing a definition of the concept here. Instead, attention is drawn to the key features that most scholars associate with the idea of the ‘state’ (see Table 2-1).

Table 2-1: Characteristics of the state

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<td>1. Organisation: the state as a paramount organ of government served by functionally differentiated (specialised) personnel e.g. the civil service and military (Finer, 1975; Tilly, 1975b).</td>
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<td>2. Territory: the territorial jurisdiction over which the paramount organ of government exercises its rule (Mann, 1993).</td>
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<td>4. Sovereignty: this is interpreted mostly in terms of international relations but it also has an internal meaning which relates to the state’s ability to assert itself over its subjects and other competing centres of power (Fritz and Menocal 2007:11; Tilly 1975:638).</td>
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<td>5. Power: the state as having monopoly over the legitimate use of force in its territory (Ghani et al., 2006; Tilly, 1975b).</td>
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<td>6. Law: this involves the creation of sanctions that define non-state actors’ engagement with each other and the state (Migdal and Schlichte, 2005).</td>
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Although Table 2-1 is useful in telling us the characteristics of the ideal state, it is muted on how the state actually works in practice. In addition, some argue that states are currently operating in quite different circumstances as compared to European contexts from which the idea of the modern state was built (Migdal and Schlichte, 2005). To Hibou, dynamic national and international transformations in which contemporary states operate often dictate that “modes of government are transformed from direct, permanent, predictable, and bureaucratized modalities to indirect, discontinuous, ex post facto, and fairly non-institutionalized ones” (2005:82). Therefore, this study also locates
itself within the framework of state-society relations, which postulates that both the organisational structure of states and how states are able to shape the nature of societies are determined through state-society interactions. Here, we learn about the workings of the state, for instance in rural Uganda, by attending to the diverse practices by state officials which take place in multiple sites as they interact with non-state actors (Corbridge et al., 2005; Migdal and Schlichte, 2005).

**State building**
The term *state building*, according to Fukuyama, relates to “the creation of new government institutions and the strengthening of existing ones” (Fukuyama, 2004:ix; also see, Fritz and Menacol 2007:13). Some add that the aim of state building is to enhance the ability of government institutions to function (Whaites, 2008:4). However, this and other functional definitions (e.g Ghani and Lockhart, 2008; Rotberg, 2004) tend to reduce the process of state building to a technocratic undertaking of “institutional building” thereby missing political aspects, such as the negotiations with the different societal actors, that are necessary to achieve and maintain the desired levels of institutional functionality (Evans, 1995; Soifer and vom Hau, 2008). The Organisation for Economic Co-operation and Development (OECD) provides a more politically attuned conceptualisation of state building, seeing it as:

> [a] *purposeful action to develop the capacity, institutions and legitimacy of the state in relation to an effective political process for negotiating the mutual demands between state and societal groups* (OECD, 2008:14, original italics).

This OECD’s definition highlights two main points about the process of state building. First, state building is not a movement towards a static goal, rather it is a process that involves continuous adaptations to fit state capabilities to the changing circumstances – hence states are “never finally built” (Whaites, 2008). Second, the definition reiterates the point that states are not built in isolation and that state-society relations are central to state building processes (Soifer and vom Hau, 2008).

Before turning the focus onto citizenship, it is important to explain two other concepts at the heart of the state building definition above: state capacity and state legitimacy.
State capacity and its dimensions
State capacity is a multidimensional concept that captures the “the ability of states to apply and implement policy choices within the territorial boundaries they claim to govern” (Vom Hau, 2012:2). Weberian theorists have traditionally conceived it as consisting of a) the bureaucratic professionalism, b) external embeddedness (Evans, 1995; Evans and Rauch, 1999) and, more recently, c) the infrastructural power of the state (Mann, 1984; Soifer and vom Hau, 2008; Vom Hau, 2012). These aspects are the parameters that this study uses to measure the impact of SD-NGO programmes on state building. They are elaborated below in turn.

Bureaucratic capacity relates to the training and expertise of government employees (Evans and Rauch, 1999; Vom Hau, 2012). Among the main structural factors postulated to enhance the organisational performance of state bureaucracies are training, meritocratic recruitment and availability of predictable long-term career rewards (Evans and Rauch, 1999; Henderson et al., 2007). However, recent research has called for the need to re-conceptualise bureaucratic capacity “as a function of the interaction between formal and informal as well as bureaucratic and non-bureaucratic institutional arrangements” (Vom Hau, 2012:25). This is because the rigid rule-based Weberian bureaucracy can be ineffective, especially at the local level, where programme implementation requires state agents to customize development responses to the particular needs of the communities they serve, as opposed to following tightly controlled rules, regulations, and mandates from the centre (Mitlin, 2008; Pritchett and Woolcock, 2004; Pritchett et al., 2010). As we explain later in the chapter, this thinking is popular in relation to ‘co-production’.

Another established position in the literature of state building, which also partly acknowledges the limits of Weberian bureaucracy, is that high-capacity states emerge out of bureaucratic reliance “on the ‘right’ kinds of relationships to non-state actors” (Vom Hau, 2012:4). Evans (1995) used the term “embedded” autonomy to refer to those dense ties between the bureaucracy and strategically selected business actors necessary to achieve economic growth. In his latest writings, Evans (2010; 2011) argues that the delivery of social services such as health and education (the capability enhancing services) requires a particular kind of “state-society synergy” different from the kind of
‘embeddedness’ that is crucial to achieving economic growth. Here, whereas economic growth requires “dense networks of ties connecting the state to industrial elites”, social services dictate that these are “replaced by a much broader, much more “bottom up” set of state-society ties” (2011:3) connecting “the apparatus of the state, administrative and political, to civil society” (2011:10).

By infrastructural power, the chapter means the institutional capability of the state to exercise control and implement chosen policies and programmes across the territory it claims to govern (Mann, 1984; Soifer and vom Hau, 2008). In principle, this necessitates functioning physical infrastructure such as roads linking the centre with the periphery, buildings, and staff among other markers of effective state control of territories.

It is important to note that the different dimensions of state capacity, as outlined above, are closely connected (Soifer and vom Hau, 2008). For instance, a professional bureaucracy without roots in society may fail to implement social programmes. Similarly, Soifer (2008:234) argues that the infrastructural power of the state “determines how far into society a bureaucracy, no matter how professional [and embedded], can reach”. Chapter Three also reports that although Uganda’s health system scores highly infrastructurally, the performance of the health sector is dismal mainly due to weak bureaucratic capacity.

**The concept of state legitimacy**

Some understand state legitimacy to refer to “the degree to which citizens regard the state as the appropriate political authority and the extent to which states can elicit citizen compliance without coercion or the threat of force” (Cammett and MacLean, 2011:5-6). To Levi and colleagues (2009:354), legitimacy simply “denotes popular acceptance of government officials’ right to govern”. It is argued by some that legitimacy is a key determinant of state capacity (Migdal, 1988; Vom Hau, 2012). According to Vom Hau, “the ability of state organizations to transform social relations, extract resources and implement policy effectively” is shaped by ideological consensus of citizens regarding “what constitutes legitimate political authority within a given territory” (2012:14). However, others argue that legitimacy is not merely a determinant of state capacity; it is also an outcome of enhanced state capacity. This is called “performance legitimacy”
which emanates from “effective and equitable service delivery” (Levi et al., 2009:358; OECD, 2008:17). The concept of performance legitimacy is the most important for this study because it provides a bridge that links state capacity and citizenship. Here, enhanced ability of the state to engage in development programmes which are valued by citizens is reflected in the changes in citizen’s legitimating beliefs (Levi et al., 2009). It is for this reason that in this thesis, the discussion of MTP’s impact on state legitimacy is structured in such a way that it flows from the analysis of the project’s impact on state capacity. This point also helps to usher in the next central concept of this research, namely, citizenship.

2.2.2 Citizenship
There is widespread agreement that citizenship is a highly slippery concept (Dwyer, 2004; 1994). Thomas Humphrey Marshall, a respected writer on the subject, saw it as “a status bestowed on those who are full members of a community” (1963:84). To Marshall, citizenship defines people’s standing in the community in that “all those who possess the status are equal with respect to the rights and duties with which that status is endowed” (1949:18). Marshall argues that a person attains citizenship status after acquiring its three constitutive components/elements of civil, political and social citizenship. However, this Marshallian triumvirate requirement for citizenship is the ideal and Dwyer (2004) calls it ‘formal citizenship’ because quite often it reflects little about people’s actual experiences, especially in developing countries where the state and state-society relations are weak. This observation calls for paying keen attention to ‘substantive citizenship’ which deals with the extent to which those who enjoy the formal legal status of citizenship can actually claim the rights that they have been formally accorded (ibid). As argued throughout the chapter, the popular understanding of ‘substantive citizenship’ includes a reference to ‘participation’ as both a right and constitutive element of citizenship (Lister, 1998a; Mohan and Hickey, 2004). The Citizenship DRC (2011:5) regards participation as “a social right which enables the capacity to claim other rights”. However, many have sounded caution that not all modes of participation have emancipatory potential (Mohan and Hickey, 2004) and that some forms can be disempowering or ‘tyrannical’ (Cooke and Kothari, 2001).
Other scholars insist that citizenship is not singular, rather there are “multiple
citizenships” sometimes formal and/or informal, and present at different societal levels
(Green, 2008a; Heater, 1999; Mohan and Hickey, 2004). For instance, in most African
countries, sub-national communities such as ethnic/tribal and religious entities are
alternative arenas for citizenship formation and practice alongside the state (Fatton,

**Citizenship formation**

After having defined citizenship, the chapter turns to citizenship formation which is used
interchangeably with citizenship building. Van Gunsteren argues that the term essentially
means the “reproduction of citizens” (1994:47). He suggests that ‘reproducing citizens’
involves having conscious efforts directed towards “the formation of people into
autonomous individuals, capable of sound judgement and [as] members of a public
community sharing a common fate ...” (ibid). To Van Gunsteren, the complexities of the
modern world do not allow such forms of citizenship “to spring up ready-made from
society”, hence deliberate efforts must be taken to facilitate its (re)production (ibid). It is
important to note that the goal of citizenship building is not limited to enabling citizens to
*be citizens* (the formal status discussed above), it also necessitates that they are aided to
*act as citizens* (the substantive view) (Lister, 1998a). According to Green (2008a:24),
“rights alone are not enough for citizenship”; individuals need “rights and the ability to
exercise them” such as resources, literacy, good health and access to vital information
(also, Krishna, 2007). This view of citizenship resonates well with Sen’s (1999) increasingly
influential thesis of development as “expansion of human capabilities” mediated through
social services especially health and education (see, Evans, 2008; Evans, 2011).

**Citizenship in rural Uganda**

In view of the foregoing discussion on citizenship and citizenship formation, the following
paragraphs specify how the empowerment of a formerly powerless social group, the
PWAs who are the focus of this study, is understood within the context of this study. The
researcher’s point of departure is that the process of empowerment, the transformation
from a state of marginalization to citizenship, is likely to happen in many small steps
starting first and foremost with regaining a sense of self-worth (also, Citizenship DRC,
2011; Green, 2008a; Lister, 1998b). In addition, it is when individuals are empowered that
they can effectively engage in community and national level activities. Therefore, for purposes of our empirical analysis in Chapters Six and Seven, the study identifies the following three levels of citizenship formation in rural Uganda:

Individual level: this involves enabling PWAs to develop the self-confidence required to express their opinion in their dealings with fellow citizens and state agents e.g. the health staff at the point of service delivery. As discussed in more detail in the proceeding sections, when people contract HIV, they become marginalized, lose a sense of agency and the absence of psychosocial skills among public health workers further undermines their ability to lead a dignified life (Robins, 2006; Ssebbanja, 2007). The latter is usually accompanied by citizens’ disengagement from social life and/or the unresponsive and stigmatising public institutions (Birungi, 1998; Gilson, 2003). Chapter Seven discusses the strategies employed by TASO to reverse this situation and enable citizens to exercise power over decisions which affect their lives. Suffice to say, empowering such people to regain a sense of self-confidence is the foundation upon which higher levels of citizenship empowerment can be constructed.

Community level: this involves developing the ability of individuals to gain capacity to join others in collective action (Green, 2008a). The community level, some argue, is particularly important for marginalized groups, including the disabled, chronically ill and women, who may find it difficult to engage in formal and national political processes (Lister, 1998b). Two additional factors highlight the salience of this level. First, this research is cognisant of the fact that individual action may be inadequate to bring about changes that are necessary for PWAs to exercise citizenship. Secondly, the community level takes into consideration the fact that most Africans, particularly in rural areas, are guided by norms of moral ethnicity centring on reciprocal obligations between the rich and poor, powerful and weak and obligation to the overall community well-being as the basis for one’s being “a good member” of the local community (Mamdani, 1996; Orvis, 2001). Here citizens are civic republicans whose rights are considered “not as inherent but as acquired through civic practice that upholds obligations to the community” as opposed to liberal citizens where “rights inhere in individuals, exist prior to community, and are guaranteed with minimal obligation to the community” (Ndegwa, 1997:602). The idea of civic republicanism implies that, particularly in times of need, PWAs have the right to fall
back to their community networks for emotional, medical and social support so that they “can live responsibly with HIV/AIDS” (TASO and WHO, 1995:3). However, they also have obligations to the community, especially when their health improves. According to TASO it is “the responsibility of people infected or affected by HIV/AIDS to cultivate self-esteem, hope, respect for life, respect for and protection of their community, care for self, care and support for dependants” (ibid).

The national level: here citizenship means engaging with the political system to build an effective state, and assume some degree of responsibility for the public domain (Green, 2008a). It is this level that is normally implied in the formal definition of citizenship. However, from an actor-oriented approach to citizenship, the ability of the poor and marginalized people to engage with the political system, as voters or as politicians seeking to occupy public offices themselves, is an indicator of increased civic and political knowledge (Citizenship DRC, 2011; Lister, 1998b; Nyamu-Musembi, 2010). It is engagement at this level that opens opportunities for influencing wider decision-making processes such as regional and national policies which affect people’s lives at the local level (Gaventa, 2002).

The three levels articulated above imply that gaining citizenship is much broader than the legal status of becoming a full rights-bearing resident of a nation. It involves, where possible, the development of citizens as actors, capable of claiming their rights and acting for themselves (Citizenship DRC, 2011; Lister, 1998a). Realising this requires multi-tiered strategies and networks (Lister, 1998b; Mohan and Hickey, 2004). It is important to recall, however, that for the marginalized to realise their citizenship the state and its agents must have the capacity to respond to citizens’ needs and demands (Gaventa, 2002).

**2.2.3 Service delivery**

Like the concepts of citizenship and the state, ‘service delivery’ lies on an ambiguous terrain, and many scholars shy away from giving it an operational definition. The World Bank (2004) argues that it can be understood as a triangular relationship between policy makers, service providers and service users (see, Figure 2-1). The focus of this research is on the service user–service provider side of the ‘service delivery triangle’. Specifically, the study investigates the interaction between service users and those service providers at
the frontline, that Lipsky (1980) calls “street-level bureaucrats” and whom Corbridge et al (2005) identify as key interlocutors between state and citizens.

**Figure 2-1: The service delivery triangle**

![Service Delivery Triangle Diagram](source: based on World Bank (2004))

The relationship between citizens, policymakers and providers in Figure 2-1 is said to operate under democratic settings where voters delegate oversight responsibilities to politicians to ensure that policy makers and service providers do their job. In most countries of the South, however, because democracy is not well institutionalised, service delivery through this ‘long route’ often fails (see, Nelson, 2007; World Bank, 2004). As indicated in Chapter One, due to this failure, development agencies are now called upon to strengthen the ‘short route’ between citizens and service providers. Although the World Bank’s interpretation of the ‘short route’ is in terms of building “clients power” to demand services from providers, Chapter Five reports that TASO’s project instead focused on building the capacity of providers first before empowering citizens to make demands on them (hence the double arrow between citizens and providers in Figure 2-1).

**Types of services**

Public services can be categorised into two broad types. The first category comprises of collective consumption services/goods in which citizens especially in the global South
necessarily have to engage in some form of collective action to secure access (Mitlin, 2008). The second type consists of ‘private’ services that can be accessed individually in formal areas. A key difference between these two is that the former is highly targeted while the latter is broad-based (Keefer and Khemani, 2005). It is argued that these two types potentially have different political implications. Mitlin (2008) suggests that collective needs, such as improving water supplies, establishing a common garbage dump, or improving drainage are more likely to be associated with citizens’ mobilisation for collective action as they are difficult to meet by low-income households acting on their own. Keefer and Khemani (2005) add that collective services can easily form ‘pork barrel’ programmes, hence, in countries characterised by patronage politics, they are attractive to politicians than private services. This research focuses on access to HIV/AIDS treatment services, a type of ‘private’, discretionary and transaction-intensive service for a) its delivery requires a large number of transactions, nearly always involving some face-to-face contact, and thus b) some discretion on the part of the provider is required in order for the service to be effective, thereby rendering it difficult to be mechanised (Pritchett and Woolcock, 2004). Based on claims that discretionary and transaction-intensive services are rife with principal-agent problems and particularly difficult for citizens “to know whether the provider has performed well” (World Bank, 2004:53), there is an implicit assumption that, of themselves, they may attract less political activity (Keefer and Khemani, 2005; Mcloughlin and Batley, 2012a).

**Co-production**

The concept and practice of co-production brings to the fore the linkage between citizenship, state building and service delivery. Some argue that in contexts where the success of state programmes is dependant on behavioural change on the part of citizens, as for example the case is with policing, health and education programmes, the joint production of public services between citizens and state agencies offers great promise (Evans, 2010; 2011; Migdal, 1988; Mitlin, 2008; Whitaker, 1980). Yet, when citizens are involved, co-production can become an avenue for promoting citizenship formation since the process can ostensibly “[extend] citizen action into areas where it was previously not present, building skills and capacities, including those to recognize and realize collective will” (Mitlin, 2008:345). Viewed this way, co-production highlights the relational nature of state and society where, as argued by Bebbington (2008), it is not only services that are
co-produced but also that the state and society have to be understood to be co-producing each other. Moreover, the non-coercive implementation of policies that the process engenders is a key indicator of state legitimacy (Brinkerhoff et al., 2012). During the implementation of MTP, there were deliberate attempts by TASO to foster co-production between PWAs and the health staff in the targeted government hospitals. These arrangements will be introduced in Chapter Five, while Chapters Six and Seven will analyse how the practice influenced state and citizenship building processes respectively. Having defined the central concepts of this research, in the next sections we start to interrogate the links between service delivery and a) state building, and b) citizenship formation.

2.3 Service delivery and state building
This section is devoted to isolating and elaborating concrete avenues through which service delivery can influence the different dimensions of state capacity. Although this is a nascent field, from the available literature, most scholars have presented the alleged effects of service delivery on state capacity in dramatic terms. Van de Walle and Scott (2011) posit that “public services are what make the state visible to its citizens...[they] are citizens’ direct line to government” (2011:9). This resonates with Corbridge et al’s argument that the state presents itself to citizens through public policies and that people see and understand the state through the daily encounters with state agents as they go about administering public programmes (Corbridge, 2007; Corbridge et al., 2005). In the discussion below, the implications of service delivery for state building are discussed in relation to the three dimensions of state capacity identified earlier, that is: bureaucratic capacity, external embeddedness and infrastructural power or territorial reach of the state. In addition, the section will also analyse the implications of service delivery for state legitimacy.

2.3.1 Service delivery and the bureaucratic capacity of the state
Perhaps the connections between service delivery and state capacity are clearer in the bureaucratic than in other dimensions of state capacity. This is because one of the most direct channels for assembling a competent Weberian bureaucracy is through education attainment (Evans, 1995; Evans and Rauch, 1999). Indeed, some argue that the state’s bureaucratic capability is about the “training and expertise of the bureaucracy” (Soifer
and vom Hau, 2008; Vom Hau, 2012). It is observed that the low emphasis that colonial governments placed on education services of the colonised natives is largely responsible for the weak development of modern state bureaucracies on the African continent (Chazan et al., 1999). Indeed, by independence very few skilled Africans were available to competently occupy the top positions of the civil service in their countries. Chazan and colleagues illustrate that in Kenya and Tanzania only 10% of the civil service personnel were Africans at the time of independence (1999:43). Comparable statistics are reported in Uganda (see Chapter Three).

Besides that direct channel, it is recognised that many service delivery programmes involve collecting data on beneficiaries, their households and communities. Many scholars, following Scott’s (1998) well crafted analysis, have variously argued that such information greatly enhance the bureaucratic capabilities of states to ‘see’ and/or plan for their citizens (Corbridge et al., 2005; Hurrell and MacAuslan, 2012). However, some analysts view the idea of development programmes being associated with increased bureaucratic capabilities of states as a ‘side effect’ to be avoided rather than an intended goal to be pursued (Ferguson, 1994; Scott, 1998). Scott (1998), in particular, shows how several ‘schemes to improve the human condition’, that emerge from such bureaucratic capabilities, have often ‘failed’ with catastrophic effects on the masses they intended to help.

Coming from a different angle, Theda Skocpol offers a different analytical avenue through which service delivery could influence the bureaucratic capacity of the state. Her central argument, based on several analyses of American social policies, is that the experience of managing a particular programme helps state agencies to draw lessons which they can then use to transform their capabilities for prevailing and future programmes (Skocpol, 1992; 1995; Skocpol and Amenta, 1986). According to Skocpol:

...because of the official efforts made to implement new policies using new or existing administrative arrangements, policies transform or expand the capacities of the state. They therefore change the administrative possibilities for official initiatives in the future, and affect later prospects for policy implementation (1992:58).
A critical reading of Skocpol reveals that her analysis of ‘policy feedback effects’ is focused on the bureaucratic apex at the national level. However, in what they call the ‘recruitment effects’ of development programmes, Corbridge and colleagues (2005) illustrate their own version of policy feedback effects at the local level. They draw our attention to the ways through which the practices of those state agents at the frontline of service delivery are modified, most times for the better, because of participating in the implementation of different service delivery programmes. They argue that new interventions for improving service delivery enable ‘street-level bureaucrats’ to widen their “circles of engagement, and perhaps also to change the terms on which these engagements are transacted” (2005:9). Comparable observations are made by Tendler (1997), especially in her case study of the preventive health care programme in Brazil. To Tendler, simple design features of service delivery programmes, such as implementation autonomy and prompt feedback on performance, can attract high levels of commitment from street-level bureaucrats. Tendler’s analysis also serves to account for the emergence of capable bureaucracies in ‘difficult settings’ that are otherwise famous for being the ‘world of rent-seeking’ (Tendler and Freedheim, 1994; also see Crook 2010).

The interest in the emergence of capable bureaucracies in ‘difficult settings’ has links to the recent focus, by development analysts, on the ‘pockets’ or ‘islands’ of effectiveness (Crook, 2010; Leonard, 2010). According to Therkildsen (2008:28), islands of effectiveness (henceforth IOEs) are “organisations that – by deliberate political design or by own efforts – manage to perform well under difficult circumstances”. Difficult circumstances here mean operating contexts in which most state agencies are ineffective and subject to serious predatory practices like corruption and patronage (Leonard, 2010). As far as IOEs are concerned, analysts are preoccupied with two issues: firstly, how IOEs can be nurtured to emerge, and secondly whether they can be used as a springboard for launching wider systematic improvements in state agencies beyond themselves. In addition to the ‘accidental’ emergence of such agencies through the experience gained from implementing development programmes, as suggested by Skocpol (1995) and Tendler (1997), some scholars have added that IOEs can also emerge as a “result of deliberate political decisions to create capacity in key parts of the public sector” (Therkildsen, 2008:29). It is observed that the intentional creation of IOEs can originate from within the state or from other sources such as CSOs. In this respect IOEs is a useful
analytical concept because, as discussed in Chapter Five, TASO attempted to create MTPs to perform as departments of excellence within public hospitals plagued with inefficiencies.

On the question of whether effectiveness can spread from the IOEs to the ‘sea’ of ineffectiveness, there are a few studies that have empirically investigated this issue (Roll, 2011). Drawing on case studies from Nigeria and Sierra Leone, Eldon and colleagues (2008) explored whether strengthening the health sector, in these ‘conflict and fragile states’, enhanced the capacity of other institutions. Although they reported that “in Sierra Leone, the relative success of decentralised health care has helped to raise the profile of these other sectors” (2008:23), there were no organised arrangements to promote cross-sector learning both in this country and the two Nigerian states of Enugu and Kaduna that the study investigated. In relation to the current study, the aspect of using MTPs as centres for dispersing improvement in performance in other departments was not explicitly stated by TASO as a goal for this project. Nonetheless, Chapter Six investigates whether it happened as an ‘externality’.

Crook (2010) argues that the conceptualisation of IOEs need not be limited to full organisations, ministries or agencies, it could be applied to committed individuals. He hypothesises that it might be possible to improve performance through “identify[ing] and work[ing] with existing competent and committed middle managers and front-line officers within particular departments and agencies, whether it be in particular rural districts or quarters of big cities” (Crook, 2010:480). However, even here, systematic research is rare, although the recent research on ‘social accountability’ has revealed how some sections of civil society have relied on such committed bureaucrats to implement reforms that resulted into responsive and/or accountable bureaucracies (Ackerman, 2004; Tembo, 2012). Tembo (2012) acknowledges that the significance of such ‘interlocutors’ varies, depending on the issue at hand and the context. Chapter Six will investigate whether and how such interlocutors were ‘game changers’ in the implementation of MTP.
2.3.2 Social services and the state’s infrastructural power

Among the authors who have attempted to link public services directly to state building are Van de Walle and Scott (2011). Drawing on the nineteenth century history of European state formation, these scholars argue that the role of service delivery in state building is clearly visible through three main avenues: public services aid the processes of state penetration of both the centre and the periphery; it standardises citizen’s experience from the state; and it can help to accommodate warring factions in society. In the discussion below, we focus attention to the process of penetration because it is closely connected to the study’s understanding of the infrastructural power of the state particularly as it relates to the spatial variation in the spread of state agencies and services (Soifer, 2008; Soifer and vom Hau, 2008).

State penetration means “the ability of the government to act directly upon the population by its own agents, instead of through intermediate local bigwigs” (Van de Walle and Scott, 2011:10 citing Finer, 1999: 161). It is argued that public works such as roads and railway networks enabled nineteenth century European states to swiftly move their agents, like army personnel, tax collectors, and school inspectors, to reach even the remotest areas of their territory. In contrast, some argue that the failure of colonial governments to establish the same in most parts of sub-Saharan Africa laid a shaky foundation for successor postcolonial states to exert control over their territories (Englebert and Tull, 2008; Fritz and Menocal, 2007; Herbst, 2000).

A less explored route of how service delivery programmes can extend the infrastructural capacity of the state is provided by Ferguson (1990). The implementation of development projects in the country-side, Ferguson argues, usually has a ‘side-effect’ of attracting the state to the periphery to establish systems of effective control such as police posts and local tax collection offices. Although Ferguson (1990) argues that this should not be a point of cerebration, for the reason that majority of citizens encounter the state as an instrument of oppression and exploitation, recent reports indicate that in reality most people complain of the state’s absence rather than its presence (Corbridge et al., 2005; Jones, 2009).
It is suggested that the methods/channels of service provision matter in determining the effectiveness of state penetration. The dominant view is that success here needs the central government to be in charge of service delivery (Eldon and Gunby, 2009; Van de Walle and Scott, 2011). Eldon and Gunby, drawing on the case of post-independence Zimbabwe, find that the centralization of service delivery “allowed the state to reach previously neglected areas and bind remote areas and populations into the state building process” (2009:18). Besides this, Table 2-1 showed that one of the key defining characteristics of the state is its ability to be “differentiated from other organizations operating in the same territory” (Fritz and Menocal, 2007:11; Tilly, 1975b:638). Therefore, Van de Walle and Scott argue that public service structures like police posts, hospitals and schools are symbols which helped European states in the process of ‘boundary-building’ when they acted as markers to differentiate the state from other socio-political organisations. From this angle, the use of non-state providers (NSPs) like NGOs could undermine this process, hence, according to Van de Walle and Scott, ‘boundary-building’ calls for the “annihilation or suppression of alternative autonomous power centres or alternative delivery mechanisms” (2011:11).

However, Soifer and vom Hau (2008:222) argue that, sometimes, the infrastructural power of the state is “grounded in the organizational entwining between state and nonstate actors”. Indeed, Skocpol’s (1992) account of the growth of formal schooling in the United States shows that it was religious communities that built free public schools in the US. State governments worked with these ‘local and voluntary forces’ and allowed them to compete among themselves (ibid). Similar accounts are given relating to the development of public water systems in the Netherlands. According to Lintsen (2002), up to the end of the eighteenth century, the “battle against water” was solely in the hands of the local communities with more than a thousand different organizations in some way or another involved in Dutch public works. He notes that:

The resultant public works system, based on the careful management of local administrators and a high degree of involvement on the part of local inhabitants whose knowledge of the local situation was excellent, was incredibly complicated (Lintsen, 2002:552).

The work of missionaries in Africa, in spreading education and health services during the colonial and postcolonial eras, also provides a comparative perspective to how non-state
actors can expand the territorial reach of the state. In several African countries, the competition between the different denominations led to rapid spread of service delivery infrastructure into the periphery and they were sustained until when states assumed responsibility for them – whether or not they had the capacities required to run things is a different issue (Doornbos, 1990; Nabuguzi, 1995). In Kenya, Brass (2010b) claims, through things like providing logistics to state agencies, collaborating on development programmes and situating themselves in remote areas where the state is thin, NGOs help to broadcast the power of the state across rural Kenya. Basing on such observations, Soifer and vom Hau (2008:224) conclude that “the expansion or reproduction of infrastructural power is not necessarily dependent on state autonomy”.

2.3.3 Service delivery and the external embeddedness of the state
For some scholars, another aspect of state building that can potentially be influenced by service delivery is the state’s abilities to develop links and build coalitions with communities (Eldon et al., 2008). It is argued that service delivery structures can help to clarify citizens’ expectations of the state, and vice-versa, and making these expectations more realistic and manageable, thereby strengthening the social compact around different issues, such as health and education (Cornwall et al., 2000; Eldon et al., 2008). There are two bodies of literature which have different starting points but converge in illuminating how service delivery can be a route for bringing about state embeddedness. The first one is the literature on co-production while the second one is that on participatory governance.

As argued in Section 2.2.3, because the success of most social services programs depend on the cooperation of the beneficiaries, state agents are compelled to devise strategies to enlist this cooperation. There is a range of studies which illustrate that quite often this leads to the emergence of ‘dense ties between the state and society’ (Evans, 1996). Tendler’s (1997) analysis of the public health programme in Ceara, Brazil is once again useful here. It elaborates how the newly hired health agents soon learnt that “mothers would not answer their knocks on the door, or would hide their children when the agent crossed the threshold” (1997:1781). This prompted the health agents to make “building relations of trust between themselves and their “clients” a central part of their jobs” (Evans, 1996:1121). It is reported that one of the effects of this process was the
development of strong ties between the health sector and ‘their’ communities generally. Joshi and Moore (2004) provide other examples of ties between the state and society in the area of security and tax collection in Pakistan and Ghana respectively; while Mitlin (2008) shows some relating to improvement of living conditions for the urban poor in the global South.

In Kenya, Brass (2011) notes that since 2002, there has been an increased trend for the GoK through different line ministries and provincial administrations to reach out to NGOs to encourage them to engage in the policymaking process and service delivery. She argues that although this trend can partially be explained by donors’ insistence on state-civil society collaborations, the view of most commentators is that this is a deliberate strategy by GoK to improve its development record:

“decades of hierarchical control led to a decline in public service provision, a crumbling economy and massive corruption under Moi. Taking advantage of the opening of Kenya’s political system and the generalized feeling of goodwill, the Kibaki administration worked to get new voices into government and to learn from nongovernmental actors” (2011:217).

In some cases this has involved hiring NGOs leaders to head various government departments. Rather than being evidence of co-option, Brass argues, this process should be seen as showing progressive mutual influence of state and society and which has resulted into “democratizing” development processes within these government agencies (2011:217). Examining these developments more critically, Okello (2010) supports Brass’ position. However, he also notes that some ex-CSO leaders such as the Commissioner of Kenya National Commission for Human Rights did not hide their paradigm shift upon entering government –indicating that “people wrongly assume that when you are in government you speak for civil society, yet the dynamics have changed” (2010:199). Thus, those who expected that the ex-CSO agents would become the interlocutors for civil society ideas in government were a bit disillusioned (ibid).

In several ways, the analysis of embeddedness shifts our understanding of the structure of the state bureaucracy from the “Weberian” model based on an authoritative and rule-based bureaucracy to flexible institutions that co-exist with others (Joshi and Moore, 2004; Mitlin, 2008). It also shines a spotlight on the thin line between the state and
society. Thus, contrary to what some literature suggest, the state and civil society do not need to be autonomous from each other for effective performance to occur (Cornwall and Coelho, 2007; Lavalle et al., 2005).

2.3.4 Social services and state legitimacy

Several scholars argue that public services such as national health systems are highly visible social institutions, and thus may play an important role in influencing public trust in government (Eldon et al., 2008; Gilson, 2003; Kruk et al., 2010; Rockers et al., 2012). In the so-called ‘conflict and fragile states’ the delivery of social services such as “effective health services signals the will and capacity of the state to act on behalf of citizens in a responsive and accountable manner, generating enhanced support for the state in return” (Eldon et al., 2008:1).

In the aftermath of colonial rule, the most popular programmes undertaken by most African leaders were the visible ones such as bureaucratic ‘Africanisation’, building of schools and hospitals, land re-distribution, nationalisation of companies owned by foreigners and elaboration of state-owned parastatals (Chabal, 1994; Ndegwa, 1998). Some of these registered good developmental outcomes, which analysts believe were enough to give legitimacy to postcolonial governments even under conditions of limited civil and political rights. For instance in Kenya, land distribution and supportive agriculture policies reduced rural absolute poverty from 50% at independence to 25% by 1980 (Ndegwa, 1998:356). Similarly health and education policies contributed to gains in the health indices whereby, between 1963 and 1980, life expectancy rose from 42 to 58 years, while child mortality rates fell by more than half, from 200 deaths per 1,000 births to 83 (Ndegwa, 1998:358). Under the guise of nationalism, some African leaders used social services like primary and secondary education to garner people’s support for their regimes. Education reforms under the 1967 Education for Self Reliance (ESR) in Tanzania explicitly placed education at the centre of nation building but history classes were used as “a tool of inculcating Nyerere’s ideas of non-racial socialism” (Bertz, 2007:173). This strategy was not only among African leaders. Corbridge and colleagues (2005:50 citing Hunter 1996) illustrate a similar process in European states where, in countries like Prussia, government schools were promoted “as means of the mass moral training of the population with a view of enhancing the strength and prosperity of the state...” This
aimed at cutting people’s identification with sub-national social organisations like ethnic groups in favour of the national state.

More recently, scholars have argued that the analysis of the relationship between public services and legitimacy needs to make a clear distinction between *quality* in service provision and *visibility*. Rockers and colleagues (2012) suggest that what matters for people’s trust in the health system and government generally are not the inputs such as personnel and budgetary allocation, rather it is the health system performance [i.e. quality and responsiveness] and health outcomes [e.g. improved health]. In part, they believe that “the levels of these inputs, and the government policies that determine those levels, may simply be unknown to the public, and therefore factor little into public perceptions of government” (Rockers et al., 2012:427). Employing multilevel regression models to cross-national data from 38 low and middle-income countries world participating in the World Health Surveys, these scholars find that individuals who reported a higher technical quality of health care were significantly more likely to trust the government (2012:427). Indeed, it makes sense that if people’s experiences at the delivery point are not good, they may withdraw their trust in government (Gilson, 2003).

In Nigeria, Eldon and colleagues (2008) compared the delivery of health services in the state of Kaduna and Enugu. In Kaduna state, most respondents claimed, the improvement of services quality helped to increase their level of confidence and trust in the state’s MoH. Meanwhile, in Enugu state health services were of poor quality, inequitable and fragmented, and unrelated to community priorities. In response, citizens’ perceptions of the state’s MoH and the state government as a whole were generally negative as most respondents felt that the state had little commitment both to good services and to the population (Eldon et al., 2008).

The focus on legitimacy cannot be completed without asking the crucial question of who provides the services (Eldon et al., 2008). According to Van de Walle and Scott (2011) it is important that the state itself delivers services in order to guarantee ‘standardisation’. The argument is that standardisation enables citizens to acquire uniform experiences from the state, which in turn aids their identification with it. In the European experience, from which Van de Walle and Scott (2011) write from, it is indicated that standardisation involved several aspects ranging from provision of identical infrastructural designs for
schools and hospitals, having an integrated school curricula and similar standards of operation in health facilities plus other government agencies. There is some evidence that when citizens feel that they are not being treated equally, they lose confidence in the state (Brinkerhoff et al., 2012).

Most recently Hurrell and MacAuslan (2012) have investigated this issue by comparing several social protection programmes implemented by GoK and those implemented by NSPs in Kenya. Although no quantitative figures are given to support their claims, the authors reported that where programmes were handled by NSPs “for the most part, these programmes are associated in most people’s minds with external agents such as the British government or NGOs, or the Equity Bank which delivers the [cash] transfers” (2012:266). Meanwhile the orphans and vulnerable children (OVC) cash transfer programme that was implemented by GoK was allegedly “associated to some extent with the Government, and there is slight evidence for the beginnings of a realisation that the Government could be the provider of resources” (ibid). Basing on such observations, these authors concluded that those accruing credit or symbolic power from these programmes are, therefore, the implementing organisations.

However, others scholars insist that NSP can serve to enhance state legitimacy if the Government can establish itself as responsible for and organizing the (well executed) contributions of other actors (Batley and Mcloughlin, 2010). In Kenya, Brass (2010a) did not find a negative effect of NGOs on state legitimacy. She reported that:

People who have sought out NGOs for a good or service within the year prior to the survey do not have statistically different views of government than those who haven’t and there does not appear to be a “transfer” of legitimacy affect [sic] from government agencies to NGOs – meaning that people who view NGOs very highly do not view government less favourably (Brass, 2010a: not paginated).

The recent position by some scholars is that the impact of NSPs on state legitimacy is context specific and that it depends on the particular relationship between the state and those NSPs (Cammett and MacLean, 2011). According to Tsai (2011), it is co-production relationships between the state and communities that offer great promise. She reports that in rural China, local state officials opined that co-producing services with community groups is beneficial to state authority because it encourages citizens’ compliance with
state demands, which otherwise would be difficult to enlist with local officials working on their own (ibid).

2.4 Service delivery and citizenship formation

T.H. Marshall, in his influential essay *Class, Citizenship and Social Development*, provides one of the earliest conceptualisations linking service delivery to citizenship formation. Marshall (1963) argues that citizenship is not complete without ‘social rights’\(^3\) because social services facilitate citizens to exercise their civil and political rights. Put differently, Marshall’s argument is that social citizenship rights are necessary for what we identified earlier as substantive citizenship, as opposed to merely formal citizenship. Allied with Marshall, Van Gunsteren indicates that without public services the poor would be compelled to forego critical components of citizenship, in particular, independent political judgment and action, by for instance selling their votes for the sake of securing “maintenance of their lives, sustenance and other elementary necessities” (van Gunsteren, 1994:37). Thus, similar to the previous section which has argued that service delivery aids state building, citizenship analysts portray services as a tool that can be used to remove the barriers to having an independent, knowledgeable and active citizenry (Krishna, 2007; van Gunsteren, 1994; 1998). Drawing mostly from developed countries’ welfare regimes, however, some scholars have argued that service delivery is a double-edged sword because it can both impact on citizenship positively or negatively. This is especially true when one focuses on the process of service delivery itself, which, it is claimed, influences some of the following citizenship outcomes: beneficiaries’ trust, self-confidence, civic engagement and/or political participation. Below, these aspects are discussed in detail.

2.4.1 Service delivery and the development of citizens trust

Although our discussion on the relationship between service delivery and state legitimacy touched on the issue of citizens’ trust, it did little to explain how trust develops. Moreover, scholars argue that service delivery impacts on trust is in two areas a) citizens’ social trust, which is understood in terms of service users’ generalised trust in other people and b) confidence in government (Kumlin and Rothstein, 2005; Wichowsky and

\(^3\) According to Marshall (1950:13) Social rights denote ‘the right to a modicum of economic welfare and security’.
Trust is a key ingredient of citizenship because it influences whether and how citizens interact with the state and with each other. It is claimed that beneficiaries’ experiences with delivery agencies convey messages about their worth as citizens, which in turn affect their orientation towards government and/or fellow citizens (Campbell, 2003; Kumlin and Rothstein, 2005; Schneider and Ingram, 2007; Tendler, 1997). Some observe that, in particular, people draw lessons from procedural justice in delivery organisations; that is to say, perceptions of whether the delivery system is fair, treats users with respect and dignity, and allows them to air their views about the programme (Kumlin and Rothstein, 2005; Levi et al., 2009). Where beneficiaries suspect unfairness in procedural justice, Kumlin and Rothstein (2005) predict, they engage in improper acts, such as falsifying or withholding vital information, to secure admission or retention in the programme. It is also claimed that these experiences may then affect beneficiaries’ perceptions about the trustworthiness not only of other state agencies but also of fellow citizens (Gilson, 2003). According to Kumlin and Rothstein, beneficiaries can for instance ask themselves: if service providers act in such a way that they cannot be trusted, why should people in other public agencies be trusted? Similarly, “if citizens, to get what they themselves deem necessary from public services, have to engage in cheating, distorting vital information and other forms of dishonest behaviour, why should people in general be trusted?” (2005:349). Rockers and colleagues’ (2012) study, alluded to in the previous section, found that persons who claimed that health providers treated them unfairly were less likely to have trust in the state. Furthermore, respondents who perceived the health care system to be responsive were more likely to trust the government, as were persons who felt involved in the design of their country’s health care system (ibid).

In a related perspective, Swidler and Watkins (2009) draw our attention to the “hidden curriculum” of development programmes. These scholars, like Kumlin and Rothstein (2005), believe that beneficiaries pick important lessons at the point of delivery which might permanently shape their character. Hossain’s (2010b) study of Primary Education Stipend Programme in Bangladesh reported that this programme provided children with incentives “to cheat the system, and to do so with the sanction of the school authorities” (2010b:1275). According to Hossain, some teachers altered students’ attendance records and exam performance to enable them to continue receiving the stipend that they should
otherwise have lost according to the programme rules. Consequently, Hossain concludes, the programme “is not only failing to ‘discipline’ children into school attendance and improved performance, it is also teaching them the lesson that it is possible and acceptable to local authorities to cheat in order to access public resources” (2010b:1276). The implications of SD-NGOs for citizens’ trust are similar to those discussed above in relation to state legitimacy, hence will not be further considered here.

2.4.2 Service delivery and the development of beneficiaries’ self-confidence

Through what she calls ‘political efficacy’\(^4\), Soss (1999) claims that service delivery can impact on beneficiaries’ self-confidence. This occurs in two ways. The first is that service delivery programmes can impact on beneficiaries’ ‘external efficacy’ – meaning government’s responsiveness to ‘people like them’, and secondly on their ‘internal efficacy’ – the belief in their own ability to make a difference politically (Mettler, 2007). The nature and degree of beneficiaries’ self-confidence at service delivery points can be understood through the work of Hirschman (1970). According to Hirschman, citizens can express themselves through exercising voice, they can exit and/or they can be loyal to the delivery agency. ‘Exit’ simply means the ability of service users to “vote with their feet” whenever they are not satisfied with the service arrangements in a particular delivery agency. Although ‘exit’ is lauded by some political and development analysts as evidence of beneficiaries’ agency (see, World Bank, 2004), to others it is an inferior form of expression. This is because exit essentially means “escape from an objectionable state of affairs” (Hirschman, 1970:30). Others submit that ‘exit’ has analytic purchase where there is a vibrant private sector and thus has little relevance in public sector contexts where there is no much choice of providers (Corbridge et al., 2005; Joshi, 2008). ‘Voice’ refers to the capacity of beneficiaries to articulate their discontent whenever they are dissatisfied. Hirschman (1970:16) contends that voice “can be graduated, all the way from faint grumbling to violent protest; it implies articulation of one’s critical opinions” with the intention of forcing a change from management. Corbridge (2007) emphasises the need for understanding the ‘faint’ manifestation of voice especially for studies investigating these issues in the context of developing countries where the freedom of expression maybe greatly constrained. ‘Loyalty’ means a special bond or personal attachment to the

\(^4\) Political efficacy refers to “the feeling that one’s activities can influence the political process and that it is worth making the effort to get involved” (Soss, 1999:369).
delivery agency which arises when service users are satisfied with the agencies from which they receive public services. In its original conceptualisation, loyalty relates closely to the concept of performance legitimacy that was described earlier in this chapter. However, as Corbridge and colleagues (2005) remind us, the conditions in many developing countries where no viable alternative sources of services exist mean that even when services are poor many poor people are unable to “vote with their feet”. In this regard, those who are forced by circumstances to put up with ineffective agencies should not be mistaken for loyal clients, rather, they are conforming (MacLean, 2011).

In line with the observations of Soss, Hirschman and others, several scholars have probed further to understand what influences people’s ability to express voice in different service delivery programmes. The overall impact of public services programmes on citizens’ self-confidence, Schneider and Ingram (2007) claim, largely depends on how policies socially construct the target population. The social construction of target populations is “the cultural characterizations or popular images of the persons or groups whose behaviour and well-being are affected by public policy” (Schneider and Ingram, 1993:334). Constructions include, among others, images like deserving, intelligent, honest, public-spirited, dishonest, and selfish. Social constructions depend on the political power of the target population (e.g. votes, wealth, and propensity of the group to mobilize for action) and also on the extent to which the general public approves or disapproves the policy's being directed toward that particular group (Schneider and Ingram, 1993). The combination of beneficiaries’ political power and public’s approval produce four main categories of target populations – the advantaged, dependents, contenders and the deviants. According to Schneider and Ingram;

*Advantaged* groups have high levels of political power resources and also carry a strong positive social construction. *Contenders* are powerful but are negatively constructed; *dependents* are socially constructed as “good” people, although weak or even helpless and they lack political power resources; *deviants* lack political power and are very negatively constructed (Schneider and Ingram 2007:339).

It is argued that these constructions will shape what and how, and by whom and for whom, social services and benefits are delivered (Gilson, 2003). Thus some groups either have their welfare needs ignored by state agencies or have them met to some extent but
in a stigmatising or residual manner. This observation shows that there is a hierarchy in the way target groups are included in public service programmes. Gilson, basing on her health sector experience, notes that unfavourable constructions lead “providers to adopt harsh and uncaring attitudes towards particular patient groups that are demeaning and undermine the quality of patient interactions with the health system” (2003:1460). A good example here is in the HIV/AIDS field where AIDS sufferers, in most societies, are often regarded as undeserving social deviants being ‘punished by God’ for their promiscuity (Joffe, 1995; Robins, 2006). In effect, programmes targeting PWAs are usually associated with stigmatising modes of delivery. Overall, providers’ practices here can promote beneficiaries’ engagement, passivity, or alienation (Wichowsky and Moynihan, 2008).

Besides the social construction thesis, other scholars have indicated that at the local level, expression of voice or exit, in part, depends on whether there are clear channels and mechanisms through which beneficiaries can provide feedback to the programme administrators and the design features of such mechanisms (Hurrell and MacAuslan, 2012). Hurrell and MacAuslan’s analysis of several social protection programmes in Kenya finds that if those involved in collecting or hearing the complaints are those formally associated with the programme, “it naturally makes attempting to complain extremely difficult” (2012:267). Relatedly, Joshi (2007b; 2008) reports that most of the formal grievance redress mechanisms, in service delivery programmes, are hinged on individual citizens’ ability to exercise agency rather than on collective action. Furthermore, such mechanisms are costly for poor people in terms of time and likely exposure, hence they tend to be avoided (ibid).

Local power dynamics are also a key influence in people’s choice of how they express themselves. In settings where patron-client relations are pervasive, maintaining good relations with the powerful individuals can be critical for the poor (Cornwall et al., 2011). Thus, if the powerful are the programme administrators, making complaints about programmes may not be a good strategy (Hurrell and MacAuslan, 2012). On this we can add that prohibitive social norms, such as the “strongly ingrained respect for and deference to authority, leadership, and elders” in Africa, can limit the degree to which programme beneficiaries can express themselves (Ringold et al. 2012, Tembo 2012).
As discussed in Chapter One, SD-NGOs are largely excluded from empirical analysis regarding the impact of their work on citizens’ voice in relation to the state, as this is assumed to be a speciality for advocacy-focused NGOs. The limited evidence available paints a gloomy picture that depicts SD-NGOs as a hindrance to citizens’ voice. For instance, Swidler and Watkins’ (2009) research in Malawi indicates that by encouraging communities to ask for funding for things which donors, including government and international agencies, consider appropriate, SD-NGOs undermine the agency of their communities and teach them to be subservient to the powerful. Robins and colleagues add that “teaching citizens the ‘ways of the state’, in order that they may be more compliant to the state, inevitably ends up undermining cultural autonomy” and may foreclose the potential for “political agency, for protest, disruption and efficacy in getting the things people demand” (2008:1083-1084). Crucially, however, Robins and colleagues do not completely rule out the possibility for positive outcomes because “training people for citizenship may both ‘domesticate’ them as well as educate and empower them; there is no political inevitability or teleological trajectory to this process” (2008:1083).

2.4.3 Social services and civic engagement of beneficiaries

It is claimed that service delivery programmes can influence the degree to which their beneficiaries engage in civic activities beyond the programme. Mettler (2002; 2007) illustrates this in her analysis of the American Servicemen’s Readjustment Act of 1944, also dubbed the ‘G.I Bill of Rights’, which extended numerous social benefits, including higher education and vocational training, to returning veterans of World War II. She explains that programme beneficiaries engaged in civic activities later in their lives as a form of paying back to the community. Beneficiaries became active in civic life, Mettler argues, because they felt grateful for what they perceived as a highly generous and life-transforming benefit that changed the subsequent course of their lives (ibid). Coming from a different angle, Robins (2004; 2006), in his numerous accounts of PWAs activism in South Africa, argues that the health transformation witnessed by AIDS sufferers, due to ART treatment, coupled with opportunities for engaging in public awareness campaigns of delivery agencies, leads PWAs to transit from being mere sick members in the community into activists on HIV/AIDS issues at local, national and sometimes international levels.
As noted from the previous section, the success of social delivery programmes dictates that a great deal of beneficiary involvement is promoted in such programmes. In some countries this has been recognized by establishing formal participatory spaces where citizens are invited to contribute towards defining the package of what is provided and how services are delivered. Popular examples here include Brazilian Health Councils (Coelho, 2007), Health Watch Committees (HWCs) in Bangladesh (Mahmud, 2007) and a variety of Health Facility Boards in countries like South Africa. It is claimed that in some contexts, such ‘spaces’ can create opportunities for citizens to learn civic skills and enhance their sense of obligation to the polity (Citizenship DRC, 2011; Cornwall and Coelho, 2007). Some argue that NGOs can train citizens to occupy these spaces. In Bangladesh, for instance, Mahmud (2007) reports that Nijera Kori (NK), an experienced NGO, played a key role in helping the government in mobilising and training villagers into HWCs which were more ‘successful’ compared to those mobilised by state agents.

2.4.4 Social services and beneficiaries’ political participation

Although there is some consensus that service delivery programmes can influence beneficiaries’ political engagement, how this happens in practice is not clearly spelt out. Some argue that the resources extended by programmes create material incentives for citizen mobilisation in the sense that individuals affected by the programme may become active on related political issues, presumably to protect or expand benefits (Mettler and Soss, 2004; Pierson, 1993; Skocpol, 1992). Campbell’s (2003) study of the impact of United States’ Social Security and Medicare programmes on the political activity of senior citizens illuminates this point. To Campbell, senior citizens were not always politically active: “In the 1950s, when Social Security benefits were modest and covered only a fraction of seniors, the elderly participated at lower rates than younger people” (Campbell, 2003:2). However, when the programme’s package was improved, it “provided the once marginalised senior population with politically relevant resources like income and free time” which catapulted them into becoming the most politically active segment of the population (ibid). It is reported that the incentives provided by this programme turned beneficiaries into a formidable political constituency that mobilised to garner critical support for the programme's further expansion in the 1970s and for staving off threats to it during the 1980s, when it experienced financial difficulty (Campbell, 2003).
A related point is that some programmes can draw the attention of politicians who are interested in courting the support of beneficiaries. A systematic review of the literature by Campbell (2008) identified three main factors that determine whether a particular program-based group definition becomes politically salient and the basis for mobilization:

(i) beneficiaries’ socio-economic status,
(ii) visibility of the group, and
(iii) stability of the programme.

Due to the centrality of these factors to this study, they are further elaborated below.

Literature focusing on Western democracies shows that political participation is more common among individuals of high education and socio-economic status (Campbell, 2003). It is therefore hypothesised that if the programme beneficiaries are the elderly, orphans and others marginalised groups, these can have difficulties in forming a formidable political constituency and may therefore not attract the attention of politicians. For instance, in Kenya, Hurrell and MacAuslan attributed the low political mobilisation from one of the social protection programmes to the fact that its beneficiaries were mostly nomadic pastoralists in northern Kenya, a marginalized group “that has tended to stay outside most domestic politics and has little leverage to make large demands” (2012:268).

By visibility, Campbell (2008) refers to the size of the target group. It is alleged that when the proportion of households in a given community targeted by the social service programme is small, it makes community-level organization difficult (Hurrell and MacAuslan, 2012). In contrast, in the Indian state of Maharashtra, significant mobilisation in the form of marches, sit-ins, sieges of government offices and court action has occurred around the Employment Guarantee Scheme (EGS) (Joshi and Moore, 2000). This is mainly because it targets a large group of unemployed adults, has substantial benefits including a minimum wage guarantee, it is constitutionally guaranteed and requires mobilisation for inclusion. In sum, Joshi and Moore reveal that the size of the “EGS contributes to the political mobilisation of the poor in Maharashtra; and … that mobilisation in turn is central to the effective implementation and longevity of the Scheme” (2000:37).
However, Joshi and Moore’s analysis of the EGS also draws attention to the role of the political context and the underlying political tradition of a given country. India, for instance, has a relatively institutionalised constitution, hence it is “possible to mobilise around the EGS without provoking repression” (Joshi and Moore, 2000:43). Contrastingly, many scholars observe that most African countries have a weak political tradition of making claims and demands on the State (Hurrell and MacAuslan, 2012; Ndegwa, 1998).

Stability, as identified Campbell’s (2008), relates to the longevity of the programme. Some argue that social service programmes achieve a stable character when they are established by legislations which oblige governments to implement them (Joshi and Moore, 2000). This observation suggests a close link between the stability of programmes and the political tradition of the country as discussed above. According to Joshi and Moore, a stable programme “makes it worthwhile for [politicians] to invest in developing their knowledge of the scheme in order to become more effective intermediaries between poor people and the public bureaucracy” (2000:45). However, most service delivery programmes in Africa are introduced to communities in forms which provide an impression that these are unexpected gifts from the Government, not to be demanded but cherished while they are available (Hurrell and MacAuslan, 2012). Put differently, programmes emerge as privileges dispensed by a ‘generous’ state rather than a negotiated outcome of state-society interaction (Ndegwa, 1998). Service delivery programmes in Africa also tend to be personalised both in terms of the giver and the receiver such that in order to obtain resources people make personal and individual representations as opposed collective demands (Hurrell and MacAuslan, 2012). The implications here are that government can easily withdraw from delivering services as it is under no obligation to maintain them. According to Ndegwa, “[a] sovereign who invents and dispenses rights to subjects can equally take them away; but when citizens assert their rights and assign them to a sovereign to safeguard, these rights are difficult to withdraw” (1998:352).

Questions of who delivers services once again appear to be influential here. Some argue that when services are delivered by non-state actors like NGOs or through other state-avoidance mechanisms, like ‘social funds’, people have no moral or legal basis to compel these institutions to deliver what they promise (Joshi and Moore, 2000). According to
Hurrell and MacAuslan, “‘rights’, in these cases, are more akin to consumer rights, and do not extend to citizenship rights” (2012:263). Wood (1997) makes similar claims adding that when states ‘franchise’ service provision responsibilities to NGOs, there is a risk that citizens lose basic political rights especially that non-state providers become accountable to the state rather than directly to those who receive the services. Moreover, MacLean (2011), in her recent research on citizenship, uses Afrobarometer data from 18 African countries, including Uganda, to show that people in contact with state agencies such as schools or hospitals were the most likely to “exercise citizenship” compared to their counterparts who accessed services from private providers. Joshi and Moore’s (2000) analysis of the project for the construction of rural drinking water infrastructure in the Lumbini zone in Nepal, however, leaves room for the possibility that external organisations such as NGOs can have a positive contribution by mobilising for joint-venture projects involving NGOs, the state and communities. They argue that this is possible where the NSP is credible in the eyes of the community (especially through demonstrable experience), promotes stable programmes (not short-term and erratic activities), and works in close links with the state (ibid).

2.5 Discussion and Conclusion

One of the main points from this chapter is the relational character in the dimensions of state capacity. The effectiveness of the bureaucracy is greatly influenced by the degree of its embeddedness with civil society. Moreover, it is also dependant on the infrastructural reach of the state in society. Yet, this chapter has also showed that the state’s infrastructural reach can greatly be enhanced by the entwining of state organisations and civil society’s (embeddedness). For their part, citizens are more likely to enter collaborative engagements with the state when the latter is perceived as a legitimate institution. It is when state agencies provide services in respectful and professional ways (both key indicators of bureaucratic capacity) that citizens get the message that the state cares about them and it is worthy their trust. Having noted this, however, there appears to be a tension between achieving a Weberian bureaucracy and embeddedness at the same time. This is because bureaucratic ideals seek to shield state agencies from societal influence (vested interest) and yet embeddedness seeks to open up the state to societal input. Although Evans (1995) claims that a right balance between autonomy and embeddedness can easily be struck by state agents, via the so-called embedded
autonomy, it is not very clear how this might play out in programmes initiated by CSOs, such as MTP that is the focus of this study.

The claim that social services can influence political processes of citizenship and state building is an appealing one. However, a cursory look at this chapter also reveals that most of the alleged links are often flagged as empirical questions to be explored rather than strongly evidenced. Moreover, a huge chunk of the literature that is currently available emanates from industrialised countries, with an apparent dearth of primary empirical evidence in the context of developing countries (Cammett and MacLean, 2011; Kruk et al., 2010) – a notable exception here being the recent attention by international agencies to building “conflict and fragile states” (Batley and Mcloughlin, 2010; Brinkerhoff, 2010; Eldon et al., 2008; Pearson, 2010). Yet as observed by Mcloughlin and Batley (2011:31) “state-building is not only a process that occurs in the aftermath of conflict and collapse but is also a continuous process in all states as they accommodate to changing environments and interactions with other states”. Therefore, further empirical analyses to probe the alleged political effects of service delivery on state and citizenship building from the perspective of ‘stable’ developing countries are needed and it is hoped that the current study will contribute to this cause.

Also relevant for our study is that the role of SD-NGOs in the processes of state building and citizenship formation is not clearly understood. According to this chapter, currently, the debate is polarized with one group of scholars showing some evidence that social services necessarily have to be produced by the state itself if they are to have any positive impact on state building and citizenship formation. However, others illustrate instances where provision by NSPs has acted as an avenue for the extension of state capabilities and/or earning legitimacy for the state. Some have thrown the possibilities open that it depends on the particular relationship that NSPs have with the state (Cammett and MacLean, 2011; Tsai, 2011). The particular kinds of relationships that are useful in this case are not fully explored. Secondly, it is also unclear which of the two processes SD-NGOs are better positioned to nurture: is it building states or constructing citizenship? Thirdly, do gains in one aspect preclude advancement in the other or is such that the two processes are mutually reinforcing?
Lastly, the concept of islands of excellence (IOEs) seems to provide a useful starting point for NGOs interested in building state capacity and promoting citizenship. Some argue that since the creation of IOEs was a central strategy in establishing developmental states in Western countries (DFID, 2009; Leonard, 2010), then they might offer a viable approach for state building in the South (Therkildsen, 2008). In the West, departments in charge of strategic functions, such as revenue collection and the military, were usually provided extra protection to implement reforms with the experience got being used to improve the other inefficient bureaucracies (DFID, 2009). In this study our interest is in investigating two issues: 1) whether TASO succeeded in establishing MTPs as IOEs within government hospitals in rural Uganda, and 2) whether MTPs had dispersal effects to other state agencies in districts where the project was implemented.
CHAPTER THREE
The Politics of Service Delivery, State and Citizenship Building in Uganda

3.1 Introduction
This chapter offers the contextual background information about Uganda that is important for the analysis in the next four chapters. The chapter examines the main factors that have shaped service delivery, state building and citizenship formation (henceforth SSC) during Uganda’s postcolonial period. Since gaining her political independence from Great Britain in 1962, Uganda has had eight changes of government, seven of which happened within the first 24 years (1962-1986). This implies that some governments were too short-lived to implement any coherent policies. This, combined with the limited availability of documentary evidence on their policies, implies that short-lived governments, especially those that did not make at least five years in office, could not be given detailed analysis. Thus, for purposes of this study, the post-independence history of Uganda is divided into four periods as shown in Table 3-1.

Table 3-1: Uganda Governments since 1962

<table>
<thead>
<tr>
<th>No.</th>
<th>Period</th>
<th>Head of state</th>
</tr>
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<tbody>
<tr>
<td>1.</td>
<td>1962 – 1971</td>
<td>Milton Obote I</td>
</tr>
<tr>
<td>2.</td>
<td>1971 – 1979</td>
<td>General Idi Amin</td>
</tr>
</tbody>
</table>

* denotes up to the time of fieldwork not the end of the regime

The chapter is accordingly structured along this periodization. In the first period (1962-1971), the chapter shows that SSC policies in the regime of Milton Obote I were mainly influenced by the legacies of colonialism that it inherited. Although the government of Idi Amin is notable for being the least concerned about SSC, seen in its record of brutalising citizens, presiding over the deterioration of the economy and collapse of the public sector, this chapter finds that there are some positive, albeit heretofore scarcely discussed, aspects of this regime that offer important lessons for SSC. The period 1980-1985, also known as Obote II, was highly ambiguous and was characterised by erratic policies that, on the one hand, aimed at containing the economic meltdown inherited from its predecessors and, on the other, responded to multiple rebel insurgencies which
sprung up following the disputed elections that brought it into power. The fourth period (1986-2011), discusses the NRM government which, many say, has managed to hold onto power with a conspicuous combination of authoritarian and democratic elements. Here, the chapter shines a spotlight on three main policy areas of the regime, namely, political and administrative decentralisation, poverty reduction, and of particular relevance to this study, the management of HIV/AIDS. Generally, the chapter finds that although SSC were shaped differently within the various governments under review, positive or negative outcomes were largely an issue of state-society relations.

3.2 Milton Obote I and the challenge of independent Uganda (1962-1971)

The main political events that shaped the regime of Milton Obote I are summarised in Table 3-2.

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>1894</td>
<td>Uganda is declared a British Protectorate.</td>
</tr>
<tr>
<td>1961</td>
<td>Two political parties, Uganda People’s Congress (UPC) and Kabaka Yekka (KY) form a coalition aimed at defeating the Democratic Party (DP) in the run up to the independence elections.</td>
</tr>
<tr>
<td>1962</td>
<td>Uganda gets independence, with Milton Obote as Prime Minister and the King of Buganda as honorary President. Self-government from the British is organised around a semi-federal arrangement.</td>
</tr>
<tr>
<td>1966</td>
<td>Inherent contradictions cause UPC and KY alliance to breakdown. The ‘divorce’ is cemented by a military invasion of the King’s palace at Mengo.</td>
</tr>
<tr>
<td>1967</td>
<td>Elections are suspended and Uganda is declared a republic with Obote as its Executive President.</td>
</tr>
<tr>
<td>1971</td>
<td>Obote’s UPC is ousted through a military coup led by Army Commander General Idi Amin.</td>
</tr>
</tbody>
</table>

This section argues that the legacies of colonialism affected the ability of the first government to formulate and promote viable SSC policies. In particular, the following three legacies of colonial rule were salient: 1) high social differentiation, 2) inadequately developed state bureaucracy, and 3) urban-centric state machinery with tenuous
penetration of the periphery. The section also argues, however, that post-colonial leaders made some miscalculated decisions which exacerbated SSC challenges during this period.

3.2.1 Social differentiation and the challenge of citizenship construction

At the time the British established a protectorate in 1894, present-day Uganda was a region inhabited by numerous ethnic groups at different stages of social, economic and political development. Politically, the southern groups such as the Baganda, Batoro, Banyoro and Banyankole had established sophisticated systems of organisation in the form of kingdoms, as compared to their northern and eastern counterparts who were considered ‘stateless’ societies due to the absence of similar hierarchical systems. Instead, theirs were organised in an egalitarian fashion along smaller political units like clans and lineages (e.g. see Jones, 2009 on the Iteso in eastern Uganda). Due to the limited human resources on the part of the colonialists, some argue, ‘indirect rule’ was proposed as the most viable political system for establishing effective control over these diverse groups (Roberts, 1962). This was to be effected through a centralised and hierarchical administrative system that the colonialists had observed in Buganda – characterised by the King at the top and assisted by an elaborate hierarchy of chiefs appointed to head Gombolola (county), Ssaza (sub-county) and Muluka (parish) (Kabwegyere, 1974; Kiwanuka, 1970). In order to operationalise this, the colonialists, in what Odoi-Tanga (2009) calls ‘ethnic compartmentalisation’, merged several of the smaller kingdoms and ‘stateless’ societies to create bigger social groups amenable to the Kiganda administrative system (see, Apter, 1961; Burke, 1964; Jones, 2009; Mamdani, 1983; 1996). The result was four Native Administrative authorities/provinces for the Protectorate, namely, Buganda/Central, Eastern, Western and Northern Province. It is argued that indirect rule, and the manner in which it was introduced in the different parts of Uganda, had several adverse effects on citizenship formation. Due to space limitation, however, only its main implications are discussed below:

As different tribes were amalgamated to form native authorities, experts indicate, a huge problem was created in form of minority groups who felt subjugated by the majority social groups. In western Uganda, for instance, the Bakonzo and Bamba were at great disadvantage vis-à-vis the majority Batoro and allegations of land grabbing, language exclusion, job discrimination and/or exclusion from public service provision were voiced
by these minority groups (Golooba-Mutebi, 2008a; Kabwegyere, 1974). Similarly, in eastern Uganda, the Bagisu are said to have enjoyed more advantages than the Sebei people (Golooba-Mutebi, 2008a). Although their grievances were suppressed throughout the colonial period, when the country attained independence, many of these groups demanded to break away from their ‘oppressors’ to reclaim their citizenship rights (Golooba-Mutebi, 2008a; Mamdani, 1996; Mutibwa, 1992).

It is also argued that under the arrangement of provincial administration, citizenship was defined according to ethno-territorial demarcations rather than membership to the nation Uganda (Kabwegyere, 1974; Mamdani, 1996). Consequently, this meant that the colonised populations achieved national independence organised as “ethnic and tribal communities with immutable interests and collective rights... rather than as individuals and free citizens” (Kabeer, 2002:96). This explains the entrenched attachment of citizens in postcolonial Uganda to what Ekeh (1975) calls the “primordial public” compared to their attachment to the nation state (Kiwanuka, 1970; Mutibwa, 1992).

Another key point here is about the position of Buganda in Uganda’s politics. In part, having played a pivotal role in the military expeditions which extended colonial rule to the different parts of Uganda, the British rewarded Baganda officials by appointing them as caretakers of the newly manufactured administrative units and to act as ‘tutor mechanics’ for the locals to become natives chiefs at a future date (Jones, 2009; Kabwegyere, 1974; Mamdani, 1996). The problem, however, was that these chiefs wielded despotic powers, whereby all functional state powers (executive, administrative, legislative, and judicial) were fused in the person of a single state agent (Mamdani, 1996). With such unchecked powers, the chiefs were “arrogant, overbearing, greedy, conceited, delight in asserting themselves, and generally “show off”” (Kabwegyere, 1974:82). Jones (2009) and Roberts (1962) elaborate this more vividly with the ‘Bakungulu’ contingent that operated in Eastern and Northern Provinces. Due to their poor behaviours and the fact that the colonialist favoured Buganda in other respects, Baganda chiefs received negative reception in other provinces, and unsurprisingly, revolts against their rule were a common occurrence. The Banyoro were particularly resentful, and not without cause: apart from Baganda armies helping the British to crush Bunyoro resistance against colonial rule, the colonialists also rewarded Buganda sizeable portions of Bunyoro land and the residents
were made tenants of Buganda King (the Kabaka) and his chiefs (International Crisis Group (ICG), 2012; Kabwegyere, 1974). People in these so-called lost counties dreaded the mistreatment that their Baganda landlords subjected them to (Dinwiddy, 1981). Therefore, whereas the Baganda wished to consolidate their privileged position upon the departure of colonialists, people of other tribes looked forward to putting this to a quick stop (Kiwanuka, 1970).

Fast forward to independence, the success of Obote’s government depended on how it addressed the above challenges. Some observe that Obote’s first administration “displayed clear signs of an inclusive nation-building project, evident in attempts for political and economic power sharing” (Lindemann, 2010:20). Buganda, at least for a while, was accommodated when Obote’s UPC made an alliance with Kabaka’s KY to form the independence government (see Table 3.2). On the economic front, the government tried to deliver to its citizens the critical public services. From 1962 through the early 1970s, Obote’s government either heavily subsidised or provided free of charge both higher education and health care delivery at all levels (Dodge and Wiebe, 1985; Gukiina, 1972; Passi, 1995). Like some African leaders, such as Julius Nyerere of Tanzania, Obote regarded education as the “most effective foundation for building a nation around national institutions” (Gukiina, 1972:145). In the first decade of independence, the number of senior secondary schools admitting Africans rose from 19 schools in 1958 to 73 schools by 1970, serving over 40,000 students (Heyneman, 1983; Jorgensen, 1981). Similarly, between 1962 and 1970, the population per physician ratio reduced from 1:15,000 to 1:9,200 (Warnock and Conway, 1999).

The progress on the social services front notwithstanding, many argue that Obote’s government failed to address the central concerns of the various social groups in a convincing and/or conclusive manner. For instance, because the government was keen at forming a unified nation of Uganda, pleas by some groups to be granted their own administrative units so as to break away from their ‘oppressors’ were ignored by the state. Hence, some of these groups were left with no option but to resort to political sabotage as evidenced by the Bakonzo and Bamba in western Uganda who made an alliance to form the Rwenzururu Movement that initially protested the Toro Monarchy, and later battled the central government from 1962 until they were granted a separate
district in 1980 (Mamdani, 1996). The Banyoro used similar tactics to force a return of their lost counties from Buganda. Moreover, Obote’s decision to grant a referendum to settle this issue in 1964 had deadening effects on his party’s fragile coalition with pro-Buganda KY and this was a precursor to the 1966 battle of Mengo in which government troops invaded Kabaka’s palace (Dinwiddy, 1981; Jorgensen, 1981; Lindemann, 2010).

3.2.2 Weak bureaucratic capacity

By 1961, just a year before to independence, the bureaucratic apex of Uganda was still exclusively occupied by the departing colonial officers. Senior positions, such as Permanent Secretaries and head of departments in all ministries, were still headed by whites (see Table 3-3). It is reported that even middle-level management (two grades from the top) was under their control. It was only in the lower ranks that Africans and Asians had some presence, with a combined composition of 50% vis-à-vis whites (Kabwegyere, 1974).

<table>
<thead>
<tr>
<th>Grade</th>
<th>Whites</th>
<th>Africans and Asians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top</td>
<td>100%</td>
<td>–</td>
</tr>
<tr>
<td>Middle grades</td>
<td>84%</td>
<td>16%</td>
</tr>
<tr>
<td>Below executive</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

Source: Extracted from Kabwegyere (1974:197)

Sector specific data also reflected a similar picture. According to Furley, by 1962 more than 90% of the teachers in secondary schools were white ‘expatriates’ (1988:177). After discovering that it had done little preparation to handover administrative power to nationals, the colonial administration recommended that: “to avoid discontinuity of basic services the “expatriate” [staff] should be retained for some time so that some Africans could train to fill high ranking posts” (Kabwegyere, 1974:197). Many argue, however, that upon independence the new government got preoccupied with the less important aspect of replacing expatriates with nationals as opposed to the more fundamental issues of the structure and values that the bureaucracy in independent Uganda should possess (Burke, 1964; Burton and Jennings, 2007; Kabwegyere, 1974). Indeed, a critical look at the government’s programme of ‘Ugandanising’ the bureaucracy brings out this point. It is argued that far from transforming the civil service to fit local conditions, the reforms here were more about:
upholding the colonial attitudes and standard operating procedures and retention of the lifestyle of colonial civil servants. At the higher levels, this lifestyle involved the following amenities: free or subsidised housing, a government car and driver, servants, and a salary equal to or greater than the salary for a similar position in Great Britain (Jorgensen, 1981:238).

Moreover, postcolonial leaders did little to change the character of the bureaucracy through well-tailored education programmes. For instance, despite the emphasis that the first two postcolonial development plans put on expanding the formal educational system, observers argue that the education curriculum “retained its British colonial orientation, [and continued] producing paternalistic administrative cadres who lacked technical skills and scorned manual labour” (Jorgensen 1981:240). In brief, Uganda’s post-independence bureaucracy was staffed by officials “notoriously unconcerned with the public” and who generally “lacked a sense of public duty” (Burke 1967:15). Some also argue that independence caused no structural changes in the system of administration at the local level. The result was that the contempt and suspicious attitudes that the local government machinery enlisted from the masses in the colonial era thrived unabated during President Obote’s regime. In a clear show of bureaucratic illegitimacy, Golooba-Mutebi (2008b:141) illustrates, the state’s first point of contact with the citizens, the chiefs, could not “venture out into villages to perform their duties without armed guards”.

3.2.3 The challenge of weak infrastructural power

At the time of independence, the state’s presence was mostly concentrated in the economically productive regions and major towns with a weak presence in the countryside. This is attributed to the colonial administration policy which demarcated some parts of northern Uganda, like West Nile, Acholi and Lango, as labour reserves for cash crop producing areas in the southern provinces (Mamdani, 1983; Moncrieffe, 2004; Nabudere, 1980). The absence of the state in the ‘unproductive’ regions was clearly reflected by the uneven distribution of public infrastructure like schools, and government expenditure on services such as education across the different regions (see Table 3-4).
Table 3-4: Distribution of colonial government educational infrastructure and expenditure

<table>
<thead>
<tr>
<th>Province</th>
<th>Primary Schools 1920</th>
<th>Secondary Schools 1940</th>
<th>Teachers Colleges 1942</th>
<th>Expenditure (education) 1940</th>
<th>Population estimate 1939</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buganda</td>
<td>368</td>
<td>4</td>
<td>6</td>
<td>43%</td>
<td>900,100</td>
</tr>
<tr>
<td>Eastern</td>
<td>44</td>
<td>2</td>
<td>1</td>
<td>24%</td>
<td>1,211,200</td>
</tr>
<tr>
<td>Western</td>
<td>42</td>
<td>2</td>
<td>-</td>
<td>33%</td>
<td>1,592,300</td>
</tr>
<tr>
<td>Northern</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>1,592,300</td>
</tr>
</tbody>
</table>

Source: Author’s calculations based on Kabwegyere (1974). The ‘N/A’ (not applicable) signifies that the figures were so insignificant that they were not recorded in the archives.

According to Table 3-4, the Northern Province was particularly disadvantaged as compared to the rest. Experts believe that this is the origin of the unbalanced development that “consigned the [northern] region to a subordination position in relation to the rest of the economy” (Hickey and du Toit, 2007:14; also, International Crisis Group (ICG), 2012). However, what Table 3-4 does not reveal are the differences within provinces. For instance, and as discussed above, Bunyoro Kingdom, which fiercely resisted colonial incursion, is said to have suffered systematic marginalisation within the Western Province. Related to this is that in all provinces most infrastructure was urban based. For the case of education, this meant that only the sons and daughters of rich men (chiefs) in the villages could manage long distances and expenses involved to access schools (Kabwegyere, 1974; Muwanga, 2000).

Therefore, upon obtaining power, the first independence government rightly prioritised the spreading of state infrastructure for services delivery (Nabuguzi, 1995). However, the manner in which this was done involved taking untimely decisions that undermined the broader policy goals here. For instance, for the state to nationalise education services delivery within the first two years of its existence was a miscalculated move given that it had no capacity, in terms of structures, finances and human resources, required to expand services to all areas by itself (Balihuta, 1999; Nabuguzi, 1995; Passi, 1995). The policy is said to have caused public disenchantment because it was not done out of mutual consent with the influential missionary bodies, who at this point controlled the majority of schools and hospitals. In fact, critics argue that this policy targeted Catholics who owned most schools in the country but were associated with the opposition Democratic Party (DP). According to Nabuguzi (1995:196), “the nationalization of voluntary sector service facilities and private enterprises were aimed primarily at political
patronage and the building of political coalitions rather than the construction of new forms of service provision”. Moreover, some commentators argue that since the government had prioritised secondary and post-secondary education (for the genuine need to address the manpower gaps), it needed NSPs to maintain and/or expand primary education (Furley, 1988). This was not done and by 1971, only 29% of children in the primary school age-group were actually in school (Furley, 1988:175). Obviously, the continued absence of service delivery infrastructure in most areas that this policy caused also limited the socialization experience for most citizens (Muwanga, 2000).

3.2.4 Weak political skills of post colonial leaders

As indicated in Table 3-2, Obote’s UPC made an opportunistic alliance with the Buganda monarchy’s Kabaka Yekka (KY) party with a view of defeating the Democratic Party (DP) during the contest for identifying the political party to form the independence government (Kabwegyere, 1974). Due to inherent contradictions, which are not engaged here in detail because of space limitations, the alliance was short-lived and ended in 1966 when government troops invaded the King’s palace of Mengo. In an effort to entrench its hegemony, Obote’s regime used this political crisis to abrogate the semi-federal independence constitution and replaced it with that of 1967 that proclaimed Uganda a Republic (Dinwiddy, 1981). The new constitution practically “erased the kingdoms of Buganda, Ankole, Bunyoro and Toro from the map of Uganda” (Mutibwa, 1992:59). In so doing, one commentator noted, Obote betrayed the “dignity and prestige of hereditary rulers” that he had vowed to uphold at independence (Dinwiddy, 1981:511). The afflicted traditionalists mobilised their subjects against the state. Unable to rely on popular support from citizens to rule, Obote now turned to two main strategies – oppression of political opponents and elaboration of patronage networks within the military and among the local ‘big men’ (Gukiina, 1972; International Crisis Group (ICG), 2012; Nabuguzi, 1995). Evidence for the latter is seen from Uganda’s security budget figures, which after 1966 ballooned to “nearly as large as the combined defence budget of Kenya and Tanzania” (Gukiina, 1972:150). It is also argued that largely due to patronage politics, by the mid-1960s most MPs from Democratic Party (DP), the major opposition political party, had been enticed to defect to the ruling UPC. For instance, by 1968 only six DP parliamentarians were left out of the 24 at independence (Mutibwa, 1992). The remnants were subjected to intense harassment and in 1969 Obote banned all opposition parties
on the pretext that they were ‘dangerous societies’ that adversely affected peace and order in Uganda.

Obote’s government set precedence for political leaders to rely on the backing of the army rather than citizens’ mandate as the basis for attaining and sustaining political power in Uganda. Moreover, because recruitment and promotion in the army favoured Obote’s compatriots from the northern tribes (Lindemann, 2010), in a bid to protest this move, most opposition movements also took a militaristic orientation and were formed along ethnic lines. These observations are exemplified by the second post-independence government which came to power through a coup d’état led by Idi Amin, the army Commander, in 1971.

In summary, the first independence government inherited several colonial legacies that made SSC an uphill task. In particular, the colonial system of indirect rule, which produced parochialism, ethno-nationalism and Buganda nationalism, made the task of building a unified Uganda very challenging for the Obote government. Obote also inherited a hollow bureaucracy as the colonial government did not prioritise building African-manned bureaucratic machinery. The colonial state also presided over a regime that promoted spatial inequalities in development to the effect that by the time of independence most of northern Uganda had not been penetrated by the state. Although these colonial legacies presented enormous governance challenges for the first government, postcolonial leaders also share some blame for the problems of weak SSC in Uganda. Evidence indicates that Obote’s government, in a bid to maintain its grip on power, used public services for patronage, exacerbated ethnic and religious differences, and dragged the military into politics by using it as an instrument for curtailing civil and political rights.

3.3 General Amin’s ‘lost decade’ (1971-1979)

Many have described Amin’s policies as a continuation of what the Obote government had set in motion. According to Golooba-Mutebi, while “Obote had undermined local government autonomy; Amin banned local councils altogether. Obote had banned political parties but retained parliament, albeit largely as a rubber stamp; Amin outlawed it altogether” (2008a:9). In 1972, Amin implemented Obote’s idea of ‘Ugandanising’ the economy by declaring an ‘Economic War’ on the Asian community in Uganda. This saw
majority of the estimated 80,000 Asians\(^5\) expelled and their assets divided among loyalists (Patel, 1972; Watt et al., 1999).

Although some branded it ‘the lost decade’ (see, Jamal, 1987), Amin’s era produced some development interventions that are noteworthy regarding their implications for SSC. Contrary to what common sense would suggest from the decaying social, economic and political conditions during this period, evidence shows that actual service delivery, including the establishment of physical infrastructure in education and health, actually increased. Government hospitals increased from 36 in 1970 to 44 in 1979 and particular emphasis was placed on lower level primary health care dispensaries whose numbers increased from 210 to 365 in the same period (Nabuguzi, 1995:195). In the education sector, both the number of primary and senior secondary schools at the end of Amini’s regime had doubled that of 1970 and enrolments at all levels grew at rates higher than they did in Obote’s ‘peaceful’ years (Balihuta, 1999; Heyneman, 1983; Muwanga, 2000; Nabuguzi, 1995). Moreover, whereas Obote’s emphasis had been on secondary and tertiary education and district hospitals, which in effect did little to socialise the majority of citizens, Amin’s regime seemed to address this gap. The number of primary schools jumped from 1,986 in 1969 to 4,229 in 1979 (Heyneman, 1983:404; Nabuguzi, 1995). In 1972, the government declared that its intentions were to boost primary education with an eye on achieving universal primary education and resources were allocated accordingly (Furley, 1988). Consequently, and as reflected in Table 3-5, socio-economic indicators during Amin years (1980 column in table below) remained favourable compared to the rest of sub-Saharan Africa.

Table 3-5: Uganda’s social indicators compared with sub-Saharan Africa

<table>
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<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Pupil teacher ratio (primary)</td>
<td>30.7</td>
<td>33.5</td>
<td>33.6</td>
<td>34.5</td>
</tr>
<tr>
<td>SSA</td>
<td>(42.)</td>
<td>(43.1)</td>
<td>(41.2)</td>
<td>(39.2)</td>
</tr>
<tr>
<td>Drop-out rate</td>
<td>na</td>
<td>22.4</td>
<td>24.3</td>
<td>24.3</td>
</tr>
<tr>
<td>SSA</td>
<td>(43.4)</td>
<td>(36.6)</td>
<td>(37.5)</td>
<td></td>
</tr>
<tr>
<td>Population per physician ('000)</td>
<td>15.0</td>
<td>9.2</td>
<td>26.8</td>
<td>21.9</td>
</tr>
<tr>
<td>SSA</td>
<td>(39.4)</td>
<td>(31.8)</td>
<td>(22.9)</td>
<td>(23.8)</td>
</tr>
</tbody>
</table>

\(^5\) Amin’s declaration excluded the 23,000 Asians who had acquired Ugandan citizenship (Patel, 1972).
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<tr>
<th></th>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy</td>
<td>44</td>
<td>50</td>
<td>54</td>
<td>48</td>
</tr>
<tr>
<td>SSA</td>
<td>(38)</td>
<td>(45)</td>
<td>(47)</td>
<td>(51)</td>
</tr>
<tr>
<td>Infant mortality (IMR)$^a$</td>
<td>130.5</td>
<td>115.2</td>
<td>113.3</td>
<td>110.2</td>
</tr>
</tbody>
</table>

Source: Adopted from Warnock and Conway (1999:10), $^a$ World Development Indicators

This begs a straightforward question that many scholars have ignored for its opposite, **what went right during Amin’s regime?** It is reported that it was citizens’ action that protected health and education from the vagaries of the political crisis. Initially formulated in the 1960s to improve pupil’s learning environment through cordial parent-teacher relationships, Parents–Teachers Associations (PTAs) turned into the vanguards that sustained the education system during the turbulent years (Dauda, 2004; Kajubi, 1991; Passi, 1995). Similar user committees also emerged in the health sector under the guidance of the mission health care system. These observations are interesting for this study because a closer look at community participation in service provision shows that it was the state that ignited this ‘co-production movement’ (Furley, 1988; Passi, 1995).

Starting from the colonial era, the government required communities to contribute land and labour for the construction of schools and local health units (Furley, 1988). Also, in Obote’s Development Plan for Education 1964/65 to 1969/70, the government expected “to spend £1,6500,000, with local authorities contributing £400,000, and parents, it was estimated, approximately £2,000,000, in the value of their efforts” (Furley, 1988:180). However, it was during the so-called lost decade that the role of PTAs and user committees for health became more pronounced as the state increased development interventions at the community level. Due to this, service standards, especially in education, remained high (Heyneman, 1983). The developments here are significant in two other respects. Firstly, they illustrate that intertwining between the state and society is necessary to realise state building and citizenship formation in resource limited settings. Secondly, they point to the political learning that citizens might have benefited from this arrangement. User committee executives were democratically elected by all users (Muwanga, 2000) and, as another observer noted at the time, “fees are only paid because services are provided” (Brett, 1991:305). Clearly, this created the spirit of mutual obligations between the state and citizens (Dauda, 2004; Tripp, 2010). Also, by refocusing...
attention to primary education and community health units, Amin’s government brought more parents into this early political learning.

The above political lessons should not, however, mask the near collapse of the state machinery that occurred in the last three years of Amin’s regime. Per capita GDP reduced from $254 in 1978 to a mere $98 in 1980 (World Development Indicators). High military spending also precluded expenditure on the operation and maintenance of public facilities (Dodge and Wiebe, 1985; Nabuguzi, 1995). Government expenditure on education in the last three years was below 2% of GDP, having been above 3% of GDP in the first five years of Amin’s regime (Balihuta, 1999). Some argue that insecurity compounded the tendency to concentrate resources in urban centres as rural areas became less secure and difficult to supply (Macrae et al., 1996). Amin’s regime took its toll on the capacity of the core bureaucracy when professionals particularly at the level of senior management ran away for their lives. Dodge (1986:755) estimates that of the 978 doctors in Uganda in 1967/1968, only 574 were left by 1979. In the same period, dentists declined from 42 to 24, while pharmacists from 116 to 15 (ibid). The disappearance of professionals constrained the state’s ability to formulate sound public policies and/or implement programmes. Retrospectively, senior bureaucrats who served in this regime noted that with time the regime increasingly relied on decrees and ad hoc collection of declarations, rather than formal policies, as a guide to government action (International Crisis Group (ICG), 2012; Kajubi, 1991; Kasfir, 1983; Macrae et al., 1996).

Many concur that Amin’s government heavily curtailed political and civic liberties as the state carried out summary executions and disappeared its opponents including prominent religious leaders who openly aired their criticisms (Golooba-Mutebi, 2008a; International Crisis Group (ICG), 2012). The regime was also evidently exclusive because the civil service and military exhibited a “striking ethno-religious bias in favour of a Nubian-Kakwa core group and Muslims in general” (Lindemann, 2010:21). Against this background, there were many disgruntled groups that took up arms against Amin’s government. As discussed below, Amin’s overthrow in April 1979 ushered in a highly ambiguous period in Uganda’s political history.
3.4 Post Amin era and the return of Milton Obote (1979-1986)

The Uganda National Liberation Army (UNLA), the Tanzanian-backed army that fought Amin, was comprised of more than 20 different military groups who had little in common except the shared desire of toppling Amin’s government (Golooba-Mutebi, 2008a; Lindemann, 2010). It is less surprising, therefore, that after the fall of Amin’s regime the country did not immediately transit to peace. Instead, between April 1979 and December 1980 Ugandans witnessed three military regimes: the first was headed by Yusuf Lule and this lasted barely two months before being replaced by Godfrey Binaisa who in turn was toppled within a year by the Military Commission headed by Paulo Muwanga (Lindemann, 2010; Tumushabe, 2009). As argued in Section 3.1, the duration served by each of these governments was too short to see any meaningful policy, whether of political or developmental character, implemented. Therefore, they are not investigated any further than this. Instead, our focus is on President Obote whose return to the top office was considered less surprising by some. This is because, the December 1980 elections, which some had anticipated to transit Uganda back to peace, were overseen by the Military Commission controlled by his staunch supporters (International Crisis Group (ICG), 2012; Lindemann, 2010). Therefore, although these elections were contested in some circles as having contained grave irregularities, the Military Commission declared Obote’s UPC as the victorious political party while some of the disgruntled groups returned to the ‘bush’ (Golooba-Mutebi, 2008a; Lindemann, 2010).

On the political front, upon his return to the presidency, Obote promised a government of national unity which, most commentators observe, was never realized. In the first place, all ministries were allocated to UPC members who were predominantly Northerners especially from his own Langi ethnic group and the Acholi neighbours (Lindemann, 2010). Some argue that the army too was dominated by the northern and eastern tribes (Golooba-Mutebi, 2008a; Lindemann, 2010). Thus, people especially from Buganda, Ankole, and the ‘West Nile’ perceived Obote II as biased against their tribes with regards to sharing the ‘national cake’. It is estimated that around five different rebel groups were formed to fight against this perceived exclusion (Lindemann, 2010). More significantly, by 1985, these civil wars were disrupting the delivery of services in most parts of the country especially in rebel-held areas such as the ‘Luwero Triangle’ (Dodge and Wiebe, 1985; Nabuguzi, 1995).
From the economic perspective, some argue, whereas Obote during his 1962–1971 term had been identified with socialistic policies, when he returned, he adopted a more capitalistic economic approach (Bigsten and Kayizzi-Mugerwa, 2001). He gave priority to market-advancing policies such as private ownership of businesses and even welcomed back Asians who had been expelled by President Amin (Dodge, 1986). This was to be expected, especially given that his return coincided with the global resurgence of neoliberalism spearheaded by the World Bank and IMF, the same IFIs he approached for resources and ‘advice’ to rebuild the economy (Bigsten and Kayizzi-Mugerwa, 2001).

True to the principles of neoliberalism, one of the first things these IFIs advised the government to do was to cut-back from public service provision (De Torrente, 1999). For instance, while the government had planned to prioritise the rehabilitation of the health infrastructure to its 1970 status, IFIs rejected this and instead advised government to prioritize immunization, primary health care and manpower training – aspects that could not easily be left to the private sector (Dodge, 1986). Consequently, the overall proportion of government expenditure on health “dropped from a consistent 7.5 to 10% of budget from 1935 through the mid seventies to less than 3.5% of the budget in the early eighties” (Dodge, 1986:755). By 1985, government expenditure on education and health, in real terms amounted to about 27% and 9% respectively of the 1970s levels (World Bank, 1993:4).

With inflation running in three digits, the monthly salaries of civil servants, including doctors and nurses, became insufficient to sustain a family for more than a week (Birungi, 1998; Jamal, 1987; Kyaddondo and Whyte, 2003). Birungi (1998), in her widely cited study on people’s trust in Uganda’s public heath system, recounts how at the point of delivery health workers abandoned their professional ethics in order to secure a means of survival. Their new survival strategies included misappropriating drugs and medical equipment for personal gain as well as introducing informal charges on officially “free services” (1998:1457). Her study further reveals that patients ‘exited’ from the state by resorting to self-medication and, for those who could afford, consulting traditional healers or private medical providers became attractive. This confirms the observations in Chapter Two that people’s trust in public institutions is sensitive to the conduct of service providers. The
deterioration in the quality of service delivery was “a betrayal of trust” and a failure on the part of the state to honour its side of the social contract (Streefland, 2005:379). As discussed later, the NRM government, which come in soon after Obote II, is still grappling with rebuilding citizens’ confidence in the public health system.

Meanwhile, the vacuum created in social service provision, by the defacto withdrawal of the state due to the war or from the de jure pressures of IFIs, was in part filled by the religious bodies which had been active since the colonial era. These were joined by the rapidly increasing number of international and local NGOs, multinational and bilateral donor agencies, and private for profit providers (De Coninck, 1992; De Torrente, 1999). Other than anecdotal observations that the engagement of non-state actors here was more in terms of replacing the state than building dense ties of state-society embeddedness, it is unclear how the activities of NSPs affected the capacity of the state and citizenship during this period. This is because of the limited empirical studies around this period and also that Obote’s government was once again deposed in the July 1885 coup d’état which saw Tito Okello becoming the new Ugandan President, albeit for only six months. The National Resistance Army (NRA) guerrillas stormed Kampala in January 1986, and by the time of fieldwork the NRM was the government still in power.

3.5 State and citizenship building under Yoweri Museveni (1986 to 2011)

When the NRA guerrillas, headed by Museveni, captured power, one of the major challenges they faced was in relation to forming a viable political coalition that would be acceptable to the entire country. This is because NRA’s ranks comprised of southern groups, such as the Banyankole (Museveni’s tribe), Banyarwanda and some Baganda (Golooba-Mutebi, 2008a; Lindemann, 2010). Therefore, the northern and eastern tribes were likely to perceive it as another southern domination in the offing. In brief, it is claimed that Museveni initially addressed this issue by introducing the so-called Movement political system which banned multi-party politics for a time being to allow people from all political stripes to serve in government on merit (Golooba-Mutebi, 2008b). Some commentators believe that up to the mid-1990s, Museveni’s government indeed had characteristics of ‘a broad social base’ (Tripp, 2010). Critics observe that as Museveni consolidated his position, however, the movement became more exclusionary
even to some who had played an active role in the liberation struggle. There is evidence that the Banyankole, the President’s ethnic group, and the Baganda have in particular benefited disproportionately from Museveni’s allocation of important positions, especially in the army, cabinet and civil service, compared to the ethnic groups from northern and eastern Uganda (Lindemann, 2010; Tripp, 2010; Tumushabe, 2009). It is for this reason that over ten disgruntled groups have tried to use armed rebellion to capture state power (Golooba-Mutebi, 2008a; Lindemann, 2010). Meanwhile, after 10 years in office, elections started to be regularly organised even after every five years. Compared to its predecessors, the NRM’s human rights record is considered by some to be average although the opposition is usually harassed, the regime tolerates high levels of corruption involving senior government officials, it often limits freedoms of speech and association, and elections are considered to be marred by gross irregularities. As discussed in Chapter Five, CSOs are allowed to operate but only in the ‘non-political’ development areas. Thus, as aptly captured by Tripp (2010), the NRM is a ‘hybrid’ regime that has both authoritarian and democratic tendencies with the former being dominant.

Those writing favourably about the NRM argue that in contrast to previous regimes, its government has been more serious about the social-economic transformation of Uganda. It is believed that its commitment can be traced from Museveni’s Marxist background and the 1980s civil war which brought his guerrillas to power. It is alleged that the war created conditions which forced rebel leaders to reach a ‘political settlement’ with the people in the war zone in order to legitimise their opposition to Obote’s government (De Waal, 1996; 2000; Englebert and Tull, 2008; Hickey, 2003). According to Hickey:

> Driven by the necessity of developing a local support base in the rural areas in which the resistance war was being waged, an ideological commitment to development, and ... a need to define itself against the predatory rule, corruption and economic failures of both current and previous regimes, provided the NRA with the basis of the contract which it forged, initially with the local citizenry and later with the country as a whole (Hickey, 2003:33).

This contract was codified in the so-called bush war ten-point program (Mutibwa, 1992).

Scholars argue that three particular elements of the agreement have endured the test of time: 1) commitment to political stability; 2) decentralised form of rule based on the

---

6 First under the “Movement” but this changed in 2005 when the country returned to multiparty politics.
resistance/local councils, including the participation for marginal groups; and 3) commitment to securing development for rural people (Hickey, 2003:46). It is important to note that apart from the first one, the second and third element have direct implications for public service delivery. It is for this reason that they are the focus of the next two sub-sections. The discussion that follows attempts to tease out the extent to which the NRM has kept these two and how this has affected state capacity and citizenship in the process.

3.5.1 Uganda’s Decentralisation Policy

The legal instrument underpinning the decentralisation system is the 1995 Constitution of the Republic of Uganda. Article 176 (1) stipulates that the system of local governments shall be based on a district as a unit under which there shall be lower local governments and administrative units. The Constitution is buttressed by the 1997 Local Governments Act which specifies the status, roles, and functions of local governments (Golooba-Mutebi, 2008b; Ssewankambo et al., 2008). As summarised in Table 3-6, the decentralisation policy is operationalised through a pyramidal system of Local Councils (LCs) which run bottom-up from the Village (LC-I), Parish (LC-II), Sub-county (LC-III), County (LC-IV), to the District (LC-V). It is the District that reports directly to the Centre. This system was initially hatched as a strategy for organising and maintaining law and order in the ‘liberated’ areas during the NRA guerrilla war (Brock, 2004; Golooba-Mutebi, 2004).

Table 3-6: Uganda’s Decentralisation Structure

<table>
<thead>
<tr>
<th>Functions</th>
<th>Local council</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Central Government</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Human resources management</td>
<td>Various Ministries</td>
<td>State composed of districts</td>
</tr>
<tr>
<td>• Rule of law and administration of justice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Economic management, including regulation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Public financial management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Revenue collection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Oversight and accountability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Public facilities and asset management</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Local government</strong></td>
<td>LC V</td>
<td>District composed of counties</td>
</tr>
<tr>
<td>• Exercise all political and executive power</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Provide services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Ensure implementation of government policy and compliance with it</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Plan for the district</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
As discussed below, the decentralisation programme has important implications for SSC in Uganda. However this has not always been in positive terms.

Undermining social differentiations?
Many argue that the replication of the LC system to the rest of the country helped in rectifying the deep-rooted identity crisis in Ugandan (Green, 2010; Hickey, 2003; Lindemann, 2010; Mamdani, 1996). This is because, in several ways, the LC system transformed the basis of citizenship from the colonial one where local citizenship was defined in ethno-territorial terms (see Section 3.2) to one extended to a broader, more universal sense in which citizenship is accorded to people on the basis of their residence in a particular area (Mamdani, 1996). In other words, this system “redefine[d] the basis of rights from descent to residence” to the effect that henceforth “all adult persons had the

<table>
<thead>
<tr>
<th>Functions</th>
<th>Local council</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Enact district laws</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Monitor performance of government employees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Levy, charge and collect fees and taxes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Formulate, approve and execute district budgets</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Administrative unit**

<table>
<thead>
<tr>
<th>Functions</th>
<th>Local council</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Advise district officers and are members of parliament</td>
<td>LC IV</td>
<td>County composed of sub-counties</td>
</tr>
<tr>
<td>• Resolve problems and disputes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Monitor delivery of services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Local government**

<table>
<thead>
<tr>
<th>Functions</th>
<th>Local council</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Enact by laws</td>
<td>LC III</td>
<td>Sub-county composed of parishes</td>
</tr>
<tr>
<td>• Approve sub-county budget</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Monitor performance of government employees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Levy, charge and collect fees and taxes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Formulate, approve and execute sub-county budgets</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Administrative unit**

<table>
<thead>
<tr>
<th>Functions</th>
<th>Local council</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assist in maintaining law, order and security</td>
<td>LC II</td>
<td>Parish composed of villages</td>
</tr>
<tr>
<td>• Initiate, encourage, support and participate in self-help projects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Serve as communication channel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Monitor administration and projects</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Administrative unit**

<table>
<thead>
<tr>
<th>Functions</th>
<th>Local council</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assist in maintaining law, order and security</td>
<td>LC I</td>
<td>Village composed of households</td>
</tr>
<tr>
<td>• Initiate, encourage, support and participate in self-help projects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Serve as communication channel with government</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Monitor administration and projects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Make by-laws</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Impose service fees</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Source: Based on Golooba-Mutebi (2008b) and Ssewankambo et al (2008)*
right to belong to a council in their place of residence” regardless of ethnic or religious affiliations (Mamdani, 1996:208). According to Hickey, the ingredients of decentralisation that helped to undercut the old ethnic-territorial basis of citizenship were:

“(a) no-party elections (b) ensuring that the boundaries of local governance units would either cross-cut ethnic communities in a bid to ensure that politics would become more integrated, less ethnically divided and/or (c) that ethnic groups were internally divided into smaller districts” (Hickey 2003:33).

Afrobarometer surveys show that in 2005 only 19% of the Ugandan population felt that they were more attached to their ethnic group than the country. However, this percentage has systematically been rising to 21% in 2008 and to 25% in 2010 (Afrobarometer, 2008; 2010). Some of the reasons that explain this trend will be highlighted in the course of the discussion below.

Promoting state embeddedness
The policy of decentralisation gave the local government structure a ‘human face’, in part, by systematically demystifying the person of the chief. As earlier argued, being citizens’ first point of contact with government, the despotic tendencies of chiefs that past governments failed to trim had alienated citizens from their state. However, the post was stripped its mystique by making chiefs answerable to popularly elected LCs (Hickey, 2003; Mamdani, 1996). Moreover, the principle of participation that underpins Uganda’s decentralisation system requires the chief to fully engage citizens in making political and development decisions in their area. Although the rates of citizen involvement and participation in LCs are regarded to be low (Afrobarometer, 2008; Golooba-Mutebi, 1999), this kind of engagement is considered to have re-opened the channels of communication between the state and the citizens (Golooba-Mutebi, 2008b; Tripp, 2010). Such arguments are in line with the observations in Chapter Two that participation can facilitate the process of state embeddedness in society. This issue is revisited in section 3.5.2 with evidence of how some populist policies of President Museveni have affected the spirit of participation and, by default, state-citizen relations.

A mechanism for political empowerment
Uganda’s decentralization policy is also credited for promoting the political participation of the masses, and, in particular, the hitherto marginalized sections of the population like
the youth, women and people with disabilities (Mushemeza, 2009). Article 180(2) of the constitution requires one third women membership of each local council and demands any subsequent law on local governments to provide for affirmative action for all marginalized groups, women included. Therefore, the number of marginalized groups joining the political arena has been substantial under the NRM government (Mushemeza, 2009; Tripp, 2001). Chapter Seven discusses how some PWAs have exploited the provisions of local council elections to gain join politics. However, other scholars have been pessimistic about the developments here, arguing that LCs are less empowering basically because they are either headed and/or their decisions are greatly influenced by the more prosperous residents (Golooba-Mutebi, 1999). Golooba-Mutebi’s (2004) work on local political participation in Mukono and Rakai districts reveals the ways in which the powerful dominate LC proceedings, sometimes in a blatantly disempowering manner for the poor. LC officials such as parish and sub-county chiefs, Golooba-Mutebi alleges, accused the villagers of laziness, irresponsibility and disrespect for those in authority. As argued in Chapter Two, such practices can undermine citizens’ political agency.

Decentralisation policy and trust in government
For optimists, due to the fact that implementation of central government development programmes is operationalised through the decentralisation system, people are likely to interpret this to mean that the government is ‘fair’ in relation to resource allocation among social groups (Lindemann, 2010). In Uganda, official figures indicate that transfers to districts increased from 11% of total GoU expenditure in 1995/96, to 20% in 1998/99 and have since stabilised at above 30% of total spending since 2000/01 (see Figure 3-1). Arguably, this is the strongest fiscal decentralisation system in Africa (Foster and Mijumbi, 2002). Indeed, partly because of this, surveys reflect that few Ugandans feel that their ethnic group is ‘always’ or ‘often’ treated unfairly by government. Afrobarometer (2010) estimates that only 25% and 24% of Ugandans in 2005 and 2010 respectively felt that government treats their ethnic groups unfairly.
However, the quantity of resources allocated to local governments has to be interpreted with a caveat. A huge proportion of this money (between 65-80%) is in form of conditional grants (Foster and Mijumbi, 2002; Francis and James, 2003; Ssewankambo et al., 2008). Conditional grants target specific sectors (e.g. education, health and agriculture) designated by central government as “priority”. This implies that they cannot be diverted to address local needs as prioritised by citizens themselves.

**Enhancing the territorial reach of the state**

The policy is credited for having a visible impact on the penetration of the state in the country side. Although some have argued that the state is still absent in most of the rural areas in a development sense (see section 3.5.2), others argue that, politically, the LC system has brought even the remotest village under the firm gaze of the state (Tripp, 2010). As observed in Table 3-6, this is especially because LCs are part of the state machinery through which information between the centre and the local community is exchanged. However, because the councillors are mostly NRM supporters, it is claimed that LCs are partisan institutions that have served to maintain the ruling party in power (Francis and James, 2003; International Crisis Group (ICG), 2012; Tripp, 2010). Coming directly from this, critics have identified the creation of new districts as another way through which this policy has been abused to entrench the NRM in power (Cammack et al., 2007; Green, 2008b). For instance, in the last 20 years, more than 80 new districts
have been created in Uganda (Okwero et al., 2010) with more than 30 being added within a span of three years in the run-up to the 2011 elections (Singiza and de Visser, 2011). Contrary to the rhetoric of ‘taking services near to the people’, critics argue that the real drive for creating new districts is because they provide patronage opportunities for the NRM leadership to buy political support (Green, 2008b; Tripp, 2010).

Impact on bureaucratic capacity
Some argue that the outcome of subdividing districts is the emergence of weak and poorly facilitated local governments that cannot effectively deliver services to citizens (Cammack et al., 2007; Ssewankambo et al., 2008). Figure 3-2 suggests that additional districts increase administrative costs while correspondingly reducing the resources available for actual service delivery.

![Figure 3-2: Function classification of districts recurrent expenditure (2000/01 - 2010/11)](image)

Source: MFPED Background to the Budget series for the respective years

According to Figure 3-2, general public administration costs have steadily increased since 2004, while sectors like education and health have contracted. Critics observe that this is the same period that more than 50 new districts came on board (Okwero et al., 2010). Apart from having general administration eating into direct service sectors, sectoral budgets themselves show that a huge chunk of resources is increasingly going towards
workers’ wages (Okwero et al., 2010). The recurrent health budget in local governments had 63.5%, 65.9% and 72.3% going to wages in the financial years 2007/8, 2008/9 and 2009/10 respectively (budget performance reports of the respective years). In the health sector, for instance, Chapter Five observes that this leaves health sub-districts incapable of performing their operational duties such as offering support supervision to lower level facilities. This also helps to explain how SD-NGOs such as TASO, as discussed in greater depth in Chapter Five, have found operational space in Uganda.

Having discussed the political implications of Uganda’s decentralisation policy, the next sub-section looks at NRM’s programmes for poverty reduction.

3.5.2 NRM and the socio-economic transformation of the rural people
Since the end of the civil war in 1986, Uganda has made important strides in the area of socio-economic development (Foster and Mijumbi, 2002; Tripp, 2010). In particular, from the second half of the 1990s, NRM sought to have a systematic programme for improving the socio-economic conditions of the poor. The Poverty Eradication Action Plan (PEAP), Uganda's national development framework that ran from 1997 to 2008, was formulated to this end (Piron and Norton, 2004). The PEAP went through three rounds of revisions done after every three years to accommodate emerging poverty issues from research and consultations. After the third PEAP (2004/05-2007/08), the government switched to a longer term focused framework of the National Development Plan (NDP) (Hickey, 2011). The current NDP (2010/11-2014/15) is the first of the six (five-year) instalments that are geared towards transforming Uganda from a peasant society to a modern middle-income country within 30 years (Republic of Uganda, 2010). Some experts have cautioned that the NDP might divert the focus of NRM from poverty reduction to investment in physical infrastructure and industries that directly stimulate economic growth (Hickey, 2011). Nonetheless, by the time of fieldwork it was still early to fully grasp the implications of the NDP for this study. Therefore the analysis below revolves around the PEAP and its implications for SSC.

The structure of poverty programmes
The PEAP was accompanied by a number of related instruments and innovations to ensure that it registers a dent on poverty. In 1998, the state endorsed the Uganda
Participatory Poverty Assessment Project (UPPAP) to engage in direct consultations with
the poor as a means of acquiring information to improve the quality of development
programmes at the local level (Thomson and Mandy, 2008). The removal of cost-sharing
in public health facilities in 2001 and abolition of graduated tax in 2006 are said to be
government responses to poor people’s voices as captured by UPPAP I and II (ibid). NRM
further showed its commitment to the poor when it created a Poverty Action Fund (PAF)
in 1998. PAF “attempts to identify those expenditure programs within the budget that are
particularly relevant for achieving poverty reduction objectives” (Foster and Mijumbi,
2002:8). Expenditure on the priority areas are “ring fenced” to protect them from budget
cuts and/or resource diversion which non-earmarked areas are subjected to. PAF
expenditure areas include primary education, primary health care services, access to safe
water and sanitation, agricultural services for poor farmers, and rural feeder roads
(Shinyekwa and Hickey, 2007). At the same time, Uganda’s major donors supported the
system of Sector Wide Approaches (SWAps) through which they became more willing to
channel resources as sector budget support rather than through disjointed project
support. This helped the NRM to allocate resources according to its policy priorities (Cruz
et al., 2006).

**Socio-economic outcomes of poverty eradication programmes**

In the health sector, GoU reforms are said to have refocused the sector’s attention to
rural areas when it abolished user fees and appended the concept of the health sub-
district onto the decentralisation programme (Yates et al., 2006). The health reforms
were initially followed by a dramatic positive change in key health indicators arguably
reflecting how they opened the sector’s doors to previously excluded citizens (Deininger
and Mpuga, 2005:72; World Bank, 2005:10). For instance, the number of new out-patient
department (OPD) contacts in both public and NGO health units increased significantly in
absolute and per capita terms. This implies that several Ugandans, who were going
untreated and/or those who had resorted to self-medication due to poor quality and
inability to meet cost sharing fees introduced in the early 1990s, were now able to have
better access to medical services. However, as summarised in Table 3-7, since 2005, most
health indicators have been worsening, with government bureaucrats describing the
sector’s performance as “extremely disappointing” (Republic of Uganda, 2010; Yates et
Some of the factors that explain this have been covered in the previous section on decentralisation while others are explained later in the chapter.

Table 3-7: Key health outcomes and performance indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2000</th>
<th>2005</th>
<th>2010</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliveries in health facility</td>
<td>24</td>
<td>29</td>
<td>33</td>
<td>50</td>
</tr>
<tr>
<td>OPD utilisation</td>
<td>0.4</td>
<td>0.9</td>
<td>0.9</td>
<td>1</td>
</tr>
<tr>
<td>DPT3 Immunisation</td>
<td>48</td>
<td>80</td>
<td>76</td>
<td>95</td>
</tr>
<tr>
<td>Immunisation for measles</td>
<td>63</td>
<td>89</td>
<td>76</td>
<td>100</td>
</tr>
<tr>
<td>Percentage of PWAs on ART</td>
<td>na</td>
<td>41</td>
<td>42</td>
<td>80</td>
</tr>
<tr>
<td>Infant Mortality Ratio</td>
<td>88</td>
<td>76</td>
<td>76</td>
<td>31</td>
</tr>
<tr>
<td>Maternal Mortality Ratio</td>
<td>505</td>
<td>435</td>
<td>435</td>
<td>131</td>
</tr>
<tr>
<td>% Health centres without medicine stock outs</td>
<td>na</td>
<td>27</td>
<td>41</td>
<td>70</td>
</tr>
<tr>
<td>% approved positions filled by qualified health worker</td>
<td>40</td>
<td>75</td>
<td>56</td>
<td>75</td>
</tr>
<tr>
<td>HIV prevalence</td>
<td>6.1</td>
<td>6.2</td>
<td>6.5</td>
<td>4.4</td>
</tr>
</tbody>
</table>

Source: Own calculations based on (Ministry of Health, 2010a; d; Okwero et al., 2010; Republic of Uganda, 2010).

In the education sector, upon the introduction of UPE in 1997, school enrolment skyrocketed to 5.303 up from 3.069 million pupils the previous year (Hedger et al., 2010). UPE is said to be pro-poor because, in particular, school attendance increased dramatically for girls aged six to eight years and household expenditure on primary education decreased by about 60% between 1992 and 1999 (ibid). As summarised in Table 3-8, UPE is credited for the increase in the adult literacy rates in Uganda from 65% in 1999/2000 to around 70% since 2002/2003.

However, critics decry the low standards of UPE schools (Tripp, 2010). It is also estimated that close to 70% of pupils who start primary one do not make it through primary seven (Statistical Abstract, 2009). Moreover, enrolment rates have not risen above 85%, an indication that 15% of primary school-age citizens are unable to enjoy their right to education (AfDB, 2009).
Table 3-8: Literacy rate for people aged 10 years and above (1999/00 to 2005/06)

<table>
<thead>
<tr>
<th></th>
<th>1999/00</th>
<th></th>
<th>2002/03</th>
<th></th>
<th>2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Total</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Uganda</td>
<td>74</td>
<td>57</td>
<td>65</td>
<td>77</td>
<td>63</td>
</tr>
<tr>
<td>Central</td>
<td>81</td>
<td>74</td>
<td>77</td>
<td>82</td>
<td>74</td>
</tr>
<tr>
<td>Eastern</td>
<td>72</td>
<td>52</td>
<td>62</td>
<td>72</td>
<td>54</td>
</tr>
<tr>
<td>Northern</td>
<td>64</td>
<td>33</td>
<td>47</td>
<td>72</td>
<td>42</td>
</tr>
<tr>
<td>Western</td>
<td>74</td>
<td>61</td>
<td>67</td>
<td>79</td>
<td>69</td>
</tr>
<tr>
<td>Kampala</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>94</td>
<td>91</td>
</tr>
</tbody>
</table>

Source: based on (UBOS, 2011:14).

Besides education and health outcomes, one might wonder what the impact of government programmes has been on poverty itself. As reflected in Table 3-9, the government is said to have reduced the poverty headcount from 56% in 1992 to 49% in 1996 then to 35% in 2000 and recently to 24.5% in 2010.

Table 3-9: Poverty trends in Uganda (1992/93 – 2009/10)

<table>
<thead>
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<tbody>
<tr>
<td>Rural/Urban</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Rural</td>
<td>59.4</td>
<td>53.0</td>
<td>39.0</td>
<td>42.7</td>
<td>34.2</td>
<td>27.2</td>
</tr>
<tr>
<td>Urban</td>
<td>28.2</td>
<td>19.5</td>
<td>10.1</td>
<td>14.4</td>
<td>13.7</td>
<td>9.1</td>
</tr>
<tr>
<td>Region</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Central</td>
<td>45.5</td>
<td>30.1</td>
<td>20.1</td>
<td>22.3</td>
<td>16.4</td>
<td>10.7</td>
</tr>
<tr>
<td>Eastern</td>
<td>59.2</td>
<td>57.5</td>
<td>37.3</td>
<td>46</td>
<td>35.9</td>
<td>24.3</td>
</tr>
<tr>
<td>Northern</td>
<td>71.3</td>
<td>68.0</td>
<td>64.8</td>
<td>63</td>
<td>60.7</td>
<td>46.2</td>
</tr>
<tr>
<td>Western</td>
<td>52.8</td>
<td>46.7</td>
<td>28.0</td>
<td>32.9</td>
<td>20.5</td>
<td>21.8</td>
</tr>
<tr>
<td>National</td>
<td>55.5</td>
<td>48.5</td>
<td>35.1</td>
<td>38.8</td>
<td>31.1</td>
<td>24.5</td>
</tr>
</tbody>
</table>

Source: Based on Uganda Bureau of Statistics (UBOS, 2011)

Although these trends look impressive, critics point to the high regional variations in the poverty levels. Up until 2005, Northern and Eastern Uganda as well as the rural areas had a disproportionate share of the poor. However, data for the 2005/6 to 2009/10 period reveals that, as compared to other regions, poverty headcount in the Northern region registered the greatest percentage decline of over 16 percentage points (from 60.7% to 46.2%). Table 3-9 also reveals significant reductions in the proportion of poor people in rural areas vis-à-vis those in urban areas.

The politics of poverty eradication programmes

7 Poverty head count is calculated as the percentage of the population below the national poverty line.
Some scholars have argued that from the 1990s, the state pursued service delivery as a “political project” aimed at reconstituting “the Ugandan society so as to erode vertical structures of social organisation which, according to Museveni, had proved disastrous for the liberal political model ever since independence” (Piron and Norton, 2004:15). In contrast to the colonial state, which is said to have only cautiously promoted formal education “because of a practical fear that Africans with such schooling were likely to become the spokesmen of a disruptive political extremism” (Pratt, 1965:527), NRM promotes schooling because of its belief that a more educated population “will be able to participate more actively in political life and, it is hoped, mobilise around non-sectarian issues” (Piron and Norton, 2004:16). Also, NRM sees the “social modernization” of citizens as a prerequisite for creating a strong state because the state’s efficiency and strength depend on skills and capital – “the formation of a reliable bureaucracy is inconceivable without skilful state employees. In addition, a national economy must be developed so that the state can extract resources for its own purposes” (Schlichte, 2008:371).

However, critics have noted that the President is increasingly substituting the practice of legitimising his regime through delivering on its social contract with patronage (Tripp, 2010). It is widely believed that popular programmes like UPE, the abolition of user fees and graduated tax, were aimed at winning elections (Stasavage, 2005). In addition, the President openly offers hand-outs to citizens as a means of buying their loyalty, and this lacks attributes of a coherent development strategy that serves all Ugandans (Selassie, 2008; Therkildsen and Kjaer, 2009:16). This clearly shows the state failing in its cardinal role of ensuring equitable development for all Ugandans, irrespective of tribe, ethnic group or political affiliation (Lindemann, 2010; Mubatsi, 2010; UNGF, 2009). Moreover, when images of the President handing over “brown envelopes” are flashed on television screens and newspapers across the country, an indirect curriculum is given to citizens:

> Every election time, voters expect the contestants, be it at LCV or MP or presidential level, to give them something mostly money, a bar of soap, alcohol, sugar, salt and sometimes meat to vote them into office. It is not the innovative ideas that a candidate presents to the electorate that form the basis for a decision to vote them but how much the voter received from the candidate.” (Mubatsi, 2010)
The Afrobarometer survey done in the run-up to the 2011 presidential and parliamentary elections confirmed these fears, which is regressive to citizenship development. Chapter Seven illustrates how PWA’s political empowerment is implicated by such developments.

In addition, questions of who funds Uganda’s development programmes and its implications for citizenship have surfaced. It is observed that international donors have been central actors in Uganda’s development especially during the Museveni era. In particular, donors’ interest in the country peaked in the second half of the 1990s decade when poverty reduction gained top position on the international development agenda. As discussed in Chapter One, the late 1990s is well remembered for the emergence of the ‘new aid architecture’ which had debt relief as a central component. Indeed, PEAP became Uganda’s PRSP and the country was the first one to qualify for HIPC debt forgiveness.

Their contribution to funding social services notwithstanding, critics argue that the heavy donor focus on development unwittingly helps legitimate undemocratic practices, corruption, and clientelism, which, in turn, undermine governance and the capacity of the state to foster sustainable development (Mwenda and Tangri, 2005; Tripp, 2010). According to Tripp (2010:188), donor aid is often “disbursed in ways that make it difficult to develop productive relationships between citizens and the state built on mutual obligation, for example, paying taxes in exchange for the provision of public goods”. For instance, the abundance of donor resources allowed the state to discourage activities of PTAs and health sector user committees (Dauda, 2004; Tripp, 2010). Consequently, citizens’ ability to mobilise and demand for accountability and responsiveness from the state has been greatly undermined (Dauda, 2004; Ssewankambo et al., 2008). To Tripp (2010), such make donors complicit in maintaining the NRM as a ‘hybrid’ regime. At the local level, the abolition of citizens’ contribution is associated with an apparent disconnect between service delivery institutions such as hospitals and schools and their communities (Dauda, 2004). This limits co-production, and, by implication, the degree of state embeddedness in society (see Chapter Two).

Lastly, some argue that from a development perspective, the state’s penetration in the rural areas is tenuous (Jones, 2009). For instance, in the health sector, the deeper you
penetrate into Uganda’s rural areas the more staffing gaps you encounter in health units. Evidence in Figure 3-3 shows that the majority of the vacancies in the public health sector are at HC-II (67%) and HC-III levels (55%), which are predominantly located in the rural communities (Ministry of Health, 2010c:21). Official statistics recently indicated that “70% of medical doctors and dentists, 80% of pharmacists and 40% of nurses and midwives, are in urban areas serving 13% of the population” (Ministry of Health, 2010b:37). Uganda’s health worker to population ratio is 1:1,298 against WHO’s recommended figure of 1:439, while the doctor to patient ratio is 1:24,725 against the recommended 1:800 (Republic of Uganda, 2010:253).

![Figure 3-3: Staffing at different levels of public health facilities](image)

Source: Based on Ministry of Health (2010d). Mulago and Butabika are the two National Referral Hospitals (HC VII), while RRR is Regional Referral Hospitals (HC VI)

As reflected in Chapter Five, even the skeleton health workforce available in rural facilities is inadequately skilled to competently provide services in key areas such as HIV/AIDS. Service delivery surveys also indicate that public health workers’ attitudes are still poor (Ministry of Health and Macro International Inc., 2008) and health workers engage in vices such as diversion of drugs, absenteeism and outright corruption in form of illicit charges for services (Okwero et al., 2010). The alarming incidence of these vices recently forced the President to threaten to “…dismiss any Gombolola [sub-county] chief and CAO [Chief Administrative Officer] who fail to detect this theft” adding that “the public should be informed that Government drugs are not for sale; they are free. Also the so-called
'consultation fees' are illegal and must stop ...” (Museveni, 2009). According to Chapter Two, such developments have serious repercussions for state-citizen relations such as encouraging citizens to “vote with their feet” out of the public service delivery system.

3.5.3 Museveni’s ‘war’ on HIV/AIDS

By the time the NRM captured power in 1986, Uganda had not only become one of the poorest countries in the world but also a hub of HIV/AIDS (Boahene 1996; Garbus and Marseille 2003; Museveni 2004). The political upheavals that started in the first decade of independence caused strain on the capacity of the state to address citizens medical needs as professionals fled while at the same time the government diverted its meagre resources towards defence-related activities (Dodge and Wiebe, 1985; Parkhurst and Lush, 2004). Subsequent crises during the 1970s-80s fuelled the spread of the disease to inconceivable proportions (Grebe and Nattrass, 2009). O’Manique (2004) summarised this point:

The social upheaval created by two decades of violence and terror, the virtual absence of a social safety net throughout the country, [and] continuous population movement fuelled by violence and insecurity provided an ideal environment for the spread of HIV infection (O’Manique, 2004:120).

Moreover, as the previous discussion in this chapter indicates, the first post-colonial government promoted an urban-centric health policy whose capacity to challenge HIV/AIDS would be doubtable even under a peaceful political setting.

Under these conditions, the state apparatus could not cope with HIV when it hit the country. In the late 1980s, studies done in Rakai and Masaka districts, the epicentre of military campaigns that ousted Amin, put prevalence rates at 35% in major trading centres, 23% in intermediate trading centres and 13% in villages (O’Manique, 2004:126). This trend soon spread to the rest of the country. By the end of the 1980s, national HIV statistics estimated that more than 20% of the adult population aged above 15 years had contracted the disease, HIV was contributing 12% to the overall mortality in Uganda, and it had became the leading cause of death among people aged 12 years and above (Tumushabe, 2006). At the time, these figures put Uganda in number one position of countries with the highest HIV prevalence in the world (Parkhurst, 2005:574).
Meanwhile, PWAs in Uganda were treated as second class citizens and many considered them as social deviants who were being ‘punished by God’ for their promiscuity (Monico et al., 2001; Seeley et al., 1991; Ssebbanja, 2007). Many were ostracized and it is claimed that even public health workers stigmatized patients they suspected of having HIV/AIDS (Ssebbanja, 2007). In fact, it is claimed that it was because of the stigmatizing care given to Christopher Kareeba, the husband to the founder of TASO, Noreen Kareeba, that she decided to form an HIV/AIDS support group in early 1987 from which TASO emerged (ibid, 2007:5; see Chapter Five for details about TASO).

However, the NRM government turned this grim picture to its advantage and Uganda instead became an admired post-conflict African state that fruitfully utilised the dynamics of the war to gain a commitment from all stakeholders to confront the epidemic. With barely four months into office, in May 1986, the NRM government made a decision to publicly acknowledge that HIV had reached epidemic proportions and that the state bureaucracy was unable to make a viable response single-handedly (Kaleeba et al., 2000; Putzel, 2004). These pronouncements projected the state recognising the epidemic as a national issue at an early stage and explicitly giving a ‘green light’ to NSPs to operate in the country (Ostergard, 2002; Ostergard and Bercelo, 2005; Putzel, 2006; Schoepf, 2003). In line with the debates in Chapters One and Two, the important question here is, how did SD-NGOs affect state-citizen relations?

Although some would predict that by calling upon non-state actors the burden of fighting the epidemic would be offloaded from the state, Uganda’s experience is different whereby these actors were obliged to strengthen rather than undermine state capacity (Putzel, 2004; Wallace et al., 2004). At the national level, the state had interest and retained what Batley and Mcloughlin (2010) call the ‘stewardship’ roles of policy making, sub-granting, regulating and monitoring services through the Uganda AIDS Commission (UAC). Some claim that this was advantageous in that:

"[b]y shifting a large portion of its sphere of activity from direct service provision to indirect management, the Ugandan state found an area of policy and intervention that it was able to handle with limited capacity, and which it could undertake without competition from other service providers" (Parkhurst, 2005:583).
There was also explicit political support from the President who personally took the lead in the HIV response (Parkhurst, 2005; Putzel, 2004). He galvanised the support of other government officials in the country and is famously quoted to have commanded that “All Ministers, LCs, [and] Senior Government officials must inform the people how to stop the spread of AIDS at all meetings without exception” (Putzel, 2004:25). It is claimed that the President’s commitment emanated from the fact that HIV had infected a huge proportion of an influential political group, the NRA “bush war heroes” (Putzel, 2004; Schoepf, 2003). This motivated Museveni to seek to reconstruct the image of HIV sufferers from that of deviants to deserving citizens. Nonetheless, as discussed in Chapter Five, this national-level commitment was undermined by the lack of capacity among government agencies responsible for service delivery at the local level.

Meanwhile, the state also used the response to HIV/AIDS to promote social cohesion that had eluded Uganda since independence (de Waal, 2003; Parkhurst, 2005). It is argued that HIV/AIDS is one area where the state managed to unite all Ugandans by creating a situation where the epidemic was put beyond partisan politics and primordial attachments along which Ugandans had historically been divided. As Putzel notes, “while Museveni faced many criticisms from opposition forces, all publicly admired the role he played in mobilising the nation around the epidemic and none put the government’s commitment to the fight against HIV/AIDS into question” (2004:26). In the same vein, the state harnessed the cooperation of religious leaders to be part of, rather than in opposition to, efforts to discuss the epidemic. Because of HIV, all religious groups in Uganda, for the first time, received equal attention from the state and state officials were instructed “to work with [religious leaders] and to avoid antagonising them” (Putzel, 2004:27). The partnership between the state and other actors became more substantive at the close of the 20th century when it started contributing a non-conditional grant towards the running costs of private not for profit (NGOs) health providers (Birungi et al., 2001; Ministry of Health, 2010b). Uganda’s response here contrasted sharply with the position taken by other African countries. For instance the government of Kenya up to the late 1990s and that of South Africa in early 2000 were not only in denial about the existence of HIV, but also harassed NGOs that attempted to intervene (Hyden and Lanegran, 1993; Ostergard and Bercelo, 2005; Parkhurst and Lush, 2004).
Generally, many have argued that as opposed to being a sign of the state’s inability to keep the social contract, NGO provision allowed the state to take credit from their good work (Grebe and Nattrass, 2009; Parkhurst, 2005). Afrobarometer surveys have also consistently showed high approval ratings (above 70%) of NRM’s handling of HIV/AIDS (Afrobarometer, 2008; 2010).

Uganda’s rosy picture, however, is contradicted by Museveni’s tolerance of corruption which at times has directly hampered the HIV/AIDS response. A good example here is the 2005 ‘Global Fund scandal’ in which money was siphoned from the Global Alliance for Vaccines and Immunization (GAVI) programme, allegedly by high ranking NRM officials, “to finance election campaigning by NRM candidates” (Tangri and Mwenda, 2008:184-85). Some also feel that the leadership of MoH has been weak since about 2003 caused by, among others, the high turnover of senior officials coupled with the President’s reluctance to replace them (e.g. MoH lacked a substantive Permanent Secretary throughout the 2000s) (Buse and Booth, 2008).

3.6 Conclusion
This chapter has argued that despite being 50 years as an independent country, Uganda is still plagued by poor service delivery, weak state capacity and citizenship. No regime has fronted a lasting solution to the colonial legacies of ethno-religious cleavages, weak bureaucracy and low penetrative reach of the state in the rural areas. Besides these colonial legacies, the chapter finds that the failure of all the four regimes discussed here to find workable political solutions to governance challenges motivated them to rely on the military, rather than citizens, to maintain themselves in power. Although elections were held, in 1980 and have been periodic since 1996 under the NRM, it is widely believed that in Uganda, he who controls the military determines the outcome of the ballot. So far, no successful change of government has occurred through peaceful and/or democratic means.

Noteworthy, however, is that the NRM government has managed to stay longer than its predecessors because of a comparatively better approach to state-society relations

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8 However, Afrobarometer surveys are limited because only one question on HIV/AIDS is asked: “How well or badly would you say the current government is handling matters of combating HIV/AIDS?”
through policies such as decentralisation, poverty reduction programmes and the handling of HIV/AIDS. The NRM’s flagship programme of decentralisation was originally touted to be the route for social, economic and political transformation of Ugandans. Indeed, it changed the basis of citizenship from decent to residence, increased citizens’ involvement in local decision making and guaranteed the political participation of marginalized groups. However, critics observe that along the way, this programme was turned into a tool for advancing the regime’s political goals and weakening the ability of the local government units to serve Ugandans. Poverty reduction has been a major pre-occupation of the state throughout the last one and half decades. Although absolute poverty has significantly reduced, some argue that the rural, northern and eastern parts of Uganda are still disproportionately poor compared to other areas. As far as HIV/AIDS management is concerned, many concur that the early commitment and personal interest of the President to fight this epidemic endeared him to even his critics. And by allowing NSPs to operate with the state taking on ‘oversight’ responsibilities, it is alleged that the NRM government positioned itself where it could claim credit from service provision done by others. This can be contrasted to Obote I who hurriedly usurped the role of missions in the education sector. This did not only affect the quantity of services provided and the extent of the state’s reach in communities, but also state-civil society relations were undermined.
CHAPTER FOUR
Researching the State and Citizenship in Rural Uganda

4.1 Introduction
This chapter has two main objectives. The first is to explain how decisions concerning the research approach employed – in terms of where and how data was collected, how it was processed and analysed, and how it is presented within appropriate ethical standards – were made. The chapter argues that rather than being based on a priori ontological commitments of the researcher, these decisions need to be based on the requirements of the research questions at hand. The second objective is to illustrate the fieldwork context in which the current study took place. To achieve these objectives, the chapter is structured as follows: the next section presents and justifies the choice of the case study in terms of the country, development sector, and study sites. This is followed by a critical analysis of the research paradigm plus the ontological and epistemological assumptions espoused by the researcher for this research project. Next, the chapter discusses the research design and conceptual framework employed. A description of the fieldwork area follows this and afterwards the discussion of the research methods, with a particular focus on mixed research approaches. A discussion of data processing, analysis and presentation, ethical considerations, and challenges encountered during the research forms the penultimate and last sections respectively. Throughout the chapter, a self-critical stance is integrated in the discussion. As opposed to being a sign of confessing weaknesses (Pillow, 2003), it is hoped that this reflexivity will help to increase the validity and confidence in this research undertaking (Cresswell, 2007; McGee, 2002).

4.2 Selection of the case studies
The research questions posed in Chapter One were investigated using Uganda as the case study country. This choice was informed by several factors. First, and as discussed in Chapter Three, Uganda is one of the countries in sub-Saharan Africa where the state is claimed to be undertaking development and service delivery as part of its political project of state building (MOFPED, 2012; Piron and Norton, 2004). Secondly, the researcher is a Ugandan citizen and his previous employment with the case study SD-NGO also influenced this choice. Although this positioning has obvious advantages such as easier
accessibility to the case study NGO, there are also potential limitations, such as biased reporting, which will be elaborated in Section 4.10. Thirdly, several scholars indicate that there are quite a number of Ugandan NGOs that specialise in social service provision as their core business (see Chapters Three and Five). However, given the argument in Chapters One and Two that NGOs’ service delivery activities are not politically neutral, the pertinent question is: what are the implications of NGOs’ service delivery for the wider project of state building in Uganda? In other words, this research is interested in exploring the varied ways through which NGOs’ programmes facilitate or hinder the Government of Uganda’s (GoU) vision of state building on one hand, and the practice of citizenship by those directly affected by these programmes on the other.

Health is a sector where NGOs have been particularly prominent in Uganda, especially regarding the response to HIV/AIDS (see Table 5-2). Several studies have shown that NGOs played a significant role in Uganda’s widely lauded handling of the HIV/AIDS epidemic and that the state gained local and international recognition and legitimacy from such a response (Parkhurst, 2001; 2005; Putzel, 2003; 2004; Tumushabe, 2006). However, one shortcoming with most studies so far is the minor role that they accord People with HIV/AIDS (PWAs) – analyses usually stop at the national level, mostly with civil society elites, government bureaucrats and donor representatives. Little is known about how HIV/AIDS interventions impact on the relationship between PWAs and the state at the local level. The largest indigenous HIV/AIDS organisation in the country called the AIDS Support Organisation Uganda Ltd (TASO) was picked to provide the empirical venue for the current investigation. TASO was considered the right NGO choice because of the Mini TASO Project (MTP) that it implemented in close collaboration with GoU to improve HIV/AIDS services in rural public hospitals. MTP presented a window through which to study the dynamics and exchanges between citizens and the state on a stage set by an NGO (see Chapter Five for a fuller introduction to TASO and MTP).

Although detailed information about both TASO and MTP is provided in Chapter Five, a few clarifications are in order at this point. In simple terms, a mini TASO is a public health facility (typically district hospital) whose “capacity is built by TASO to offer quality comprehensive HIV services to its catchment population” (TASO, 2005a:2). A ‘mini’ TASO
is to be distinguished from a ‘full’ TASO branch in two respects: one, the latter is an NGO whereas the former operates as part of the public health system; two, the latter has a wider catchment area in terms of geographic coverage which can span into several districts while the former is restricted within the jurisdiction of its parent district local government (DLG). The latter distinction is important for it affects the territorial reach of MTPs. Although the official start of MTP is traced to around 2003, mini TASOs continued to be opened up to 2010, the year the project was closed. For purposes of this study, the minimum age of MTPs for case studying was set at five years to ensure that only ‘mature’ projects, old enough to have registered impact, were studied. In consultation with TASO two sites of Kamuli and Masafu were identified for detailed investigation while a non-MTP hospital of Iganga was also picked to provide a comparative viewpoint. Brief visits were organised in five additional MTP sites. In the next section, focus is on discussing the research paradigm, saving detailed description of the study areas for Section 4.5 while further discussion of TASO and MTP is provided in Chapter Five.

4.3 Choosing the research paradigm for the study

Given our evolutionary and epistemological predicaments, the available strategy in science is to try to revise some beliefs even while trusting most of what we already know (Cook and Campbell, 1986:145). Although there is no universally accepted definition of research paradigms, the general understanding is that they are “the worldviews or belief systems that guide researchers” (Tashakkori and Teddlie, 1998:3). More specifically, Maxwell (2005:36) has described a research paradigm as “a set of very general philosophical assumptions about the nature of the world and how we can understand it”. Some submit that paradigms have associated elements of ontology, epistemology and methodology that are connected to each other in a hierarchical top-down mode.9 Whereas some argue that the researcher’s paradigmatic orientation influences the choice of research questions and how to research them (Aitken and Valentine, 2006; Guba, 1990; Guba and Lincoln, 1994), others contend that research questions should be the determinant of the appropriate paradigm suited to investigate them (Cresswell, 2007; Denscombe, 2007; Morgan, 2007; Tashakkori and

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9 According to Krauss (2005:758-759) “as ontology involves the philosophy of reality, epistemology addresses how we come to know that reality while methodology identifies the particular practices used to attain knowledge of it”.
Teddlie, 1998). The researcher is sympathetic to the latter view. Tashakkori and Teddlie (1998:5) observe that “many active theorists and researchers have adopted the tenets of paradigm relativism, or the use of whatever philosophical and/or methodological approach [that] works for the particular research problem under study”. This includes the possibility of employing multiple paradigms in a single research undertaking (Morgan, 2007).

The current research originated from the researcher’s interest in understanding the influence of SD-NGOs’ programmes on political processes of state building and citizenship formation in Uganda. As earlier stated, the researcher observed that previous research on related aspects disproportionately focused at the national level and privileged the view of experts over the experiences of beneficiaries and implementers of programmes at the local level. Therefore, the researcher felt that the current study should be undertaken with people directly implicated in these programmes at the centre of the investigation. The point being made here is that a social constructivist paradigm was the starting point for this research, that is, “understanding the complex world of lived experience from the point of view of those who live it” (Schwandt, 1994:118), as opposed to ‘objective’ extraction of data that restricts beneficiary engagement in the research process.

There was one major factor, however, which made social constructivism an inadequate paradigm for this study. The broader question that the research sought to answer – whether SD-NGOs can promote avenues for state building and citizenship formation – had explicit assumptions that NGO interventions are external events which can cause change in the organisation of state agencies and their relations with citizens. One can argue that investigating such a question requires going beyond asking people their lived experiences. As observed by Kazi, constructivist approaches “tend to concentrate on the needs of stakeholders and their perceptions, and therefore may fail to capture the effectiveness of a programme in a more comprehensive way” (2003:19).

However, among the alternative research paradigms available, positivism was the least adequate candidate as its philosophical stances are rather restrictive. According to positivism ‘facts speak for themselves’ and they are established by taking apart a
phenomenon to examine its component parts (Olsen, 2004). The object of study is regarded to be independent of researchers as knowledge has to be ‘discovered’ and verified through meticulous objective observations.measurements of phenomena (Krauss, 2005). Thus, adopting positivism would necessitate studying non-material issues like state building and citizenship formation in a laboratory-like setting.

Critical realism has been fronted as the “ameliorative third path” alternative to the extremisms of both positivism and constructivism (Harvey, 2002:163). It posits that instead of looking for “social laws” as suggested by positivism we should be searching for causal mechanisms and how they work in different contexts (Sayer, 2000; Tilley, 2000; Tilley and Pawson, 2004). To realists, consistent regularities can only arise under “closed systems”, yet in the world where development programmes are implemented, it is a constellation of complex “open systems” whereby the same intervention such as MTP can potentially produce different outcomes in different contexts (Downward and Mearman, 2007; Pawson and Tilley, 1997; Sayer, 2000). On this point, critical realism borrows a leaf from social constructivism which posits that social phenomena are concept-dependent and need interpretive understanding (Barrett et al., 2010). However, unlike the latter, the former does not exclude causal explanation (Sayer, 2000). Thus, according to Pawson and Tilley (1997), explanation of social regularities or outcomes is not achieved by the action of independent variables on dependent variables, by the operation of intervening variables, or by the chain reaction of such variables. Rather, it comes from an understanding of mechanisms acting in social contexts – the historical and material conditions such as social norms, power relations and socio-economic status in which people live (Kazi, 2003). What this means for our research is that SD-NGO programmes have to be looked at as interventions that can set in motion particular mechanisms which when combined with the context can lead to regularities in different components of state building and experiences of citizenship. Hence Pawson and Tilley’s (1997) conjecture is that “Regularity = Mechanism + Context”.

Central in critical realism, is that the world is stratified and operates at three levels – the “real”, the “actual”, and the “empirical” (Sayer, 2000). The empirical domain consists of events that can be observed; the actual domain consists of events whether or not they
are observed; and the real domain consists of the structures and mechanisms that produce these events. Two crucial points emerge from this observation. First, critical realists acknowledge the fallibility\(^{10}\) of researchers’ knowledge (Barrett et al., 2010; Olsen and Morgan, 2005; Yeung, 1997). This implies that facts may not speak for themselves and that we should not write-off the existence of those things that we cannot see as positivism suggests (Sayer, 2000). Coming from this, and as argued by Kazi (2003), the realist researcher may not be satisfied with appearances, such as achievement of a programme outcome with the majority of service users. He/she must seek to find an explanation for why the programmes was successful with the majority, but not with minority, and to identify the potential causal mechanisms that produced the outcomes. Secondly, the stratification suggests that “it is possible to adopt different ontological assumptions in each domain, particularly the ‘empirical’ and the ‘real’ domains” (Blaike, 2000:119). Indeed critical realists recommend that getting closer to ‘reality’ needs gathering evidence from “as many sources – of data, investigations, theories, and methods – as possible” (Guba, 1990:21).

As a precursor to the next section, it is important to note that the version of critical realism that guided this study resembles the ‘intensive approach’ identified by Sayer (2000). This approach investigates the workings of a given process in a particular case or small number of cases, by asking what makes things happen in specific cases or ‘what produces a certain change?’ (2000:21). Intensive approaches are applicable in studies interested in establishing causal explanations (though not representative explanations). This is to be distinguished from the ‘extensive approach’, which focuses on showing how widespread certain phenomena and patterns are in a population. In other words ‘extensive approaches’ are interested in questions relating to regularities, patterns and distinguishing features of a population (ibid). The former predominantly employ ethnographic research methods while the latter survey-based analysis (although both research methods can be used to complement each other in one study). In brief, critical realism as discussed here places emphasis on four main points:

i) the need to stipulate the possible outcomes of the intervention

\(^{10}\) That the things that make up reality exist independently of whether their existence, nature or effects are observable, known or understood by humans.
ii) identify generative mechanisms that produce outcomes
iii) understand the context in which the intervention takes place, and
iv) employ various research methods to get different perspectives of the issue being investigated.

In the next section, we discuss our research design.

4.4 The complexity of choosing a research design

In preparation for fieldwork, it was planned that the research design employed should be able to provide us with a basis upon which to (dis)prove whether service provision in public hospitals supported by TASO caused changes in the citizenship status of service users and state capacities. As rightly observed by Kazi (2003), critical realism gives little guidance on research designs, indeed, choosing one for this research was perhaps the most difficult challenge faced in this study. As will become clearer in the forthcoming subsections, in the end, the journey that led to the choice of the research design employed in this study fitted Denscombe’s observations below:

In practice, the social researcher is faced with a variety of options and alternatives and has to make strategic decisions about which to choose. Each choice brings with it a set of assumptions about the social world it investigates. Each choice brings with it a set of advantages and disadvantages. Gains in one direction will bring with them losses in another, and the social researcher has to live with this. There is no ‘one right’ direction to take. There are, though, some strategies that are better suited than others for tackling specific issues. The crucial thing for good research is that the choices are reasonable and that they are made explicit as part of any research report” (2007:3).

4.4.1 The (im)possibility of quasi-experiments in development programmes

The initial plan was to use a “case design” which aims at achieving “analytic generalisation” (Yin, 1989; 2003). This involves using a conceptual framework, worked out before fieldwork, as a template with which to compare the empirical results from the case study (see Figure 4-2 for our conceptual framework). Scholars who use this type of case study design agree that analytical generalisation gains potency when two or more cases are investigated (Schofield, 2000; Yin, 1989; 2003). This is because it is after more than one case study has supported the original theory that “replication may be claimed” (Yin,
In instances where all case studies are derived from the treatment/intervention population, this is called ‘literal replication’ (De Vaus, 2001; Yin, 2003). To enhance the robustness of the research, Yin suggests that non-intervention/control cases should be investigated too. When the findings from non-intervention cases negate the theory predictions but those from intervention units support it, then the intervention is confirmed to have worked and this is called ‘theoretical replication’.

Translating literal and theoretical replication to our research, it was proposed that four sites, two public hospitals where MTP was implemented and two non-intervention/control hospitals, should be studied (see Figure 4.1). At first sight this design looked simple – one would just need to compare the four sites to determine whether the MTP worked or it did not. However, on closer inspection, it had major flaws that made it less appropriate for this study.

**Figure 4-1: The multi-case replication design**

![Diagram]

*Source: Author’s diagram*

The multiple-case study as proposed above is akin to the conventional quasi-experimental designs (see, Cook and Campbell, 1986; Shadish et al., 2002). Actually, Yin (1989:53) states that “the ability to conduct six or ten case studies, arranged effectively within a multiple-case design, is analogous to the ability to conduct six or ten experiments ...”. Although the potential drawbacks of experimental designs in social programmes are well documented, the following were major for this study. The first limitation presented itself
in terms of cost (De Vaus, 2001). Each study site qualified as a fully-fledged study, implying that the whole undertaking needed a budget for four projects. Secondly, there was a risk that multiple cases might compromise the attention paid to each case which could “undercut the depth of understanding of individual sites” (Schofield, 2000:81). The third, and perhaps most fundamental drawback of such a research design lies in the ontological assumptions behind replication. By arguing that the replication logic in multi-case studies is similar to that in multiple experiments, Yin and his followers appear to believe in a closed system world. However, as observed in section 4.3 many agree that experimentation in the social world is very difficult because there are scores of events and factors that make programmes permeable and plastic, implying that it is impossible to hold other things constant. Related to this point, there was a dilemma in finding suitable control sites. The study had hoped to identify hospitals that were similar to MTP hospitals in terms of administrative arrangements (government owned) and in the same political/administrative region (within the same DLG). However, it turned out that each district had one main government-owned hospital, and therefore no comparison point could be got here. These were not minor shortcomings and the researcher could not find quick fixes before fieldwork.

4.4.2 Addressing the limitations of quasi-experimental approaches

In this subsection we discuss how, whilst in the field, the research design was modified to address some of the challenges identified above.

Pragmatism

The researcher sought to approach the field with an open mind and exercise ‘pragmatism’. Pragmatism was used here in relation to how Tashakkori and Teddlie (1998) employed it to describe choices involved in complex research undertakings which require more than one research approach. The following key points, ordered hierarchically according to their relative importance, were set to guide fieldwork:

1. Since the study is about TASO’s MTP, give priority and adequate attention to MTP sites,

2. even with MTPs study two sites, one case at a time, to capitalise on depth rather than breadth of the analysis, but
3. if time is saved and there is an interesting lead that can be pursued in another site, then consider studying other sites.

Fast forward into the field, and the study started with mixed fortunes. On the positive side, TASO approved our research protocol on time\textsuperscript{11}, and ethical approval from the Uganda National Council of Science and Technology was granted early (both approvals were secured by December 2010 and not January 2011 as earlier anticipated). On the negative side, there was a scare when Kaberamaido MTP, one of the main case study sites that the researcher had been in contact with, developed complications which made it unfit for purposes of the current research. Three key staff in this MTP left at the same time for further studies which effectively meant that we would get limited insight into the workings of this site and respondents would certainly be biased about staffing and related issues – this is a good example of the permeability of programmes. It was also established that at the time TASO went to this hospital there were no existing HIV/AIDS services. This meant that the study could not make ‘before’ and ‘after’ intervention comparisons. Therefore, Masafu MTP, situated in the same Eastern Region as Kaberamaido, was picked to replace it. Masafu hospital, which is located in Busia district, was chosen to represent cases where MTP had had limited success as compared to Kamuli that represented the “successful” cases. The decision on success/failure of MTPs was made following the guidance of TASO officials at Central and Eastern Region offices. TASO officials depended on indicators, such as the number of clients served, timeliness of reporting, and their personal observations of staff-clients relations in MTPs among others. Having a ‘successful’ and ‘failed’ MTP was a strategic decision that helped to dispel the wrong assumption that MTP was uniformly effective in all sites as the proponents of ‘replication’ would assume. By the end of May 2011, fieldwork in the two sites had been completed, which meant that there were two ‘free’ months at the researcher’s disposal (the original forecast was that data collection in the two sites would be completed at the end of July 2011).

The ‘control’ sites

\textsuperscript{11} Although TASO requested a research fee of $500 that had not been budget for.
The saving on time allowed the researcher to consider probing how findings from the two study sites compared with other MTP hospitals. Quick field visits were organised in five additional sites, including Arua, Lira, Kaberamaido, Pallisa, and Sembabule MTPs, where observations were made, key informant interviewed and a few questionnaires administered\textsuperscript{12}.

With half of TASO’s intervention sites seen, the researcher considered it wise to look outside MTPs. Having data on the situation in non-TASOs hospitals would “ensure that observed changes are not mistakenly credited to the action program [MTP] when in fact exogenous factors are responsible” (Weiss and Rein, 1970:103). It is important to note that the goal of having a ‘control’ site had evolved from the idea of ‘replication’ to having comparative points that would enable the researcher get deeper understanding of the workings of the generative mechanisms that produced various outcomes in MTPs. The choice was therefore not difficult to make because the researcher was aware of a non-MTP facility called Iganga hospital, within the same geographical region as Kamuli MTP, which fitted this purpose. Other than being in separate districts, Iganga hospital had characteristics closely comparable to Kamuli (see discussion in Section 4.5). The research approach employed in Iganga was similar to that employed in our intervention sites of Kamuli and Masafu, except that in the former the study largely focused on collecting quantitative data.

**The temporal element**
Apart from comparing MTPs with a control site, the study included temporal-retrospective questions in both the small-scale survey and in-depth interviews to create what De Vaus (2001:61) calls a “pseudo ‘before’ measure”. This would contribute further evidence for attributing the observed changes to the intervention, MTP. One of the obvious weaknesses of retrospective interviews is that people forget and therefore become less accurate with the passage of time (De Vaus, 2001; Grover et al., 2011). Moreover, literature is silent on whether there is a time limit beyond which this method becomes obsolete. Nonetheless, there are several suggestions for enhancing recall in

\textsuperscript{12} However as explained later in the chapter, because the selection of respondents who filled the questionnaires did not conform to the selection criteria of the main study sites, they were excluded from final analysis.
social research. It is suggested, for instance, that when people are recalling experiences from a specific event and time period, their recollections of past happenings and the circumstances surrounding the events are enhanced (Côté et al., 2005). Therefore, our interviews endeavoured to include questions and probes to help respondents reconstruct specific events and details. However, even here we had to be careful as psychologists warn that human memory is ‘constructive’ whereby informants may reconstruct their actions/events as they think they ought to have happened – “reconstruction of the past in relation of the present” (De Vaus, 2001:228). Examples of this phenomenon are reported in Chapter Six where the researcher suspected ‘exaggerations’ in PWAs’ assessment of service quality. We addressed this by having multiple questions measuring a similar aspect such as including ‘willingness to pay’ as an indicator of service quality.

In brief, it can be said that in order to distil the impact of MTP, the research design included two intervention sites and one control hospital as opposed to the two-by-two originally proposed. However, it also included field visits to other MTPs where observations and qualitative interviews were done. Then, our interviews included retrospective questions to get an approximate sense of the situation ‘before’ and/or ‘without’ intervention.

4.4.3 The Conceptual Framework
As argued by Tilley and Pawson (2004:9), before embarking on a realist evaluative study one needs a hunch of how “programmes activate mechanisms amongst whom and in what conditions, to bring about alterations in behavioural or event or state regularities”. Figure 4-2 shows the conceptual framework which hypothesised, on the one hand, the links from MTP to state building and, on the other, MTP to citizenship. It was envisaged that this framework would be refined in line with the evidence from the field. This is duly done in Chapter Eight.

This conceptual framework was informed by the theoretical literature on the politics of service delivery as reviewed in Chapter Two combined with the review of TASO’s MTP documents done before fieldwork. According to Chapter Two, it was suggested that a combination of factors, some of which date back to the colonial encounter, worked
against the development of effective state-led service delivery in sub-Saharan Africa. Instead of producing a virtuous circle of state and citizenship building, in most African countries, there was a vicious downward spiral of state deterioration and destruction of citizenship. Such observations led some analysts, that this research calls NGO optimists, to argue that this situation could be reversed with careful interventions, for instance by non state providers (NSPs), ‘working on both sides of the equation’ – whereby on one side they ‘civilise the state’ and on the other empower citizens to engage the state (Chapter One; also Gaventa, 2002; 2004). Such an arrangement, as elaborated in Chapter Five, is akin to what TASO attempted to accomplish through MTP. In other words, for service delivery to have positive outcomes in developing countries, a helping hand (labelled 5) is needed on one side to enhance state capacity to deliver and on the other to mobilise citizens to reconnect with the state.

**Figure 4-2: Conceptual framework**

In view of the above, for the case of MTP, the study formulated the conjecture that joins state building, service delivery and citizenship to run as follows: Service delivery programmes (in this case MTP, marked 2) supply direct effects to beneficiaries in terms of resources and indirect effects in terms of interpretive messages, that is, service users’ interpretation of service quality and self-worth, based on how well they are handled at
the delivery site. A combination of these effects (labelled 3) in turn might influence the ability of service users to engage in civic and political activities (labelled 4). We hypothesised further that citizens’ action can provide feedback loops to the state which might influence future programming for service delivery.

In addition, the study hypothesised that the ‘state civilising’ attributes of MTP, such as health workers’ shadowing, training and financial facilitation (see 5), would enhance state capacity in terms of increasing bureaucratic power and ability to supply services across its territory. It was assumed further that the state would earn legitimacy as a result of meeting citizens’ valued needs. From the policy feedback thesis, it was anticipated that the experience of implementing the programme as well as the feedback from citizens would concretise these state capacities (see links 1$\leftrightarrow$2 and 4$\rightarrow$1). In brief, the central proposition was that MTP would cause a virtuous circle of improvement for both citizenship and state capacities. Chapters Six and Seven reveal the extent to which these assumptions were realised in our study sites.

4.5 Description of the study area

As noted already, fieldwork was mainly carried out in three districts of rural Uganda – Kamuli and Busia district representing the districts where TASO implemented MTP, with Iganga acting as the non-intervention/control district. The profiles of each one of these are outlined below while their geographical locations are represented in Figure 4-3. An important disclaimer for the discussion below is that district local governments (DLGs) in Uganda rarely possess up-to-date data. For instance, although most of the sources cited are recent, they draw on the Uganda Population Census done in 2002. As reported in Chapter Three, a lot has changed especially with respect to socio-economic aspects where recent reports indicate significant national-wide improvements. For instance, whereas the proportion of people below the poverty line in eastern Uganda was at 46% in 2002, it reduced to 35.9% in 2006 and further down to 24.3% in 2009/10 (Table 3-9). The challenge, however, is that recent national reports do not provide data disaggregated per district.
4.5.1 Kamuli District

Kamuli district, like Iganga, is located in central-eastern Uganda – about 150 km from the capital Kampala. Kamuli is part of the Busoga region and like other Ugandan districts it derives the name from its 'chief town'. The district is largely rural – Kamuli town is the only recognised urban centre with around 3% of the district’s population (Kamuli DLG, 2009). Poverty is endemic in the district whereby 49.1% of the population is considered to live below the poverty line (UBOS and ILRI, 2007). Kamuli DLG (2009), drawing on the 2002 Uganda population census, reports that around 80% of its people are categorised as peasants who earn their livelihood from subsistence farming. Literacy is at 59%, which is also comparatively low in relation to the national average of 69% (Kamuli DLG, 2009). By 2006, the district had 68 health units, with only 48.9% of the parishes having a health centre (Kamuli DLG, 2006). Although its 7.2% HIV prevalence rate is higher than the national average of 6.4%, Kamuli is better off than Busia district, where prevalence is estimated to be 10% (Busia DLG, 2011; Kamuli DLG, 2009; UBOS, 2011). As discussed in more detail in Chapter Five, implementation of MTP was done in Kamuli District Hospital. For more vital statistics on Kamuli district see Table 4-1.

Figure 4-3: Map of Uganda showing location of the main fieldwork sites

Source: http://www.ugandamission.net/aboutug/map1.html
4.5.2 Busia district

Busia is the smallest of the three districts considered with a population almost half that of Kamuli (see Table 4-1). The district is situated in eastern Uganda at the Uganda-Kenya border. Being a border district, over 2% of its population are Kenyan nationals. However, the largest ethnic group is that of the Basamia representing 46% of the population, followed by the Bagwe at 25%, Bagisu at 13%, and Basoga at 3% (Busia DLG, 2011). Busia DLG (2011:24), citing the 2002 national census, reports that 68% of the district’s households are peasants, while those engaged in formal employment are 11% and 10% were reported to have business enterprises. Literacy is reported at 63% marginally higher than Kamuli’s 59%. Like Kamuli, a huge percentage of the population (around 50%) was reported to live below the poverty line as of 2002 (Busia DLG: ibid). Although it has one main town, 16% of Busia’s population is considered urban (UBOS and ILRI, 2007). MTP was implemented in the district’s main hospital called Masafu Hospital. While most district hospitals adopt the names of their parent districts, in Busia the main hospital is named after the sub-county where it is located. Thus, Masafu-Busia will be used to make it easier for the reader to recognise this hospital. The proportion of the district’s population within a distance of 5 km or less to a health facility is 82.2%, higher than the national figure of 73.3% (Busia DLG, 2011:27). However, as argued in Chapter Six, these figures have to be cautiously considered because most of the health units are inadequately resourced. According to the MOH, only 34% of the approved health posts are filled in Busia district (Ministry of Health, 2010d).

Table 4-1: Vital Statistics of the main study districts

<table>
<thead>
<tr>
<th></th>
<th>National</th>
<th>Kamuli District</th>
<th>Busia District</th>
<th>Iganga District</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area in Square KM²</td>
<td>4,301.50</td>
<td>759.4</td>
<td>2,482.30</td>
<td></td>
</tr>
<tr>
<td>Population (2011)</td>
<td>32.9 m</td>
<td>468,700</td>
<td>281,200</td>
<td>466,200</td>
</tr>
<tr>
<td>Doctor Patient Ratio</td>
<td>1:24,725</td>
<td>1:114,834</td>
<td>1:90,094</td>
<td>1:42,521</td>
</tr>
<tr>
<td>% medical posts filled (2011)</td>
<td>56</td>
<td>49</td>
<td>34</td>
<td>73</td>
</tr>
<tr>
<td>Hospital beds (2011)</td>
<td>123</td>
<td>52</td>
<td>115</td>
<td></td>
</tr>
<tr>
<td>HIV prevalence rate</td>
<td>6.4</td>
<td>7.2</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>HDI (2005 estimate)</td>
<td>0.581</td>
<td>0.548</td>
<td>0.556</td>
<td>0.567</td>
</tr>
<tr>
<td>Urban Proportion (2011)</td>
<td>15.8</td>
<td>2.4</td>
<td>16</td>
<td>16.6</td>
</tr>
<tr>
<td>Poverty Index (2005)</td>
<td>25.44</td>
<td>24.1</td>
<td>31.2</td>
<td>25.2</td>
</tr>
<tr>
<td>% below poverty line</td>
<td>38.8%</td>
<td>49</td>
<td>50</td>
<td>46</td>
</tr>
<tr>
<td></td>
<td>(2002)(^a)</td>
<td>2005/2006(^b)</td>
<td>2005/6(^b)</td>
<td>2011(^c)</td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------------</td>
<td>----------------</td>
<td>-------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Literacy</td>
<td>69</td>
<td>63.2</td>
<td>62.7</td>
<td>65.7</td>
</tr>
<tr>
<td>Life expectancy</td>
<td>50.4</td>
<td>50.1</td>
<td>45.5</td>
<td>49.4</td>
</tr>
<tr>
<td>Revenue as % GOU transfers</td>
<td>92.5</td>
<td>90.7</td>
<td>95.9</td>
<td></td>
</tr>
</tbody>
</table>

*Source:* \(^a\)(UBOS and ILRI, 2007); \(^b\)(UHDR, 2007); \(^c\)(UBOS, 2011); \(^d\)(Busia DLG, 2011)

\(^e\)(Kamuli DLG, 2009)

### 4.5.3 Iganga district

Iganga district and Kamuli are located in the same Busoga region and these two used to share borders until Luuka district was carved out of the former in 2009. Their population sizes and ethnic composition are also comparable. However, compared to Kamuli and Busia, the literacy rate of Iganga’s population is higher at 66%. In addition, although poverty is endemic with 46% of the population said to live below the poverty line (UBOS and ILRI, 2007), this figure depicts that it is comparatively better than Kamuli and Busia. With 17% of its population regarded to be urban, Iganga and Busia perform better than Kamuli in this respect (UBOS, 2011). Fieldwork was done in the district’s main hospital where TASO did not implement MTP.

Overall, minor differences in favour of Iganga district notwithstanding, the foregoing discussion suggests that the three districts considered for this study are comparable with respect to most socioeconomic aspects. As summarized in Table 4-2, this argument is further sustained by the socio-demographic data of the respondents selected from the three study sites.

### 4.6 The choice of research methods

Drawing insights from others who have done similar studies, the researcher learnt that in order to understand how the state works in practice, and, in particular, how it relates with ordinary citizens, attention has to be given first to the sightings of this state by actors placed at different vantage points (Corbridge et al., 2003a; 2005; Corbridge et al., 2003b; Jones, 2009; Williams et al., 2003). In respect to the current project, the sightings of the state by the following four key groups of actors were considered vital:

1. The sightings of the state made by poorer people – the PWAs who seek services from it.
2. The sightings made by men and women who are constituted as employees of the state;
3. Sightings by the reforming agency (TASO) through its employees; and
4. The sightings of the state made by other development actors in Uganda, such as members of national and international agencies.

However, in line with a critical realist approach, researchers must also look beyond the varied realities presented by respondents to acknowledge the structures and material conditions which may be producing and interacting with such realities. Such requirements necessitated drawing on multiple research methods, both qualitative and quantitative.

For purposes of simplicity, although this study fitted Sayer’s (2000) ‘intensive’ research approach, it can heuristically be divided into two ‘arms’ – the ‘quantitative arm’ involving the use of survey techniques and the ‘qualitative arm’ where ethnographic techniques were employed. As discussed below, in both arms, the researcher endeavoured to conform to their original values and application techniques, for example with regards to sample selection, data collection, and data analysis.

4.6.1 Small scale survey

In order to establish how widespread PWA’s perceptions and opinions were on topical issues central to answering our research questions, part of the study involved a small-scale survey of service users. In all study sites, this preceded the main qualitative component of the study. It is important to note that the research instrument used here was pilot-tested on the clients of TASO Tororo during the last week of November 2010. Although there was limited time to engage full-scale data analysis in the field to enable the results of the survey to meaningfully inform qualitative interviews, the survey process enabled the researcher to get useful information that informed the choice of key informants and it highlighted aspects of MTP on which to seek in-depth insights. In the next subsections, we discuss the process of sample selection and describe the characteristics of the selected samples.

Sample selection

Originally, our plan for the small-scale survey was to select a representative sample of PWAs using simple random sampling techniques. After trying this in Masafu, the
researcher abandoned it because the sampling frame got from hospital records was not up-to-date, even including PWAs who had died or relocated to other areas\textsuperscript{13}. Secondly, the rural setting of the study sites meant that PWAs were spread across a wide geographical area many of which were served by poor road networks. This made it too costly in terms of both time and money to trace respondents in their homes. Thus, simple random sampling and finding respondents in their homes were abandoned. Instead, the researcher decided to study all PWAs who came for services at MTPs as long as they met the inclusion and exclusion criteria described below.

**Inclusion criteria**
The main inclusion criterion was the individual’s duration at facility. PWAs needed to have registered not later than 2006. This was done to ensure that knowledgeable respondents were picked to allow the ‘before’ and ‘after’ intervention analysis. It is mainly due to this strict requirement that our study sample is relatively small (see Table 4-2). Important to note, however, is that for the in-depth interviews several recently registered clients, who were deemed to have valuable information, were involved (e.g. PWAs who had assumed leadership responsibilities).

The second criterion was the availability and activeness of PWAs. Only those clients who managed to come for services at the health facility during the study period were included. However, some PWAs who did not turn up for services but were deemed to have in-depth information about MTP were followed up in the “qualitative arm”.

**Exclusion criteria**
Frail patients or those visibly drunk were not interviewed on ethical grounds that they were in unsound state of mind. The study also excluded underage PWAs; all our respondents were 18 years and above. Those unwilling or unable to cooperate or comply with research activities were left out. For instance the researcher came across two clients who were deaf and dumb and could therefore not respond to the questions.

**Sample description**

\textsuperscript{13} It was disturbing for family members to be asked whether their deceased relative was ‘available’ for an interview.
As noted above, this study selected the entire population (N) of PWAs that met the inclusion criteria in Masafu-Busia and Kamuli MTPs and in Iganga hospital. The final number of respondents considered for the mini-survey was 178 PWAs\(^\text{14}\). Table 4.2 summarises the socio-demographics of respondents from the three sites in terms of sex, age, education, occupation, religion and marital status of respondents.

Table 4-2: Socio-demographic characteristics of the survey sample

<table>
<thead>
<tr>
<th>Socio-demographic features</th>
<th>Categories</th>
<th>Kamuli (N=61)</th>
<th>Masafu (N=71)</th>
<th>Iganga Control (N=46)</th>
<th>Kruskal-Wallis (X^2) (p-value)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>Male</td>
<td>42.6%</td>
<td>43.7%</td>
<td>45.7%</td>
<td>0.098 (.952)</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>57.4%</td>
<td>56.3%</td>
<td>54.3%</td>
<td></td>
</tr>
<tr>
<td>Age group</td>
<td>20 - 29</td>
<td>1.6%</td>
<td>7.0%</td>
<td>4.3%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>30 - 39</td>
<td>32.8%</td>
<td>45.1%</td>
<td>30.4%</td>
<td>3.114 (.211)</td>
</tr>
<tr>
<td></td>
<td>40 - 49</td>
<td>50.8%</td>
<td>29.6%</td>
<td>45.7%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>50+</td>
<td>14.8%</td>
<td>18.3%</td>
<td>19.6%</td>
<td></td>
</tr>
<tr>
<td>Education level</td>
<td>None</td>
<td>11.5%</td>
<td>2.8%</td>
<td>10.9%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary</td>
<td>57.4%</td>
<td>64.8%</td>
<td>45.7%</td>
<td>1.786 (.409)</td>
</tr>
<tr>
<td></td>
<td>O'Levels</td>
<td>26.2%</td>
<td>28.2%</td>
<td>32.6%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A'Levels</td>
<td>3.3%</td>
<td>1.4%</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Post-secondary</td>
<td>1.6%</td>
<td>2.8%</td>
<td>10.9%</td>
<td></td>
</tr>
<tr>
<td>Occupation</td>
<td>Employed Govt</td>
<td>1.6%</td>
<td>0.0%</td>
<td>6.5%</td>
<td>3.758 (.153)</td>
</tr>
<tr>
<td></td>
<td>Employed Priv Co.</td>
<td>4.9%</td>
<td>4.2%</td>
<td>2.2%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Peasant</td>
<td>63.9%</td>
<td>71.8%</td>
<td>47.8%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Casual labourer</td>
<td>9.8%</td>
<td>2.8%</td>
<td>2.2%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Self-employed</td>
<td>18.0%</td>
<td>21.1%</td>
<td>34.8%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>1.6%</td>
<td>0.0%</td>
<td>6.5%</td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
<td>Married Mono</td>
<td>27.9%</td>
<td>42.3%</td>
<td>50.0%</td>
<td>3.934 (.140)</td>
</tr>
<tr>
<td></td>
<td>Married Poly</td>
<td>16.4%</td>
<td>21.1%</td>
<td>8.7%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Separated/Divorced</td>
<td>19.7%</td>
<td>9.9%</td>
<td>10.9%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Widowed</td>
<td>36.1%</td>
<td>21.1%</td>
<td>30.4%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Never Married</td>
<td>0.0%</td>
<td>5.6%</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td>Catholic</td>
<td>11.5%</td>
<td>25.7%</td>
<td>23.9%</td>
<td>.840 (.657)</td>
</tr>
<tr>
<td></td>
<td>Protestant</td>
<td>59.0%</td>
<td>45.7%</td>
<td>32.6%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Muslim</td>
<td>9.8%</td>
<td>4.3%</td>
<td>34.8%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other Christian</td>
<td>19.7%</td>
<td>24.3%</td>
<td>8.7%</td>
<td></td>
</tr>
</tbody>
</table>

\(^\text{14}\) Two questionnaires both from Masafu-Busia MTP were dropped – they had several sections of missing data. Also 28 questionnaires from the additional five MTPs, which did not conform to the sample selection criteria, were not included in the analysis.
Statistical tests using Kruskal-Wallis tests (explained in Section 4.8) showed that there were no significant differences in the various socio-demographic variables of PWAs in the three study sites. However, the researcher does not assume that the populations of the different sites are normally distributed, hence as explained in Section 4.8, the study relied more on simple descriptive statistics and, where necessary, used nonparametric tests.

**Secondary quantitative sources**

Secondary sources consist of written documents, published or otherwise, and data which is recorded without the intervention of the researcher (Stewart and Kamins, 1993). The study made use of two broad types of secondary materials – quantitative and qualitative records. Here we discuss the quantitative sources while qualitative sources are discussed in subsection 4.6.2. The quantitative category of secondary sources consisted of a database of the Afrobarometer survey on Uganda (round 4.5.2) which was done in the run up to the 2011 elections (Afrobarometer, 2011). This was used to compare some variables, such as people’s evaluation of health services and trust in state institutions, which our mini-survey also looked at (see Chapter Six).

**4.6.2 The “Qualitative arm” of the study**

In what can be termed the “qualitative arm” of the study, the researcher employed ethnographic methods to acquire in-depth insights and thick descriptions of respondents’ lived experiences and understanding of contexts which influenced the working of MTP. Among other methods, the researcher used key informant interviews, Focus Group Discussions (FGDs), observations and review of qualitative secondary sources. These are briefly discussed below.

**Key informant interviews**

As shown in Table 4-3, various categories of respondents were identified as key informants. These were purposively selected based on their knowledge about the project and related issues under investigation.
Table 4-3: The Qualitative sample

<table>
<thead>
<tr>
<th>Source</th>
<th>Respondent Categories</th>
<th>PWAs</th>
<th>Health workers and other KI</th>
<th>Total Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Male</td>
<td>Male</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Female</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Masafu MTP</td>
<td></td>
<td>4</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Kamuli MTP</td>
<td></td>
<td>4</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>Other MTPs</td>
<td></td>
<td>1</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td>TASO KI</td>
<td></td>
<td>2</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Government, CSOs and Others</td>
<td></td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>11</strong></td>
<td><strong>20</strong></td>
<td><strong>53</strong></td>
</tr>
</tbody>
</table>

The main category of key informants was the PWAs. Here, the researcher conducted in-depth interviews with the aim of getting detailed information about PWAs’ experiences with the project, how it affected their behaviours, operations of the hospital, conduct of staff, and relationships among the different people. For such in-depth interviews, the selection of respondents was strategically made by the researcher in line with the study’s informational needs. The aim here is not about getting representative numbers of respondents to be interviewed but, rather, the ability to add a substantive perspective on the issues investigated (Maxwell, 2005). In fact, some respondents were interviewed more than once as a follow-up on issues that arose from their own interviews or other sources. PWAs selected for in-depth interviews included client representatives/leaders, volunteers/expert clients, those who stood for elective positions, clients who were seen exercising ‘voice’ in the process of getting services, and/or those who had quit seeking services among others. This research method had several advantages, such as the ability to gather more detailed and richer data, and the face-to-face repeated contact also offered some immediate means of validating the data. Besides, the context of our study area, in terms of rural setting and limited literacy levels for some informants, automatically eliminated other methods that could have worked as substitutes such as telephone interviews (Denscombe, 2007). The disadvantage, however, is that this method generates huge volumes of textual data that is cumbersome to analyse (see below).

Besides PWAs, the researcher also interviewed local government officials in each study site. The researcher engaged the frontline health workers, hospital administrators and district officials. The aim was to get an opportunity to obtain information from health
workers about issues pertaining to management and supervision, job satisfaction, education and training opportunities, as well as specific information about user–staff interactions.

Interviews were also held with key TASO staff falling under two categories. The first category was those staff at the Regional Offices, in charge of overseeing Mini TASO activities in their respective regions. Here the researcher interacted with Regional Managers and Project Officers from TASO Eastern, Central, and Northern Region. The second category of TASO staff was those at TASO headquarters in Kampala including the Executive Director and other senior officials heading various directorates.

The last category was key informants outside the project. The study identified people with expert knowledge about the research area such as officials from the Uganda AIDS Commission (UAC), Uganda Network of AIDS Service Organisations (UNASO), officials from National Forum of People Living with HIV/AIDS Network in Uganda (NAFOPHANU) and former TASO employees. The characteristics of respondents under these various categories is summarised in Table 4-3.

**Focus Group Discussions (FGDs)**

Besides the FGDs done with TASO Tororo clients to refine the survey instrument and its eventual pre-testing, the study had two additional FGDs one with PWAs and the other with health workers. Both FGDs were carried out at the beginning of fieldwork. The PWAs’ FGD was in Masafu and it was aimed at exploring the salient issues in the project from the perspective of senior PWAs who were working as volunteers/expert clients at MTP. The second FGD involved representatives of health workers from various MTPs who had gathered to attend a counselling training in Masaka (this was done in January 2011, the second month of fieldwork). In addition to serving similar purposes as the PWAs’, this FGD also provided the researcher with a glimpse into the operations of the project in other areas outside the main study sites. However, although the study had planned to have several FGDs with service users per study site, this method was not widely used after noting that it stifled honest discussions on sensitive issues like those related to the behaviour of health workers.
**Direct observation**
The researcher used direct observation at clinics and focused on the interactions between patients and service providers. The information from here helped to understand some of the issues reported by respondents in interviews. Also this method was vital in identifying respondents for ‘case studying’ (e.g. PWAs who raised complaints at the clinic). The researcher also directly observed departmental meetings involving health workers and expert clients to get more insight into staff-client relations. In the initial meetings members were apprehensive due to the presence of the researcher but the situation normalised with the researcher’s continued presence at the facility that helped people to get accustomed to him. This point serves to emphasise the need to spend ample time in the field (at least a month in each study site) to enable the construction of rapport.

**Secondary qualitative sources**
The researcher got hold of MTPs’ periodic reports (monthly, quarterly and annual); reviewed minutes of meetings; financial records; departmental records of the HIV/AIDS clinic; district statistical abstracts and reports; and also gathered some ‘loose memos’ on the notice boards which had interesting information. Documents especially previous minutes were also instrumental in aiding the identification of respondents for in-depth qualitative interviewing. Although some submit that studies with a retrospective component benefit from the use of existing records (De Vaus, 2001), others, such as Yin (2003) and Stewart and Kamins (1993), caution that documents must be carefully used and should not be accepted as literal recordings of events that have taken place. The researcher often made consultations with the relevant officials to double-check or seek clarifications about observations from these secondary sources.

**The Research Matrix**
Although this is not a data collection method per se, the study borrowed a leaf from Corbridge and colleagues (2003b) that in order to keep track of the various aspects of the research during fieldwork, one needs something similar to a “logical framework” or a research matrix. This helps to link each research question to specific indicators, sources of information and appropriate research tools to gather the data. The research matrix helps to avoid “the dreaded feeling of returning from “the field” without having asked key
questions” (Corbridge et al., 2003b:249). A copy of the matrix employed in this research is attached as Appendix 1.

Having catalogued the research methods employed in this study, the next subsection critically assesses the mixing of quantitative and qualitative approaches in this study.

4.7 Strengths and limitations of Mixed Methods Research approaches

Before getting into the nitty-gritty of assessing mixed methods research, it is important to define the concepts here. As with most terms in the social sciences, no universally accepted interpretation for either qualitative or quantitative research approaches exists. According to Hulme:

Quantitative approaches are characterised by studies that apply mainly statistical analysis to data collected by standardised questionnaire(s) through survey methods ... and that comes from a sampling frame that indicates it is representative of a broader population.

[In contrast,] Qualitative approaches are characterised by mainly narrative analysis focusing on the meanings that actions have for people. Data is usually collected by ethnographic (conversation, semi-structured interviews, life histories, oral histories and observation) or participatory methods ... much of which is non-numeric and which comes from relatively small ‘n’ datasets that make it difficult to infer being representative of a broader population ... (2007:6, original emphasis and brackets).

Hulme’s description is related to that of Blaike (2000:232) who finds that “Quantitative methods are generally concerned with counting and measuring aspects of social life, while qualitative methods are more concerned with producing discursive descriptions and exploring social actors’ meanings and interpretations”. However, most scholars acknowledge that, in practice, the distinction between qualitative and quantitative approaches is blurred as it is possible to take a more qualitative approach to tabular data and vice versa (Kanbur and Shaffer, 2007; Olsen and Morgan, 2005; Onwuegbuzie and Leech, 2005).

But what does mixing research approaches entail in practice? There is some consensus that mixed research involves:
drawing on the conceptual and analytical frameworks of at least two disciplines in the design, analysis, and interpretation of the research, while at the same time combining a broad range of data collection methods – in most cases including both quantitative and qualitative methods. (Bamberger, 2000:18).

This research argues that it is useful to think of mixed research approaches as a continuum regarding the degree to which aspects of qualitative and quantitative approaches are included in a study. Studies may be categorised as predominantly quantitative or predominantly qualitative. Basing on Johnson and colleagues’ (2007) continuum in Figure 4-4, the research approach employed in this study can be described as ‘Qualitative Mixed’.

**Figure 4-4: The continuum of mixed research approaches**

![Mixed Methods Continuum](image)

*Source: adopted from Johnson and others (2007:124).*

Some literature suggests that mixed approaches gain potency when they are sequenced to maximise the benefits of one approach in the next research phase that involves using another approach (Blaike, 2000; Tashakkori and Teddlie, 1998). For instance, qualitative results can be used to identify themes that can then be quantitatively measured and validated or data from survey can be followed up by a wave of in-depth interviews. In the present study, the researcher started with FGDs to refine the survey instrument, and then
the process of conducting the small-scale survey was used to identify issues and names of key individuals who were then traced for qualitative interviewing.

Having made those conceptual clarifications, we now turn the spotlight on the pros and cons of mixed approaches. On the positive side, it has been argued that studies that involve complex phenomena, mixing research approaches is necessary to refine the conceptual and analytical frameworks guiding the study (Bamberger, 2000). As noted already, for this research a couple of FGDs were carried out at the start of the research which helped to refine the survey instrument. These FGDs showed, for instance, that local people had fewer interactions with high level state structures such as courts and were less familiar with parliamentary politics, which the researcher had tabled as indicators for testing respondents’ political skills and state legitimacy. Local people instead showed that local councils were the most relevant state structures in their lives. Such observations enabled appropriate revisions to be made to the survey instrument.

Like poverty, the concepts of state building and citizenship that we explore in this thesis are multi-dimensional in nature (Cammett and MacLean, 2011; Gaventa, 2010; Vom Hau, 2012). Relatedly, the character of the various dimensions of our central concepts could not be understood by one research approach alone. To understand bureaucratic capacity, for instance, qualitative approaches were necessary to tap into the rich details of health workers’ experiences on how the MTP changed their competencies. Such experiences are not easily amenable to quantitative aggregates, not least, because few health workers were trained by TASO. However, there were some aspects that could easily be quantified such as how PWA’s perceptions about service quality, and how the number of people served changed before and after the intervention among others. Furthermore, the study sought to establish whether changes in the delivery of services by the state affected citizens’ approval of various state structures (legitimacy) – this also had to be analysed with both in-depth insights and a representative sample of the people affected by the intervention in different study sites.

Another great benefit of mixed methods studies is that they allow the researcher to balance the goals of data collection with respect for the people who are the subject of
investigation. In this research, quantitative approaches were a necessity but represent a positivist world-view that privileges objective observation and precise measurement which detach the researcher from the participants thereby rendering people as physical objects to be researched on (Karnieli-Miller et al., 2009). Through in-depth interviews, the researcher aimed at putting respondents at the centre of this study by showing that their experiences and constructed social realities were valued. This is part of “respectful inquiry” and it directly goes into the ethics of research (Byrne-Armstrong et al., 2001).

Last but not least, choosing mixed methods was also influenced by the desire to produce information in formats preferred by, and easily acceptable to, policymakers. Many observe that policymakers find qualitative analysis of development issues less compelling as compared to reports with quantitative or mixed methods analyses (Barrett et al., 2010; Blaike, 2000; Hulme, 2007). McGee and Brock (2001) illustrate this observation. They note that initially women movements had difficulties in advancing their issues because they relied on qualitative accounts and recommendations that could not easily be translated into clear policy responses. It is claimed that policymakers, for example, had no idea of the prevalence in the general population of the issues that women activists reported. Therefore, since this study intended to provide policy relevant findings that could be used in improving future programming on service delivery, state building and citizen empowerment, mixed approaches were more appealing. This is what Morgan (2007) means by the need to achieve a sufficient degree of mutual understanding with not only the people who participate in our research but also the colleagues who read and review the products of our research and the policymakers who utilise the findings to advance human conditions.

However, in spite of the advantages that mixed research approaches promise, many researchers are sceptical about using them. One of the main reasons for this is that at the methodological level, research projects are still crafted in ways that justify the use of alternative approaches as merely playing a “supplementary and illustrative role” (Du Toit 2005:11) but not for their ability to “inject distinctive perspectives” in the research process (McGee and Brock 2001:28). Due to this, integration efforts are viewed by the
adherents of either approach as designed cooption and as seeking to consolidate the hegemonic position of one discipline over the other (Tashakkori and Teddlie, 1998).

In what is touted as the ‘incompatibility thesis’, several researchers have reservations for fully integrated research approaches based on ontological, epistemological and methodological chasms that are allegedly opened when two research approaches are ‘forced’ to work together (Onwuegbuzie and Leech, 2005; Tashakkori and Teddlie, 1998). It is claimed that mixed methods researches are suspect to lacking rigour because more often the practice require researchers to abandon the original conceptual and methodological standards of the different approaches including the ways in which data should be collected, interpreted, and presented (Blaike, 2000). For instance, some integration may require a certain degree of standardising tools and statistical sampling of respondents from qualitative approaches to allow comparisons and representativeness respectively. It is argued that in so doing, the basic tenet of qualitative research, that is collecting data in a natural setting with people’s responses guiding the process, is lost (Kanbur and Shaffer, 2007). Therefore, abandoning particular assumptions, rules and expectations regarding the conduct of different methods lead to ‘corruption’ of those methods and the results obtained through such revisionism become questionable (Downward and Mearman, 2007). Thus, fanatics of both qualitative and quantitative approaches concur that for the method to be valid, one needs to adhere to its original values and application techniques.

It is important to note that the experience from the current study shows that these challenges are not unsolvable. As foreseen by Paul Streeten, ‘the only forum where interdisciplinary studies in depth can be conducted successfully is under one skull’ (cited in, Hulme and Toye, 2006). To this end, the researcher invested time into learning how to use both qualitative and quantitative methods before fieldwork. Even at the point of data analysis, the researcher trained on how to use both quantitative analysis software packages such as Statistical Package for the Social Sciences (SPSS) and qualitative data analysis techniques particularly Nvivo. It is this competency that, as earlier noted, enabled the researcher to adhere to the methodological requirements of quantitative and qualitative approaches at all the stages of the research process, that is, during data
collection, analysis and presentation. Therefore, a key methodological contribution made by this research is the illustration of how individual researchers can transcend methodological boundaries that might constrain investigating complex topics that genuinely call for mixing research approaches. Specifically, this research illustrates how state capacity and citizenship formation – the political outcomes that are less direct but ostensibly influenced by service delivery programmes of NGOs – can be investigated.

4.8 Processing, analysis and presentation of findings

This section discusses the processes involved in handling our quantitative and qualitative data during and after fieldwork.

4.8.1 Processing, analysis and presentation quantitative data

Data from the mini-survey was processed for computer-aided data analysis using SPSS version 16. Since this research involved comparing findings across three main study sites, Kruskal-Wallis was the main testing method used in identifying whether or not there were differences between them. The Kruskal-Wallis test is a nonparametric test that compares three or more unpaired groups or independent samples (Cohen et al., 2007). However, because “the Kruskal-Wallis test tells us only that there is or is not a statistically significant difference, not where the difference lies” (Cohen et al., 2007:555), whenever significant differences were observed, Post-hoc testing\(^{15}\) using Tukey-b honestly significant difference (HSD) would be done.

Besides the “between sites” comparison explained above, in some instances “within site” comparisons were also necessary. This is because, as already noted, the questionnaire integrated a temporal element to compare the pre and post MTP conditions in the two intervention sites of Kamuli and Masafu-Busia. To establish whether there were significant differences between pre and post intervention responses, the Wilcoxon Signed Rank Test was used. This is also a nonparametric test used for samples measured on two occasions or under two different conditions (Cohen et al., 2007; Ott and Longnecker,

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\(^{15}\) Post hoc tests are designed for situations in which the researcher obtains a significant test with a factor that consists of three or more group values and additional exploration of the differences among groups is needed to provide specific information on which group values are significantly different from each other.
However, there is a caveat that has to be considered while interpreting results from nonparametric statistics, which is that they cannot provide definitive measures of actual differences between population samples. In brief, a nonparametric test may tell you that two interventions are different, but it cannot provide a confidence interval for the difference. For the presentation of findings, the study uses descriptive statistics, graphs, cross-tabulations and tables.

4.8.2 Qualitative data processing and analysis

On the qualitative side, most interviews were audio recorded and later transcribed by the researcher. Due to the fact that most interviews were done in the local language the researcher transcribed meaning rather than verbatim. Qualitative data analysis was aided by Nvivo version 9 (Nvivo 9). Nvivo is a Computer Assisted Qualitative Data Analysis Software (CAQDAS) that supports the analysis of nonnumerical and unstructured data by indexing, searching, and theorizing. The software’s main advantage lies in its ability to facilitate logical storage, organisation and retrieval of huge volumes of textual and other qualitative type data. The logical sequencing of the data into categories or themes facilitates in-depth perusal of the different interviews in an ordered manner, requiring much less time and avoiding the confusion of manually going through text printouts (see Appendix 2 for an exemplar of NVivo analysis).

4.9 Ethical Considerations

The main participants in this research were the people with HIV/AIDS (PWAs). These are categorised as vulnerable people, because they suffer from a stigmatising and chronic illness (Liamputtong, 2007). The researcher took the necessary precautions to ensure that they and other participants in the study were not adversely affected because of their involvement. The study complied with the ethical standards required of a research undertaking of this calibre by ensuring that critically ill clients are left out for their safety (also see, exclusion/inclusion criteria above). The researcher honoured participants’ right of being informed about the nature and consequences of the research by seeking for their informed consent based on full knowledge of the research. Most importantly, study participants voluntarily participated “without physical or psychological coercion”
(Christians, 2005:145). Participants were informed and assured of their right to refuse to participate and withdraw from the research anytime if they so wished.

The study endeavoured to respect the confidentiality and privacy of participants to safeguard against unwanted exposure. In line with this, the study has concealed the true identity of the participants and where names are mentioned these are pseudonyms instead of their real names.

Lastly, the study sought ethical approval from research regulating institutions at various levels before embarking on fieldwork. The researcher started with the University of Manchester Research and Ethics Committee. Approval was also got from TASO Research Review Board and the Uganda National Council for Science and Technology. The study endeavoured to strictly adhere to the conditions of approval from these institutions. Copies of the approval letters are attached as Appendix 5.

4.10 Challenges encountered in the field

Due to the rural setting of the study and associated low literacy levels of the population, we encountered difficulties in trying to explain concepts such as the ‘state’ and ‘legitimacy’ that have no direct translations in the local language. Language also proved to be a challenge in some interviews. This issue arose in a few interviews in Busia where Samia the main language employed is less related to Luganda – the researcher’s mother tongue. According to Sands and others (2007), language differences between an interviewer and interviewee can challenge the interviewer’s ability to enter into a meaningful conversation thereby limiting the collection of valuable data. The researcher used a translator to go around this challenge.

Districts had severe inadequacies in maintaining proper records, especially because they mostly relied on manual storage systems. Such systems, as reported in Chapter Six, are associated with a high incidence of missing records – a problem that was more acute in the non-MTP hospital. The study areas also had irregular electricity supply and this affected the possibility of photocopying some of the useful documents that the researcher was interested in.
There was a problem of getting audience from some respondents. Several key informants were always ‘busy’ and others dishonoured their appointments. In a few cases the researcher was compelled to engage into very rushed conversations that fell short of the standards of qualitative interviews.

Lastly, and similar to other researchers, the author had his preconceptions especially due to his previous links to TASO. Prior to commencing this PhD course, the researcher worked in TASO’s service branch of Tororo as the Project Officer for four years. Such positioning pose a risk of biased reporting (mostly favourable) and/or biased responses from respondents (McGee and Gaventa, 2010). However, several points need to be considered on this. The researcher worked in TASO branches which as discussed in Chapter Five, are operationally independent from MTPs. In fact, the organisation has separate structures as regards to reporting lines for activities in MTPs and TASO service branches. Therefore during his service as a TASO employee the researcher had minimal contact with and knowledge about MTPs. For instance, the researcher had not met any of the PWA respondents in MTPs before this fieldwork and had only visited Busia MTP. Additionally, this positioning had some benefits. It was the prior knowledge about MTP that facilitated its selection as a suitable case for empirically investigating our research questions. As argued by some, “the strategic selection of cases requires that we know something of the characteristics of a case before the case study proper begins” (De Vaus, 2001:239). Most importantly, during fieldwork one would hardly know that the researcher had ever worked with TASO. The easy access that was hoped was in reality not realised as the researcher was treated like all external investigators who carry out research in this organisation. Our research protocol had to be reviewed by the organisation’s internal ethics committee and the researcher had to pay the $500 research fee charged from international investigators. Moreover, in some cases there was difficulty in securing interviews from senior officials, who probably in their subconscious still considered the researcher as their old ‘subordinate’.

Overall, the researcher believes that a great deal of reflexivity, during data collection, analysis and presentation, enhanced his ability to undertake this study professionally.
Every effort was made to listen to the people whose view of their own world he sought to understand. Finally, in order to minimise “social desirability”, respondents were not informed about the researcher’s prior relationship with TASO.

4.11 Conclusion
This chapter aimed at discussing how the researcher went about the key decisions relating to ontological, epistemological and methodological aspects for this study. The study’s interest is to understand how people’s experiences, attitudes and behaviours vis-à-vis the state and capacities of state agencies were affected by TASO’s implementation of MTP. The research approach chosen to investigate this issue can usefully be described as a social constructivist version of critical realism, which employed contextually-grounded qualitative methods within a mixed methods approach. The chapter acknowledges that all research approaches have their strengths and weaknesses but the choice should ultimately be based on the nature of the research questions at hand. In the next chapter, further details concerning the SD-NGO TASO and its MTP are provided to put the reader in a better position to judge the impact of this project on state building which is discussed in Chapter Six and citizenship formation that is handled in Chapter Seven.
CHAPTER FIVE
Background and Structure of TASO’s Plan for Building State and Citizenship Capacity

5.1 Introduction
This chapter has the straightforward goal of describing the SD-NGO TASO, its MTP and how the project was elaborated in our study sites of Kamuli and Masafu-Busia. This description is important for it forms the baseline upon which the changes in state capacity (Chapter Six) and citizenship (Chapter Seven) that the study links to MTP will be compared. In view of this goal, the chapter is structured as follows: the next section locates TASO as a ‘development partner’ of GoU in the implementation of HIV/AIDS activities within the broader context of the Ugandan NGO sector. This is followed by the description of MTP itself in terms of its origins, aims and objectives. A brief analysis of the pre-existing situation in the field sites of Kamuli and Masafu-Busia prior to TASO’s intervention will follow. After this, a step-by-step discussion of how the project was expected to be implemented vis-à-vis what actually transpired on the ground will follow with a focus on the following: project initiation, staff training, funding management and handling of phase out. The last section concludes the discussion.

5.2 TASO and its role in HIV/AIDS management in Uganda
TASO stands for The AIDS Support Organisation (TASO) Uganda Limited. It is an indigenous NGO established in 1987 to “contribute to a process of preventing HIV, restoring hope and improving the quality of life of persons, families and communities affected by HIV infection and disease” in Uganda (TASO, 2007a:2). From a mutual group comprising of 16 volunteers whose initial aim was to provide emotional support and encouragement to members infected and affected by the HIV infection (Grebe and Nattrass, 2009; Ssebbanja, 2007), TASO has grown into one of the largest HIV/AIDS service NGOs in Africa (Grebe and Nattrass, 2009; TASO, 2008), and it is widely regarded as a global role model on HIV/AIDS management (Danida, 2007; Garbus and Marseille, 2003; Museveni, 2004). Across Uganda, TASO operates 11 service centres and these are organised into four Regional administrative units (see Figure 5.1). In addition, TASO has its own semi-autonomous Training centre and Headquarters located in Uganda’s capital, Kampala. TASO’s vision is to see “a world without AIDS” (TASO, 2007a:2).
Since its inception, TASO’s core business has been HIV counselling, medical care, social support, advocacy for PWAs, and capacity building of communities and organizations both public and private to provide HIV/AIDS care and prevention services (TASO, 2002:51-56). Since the early 1990s, TASO is projected to operate an annual budget in millions of dollars with the figure crossing to over $10 million per annum in the mid-2000s (Coutinho et al., 2006). As the discussion in the following sections reveals, this puts TASO among the top-funded NGOs in Uganda. According to Coutinho and colleagues (2006), TASO’s budget is distributed among its core activities as follows:

a) 26% for Medical Services
b) 24% for Counselling Services
c) 5% for Social Support Services
d) 1% for AIDS Education and Advocacy

Source: (TASO, 2005b)
e) 20% for training and building the capacity of other organizations

f) 24% for Administration.

Two important points need to be highlighted at this point. First, the mini TASO Project (MTP), which is the focus of this study, falls under component (e) ‘training and building the capacity of other organizations’. However, this is not the only capacity building activity for TASO, the NGO has other projects, such as TEACH (TASO Experiential Attachment to Combat HIV/AIDS) which identifies personnel from HIV/AIDS organisations (including government) within Uganda and across Africa for a month’s field attachment amongst TASO’s service branches (TASO, 2007a). Besides this, TASO trains CBOs and CSOs on HIV/AIDS issues. The second point is that the list of TASO’s activities above shows that the SD-NGOs versus Advocacy NGOs dichotomy, as explored in Chapter One, is difficult to sustain as activities d) and e) are not service delivery per se.

To illustrate its contribution to Uganda’s HIV/AIDS interventions, Table 5-1 summarises outputs of TASO service branches on selected activities in the period 2003-2009.

Table 5-1: Selected outputs of TASO (2003-2009)

<table>
<thead>
<tr>
<th>Selected activities</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual PWAs registered</td>
<td>15,934</td>
<td>25,194</td>
<td>23,385</td>
<td>21,066</td>
<td>23,800</td>
<td>21,270</td>
<td>23,454</td>
</tr>
<tr>
<td>Annual PWAs counselled</td>
<td>30,512</td>
<td>43,498</td>
<td>49,362</td>
<td>54,009</td>
<td>59,949</td>
<td>65,822</td>
<td>76,413</td>
</tr>
<tr>
<td>PWAs given medical care</td>
<td>33,704</td>
<td>48,612</td>
<td>75,290</td>
<td>76,709</td>
<td>83,817</td>
<td>88,274</td>
<td>83,777</td>
</tr>
<tr>
<td>Annual ART enrolment</td>
<td>-</td>
<td>1,001</td>
<td>5,003</td>
<td>4,098</td>
<td>8,079</td>
<td>5,885</td>
<td>9,889</td>
</tr>
<tr>
<td>Number of MDD shows</td>
<td>757</td>
<td>804</td>
<td>1,017</td>
<td>954</td>
<td>928</td>
<td>728</td>
<td>588</td>
</tr>
</tbody>
</table>

Source: TASO annual reports for the respective years.

Although the numbers in Table 5-1 look impressive, they can only be appreciated in relation to the organisation’s contribution to national efforts. Unfortunately, MoH has “no reliable facility data available to ascertain trends in coverage of HIV services” (Ministry of Health, 2011:13). However, there are other respected sources for national HIV/AIDS

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16 TEACH was funded by Sida (Swedish International Development Agency) for the implementation period of 6 years (2005-2011).
performance information such as the United Nations General Assembly Special Session on HIV/AIDS (UNGASS). A recent UNGASS report indicates that the number of Ugandans receiving ART services (from all providers) was 67,525 in 2005, 141,416 in 2008, and 200,213 in 2009 (UNGASS 2010:33). For the same period, TASO had a total number of 5,788 people on ART in 2005 (8.6% of the national total), 22,649 in 2008 (16% of the national total) and 34,818 in 2009 (17.4% of the national total). TASO’s performance can further be understood when one looks at its position within the NGO sector in Uganda.

5.3 The state of Uganda’s NGO sector
In Uganda, NGOs represent one of the fastest growing sectors: from under 500 NGOs in 1992 (World Bank, 1994:21), their number skyrocketed to 2,655 in 2000 and to approximately 4,000 in 2003 (Wallace et al., 2004:18). Recent estimates put the figure in the region of 10,000 (Grover et al., 2011; NGO Forum, 2011) and the sector is described as “still growing” (Wallace et al., 2004). This proliferation is, however, not unique to Uganda especially when quick comparisons are made with her East African neighbours. For instance, Kenya’s NGO sector grew from 511 NGOs in 1996 to 2,511 in 2003, jumping to 6,000 in 2008 (Brass, 2011; Brass, 2012). In Tanzania, there were 41 registered NGOs in 1990 exploding to more than 10,000 in 2000 (Hearn, 2007). Some analysts also argue that this surge in NGOs numbers must not be interpreted as evidence of civil society numerical strength for much as multitudes of NGOs are forming, an equally phenomenal rate of ‘NGO mortality’ could be taking place. Barr and colleagues, in their 2002 survey into the activities of the NGO sector commissioned by the Office of the Prime Minister (OPM) of Uganda, estimates that merely between 15 to 30% of NGOs officially registered with Ugandan authorities were active in the field (2005:662). However, the 2008 follow-up study put the survival rate of NGOs seen in 2002 at 83% (Burger and Owens, 2011:10; Grover et al., 2011). Furthermore, in spite of the high numbers, Uganda’s NGO sector is dominated by a few large players which enjoy a disproportionate share of resources (both financial and human) from both internal and external sources. For instance, whereas Barr and colleagues reported that “two thirds of surveyed NGOs [had] revenues of less than US$ 50,000 per year” and that the median revenue for all NGOs was USD $22,000 (2005:665), TASO is said to operate a multi-million dollar budget annually (Coutinho et al., 2006). In terms of human resources, the situation is not much different: the big three NGOs in the aforementioned survey accounted for three quarters of the manpower
resources of the entire sample of 295 NGOs (Barr et al., 2005:669). Barr and colleagues report a median of 18 employees for NGOs in their sample. TASO can be described as one of the biggest NGOs in Uganda for it has had more than 1,000 employees since 2005 with each of its 11 service centres having at least 80 full-time staff members (Coutinho et al., 2006).

Given the statistics above, some have posed a provocative question: “Without money or staff, what can NGOs in Uganda do?” (Werker and Ahmed, 2008:85). Some claim that they do not do much. Barr and colleagues’ (2005) study and its 2008 follow-up by Grover and others (2011) report that most Ugandan NGOs describe their activities in general terms like “raising awareness” and “advocacy”. According to these researchers, these are “talk” activities that give no material benefits to communities. Moreover, the output from the ‘talk’ activities is dismal. Evidence presented by Barr and colleagues (2005:663) shows that only 50% of the NGOs in their sample could reach 400 people in a whole year through their awareness campaigns. In comparison, TASO’s awareness campaigns in the year 2006 (reported in Table 5-1) were estimated to have reached 294,454 people (TASO, 2007b) – this output is more than 700 times higher than that of an average NGO.

Generally, when it comes to identifying activities to engage in, many Ugandan NGOs embrace a “holistic” or “multi-sectoral” approach whereby they engage in multiple issues as opposed to specialising in one sector (Barr et al., 2003; Grover et al., 2011; Wallace et al., 2004). NGOs claim that this strategy offers flexibility not only in resource mobilisation but also in dealing with the multidimensional concerns of their clients and stakeholders. However, some scholars (e.g. Michael, 2004) argue that the absence of specialisation preclude NGOs from acquiring expertise in any particular field, which consequently undermines their development potential. TASO’s experience seems to support this argument. By focusing its attention on HIV/AIDS, TASO was able to develop its profile as a credible NGO capable of building relationships with communities as well as develop effective community-based service delivery strategies. Scholars elsewhere have argued that such niche skills make NGOs appealing not only to state agencies but also to community members (Batley, 2011; Chhotray, 2008; Joshi and Moore, 2000). Thus, as discussed later in the chapter, this explains why when TASO decided to expand its operations in the 2000s many local governments were eager to partner with it.
5.3.1 NGO-state relations in Uganda: Drivers and impact on performance

Several observers suggest that TASO managed to expand its operations and build a reputation in the HIV/AIDS sector largely due to the cordial relationship it has enjoyed with the state since its inception (Dia, 1996; Grebe and Nattrass, 2009). For instance, TASO’s transformation from an informal support group to a formal organisation started when the Medical Superintendent of Mulago hospital (Uganda’s national referral hospital) offered premises where it established its first office in 1987 (Calvarese et al., 2007; Ssebbanja, 2007; TASO and WHO, 1995). Even after TASO got resources from international donors agencies, which would allow it to establish offices in locations of its choice, the government continued to donate portions of hospital land where all but one of the 11 TASO service centres are currently situated\(^\text{17}\) (Coutinho et al., 2006). Of course, this could be taken as evidence of the privatisation of public services by the state. However, ‘privatisation’ in the Ugandan context does not necessarily imply the reduction of the role of the state in service delivery. Instead, it is a complex sharing of responsibilities between the state, NGOs and private for profit providers (also see Therkildsen and Semboja, 1995:3) in which, as exemplified in Table 5-2, all the three actors have increased their presence over the last decade.

### Table 5-2: Health facilities in Uganda by level and ownership

<table>
<thead>
<tr>
<th>Facility level*</th>
<th>2004</th>
<th>2006</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Govt</td>
<td>NGOs</td>
<td>PHP</td>
</tr>
<tr>
<td>Hospitals</td>
<td>55</td>
<td>42</td>
<td>4</td>
</tr>
<tr>
<td>Health Centre IV</td>
<td>151</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Health Centre III</td>
<td>178</td>
<td>164</td>
<td>22</td>
</tr>
<tr>
<td>Health Centre II</td>
<td>1055</td>
<td>388</td>
<td>830</td>
</tr>
<tr>
<td>Total health units</td>
<td>1439</td>
<td>606</td>
<td>858</td>
</tr>
</tbody>
</table>

* Source: based on (Ministry of Health, 2010d)
* Health centres correspond to the respective local council level (see Table 3-6).

At the district level, all TASO branches are members of their respective District AIDS Coordination Committees (DACs) – the government structures responsible for designing

\(^\text{17}\) Only TASO Mbarara is not located on government land due to limited space within Mbarara hospital.
and implementing district HIV/AIDS policies and programmes (Muriisa, 2006; TASO, 2002). The district administration in return has reciprocal representation on the governance structures of TASO’s 11 service centres called Centre Advisory Committees (CACs)\(^{18}\), whereby the District Health Officer (DHO) of the local government that hosts a TASO service centre is an ex officio on the CAC (Bukenya, 2008). Therefore, Muriisa’s (2006:170) observation that TASO’s relationship with the state is “symbiotic and enacted in a reciprocal way” seems accurate. Although as argued in Chapter One, critics suggest that such closeness leads to NGO co-optation, TASO’s experience supports those who observe that NGOs register more impact when they have close ties with the state (see, Lavalle et al., 2005).

TASO-state relations have to be understood within the broader context of the national HIV/AIDS response in Uganda. The formation of TASO, as hinted in section 3.5.3, coincided with the period in which the then new NRM government acknowledged that the magnitude of the HIV/AIDS problem it had inherited from its predecessors was at a scale that it could not handle on its own. Therefore, by supporting one of the earliest organised responses, TASO, the state wanted to signal its commitment to, and encourage other non-state actors to engage in, the HIV/AIDS response. This ‘signalling’ can be observed further when the state appointed 10 representatives of NGOs (including TASO’s) on the advisory committee of the AIDS Control Programme\(^ {19}\) (ACP) (Bukenya, 2008). Ssebbanja (2007:18) vividly brings out the mood the act of including TASO on the ACP had, which is reflective of what other NGOs could have felt:

> The National AIDS Control Committee recognised the importance of what TASO was doing, and invited Noerine Kaleeba [TASO founder] to join it as a member. This gave us an opportunity to emphasise the importance of proper care and support for people living with AIDS... and allowed us to start promoting – within the government health system itself – the TASO message ... (Ssebbanja, 2007:18).

Thus, in the eyes of TASO, the state was perceived as receptive and willing to learn from non-state actors through a process of genuine consultation (Coutinho et al., 2006).

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\(^{18}\) These nine-person CACs are elected by clients and subscribing members of the community within which the centre operates. They are elected during the centre’s annual general meeting and advise the centre management. They also play a crucial role of mobilising community awareness of, and support for, TASO.

\(^{19}\) ACP was the first government organ that was established in the office of the president to coordinate HIV/AIDS response in the country.
However, those NGOs that play a ‘watchdog’ role over issues like corruption and activities of the military – issues that Ugandan authorities consider as “no go areas” for NGOs/CSOs – are harassed and, as recently stated by a senior government official, NGOs are ‘advised’ to “back off politics” 20. The persistent ones have had their operating licences delayed or revoked. Examples here include the Uganda Human Rights Education and Documentation Centre (UHECOC), which was deregistered in 1999 after it hosted a critical seminar on corruption in Uganda (Dicklitch, 2002: 211). Recently, Oxfam GB and the Uganda Land Alliance have been threatened that their operating licenses will not be renewed because of producing a critical report on state-orchestrated land grabbing in the country 21. Consequently, although there are a good number of Ugandan advocacy oriented CSOs 22, they engage in a great degree of self-censorship vis-à-vis the state. This is evidenced by NGOs’ strategies of operation. According to Grover and colleagues:

45% of those organisations involved in advocacy use meetings with national government to raise issues and 84% use local government meetings. In comparison fewer NGOs use petitions or marches (around 10% each) to advocate their cause, whereas over 40% use public broadcasting to express their views (Grover et al., 2011:14).

Paradoxically, even human rights NGOs shy away from confronting the regime on ‘hot’ issues, hence they are described as engaging in ‘the politics of being non-political’ (Dicklitch and Lwanga, 2003).

The harsh operating environment is reflected further in the stringent regulations that Ugandan NGOs have to conform to which, once again, appear to be thornier to political/advocacy oriented NGOs than their SD-NGOs counterparts (Grover et al., 2011). Currently, NGOs are governed primarily by the NGO Registration Act first enacted in 1989 and amended in 2006 (Tiwana, n.d). This Act has been a centre of controversy, as it is seen in the NGO circles as a government tool for not only circumscribing the scope of their work to “residual welfarist” activities, but also a licence to meddle into their management and operational decisions considered by many to be internal NGO matters.

22 Indeed, 71% of NGOs in Uganda claim to have advocacy programmes (Grover et al., 2011)
(Forum, 2009; NGO Forum, 2011; Tiwana, n.d). One of its most controversial aspects is that it bars NGOs from making contact with communities without prior consent of LC officials and/or the President’s representative in the area (Forum, 2009; Tiwana, n.d). It is argued that such restrictions act as a sifting mechanism that eliminates politically sensitive messages from reaching the grassroots. This explains why the few politically vocal NGOs are only active in Kampala and its suburbs with a thin presence in upcountry areas. These observations indicate, as argued in Chapter Three, that LCs are used by the state as a tool for political control. However, in their support of the stringent regulations, Ugandan authorities argue that tough legal trappings are aimed at discouraging unscrupulous people from infiltrating the NGO sector (Burger, 2012). Authorities often cite the Movement for the Restoration of the Ten Commandments, a registered faith-based NGO that masterminded the gruesome murder of around 1000 of its followers in the year 2000, as an example of laxity in laws that must never be allowed to reoccur (Barr et al., 2005). It is perhaps because of such security concerns that the NGO registration Board is under the Ministry of Internal Affairs albeit to the displeasure of the NGO fraternity. According to NGO activists, entrusting the supervision of NGOs with the ministry in charge of the country’s security is an indication that the government is more concerned about its security than the welfare of its citizens that NGOs strive to improve (Dicklitch, 1998; Wallace et al., 2004). These developments should not be surprising given the dominance of authoritarianism in the ‘hybrid’ character of the NRM regime (see Chapter 3).

The background of NGO leaders also appears to influence state-NGO relations. It is argued that one of the main ingredients in TASO’s interaction with the state is the fact that most of the 16 founder members were originally government employees working in various capacities at Mulago hospital (Calvarese et al., 2007; Ssebbenja, 2007:6). Some believe that this gave an impression to state functionaries when TASO was launched that it was the government itself instigating a response to HIV/AIDS. This observation contrasts the usual academic accounts that TASO founders were private members of civil society who came together in response to the state’s inaction (Tumushabe, 2006). Moreover, the positioning of the founders as public officials, many of whom held senior positions in the
national hospital\textsuperscript{23}, presented an opportunity for them to use their personal contacts to the benefit of the infant organisation (Grebe and Nattrass, 2009). For instance, in the first five years of TASO’s existence (up to 1991), founding members held their government jobs concurrently with TASOs (Ssebbanja, 2007). This implies that they were allowed by their “friends” in government to work part-time yet still drew the salaries of full-time government employees. A related point is that for a considerable period of time, TASO never hired its own doctors as its AIDS clinics benefited from the services of health workers seconded by [colleagues in] government hospitals (Ssebbanja, 2007; TASO, 2007a). Thus, as observed by Edwards and Hulme (1992:18), “personalities and relationships” between individual NGO leaders and state officials are a vital element for effective performance of development NGOs, and could be more beneficial than autonomy.

Last but not least, NGO-state relations in Uganda are also shaped by the influential donor agencies. At the time of forming TASO, powerful multilateral and bilateral donors were backing GoU to formulate national HIV strategies whose implementation was to depend on the contribution of various actors from different sectors. This culminated into the formulation of the so-called Multi-sectoral Approach to the Control of HIV/AIDS in Uganda (Bukenya, 2008). Some international donors agencies like Danida and USAID chose to channel their funding through selected NGOs like TASO, Straight Talk Foundation (STF) and Hospice Africa Uganda (HAU), with claims that this was “earmarked” funding for specific interventions in the National Health Plan but only “competently provided” by the selected NGOs (see, Danida, 2004; 2007). Donors clout, from finances, technical experience and political influence, allowed them to sustain the momentum for implementing the inclusive partnership approach and creation of an enabling environment for civil society to participate in the AIDS response, both of which had been initiated by the state itself (Chapter Three; Grebe and Nattrass, 2009). Arguably, this helped to avert the prediction in some literature that direct funding by foreign governments to NGOs (regardless of the activities they engage in) makes the state suspicious of such NGOs (Bratton, 1989).

\textsuperscript{23} TASO’s first Director Noerine Kaleeba was previously the Principal of the School of Physiotherapy at Mulago Hospital while Dr Elly Katabira the first Medical Coordinator of TASO (now a professor of Medicine) was Medical Officer in the same hospital.
What can be extrapolated from the foregoing discussion is that while NGOs have blossomed since 1986, there are serious resource and political constraints that prevent them from operating effectively. In particular, advocacy or ‘political’ NGOs have a hostile operating environment because their activities attract state repression. However, building on the discussion in Chapter Three, the section has illustrated that the state does not only welcome SD-NGOs but it also (sometimes) provides assistance to help them form, allows them to receive foreign funding, and it consults them in formulating national policies. These observations should not be surprising given donors’ support which also chimes with the personal interest of the President in Uganda’s response to the HIV/AIDS epidemic. In the next section, the chapter analyses the history of MTP.

5.4 The invention of the Mini TASO Project: consolidating relations with the state or bait for capturing donor funds?

According to TASO officials and the organisation’s 2003-2007 Strategic Plan (TASO, 2002), it was realized during the late 1990s that the existing TASO centres only covered areas around the Trans-Africa Highway which runs from western Kenya through eastern Uganda to Rwanda via central and western Uganda (see Figure 5-2). Indeed, from 1991 to 2004 TASO operated seven centres, namely, Mbale, Tororo, Jinja, Kampala (TASO Mulago), Entebbe, Masaka and Mbarara which, as indicated in Figure 5-2, are located along the aforesaid highway except for TASO Entebbe and Mbale. This left the north and western parts of Uganda “inadequately covered by TASO and indeed by any other significant care and support organization” (TASO, 2002:57).

This maldistribution of TASO centres was not so much in relation to the NGO’s preference to areas that have social amenities over rural areas which, to some critics, is often the case with Southern NGOs (Jones, 2009; Mercer, 2002; Werker and Ahmed, 2008). Rather for TASO, “[it] was on purpose because those days HIV prevalence was highest in towns along [this] highway. It was only later that the epidemic become generalized” (former TASO staff HQ male official, 6th/5/2011). The 2003-2007 strategic plan makes similar claims, although it acknowledges that TASO’s strategy was “reactive” and that “since the epidemic has now spread to the rest of the country, there is need to come up with an

24 However Mbale and Entebbe according to the map are also just a few kilometres away from this highway.
approach that reasonably addresses the HIV/AIDS crisis with due regard to a more equitable distribution of services at a National level” (TASO, 2002:59).

Figure 5-2: Map of Uganda showing the main highways

Source: (http://www.maps-guide.net/uganda/maps.htm).
Note: The Trans African highway is the one that runs from Tororo, through Jinja, Kampala, Masaka, and Mbarara before connecting to Rwanda.

Given this background, TASO strategists identified ‘scaling-up’ as a priority activity for the 2003-2007 strategic period (TASO, 2002). They formulated a two-pronged approach for scaling up, a ‘direct’ and an ‘indirect’ approach. The direct approach, which is similar to what Edwards and Hulme (1992) call the ‘additive strategy’, involved setting up new TASO service centres.25 However, it was observed that TASO could not rely on the direct expansion strategy alone because “a fully fledged centre” requires a lot of resources in terms of infrastructure and personnel to run it (various interviews with TASO KIs 2011). Therefore, according to TASO officials, this justified an indirect-cheaper approach through transforming already existing government hospitals to start delivering “TASO-like services” (also see, TASO, 2007a). This is akin to Edwards and Hulme’s (1992) ‘multiplicative strategy’.

25 Between 2004 and 2005, 4 new TASO centres were created in the districts of Gulu, Soroti, Rukungiri and Masindi.
Apart from the need to scale up services at a cheaper cost, TASO (2005a) enumerates two additional points justifying this so-called indirect expansion approach. One is that TASO had learnt from its previous experience that no single organisation or project could solve all the problems in the HIV/AIDS sector on its own, hence “building the capacity of other organisations, hospitals in this case, to do similar work would help reach more people” (2005a:2). The second one is that the idea of mini TASOs coincided with the period when the GoU was planning to accelerate ART services access for the poor. In TASO’s view, however, the local governments, meant to implement this, were ill-prepared for ART because they had “inadequate levels of capacity, resources, community mobilization and community involvement” (TASO, 2007a:18; also see Chapter Three on how districtisation has further weakened bureaucratic capacity in Uganda). At this time, government health facilities were only focusing on facility-based delivery and supply of drugs to patients, yet, from TASO’s experience, successful HIV/AIDS service delivery required a combination of facility and community based approaches as well as a strong emphasis on addressing patients’ psychosocial needs through counselling (Ssebbanja, 2007). Since TASO had made a name for itself in the area of community-based and psychosocial HIV/AIDS management, it became the self-appointed ambassador for redressing this capacity gap in local governments. Thus, MTP had a twin objective of a) contributing to building the capacity of public health institutions to integrate and provide HIV/AIDS prevention, care and support services, and b) increasing the number of people accessing HIV/AIDS services in public health institutions (TASO, 2005a).

However, apart from these “official” reasons from TASO, the study identifies another factor that could have influenced the NGO’s decision to create MTP. It is observed that the advent of ART expansion plan noted above was accompanied by generous international funding programs such as the World Bank’s Multi-Country HIV/AIDS Program (MAP), United Nations’ Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and United States’ President’s Emergency Plan for AIDS Relief (PEPFAR). MAP and GFATM, in particular, put emphasis on building the capacity of the public health system. MTP, therefore, can be interpreted as a strategy that TASO used to position itself to maximally tap funds from these initiatives. The abundance of resources might explain why, by the end of 2006, 12 MTPs had been created (TASO, 2005a:12) instead of the six
suggested in the 2003–2007 strategic plan (TASO, 2002:67). Palmer (2006:239), in her comparative analysis of NGOs in Africa and Asia, makes similar observations that NGOs “were not only motivated to fill gaps in inadequate public sector provision but also were keen to access resources from donors and/or government to sustain or develop their organizations”.

The above notwithstanding, owing to its credibility and good relations with central government, many districts eagerly welcomed TASO’s idea for an intervention to improve their performance. During fieldwork, respondents in MTPs reported that the “TASO brand” had become so prominent to the effect that merely calling district hospital’s HIV/AIDS departments “mini TASOs” attracted service users they had failed to bring on board before. A male FGD discussant from Kiwoko MTP (found in Luwero district) brought out this point:

TASO being one of the organizations that were pioneers for the care of HIV patients just that name makes a difference when they come to the area. [When] they came in Kiwoko it happened that we had a clinic but people were not turning up as many, but when they heard that we are now a “mini TASO”, just because of that name, it made a difference... when we added in these programmes like my colleague said the radio programme, sensitisation programme and drama group activities, the number [of PWAS] increased. At first they were like 250 but right now the clinic is in 1500 people (male health worker Kiwoko MTP, 24/1/2011).

However, this point in turn highlights the need to examine how beneficiaries would respond when the NGO that attracted them to these state agencies withdraws. In other words, can government hospitals maintain the confidence of service users on their own? This issue is integrated in the analysis of Chapters Six and Seven. In the next section, the chapter analyses the situation in the study sites before MTP.

5.5 Kamuli and Masafu-Busia hospitals before TASO’s intervention

Prior to TASO’s intervention, both Kamuli and Masafu-Busia hospitals had introduced ART programmes in 2005. Although GoU guidelines are not specific on numbers, they stated that before a health facility is accredited to provide ART services, it ought to have capabilities in various areas including:
a) the presence of basic physical infrastructure (space for HIV counselling and testing, clinical assessment, drug storage and laboratory),

b) qualified personnel with experience in HIV/AIDS management, and

c) the ability to ensure the provision of follow-up care and support for families and communities with people living with HIV/AIDS. (Okero et al., 2003:5).

These aspects are closely linked to the dimensions of state capacity identified in Chapter Two. This is in the sense that whereas the availability of skills in counselling and ART management is akin to bureaucratic capacity, physical infrastructure relates to infrastructural capacity while follow-up care and support for families and communities is a combination of embeddedness and infrastructural/penetrative capacity.

Critics observe that in many hospitals, the reality on the ground at the time they started ART programmes sharply contrasted with the above policy prescriptions. Speaking in relation to the overall national situation, one observer noted that when MoH published a list of health facilities accredited to provide ART in early 2005:

“it was realized that some of the listed units did not have the necessary preparations for provision of ART in terms of personnel training, laboratory equipment, a well-organized AIDS clinic ... [and that] staff of some of the listed units saw their names in the newspaper without having been contacted or assessed by the Ministry of Health” (Orach, 2005:22).

As briefly discussed below, Masafu-Busia and Kamuli hospitals also had weak bureaucratic capabilities, limited embeddedness and low penetrative/infrastructural power. In turn, these weaknesses combined to limit the advancement of service users’ citizenship status. A useful caveat for the analysis below is that the researcher was unable to obtain records on key aspects such service delivery quality, although we tried to go around this issue by incorporating a temporal element in our interviews with the relevant stakeholders.

5.5.1 Bureaucratic capacity

In terms of bureaucratic capacity, which here relates to the training and expertise of government employees (Soifer and vom Hau, 2008), it is reported that when Masafu-Busia hospital introduced ART services, only one staff had been trained by MoH in ART administration. According to a senior medical officer in this hospital, this greatly constrained service provision:
The challenge we had before [MTP] was initiation, I was the only one to initiate because I was the only one trained [and yet] I was also the manager of the facility. The team I was working with had very basic understanding of the processes involved (Male health worker Masafu hospital, 14/4/2011).

Although the situation in Kamuli hospital was comparatively better than that of Masafu-Busia, they only had three Clinical Officers and two nurses trained by MoH to provide HIV/AIDS services (Female health worker Kamuli hospital, 21/3/2011). Paradoxically, however, even the so-called trained health workers claimed that they lacked psychosocial skills and that this limited their ability to educate and provide counselling services to PWAs (interviews with various health workers in Kamuli). This means that MoH training had focused on the medical aspects of ART management. This observation chimes with the findings of a 2008 MoH commissioned survey which reported that “only one-third of facilities prescribing ART and/or medical follow-up services have a provider trained in ART prescription or medical services and in counselling for adherence to ARV drug therapy” (Ministry of Health and Macro International Inc., 2008:187). Although patients’ enrolment on ART is influenced by many factors, health workers argued that it was primarily because of their inadequate skills in mobilization, counselling and ARV administration that they recruited fewer patients before MTP (Male health worker Masafu hospital, 14/4/2011).

**Figure 5-3: Annual enrolment of PWAs on ART in Kamuli and Masafu-Busia**

![Graph showing annual enrolment of PWAs on ART in Kamuli and Masafu-Busia](image)

Source: *Authors’ calculations based on ART registers*

According to Figure 5-3, in 2005 Masafu hospital only managed to recruit 27 PWAs on ART. When TASO came in 2006, the year’s enrolment was 135 patients, indicating 400%
increase from the previous year. Similarly, Kamuli hospital registered a steady increase in PWAs’ annual enrolment on ART after getting MTP.

For their part, several PWAs claimed that before TASO they received inadequate advice concerning treatment at the time they were enrolled on ART. This is exemplified by this respondent in Masafu-Busia: “I started getting treatment and then when I improved, I stopped taking drugs. This is because during those days, health workers would not tell us the importance of taking drugs consistently” (Male PWA Masafu hospital, 20/4/2011). The issue was that health workers concentrated on dispensing drugs thereby ignoring the psychosocial needs of their patients.

5.5.2 Bureaucratic embeddedness

Health workers in both sites had limited ability to create “dense sets of interactive ties” with their PWA clients, families and communities constituting the hospitals’ catchment area. It is reported that before MTP, health worker–patient relations were tense and characterised with ‘mutual mistrust’ (FGD with MTP service providers, 24/1/2011). Characteristic of the situation in public health facilities reported in Chapter Three, some PWA respondents claimed that instead of providing services, health workers would blame them for their condition of being HIV positive: “those days health workers looked at us as sinners. This even created self-stigma among patients. People refused to come out to test” (Male PWA Kamuli hospital, 1/2/2011). Apart from being antithetical to the development of trusting worker-patient relations which is the bedrock of effective health services (Birungi, 1998; Gilson, 2003; Goudge and Gilson, 2005), PWAs emerged from such relationships as second-class citizens. As discussed in Chapters Two and Seven, connotations of PWAs as ‘sinners’ point to the way PWAs were negatively constructed by health workers, and arguably, service providers with such attitudes are unlikely to have respectful relationships with clients. Indeed, some PWAs reported cases of physical harassment (Male PWA, Kamuli, op cit.). This observation also has parallels with reports that Ugandan elites tend to blame poor people for predicaments such as poverty that they find themselves entangled (Hickey, 2005). However, health workers defended themselves by stating that their poor attitudes were not because of personal choice, rather because they lacked knowledge, skills and other resources to enable them serve their patients professionally (interviews with two female health workers, Kamuli hospital...
14/1/2011 and 21/3/2011). As explained in the following sections, TASO appears to have concurred with this position as it prioritised working on the ‘supply side’ before empowering citizens to make demands. Another example of weak embeddedness is reflected in the absence of strong links between these hospitals and non-state actors such as NGOs. Indeed, one of the key determinants of TASO’s decision to select a particular hospital for MTP was the absence of such partnerships in the area of HIV/AIDS service provision. Similarly, it was also pointed out that at this time PWAs did not have membership groups to bring them together with each other and/or with the state (Male PWA Kamuli 10th/2/2011).

5.5.3 Penetration/infrastructural capabilities

Both Masafu-Busia and Kamuli hospital had no dedicated space for conducting counselling, which is crucial in addressing the psychosocial needs of PWAs. In addition, both sites had tenuous reach into the community before TASO’s intervention. As explained later in the chapter, there were no community programmes such as outreaches or home visits to monitor patients, but also to have services reach communities far away from these hospitals. Although the GoU Health Sub-District (HSD) structure dictates that the highest facility in the district, such as district hospital, has the responsibility to supervise and offer technical support to the lower ones, a combination of staffing shortages and inadequate skills meant that Masafu-Busia and Kamuli hospitals were unable to fulfil their supervisory obligations. This would have enabled PWAs to receive services from the rural facilities nearer to them. It was also reported that the budget from central government did not cater for community activities such as medical outreaches (Male health worker, Masafu hospital 4th/1/2011). Therefore, PWAs far away from the district hospitals, especially the poor, had difficulties in accessing health services. For instance, PWAs on the fringes of Lake Victoria in Lunyo sub-country (Busia District Local Government) would need transport costs of about USD $5 per month for the 30 km journey to Masafu hospital (several interviews with PWAs in the area, 20/4/2010). Given the socio-economic status of PWAs discussed in the previous chapter, such a cost was beyond reach for many. The same was true for PWAs in Kidera sub-county in Kamuli district (see maps below). Thus, whereas those citizens near the hospitals would ‘see’ the state albeit in rough encounters, many of those far away would rarely glimpse it at all (also see, Jones, 2009).
5.5.4 Implications for perceived quality of services

Given the above conditions, it is little surprise that our survey found that PWAs unfavourably rated the quality of services before MTP. Figure 5-5 summarises PWAs responses on eight selected indicators about service quality that is – staff responsiveness, privacy in consultations, opportunity to discuss concerns with health workers, the quality of explanations received, drug availability, waiting time, number of days services were available and the hours of service. PWAs ratings were below average on all aspects. However “waiting time” and “number of days services are available” had comparatively better ratings in both sites. For “waiting time”, the possible explanation is that since only fewer people were using the services, they would spend relatively less time at the facility. For “number of days”, it is because PWAs were free to come to the hospital as any other out-patient (OPD) patient. In the next section, we analyse the process of establishing MTPs and how TASO planned to address some of the above constraints in the targeted hospitals.
5.6 The process of establishing MTPs: ‘best fit’ or institutional isomorphism?

As noted already, through MTP, TASO aimed at recreating “TASO-like” approaches of service delivery in government hospitals (TASO, 2005a). In fact, besides introducing a similar service package, TASO also tried to re-create an administrative structure in government hospitals similar to that of its 11 service centres. For instance, the executive head of a TASO centre is the Centre Manager, similarly, for each MTP, hospitals were required to appoint among the existing staff someone to take the position of the Project Coordinator. In TASO, each Centre Manager is assisted by 5 Heads of Departments (HoDs), namely Medical Coordinator, Counselling Coordinator, Accountant, Human Resource Officer, Project Officer and Data Manager. Similarly the Project Coordinator in Mini TASOs was to be assisted by a Medical Coordinator, Counselling Coordinator, Community Coordinator/Drama Instructor and Data Manager – all of whom were to be selected from the already existing MoH staff (TASO, 2005a). It is important to note, however, that whereas each of the HoDs in TASO supervises a team of tens of frontline staff, this varied greatly in MTPs because hospitals comparatively had fewer staff than TASO. Moreover, whereas HoD positions in TASO go to individuals who have undergone specialized experiential and didactic training in leading HIV/AIDS programming, management of organisations and formal training (at least degree holders) (Molldrem et al., 2009), MTPs had less trained personnel whose main source of management training came with the establishment of mini TASOs.
At first sight, therefore, TASO’s strategy to ‘export’ its NGO-based approaches into the
government setting looks like ‘institutional isomorphism’ – the process of influencing one
organisation to adopt the character of another so that the two become “more alike in
identity, form and structure” (Teamey and McLoughlin, 2009:36). However, the
organisation also had an elaborate plan to ensure that its practices from the ‘NGO world’
are acceptable in the ‘government world’. According to TASO documents (TASO, 2005a;
2007a) and as corroborated with interviewees, MTPs were established through a three-
phased programme that involved: 1) Preliminary mobilisation, 2) Capacity building, and 3)
Service delivery phases. Thus, one can argue that these were elaborate processes aimed
at achieving ‘best fit’ (Levy, 2004). In the next section, we examine how this worked in
practice.

5.6.1 The preliminary/ mobilisation phase
According to TASO, identifying a local government to set up a Mini TASO was not always a
straightforward exercise as it would involve choosing from among several competing
districts (Female, TASO Central Region official, 7th/3/2011). Therefore, the preliminary
phase had three linked activities whose aim was to guide the selection process.

a) Data collection and analysis: This involved a desk-based research to assess the
HIV/AIDS status of the competing districts. Priority was given to those districts with high
HIV prevalence rates coupled with low presence of HIV/AIDS service providers. Although
this study was unable to access reports that guided the selection of the two study sites,
the TASO 2005 Midterm Review (conducted by external consultants) confirmed that MTPs
were established in “needy” districts. According to this review:

The mini-TASOs that build capacity within the MOH facilities are strategically
located in districts with extremely limited availability of and access to, and a high
demand for, HIV/AIDS services. The mini-TASOs are thus contributing directly to
expanding service coverage within Uganda and to improving the quality of life of
PLWHA ... (Scott et al., 2005: no pagination).

Indeed, recent research indicates that NGOs working in such remote areas help African
states to broadcast power over their territory (Brass, 2010b).
b) District ACOW: After selecting the district of intervention, TASO would disseminate the findings and mobilize the district leadership in the successful district for an AIDS Care Orientation Workshop (ACOW). Through the week-long ACOW, TASO would sensitise the district political and bureaucratic leadership about the values, principles and mission that TASO stands for, HIV/AIDS care and the range of services that are expected to be offered when MTP is established. It is claimed that ACOWs aimed at creating favourable attitudes or “political will” among the district stakeholders necessary to support MTPs in areas like allocating working space and accepting health workers to engage in the project (former TASO staff HQ official, 6th/5/2011). This observation has an important message that even though TASO is said to be non-political, it was cognisant of the political forces likely to influence the implementation of the project at the local level. Lange (2008) shows how the failure to handle such local politics caused premature termination of a sustainable housing project in Mwanza Tanzania. Local councillors vigorously opposed the project because they were not involved in its planning leading them to believe that it was empowering their political rivals – the leaders of the CBOs identified to implement the project at the local level. In the case of TASO, stakeholders were able to understand how project resources were to be used.

c) Signing of the memorandum of understanding: After the district ACOW, an MOU spelling out the roles of the district administration, implementing hospital and TASO would be signed. Whereas most studies on SD-NGOs and state relations have focused on agreements emanating from the state (e.g., Batley, 2011; Batley and Rose, 2011), here it was the SD-NGO that initiated the agreement. However, TASO’s MOUs are best seen in terms of what Batley (2006) calls a “collaborative partnership” – a form of flexible relationship binding formally constituted organisations in a joint venture.

For both activities b) and c), district officials in our study sites confirmed that they were consulted and satisfied with the level of involvement TASO made while bringing MTP to their districts. One of the top bureaucrats in Busia district even claimed that he was the one who approached TASO Eastern Region to bring MTP to his district:

> when you talk of Mini TASO in Busia, it is me who asked for it. Research was done sometime in 2000 [needs assessment discussed in a) above] when the process of developing this concept was just starting and there was a heavy workload here.
So I requested to be the first ones to benefit because TASO Tororo [the nearest TASO service centre to Busia] was far and yet people were pouring to our facility [Masafu-Busia]. So it was really our request – it was demand driven (male District official, 18/4/2011).

This official stated further that:

I remember when they were more or less ready they came and prepared an MOU. That MOU was spelling out our responsibilities and their responsibilities. And for us what I remember was the commitment that we would provide the health workers and the health facility – the structure. And they would provide [UGX] 50 million per year. TASO would provide that money to the Mini TASO.

The situation was similar in Kamuli where the researcher was able to access the MOUs signed between TASO, Kamuli Hospital and the district.

5.6.2 Capacity building phase

This second stage in establishing MTPs involved organising training sessions by TASO aimed at equipping selected MTP staff with various skills to enable them to competently do their new job. According to TASO, “the training modules are technically designed to equip the hospital staff with basic knowledge and skills necessary in the planning and implementation of HIV/AIDS services” (TASO, 2005a:6). In Table 5-3, the training modules and the actual numbers of people trained in Kamuli and Masafu-Busia are presented.

<table>
<thead>
<tr>
<th>No</th>
<th>Training</th>
<th>Duration</th>
<th>Target per MTP</th>
<th>Actual Kamuli</th>
<th>Actual Masafu/Busia</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Project Planning and Management (PPM)</td>
<td>2 weeks</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>2</td>
<td>HIV/AIDS Counsellor training</td>
<td>6 months modular</td>
<td>20</td>
<td>12</td>
<td>10*</td>
</tr>
<tr>
<td>3</td>
<td>Monitoring and Evaluation Principles and Practices</td>
<td>1 week</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>Principles and Practices of ART</td>
<td>1 week</td>
<td>30</td>
<td>12</td>
<td>10*</td>
</tr>
<tr>
<td>5</td>
<td>Management of opportunistic infections</td>
<td>1 week</td>
<td>20</td>
<td>12</td>
<td>10*</td>
</tr>
<tr>
<td>6</td>
<td>Training for community trainers (TOT)</td>
<td>Modular 6 months</td>
<td>10</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>No</td>
<td>Training</td>
<td>Duration</td>
<td>Target per MTP</td>
<td>Actual Kamuli</td>
<td>Actual Masafu/Busia</td>
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<td>----</td>
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</tr>
<tr>
<td>7</td>
<td>Peer counselling training (for PWAs)</td>
<td>2 weeks</td>
<td>20</td>
<td>20</td>
<td>15</td>
</tr>
<tr>
<td>8</td>
<td>Counsellor Supervision</td>
<td>1 month modular</td>
<td>3</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>9</td>
<td>Resource mobilization and advocacy</td>
<td>1 week</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>10</td>
<td>MDD group members trained in message devt, communication skills and advocacy</td>
<td>2 weeks</td>
<td>15</td>
<td>15</td>
<td>15</td>
</tr>
</tbody>
</table>

Source: Based on (TASO, 2007a:54-55), columns for actual are based on interviews with service providers at MTPs.

From Table 5-3, it is clear that the capacity-building programme had a dual objective of providing technical knowledge regarding HIV/AIDS service delivery and administrative knowledge for managing projects. Although the table appears to show that Kamuli and Masafu-Busia had comparable numbers of health workers trained in the various courses, some caveats are in order for the marked figures (*). In Masafu-Busia, due to limited staffing levels, one third of the trainees were outsourced from other health facilities in the neighbouring sub-counties of Dabani, Busia Town Council, and Lumino (for locations see Figure 5-4). Although TASO assumed that these health workers would be able to provide services in Masafu-Busia, this idea faced two main challenges. The first one is that when their parent facilities started providing ART services, attendance in Masafu-Busia became irregular (interviews with a trained male Clinical Officer in Busia HC IV and female Comprehensive Nurse in Dabani HC IV, 18/4/2011). In addition, and as explained in Chapter Six, their vigilance also depended on the availability of monetary facilitation from TASO to the effect that when its funding completely stopped their participation in the HIV/AIDS clinic followed suit. From the staff training perspective, therefore, MTP implementation in Masafu-Busia was partial.

Meanwhile, as item six in Table 5-3 indicates, TASO prepared trainers of trainers (TOTs) to act as an “inbuilt mechanism” for maintaining the transfer of HIV/AIDS skills in targeted hospitals and beyond. A former TASO employee who was central in designing this project observed that:

You know one of the main challenges in public health facilities are the transfers.
You train people but the next day they are transferred elsewhere. But what we
[planned was] that once you have ToTs within these facilities, immediately one is transferred, then TOTs train the new staff. This was an achievement e.g. in Arua which became the capacity building hub for the whole of the west Nile region and even beyond in Congo and Sudan. So to me [this MTP] was actually not only serving people in Arua, but you can see even across borders (Former TASO staff, 6/May/2011).

In reference to the discussion in Chapter Two, concerning the spread of bureaucratic capacity, the TOT aspect here shows that TASO was trying to create MTPs as Islands of Effectiveness (IOEs) for dispersing good practices within targeted hospitals and beyond. This issue is revisited in Chapter Six.

5.6.3 The Service delivery phase

After the capacity building phase, MTP would be ready to launch for service delivery. Here, focus is put on one key aspect in this phase, namely, the mechanisms of service delivery supported through MTP. TASO (2005a) identifies the following as the main service delivery mechanisms in MTPs26.

i) Facility-based clinics: This was the main method of service delivery used by hospitals before MTP. Here, health workers expected patients to seek services from the facility with minimal reversal linkages involving health workers taking services to patients in their homes/communities. As discussed above, facility-based care has several disadvantages including: failing to cater for those patients who may lack transport or are too sick to come to the health facility. It also limits the visibility of the state among those who reside far way from the main health facility. Therefore, although TASO’s training of health workers improved the operation of facility-based clinics, the NGO was aware of the limitations of this strategy, hence it also supported the introduction of alternative delivery mechanisms.

ii) Outreaches: This involved dispatching teams of health workers from MTPs to take counselling, medical and ART services to communities far away from hospitals. Outreach points were established in lower level health units. On the side of government, this arrangement would enable the mentoring of health staff in lower health units in HIV/AIDS service delivery. For patients, outreaches reduced the distance to service delivery centres. In Masafu-Busia, there was one outreach site in

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26 These were also confirmed through observations and interviews.
Mbheinyi HC II which is located at the extreme end of Lunyo sub-county near Lake Victoria. Kamuli MTP had two outreaches, one in Kidera sub-county and the other in Bugaya sub-county (for locations see Figure 5-4).

iii) **Home visits**: a home visit is similar to an outreach in the sense that they both involved taking services to patients in the community. However, the former differed from the latter in the sense that it involved taking services to the homes of patients while in the latter case services were taken to a health facility where patients in the neighbourhoods would then access them.

iv) **Community awareness campaigns**: As a TASO KI argued, unlike diseases like malaria that do not carry stigma, “HIV is unique because you have to find ways of enticing people to seek for HIV/AIDS services... you have to create demand [for it]” (male TASO HQ, 7th/3/2011). Therefore, TASO established a music dance and drama (MDD) group per MTP to mobilise PWAs and their families for HIV/AIDS. According to a senior official in Kamuli hospital, “the group would go out and sensitise people, first about the existence of the services in the hospital, secondly about the benefits which people would get once they enrol on the services. And that somehow mobilised people” (Male respondent Kamuli, 1st/3/2011).

To sum up this section, the following key points are worthy noting. MTP intervention as elaborated so far reveals that TASO’s main entry and focus was on the conventional ‘supply side’ of state building. This is because, aside from training peer counsellors and establishing MDD groups, all the activities were concerned with empowering health workers. Two main factors can explain this state of affairs. First, it appears that focusing on the ‘supply side’ was a deliberate strategy by TASO’s staff who thought that it had more chances of bringing about improvement in service delivery than empowering citizens to make demands on health workers. A Key informant, who was central in designing MTP, rhetorically framed the argument as follows:

> You cannot [depend on] training service beneficiaries. You train service beneficiaries to do what? To demand for better services? To tell [health workers in] these facilities to change their attitudes? I think you first focus on the supply side. Of course you can train the beneficiaries to be assertive but how long will it take? (Former TASO HQ official, Kampala, 6th/5/2011).
Such an argument is supported by scholars like Campbell and colleagues (2009) who remind us to be cognisant of the fact that people exposed to prolonged marginalization may have lost their confidence to act as citizens. Several scholars also argue that in situations where ‘street-level’ bureaucrats lack the basic capabilities to deliver, which was the case for the local governments reviewed here, limited improvements in performance can be expected out of empowering citizens to make demands on them (Gaventa and Barret, 2010; Mitlin, 2008; Satterthwaite, 2008). Although not proven through empirical data, another possible reason why TASO gave secondary consideration to the ‘demand side’ is the nature of Uganda’s political context. As discussed earlier in this Chapter, the state is uncomfortable with advocacy and empowerment activities of NGOs. Moreover, given the history of the interaction between TASO and government, the former was keen on maintaining its friendly stance.

The above observations notwithstanding, a critical analysis of TASO documents and responses of KIs provide hints at several indirect but nuanced strategies that TASO engaged in to promote the ‘demand-side’. In the first instance, it was assumed that some of the future MTP clients would be former clients from the NGO’s service branches. Arguably these clients would ‘return’ to government hospitals with TASO’s standards of health care as a yardstick for the quality expected from MTPs. Secondly, parallel to the process of launching MTPs to start service delivery was the mobilisation of existing PWAs at the selected government health facilities to organise into various clients committees. One of the TASO documents mentions in passing that:

> For the project to start, there is need to involve a few key staff from an already established TASO centre ... [and] the leaders/representatives of [PWAs] are also requested to support the Mini TASO in its infant stages to help it establish client councils as well as sharing experiences with both the Mini TASO staff and the clients (TASO, 2005a:6).

PWA representative committees and related structures were expected to mediate state-citizens’ interactions in MTPs. The challenge, however, was that TASO did not insist on establishing clients’ councils in all MTPs, the decision was optional – thus whereas Kamuli embraced such committees, Masafu-Busia did not have them. Thirdly, TASO emphasised service co-production between health workers and ‘expert’ PWAs. Here, PWAs were given appropriate training, in Peer Counselling and Music Dance and Drama (MDD), to
competently do their new job (See Table 5-3). Both Chapters Six and Seven discuss the role of service co-production and expert clients in state and citizenship building respectively.

5.7 MTP funding and the politics of resource mobilisation in TASO

An important aspect of MTP especially at the service delivery stage was funding. As discussed earlier in the chapter, one of the main challenges of the health sector was (and still is) the inadequacy of financial facilitation. Therefore at the centre of MTP service delivery phase was the provision that all MTPs were entitled to an annual ‘seed grant’ of UGX 50 million. Among other things, seed grants were to enable MTPs to make infrastructural improvements to create office space, procure medical supplies and to facilitate the implementation of both facility-based and community-based activities. However, as explained below, of all the aspects of MTP it is perhaps the funding component that was least appropriately handled by TASO. Discussions with respondents in MTPs indicated that although they signed MOUs allocating UGX 50 million annually, in practice they never received this money in full in any single financial year. As reflected in Figure 5-6, our calculations of financial releases to MTPs showed that less than half of the UGX 250 million that was expected in Kamuli and Masafu-Busia during the period 2006 and 2010 was actually disbursed.

**Figure 5-6: MTP funds received by Kamuli and Masafu hospitals**

[Graph showing UGX funds received by Kamuli and Masafu hospitals]

In absolute terms, over the five years of the project, Masafu got UGX 67 million while Kamuli got UGX 91 million. This implies that the latter got 27% more than the former.
These differences in funds disbursement should also be regarded as part of the uneven implementation of the MTP between our two study sites, which Chapters Six and Seven link to the variations in the project’s impact. As reflected in Figure 5-6, significant variations between the two study sites were recorded between 2008 and 2009. During this period, it was claimed that TASO Eastern Region, which is responsible for Masafu-Busia, did not have a substantive Regional Manager and this affected funds disbursement (TASO Official 4\textsuperscript{th}/1/2011).

Understanding why TASO had challenges in meeting its financial obligations to ‘partners’ is intimately connected to three factors a) challenges in local resource mobilisation, b) donor politics and c) the imperative for the survival of TASO’s own branches. The discussion below handles local resource mobilisation and donor politics while issues of preserving TASO’s own branches are explicated in the next section as they are linked to the closure of MTP.

Although TASO is a membership-based organisation, as with other NGOs in Uganda, it almost entirely depends on foreign funding (see Barr et al., 2005). Its budget comprises of over 95% donations from international sources, 2% from GoU, and 3% from local sources (Coutinho et al., 2006:138; Scott et al., 2005). Local resource mobilisation is adversely affected by high poverty levels in Uganda. According to some analysts, the fact that over 90% of TASO clients survive on less than $2 dollars a day means they can only make modest contributions (Coutinho et al., 2006; Werker and Ahmed, 2008). Local mobilisation efforts are also dampened by public perceptions that TASO receives more than enough funds from foreign donations. TASO’s 2005 mid-term review of for instance observes that:

...fundraising efforts have been hampered by the general public’s perception that TASO has got adequate donor funding and does not need any more financing for its activities. They hear on the radio that TASO has received multi-million dollar grants from international sources and, if anything, wonder why their TASO centre is not receiving more funds to help them (Scott et al., 2005: no pagination).

The implications of limited local resource mobilisation for NGOs are that they get to depend disproportionately on official funding (Edwards and Hulme, 1995; Fowler, 2010). However, as discussed below, foreign funding tends to be unpredictable and/or has
stringent conditions on how it should be used. One of the senior officials in TASO summarized this point: “Money was not always as forthcoming as we had hoped. So sometimes there were delays in releasing [from donors] and when there are delays it passes on to partners because TASO has no money of its own to give to the partners” (Male TASO HQ official, 13/7/2011).

Although TASO depends on foreign donors, between 1996 and mid 2000s it had latitude in allocating resources according to priorities in its strategic plan. This is because in the 1990s TASO had courted its then big donors, namely, Danida, DFID, Sida, USAID and EU to shift from project support to a ‘basket’ funding approach\(^{27}\) (Ssebbanja, 2007). Basket funding was a key ingredient that had enabled creative programmes that helped TASO to expand in the 1990s. However, as discussed below, the dynamics of HIV/AIDS international funding during the 2000s affected this funding strategy and by 2007 TASO appeared to have lost control of its finances.

Around 2000, Uganda and indeed most developing countries witnessed a major funding shift from European-based donors towards multilateral donor programmes of the United Nations inspired Global Fund and World Bank’s MAP and later to the much more stringent United States’ bilateral programme of PEPFAR (Grover et al., 2011; Oomman et al., 2007; UAC, 2007; Zikusooka et al., 2009). What is crucial for our discussion on TASO is that PEPFAR, which contributes over 80% of the total HIV/AIDS resources in Uganda (Government of Uganda, 2010; Oomman et al., 2007; UAC, 2007; Zikusooka et al., 2009), prefers to channel its resources off-budget through NGOs (Zikusooka et al., 2009). TASO heavily benefited from PEPFAR funding\(^{28}\), but not without consequences. The first challenge is that PEPFAR money is earmarked to ART activities within TASO service branches (Interview with Male TASO HQ official, 28/1/2011). Secondly, receiving PEPFAR money carried a risk of pushing away ‘basket’ donors whose funding had more flexibility for it could be allocated to any activity within the strategic plan. Indeed, the TASO 2005 mid-term review had warned that:

\(^{27}\) Basket funding in TASO is where several donors put resources in a pool to fund TASO’s strategic plan rather than individual projects. It is a form of budget support.

\(^{28}\) In 2010 PEPFAR allocated USD $15.2 million which is well above 70% of TASO’s annual budget (Country Operation Plan (COP) [http://www.pepfar.gov/documents/organization/145738.pdf](http://www.pepfar.gov/documents/organization/145738.pdf)).
Significant increases in PEPFAR funding ... introduce a risk that some of TASO’s donors participating in the basket-funding mechanism will consider re-allocating their support to other Ugandan organisations, which are considered to be more in need of funding... (Scott et al., 2005: no pagination).

This prediction came to pass when in 2007 TASO’s ‘basket’ donors supported the creation of the national Civil Society Fund (CSF) that effectively opened the competition for these resources. Although a USAID commissioned assessment of the impact of US funding on selected NGOs in Uganda claimed that “TASO has in place a four-stage contingency plan for the reduction or cessation of U.S. Government funding” (Molldrem et al., 2009:18), probably because basket donors had issued assurances that its funding in CSF would be “ring-fenced” (Danida, 2007), these guarantees were only for the first phase of CSF (2007-10) (Danida, 2007). At the time of fieldwork, CSF phase one had been concluded and phase two, which granted more powers to Ugandan authorities, had started. As explained in the next section, when CSF Management became more independent in allocating resources, they questioned why TASO was ‘donating’ to government money allegedly meant for CSOs. As explained below, it was mainly due to failure to secure funding from CSF that TASO wound-up MTP.

5.8 The untimely demise of MTP

TASO strategists were aware that the NGO’s involvement in government hospitals was a time-bound activity aimed at building their capacities and then “move to other underserved local governments” (Female TASO central region official, 6/12/2010). This understanding was supported by the existence of an exit strategy or phase out plan for MTPs in TASO’s strategic plan 2007-2011 (TASO, 2007a). Central to the exit strategy was a suggestion that only MTPs older than five years would be targeted for exit and more importantly that they would first be assessed to ascertain their readiness for exit (TASO, 2007a:91). As summarised in Table 5-4, the plan outlined specific activities that would be carried out in those MTPs earmarked for exit.

<table>
<thead>
<tr>
<th>No.</th>
<th>Activities</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Organisational Development (OD) support</td>
<td>2 visits</td>
</tr>
<tr>
<td>2.</td>
<td>Refresher in counselling and medical care</td>
<td>10 people</td>
</tr>
<tr>
<td>3.</td>
<td>Curricular development for sustainability</td>
<td>3 Courses developed</td>
</tr>
<tr>
<td>No.</td>
<td>Activities</td>
<td>Target</td>
</tr>
<tr>
<td>-----</td>
<td>---------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>4.</td>
<td>Tailored courses in sustainability, leadership and fundraising</td>
<td>10 people</td>
</tr>
<tr>
<td>5.</td>
<td>Participatory phase out plan developed for and with the partners.</td>
<td>Mini –TASO phase out plan ready by end of 2008</td>
</tr>
<tr>
<td>6.</td>
<td>Conduct capacity assessment of Mini-TASO to inform phase out process</td>
<td>All mini TASOs operating by 2003 assessed for capacity</td>
</tr>
<tr>
<td>7.</td>
<td>Phase out old supported Mini-TASOs</td>
<td>MTPs functional by 2003 phased out by the end of 2010</td>
</tr>
</tbody>
</table>

*Source: based on TASO strategic plan (TASO, 2007a).*

However, TASO did not adhere to any of the provisions of this plan, instead, the entire project was unceremoniously terminated at the end of 2010. The question then is: what caused the hurried exit? Before we provide a response to this question, it is important to note that whereas middle level managers in TASO acknowledged that the closure of MTPs was haphazardly executed, some top officials denied this. Some even argued that there was no need of implementing the phase out plan. According to one senior TASO HQ official:

> You see the proposed trainings for exit were similar to those we had already given to health workers in those facilities[^29]. I don’t think there would be a difference in the curriculum in the project planning training at the start and that one at the end. Because as we intervened in the hospital, those trainings were done, we trained people in ART, trained people in counselling, trained people in OI management etc. so if we carried out another set of trainings, the difference would be maybe in extra resources spent. Otherwise the content of the training would be the same (Male, TASO HQ official, 13/7/2011).

However, this is a weak defence considering that many of the trainings mentioned had been done more than five years ago and therefore people needed refresher courses as rightly suggested in the strategic plan. Secondly, the exit plan had suggested new courses like OD and the “tailored courses in sustainability, leadership and fundraising”, which arguably might have put MTPs in a better position to sustain themselves.

The immediate factor behind the hurried phase out was that TASO found it difficult to secure more resources for the project. TASO’s last bid for funds to finance MTPs was...  

[^29]: Here the officer was referring to the ‘capacity building’ phase of MTP discussed earlier.
declined by its financiers on grounds that the organisation was channelling these funds to government agencies yet CSF money was designated to benefit CSOs (various interviews with current and former TASO employees). However, as it will become more clear in the next two chapters, MTP was promoting improved ways of state-society engagement that should have qualified it for CSF funding had evidence to this effect been presented by TASO. This therefore brings us to one of the underlying factors for the project’s demise, which is poor monitoring and evaluation. In a somewhat belated realisation, TASO officials apologetically noted that:

TASO did not bring out its prominence in what it was doing in the Mini TASOs. We did not publish or document our activities in this area. If we had documented out mini TASO activities, I think these donors would have said: ‘why don’t we give TASO money to improve and replicate these activities to other areas’? (Male, TASO HQ official, June 2011).

The study finds that despite being recommended by the 2005 Midterm Review (Scott et al., 2005) and subsequent commitment in the 2008-2012 strategic plan (TASO, 2007a) that proper documentation of MTP will be done, no serious effort was made to this effect by TASO. The monitoring and evaluation problem also had another underlying factor. Our investigations established that lack of documentation was just an iceberg tip because the real problem was that TASO systematically tried to undermine the success of this project. It is hypothesized that during the implementation of MTP, senior officials within TASO realised that MTPs were producing outputs comparable to the well facilitated TASO service centres. Therefore, they feared that publicising the success of MTP would undermine the existence of TASO service branches. As shown in Table 5-5, TASO service branches outputs had started trailing those of MTPs in 2007.

Table 5-5: Comparison of MTPs and TASO centres on key output areas

<table>
<thead>
<tr>
<th></th>
<th>Year 2005</th>
<th>Year 2006</th>
<th>Year 2007</th>
<th>Year 2008</th>
<th>Year 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individuals counselled</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MTPs*</td>
<td>16,255</td>
<td>40,569</td>
<td>115,142</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>TASO service branches</td>
<td>49,362</td>
<td>54,009</td>
<td>59,949</td>
<td>65,822</td>
<td>76,413</td>
</tr>
<tr>
<td><strong>Individuals treated</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MTPs*</td>
<td>14,624</td>
<td>29,401</td>
<td>109,508</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>TASO service branches</td>
<td>75,290</td>
<td>76,709</td>
<td>83,817</td>
<td>88,274</td>
<td>83,777</td>
</tr>
</tbody>
</table>

Source: TASO annual reports for the respective years (TASO, 2006; 2007b; 2008; 2009)

* Number of MTPs = 5 in 2005; 8 in 2006; and 12 in 2007. There were 11 TASO branches throughout this period.
According to Table 5-5, TASO absconded from reporting on key MTP outputs when in 2007 with almost the same number of service units (12 MTPs and 11 TASO service branches) the performance of MTPs surpassed that of mainstream TASO service branches. It is possible that sooner rather than later, donors previously sceptical about the performance of state facilities (Batley and Rose, 2011) would have got a different picture and perhaps advised TASO to concentrate on putting the state in the driving seat for service delivery. This would be a death sentence for TASO’s 11 service branches whose survival thrived on the continued promotion of funding arrangements where NGOs appear to replace the state. Senior officials in TASO acknowledged that “our survival as TASO [is] number one priority” (Male staff TASO HQ, 13/7/2011) – implying that this had to guaranteed even if it meant starving MTPs of financial facilitation or completely closing down the project.

5.9 Conclusion
This chapter has presented TASO as a SD-NGO that has transitioned through all the three generations of NGOs as stipulated by Korten (1987, also see Chapter One). The organisation started as a welfare and relief self-help group for providing emotional support to friends and families and operated as such in the period 1987-1993 (first generation); then it embarked on promoting small-scale community self-reliance and development through community mobilisation and training 1994-2000 (second generation); and since the 2000s it has operated as a third generation NGO focusing on capacity development for itself, and other organisations including government institutions. It is this third phase that relates directly to MTP. It is worth noting that progress from one generation to another one does not necessarily lead to abandoning activities of the earlier generations. Instead TASO’s experience shows that organisations just add on what they already have with the outcome being an NGO with features of all generations. Indeed Grover et al. (2011:17) reports that “it is more common for Ugandan NGOs to introduce activities than to discontinue them”. This observation helps to illustrate Chhotray (2008) and Lister and Nyamugasira (2003) observations in Chapter One that the distinction between “SD-NGOs” and other NGO categories is slippery.
The chapter has also showed that TASO is comparable to organizations, which according
 to Joshi and Moore (2000), employ a ‘passive marketing’ strategy in that they first set
 examples of good work and reliability and then rely on their reputation to interest
 partnerships with governments and communities. This chapter showed that before
 embarking on expanding its activities, TASO first accumulated experience through its
 service branches and when time for expansion came local governments were eager to
 partner with it. Community members also enthusiastically took up services from
 government hospitals when they became “mini TASOs”. However, this has implications
 for sustainability after TASO’s withdraw. The key question here is: can government
 hospitals maintain the confidence of service users on their own? This issue will be
 revisited in Chapter Eight.

Another key point is about the ‘theory of change’ that underpinned MTP. A critical look at
 the project shows that TASO focused more on promoting the ‘supply side’ than the
 ‘demand side’ of service delivery. The chapter has argued that TASO’s reading of the
 situation in government hospitals was that their lack of performance was attributable to
 structural constraints in the government system rather than personal attitudes of the
 individual officials. In such circumstances, the organisation observed that amplifying
 citizens’ ‘voice’ would have caused limited responsiveness from state officials. This
 observation has parallels with recent debates concerning the potency of social
 accountability initiatives that rely on citizens’ action in bringing about public
 accountability (e.g., Batley et al., 2012; Booth, 2012; Brett, 2003). We shall reengage this
 debate in Chapter Eight after discussing the performance of TASO’s strategy in the two
 study sites in Chapters Six and Seven.
6.1 Introduction
Following the political upheavals that punctuated the first half of Uganda’s postcolonial period, the capacity of the state to deliver social services was severely diminished. However, as discussed in Chapter Three, ever since the NRM captured state power in 1986, it has exhibited some commitment to reverse this trend by increasing the engagement of state agencies in direct service provision, albeit alongside NGOs and private for profit providers. The area of HIV/AIDS, in particular, has received high priority with President Museveni himself spearheading government’s action, thereby giving the response the much needed ‘political will’ (Putzel, 2004). When Antiretroviral drugs (ARVs) become available, GoU further exhibited commitment by seeking to scale-up ART service provision through its decentralised health system (Chapter Five; Richey and Haakonsson, 2004). In what is known as the ‘inclusive policy’ on HIV/AIDS, the state explicitly welcomed SD-NGOs and other non-state actors to operate as key stakeholders in fighting the epidemic (Parkhurst, 2005). It is within this context that TASO’s strategy to work with, rather than circumvent, the inefficient bureaucracy in rural Uganda has to be understood. This environment was conducive for state-NGO collaboration because, at least at the national level, the state showed commitment to service delivery. However, as argued by Edwards and Hulme, the decision for NGOs to work with government “must be based on an assessment of the ‘reformability’ of the structures under consideration” (1992:18). This chapter aims to establish the extent to which TASO, through MTP, was able to enhance state capacity to deliver health services in the targeted local governments. It does this by investigating the impact of MTP on the dimensions of state capacity explored in Chapter Two, namely, bureaucratic capacity, embeddedness and infrastructural power. The chapter will also analyse how the changes introduced by TASO might have influenced state legitimacy. The Chapter is structured accordingly, following these four aspects in turn.

6.2 The impact of MTP on the bureaucratic capacity of the state
Bureaucratic capacity focuses on the internal quality and coherence of the state apparatus (Vom Hau, 2012). According to Chapter Two, although some believe that the
main determinant of a coherent bureaucracy is the availability of skilled human resources operating in a structured organisational hierarchy, recent research cautions against overemphasising the formal aspects of bureaucratic capacity. It is argued that in developing countries, for instance, performance in many organisations is a function of the interaction between formal and informal as well as bureaucratic and non-bureaucratic institutional arrangements (Booth, 2012; Vom Hau, 2012). With that in mind, this section identifies and assesses the performance of the different strategies that TASO used to build the bureaucratic capacity for delivering HIV/AIDS and other health services in general.

6.2.1 Capacity for delivering HIV/AIDS services

Arguably, one of the most direct indicators of the strength of the bureaucracy in development interventions is the outputs that state agencies are able to produce. Indeed, some scholars suggest that state capacity can be understood in terms of the ability of state agencies to supply public goods (Fukuyama, 2004; Soifer and vom Hau, 2008; Tilly, 1975a). Thus, in the next paragraphs we establish whether MTP made a difference in terms of the direct service delivery outputs, such as increasing the number of PWAs enrolling for HIV/AIDS services, in the targeted districts. There was consensus among respondents that the project enabled targeted local governments to increase access of HIV/AIDS services to their constituents and positive responses similar to the ones below were widespread:

...the numbers speak for themselves, from 250 to 2000 PWAs on care and we were on an upward trend [by the time the project ended]. This just tells you that yes, it was really worth it (male, senior medical staff Masafu hospital 14/4/2011).

A key informant from TASO added that:

At the time we rolled out this programme, the general characteristic among government hospitals was the very low turn up of HIV/AIDS clients. However, five to six years down the road, as you go in most of these facilities you will realize that the clients are now very many. And of course for me, I attribute this to the success of the program in terms of the ability of government staff to manage HIV/AIDS cases (Female TASO Central Region official, 6/12/2010).

These two comments make the point that TASO enhanced the ability of personnel in the targeted facilities to deliver HIV/AIDS services. Table 6-1 summarizes the main outputs.
from MTP activities in the study sites (also see Figure 5-3 and Table 5-5 for the trends in ART enrolment).

Table 6-1: HIV care related outputs in the study sites

<table>
<thead>
<tr>
<th></th>
<th>2005a</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PWA adults on care (cumulative)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kamuli</td>
<td>334</td>
<td>830</td>
<td>1443</td>
<td>2502</td>
<td>3412</td>
<td>4152</td>
</tr>
<tr>
<td>Masafu-Busia</td>
<td>256</td>
<td>400</td>
<td>732</td>
<td>1093</td>
<td>1506</td>
<td>2113</td>
</tr>
<tr>
<td>Iganga b</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2726</td>
<td>2704</td>
</tr>
<tr>
<td><strong>Children (1-14 years) on general care (cumulative)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kamuli</td>
<td>6</td>
<td>28</td>
<td>83</td>
<td>167</td>
<td>235</td>
<td>321</td>
</tr>
<tr>
<td>Masafu-Busia</td>
<td>8</td>
<td>33</td>
<td>45</td>
<td>97</td>
<td>163</td>
<td>206</td>
</tr>
<tr>
<td>Iganga</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>63</td>
<td>78</td>
</tr>
<tr>
<td><strong>PWA served in outreaches (annual)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kamuli</td>
<td>621</td>
<td>771</td>
<td>842</td>
<td>1121</td>
<td>652</td>
<td></td>
</tr>
<tr>
<td>Masafu-Busia</td>
<td>100</td>
<td>257</td>
<td>216</td>
<td>356</td>
<td>244</td>
<td></td>
</tr>
<tr>
<td>Iganga</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MDD Community Awareness (annual)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kamuli</td>
<td>1342</td>
<td>5440</td>
<td>7358</td>
<td>8806</td>
<td>1987</td>
<td></td>
</tr>
<tr>
<td>Masafu-Busia</td>
<td>858</td>
<td>2035</td>
<td>2961</td>
<td>3203</td>
<td>663</td>
<td></td>
</tr>
<tr>
<td>Iganga</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Counselling sessions (annual)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kamuli</td>
<td>2766</td>
<td>5274</td>
<td>6340</td>
<td>7406</td>
<td>6876</td>
<td></td>
</tr>
<tr>
<td>Masafu-Busia</td>
<td>1395</td>
<td>2766</td>
<td>2220</td>
<td>3900</td>
<td>2279</td>
<td></td>
</tr>
<tr>
<td>Iganga c</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: TASO Central and Eastern Region annual reports for the respective years. For Iganga, National HIV care monthly monitoring report book.

a Year 2005 represents the pre-MTP period which was mainly characterised by dispensing drugs to PWAs. This explains the blanks for community activities and counselling.

b Iganga figures here need to be cautiously considered. Although PWA enrolment is expected to be cumulative, the figure for 2010 was less than that of 2009 suggesting inaccuracies in reporting due to poor records keeping.

c Iganga hospital health workers claimed that they give counselling to their PWA clients. However, because this aspect is not catered for by the MoH reporting system, they do not keep records about it. It is also for the same reason that Kamuli and Masafu-Busia did not document it prior to 2005.

Table 6-1 shows that in both Kamuli and Masafu, MTP was accompanied by an increase in quantitative outputs from HIV/AIDS related activities. Overall, during MTP period, the number of PWAs receiving treatment in Kamuli increased from 334 in 2005 to 4152 at the end of 2010. Besides dispensing of drugs to PWAs, however, most of the other HIV/AIDS related activities here were introduced with MTP and therefore had no baseline with which to be compared.
end of 2010. In the same period, PWAs in Masafu-Busia increased from 256 to 2113. On average, this translates into an annual percentage increase in PWA enrolment of 71% and 53% for Kamuli and Masafu-Busia respectively. Additionally, the table also shows that MTPs were providing a more diversified package of HIV/AIDS services, combining prevention, care, and treatment strategies, which experts recommend for effective programmes (TASO, 2007a; UAC, 2007; WHO, 2009). In contrast, Iganga hospital only put emphasis on HIV/AIDS treatment. Several key informants, and Chapter Five, noted that this was a general trend in non-MTPs where health workers are said to engage in the ‘conventional medical approach’ – “where you diagnose the disease and treat using drugs” (Male TASO Eastern Region official, 4/1/2011). Experts believe that such biomedical approaches are inadequate in managing HIV/AIDS, not least because they tend to individualise and depoliticise issues of health and well-being (Prince, 2012; Robins, 2006). As discussed throughout this Chapter, MTPs were accompanied by social mobilisation, outreaches and psychosocial activities, though some of these were not sustained after TASO funding. The proceeding subsections assess specific MTP interventions that could have facilitated the performance observed in Table 6-1.

6.2.2 MTPs and availability of medical supplies in public facilities

One of the key achievements of MTP observed by respondents was that it attempted to address the challenge of unreliable supply of essential drugs in the targeted facilities. The absence of drugs in public health facilities is one of the key barriers to health care access in Uganda. A nationwide study commissioned by MoH to document access to and use of medicines in Uganda, established that only 33% of the households believe that public health facilities have medicines (Ministry of Health, 2008). Similarly, in all MTPs, PWAs and health workers alike explained that the erratic supply of medicines especially the prophylactic drug Cotrimoxazole (Septrin) was perhaps the main problem that they faced prior to TASO’s intervention (see Section 5.5.4). Based on this, in the annual ‘seed grant’ to MTPs, TASO provided an allocation for purchasing such drugs. The drugs budget line took the biggest share at around 20% in both study sites (male TASO HQ official, 28/1/2011).

Apart from the medical requirement that HIV/AIDS patients need consistent supply of drugs (a key bureaucratic capability) to respond well to treatment (Katabira et al., 2009),
this intervention had associated benefits in other dimensions of state capacity. First, the reliable provision of drugs is at the heart of citizens’ expectations from a functioning health system (Nazerali et al., 2006) and drug availability influences the perceptions of patients/citizens about the trustworthiness of government employees in the health sector (Chapter Two; OECD, 2012; Ssengooba et al., 2007). According to Ssengooba and colleagues, government health workers complain that whenever there is stock out of drugs, patients wrongly assume that they have ‘stolen’ this medicine into private clinics (2007:11). Indeed, one respondent in Iganga hospital associated the stock out of drugs there with corruption. He lamented that “corruption is too much in this hospital, even after you have seen a lorry entering with consignments they will tell you drugs are not there!” (Male PWA Iganga, July 2011). In Kamuli and Masafu-Busia hospital, health workers reported that prior to TASO’s intervention, they would advise patients to buy from private providers and this had far-reaching implications for state building. As reported in Chapter Four, poverty is endemic in our study sites and most of the patients are peasants without meaningful sources of income to afford. Even the MoH survey alluded to earlier revealed that 64% of Ugandan households felt that medicines on the private market were not affordable (Ministry of Health, 2008). Thus, some argued that telling clients to buy from private providers discouraged them from coming to what they considered to be irrelevant state facilities (health workers’ FGD, 24/1/2011) – this encouraged citizens to exit from the state. This finding is corroborated by Nazerali and colleagues (2006) who observe that, in Uganda, hospital attendance is greatly determined by the availability of drugs. Therefore, by providing a budget allocation for drugs, TASO was able to restore the confidence of service users in state facilities (see Table 6-2).

According to Table 6-2, whereas 84% of PWAs in Kamuli felt that there was poor availability of drugs before TASO, their opinion after implementing MTP changed with 85%, at the time of fieldwork, claiming that drugs supply was good. Similarly, for Masafu-Busia, 83% shared the view that drug supply before MTP was poor, but the situation improved after TASO’s intervention. Meanwhile, in Iganga, the majority of respondents felt that drug supply is just fair in their facility, with marginal changes occurring over a five years’ period.
Table 6-2: Clients’ perception of drug availability

<table>
<thead>
<tr>
<th>Facility</th>
<th>Drug availability</th>
<th>Pre-MTP</th>
<th>Current</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kamuli</td>
<td>Poor</td>
<td>83.6%</td>
<td>4.9%</td>
</tr>
<tr>
<td>(n=61)</td>
<td>Fair</td>
<td>14.8%</td>
<td>9.8%</td>
</tr>
<tr>
<td></td>
<td>Good</td>
<td>1.6%</td>
<td>85.2%</td>
</tr>
<tr>
<td>Masafu</td>
<td>Poor</td>
<td>83.1%</td>
<td>4.2%</td>
</tr>
<tr>
<td>(n=71)</td>
<td>Fair</td>
<td>15.5%</td>
<td>38.0%</td>
</tr>
<tr>
<td></td>
<td>Good</td>
<td>1.4%</td>
<td>57.7%</td>
</tr>
<tr>
<td>Iganga</td>
<td>Poor</td>
<td>19.6%</td>
<td>17.4%</td>
</tr>
<tr>
<td>(n=46)</td>
<td>Fair</td>
<td>60.9%</td>
<td>67.4%</td>
</tr>
<tr>
<td></td>
<td>Good</td>
<td>19.6%</td>
<td>15.2%</td>
</tr>
</tbody>
</table>

Note: Current denotes the time of fieldwork

It is important to note, however, that the solution offered by TASO to address this problem was temporary in nature as supplies depended on funding availability. Soon after TASO had ended MTP, clients and health workers stated that MTPs were re-experiencing drug stock-outs. One service user had this to say:

My problem, as I have already told you, is the absence of some drugs. There is no consistency of drug availability. Take for example the previous three months we did not have any Septrin available. When TASO was still here it would give us money for a buffer stock (Male PWA Masafu-Busia, 11th/4/2011).

Data from Table 6-2 suggests that this problem was much felt in Masafu-Busia where fewer respondents felt that the supply of drugs at the time of fieldwork was good (58% compared to Kamuli’s 85%). This observation is also in line with one of the main weaknesses of MTP that is flagged throughout this chapter, namely, that several of the strategies the project promoted had a short-term orientation. Providing money to hospitals to purchase drugs could not solve the root causes of drug stock-outs that experts attributed to the complex and inefficient procurement systems controlled by a government agency at the national level (Male UAC official, 9th/6/2011; OECD, 2012).

6.2.3 Human resources management

As far as human resources are concerned, MTP aimed at responding to two closely connected challenges in government hospitals, namely, staffing shortages and inadequate skills among the existing staff. The strategies employed to address these challenges and the extent to which they were successful is discussed below.
The training of government health workers

According to Chapter Five, the health staff in government facilities lacked the technical skills, such as ART administration and psychosocial skills including proper communication with patients, which are required to manage HIV/AIDS. Drawing on its experience as the pioneer HIV/AIDS psychosocial NGO in Uganda, TASO sought to address these through its home-grown training programmes. Key informants familiar with TASO’s trainings observed that programmes like counselling were from the perspective of TASO not merely about giving health workers technical knowledge alone, but also changing staff attitudes. To TASO, effective HIV/AIDS management calls for building trusting relationships between service providers and their clients. As illustrated below, through such strategies, TASO aided the state to “see” like an NGO. For details of the different training modules and the number of people who were trained per study site see Chapter Five (Table 5-3).

In both Kamuli and Masafu-Busia, most health workers who attended TASO trainings attested that their attitudes towards HIV/AIDS work changed for the better as exemplified by some of the responses below:

I used to discriminate against those patients. I would fear them. Even conversing with them I thought would make me catch HIV. I could not support them properly. But ever since I went for the counselling training, they became my best friends. I was taught that the best way of helping patients is to put yourself in his/her shoes. You have to ask yourself ‘supposing I am the one in that condition, which kind of help would I want to be given?’ So once you put that thing in mind, you just find yourself interested in helping them (Male health worker, Masafu-Busia MTP, 22/12/2010).

Similarly in Kamuli hospital, one of the senior health workers had this to say:

Our attitude towards clients ... was not very friendly...We used to have many PWAs but we would just under look them. [However] after the training by TASO we were able to change our attitudes towards PWAs and [started] handling them in a better way... we started moving to the wards to look for our clients, counsel them – to provide them with the psychosocial support, give them information.

In particular, participants in the health workers’ FGD (held on 24/1/2011) invariably referred to TASO’s training programmes as very inspirational.
regarding HIV and Positive Living. This actually improved our relationship with the
PWAs (Female health worker Kamuli hospital, 21/3/2011).

Generally health workers claimed that the training and mentoring from TASO reduced the
tendency of negatively ‘constructing’ PWAs as ‘sinful’ and treating them as second class
citizens (Gilson, 2003; Schneider and Ingram, 2007) to being regarded as citizens who
deserved humane treatment. This relates to what Corbridge and colleagues (2005)
identified as the ‘recruitment effect’ of development interventions in improving the
‘sightings’ of street-level bureaucrats for the poor. Retrospectively, whereas 82% and 80%
of the clients in Kamuli and Masafu-Busia described the responsiveness of TASO in the
pre-MTP era as poor, Section 6.5 reports that this had completely reversed with MTP.

The skills acquired here also had wider implications for state building beyond the
HIV/AIDS sector. According to Chapter Two, state officials’ interpersonal skills are
generally identified as a key component of bureaucratic capacity for ‘capability
enhancing’ sectors such as health and education. Similarly, Chapter Three also showed
how the lack of people-handling skills among the traditional chiefs contributed to the
alienation of ordinary people from the state during the colonial and a significant part of
the postcolonial period in Uganda. In our study sites, Section 6.5 shows that health
workers’ relationships with service users had a big influence on state legitimacy.

TASO’s efforts in this area, however, were threatened by the ever increasing number of
clients vis-à-vis the static number of health workers available in MTPs. Several
respondents suggested that this could even have compromised the quality of services
offered, especially counselling. For instance, one service user claimed that in the event of
heavy workload, health workers would be more concerned with finishing people in the
queue rather than serving “in order to satisfy the client” (Female PWA Kamuli,
21/3/2011). Another respondent noted that “the problem here is that one counsellor
could be responsible for like 100 clients, which means that they can’t effectively follow
them up” (Male PWA Kamuli, 1/2/2011). These concerns were confirmed by a TASO key
informant who argued that:

Health workers in MTPs are overwhelmed, and I think they may not really do
proper counselling. Moreover, these are not specialised counsellors, rather, they
are also midwives or nurses who are taking on an additional responsibility of
counselling. So when you talk about the quality of counselling, it is not to the
expected standards, they just try to do something (Female TASO Central Region
official, 6th/12/2010).

A related challenge noted by several respondents was the high mobility of staff in the
public health sector. One TASO official, in a frustrated tone, lamented that “you train a
group of health workers and you think they will be able to move the project, but
tomorrow you find them transferred to other places” (Female TASO Central Region
official, 6th/12/2010). In Kamuli for instance, at the time of fieldwork, of the 12 people
trained by TASO at the start of MTP, less than half were still in active service at the
hospital (Female health worker Kamuli hospital, 14/1/2011). This problem is in part
attributable to the poor remuneration that health workers receive, which makes them
unstable in their profession. For instance, a recent survey reported that Medical Officers
in Uganda’s public service received $3,500 while Registered Nurses got $1,750 as annual
salary (African Health Workforce Observatory, 2009:45). Nonetheless, TASO suggested
some strategies to address some of these staffing challenges as discussed below.

**MTP and the challenge of inadequate staffing**

Among the several strategies fronted to address the problem of low staffing was the idea
to equip health workers to double as clinicians and counsellors. ‘Multi-skilling’, claimed a
TASO official, was ideal given that health facilities could not commit say ten health
workers to become specialised counsellors and another ten to focus on ART
administration (Female, TASO Central Region official, 7th/3/2011). Hence, as another key
informant put it, “it is the very medical staff who were given ART training that also went
for counselling” (senior male Medical Officer Pallisa District, 20/5/2011). In a related
perspective, TASO allowed lowly qualified staff to be trained on job to engage in HIV/AIDS
activities. A respondent from Masafu-Busia noted that “all health workers were trained in
HIV management, irrespective of cadre; hence people like nurses, nursing assistants,
theatre attendants etc. henceforth worked as clinicians” (Male health worker Masafu-
Busia, 20/4/2011). Critics can argue that this is not a clear positive step with regards to
building bureaucratic capacity as it could simply mean removing responsibility from
professional staff to cheaper and more flexible but less competent staff. Indeed, in
Botswana, Swidler (2007) reports that government officials resisted such strategies in
HIV/AIDS service delivery. However, in some contexts, when less technical employees are
used it does not necessarily preclude the achievement of quality results. Tendler’s analysis of the primary health care project in Brazil shows that the health agents used had less technical training than qualified health staff yet they exhibited high levels of dedication to their jobs and the achievements of the project up to today are regarded as exemplary (Tendler, 1997; Tendler and Freedheim, 1994). Similarly, Section 6.5 reports high levels of clients’ satisfaction with the quality of services in our study sites. Having said this, however, it is important to note that the interventions here did not completely solve the challenges of inadequate staffing because this system too could not cope with the continued rise in clients’ numbers. It was partly due to this that TASO turned the attention to using service users themselves to help “co-produce” the services.

Service co-production in MTPs

Thus, another strategy that TASO employed to address staffing challenges in public facilities was co-production. The study finds that hitherto the implementation of MTP, involvement of service users in government hospitals was generally minimal as even co-financing of services through user fees had been abolished in 2001 (see Chapter Three). However, avenues to enlist direct engagement of PWAs in service delivery, such as through MDD groups, peer/expert counselling, and payment of user fees had long been part of TASO’s history as a solidarity group that relied on voluntarism and members’ contributions (Grebe and Nattrass, 2009; Ssebbanja, 2007). The organisation attempted to promote some of these aspects in government hospitals. As explained in Chapter Five, in each MTP, TASO facilitated the formation of one MDD group and trained 20 PWAs to work as expert/peer counsellors. These were able to engage in sensitisation campaigns, gave testimonies about their lives, and also helped in organising fellow clients during clinic days by giving health education, sorting files, packing drugs and recording the weight of fellow patients among others. Several health workers acknowledged that the work of peers greatly relieved them of the heavy workload at MTPs (health workers’ FGD, 24/1/2011; observations at MTP clinics). Besides this, as Campbell and Cornish (2010b) note, a major role played by peers is their ability to reach socially marginalized groups inaccessible to mainstream health workers. MDD group members attested to how their group was very helpful in mobilising the community. For instance, health workers started pairing with drama groups such that whenever the latter would go for community awareness raising campaigns, the former would test for HIV people turning up to watch
the MDD shows. Those found positive would be encouraged to start accessing medical services. In this way, drama groups were not only instrumental in raising awareness about HIV/AIDS in remote villages but they were also a conduit through which some villagers accessed medical services from the state. As discussed in Section 6.4, this in itself is a key aspect of infrastructural power. According to data in Table 6-1, between 2006 and 2010, the average annual reach of such community awareness campaigns in Kamuli was 4900 people while that of Masalu-Busia was 1900. This performance is impressive considering that majority of Ugandan NGOs (which are considered by some to have a comparative advantage over state agencies in community mobilisation) reportedly have an average reach of less than 500 people annually (see Chapter Five, 5.3). Co-production also had several implications for citizenship and these will be explored in Chapter Seven.

Nevertheless, like the case of using less technical health workers, the use of PWA peers in service delivery is challenged in some quarters. There is a fear that involving PWAs may compromise service quality because it might discourage the hospital from bringing in more qualified health workers. Indeed, interviews with senior officials in the different MTPs showed that they had become comfortable with using PWAs and the less technical staff to provide services (Male health worker Kaberamaido MTP, 18/5/2011). Scholars have long sounded caution about some of the adverse forms of co-production, which serve to promote the neoliberal agenda of slimming public expenditure (Mattson, 1986; Mitlin, 2008).

The ‘motivation’ of government health workers

The foregoing discussion has revealed that the introduction of MTPs increased the workload of staff in public hospitals thereby exacerbating the staffing problem. In MTPs, health workers had to combine attending to OPD patients and/or doing ward rounds with HIV/AIDS activities. Moreover, as explained later, MTP brought on board new activities such as extra data collection, home visiting, and community sensitisation among others. These were perceived as extra work by health workers. The strategy employed by TASO to address workload complaints was to provide health workers with financial incentives as a way of compensating them for the extra effort. According to a senior TASO official:

Our strategy did not intend to recruit new HR [human resources], yet we realised that the staffing levels of some of the health units were very, very low. And when
you come up with projects like this one it is like you are creating more work for them [health workers]. This was the rationale behind the allowances to these people (Female, TASO Central Region official, 7\textsuperscript{th}/3/2011).

Thus, within the annual budget to MTPs, there was an allocation for ‘motivating\textsuperscript{32} health workers who picked ‘extra’ work. With TASO’s guidance, this was UGX 5,000 per workday (roughly $2.5) across all MTPs. To the poorly paid health workers, such allowances were a huge incentive, for example in a month, some would collect as much as 15% equivalent of the nurse’s salary. Hence, several respondents noted that “when they opened the mini TASO, all our counsellors and technicians were very much willing to come on [clinic] days and serve knowing that at the end of the day they will sign for UGX 5,000” (Male health worker Masafu-Busia, 22/12/2010).

This arrangement, however, had several drawbacks. First, there was a risk of detracting the attention of the state from citizens with other ailments to those with HIV/AIDS. Although several respondents claimed that health workers first attended to patients in OPD and/or mostly used their ‘offs\textsuperscript{33} to serve at the HIV/AIDS department, others argued that the urge to make money affected their attention to the non-HIV/AIDS patients (Male health worker Kaberamaido MTP, 18/5/2011). One health worker in Masafu-Busia rhetorically expressed this point:

> At the hospital, other patients used to suffer indirectly because the number of staff was kind of reduced. Like me, I would spend most time in the field on HIV/AIDS activities. So if another patient came in at the hospital and needed my attention he/she would not get me (Male health worker Masafu-Busia 20/4/2011).

Besides this, some key informants were apprehensive about the quality of services by health workers who claimed to use their ‘offs’. A respondent in Kamuli argued that “you see when these health workers come after night duty they give services when they are really tired” (Female peer counsellor 23/4/2011). This clearly implies a reduction in capacity to deliver quality services. Another respondent indicated that this exhibited lack of commitment to HIV/AIDS on the part of the state – “So it was a by-the-way activity because people worked in the HIV department as a form of leisure” (male PWA Kamuli, 10\textsuperscript{th}/2/2011). Moreover, the motivation depended on TASO’s funding. It is reported that

\textsuperscript{32} Health workers often referred to allowances from TASO as their ‘motivation’ for doing extra work.

\textsuperscript{33} Being ‘off’ is a slang used to refer to days/hours when a health worker is supposed to be off-duty having completed his/her shift.
when the funding from TASO stopped, MTPs especially in Masafu-Busia witnessed corresponding cutbacks in the attendance of health workers. This is because even those staff who used to get allowances “were now saying that they can’t work for free” (Male health worker Masafu-Busia hospital 24/1/2011).

The introduction of allowances had other negative implications for state capacity. Some analysts argue that ‘quick returns’ in form of allowances contravene the principle of predictable ‘long-term career rewards’ upon which coherent bureaucratic organisations are founded (Evans and Rauch, 1999; Henderson et al., 2007). Relatedly, giving allowances to civil servants has recently been singled out for promoting clientelistic behaviour within the civil service in Africa (Ridde, 2010; Søreide et al., 2012). According to Ridde, “very often, these practices have dramatic impacts on the healthcare system. The players plan their actions around the primary goal of acquiring [allowances], rather than of effecting changes among the publics targeted by their intervention” (2010:2). In Kamuli, when a senior health worker was asked whether TASO activities were associated with any negative outcome, this is what he had to say:

The only negative thing I saw was that of having our staff getting used to receiving an incentive, which led them to develop those feelings that if ‘I provide a service I should be paid for it’. When it withdrew the clinic almost collapsed. Otherwise everything else was positive (Male health worker 1st/3/2011).

These points suggest, therefore, that instead of addressing HR challenges in public hospitals, in some ways, MTP ended up escalating them.

6.2.4 The creation of HIV/AIDS departments

Chapter Five indicated that all hospitals targeted by MTP lacked dedicated office space for activities like counselling, which is a crucial aspect of bureaucratic capacity required for effective HIV/AIDS service delivery. Indeed, prior to MTPs, PWAs were attended to “as general cases” in OPD. As noted earlier in this chapter, this was in part due to the fact that there were only few PWAs, hence, managers of these hospitals saw no need for a separate department to handle HIV/AIDS patients. Both patients and health workers, however, concurred that this state of affairs negatively affected PWAs. A senior health worker in Kamuli MTP indicated that due to this “HIV/AIDS was not a streamlined service
and the disease being the way it is, I think people were not benefiting ...” (male staff Kamuli, 2\textsuperscript{nd}/3/2011). The lack of office space also perpetuated the practice of focusing on dispensing drugs thereby leaving patients’ psychosocial needs unattended (Female health staff, Masafu hospital, 27/12/2010). In an apparent attempt to enlist the attention of the state for PWAs, therefore, TASO pressed local governments to create separate HIV/AIDS departments in all hospitals that implemented MTP.

Departmentalisation implies that PWAs were made a separate category of patients, distinct from those suffering from other ailments such as malaria and measles. According to Chapter Two, such practices make citizens more legible to the state and with this clearer ‘view’ the state can provide services that correspond to their needs (Corbridge et al., 2005). According to a senior health official in Kamuli hospital “when the Mini TASO was started, it became a central place where we could easily send people to be worked on in line with HIV/AIDS conditions” (male respondent, 1\textsuperscript{st}/1/2011). Even patients claimed that creating a separate department helped to push HIV as a priority in their hospitals: “the presence of this department helped to remind the hospital management that HIV is part of the services they were supposed to provide. You know, they used to think that HIV was not a priority to them ...” (Male PWA Kamuli, 10\textsuperscript{th}/2/2011).

The state’s visual capabilities were improved further when TASO introduced several data forms to help health workers to collect information on PWAs. TASO trained records clerks, and funded the establishment of records storage facilities such as filing cabinets and supplied clients’ files. These interventions had visible impacts, because, as already noted, MTP sites kept far more data on their service delivery activities as compared to Iganga hospital where the project was not implemented (see subsection 6.2.1). In Kamuli, some claimed, this record keeping experience was used to improve hospital-wide records management (Male staff Kamuli, 27/6/2011). When data showed that more clients were attending clinics, MTP administrators were prompted to increase on the number of clinics days and later to introduce an ‘Appointment System’. These were important aspects that require further elaboration. Having started with one clinic day a week, by the time of fieldwork, the HIV/AIDS clinic in Kamuli was operating four days in a week as follows: Mondays were for adults on ART, Tuesdays for children, and Wednesdays and Thursdays for pre-ART adults. Fridays were designated for records management. PWA leaders
observed that this helped to reduce on the congestion of patients at the clinic (Female PWA Kamuli, 22/4/2011). The Appointment System, for its part, was introduced to allocate PWAs specific days on which to visit the clinic. This was important in as far as it increased reliability of state-citizen interaction in Kamuli MTP. Here, citizens become more legible to the state, which is an indicator for enhanced bureaucratic capabilities (Chapter Two). The appointment system also had citizenship building effects which are discussed in Chapter Seven.

The effects of some of these interventions also spilled into improvements in other dimensions of state capacity such as infrastructural power (discussed in section 6.5). In Kamuli for instance, when data showed that MTP was serving fewer children compared to adults, health workers started to make home visits with a view of ‘capturing’ these children in their homes:

Home visiting was important because we used to have very few children in the clinic. With home visits we managed to do HIV testing at home [and] with that we captured so many children to come to the clinic (Female health worker Kamuli hospital, 14/1/2011).

This could explain why Kamuli had more children on care compared to other sites (see Table 6-1). What is important to note, however, is that in 2011, Iganga hospital also managed to open its own HIV/AIDS department and had started proper records management with the help of a US-funded STAR-E project.

Nonetheless, turning HIV/AIDS clinics into separate departments or making PWAs to be ‘seen’ as a particular category of citizens was disadvantageous to some. For instance, it was reported that there is a section of PWAs who were better served when HIV/AIDS services were being handled in OPD. This is because some did not want to be openly identified by members of the public as AIDS suffers and OPD had the advantage of concealing the type of illnesses that patients were suffering from. Therefore, when MTPs were established, some PWAs were hesitant to seek medical treatment from there – they wanted to be served in private (Male expert client, 1st/2/2011 and Female health worker 14/1/2011). Since MTPs had no ‘private wing’, some resorted to getting their drugs through intermediaries especially PWAs who worked as volunteers (Female health worker 14/1/2011; health workers and volunteers meeting Kamuli MTP 29/4/2011). One
respondent admitted that he was helping several of such clients who, allegedly, still had ‘self-stigma’ (Male PWA Kamuli, 10/2/2011). Therefore, as Scott (1998) would argue, enhanced visual powers of the state came at the expense of citizens losing their privacy.

6.2.5 MTPs as islands of excellence

Apart from the direct strategies of building bureaucratic capacity discussed above, this study also sought to establish whether and how MTP impacted on other departments within and beyond the hospitals where it was implemented. The theoretical lens used here relates closely to the concept of IOEs which, as explored in Chapter Two, has two distinct functions. First, some argue that within the context of Southern countries, where high performance bureaucracies are an exception rather than the rule, promoting semi-autonomous agencies offers the most realistic strategy for building state capacity. The second conceptualisation moves a step further and probes whether once established, IOEs could have dispersal effects to other state agencies. The first function is the gist of this entire chapter, which is, establishing whether MTPs became centres of high performance within the targeted rural hospitals. In this subsection, therefore, this aspect will not be further considered, instead, the focus is put on analysing whether MTPs had dispersal effects in the study sites. Roll (2011:3-4) identifies three channels through which IOEs can lead to broader changes beyond the confines of one agency/department:

a) Through the ‘demonstration effect’ where other departments/agencies imitate from the effective one,

b) ‘bureaucratic contagion effect’ where the effectiveness of one department/agency breeds competition among others to perform better, and

c) ‘bureaucratic seed effect’ where emissaries from the effective department/agency are redeployed to lead the less ineffective ones in expectation that they will be able to apply similar work methods to cause improvements.

In relation to Roll’s channels of impact dispersal above, the study found few systematic attempts to spread the impact of MTP beyond the newly created HIV/AIDS departments.

Firstly, there was no evidence that Trainers of Trainers (ToTs) did their job. According to Chapter Five, TASO projected TOTs as ‘bureaucratic seeds’ that would replenish hospitals with staff skilled on HIV/AIDS issues. We have discussed already that all MTPs had shortages of skilled staff, and yet, no study site reported that their ToTs were doing
The study observed, however, that leaders in Kamuli hospital had introduced a system of periodically rotating health workers in the HIV/AIDS department to other departments. Although the intention of the architects of the rotational system was to enable “people to gain practicing experience” (female health worker Kamuli, 22/3/2011), we can expect that those transferred might be able to take the newly acquired practices to other departments. However, by the time of fieldwork, it was too soon to observe the impact of this initiative as it had just started.

Meanwhile in Masafu, respondents could not explain whether the experience from the ART department was helping them to improve the performance of other departments or not. However, as explained in Chapter Five, TASO trainings in this particular MTP included health workers from other health centres in the district. This could be interpreted as combining Roll’s (2011) ‘demonstration effect’ and ‘bureaucratic seed effect’. We interviewed one of such health workers from Dabani Health Centre IV. She claimed that TASO’s trainings and experience of practicing ART administration at Masafu-Busia helped them in setting up their own ART clinic in 2010 (interview with a female health worker Dabani HC IV, 18/4/2011). This respondent even claimed that it was one of the two staff involved in Masafu-Busia MTP that was appointed to head the new ART project in Dabani HC IV. One of the visible aspects copied from MTP, as observed by the researcher, was the manner in which they organised their records. We observed that Dabani had made a copycat filing system in relation to that of Masafu-Busia. These are good examples of Skocpol’s observation that the experience gained from implementing development programmes can become a basis upon which improvements in current or future programmes can be organised (Skocpol, 1992; 1995). Nonetheless TASO’s impact in Dabani HC IV should not be overemphasised because the ART project there was sponsored by different NGOs and it involved (re)training of health workers, for instance in child counselling and ART management (interview with a female health worker op.cit.). In addition, we did not spend sufficient time in this facility to allow more systematic observations.

6.2.6 The emergence of ‘reform champions’

As observed in Chapter Two, some argue that the conceptualisation of IOEs does not need to be limited to whole agencies or departments, it can also be applied to committed
individuals within state agencies (Crook, 2010). Indeed, our evidence indicates that MTP operated well in sites where cadres committed to performance improvement existed. Recent development literature calls these ‘reform champions’ (Citizenship DRC, 2011; Cornwall and Coelho, 2007; Goetz and Gaventa, 2001a) or ‘interlocutors’ (Tembo, 2012). Although not explicitly stated as ‘reform champions’, several key informants observed that the performance of MTPs depended much on the creativity of the leaders in government hospitals (two former TASO HQ officials, 6th/5/2011; 23/4/2011).

In order to ascertain the contribution of TASO in the emergence of such individuals, however, it is important to establish whether or not such individuals were active prior to MTP. In Kamuli, it is reported, there were two resilient male health workers who upheld the project through the hardships that it encountered in the early years (General meeting op cit; interview with Female PWA leader 22/4/2011). Before TASO’s intervention, these two health workers were ordinary Clinical Officers. With MTP, they went through the various training programmes by TASO and were assigned more responsibilities – one was selected to work as the Project Coordinator (also doubled as the Counselling Coordinator) while the other became the Medical Coordinator. In particular, the Project Coordinator’s commitment was instrumental in advancing innovative approaches as reflected in some of the initiatives he introduced that did not exist in Masafu-Busia MTP. These included:

1. Implementing the system of clients’ representative committees through which PWAs elected their leaders to represent them in the HIV/AIDS department.
2. Introduction of the idea of holding quarterly General Meetings which brought together health workers and District level politicians such as councillors to interact with PWA service users.
3. Linking the project to several NGOs that were in position to bring complementary services to the benefit of MTP and PWAs at large.
4. When health workers held back during resource scarcity, ‘volunteer’ health workers from the neighbouring Mission hospital were brought on board in a bid to fill the vacuum.
5. Initiated the idea of PWAs paying user fee for HIV/AIDS services.

Points 1-4 are discussed in Section 6.3 as part of the ‘external embeddedness’ of MTP while user fee (point 5) is discussed in Chapter Seven as a central point that was key in mobilising citizen action in Kamuli hospital.
In order to nurture their growth in other places, Cornwall and Coelho (2007) argue, it is critical to analyse the incentives of such champions of change. To Paul (2011), there are some benevolent bureaucrats with a genuine commitment towards improving citizens’ welfare. According to this view, when such bureaucrats receive suggestions on how their agencies can improve, they are determined to implement those reforms. As already argued, the trainings and inspiration from TASO enlisted the commitment of many bureaucrats towards service delivery for PWAs. However, others argue that the emergence of reform champions also requires a favourable management style in state agencies. To Tendler (1997), innovative bureaucrats are likely to emerge in agencies with flexible managerial practices, which for instance allow employees to make operational decisions without rigid bureaucratic encumbrances. Some respondents argued that in Kamuli, the hospital had a relatively flexible top leadership which allowed the MTP Coordinator to try out new operating approaches (Male, former TASO HQ official, 6\textsuperscript{th}/5/2011; also see discussion on state embeddedness).

However, some scholars claim, assuming that “bureaucrats are simply ignorant of the problems with government” and are eagerly waiting for an external agency to teach them what to do, is a naive view of the politics of bureaucratic inefficiency (Ackerman, 2004:458). It is argued that bureaucrats are more likely to support reform initiatives where they have no vested interest in maintaining the status quo (Chhotray, 2008; Corbridge et al., 2005) and/or when they stand to benefit from the implementation of the reforms. In Kamuli, for instance, the Project Coordinator’s enthusiasm stemmed from the fact that this position placed him in firm control of the funds from TASO. Since top management had a hands-off leadership style, he had latitude to divert some of it for personal use. Therefore, the innovations witnessed during his time could be interpreted as avenues through which he also benefited personally, for instance through diverting resources meant for implementing the various activities. Indeed, several of the health workers interviewed alleged that he was secretive with regards to the amount of resources received for the project, something that heightened suspicions that he used to swindle staff and clients’ money from TASO (female health worker 14/1/2011; male health worker, 2\textsuperscript{nd}/3/2011). As discussed in more detail in Chapter Seven, it was also due to accusations of lack of transparency and dictatorship that some PWAs leaders mobilised against him to
be transferred. Meanwhile, in Masafu, the coordinator’s position was not attractive as MTP activities were tightly controlled by the Medical Superintendent himself.

Although these observations are paradoxical, in the sense that the bureaucrat who appeared to be committed to the project was at the same time exhibiting ‘corrupt’ tendencies, recent research by the African Power and Politics Programme (APPP) reveals that this should not be surprising. APPP research shows that, in some contexts, neo-patrimonial practices by state agents can have developmental impacts, for instance, where some agencies are identified and supported to develop bureaucratic capacities for purposes of generating revenue required to maintain patronage networks of the ruling elites (Booth, 2011a; Cammack et al., 2010). In the meantime, when the new Project Coordinator (a ‘non-corrupt’ one) took over, she formed an inclusive team and promoted transparency. However, some claimed, she was not as committed and innovative as her predecessor. This claim was made by six out of the eight PWAs who were conversant with the issue of MTP leadership. One of the PWA leaders summarised the key points of comparison between the two leaders as follows:

He [the first coordinator] was transferred but it is him who understood how the project worked ... the lady who replaced [him] does not have the capacity to take the project forward... they [health workers] are no longer even calling PWAs for meetings [yet he] used to call us to meet. He would call people at the district like the councillors in charge of health, DHO and other health workers in the facility. These meetings used to be quarterly but we have now taken a long time without meeting ... Right now I don’t think that even the MDD group is as functional as it used to be (Female PWA leader Kamuli, 22/4/2011).

These observations also relate to another important issue that reforms initiated by reform champions tend to lose momentum when new leaders are brought on board (Goetz and Jenkins, 2001).

To sum up the discussion so far, what is emerging from the foregoing analysis is that TASO’s record in building the bureaucratic capacity of the state had varied impacts. On the positive side, the ability of targeted hospitals to deliver HIV/AIDS services was definitely strengthened through strategies like health workers’ training, funding of drugs purchase and the creation of independent HIV/AIDS departments. The latter are likely to
continue focusing the attention of the state on PWAs even though TASO phased out its support. The management of records in MTPs was greatly improved and health workers acquired vital skills in psychosocial counselling. These two aspects enhanced the ability of the state to ‘see’ its citizens in improved ways. On the negative side, however, the discussion also shows that some of the solutions fronted by TASO were clearly ‘band-aid’ in nature. Some interventions, like funding drugs purchase, did not confront the root causes of problems. Drugs scarcity, according to some commentators, was due to the re-centralisation of medical supplies coupled with inefficiencies within the state agency responsible for their procurement and distribution (Male UAC official Kampala, 9th/6/2011; Nazerali et al., 2006). Moreover, other solutions such as giving allowances to health workers, to do work which they are mandated to do anyway, bred a culture of ‘no money no work’ that is antithetical to constructing a bureaucracy based on long-term career rewards. The evidence on MTPs as IOEs with dispersal effects reflects that, overall, the project’s impact on wider health service provision was limited; and as a route for nurturing reform champions, the conclusions are ambiguous for these have both progressive and regressive tendencies. In the next section, we turn the spotlight on the record of MTP in relation to enhancing the external embeddedness of the state.

6.3 MTPs and the external embeddedness of the state

One of the established positions in the literature of state building is that high-capacity states emerge out of bureaucratic reliance “on the ‘right’ kinds of relationships to non-state actors” (Vom Hau, 2012:4). As observed in Chapter Two, the delivery of capability-enhancing services is influenced by a particular kind of “state-society synergy” different from that crucial to achieving economic growth through industrial transformation. This is in the sense that whereas economic growth requires “dense networks of ties connecting the state to industrial elites”, social services dictate that these are “replaced by a much broader, much more “bottom up” set of state-society ties” (Evans, 2011:3) connecting “the apparatus of the state, administrative and political, to civil society” (2011:10). In the context of this study, two types of dense systematic sets of ties with civil society were discernible: ties with formal/informal organisations, and relationships with the clients’ community.
6.3.1 Embeddedness with civil society organisations

According to TASO, HIV/AIDS is a multidimensional problem whose effective management not only needs enormous resources but also requires more than health services (male TASO Eastern Region official 4/1/2011). This means, in TASO’s view, that no one single organisation can possibly address this problem single-handedly (Chapter Five). With this ideology in mind, one of TASO’s training modules for the management teams in MTPs was in relation to issues of resource mobilisation, advocacy and networking and partnership building (former male TASO HQ official Kampala, 23/4/2011). The aim here was to empower MTP leaders to attract other development agencies to provide complementary support in order to advance the goals of MTP.

The study observed that compared to Masafu MTP, Kamuli was better at linking up with CSOs to enlist support to complement that provided by TASO. The first Project Coordinator, for instance, successfully lobbied Plan International to support MTP activities with a CD4 machine. (Male PWA leader Kamuli 21/3/2011, and minutes of General Meeting 25/4/2009). CD4 testing had been identified as a problem that prevented PWAs from being enrolled on ART because tests were being done in Jinja district and at a cost that many PWAs found prohibitive (Female expert client Kamuli 4/4/2011). Due to the problems of electricity in the district, the Project Coordinator had to lobby another CSO, Baylor College of Medicine, for a standby generator to facilitate the operation of the CD4 machine. It is reported that “Baylor also promised to facilitate the project with a solar-panel system to ensure a well-moderated temperature of the reagents ... in a bid to avoid false CD4 test-results” (General Meeting op cit). The Coordinator also lobbied the District Health Officer (DHO) to fund radio talk shows to air MTP activities on the most popular radio station in Kamuli. Chapter Seven shows how the media was an important component of civil society that citizens relied on to enlist accountability from state officials. One of the senior health workers in Kamuli reported that MTP relationships with these agencies were maintained even after the departure of the Project Coordinator who initiated them (Female health worker, 21/3/2011). This respondent cited the example of Plan International that the new management lobbied to provide a lunch refund for some of the volunteers trained by TASO plus giving contracts to the MDD group to perform in

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34 This helps in determining whether PWAs have reached the recommended stage for starting ARVs.
their activities. It is only radio talk shows that were stopped following the death of the DHO who was sponsoring them. Generally, these examples illustrate how “organisational entwining between state and nonstate actors” (Soifer and vom Hau, 2008:222) can “enable the flow of knowledge and resources, facilitate policy implementation, and secure the responsiveness of state agencies” (Vom Hau, 2012:4).

Although it might be difficult to wholly attribute the coming of the abovementioned CSOs to Kamuli hospital as efforts of MTP, especially because the President and NRM government generally encourage CSOs to join hands with the state to fight HIV/AIDS, some key informants noted that it is TASO’s training programme in resource mobilisation and advocacy that taught government officials how to lobby other agencies for resources (Female staff Arua hospital, 17/5/2011). Indeed, in Kamuli, MTP leaders ensured that the resources from these CSOs were complementing those provided by TASO. Therefore, as argued by some TASO key informants, by creating MTPs, “TASO laid the foundation upon which other organisations have built [state capacity]” (former TASO HQ staff Kampala, 23/4/2011). Meanwhile, in Masafu-Busia, no serious partnership between MTP and CSOs was observed. The project had no CD4 machine and when TASO funding stopped, there were challenges in taking patients’ blood samples to Mbale Regional Hospital for these tests to be done (Male health worker Masafu hospital 4/1/2011). The findings here provide an important lesson for NGO-state relations. Whereas some scholars, and Chapter Five, argue that effective NGOs are mostly those that have close links with different agencies of the state (see Lavalle et al., 2005), our findings suggest that state agencies, especially those in charge of delivering social services, also thrive where they have close ties with NGOs (Soifer and vom Hau, 2008; Vom Hau, 2012). Conversely, Chapter Three illustrates how antagonistic relations between Obote I regime and the missionaries, who controlled a huge proportion of education and health service delivery, made them reluctant to expand service delivery with far-reaching consequences for state territorial reach and legitimacy.

6.3.2 Embeddedness with the clients community
TASO encouraged MTPs to copy mechanisms, such as clients’ representative committees, that are used by its service branches to maintain close relations with their communities. As observed in Chapter Five, however, because TASO avoided to be branded ‘political’, it
did not make the adoption of these mechanisms mandatory. This is another way in which MTP implementation varied across sites for it is mainly MTPs with enterprising leaders that implemented these. Table 6-3 outlines the distribution of the different mechanisms which were operated in the different study sites. For purposes of simplicity, the study collectively termed them “dialogue structures”.

<table>
<thead>
<tr>
<th>Dialogue structure type</th>
<th>Kamuli MTP</th>
<th>Masafu-Busia</th>
<th>Iganga</th>
</tr>
</thead>
<tbody>
<tr>
<td>PWA/clients representative committee</td>
<td>Yes</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Clients welfare committee meetings</td>
<td>Yes</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Staff meetings with drama members</td>
<td>Yes</td>
<td>Yes</td>
<td>-</td>
</tr>
<tr>
<td>Staff-peer counsellors meetings</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>General PWA meetings</td>
<td>Yes</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

According to Table 6-3, Kamuli had five dialogue structures compared to Masafu-Busia’s two while the two PWA volunteers in Iganga claimed that they only took part in departmental meetings. This subsection argues that dialogue structures acted as avenues for balancing citizens’ expectations of the state and vice versa. This is an important aspect of state building for it points to the process of building a social contract \(^{35}\) between the state and citizens (see Chapter Two section 2.3.3). According to the OECD (2008:17) a social contract emerges from a dynamic interaction of four factors:

a) expectations that a given society has of a given state;

b) state capacity to provide services;

c) elite will to direct state resources and capacity to fulfil social expectations; and it is mediated by

d) the existence of political processes through which the bargain between state and society is struck, reinforced and institutionalised.

When closely examined, some of the ‘dialogue structures’ in Kamuli, such as the General Meetings, were engendering some of these processes with a view “of reaching a state of dynamic equilibrium between the expectations of society and state capacity to meet

\(^{35}\) Social contract is understood here to refer to a dynamic agreement between state and society on their mutual roles and responsibilities (OECD, 2008).
these expectations” (OECD, 2008:17). Excerpts from some of the meetings will illustrate this point.

In the PWA’s meeting on 30/01/2010, deliberations of members enabled them to understand the structural constraints that prevented the hospital from having enough drug stocks for clients. In this meeting, one female PWA had “lamented over the on-and-off stockouts of contrimoxazole and sometimes ARVs in Kamuli District Hospital and other health facilities in the district and said that something had to be done in order to rectify the situation”. In response, the chairperson of PWAs reported that:

he had talked to the Project Coordinator about the stockouts and was convinced by the explanation that the stockouts were nationwide. [He added] that the management of the hospital was very mindful of the situation and everything possible was being done to minimize the stock outs (PWA’s meeting on 30/01/2010).

Another example of how these mechanisms helped to align citizens’ expectations with state capacity was recorded in the General Meeting of 25/4/2009 where the District Secretary for Health was the “Chief Guest”. After the Chief Guest’s remarks, PWAs were requested to raise their concerns. One male PWA took to the floor and asked the official “what is the contribution of government towards the welfare of [PWA] in addition to that [support] offered by TASO?” According to the meeting minutes, the Chief Guest answered that “Government already contributes in terms of staff, infrastructure, and drugs e.g. ARVs etc”. When another PWA got his chance to speak, he requested that the district should consider empowering Health centre IIIs and IVs to “to administer ART in a bid to reduce congestion at the district hospital [MTP]”. The Chief Guest’s response was that the decision to grant lower health centres powers to deliver ARVs comes from the central government (MoH) and urged PWAs to be patient; “Rome wasn’t built in a day. Hopefully, this will be achieved in the long-run” she reportedly informed them. These examples show that such channels of communication enabled the state to hear citizens concerns and citizens in return understood what the state was doing about their situation.

This way of organising General Meetings can be compared to ‘citizen juries’ in India as described by Corbridge (2005) and Goetz and Gaventa (2001a). Like citizen juries, General Meetings in Kamuli brought together politicians, government health workers, PWAs and
sometimes members of the press and involved state officials getting feedback from citizens and in return giving explanations for state action or inaction. Through such avenues, MTP became a means “for bringing the citizen and the state into … unmediated encounter that offers each party an undistorted sighting of the other” (Corbridge et al., 2005:44).

The importance of dialogue structures was emphasised by quantitative data. When respondents were asked in the mini-survey as to how much they thought their respective hospitals paid attention to what people like them think before they decide on what to do, Kamuli MTP performed better (See Table 6-4).

<table>
<thead>
<tr>
<th>Facility Category</th>
<th>Attention by hospital</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not much</td>
<td>A little bit</td>
</tr>
<tr>
<td>Kamuli</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td>% within Facility Category</td>
<td>16.7%</td>
<td>21.7%</td>
</tr>
<tr>
<td>Masafu-Busia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td>35</td>
<td>7</td>
</tr>
<tr>
<td>% within Facility Category</td>
<td>50.0%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Iganga</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td>35</td>
<td>4</td>
</tr>
<tr>
<td>% within Facility Category</td>
<td>79.5%</td>
<td>9.1%</td>
</tr>
</tbody>
</table>

From Table 6-4, 62% of the PWAs in Kamuli and 40% in Masafu-Busia reported that their hospitals are paying “a great deal of attention” to what they think while only 11% of the PWAs in Iganga, where TASO had no intervention, felt the same. A majority of PWAs (80%) in Iganga thought that their facility did not pay “much attention” to them, but only 17% and 50% in Kamuli and Masafu-Busia respectively felt as such. This data suggests that where the MTP was fully implemented (in Kamuli), state-society interactions became regular which made citizens feel that the state was interested in listening to their concerns.

In sum, as far as the external embeddness of the state is concerned, impact was contingent on three factors: training/capacity, commitment and working environment. Although TASO trained MTP leaders in resource mobilisation, advocacy and networking, it had less control over the actual utilisation of these skills. In Kamuli, where the Project Coordinator was more enterprising, MTP generated close relations with several CSOs and
more mechanisms for dialogue with its clients as compared to Masafu-Busia. However, it has also been suggested that staff innovation also depended on the management style of top leadership in the different hospitals. Scholars like Edwards and Hulme (1992) observe that rigid bureaucratic procedures limit innovation in government agencies while, conversely, Tendler (1997) suggests that open management systems steer it. Indeed, in Kamuli top leadership gave leeway to heads of departments to take independent decisions regarding the operation of MTP as compared to Masafu-Busia. Besides this, evidence here supports the observation made in Chapter Two that state and civil society do not need to be autonomous from each other for effective performance. In our study sites, given the resource constraints that hospitals experienced, entwining with CSOs helped to generate resources that complemented those provided by TASO. In addition, embeddedness with the clients’ community, especially in Kamuli, appeared to provide the crucial ingredients needed in the negotiation of social contracts between the state and citizens. In the next section, we look at MTP’s impact on the infrastructural power of the state.

6.4 MTP and the state’s infrastructural power

According to Chapter Five, the architects of MTP had great concerns about the limited spatial spread of HIV/AIDS services in rural Uganda. Although some suggest that it is physical infrastructure like hospital buildings that are crucial in aiding the state to penetrate the territory it claims to govern to implement chosen policies (Chapter Two; Soifer and vom Hau, 2008; Vom Hau, 2012), Chapter Three observed that the current GoU investment in health sector infrastructure improvement, through the health sub-district structure, is still ineffective. This is attributed to structural constraints facing rural facilities, such as limited resources, staffing and inadequate skills for service delivery, which are akin to challenges that existed in MTP sites before TASO’s intervention. The main strategy TASO proposed to address the spatial gap in service delivery was to make these otherwise moribund rural facilities operational through the concept of “medical outreaches”. TASO assumed that monthly visits by staff from the nearest MTP to “provide HIV related services at these facilities would lead to capacity building … in HIV/AIDS management in the long run” (TASO, no date:4), supposedly through on-job training. As indicated in Chapter Five, Kamuli had two outreaches, Masafu-Busia had one while Iganga hospital did not operate outreaches at all.
Key informants from Sembabule MTP claimed that this approach was instrumental in capacitating some of the health facilities in their district:

at the time TASO came, ours was the only health centre proving ART services in the whole of Sembabule district. We wanted to build the capacity of other health centres. So we started these outreaches in other three health centres of Mateete HC III, Lwebitakuli HC III and Lwemiyaga HC III. Mateete is now one of the best performing facility in providing ART services. At the moment they have like 400 patients on ART (Male and female health worker in Sembabule MTP, 26/5/2011).

However, the results from other MTPs were rather disappointing. This study established that, rather than being focal points for building the capacity of lower health facilities, outreaches were merely points where PWAs would converge to meet MTP staff to receive their drugs. For instance, in Masafu-Busia, due to the fact that Mbehenyi HC II only had two health workers (40% of the expected number (African Health Workforce Observatory, 2009)), they could not get time to see what the health workers from Masafu-Busia MTP were doing during outreaches. According to one of the staff in Mbehenyi, “they would serve their PWAs and we would also concentrate on our malaria and the usual OPD” (Female health worker Mbehenyi HC II, 20/4/2011). This suggests that no mentoring or sharing of ideas was taking place as TASO officials might have wanted. This finding also confirms our earlier observations that MTPs did not act as effective IOEs for dispersing learning opportunities beyond the targeted HIV/AIDS departments. In fact, by the time MTPs were wound-up in 2010, TASO itself was reconsidering the methodology of outreaches after acknowledging that “this approach has not resulted into building capacity of the health unit staff to implement HIV/AIDS services on their own” (TASO, no date:4).

Although MTP failed to improve the capacity of rural health facilities through outreaches, this does not mean that PWAs in remote communities missed out on accessing services. To the contrary, and as summarised in Table 6-1, a sizeable number accessed services through outreaches and other community strategies such as home visits and community awareness campaigns. This is no mean achievement considering that most of those clients would not have managed to seek services directly from the far-away MTP hospitals.
(various interviews with clients in Mbehenyi, Masafu Busia 20/4/2011; Male health worker, Masafu-Busia hospital, 24/1/2011; Male TASO Northern Region Official 16/5/2011). Meanwhile, even here, Kamuli performed better than Masafu-Busia in terms of absolute numbers of clients served in outreaches – with the former annually serving an average of 800 PWAs and the latter 230 PWAs (see figures in Table 6.1). One of the main reasons for this is that whereas outreaches in Masafu-Busia were solely dependent on TASO funding, in Kamuli these activities used to be cushioned by PWAs contributions from user fees (see fuller discussion in Chapter Seven).

In summary, data in this section reveals paradoxical findings regarding NGO interventions in building the state's infrastructural power. Our evidence suggests that NGO approaches like outreaches can temporarily help the government to deal with the immediate concerns of pushing services to the rural population. However, such strategies may not address the structural challenges that impede the capacity of state agencies to supply services on a sustainable basis. In the last section of this chapter, we examine how MTP activities might have impacted on the legitimacy of the state.

6.5 MTP and the legitimacy of the state
According to Chapter Two, the literature generally identifies the following three factors as the main sources of state legitimacy:

a) Effective state provision of public goods and services, provided at levels of quality, quantity and equity satisfactory to most citizens (Brinkerhoff et al., 2012; Cammett and MacLean, 2011; Di John, 2011; Van de Walle and Scott, 2011).

b) Management of political participation and accountability, which ... results in responsive and accountable government, representation and inclusiveness (Brinkerhoff et al., 2012:276).

c) Security, where state authority and power assure its monopoly on the use of force to maintain border integrity, preserve law and order and protect people and property (ibid).

Given the discussion in this chapter, so far, it can be argued that MTP (to varying degrees) is linked to points a) and b). Section 6.2, in particular, argued that its weaknesses notwithstanding, MTP generally bolstered the performance of the targeted government health facilities as reflected in the numbers of people served in various service categories.
Moreover, through this project, TASO put the state in the driver’s seat to steer service provision. As discussed in Chapters One, Two and Three, this would enable the state to claim the credit associated with the project. This section, therefore, investigates the impact of MTP activities on citizen’s confidence in the state. Some analysts argue that legitimacy develops at different levels and it is important to identify the linkages between them (Kruk et al., 2010). Hence, for a systematic discussion, we analyse legitimacy at two levels – the local and sub-national levels.

6.5.1 Legitimacy at the facility level

Following Corbridge and colleagues (2005), this study predicted that PWAs might have developed new and perhaps improved ‘sightings’ of the state as a result of the changes in health worker’s attitudes towards them, the manner in which they were being handled during service provision, and through the different avenues that were established to have direct interactions with health workers and other state agents. From the qualitative interviews, several respondents talked of progressive improvements in their relations with health workers in particular and the respective health facilities in general. One of the PWAs leaders in Kamuli hospital claimed that:

[MTP] created a link or relationship between health workers and clients, clients with HIV/AIDS. Before TASO came in, there was a big bridge whereby health workers were at the extreme end and we PWAs on this other end... health workers had no good relations with us. However when TASO came, it trained health workers in counselling. ...those health workers, who had no proper communication skills, were able to abandon their old ways (Male PWA leader Kamuli hospital, 21/3/2011).

Such qualitative observations open a crucial question, how wide were such improved sightings for the state spread in the general PWAs population? To address this issue, a mini-survey was conducted to evaluate the perceptions of PWAs on four indicators designed to measure the quality of health worker–service user interactions before and after MTP. These indicators were: health workers’ responsiveness, PWAs’ ability to discuss concerns with health workers, the quality of explanation received, and privacy during consultations.
According to Figure 6-1, for MTPs, the mean score on all the four indicators was below 1.5 before MTP while surprisingly that of Iganga facility was above 2.5. This implies that most PWAs in MTPs judged that as far as their engagements with health workers were concerned, the quality was poor before TASO’s intervention, while PWAs in Iganga thought that their facility performed fairly well at the time they registered with their facility. However, with the implementation of MTP, the mean scores in both Kamuli and Masafu-Busia jumped to above 2.5 and were comparable with those of Iganga. These results are in agreement with qualitative observations that PWA’s trust in health workers during service delivery had improved.

Figure 6-1: Quality of staff – service user interactions

Note: 1 = Poor, 2 = Fair, 3 = Good.

However, how do we explain the apparent high rating of respondents in Iganga on the same indicators? There are several plausible explains for this. One is that perhaps Iganga genuinely had high quality services. At the time of fieldwork, the HIV/AIDS clinic had been given a new building which increased office space for health workers to operate. However, a recent study by Lubega (2011) provides contra findings in other areas. According to Lubega (2011), due to limited staff numbers, clients in Iganga hospital were reportedly not receiving counselling – something that our observations during the month’s stay at the clinic also noticed. The second reason could be that PWAs in this facility were happy just because they were getting access to life prolonging treatment and
therefore minding less about the quality. This argument is supported by Brinkerhoff and colleagues whose analysis of water provision in the post-Saddam era in Iraq noted that:

[in] contexts with extremely poor service provision, the value to citizens is in getting any service at all. Users want (state or other) providers to establish a basic minimum level of service, rather than to make improvements in existing services (2012:285).

The third plausible explanation is that PWAs in Iganga hospital had had no intervention to enable them to form a point of comparison, hence, they felt that the situation in their facility has always been effective. Relatedly, this anomaly could be a sign of the limitation of the recall methodology employed by the study. As discussed in Chapter Four, it may just be difficult for respondents to accurately remember things that occurred five years ago.

Nonetheless, a clear picture about respondents’ evaluation of health workers and the quality of services emerges when we consider PWA’s willingness to pay for services from their respective health facilities. Some argue that people’s confidence in the quality of public agencies is reflected in their willingness to pay for the services delivered there (Brinkerhoff et al., 2012).

Figure 6-2: Willingness to pay for health services in the respective study sites

According to Figure 6-2, whereas over 96% of respondents in Kamuli and 73% in Masafu-Busia expressed willingness to pay, the figure was only 32% in Iganga. Therefore, if we
take willingness to pay as an indicator of people’s trust in public agencies, then Kamuli would be the most trusted hospital followed by Masafu-Busia. Additionally, and in line with our earlier observation, impact appears to be greater where the project was fully implemented, for example Kamuli where PWAs were already contributing some user fee, respondents were more willing to pay compared to Masafu-Busia.

6.5.2 Legitimacy beyond the facility level

*If the people who manage the hospitals are good, then the common Ugandan will benefit from the government* (PWA Kamuli MTP, 21/3/2011).

As indicated in Chapters Two and Three, some argue that interactions between providers and users at the point of service delivery convey messages that affect citizens’ orientation towards government as a whole. Therefore, basing on the observed improved PWAs sightings of health workers within MTPs, the study sought to establish whether these sightings extended to the rest of the state apparatus. To address this issue, analysis was done in two phases: first, given the low confidence among Ugandans for public health facilities due to the history of marked deterioration in the functioning of state agencies that resulted into citizens’ loss of trust in, and withdrawal from, the state (see Chapter Three), the study analysed whether PWAs had developed a different opinion for other state health facilities other than MTPs. As highlighted in the previous sections, MTPs directly or indirectly had contact with local councils which, according to Chapter Three, are the main state structures that ordinary Ugandans interact with. Thus the second phase involved assessing PWAs’ trust in local councils.

**Trust in other government health facilities**

As far as trust in other government health facilities is concerned, findings suggest that PWAs in MTPs had more favourable sightings of these institutions than PWAs in Iganga. Using their experience at MTP, PWAs were asked to state how much trust they had for other government health facilities. From Table 6-5, respondents in Kamuli and Masafu-Busia scored highly with the percentage claiming to have “a great deal of confidence” in government facilities being 85% and 77% respectively compared to 48% in Iganga.
Table 6-5: Cross tabulation for Facility category and Trust in government hospitals

<table>
<thead>
<tr>
<th>Facility Category</th>
<th>Trust Government hospitals</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No Confidence at all</td>
<td>Some confidence</td>
</tr>
<tr>
<td>Kamuli</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>% within Facility Category</td>
<td>1.7%</td>
<td>13.6%</td>
</tr>
<tr>
<td>Masafu-Busia</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td>% within Facility Category</td>
<td>1.5%</td>
<td>21.2%</td>
</tr>
<tr>
<td>Iganga</td>
<td>3</td>
<td>21</td>
</tr>
<tr>
<td>% within Facility Category</td>
<td>6.5%</td>
<td>45.7%</td>
</tr>
</tbody>
</table>

We triangulated these findings by comparing them to those from a recent survey conducted by Afrobarometer in 2011. The Afrobarometer survey asked Ugandans to express their opinion on how well the government has handled the issue of improving basic health services. Although the phrasing of the question was a little different to ours, in the sense that Afrobarometer asked about government’s response to health generally, it is plausible that people would respond to it in consideration of their experiences at public health facilities. Another caveat here is that the Afrobarometer sample from Busia was too small to allow meaningful quantitative calculations in this district.

Table 6-6: Government handling of health services

<table>
<thead>
<tr>
<th>District</th>
<th>Handling of basic health services</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Badly</td>
<td>Fair</td>
</tr>
<tr>
<td>Kamuli</td>
<td>Count</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>% within District</td>
<td>39.7%</td>
</tr>
<tr>
<td>Busia</td>
<td>Count</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>% within District</td>
<td>6.2%</td>
</tr>
<tr>
<td>Iganga</td>
<td>Count</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>% within District</td>
<td>25.4%</td>
</tr>
</tbody>
</table>

Source: author’s computation based on Afrobarometer 2011 volume 4.5.2

A comparison of results in Tables 6-5 and 6-6 reveals that PWAs in Kamuli had greater confidence in government facilities compared to the general population in Kamuli. However, PWAs in Iganga had comparable confidence levels with the rest of population in their district. Generally, the high confidence that respondents from MTPs had in other health facilities can be attributed to the fact that some of them used to pick their drugs from government health facilities where health workers from MTPs used to organise...
monthly outreaches. As exemplified by the quote below, some PWAs thought that TASO actually built the capacities of these health facilities too:

I have liked the spirit now in government people [health workers], they have integrated everything. You find that health workers have a heart ... because TASO is now training [them] they have that heart that allows helping our people [PWA] (FGD with service users Masafu-Busia, 14/12/2010).

In a related perspective, respondent in Arua reported that:

TASO has empowered health workers to provide services to PWAs. It is these NGOs that have empowered government health workers to provide hospitality to patients. This encouraged people to come out. Otherwise there was nothing much that the government was doing before these organisations came in. The health workers were not doing much (Male PWA Arua, 17/5/2011).

Nevertheless, it is important to note that some clients in MTPs were still sceptical of the situation in government hospitals. Although they acknowledged that MTP sites had improved, the performance in other government facilities was still poor. From Kamuli, a female respondent reported that “I think that it is only here where there is improvement. This improvement has been recorded because of TASO intervention. But when you go to health units elsewhere, they won’t care about you. Plus medicine won’t be there” (Female PWA Kamuli, 21/3/2011). Similarly, respondents in an FGD of service users in Masafu-Busia observed that “good performance in government hospitals is in Masafu-Busia MTP. Other government facilities in the district just write medicine for you and you wonder where you are going to get [the money to buy] it” (FGD participant Masafu hospital 14/12/2010). Meanwhile, these observations are also in line with our earlier argument that the impacts from MTPs did not spill-over to state agencies beyond the intervention sites.

Trust in local governments

The discussion here proceeds by illustrating some of the direct links that MTP had with local councils in Uganda. In Kamuli MTP, as noted in Section 6.3.2, General Meetings often involved members of elected local councils. From the reviewed minutes, such meetings provided opportunities for these councillors to explain their council’s position on several aspects that PWAs had interest in. Some politicians are said to have used these forums to suggest that the government is the one that brought MTP to their area. For instance, in one of such meetings, the District Secretary for Health of Kamuli is quoted to have
“requested the clients to join hands with her and thank the NRM Government for its dedication in HIV interventions and other viable programmes” (General Meeting 25/4/2009). Therefore, this study predicted that PWAs in Kamuli MTP would have higher levels of confidence in their elected councils than those in Masafu-Busia. This is because in Masafu-Busia, PWAs had limited opportunities for direct engagement with elected councils.

When we asked respondents in the mini-survey how much confidence they had in their elected local councils, 61% of respondents in Kamuli MTP claimed to have “a lot of confidence” compared to 51% in Masafu-Busia. Moreover, while respondents who had “no confidence at all” in their elected councils were only 7% in Kamuli MTP, in Masafu Busia they were 20%. Meanwhile, 48% of respondents in Iganga indicated that they had a lot of confidence in the elected councils, a figure that is significantly less that of Kamuli but comparable to that of Masafu-Busia.

Similar to the case of public health facilities, we compared our data with the nationally representative survey conducted by Afrobarometer in early 2011. Specific district-level comparisons, as presented in Figure 6-3, showed that PWAs have more favourable evaluation of their local councils as compared to other respondents in their respective districts except in Busia district where 75% of the general population claimed to have a lot of confidence in the elected councils. However, Afrobarometer findings in Busia have to be interpreted with care as the study only had 16 respondents from this district. Such a sample can be taken as inadequate for useful quantitative comparisons.

The findings so far presented are contra to the view held by some scholars reviewed in Chapters One and Two that NGOs’ activities are inherently contradictory to developing state legitimacy (Cannon, 2000; Fritz and Menocal, 2007; Ghani et al., 2006; White, 1999). Instead, our results support the opinion that, in some contexts, the activities of NSPs like TASO can bolster state legitimacy (Cammett and MacLean, 2011). Interestingly, there was also evidence of corresponding increase in the trust that respondents had for NGOs.
According to Figure 6-4, over 90% of the respondents in Kamuli MTP and 80% of respondents in Masafu-Busia MTP claimed to have “a great deal of confidence” in NGOs compared to 48% in Iganga. This finding can be interpreted to suggest that whereas NGO interventions increase citizen trust for CSOs this does not negatively affect their trust in the state. In other words, citizens’ trust in the state can comfortably co-exist with equally high trust levels for NGOs (see, Brass, 2010a).
In summary, according to the evidence in this section, enhanced capacity of the state to deliver services can increase citizens’ trust in state agencies especially those that are directly responsible for the delivery. PWAs’ higher confidence levels in state agencies in Kamuli compared to Masafu MTP and Iganga suggests a direct relationship between the levels of performance of state agencies with the level of trust that they can attract from citizens. This is in line with recent evidence by Brinkerhoff and colleagues (2012).

However, wider state-society relations also matter here. As reported in Chapter Three, opinion surveys indicate that the state is nationally recognised for its commitment to addressing HIV/AIDS, and this thinking is reinforced at the local level by the local councillors. Therefore, it should be unsurprising that in Kamuli, where these councillors had frequent interactions with PWAs through General Meetings, more respondents trusted the state compared to other sites. Another important point here is the role of NGOs in constructing state legitimacy. Contrary to the commonly expressed belief that activities of NGOs erode state legitimacy, through its MTP, TASO appears to have bolstered it instead. In the next section, we provide the overall conclusions for the discussion in this chapter.

6.6 Discussion and conclusion
This chapter has produced interesting findings indicating that the impact of MTP varied across both the different research sites and dimensions of state capacity. As far as impact on the dimensions of state capacity is concerned, and as elaborated below, MTP performed well on specific aspects of bureaucratic capacity and embeddedness compared to infrastructural power. For instance, in relation to bureaucratic state capacity, health workers got useful skills that enabled the state to ‘see’ like an NGO, the new departments are likely to continue serving PWAs, and records management in some areas improved citizens’ legibility. However, other interventions to enhance bureaucratic capacity, such as the purchase of drugs for hospitals and giving allowances to government staff, were short-term focused and hence were bound to stop when the flow of resources from TASO ended. In relation to variation across study sites, findings indicate that impacts were stronger in Kamuli compared to Masafu-Busia. The differences between Kamuli and Masafu-Busia MTPs are attributable to the fact that the implementation of the project was comprehensive in the former and the working environment there, too, was receptive to MTP-like interventions. For instance, the leadership in Kamuli gave leeway to MTP staff
to experiment with new working approaches – something that might explain why Kamuli exhibited more innovativeness in various aspects compared to Masafu-Busia. Meanwhile, the non-MTP site of Iganga had inferior results when compared to the two MTPs. The chapter has illustrated that MTPs offered a more comprehensive package of services covering prevention, care and treatment aspects of HIV/AIDS. In contrast, Iganga hospital, like the case is with most Ugandan public facilities, only concentrated on treatment which experts believe is inadequate in handling HIV/AIDS. Generally, these findings suggest, therefore, that MTP-like interventions can work if comprehensively implemented in the right context.

Another important message from the Chapter is that even when NGOs insist that their projects are non-political, they are not always successful in shielding them from politics (Chhotray, 2008). At the point of implementation, officials tend to re-interpret the rules of these interventions especially to make them serve their interests (Corbridge et al., 2005). This was reported in Kamuli where the first Project Coordinator was accused of using project resources for personal benefit, albeit also introducing initiatives that were highly beneficial for state-society relations.

The Chapter has responded to the charge against NGOs that their activities put them in face to face competition with the state for citizens’ loyalty and identity (see Chapters One and Two). The evidence presented shows that this unfolds in contradictory ways. Whereas, on the one hand, PWAs in MTPs showed high levels of trust for state structures like health facilities and local councils, on the other, they also exhibited high levels of trust for NGOs. Hence NGO activities do not necessarily imply a zero-sum game as some literature has tended to put it. Our findings parallels those made by Brass (2010a) in Kenya and most recently by Cammett and MacLean based on empirical observations from a cross-section of developing countries, where they concluded that “the impact of NSPs is context specific and depends on the particular relationship between the state and NSPs” (2011:8). State agents, especially in Kamuli, used the skills acquired from TASO’s trainings to create dense ties with other CSOs. The ensuing relationship enabled the state to claim credit from the implementation of CSO-supported activities. To be fair, however, it appears that CSOs find it easy to accept collaboration with state agencies due to the national-level commitment of the NRM to fighting HIV/AIDS.
The chapter also provides important information on the process of how state legitimacy develops. Our findings in this respect are in line with observations that “legitimacy comes in large part from government delivery of services that people want and need” (Di John, 2011:270-71). However the differences between PWAs trust in the health facility where they mainly receive services, other health facilities and local councils suggest that the impact of services varies across the different state institutions. Here, the impact of MTP on state legitimacy was more visible at those layers near the point of delivery, the hospital, than layers not directly connected to the service delivery point, the LCs. This implies that the process of building state legitimacy is multi-layered running “from the micro dynamics of the provider-patient interaction, to the overall relationship between a health facility and the community in its catchment area, to a citizenry’s general perception of the trustworthiness of government in fulfilling its obligations” (Kruk et al., 2010:93).

On balance, when SD-NGOs engage in collaborative interventions with the state, they can influence state capacity to provide services (Batley and Rose, 2011). However, the extent to which positive effects can occur depends on both intervention/approach factors and contextual factors, some of which are beyond the remit of NGOs. The expertise of the NGO, its ability to share skills with its partners, and the availability of funding are among the key intervention factors here. In addition, the ability of such interventions to nurture effective leaders within the state – the reform champions – seems to be paramount. As discussed throughout this chapter, many of the innovations that came with MTP were linked to such leaders. Nonetheless, the chapter warns that such leaders are not benevolent, and that their emergence also depends on the management style of the top leadership in state agencies. Another critical contextual factor is the capacity of the state at the national level. The state needs to hire staff to keep up with the increasing number of service users and resources to maintain the flow of medical supplies. Other key contextual factors include the history of prior engagement between the NGO and the state and the availability of other CSOs and working relationships among themselves and with the state. In the next chapter, the study examines TASO’s record in the area of citizenship formation.
CHAPTER SEVEN
MTPs and the ‘Construction’ of PWAs: A Transition from Subjects to Citizens?

7.1 Introduction

Some scholars have recently suggested that the starting point for understanding the impact of any development initiative should be “the analysis of its consequences, both positive and negative, for the way citizenship is being actively experienced” (Spink, 2007:159). The impact of development interventions, it is argued, should not only be based on “simple technocratic measures”, such as how they produce rapid, cheaper, or more quantities of outputs (Evans, 2011) but, rather, in their capacity to generate tangible, acceptable and clear consequences for the conditions and practice of citizenship, both for those receiving and those providing services (Mcloughlin and Batley, 2012b; Spink, 2007; Williams et al., 2011). It is from this perspective that this chapter focuses on analysing the impact of MTP on the citizenship status of PWAs in rural Uganda.

The analysis in this chapter is developed around the key debates regarding the implications of service delivery for citizenship that we explored in Chapter Two. According to Chapter Two, encounters at the point of delivery can structure beneficiaries’ capabilities to assert themselves. Employing Hirschman’s (1970) Voice and Exit framework, this chapter analyses how MTP influenced PWAs in our study sites along these lines. Chapter Two also noted that service delivery programmes can influence beneficiaries’ engagement in civic activities, as for instance when service users become active in civic life to reciprocate the generosity and life-transforming benefits of a well-implemented service delivery programme (Mettler, 2002; 2007). Therefore, the second aspect that this chapter investigates is the extent and ways in which MTP influenced PWAs’ engagement in civic activities. Some researchers argue that the resources extended by delivery programmes can be an incentive for the mobilisation of beneficiaries to become active on related political issues, presumably to protect or expand the benefits from the project (Campbell, 2003; Mettler and Soss, 2004; Pierson, 1993; Skocpol, 1992). This chapter also assesses the influence of MTP on PWAs’ political participation. Noteworthy, beneficiaries’ ability to express themselves, willingness to engage in civic activities and confidence to participate in formal political contests respectively chime with the three levels of citizenship – individual, community and
national – that were identified in Chapter Two. The remainder of the discussion is structured along these lines.

**7.2 ‘Queuing, photocopying and complaining’ like a PWA**

One of the presuppositions of this study was that in sites where MTP was implemented, PWAs would be more empowered to speak out, for example, in protest of poor standards of healthcare or health workers’ misconduct. In contrast, where MTP was not implemented, it was expected that PWAs would be subservient. Indeed, as explained below, in Kamuli where MTP implementation was more comprehensive clients expressed themselves more confidently than Masafu-Busia and certainly both sites did better than Iganga hospital where the project was not implemented at all. The levels of empowerment, ranging from deference to authority to outright challenge, are well captured by what Corbridge (2007) metaphorically summarised as “queuing, photocopying and complaining”.

To establish how and why citizens expressed themselves, respondents were asked in the mini-survey whether they ever felt unhappy with the approach of a health worker over the past one year. The goal here was to lay the ground for asking a follow-on question concerning how respondents reacted in the event of unsatisfactory conduct of health workers. According to Figure 7-1, almost 20% in Kamuli answered in the affirmative that they were dissatisfied in the previous year, in Masafu-Busia it was 13%, and 7% in Iganga.

When asked what action they took when dissatisfied, respondents gave varied responses ranging from “I just kept quiet”, “it was my problem because I missed my appointment”, “I approached the concerned staff” and “I reported to hospital management” and so on and so forth. In order to conceptualise these responses into useful categories, the chapter draws on Hirschman’s (1970) *Exit, Voice and Loyalty* framework. In the context of the current analysis, however, Hirschman’s concept of loyalty has limited analytical value for when a patient claims that *I just kept quiet because I had no option* that is surely not loyalty. Instead, we find that this can usefully be categorised as “conformity”. Thus, the responses were summarised as “conformity”, “exit” and “voice” and this ordering is reflective of the levels of citizens’ empowerment. According to Soss (1999), and as elaborated in Chapter Two, conformity implies a sense of resignation or citizens’ lack of
self-confidence that their action can cause change, while voice is its opposite, that citizens believe their action matters.

**Figure 7-1: Dissatisfaction with the approach of a health worker over the past year**

Therefore, rather than looking at complaining as a sign of low quality of services here, it is better be looked at as PWAs’ evaluation of the changeability of things at the MTP. One respondent in Kamuli aptly made this point, “for us what we want is good services. We speak to them [staff] and you see them changing. We don’t want them to leave but we are interested to see them change” (Male PWA Kamuli, 10th/2/2012). Exit also reflects citizens’ agency but it is considered here to be a weaker form of self-efficacy as compared to voice. According to Hirschman (1970), exit is an act of citizens escaping objectionable state of affairs rather than working on them. According to Table 7-1, PWAs in Kamuli were more likely to resort to voice as compared to Masafu-Busia or Iganga.

**Table 7-1: Respondents action when dissatisfied with health workers**

<table>
<thead>
<tr>
<th>Facility Category</th>
<th>Count</th>
<th>Response when unsatisfied</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Conformity</td>
<td>Exit</td>
</tr>
<tr>
<td>Kamuli</td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>% within Facility Category</td>
<td>33.3%</td>
<td>8.3%</td>
<td>58.3%</td>
</tr>
<tr>
<td>Masafu-Busia</td>
<td></td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>% within Facility Category</td>
<td>75.0%</td>
<td>12.5%</td>
<td>12.5%</td>
</tr>
<tr>
<td>Iganga Control</td>
<td></td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>% within Facility Category</td>
<td>100.0%</td>
<td>.0%</td>
<td>.0%</td>
</tr>
</tbody>
</table>
Apart from observing its spread, the study went an extra step to explore how complaints were manifested and how the different manifestations were dealt with by health workers. In order to address this issue, the researcher had to rely on case studies which were identified through reviewing documentary evidence and/or observations of state-citizens encounters in action. Indeed, Corbridge and colleagues suggest that “We learn ‘the state’ – about its different boundaries, about its workings, about perceptions of ‘it’ – precisely through case studies” (2005:25). The study noted several telling incidents especially in Kamuli MTP that are worthy of detailed exploration; however due to space limitations focus will be limited to the main ones.

7.2.1 PWA complaints as ‘rude’ accountability

Our first case study involved a 47 year old PWA in Kamuli whom we shall call Peter. In terms of education, Peter was an average PWA because, like most respondents in Kamuli, he had completed primary education (see Chapter Four). Peter’s saga followed his attempt to seek services on a clinic day meant for children on March 8, 2011. One of the health workers at the triage table attempted to send him back home arguing that he was meant to pick his drugs a day before – the designated clinic day for adults. Peter tried to explain that another health worker had specifically given him this ‘appointment’ because he had two toddlers who needed close follow-up, but the health worker seemed not to listen to any of that. According to our observations, it was at this point that Peter became rude and accused her of mistreating patients. He wondered “if the date in the book says that I am coming back here on this day, how do you tell me that it is a wrong appointment when health workers make these appointments with calendars on their tables?” Peter vowed not to leave unless he saw the health worker who had given him the appointment. To cut the story short, he managed to secure services that he had come for that day. The researcher later fixed an interview with him. When asked why he had responded in the way he did well knowing that it could jeopardise his relations with health workers, he responded that:

First of all, this government brought us this medicine and it is free of charge. And we were given freedom to access this treatment as long as you are tested and confirmed positive. Secondly, I am one of the people who have stayed here for quite some time because I started getting medication from here in 2005. I was properly educated, the
counselling I got was very thorough, and [therefore] I know what to do.... In counselling these issues come up... (Male PWA Kamuli, 8\textsuperscript{th}/3/2011).

Peter was not alone in complaining, another youthful PWA explained to the researcher that “there was one health worker who used to be rude. I also complained about him face to face. I told him that you make us fear to come to the hospital” (Male PWA Kamuli, 1/2/2011).

A related story involved some staff who were inconsiderate to weak clients and how one PWA leader intervened to address the situation. The incident was reported by a female client leader we named Maria and it took place in 2009 (Interview with Maria 22/4/2011)\textsuperscript{36}. She explained that clients’ leaders at the MTP had agreed on a working arrangement to exempt weak clients from waiting in the queue. However, one day when a client who was in visible pain because of the wounds around her reproductive organs attempted to utilise this provision, she was rebuked by the staff in Records Department, whom she had requested for her medical file. Knowing the clients’ position, Maria decided to intervene: “me as a leader at the clinic, I went to request for special consideration on behalf of this weak client ...I told the staff, ‘you should handle us well, this lady came when she is very sick, why are you not considerate to her?’” (Interview with Maria \textit{op. cit}). However, this staff took her counsel in bad terms, “he barked at me too in front of all other patients” she reported. Maria narrates that another staff, who had overheard the exchange, “came out and told me that I should leave ... But then, I assured both of them that it is my role to ensure that these clients are handled well”. She allegedly explained to them that “I was only informing him to understand this lady’s situation and I only raised my voice because this gentleman rebuked me in front of the people that I represent, people who voted for me...” Maria claimed that “these are the same staff whom we complained about in some of our meetings and one of them was removed from the facility”.

There are four main lessons that can be drawn from these cases. In the first place, they highlight the importance of some of the welfarist aspects of MTP, such as counselling, and

\begin{footnote}
\textsuperscript{36} This was a memorable incident for PWAs because the researcher first learnt about it from an interview with another respondent who recommended talking to Maria for a fuller account.
\end{footnote}
the ‘technical’ ones, like the appointment system, in the empowerment of PWAs. In the case of counselling, Peter explained that mundane counselling procedures, such as encouraging the client to ask questions where things are not clear and verbal expression of PWAs, were transferable skills which helped in day to day life. Key informants argued that at the heart of TASO’s counselling is the philosophy that:

Major change starts with the individual and it is by the individual ... You cannot talk about change at community level without change at individual and family levels. So by providing counselling I think we have been able to empower individuals, then the families, and subsequently the communities (Male, TASO Eastern Region official, 4th/1/2011).

Such a counselling approach goes beyond what Campbell and Cornish (2010a) call technical communication, which stops at “the transfer of factual knowledge (such as AIDS awareness) and technical skills (such as acquiring and using condoms)”, to transformative communication that incorporates “more politicised process, through which marginalised groups develop critical understandings of the political and economic roots of their vulnerability to ill-health, and the confidence and strategies for tackling them” (Campbell and Cornish, 2010a:2). Robins’ research in South Africa makes a similar point in relation to how TAC and MSF clients learned that the problem of inequitable access to HIV treatment was a product of the greed and profiteering of global pharmaceutical companies and the state’s “indifference and inaction in relation to the provision of HIV/AIDS treatment in the public sector” (2006:313). He concludes that TAC and MSF officials “are not only interested in medical treatment but also concerned with creating “empowered citizens” who understand the connections between biomedicine, the wider social world, and the political economy of health” (2006:315).

Activities like counselling also appear to be the first step necessary to feed into the ‘levels of citizenship’ identified in section 2.2.2 for substantive citizenship. As will become clearer in this chapter, some PWAs have apparently been in position to utilise the exposure from MTP activities to engage in active politics in their communities. Thus, as Maria later observed:

These days you cannot despise people with HIV/AIDS. The exposure at the facility has taught us how to present ourselves in public. We can talk about ourselves, if for instance we are in a meeting somewhere, we can give testimonies. So people who did
not know how to speak out have actually learned (interview with Maria op. cit).

Campbell and Cornish call this a form of ‘expanded empowerment’ which relates to the ability of project beneficiaries to identify and utilize opportunities “to ‘export’ their experience of effective action to situations beyond training and services” (Campbell and Cornish, 2010a:10-11). It is important to note that ‘transformative communication’ is crucial for groups of people who may have lost their confidence to act as citizens in the face of seemingly unsolvable problems, such as poverty and diseases like HIV/AIDS (Campbell et al., 2009).

The second lesson, however, reveals some of the potential contradictions of interventions like MTP in citizenship building. Sceptics inspired by Foucault caution that activities such as counselling should not be looked at as a neutral “integral part of testing for HIV, but as a new central arena for governing the conduct of people living with HIV/AIDS” (Rasmussen, 2011:107). It is argued that some service providers can turn counselling into some sort of moralised teaching sessions which could normalise the conduct of PWAs thereby “end[ing] up dampening, rather than deepening, the potential for political agency ...” (Robins et al., 2008:1084). In relation to such concerns the study observed that the strict adherence requirements of ART put intense pressure on health workers to invent technologies which discipline PWAs to follow their treatment regime (Colvin et al., 2010). This might explain why Peter’s antagonist was insisting on the appointment system – a system designed to regularise the ‘appearance’ of specific PWA categories on specified clinic days. The study observes several disadvantages with the religious enforcement of such technologies. For PWAs who could not fight their way like Peter, there were reports that they discontinued medication for fear of being rebuked by health workers37 (Male expert client, Kamuli, 1st/2/2011). But more fundamental for our research is that PWAs are forced into vices that potentially debilitate ‘positive’ citizenship formation in that every time they miss the appointment, they have to ‘manufacture’ an alibi to justify their absence (Male expert client, op cit). This is not surprising as literature based on the welfare regime in industrialised countries similarly predicts that programmes can encourage beneficiaries to engage in improper acts such as falsifying or withholding vital

37 For a fuller anthropological account of how PWAs are disciplined into following this tight treatment regime in Uganda see Rasmussen (2011).
information to secure admission or retention (Kumlin and Rothstein, 2005). Such dishonest practices can become normalised as part of citizens’ conduct.

The third lesson is that Peter’s case shows how PWAs had started envisaging access to drugs as their right that is guaranteed by the state. This state of affairs contrasts sharply with the pre-MTP situation where access to services was seen as a favour from health workers (see Chapter Five). Moreover, the ability of health workers to maintain a big social difference from the patients, which underpin exploitative practices, was challenged as revealed in Maria’s example.

Fourth, these case studies resemble what Hossain (2010a) recently termed as “rude accountability”. Hossain coined this concept to refer to the informal tactics such as undressing, shouting and spreading rumours that poor people can employ to express displeasure and secure improvement in service delivery from ‘street level bureaucrats’. Some argue that these tactics are applicable in contexts where formal arrangements for redressing grievances like those preferred by the donor community are non-existent or ineffective (Hossain, 2010a; Tsai, 2007). However, others (e.g. Booth, 2011b) suggest that such accountability tactics become effective when they instigate the traditional horizontal accountability mechanisms of government as the two news captions from one of Uganda’s independent newspapers, the Monitor, illustrate in Figure 7-2. The first caption shows how a man in Kidera HC (incidentally one of the hospitals where Kamuli MTP used to have outreach clinics) undressed to protest the lack of attention from health workers. Within two weeks of being published in the press, district officials had dispatched a ‘fact finding mission’ to the hospital and the head of national medical stores in Kampala had also sent a team to establish why the health facility lacked drugs. With the media and government attention on them, the health workers at this hospital reportedly improved their handling of patients. This is the point emphasised by Booth (2011b) that “bottom-up pressures” can only succeed where service providers have incentives to change.

7.2.2 “Accountability by stealth”
Besides the individualistic face-to-face confrontation that preoccupied most of Hossain’s argument, we further the idea of rude accountability by introducing a concept of ‘stealth accountability’. Corbridge and colleagues remind us that poor people are more likely to
“engage their antagonists by stealth and behind the scenes” (2005:45). As the fourth of our exemplars below reveals, in some circumstances, it is safer for poor people to engage the politics of accountability indirectly especially where the type of services they receive requires them to routinely face their antagonists (also see Joshi, 2007b).

Figure 7-2: Rude accountability in Kidera HC

The study discovered the case of “accountability by stealth” from the recorded minutes of the meeting that took place between service users, their leaders and health workers in Kamuli MTP on 25/4/09. Specifically, the case is in relation to how PWAs in Kamuli secured responsibility for managing user fee collections which was formerly in the hands of the first MTP Project Coordinator we reported in Chapter Six. They accused him of ‘personalising’ the programme because he did not allow them to see how ‘their’ money was being utilised. To compel him to change, some PWAs stealthily circulated rumours “to the RDC38 and to the media that things were going amiss” at MTP (General Meeting 25/4/09). Hossain was spot-on when she observed that “the fear of public embarrassment is a serious matter to public officials” (Hossain, 2010a:913; also see, Tsai, 2007). This is because, in a bid to diffuse what the accused health worker referred to as “rumours” spread by “uninformed clients”, he used the meeting where PWAs, health

38 RDC is the Resident District Commissioner who works as the President’s representative in the district.
workers, hospital administrators, technical and political bureaucrats from the district and media representatives were all present to explain his actions (General Meeting op. cit.).

It is reported that the Coordinator conceded ground by allowing a three-person committee comprising of the chairperson, secretary and treasurer to be put in place to “monitor the collection, utilisation and accountability of user fee” (Meeting Minutes op. cit.). When at a later date PWAs felt that he was interfering in the committee’s work, it took another episode of stealth complaining to have him acted upon by his bosses. This time, PWAs sent a letter petitioning the Medical Superintendent (MS) of the hospital and DHO about the manner in which MTP activities were being handled (Male PWA Kamuli 10th/2/2011). The exact number of PWAs who drafted the petition is still a mystery but what is known is that they covertly slid copies of the “strongly worded letter” into several offices, including MS, DHO and that of the RDC (Male PWA Kamuli 10th/2/2011; Female PWA 21/3/2011). Note that they did not use the official hospital suggestion box because they were aware that its contents could be tampered with and some do not reach the concerned hospital administrators – as one of the PWA leaders observed: “that suggestion box by the way is a general thing. It is not for the ART clinic, it is for the whole hospital” (Male PWA Kamuli 7th/2/2011). The issue was concluded by the transfer of this health worker to a lower level health unit (Male senior health staff Kamuli 1st/3/2011).

Its achievements notwithstanding, accountability through such contentious actions (rude and stealth accountability) has its challenges. Hossain reminds us that achievements of such methods are “short-term and reversible” – implying that improvements are recorded for a month or two after which the situation returns to ‘normal’ (2010a:921). In Kamuli, some respondents noted that voice or rather ‘pushing’ had peculiar risks in the health setting where the target is the people who provide medical treatment. One version of this is that voice places a serious risk on the life of the loud patients as one respondent candidly observed: “Did you not know that a medical person can kill you off if he/she is fed up with you? They can overdose you. So we do not over push, we have limits” (Female PWA leader Kamuli, 22/4/2011). A related point is that the “price of complaining is to put at risk access to the very resources one is trying to secure” (Hossain, 2010a:914). In the 25/4/09 General Meeting alluded to earlier, one of the suspected ‘rumour mongers’ was ‘unanimously’ banished from the facility, “WITH IMMEDIATE EFFECT” (General Meeting
op. cit. and original emphasis). In addition, a stern warning was passed that “PWAs must stop acting as supervisors over hospital staff” (Meeting Minutes op. cit.). Last but not least, some respondents also shunned engaging in any form of ‘voice’ for the fear that voice could be interpreted by health workers as a sign of mistrust and kicking them in the teeth: “some of us we were found on the deathbed. So how can you challenge a health worker who got you from there?” one respondent asked (Male PWA, Kamuli, 1st/3/2011). These examples reflect the challenges of empowerment through programmes whose services Chapter Two categorised as “discretionary and transaction-intensive”. The medicalised nature of the treatment regime suggests that only the brave PWAs could openly challenge health workers. Generally, literature also points to the limitations of accountability initiatives which start from the general premise that public officials cannot be trusted (Joshi and Houtzager, 2012). It is suggested that citizens might prefer avenues that foster “a more trusting, collaborative approach to resolve issues of poor services through collective deliberation and joint problem solving” (ibid, 2012:152). Avenues that resemble this idea were available in Kamuli MTP and are discussed below.

7.2.3 Voice and accountability through participatory spaces

As observed in Chapter Six, MTPs had various dialogue structures such as General Meetings which, arguably, are akin to the participatory spaces where citizens are “invited inside the governmental apparatus itself” to influence programmes that directly affect them (Ackerman, 2004:451). Such structures, it is claimed, can increase citizens’ interest in the activities of public agencies, can lead to more effective allocation of resources, and citizens vigilance in turn can increase incentives for service providers to modify their behaviours in pro-poor ways (Bruns et al., 2011; Williams et al., 2011). There is some evidence that through these mechanisms PWAs in Kamuli-MTP were in some ways able to influence how the hospital functioned. As excerpts from some of the meetings below illustrate, it was through ‘dialogue structures’ that the HIV/AIDS department in Kamuli become institutionalised.

In the PWA’s committee meeting held on 27/03/2010, it was recorded that:

Member Margaret raised a complaint that the staff of Kamuli District hospital were slow in attending to the ART clinic clients.
Richard another member explained that the medical staff in the hospital had a heavy workload because they are the same people who work in the various wards of the hospital and therefore had enough excuses for delaying.

The Project Coordinator promised to raise the issue with the MS [Medical Superintendent] so that permanent staff are allocated to the HIV/AIDS department (PWA committee meeting on 27/03/2010).

In the PWA’s committee meeting of 29/05/2010, which the MS attended, he informed members that:

we came to a conclusion to let the Mini TASO become a separate department and be provided with separate staff... Since it has become a department, it will run like any other department ... So if someone does not come to duty, he/she will attract disciplinary action like any other person who fails to come to duty in other departments. Any misconduct on a TASO clinic should be handled like any from other departments.

Further complaints from PWAs caused the Medical Superintendent to issue a circular warning all Kamuli hospital staff about their conduct as exhibited in the ‘Internal Memo’ pinned at the hospital notice boards on 24/12/2010 (see Figure 7-3).

Figure 7-3: Medical Superintendent’s warning to health workers in Kamuli
For some PWAs, such communications sent a signal that their deliberation in ‘dialogue structures’ was causing the hospital to listen to their concerns. One of the PWAs leaders, for instance, argued that “because clients’ issues are raised in meetings and the medical staff are made to know about clients’ concerns, they have changed their ways and in most cases [our concerns] are handled well” (Male PWA representative Kamuli, 7\textsuperscript{th}/2/2011).

However, other PWAs were ambivalent on the effectiveness of dialogue structures. This is reflected in the response given by one respondent when asked about the effectiveness of meetings with the health staff:

When we have meetings with health workers they give us time to give our reports. Sometimes they take on our suggestions [but] other times they do not… Sometimes when we speak about certain things the problem becomes worse (Male expert client, 1\textsuperscript{st}/2/2011).

Therefore, although some action could be taken in response to the complaints from PWA, such as the transfer of some health workers, not many of the other suggestions by PWA leaders were acted upon. When PWAs consistently brought out the issue of staffing shortages at the clinic, it is claimed that the head of the facility asked whether “among us there is someone with qualifications to do [the] work” (female PWA Kamuli, 21/3/2011). This observation could be interpreted as a sarcastic reference to the lack of medical qualification of most PWAs at Kamuli MTP. As observed in Chapter Four, the majority of them at best completed primary education. However, it could also be related to the fact that some decisions, like those pertaining to recruitment of personnel and supply of drugs, are managed by a higher authority and therefore beyond the purview of frontline staff and middle-level managers. In such situations where the objects of complaints cannot do much to address them, it might cause citizens frustration with potential to undermine their enthusiasm for dialogue structures (Hossain, 2010a; Joshi, 2010; Robins et al., 2008). As one of the respondents concluded, “for me I think our suggestions are not valued” (Female PWA Kamuli, 21/3/2011).

Generally speaking, the foregoing discussion suggests that service delivery programmes can offer opportunities through which the poorest can start to build a sense of being a citizen. Activities that would conventionally be regarded as ‘welfarist’, such as counselling, or ‘technical’ such as the appointment system, became a means of empowering PWAs as
they encouraged “speaking out”. Some patients were able to demand that they receive the attention of health workers precisely because the ‘appointment’ in their books showed that they should be served on that day. This is akin to documented cases in India where women and men categorised by the state as Scheduled Castes and Tribes or as members of Other Backward Classes are able to demand their entitlements such as pension basing on “scraps of paper” supplied to them by the state as proof of “entitlement to welfare benefits” (Corbridge et al., 2005:20). In Kamuli MTP, where different clients committees were created, PWAs got more avenues for exercising voice. Such committees are important for marginalized people to gradually develop their self-confidence and the sense of being a citizen. Therefore, as rightly observed by some, programmes like MTP can “create a series of sites where ordinary people might come to see the state in ways they have not done before” (Corbridge, 2007:197). In the next section, the chapter discusses the extent to which MTP influenced beneficiaries’ engagement in civic activities.

7.3 MTPs and the civic engagement of PWAs

According to Chapter Two, beneficiaries of well managed service delivery programmes are more likely to engage in civic activities as a form of paying back to the community in appreciation of this support (Campbell, 2008; 2002; 2007). We anticipated that this ‘reciprocity thesis’ could be applicable to our study especially in the better performing MTPs. Edwards (2009:86) loosely describes civic engagement as a “composite of associational life and voluntary interaction”. Therefore, the study measured PWAs’ civic engagement in three areas, namely, participation in associational activities, offering one’s time towards achieving a public goal, and contributing money for a public goal.

7.3.1 MTP impact on PWAs’ associationalism

This research finds that for PWAs in MTPs, service delivery from state agencies was accompanied by more “capability and willingness to relate to, and to work with, one another” (Evans, 1996 citing Lam 1994:288). More specifically and in agreement with scholars such as Bebbington (2008), Moore and Putzel (1999), and Tendler (1995), our evidence shows that contact with the state stimulated PWAs to create new or join existing groups, associations and networks. As summarised in Figure 7-4, in Kamuli 64% of the respondents said that their contact with MTP had enabled them to join local groups.
compared to 56% in Masafu-Busia. The rate of associationalism was significantly lower at 24% in Iganga where TASO had no intervention.

Figure 7-4: Associationalism in the study sites

In trying to account for the differences in associational activities among the study sites, several points related to MTP were observed. In the first instance, MTP gave health workers the task of mobilising PWAs to join groups, a role that is above and beyond ‘normal’ medical work requirements. Besides this, the idea of creating a separate department for PWAs also played a key role in mobilising PWAs to join associations. As hinted in Chapter Six, one of TASO’s aims in creating HIV/AIDS-focused departments was the desire to enhance interactions among patients. As a result of the closer interactions that these dedicated departments enabled, some PWAs realised the importance of coming together to “share experiences” and engage in self-help activities (various interviews with PWAs in both Kamuli and Masafu). And, perhaps more directly, MTP involved establishing Music Dance and Drama groups (MDD) in all hospitals where it was implemented (see Chapter Five).

Some, however, have indicated the need to explicitly analyse the links between local associations and citizenship (Gaventa and Barrett, 2010; Houtzager and Acharya, 2011). This is because, contrary to the Tocquevillian view “that associations [automatically] empower their members to engage in public politics, hold state officials to account, [and] claim public services” (Houtzager and Acharya, 2011:1), in reality not all associations are
able to do this and/or some may actually have ‘uncivil tendencies’ that are contra to promoting a ‘good society’ (Edwards, 2009; Robins et al., 2008). To some PWAs, associating with others had intrinsic benefits:

I used to be alone before coming here. I used to have a lot of thoughts. When I came to MTP, I joined the other volunteers, I shared with other patients and now I am feeling better. I have realised that when you are alone with a problem, your condition cannot improve. But if you have a problem and you are three or four people you can share. You can give each other advice (Male PWA, Masafu-Busia, 24/1/2011).

A closer look at the MDD groups, one of the association types that PWAs were engaged in, showed strong links between associationalism and active citizenship. MDD group members (numbering between 15 and 20 PWAs per MTP) testified that the group exposed them to experiences that they might otherwise never have had in their lives. For instance, TASO used to organise annual regional drama festivals where several Mini TASOs and TASO service branches competed. These were opportunities for PWAs to travel beyond the borders of their own villages or districts. Regional winners would proceed to take part in the bigger national drama festivals (TASO, 2008; 2010). In these arenas, PWAs mixed with new people and heard how things were being done in other parts of the country. According to Gaventa and Barret (2010), such exposure broadens poor people’s horizons which opens opportunities for them to influence their destinies. A drama member from Kamuli summarised this point:

Drama has given me experience and I have become known to other people in Kamuli and beyond. In 2009 we went to Jinja in the drama festivals and thereafter we went to Entebbe. We made friends with people from Kagadi and other MTPs. This helped me to get rid of the stigma I had (male PWA, Kamuli 10th/2/2011).

Relatedly, drama members talked of how such opportunities enhanced their ability to speak in public: “For me I did not know that I would ever stand in front of people to talk about myself. But, through drama, that is exactly what I started doing... I even became the chairman of PWAs in my sub-county of Kitayundwa” explained another respondent (Male PWA Kamuli 7th/6/2011). According to Cornwall and Coelho (2006:8) it is through participating in such activities that “citizens cut their political teeth and acquire skills that can be transferred to other spheres”. Campbell and Cornish (2011:6), drawing on the case
of the Sonagachi project for sex workers in India, illustrate how the opportunity of being involved in peer education activities gave sex workers the “ability to ‘speak’—at public events, [and] to the media” which in return enabled them to learn “how to negotiate with police and politicians”. Relatedly, Williams and colleagues (2011) report of a participatory programme called Kadumbashree in the Indian state of Kerela where the involvement of formerly marginalized women in neighbourhood groups and state activities made them gain visibility in the public sphere. In the case of MTP, some drama members like the two cited above similarly used their newly acquired confidence and public speaking experience to venture into politics. In the context where operations of advocacy oriented CSOs are restricted to Kampala (see Chapters Three and Five), such examples illustrate the political training role that such associations have taken on in rural Uganda. This finding is in line with recent observations that local associations are the most effective type of agencies for citizens’ empowerment in non/semi democratic political contexts in the South (Citizenship DRC, 2011; Gaventa and Barret, 2010).

7.3.2 MTP and PWAs’ voluntarism

Before we undertake detailed discussion of PWA’s voluntarism, the following caveat needs to be noted. Given that other research on civic engagement in Uganda has showed that many Ugandans do routinely engage in various acts of voluntarism (cf. Afrobarometer, 2011; Barr et al., 2003; DENIVA, 2006), respondents were asked to specifically mention those activities in which they participated in relation to helping their MTPs to achieve a specific goal. Specifically, respondents were asked, “in the last five years, have you contributed your time towards helping this MTP to achieve a specific development goal?” According to Table 7-2, 46% of all respondents in Kamuli claimed to have engaged in civic-related activities while 35% in Masafu-Busia did the same, the proportion of respondents who did the same in Iganga was 22%.

The research engaged qualitative analysis to establish the nature of activities and the motivation behind respondents’ decision to participate in civic action. The commonest activity in which PWAs were engaged was the sensitisation of other community members on HIV/AIDS issues. PWAs explained that the rationale for engaging in sensitisation activities was to encourage community members to ‘come out’ to get to know their sero-
status and seek medical services ‘before it is too late’ (several interviews from both Kamuli and Masafu-Busia).

Table 7-2: Clients engagement in civic activities

<table>
<thead>
<tr>
<th>Facility Category</th>
<th>Contributed time</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Kamuli</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td>33</td>
<td>28</td>
</tr>
<tr>
<td>% within Facility Category</td>
<td>54.1%</td>
<td>45.9%</td>
</tr>
<tr>
<td>Masafu-Busia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td>46</td>
<td>25</td>
</tr>
<tr>
<td>% within Facility Category</td>
<td>64.8%</td>
<td>35.2%</td>
</tr>
<tr>
<td>Iganga Control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td>36</td>
<td>10</td>
</tr>
<tr>
<td>% within Facility Category</td>
<td>78.3%</td>
<td>21.7%</td>
</tr>
</tbody>
</table>

In particular, and as observed by Robins (2004; 2006) in South Africa, those PWAs who witnessed a ‘near-death experience’ before they were put on treatment felt obliged to get involved to prevent others from going through the same. As one senior medical officer in Masafu-Busia noted: “they are passionate about the care of other PWAs because they have an experience and they know that if it was not for the same care, probably they would be dead” (Male health worker Masafu-Busia, 14/4/2011). With their mantra *once I go through it I can talk about it better*, PWAs observed that:

I feel that my fellow PWAs should have better health. This is because for me I was brought on a stretcher, I was just pushed on a wheelchair. So if I can [now] do my work without being disturbed by sickness, I feel compelled to teach others (Female PWA Kamuli, 21/3/2011).

Equally, some respondents felt that they did not want to be paid for helping others since themselves they never paid for the support they got. Others related voluntarism to a national duty: “to me this is a national duty because if I refused [to work] that would not be service to the country” (male PWA Masafu 24/1/2011).

Critics may argue that these reasons are very specific to a particular disease and for that matter may not apply to other contexts. However, Mahmud’s study of Health Watch Committees (HWCs) in Bangladesh also reported that most people participated because they “thought it was a good cause and might bring some benefit to the community” (2007:63). To Mahmud, many volunteers never asked for money, the only thing they wanted in return for their involvement “was to be taken seriously” (2007:64). In our study, PWAs’ decision to volunteer was also related to other factors such as social norms
that would be relevant even when it is another problem that needed to be addressed. For instance, one observer in Busia district noted in response to the issue of PWAs working without pay at Masafu-Busia MTP; “they [PWAs] knew that they were helping their community, some of whom were relatives. So such conditions maintained them at the facility without pay” (male member of the PWA Network BUSNET, 21/4/2011).

However, given the high unemployment rates in the study sites, as reported in Chapter Four, it may well be the case that PWAs had fewer alternative options for utilising their time. This study, like others (c.f. Maes, 2010; Ridde, 2010; Swidler and Watkins, 2009), noted that some PWAs engaged in civic activities with the expectation to access economic benefits. Some expected to get opportunities for ‘workshops’ which would enable them to benefit from the accompanying per diems while others expected to get connections for permanent jobs. Such expectations contrast with state and donors’ implicit assumption “that people who work in the field of community development are – and should be – motivated by a passion or desire to help, and are thus willing to do unpaid work” (Colvin et al., 2010:1188; also, Swidler, 2007). Additionally, civic engagement, especially volunteering at the health facility, was for many a form of ‘social security’. Here, several respondents argued, being active at the health facility made them friends with health workers and they expected that the latter would be quick in responding to them in times of need. As observed by one of the respondents in Masafu-Busia: “For volunteers when you fall sick health workers will attend to you promptly since they know you personally” (Female PWA expert Masafu, 4/1/2011). Although optimists can argue that reciprocity is an important virtue that leads to the development of trust among people in the civil society (Edwards, 2009), critics can use the same evidence to make the case that PWAs’ voluntarism was opportunistic aimed at their own benefit and not the public (Prince, 2012).

The ultimate test of PWA’s incentives for civic engagement came with the interruptions of funding from TASO. In Masafu-Busia, some volunteers complained about their colleagues who could not continue without facilitation:

People are coming late here and the problem is worsening. We used to start at 9:00am but now the clinic opens at ten o’clock. It is because TASO closed and since June [2010] people have not been getting their facilitation. Many volunteers
have stopped coming – we used to be like ten but now only six are active (Female PWA expert Masafu, 4/1/2011).

The study established that most PWA volunteers in Kamuli had maintained their attendance at the MTP. However, it remains to be seen how far they will continue doing so, because, as a senior nurse in Masafu-Busia MTP observed, “one cannot really volunteer for life” (female health worker, 29/12/2010).

7.3.3 Direct monetary contributions

In this subsection, the focus is put on the collection of user fees, an issue that was peculiar to Kamuli MTP. As reported in Chapter Three, health services in Uganda were declared free after the 2001 presidential directive abolished user fees in public health facilities (Tashobya et al., 2006). However, at the end of 2006, Kamuli MTP through its first Project Coordinator copied TASO’s policy of charging clients when it reintroduced user fees. Here, only PWAs were required to pay, and like in all TASO centres, PWAs were charged UGX 500 ($0.25) per monthly clinic visit. An important disclaimer, therefore, is that user fee was not a mandatory MTP component and it can be regarded as a local initiative that was implemented through the action of local leaders (see Chapter Six).

Although studies elsewhere show that such initiatives are regressive and could exacerbate inequities in access to public services among the poor (Gilson et al., 1995; Tashobya et al., 2006), the situation was different in Kamuli. The management committee for user fee in Kamuli exercised flexibility and would waive fees for the very sick to ensure that nobody missed out on medical care because of non-payment. During the entire fieldwork stay in Kamuli, the researcher never witnessed (or heard reports of) patients being turned away due to failure to pay. The popularity of user fees was further exhibited in May 2011 when MoH officials on a monitoring visit to Kamuli hospital tried to scrap the initiative over concerns that it could disproportionately be limiting poor PWAs from accessing free government services. PWAs requested that the matter be subjected to a vote by service users and those in favour of its maintenance won (researcher’s observation). Moreover, as suggested in Chapter Six, the high rates of PWAs willingness to pay for health services in Kamuli hospital (96%) could also be an indicator of the popularity of this initiative.

39 Other MTPs like Ssembabule, Kiwoko and Arua also reported charging user fees although this study did not research their schemes in detail.
40 This amount was increased to UGX 1000 in April 2011 due to double digit inflation at that time in Uganda.
This research established that the collections generated the money needed to cater for PWAs’ breakfast on clinic days and enabled them to purchase benches and mats on which clients sat while waiting for services. These items are not provided for in the government’s allocations to public hospitals and they were not in TASO’s budget to MTPs. Besides, user fee collections also acted as a safety net for the most needy service users. PWAs who would get admitted in the hospital unaccompanied were supported from the collections to get food and other basic necessities (Male PWA leader Kamuli hospital, 21/3/2011; female PWA Kamuli, 21/3/2011). As reported further in Chapter Eight, such support gestures were perceived by the recipients’ families as manifestation of a caring state. Various interviews with committee members and health workers revealed that in the past this money would be used to further the cause of PWAs beyond Kamuli hospital by contributing towards meeting the expenses for operating outreach services in Bugaya HC III and Kidera HC IV. It was reported that user fee contributions would go towards meeting transport costs estimated at UGX 150,000/= or (USD $75) per month. Apart from illustrating public spiritedness, solidarity and a shared identity of PWAs going beyond the boundaries of one community, this, also in part, aided the territorial reach of the state to remote areas. Specifically, this last point explains why Kamuli MTP was in position to operate its outreach activities more effectively than Masafu-Busia (see Chapter Six).

In addition to the above, this study finds that locally initiated payments played an important role in constructing citizenship in Kamuli MTP. There was some evidence that payment of user fees was linked to strengthening the demand side of health services in terms of voice, accountability and pressure to improve quality. Section 7.2 discussed how user fees formed the nucleus of the struggle between MTP’s first Project Coordinator and PWAs that culminated in rounds of contentious activities in which the latter demanded for transparency and greater responsibility in the management of their contributions. As discussed in Chapters Two and Three, where patients do not contribute, they have no basis to demand for accountability or representation in the management of service delivery programmes (also, Tripp, 2010). Therefore, it can be deduced that user fees payment is another factor that explains why Kamuli MTP performed comparatively better than its Masafu-Busia counterpart where PWAs made no payments and equally got no representation. User fee payment, as described here, is akin to payments through PTAs
which enabled parents to sustain the quality of services in public schools in the face of low funding from central government during the volatile years of President Amin in the 1970s (see Chapter Three).

7.4 PWAs’ quest for direct political participation: Success, failure and phobia

We have encouraged our [PWA] colleagues to stand for these elective posts, example Beatrice stood in Town Council although she did not pass. Here in this village we have James, this one passed through as NRM flag bearer for LC III. For me I am a councillor at the sub-county, I passed through unopposed (Female PWA Kamuli, 22/4/2011).

As observed in Chapter Three, the system of local councils that underpin the decentralisation policy opened opportunities through which people right from the village, the smallest administrative unit in Uganda, could directly participate in politics. The ability to occupy such political spaces is a sign of empowerment (Green, 2008a; Nyamu-Musembi, 2010), and the discussion below explores the motivations, performance and challenges for PWAs who decided to stand for elective politics in the 2011 local council elections in Uganda.

Table 7-3: PWAs participation in direct political contest in the study sites

<table>
<thead>
<tr>
<th>Facility Category</th>
<th>No. of contestants</th>
<th>Position</th>
<th>Successful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kamuli MTP</td>
<td>Five (3F:2M)</td>
<td>- Sub-county councillors</td>
<td>- Three sub-county councillors</td>
</tr>
<tr>
<td>Masafu-Busia MTP</td>
<td>Three (2F:1M)</td>
<td>- Sub-county councillors</td>
<td>- Two sub-county councillors</td>
</tr>
<tr>
<td>Iganga control</td>
<td>Two (0F:2M)</td>
<td>- Sub-county councillors</td>
<td>- Unknown</td>
</tr>
</tbody>
</table>

Source: Based on field observations

According to the evidence summarised in Table 7-3, the status of PWAs’ direct political involvement in politics stood as follows in the different sites: Kamuli had the highest number of PWAs who contested – with a total of five contestants, three women and two men. This is in line with what we had predicted that successful MTPs would have more politically engaged PWAs. Although one of the female contestants reported that she was politically active even before she joined MTP (Female PWA Kamuli, 22/4/2011), we retained her in the discussion because her story linked her continued success to MTP. Of
those who contested in Kamuli three succeeded, having stood as NRM flag bearers. Masafu-Busia MTP had three contestants – two women and one man – these all stood to represent their respective Parishes to the Sub-county. A man and one woman succeeded on the NRM party ticket.

Although we did not meet any contestants in Iganga and even the two PWA experts who worked at this facility said none of the clients there had contested, during the survey some respondents claimed to have knowledge of two PWAs who stood as councillors in different sub-counties. In MTPs, especially Kamuli, the number of PWAs who stood for local council office is comparable to that reported in a recent study among Kenyans trained in political mobilisation by advocacy-based NGOs (Nyamu-Musembi, 2010). Nyamu-Musembi reports that of the 250 respondents trained by advocacy-based NGOs, 6.8% had contested for local council office compared to 1.6% (N=250) of the untrained respondents (2010:34). Although the Kenyan context is different from that of Uganda, there is a powerful massage here that service delivery programmes could be a means for building political skills of citizens and could be as good as direct advocacy training.

Another issue that we attended to in this area was to establish whether it was participation in MTP activities that triggered PWAs political ambitions or some other factors. When we posed this question, only a handful of TASO officials wished to indulge in discussions which insinuated that their programme was encouraging people to engage politics. As discussed in Chapters Three, Five and Six, NGOs that are suspected of engaging in ‘politics’ in Uganda are harassed by the state. Nonetheless, two TASO officials with frequent contact with MTPs had already noticed developments in this area. For instance, one female staff observed that: “If you go to Kagadi the chairperson drama is the same area councillor for that place. If you go to Kiboga, the chairperson for drama for Kiboga mini TASO is the LC5 councillor for that sub-county” (TASO Central Region staff Kampala, 6th/12/2010). Although issues of causality could not be easily disentangled, in her opinion, PWAs contested as a result of “the exposure at all levels, at management level, [and] at the leadership of the district” (ibid). The way “exposure” is framed here implies several things. One is that political contenders saw MTPs as having an already mobilised group of voters to solicit votes from. The second one is that engaging in MTP activities made people popular or visible to voters. Third, and consistent with our earlier observations in
this chapter, participation in MTP activities could have strengthened the confidence of PWAs to speak in public. We discuss these issues in turn with data from the candidates and PWA-voters.

As observed in Chapter Two, the idea of ‘mobilised voters’ is popular in the literature on welfare programmes of industrialised countries where politicians, external to the programme, target beneficiaries to canvass for their votes (Campbell, 2008). Our findings are a bit different in the sense that it was among beneficiaries themselves that political candidates emerged. In order to test whether PWA political contestants exploited the opportunity of an “already mobilised electorate”, we asked service users if they had ever seen fellow PWAs campaigning for elections at the health facility.

According to evidence in Table 7-4, a sizeable number of respondents from MTP sites claimed to have witnessed PWA political contestants campaigning. Although it is possible that candidates could have campaigned on days when some respondents had no medical appointment at the respective facilities, those who acknowledged seeing PWAs campaigning in Iganga were comparatively fewer (11% of respondents) as compared to 53% and 45% in Kamuli and Masafu-Busia respectively. Some contestants acknowledged that “because the community people who come to get treatment at the [MTP] facility … are the very voters … if you campaign at the facility, they sell your name to the rest of other community members” (successful female contestant, Kamuli 22/4/2011).

<table>
<thead>
<tr>
<th>Facility Category</th>
<th>Seen PWA campaigning to be elected?</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Kamuli</td>
<td>29</td>
<td>32</td>
</tr>
<tr>
<td>% within Facility Category</td>
<td>47.5%</td>
<td>52.5%</td>
</tr>
<tr>
<td>Masafu-Busia</td>
<td>39</td>
<td>32</td>
</tr>
<tr>
<td>% within Facility Category</td>
<td>54.9%</td>
<td>45.1%</td>
</tr>
<tr>
<td>Iganga Control</td>
<td>41</td>
<td>5</td>
</tr>
<tr>
<td>% within Facility Category</td>
<td>89.1%</td>
<td>10.9%</td>
</tr>
</tbody>
</table>

On the visibility thesis, again some contestants argued that MTPs gave them an opportunity to engage in activities which made them popular to other community members. This probably explains why most of the PWA political candidates that we interacted with were those who worked as volunteers at their respective facilities. One
PWA in Masafu-Busia MTP who was unopposed on the position of Councillor to Masafu sub-county claimed that:

I am a very popular man in the community. What I have done so far is self-evident. I have saved many lives of parents and their children. People [opponents] would definitely fear to stand against me because what I have done speak for itself. I know my people personally and they know me (male PWA expert Masafu-Busia, 15/4/2011).

This expert’s claims had some credibility because he knew where most PWAs lived, even those who came from sub-counties different from his (field observations). We asked him why he did not stand for a bigger position such as being the substantive LC III chairperson if he was as popular as claimed. He explained that this was the beginning of a long term strategy: “you wait for 2016, now I just want to show people that I can deliver. In 2016, my achievements will be the basis for the campaign” (ibid). Like this expert, several of the PWAs who contested were first timers in active politics (the exception here is the Kamuli lady who stated that she was politically active even before MTP).

A key underlying factor that motivated PWAs (especially the Masafu-Busia group) to join politics was the realisation that people in power were not doing enough to mobilise PWAs for development. Some respondents, for instance, claimed that PWAs had not benefited as much as they should from GoU development programs like the National Agricultural Advisory Services (NAADS) and the Northern Uganda Social Action Fund (NUSAF) (various interviews Masafu-Busia). They argued that although PWAs were nominally represented in technical committees such as the District AIDS Taskforce (DAT) and the District AIDS Committee (DAC), such committees had no say in allocation of resources for general development programmes that PWAs wanted to benefit from (male member of the PWA Network BUSNET, 21/4/2011; and female PWA leader Kamuli, 21/3/2011). Related to this, PWAs felt that they had to engage in politics in order to prevent “ghost” or fake HIV organizations and groups from taking their projects. One senior health official in Pallisa district revealed that: “In this district we have instances where people come and masquerade as HIV positive groups and they even get funding. But if now the PWAs themselves are active, it becomes very difficult for other people to come and take their funds” (male, Pallisa district health official, 20/5/2011).
Related to this, it was alleged, local politicians operated as gatekeepers to these programs: “they give feedback to the state that things are okay yet the needy people are not benefiting. It is the middlemen who are benefiting” one KI charged (male TASO Eastern Region official, 4/1/2011). PWAs leaders in Busia district cited vivid examples of how district councillors had sabotaged the implementation of HIV programs. In response, PWA leaders decided to “mobilise our people not to vote the former councillors at the district”, because they delayed the approval of projects like that Star-E, a USAID-funded organisation, had brought (Male member of the PWA Network BUSNET, 21/4/2011).

According to this respondent, less than five of the 17 councillors were able to retain their seats. However it was difficult to confirm whether those who failed to retain their positions did so due to PWAs’ smear campaign. Meanwhile, a respond in Kamuli expressed a similar opinion, that PWAs would benefit more if they had their own representatives to track their support from central government and other sources. He observed that “sometimes, when things reach the district they ask, ‘where are PWAs?’ and there is normally no one to represent us ... [so] we do not receive them on the ground. If we get elected, then we shall be able to get our resources directly” (Male PWA, Kamuli 1st/2/2011).

These examples suggest that PWAs thought that by getting direct representation at various levels of decision making, they would be in position not only to protect their entitlements but would also lobby so that other development programs are beneficial to them. Recent scholarship in this area has shown, however, that this kind of political mobilization might imply that “citizens who are more politically active receive more benefits —and, potentially, more expansive and encompassing benefits—than less active or apolitical citizens” (Cammett and MacLean, 2011:11). This, some argue, is “violating the citizenship principles of universality and equality” in access to public services (Houtzager and Acharya, 2011:3).

Before concluding this section, a brief look at the reasons why some PWAs lost and perhaps why others did not participate in the 2011 elections in Uganda is needed. This will enable us in part to establish whether or not PWAs were shunned by voters due to the negative constructions associated with their HIV status. For, as one respondent
observed, “it is not PWAs alone who decide”, candidates had to face other voters outside their MTP enclave (Male member of PWA Network BUSNET, 21/4/2011).

According to one female contestant in Kamuli, her failure was due to lack of resources: “I competed with NRM flag bearer as well as FDC’s. These had their party backing and they were given ‘logistics’ [money and materials such as t-shirts and posters]. So I was defeated because my opponents used money power” (Female PWA Kamuli, 21/3/2011). Like this respondent, most of the unsuccessful contenders attributed their failure to lack of resources to meet the basic campaign costs such as printing adequate campaign posters and transport to traverse the country side. Meanwhile, another female contestant in Pallisa attributed her loss to being known in her village as someone who works at the hospital. However, her situation was not in relation to being negatively linked to the HIV status. In her case, villagers suspected that she was getting a lot of money for being a ‘musawo’ (health worker) at the district hospital. She reported that although she tried to explain to the electorate that she was just an unsalaried volunteer, they thought that she was just a mean candidate (Female PWA Pallisa, 20/5/2011). In the same regard, one of the PWA leaders in Busia district also claimed that voters were much interested in financial rewards than issues that candidates presented in their manifestos. According to him “problems came when we fail[ed] to mobilise money for our candidates to give out” as their competitors did (Male member of PWA Network BUSNET, 21/4/2011). A cursory look beyond the study sites revealed that the observations reported here were true reflections of political contestation in Uganda right from the top which, as indicated in Chapter Three, had become heavily commercialised.

Reports that Uganda’s politics had made a sharp commercial turn were rife in the media both local and international during the 2011 elections (Gatsiounis, 2011; Mubatsi, 2010; Rice, 2011). Vote buying orchestrated by people from the highest office in the land influenced most people into believing that they had to be paid for their votes (Afrobarometer, 2011; Mubatsi, 2010). The Afrobarometer opinion poll conducted in the run up to the presidential elections reported that only 33% of the respondents felt that it was ‘wrong and punishable’ for a voter to accept money in return for his or her vote. It is such a political atmosphere that PWAs who stood for elections had to navigate. This implies that either those PWAs who were successful worked exceptionally hard to
convince the voters or that they supplied more electoral bribes than their competitors. Time constraints could not allow the researcher to sufficiently engage in the campaigns of all PWAs in order to disentangle these issues though the socio-economic status of PWAs, as described in Chapter Four, would suggest the former.

Generally speaking, therefore, the evidence from this section clearly shows that MTP contributed to what Nyamu-Musembi (2010:31) calls “the pluralization of association life”, engagement in voluntary activities, speaking out, as well as bolstered political contestation by PWAs at the grassroots level. The latter is evidence that engagement in MTP activities taught political skills at the local level. All these aspects played out in line with our argument that impact was stronger where there was fuller implementation of MTP (better in Kamuli compared to Masafu-Busia), and that the performance of MTP sites was better than that of Iganga where the project was not implemented.

7.5 Discussion and conclusions
In Kabeer’s “Growing citizenship from the grassroots”, she argues that it is difficult for service delivery organisations to perform citizenship ‘growing’ roles (Kabeer, 2003a). Kabeer, and others who share this view, argue that rather than being a transforming apparatus, social service delivery creates new forms of dependence between the delivery agency and service users. However, this chapter has provided evidence that service delivery programmes can promote citizens’ empowerment and political skills in developing countries. Even when the delivery agency does little in terms of direct political mobilisation of beneficiaries, service delivery programmes can create opportunities for increased citizen engagement which enable people to change their relationship with service-providers, be taken more seriously and begin to take greater responsibility for their own health (Pearson, 2010). It has been argued that lessons from programme activities can allow beneficiaries to become more active citizens in other arenas. This, in rural Uganda, was enhanced by the presence of the decentralisation policy which created opportunities for political participation at the local level.

Our findings on the political significance of service delivery programmes relate closely with those of a recent qualitative study in the United States about PWA Treatment
Advocates (a group synonymous to expert clients in MTPs) (Mutchler et al., 2011). According to this study, the Treatment Advocates (TA) system enabled clients to:

“learn skills they need to advocate for better healthcare for themselves... became more knowledgeable about treatment issues, more able to research relevant treatment information, more skilful in anticipating and asking questions of healthcare providers, and more able to assert their needs in the healthcare setting” (Mutchler et al., 2011:87-88).

Although Mutchler and colleagues analysis does not extend beyond the healthcare setting, this TA system appears to be sowing the seeds for “queuing, photocopying and complaining” that we have illustrated in this chapter. For instance, they reported that one client worked with the TA to write a letter of complaint about medical services he received (Mutchler et al., 2011). As Corbridge notes in relation to the activities of Village Education Committees (VECs) in India, “it is through such activities and experiences that a sense of being a citizen is built up” (Corbridge, 2007:197). This is because such activities can help the poor to build their skills of assertiveness and the interactions between poor people and state agents enable “the poorest begin to understand the state as something other than an abstraction” (Corbridge, 2007:196).

In both Kamuli and Masafu-Busia MTPs, most aspects of civic engagement can usefully be conceptualised as falling in the banner of ‘co-production’. Generally, what the discussion in this chapter has implicitly pointed to is the fact that service delivery was co-produced by the state and society (Mitlin, 2008), and also that the state and society themselves co-produced each other (Bebbington, 2008). When citizens engaged in volunteering as expert clients, community sensitisation campaigns through MDD activities, and/or by contributing to the costs of outreach activities through user fees, they did not only gain opportunities to develop their sense of citizenship, but they also increased the presence of the state in the countryside and its legitimacy in the eyes of community members.

These observations have parallels with recent research on the politics of non-state service provision. Cammett and MacLean (2011:14), citing Tsai’s (2011) work on China, point out that the co-production of services between communities and the local government “may produce more engaged citizens who are more willing to comply with state demands and, more broadly, the duties of citizenship”. And citizens’ voluntary compliance with state demands is a key indicator of state legitimacy (Chapters Two and Six).
A systematic review of the literature by Campbell (2008) showed that three main factors determine whether a particular program-based group definition becomes politically salient and the basis for mobilization: beneficiaries’ socio-economic status, visibility of the group, and stability of the programme. We find these three factors applicable to this study though some in contradictory ways. For instance, as compared to her view that low income groups are unlikely to be the focus of political mobilization by political entrepreneurs (2008:6), this study has shown that the poor can mobilize themselves to join politics. The perception among PWAs that powerful local politicians are capturing projects meant to benefit them was one of the factors that motivated them to join politics. Generally, our findings in this respect parallel observations made by a bigger research project covering several developing countries that “contrary to what is often found in richer countries, low income is not itself a bar to political participation; poor people are as active politically as their wealthier counterparts, though in different ways” (Future State, 2005:22-23). Afrobarometer research which focuses on African countries also arrives at a similar conclusion (Bratton, 2005). Nonetheless, in the Ugandan context, wealth was a limiting factor for PWA political contenders because some voters had become conditioned by the developments at the national level to be more interested in handouts from contestants rather than issues that candidates stood for.

The findings about user fees are in line with recent observations by the literature on taxation, that tax is a catalyst to the development of voice and accountability as taxpayers develop a stake in government to ensure that their contributions are appropriately used (Brautigam, 2008; Di John, 2007; Future State, 2005). Indeed, user fee in MTPs was one of the ‘micro-reforms’ that helped to keep service users interested in health facility affairs and provided a basis for them to demand accountability. As the chapter has illustrated, however, channels for demanding accountability were not limited to the formal mechanisms such as participatory initiatives which development agencies especially the World Bank tend to promote. Findings showed that “rude” and “behind the curtain” accountability mechanisms were among the preferred mechanisms that poor people engaged in. Nonetheless, the limitations of both ‘rude’ and collaborative accountability mechanisms suggest that these strategies need to be seen as complementing each other rather than as substitutes.
Contrary to the argument that “Uganda has no citizens” (Mwenda, 2009), this chapter suggests that PWAs could be among the first Ugandans on track to acquiring the social rights of citizenship through health. Our case studies have illustrated that some PWAs now believe that services, especially drugs, are their entitlements guaranteed by the state. But even when we move outside MTP sites, newspaper reports and comments from HIV/AIDS experts show that it is now common in Uganda that when there is drug stock-outs for other ailments the ‘noise’ is not as loud as when drug stocks for HIV/AIDS run dry (senior officer NAFOPHANU, Kampala 22/11/2010). In the run up to the February 2011 elections, PWAs were among the few organised groups who threatened not to vote parties or political candidates that did not have a clear provision in the manifesto catering for their drugs – hence they vowed that ‘no HIV drugs, no vote’ (Kasozi, 2010; Makuma, 2010). Although it is difficult to wholly attribute such a nation-wide development to the MTP41, the accumulation of experiences from similar programmes has definitely ‘taught’ PWAs how to complain in different forums across the country.

41 Chapter three mentioned that the President through his countryside tours encourages people to report inefficiencies in hospitals.
CHAPTER EIGHT
The Politics of Service Delivery NGOs: Summary and Conclusions

8.1 Introduction

This thesis has argued that SD-NGOs have the potential to play important roles in building state capacity and citizenship in developing countries. The purpose of this chapter is to pull together the key findings from the empirical data presented in the previous chapters with the view of readdressing the central question investigated by the study, that is, can SD-NGOs work in ways that simultaneously improve the capabilities of both states and citizens. To respond to this issue, the thesis drew on the work of a prominent SD-NGO in Uganda called TASO and focused on its “min-TASO Project” (MTP). MTP sought to build the capacity of decentralised government health facilities in the area of HIV/AIDS management and also to construct the capacity of PWA-citizens to demand for these services (see Chapter Five). The project was implemented in more than 15 district hospitals in rural Uganda and our research focused mainly on two case study sites of Kamuli and Busia districts, supplemented by the analysis of a non-MTP site of Iganga district hospital.

Overall, MTP delivered important gains in terms of citizenship, particularly in relation to building the confidence of PWAs to express ‘voice’, their capacity to engage in civic activities, and ability to participate in formal political contests. However, it deserves mentioning that the project may have detracted the state from the services offered to ‘ordinary’ (non-PWA) patients. The project’s state-capacity building effects were more uneven even within the various dimensions of state capacity analysed here. The project registered more success with specific aspects of bureaucratic capacity such as building the skills base of staff for HIV/AIDS service delivery and establishing HIV/AIDS departments which allowed PWA citizens to become more legible to the state. Interventions to improve record-keeping and psychosocial counselling enhanced the state’s ability to ‘see like NGOs’ which, in turn, enabled the state to “see the poor as citizens” (Corbridge et al., 2005:150). However, the project failed to find a lasting solution to inadequate staffing and problems of unreliable medical supplies in government hospitals. Similarly, the territorial reach of the state, supported through community activities like outreaches and home visits, only enabled the state to meet the short-term needs of the population but
not its capacity to address them on a sustainable basis. These observations notwithstanding, MTP activities appear to have enhanced state legitimacy in the eyes of PWAs as more people gained access to life-saving services and patient-service provider relationships improved. Noteworthy, the different findings in each of our three field sites underline the extent to which the effects identified here, at least to an identifiable extent, were as a result of whether MTP was implemented (better results were discernible in Kamuli and Masafu-Busia than in Iganga) and how thoroughly this took place (better results in Kamuli, where the project was more thoroughly implemented and supported than Masafu-Busia).

The ensuing discussion is structured as follows: it starts by analysing the relationship between state building and citizenship formation, before summarising the study’s main findings on each research question. The chapter will then present the main implications for development theory, policy and practice that can be drawn from this study. The penultimate section investigates the specificity of our findings to the HIV/AIDS sector, while the final section presents policy recommendations and suggestions for further research.

8.2 The relationship between state building and citizenship formation

Although state building and citizenship formation have been analysed separately, in Chapters Six and Seven respectively, this section argues that the two processes are closely linked. In line with recent research, it is observed that state building is relational in nature, in that expanding or reproducing state capacity involves a good deal of intertwining between state and society (Evans, 2010; 2011; Soifer and vom Hau, 2008). For instance, building bureaucratic capacity required empowered citizens who could co-produce with the state and/or pressurise it to implement reforms. Similarly, it is argued that citizenship too cannot be ‘cultivated’ in isolation from the processes of state building in part because its development is influenced much by what happens inside the agencies of the state with which people interact (Chopra et al., 2011; Corbridge et al., 2005; Cornwall et al., 2011). However, the experience of MTP suggests a sequence here whereby state building precedes citizenship building. According to Chapter Five, although some citizen empowerment activities, such as the training of peer counsellors and MDD group members, were carried out alongside health workers’ capacity building, it was not
until the launch of MTPs for service delivery that citizens started to be engaged fully by the state. Indeed, Chapters Five and Seven argue that it is after public agencies improve services that citizens become more willing to seek services from the state, are more willing to co-produce services with it, and are more likely to join others to form associations, often with the guidance of state agents.

This way of looking at state and citizenship building has a bearing on current debates concerning the governance of public service delivery. This is particularly in relation to suggestions that strengthening the “demand side” or “short route” to accountability (World Bank, 2004), that is, bringing ‘empowered’ citizens into direct relations with service providers, offers great potential for enlisting state accountability and responsiveness. Our evidence is in agreement with critical observers who consider it naïve to expect that empowering citizens alone can compel state officials in poorly performing state agencies of the South into action (Booth, 2012; Joshi, 2010; McGee and Gaventa, 2010; Menocal and Sharma, 2008). As explored in Chapter Five, with regards to pre-existing state capacities to deliver ARVs before MTP, state officials’ lack of responsiveness and treatment of PWAs as second class citizens was not simply a matter of personal attitudes of individual officials, rather a genuine lack of even basic competencies, such as customer care skills and sufficient resources to facilitate them to do their job. In fact, evidence in Chapter Three suggests that the state had chosen to recognise PWAs as deserving citizens especially due to President Museveni’s personal commitment to the response since the late 1980s (Parkhurst, 2005; Putzel, 2003; 2004). Hence, in this context, the challenge for the state was that of capacity rather than commitment to deliver services. If ‘street-level’ bureaucrats lack the basic capabilities to deliver, some scholars argue, limited improvements in performance can be expected out of empowering citizens to make demands on them (Gaventa and Barret, 2010; Mitlin, 2008; Satterthwaite, 2008). What the findings of this study are suggesting is that in order for ‘demand side’ interventions to work, one has to first introduce ‘supply side’ reforms and influence the incentives of bureaucrats in order to create ‘receptive social environments’ in which government officials are not only able to hear but are also able to act on citizens’ demands (Campbell and Cornish, 2010a). In brief, state building precedes citizens’ empowerment (Batley et al., 2012; Booth, 2012; Brett, 2003).
Although activities focusing on state building and legitimacy on one side and citizens’ empowerment on the other were sequenced in that order, over time, the two “sides” started to reinforce each other in a more iterative process of feedback. One example is that of PWAs experts/peers whom MTP brought on board to help during clinics with tasks such as organising fellow PWAs, recording their particulars upon arrival, and giving testimonies of their experiences with HIV/AIDS. Through these simple activities, expert clients became a key factor in reconstituting trust/legitimacy in the strained relationship between the state and society that existed before TASO’s intervention (see Chapter Five). PWAs were explicit about how their work helped to ‘create a relationship’ between the community and the hospital. They routinely reported on clients who were bedridden and those who missed their clinic appointments so that health workers could visit them in their homes (various interviews in Kamuli; FGD with expert PWAs Masafu-Busia 14/12/2010). Through their own initiative, in Kamuli MTP, these PWAs also gave material and emotional support to clients admitted in hospitals especially those without relatives (see Chapter Seven). Therefore, in addition to helping health workers to “reach deep into the villages to get people who were really finding it difficult to reach health centres” (FGD with health workers from various MTPs, 24/1/2011), such activities also projected an image of a caring state in the eyes of community members. These observations have parallels with Tendler’s (1997) work in Ceará which illustrates the value of mundane activities like those discussed here. According to Tendler, it is mundane activities which sometimes fell outside the definition of a health worker’s job, such as helping mothers with household chores, bathing their kids, trimming their fingernails and hair among others, that helped to restore people’s trust in a hitherto perceived uncaring state (Tendler, 1997; Tendler and Freedheim, 1994:1783). As captured by Bebbington, “while [Tendler’s] focus was more on service provision than on state formation, the implication was that the creation of trust at the everyday interface of state and citizen is also central to ensuring and deepening the legitimacy of the state” (Bebbington, 2008:273).

Having made those clarifications, in the next section we summarise the key findings of the study per each of the research questions.
8.3 TASO’s impact on the capacity of the state in rural Uganda

As argued in Chapters Two and Six, the impact of MTP on state capacity was investigated by critically examining the project’s influence on the following dimensions of state capacity: bureaucratic capacity, embeddedness, and the infrastructural power of the targeted state agencies. Evidence was also collected on the implications of MTP for state legitimacy. The findings on these aspects are summarised below.

8.3.1 Bureaucratic capacity

One of the main achievements of MTP is that it empowered the targeted government facilities to deliver ART and related health services to more people in rural Uganda. PWAs receiving treatment in Kamuli increased from 334 in 2005 to 4152 at the end of 2010, while those in Masafu-Busia, over the same period, increased from 256 to 2113. This reflects an average annual percentage increase in PWA enrolment, during the MTP period, of 71% and 53% for Kamuli and Masafu-Busia respectively. For many of the PWAs enrolled onto care, no alternative sources of these health services existed. Therefore, its limitations notwithstanding, the project saved the lives of hundreds of rural Ugandans.

Chapters Five and Six illustrate how TASO, drawing on its close relationship to government and record as a premier psychosocial NGO focusing on HIV/AIDS in Uganda, built the human resource capacity of government health facilities. The organisation trained and mentored health workers to acquire ART administration, counselling and interpersonal relations skills. Here, TASO’s programmes enabled health workers to adopt practices for nurturing trusting social relations with their clients and catchment communities. These are usually considered to be niche areas for NGOs (Batley, 2011), hence our claim that TASO got the state to start ‘seeing’ like an NGO. The importance of such a posture for the state was highlighted in Chapter Three where it was argued that service delivery during Obote I failed to stir citizens’ support for the state precisely because of poor provider-user relations. Under the NRM regime, the state through President Museveni decided to recognise PWAs but its agents lacked skills for mobilising and serving people. Therefore, TASO was instrumental in developing the state’s capacity to bring PWAs more effectively within the ‘social contract’. However, some of TASO’s achievements here were temporary in nature rather than long-term. Chapter Six indicates
that good counselling was for instance threatened by the explosion of clients for which no strategy for further staff recruitment and training existed.

Another visible impact of MTP was the creation of independent HIV/AIDS departments in all targeted hospitals and these also enhanced the state capacity to deliver for PWAs. Among other things, these departments were associated with improvements in the management of records, which Chapter Six credited for sharpening the state’s ‘visual’ powers (Corbridge et al., 2005) by enabling hospitals to use the improved information management systems to tailor services according to the individual needs of HIV/AIDS patients. This is a step towards developing rational-bureaucratic capacities of the state. However, MTP practices like paying allowances to staff who worked in the newly created HIV/AIDS departments ran counter to promoting the long-term career rewards that are central in developing a coherent bureaucracy.

The study found inconclusive evidence on whether the improvement in HIV/AIDS departments – the IOEs in targeted hospitals (Crook, 2010; Therkildsen, 2008) – spilled over into hospital-wide improvements. Whereas some avenues for learning and exchanging ideas were discernible in Kamuli MTP, such initiatives were new and therefore it was premature to assess their impact at the time of fieldwork. What can be said, however, is that as suggested by Crook (2010), the concept of IOEs gains potency when it is not limited to organisations but, rather, extended to committed individuals or ‘reform champions’ within government. This thesis established that in MTPs where such people emerged, the programme was associated with more innovations which helped to enhance aspects of state capacity and citizenship formation than where they did not exist. The thesis, however, highlighted the need to understand a) the interests of such individuals as they may not always be aligned with development goals, and b) the challenges associated with sustaining reforms once such leaders exit.

8.3.2 Aiding government health facilities to embed in society

As argued in Chapter Two, the state’s ability to create social ties with societal actors (including beneficiaries of services) is a key factor in influencing the effectiveness of government programmes. According to Chapter Three, the first post-independence regime in Uganda made errors when it promoted service delivery policies that pushed it
on a collision course with the main NSPs – the Christian missionaries. The poor relations between these two forced NSPs to cut back on opening more service provision outlets for fear of being nationalised at a later date. The effect of this was to slow the expansion of public services in the countryside. In contrast, as reported in Chapters Three and Five, the open door policy of the NRM regarding the role of NGOs in supporting PWAs is not only helping the state to meet its service delivery obligations to citizens, but it also allows it to claim the credit from services delivered by NGOs (also, Parkhurst, 2005). Moving this discussion to MTP, Chapter Six noted that the performance of this project especially in Kamuli was bolstered by the creation of strong ties between the hospital and other CSOs that provided support to complement that offered by TASO. In addition, TASO encouraged a system of co-producing services where MTPs worked with “expert” service users who helped to improve hospital-community linkages. Generally, the findings here are in line with observations in Chapter Two that building state capacity to deliver public services calls for rethinking how state agencies operate, from the view that they are “all-knowing [and], all-able institutions” (Mitlin, 2008:345), to one where they seen as flexible institutions that need to co-exist with other organisations and which incorporate tacit knowledge of community members in implementing development programmes (Mitlin, 2008; Pritchett and Woolcock, 2004). Crucially, the evidence presented in Chapter Seven supports the suggestion that PWAs’ engagement with service provision, in co-productive arrangements, goes well beyond improving service functionality. As observed by Mitlin, co-production activities “strengthen local citizen organization, and in so doing provide a platform for wider civic engagement and greater political engagement by the poor” (2008:352), an issue we return to below (see Sections 8.4.4 and 8.4.5).

8.3.3 Impact on the infrastructural power of the state

The outreach strategy which involved spreading MTP services through to other health facilities did not enhance the capacity of those facilities to deliver services on their own. Although these lower facilities faced challenges akin to those faced by MTP hospitals before the intervention of TASO, Chapter Six notes, the project expected health workers there to learn by simply observing MTP staff going about service delivery during the monthly visits to these units, which did not materialise. This limitation notwithstanding, outreaches allowed people from distant communities to access services thereby placing a hitherto invisible state (Jones, 2009) under the gaze of villagers albeit on a temporary
basis. Once TASO funding stopped, outreaches were among the first MTP activities to be phased out.

8.3.4 Impact on the legitimacy of the state

PWAs in both Kamuli and Masafu-Busia noticed significant improvements in health workers’ responsiveness during the MTP period: they received more opportunities to discuss concerns, there was noticeable improvement in privacy during medical consultations and they received clearer explanations from health workers compared to the situation before the project (see Chapter Six). Medical supplies such as drugs were also more accessible thereby allowing the state to save more lives. These aspects translated into increased service users’ trust in the targeted hospitals, other government hospitals, and also local council structures. One of the key indicators of trust in state institutions is service users’ willingness to pay for services from these agencies (Brinkerhoff et al., 2012). According to Chapter Six, 96% of the respondents in Kamuli and 73% in Masafu-Busia expressed willingness to pay, compared to 32% in Iganga. These findings provide useful hints as to how legitimacy is created whereby, similar to Kruk and colleagues (2010) recent observation, this study argues that the process of building state legitimacy is multi-layered starting from reworking the micro dynamics of the provider-patient interaction, followed by the overall relationship between health facilities and communities in their catchment area and then upwards to PWAs general perception of government.

On balance, as far as state building is concerned, evidence suggests that TASO’s influence varied across the different dimensions of state capacity as well as intervention sites. In both Kamuli and Masafu-Busia, impact was clearly more registered within the dimension of bureaucratic capacity. This is logical given that TASO’s expertise lies in its psychosocial approaches to managing HIV/AIDS. Therefore, it could easily organise training programmes for health workers and dispatch its team to see to it that services are provided in MTPs. Wider literature on NGOs also supports the view that NGOs could have strength in inculcating service delivery skills in government staff (Batley and Rose, 2011; Bebbington and Farrington, 1993) and in helping to “forge more productive linkages between communities and public institutions than states are able to establish on their own” (Cammett and MacLean, 2011:7) compared to building the infrastructural power of
the state. The main reason for this is that infrastructural aspects require huge investments in terms of time and other resources which, considering their size and funding, NGOs are structurally unsuited to manage. In Uganda, the territorial reach of services called for solutions to structural problems like the shortage of skilled human resources in rural health facilities as well as the ineffective supply chain of drugs and other medical supplies as opposed to relief-style operations of outreaches that TASO used. However, it is important to reiterate that these problems are not peculiar to TASO, rather as Chapter One stated, they tend to be shared by most SD-NGOs (see, Dicklitch, 1998) and perpetuated by official agencies who look for easily fundable answers “to messy and complex problems” (Hulme and Edwards, 1997a:276).

8.4 TASO’s influence on the condition and practice of citizenship in rural Uganda

In Chapters Five and Seven, it was argued that although TASO designed MTP without explicitly mentioning citizenship building as one of its major goals, the project had important implications for the experience and practice of citizenship and perhaps registered more impact in this area than state building itself. The evidence presented in this study reveals that MTP’s impact on PWAs’ citizenship was exhibited in the following areas: a) enhanced ability of beneficiaries to exercise voice, b) increased associationalism among previously unorganised and marginalised PWAs, c) increased engagement in voluntary activities, and d) more PWAs gained confidence to stand for elections.

8.4.1 MTP and the construction of PWAs’ voice

Partly due to what Campbell and Cornish (2010a) call the “transformative communication” approaches, such as counselling, that TASO introduced in government hospitals, PWAs developed critical understandings of the political and economic roots of their vulnerability to ill-health, and gained confidence to devise ‘speaking out’ strategies for tackling them. Some PWAs started seeing access to health services as a right that is guaranteed by the state rather than favours from health workers, and for the first time, they started to challenge health workers who appeared to deny them their entitlements. A variety of strategies were used by PWAs to express their concerns. First, some MTPs created formal channels such as participatory forums or ‘dialogue structures’ in which PWAs were invited. It is such formal mechanisms that are usually promoted by international development agencies to improve the governance of service provision (cf.
Gauri, 2011; Ringold et al., 2012; World Bank, 2004). However, other PWAs engaged in certain forms of “rude accountability” (Hossain, 2010a). This was for those who could not wait to express their discontent in the formal forums or saw these as ineffective and/or uncomfortable places to exert their agency in. PWAs also engaged in more stealthy strategies – the weapons of the weak – through which they exposed health workers who behaved unprofessionally. This research finds that PWAs’ engagement in “behind the curtain” escapades, such as writing anonymous letters or badmouthing errant health workers to their superiors and the press among others, should be interpreted as calculated moves to minimise the risks, such as exposing the “loud clients”, that are associated with direct participation and other formal voice mechanisms (Joshi, 2007a).

This research argues, however, that rather than looking at the various ‘voice’ strategies in terms of which one is better over the other, it is useful to look at them as complementary whereby users draw on various combinations depending on specific circumstances (Joshi and Houtzager, 2012), and this is especially important in developing countries where the freedom of expression is constrained (Corbridge, 2007).

8.4.2 Increased voluntarism

Similar to Robins’ (2004; 2006) HIV/AIDS research in South Africa, this study finds that PWAs, especially those who witnessed a ‘near-death experience’ before they were put on treatment, felt more obliged than ordinary (non-PWA) citizens to get involved in civic activities such as giving one’s time to participate in awareness raising campaigns, home visiting the sick, and sharing personal testimonies among others things. Yet, because the study reported that PWAs in the non-TASO hospital of Iganga did not engage in these activities with comparable levels as those in MTPs, we cannot take it for granted that the voluntarism of PWAs is typical to the entire HIV/AIDS sector. In line with Mettler’s (2007) arguments elaborated in Chapter Two, people engage in civic activities because they are grateful for what they perceive to be generous and life-transforming programmes. Similarly, PWAs in MTPs reported that their motivation emanated from receiving services that they considered to be life-saving and of high quality. In addition, TASO introduced a deliberate programme of encouraging service users to look at engaging in civic activities as a moral duty to prevent other community members from acquiring the virus. However, Chapter Seven cautioned that the high levels of voluntarism could be indicators of high levels of unemployment in the study sites. Here, PWAs’ engagement in voluntarism would
be interpreted as attempts to secure employment rather a genuine interest in helping others in the community.

**8.4.3 Direct monetary contributions**

Besides offering their time and experience, PWAs in Kamuli also offered direct monetary contributions through user fees which they paid per clinic visit. As opposed to being a form of exploitative ‘informal privatisation’ of services, the study finds that user fees collection in this MTP was an example of what Booth (2011a) calls a positive ‘micro-reform’ in public agencies that improves service delivery despite being a deviation from the national guidelines. In the case of Kamuli MTP, user fees enabled PWAs to address some of their welfare needs, assisted the needy, and it helped to make service users to feel that they have a stake in health facility affairs. Some can argue that through paying such fees, PWAs learnt the importance of mutual obligations whereby they have to contribute something to the state before expecting services in return (Dauda, 2004; Tripp, 2010). In addition, according to Chapter Three, it was precisely through such contributions that public services were sustained during the volatile years of General Amin. Indeed, in Kamuli, user fees had a positive ‘spillover effect’ because the collections were sometimes used as a back-up fund that would facilitate outreach activities in periods when resources from TASO were delayed.

**8.4.4 Increased associationalism**

This research also finds that as citizens experience increased engagement with a responsive state, they gain more capability and motivation to relate to, and to work with each other, as evidenced by the higher levels of associational activity in MTP sites compared to the non-TASO hospital of Iganga. Chapter Seven shows that MTP gave health workers extra roles beyond their medical job requirements to mobilise PWAs to join groups. This was regarded as a strategy to enable PWAs to access services such as livelihoods support that are necessary to complement the psycho-medical ones provided in MTPs. Indeed, PWAs reported that groups enabled them to share experiences related to their medical condition, engage in self-help activities for economic empowerment, acquire life-skills like speaking in public, and others got connections to national organisations and networks among other benefits. Therefore, in contrast to the commonly held view that autonomous organising of citizens grows outside or in spite of
the state, the evidence presented in this study indicates that contact with the state actually stimulates it (also see, Bebbington, 2008; Moore and Putzel, 1999).

8.4.5 Involvement in political contestation

A key theme that runs throughout this study is that citizenship building appears to work in a “snowballing” fashion whereby enhanced citizen engagement in one arena strengthens the possibilities of successful engagement in other areas. It is evident that citizen action – whether through contentious action, MDD activities or engaging in co-production – left behind key transferable skills that some PWAs used to engage in other empowerment activities such as direct politics (see Chapter Seven). This finding corroborates those of other recent research on citizenship (see, Campbell and Cornish, 2010a; Citizenship DRC, 2011; Cornwall and Coelho, 2006; Williams et al., 2011). Although many of the PWAs who stood in the 2011 elections went for the lowest political positions, some of them argued that this should be seen as the beginning and promised a much bigger contest in the next election cycle. In this way, the lower political positions would provide what Campbell and Cornish (2011) call the “small wins”, which might help these formerly marginalized people to acquire the self-confidence necessary to propel them to more ambitious political positions in proceeding election cycles. This is similar to what is reported by the Citizenship DRC that “the journey from silence to a sense of citizenship [occurs] in many small steps” (2011:8).

Generally speaking, as far as citizenship formation is concerned, PWAs in our study sites spoke positively about their experiences from the project. They emphasised that their situation which was defined by a sense of resignation (as many thought that they were dying soon) was significantly improved upon the implementation of MTP. The view of the majority of PWAs interviewed for this study resembled that of a client in Kamuli who summarised his experience as follows:

Of course, we have been empowered ... first our life, we were badly off by the time TASO came, but right now we feel a lot of energy in our body to work and we have hope that we never had because we thought that we were dying soon. You see when this virus got some of us, we sold everything we had thinking it was witchcraft. So that is where TASO found us. Through TASO the project managed to revive our thinking that tomorrow is not the end. People who had lost interest
even in educating children we revived them, people who had stopped thinking about other developments in life, we started again and right now as I speak, I have like 10 acres of cassava, I have also completed my house ... (Male PWA Kamuli hospital, 21/3/2011).

Basing on the evidence presented, it can be said that TASO, as other similar NGOs, was more effective in the area of constructing citizenship compared to state capacity. In the next section, the chapter summarises the key lessons from the MTP experience.

8.5 Lessons from TASO’s experience with state and citizenship building

8.5.1 Social services and politics

Although it is over two decades since analysts, such as Skocpol and Amenta (1986) and Pierson (1993), claimed that the delivery of public services produce politics in developed countries, similar analyses have been slow to emerge in the context of the global South (Batley et al., 2012; McLoughlin and Batley, 2012b). Instead, research in the South has mostly focused on what motivates policy makers to put in place or otherwise fail to support pro-poor public programmes, on the one hand, and how state officials at the point of implementation administer public programmes, on the other (e.g., Hickey, 2009a; Putzel, 2004). Although this is an important field, its inverse, the possibility that social service delivery can influence politics, also needs further exploration. The theme running throughout our findings chapters, and to an extent in the discussion below, is that MTP and other similar programmes can usefully be seen as a “theatre of politics” where “citizen[ship] formation, political competition, and the development of state capacity and legitimacy” plays out (Batley et al., 2012:131). Thus, service delivery is (a) driven and shaped by politics but it is also (b) a theatre of politics where these wider political processes are played out and (c) where they themselves also get reshaped.

8.5.2 The ‘anti-politics’ of service delivery NGOs

Closely related to the above is that the impact of service delivery interventions cannot be predicted ex-ante on the basis of the implementing agency’s characteristics (also, Cammett and MacLean, 2011; Hulme and Edwards, 1997a). This is in reference to the various criticisms levied against SD-NGOs (Chapter One). For instance the
‘depoliticisation’ critique suggests that simply because SD-NGOs engage in service delivery as their core business, their activities are bound to have less, if any, positive political outcome on state-society relations, and will tend to reduce state accountability and undermine the social contract between the state and citizens. In contrast, the findings of this research indicate that ‘technocratic’ activities such as creating new departments and streamlining the system of records keeping can have positive political implications. In our study sites these enabled the state to acquire ‘visual’ abilities (Corbridge et al., 2005) necessary to improve services for PWAs. Citizens on their part could use their entry into an ‘impersonal’ bureaucratic system via record-keeping to insist on getting services as of right. Secondly, activities of NGOs do not automatically lead to loss of legitimacy on the part of the state. In the context of the current research, delivering life-saving ARVs and related HIV/AIDS services with the SD-NGO TASO, the state and PWA citizens working in collaboration appears to have provided an “enabling environment” for developing productive state-society relations. Moreover, it appears that SD-NGOs have an edge in citizens’ empowerment because their mobilization is linked to a tangible benefit. Kabeer’s work in Bangladesh reports that “the absence of immediate economic gains may discourage the longer term participation of the very poor” in empowerment activities (2003b:37-38). Lastly, it is important to note that SD-NGOs are not monolithic entities with similar activities across time and space. Some SD-NGOs can combine service delivery activities with political strategies (Chhotray, 2008). For MTP, TASO appears to have employed the onion strategy (Fowler, 1993) where politics was embedded within the transformative communication strategies such as counselling as well as group formation activities (see Chapter Seven). Thus, the question of NGO influence on politics is an evidence-based one that can only be settled with empirical research.

8.5.3 The history of NGO-state relations

The history of previous engagements between NGOs and the state has a significant influence on the strategies used by the former in future engagements. According to Chapters Three and Five, the NRM regime recognised PWAs as deserving citizens and actively endorsed service delivery NGOs to freely operate on issues around HIV/AIDS. Unsurprisingly, TASO claimed to be driven by the premise that cooperation with the state is the best way to achieve development outcomes. The good relations between TASO and
the state that ensued saw the former receiving material support in form of land, staff secondments and other resources which enabled the infant TASO to mature into an influential SD-NGO. This background influenced the context of ‘partnership’ within which MTP was conceived. As Batley observes, with examples from Bangladesh, India and Pakistan, NGOs in similar circumstances as TASO would as much as possible avoid conflict or confrontation with the government—“not only because the NGO would lose business but also because it would sacrifice influence” (2011:317). Nonetheless, even with a history of good relations, NGOs that choose to work with government have to confront other enduring challenges for their interventions to be effective (Edwards and Hulme, 1992; 1995; Hulme and Edwards, 1997b). Chapter Six illustrates how factors such as the centralised procurement procedures of medical supplies, inadequate salaries for staff, and recruitment processes that are insensitive to the local needs of rural facilities among others, formed part of the wider structural constraints that affected the effectiveness of MTP, regardless of TASO-state relations.

8.5.4 Impact of government delivery for citizenship development

People’s contact with public delivery agencies matters for “exercising and becoming citizens” and it acts as a stimulus for citizen mobilisation (Wood, 1997). However the caveat here is that this depends on the quality and methods of service delivery. In the first place, Uganda’s experience shows that poor quality services encourage exit or citizens’ disengagement from the state (Chapters Three and Six). Chapter Seven also argues that since groups faced historically with seemingly unsolvable problems such as HIV/AIDS may have lost their confidence to act as citizens, service delivery agencies need to provide opportunities that they can exploit to exercise experiences of agency as a means of gradually restoring their self-confidence. This implies that mere contact with state agencies is not enough to activate citizenship as assumed by some (e.g., MacLean, 2011). Our argument is supported by a recent multi-country analysis of citizenship experiences by Citizenship DRC which finds that:

To develop such an active citizenry ... requires time and experience. Through trial and error, citizens gradually acquire crucial knowledge, a sense of their ability and a disposition to act. Such knowledge may be of one’s rights and responsibilities, more technical knowledge needed to engage more effectively with the state, or awareness of alternatives to the status quo. (2011:9).
The experience of MTP shows that state officials such as health workers can be tasked to mobilise their clients to form groups, encourage them to participate in service delivery, and/or they can invite them in decision making spaces like staff meetings, all of which offer opportunities to learn and exercise agency. This indicates that acquiring the capacity to ‘see citizens like an NGO’ is an essential part of the state’s repertoire in terms of social service delivery, and that once public agencies improve on this aspect, citizens become more willing to seek services from them, to co-produce with them and are consequently more likely to acquire lessons to further the practice of citizenship. This observation does not only underline the key political roles for SD-NGOs, it also challenges the tendency by some scholars (e.g., Kabeer, 2003a; Kabeer, 2011; Kabeer et al., 2010) to view empowerment and social mobilisation of poor people in developing countries “as a phenomenon occurring outside the public sector – often in protest against state actions, or in spite of the state, or under the threat of repression by the state” (Tendler, 1995:1).

8.5.5 The politics of co-producing with the state

Constructive engagement between the state and society that involves the former incorporating the tacit knowledge of community members in organising development programmes can be important for development success (Mitlin, 2008; Pritchett and Woolcock, 2004). This study has illustrated how co-production activities with PWAs boosted the bureaucratic effectiveness of MTPs, increased state legitimacy, and extended the reach of government programmes in the communities. Therefore, the argument explored in Chapter Two that the desirable organisation arrangement is a centralised bureaucracy which can directly penetrate society and put citizens in unmediated encounters with the state (Houtzager, 2005; Houtzager and Pattenden, 2005; Van de Walle and Scott, 2011) may not be appropriate in some contexts. For HIV/AIDS, this research supports the view that effective service delivery is likely to occur where programmes are designed to respond to the varied (as opposed to standardised) needs of the intended beneficiaries. This highlights the centrality of enlisting citizens’ participation not only in designing programmes but also in their implementation and evaluation. Some scholars support the view that this is a condition for success in most social programmes (Evans, 2010; 2011; Mitlin, 2008). According to Mitlin, as opposed to promoting the Weberian model of an authoritative bureaucracy, an effective state “needs to negotiate with local citizens to ensure their participative involvement, not only with respect to
individual changes in behaviour but also because some things can most effectively be managed locally, with citizen engagement” (2008:353).

8.5.6 Evidence on ‘Islands of Effectiveness’

The current position of international development is to de-emphasise the ‘best practice’ approach to advancing development in the South in favour of the ‘best fit’ approach that focuses on supporting institutions that are appropriate for the specific context in which they operate (Levy, 2004). Chapter Two suggested that this could be operationalised through the concept of IOEs, whereby development agencies such as NGOs would implement reforms first in specific state agencies or departments before utilising the lessons to scale-up the reforms in other agencies (see Therkildsen, 2008). MTP offered a ‘natural’ experiment of IOEs whereby in our study sites, one of the hospital departments (HIV/AIDS) was offered extra facilitation by TASO to improve service provision in relation to other departments. Two related questions emerge here: was TASO successful in establishing MTPs as IOE; and if so, did they have dispersal effects to other state departments/agencies? Basing on the number of people served and clients’ evaluation of the pre and post MTP quality of services, it can be claimed that MTPs were IOEs, albeit to a greater or lesser extent depending on how fully rolled-out and resourced they were. However, this conclusion also has to take into consideration the weaknesses of some strategies that TASO promoted. The main one was the short-term focus of interventions, like purchase of drugs, use of less technical staff and outreaches, which only dealt temporarily with the challenges of stock out of drugs, inadequate staffing and territorial reach of health services. Although such interventions helped to improve the state’s vision of its citizens for a while, critics such as Dicklitch (1998) would argue that this is evidence of the inherent weakness of SD-NGOs in applying band-aid solutions to development problems rather than petitioning for longer-lasting reforms.

As far as MTPs being sites for dispersing good practices to other state agencies is concerned, the results were rather disappointing. After five years of implementation, we found little evidence of systematic cross-fertilisation of ideas among the different departments in the study sites. According to Chapter Six, there was even some evidence of negative learning taking place. Instead of promoting collaboration among departments, MTP appears to have divided health workers into those who received ‘motivation’
through financial incentives for working extra in HIV/AIDS departments and other staff who received nothing. The observations here, and the fact that the main success of MTP was in relation to helping the state to see like an NGO, suggests that NGOs are not natural builders of state capacity per se, but are actually rather partial ones which in any case tend to be better on the civil society front than political society.

8.5.7 The relational character of state building and citizenship formation

This thesis has pointed to the mutually constitutive character of state building and citizenship formation. This is in contrast to one of the current dominant development positions that regard state building and empowerment of citizens as two mutually exclusive undertakings from which policy makers and practitioners can choose – either to work on the “supply side” or “demand side” (cf. World Bank, 2004). Moreover, the tendency is to suggest that “demand side” interventions have more promise to bring about improvement in the functioning of state agencies and responsiveness to citizens compared to the “supply side” reforms (see, McNeil and Malena, 2010; Odugbemi and Lee, 2011; Ringold et al., 2012). On its part, this study finds that state building endeavours are more likely to succeed where both the supply side and demand side are approached in a sequential manner such that the state gains ability to be responsive to citizens first before they can start putting pressure on it. Our findings are in agreement with recent research which argues that “demand side” interventions only work when there is a ‘receptive environment’ (created by supply-side reforms) in which government officials can hear and competently respond to citizens demands from below (Batley et al., 2012; Brett, 2003). Nonetheless, our findings also show that if implemented in an integrated way, demand side activities can reinforce the supply side by for instance promoting the reach of government programmes in the communities, thereby creating an iterative process of feedback.

These observations place us in a better position to modify the conceptual framework, first outlined in Chapter Four, concerning the role of SD-NGOs in state and citizenship building (see Figure 8-1).
The conceptualisation in Figure 8-1 goes beyond “working on both sides of the equation” (Gaventa, 2002; 2004) by acknowledging that there are additional processes that lie between the state and citizens. It suggests that the influence of service delivery programmes on state building, legitimacy and citizenship formation is mediated by a complex mix of contextual factors. These include but are not limited to: pre-existing state-society relations, operating environment for civil society, influence of donors, and the character of both formal and informal political institutions among others. This line of thinking also operationalises suggestions that state and citizenship building are about negotiating expectations between the state and society (OECD, 2008) by outlining the factors that underpin such negotiations. An important caveat here is that it is likely that contents of each box in the diagram above will vary from one project to another.

8.5.8 The role of monitoring, evaluation and documentation for NGOs

According to Campbell and Cornish (2010a) monitoring and evaluation activities, including audits and engaging in various forms of evidence-based publicity, boost the projects’ “symbolic value” which, especially for resource-dependent organisations, is important to keep donors motivated to continue funding and possibly to promote the expansion of NGO approaches (also see, Booth, 2012; Hulme and Edwards, 1995). As reported in
Chapter Five, when the rationale of using Civil Society Fund (CSF) money to build the capacity of government health facilities was queried, TASO had no evidence to prove the project’s worth. Monitoring and evaluation activities would also have provided reference for other national and international organizations looking for new ways of addressing similar development challenges. In brief, TASO did not actively engage in “influencing public opinion” about MTP yet it is through such influence that certain groups are able to forge hegemony and legitimise particular approaches as viable development alternatives (Mitlin et al., 2007). This diminished the chances that MTP model will influence development policy in Uganda and beyond. And as poignantly stated by Edwards and Hulme (1995:224) “an inability to demonstrate impact and effectiveness in a reasonably rigorous manner ...[is likely to lead NGOs] into areas where they are not doing very much that is useful”.

8.5.9 NGOs and the politics of donor funding

Although the MTP model as discussed in this thesis reveals the potential for a more relational and collaborative approach to delivering services, TASO deliberately avoided publicising this for fear of undermining funding prospects for their main model of NGO-led delivery. Chapter Five reported that TASO officials feared that the success of government health facilities (MTPs), hitherto known for their ineffectiveness, would result into donors’ loss of favour for the service delivery model where NGOs are allowed to set up parallel structures alongside those of the state. Since this is the approach that TASO’s own service branches thrived on, in what can be interpreted as an attempt to maintain the flow of donor funding to its service branches, the NGO chose to sacrifice the further advancement of the MTP model. The key lesson here is that when NGOs are dependant on external funding, the impulse for self-preservation can cloud their pursuit of alternative development (Edwards and Hulme, 1995; Fowler, 2010). However, donors are also implicated here for promoting ‘anti-statist’ development approaches through funding programmes, such as CSF, which explicitly prohibit NGOs from pushing resources into state agencies. Little wonder, GoU officials decry the predominance of donors who prefer ‘off-budget’ project support in the health sector (Ministry of Health, 2010b; Örtendahl, 2007).
8.6 The specificity of the findings to the HIV/AIDS sector

Can the conclusions from this study be applicable beyond the confines of the cases investigated? This is a key question that this section seeks to respond to. It is particularly important because HIV/AIDS is regarded to be a unique condition and therefore might provide an exceptional context for NGO programmes associated with it than is likely to occur in the ‘normal’ social sector programmes such as drinking water supply. Therefore, it is important to establish whether or not the conclusions drawn in this study are peculiar to programmes in the HIV/AIDS sector and therefore may not be generalized through potential NGO interventions in service delivery in other arenas.

Among the main pointers to the HIV/AIDS exceptionalism is that, at the international level, the epidemic has attracted high political commitment from powerful politicians, celebrities and development agencies – witnessed in part by the vast resources that the response has generated (Smith and Whiteside, 2010; Swidler, 2007; Whiteside, 2010). Chapter Five observed how HIV/AIDS has been accompanied by numerous multi-million dollar international funding programs such as the World Bank’s MAP, United Nations’ GFATM, and United States’ PEPFAR. One can argue that such an atmosphere provides fertile grounds for a high degree of society mobilisation around issues of HIV/AIDS than is likely with other social problems. Within the Ugandan context, Chapter Three indicated that HIV/AIDS is one area where the NRM government put special emphasis upon capturing state power in 1986. It is claimed that, in part because HIV was identified among a core group of NRA soldiers that brought his government to power, President Museveni emphasized that fighting it was a “patriotic duty” requiring openness, communication and strong leadership at all levels (Green et al., 2006; Parkhurst, 2005; Putzel, 2004; Schoepf, 2003). The president’s charismatic directness in addressing HIV/AIDS placed it high on the development agenda which in turn encouraged constant and candid national debate and media coverage of aspects around this epidemic (Green et al., 2006). Some suggest that the response was even able to transcend ‘primordial politics’ along which Ugandans had historically been divided (Chapter Three). Therefore, and as noted in Chapter Six, these developments might have given the response to HIV/AIDS the much needed ‘political will’ or commitment that defined the seriousness with which government hospitals in rural Uganda undertook TASO’s HIV/AIDS project.
Besides that, the fact that PWAs comprise a social group faced with a seemingly incurable disease which often involves several ‘near-death experiences’ increases the likelihood that HIV/AIDS stimulates greater activism from sufferers (Robins, 2004; 2006). The experiences of illness, stigma and treatment, Robins (2006) argue, provide PWAs with the “raw materials” with which to construct new HIV-positive identities and social solidarities. The hypothesis is that “the extremity of “near death” experiences of full-blown AIDS, followed by “miraculous” recovery through ART, can produce the conditions for AIDS survivors’ commitment to “new life” and social activism” (Robins, 2006:314). Related to this is the nature of HIV/AIDS treatment services. Chapter Two noted that HIV services are well categorised as ‘private’ and transaction intensive social services and therefore the kind of state support that is sought by PWAs essentially involves a ‘private’ relationship of the individual with the state. One can argue that this leads to numerous *individual* and *private* transformations in PWAs which in effect foster changes in their behaviours as citizens.\(^{42}\)

Although insightful, the above factors cannot fully explain the social mobilisation and empowerment of PWAs observed in the study sites. This assertion is based on several factors. First of all, the study sites in which MTP was implemented are located in the rural areas where, as argued in Chapters Two, Three and Four, prohibitive social norms, such as a strongly ingrained respect for and deference to authority, leadership and elders, are pervasive (also see, Mamdani, 1996). This, combined with the social stigma associated with HIV/AIDS is likely to make PWAs choose to maintain ‘good’ (dependent) relations with powerful figures in their lives such as health providers than mobilisation as a strategy to gain access to and/or sustain the flow of benefits that was reported in the study sites. Secondly, according to Chapters Two and Seven, HIV/AIDS services being “discretionary and transaction-intensive” suggest that related programmes, keeping other factors constant, are ofthemseves poorly positioned for beneficiary empowerment. HIV treatment is individualised and this, according to McLoughlin and Batley (2012a), has a negative effect on the ability of clients to mobilise for collective action. In addition, such services are difficult to standardise and control (Mcloughlin and Batley, 2012a; Pritchett and Woolcock, 2004) and their high technical knowledge accord disproportionate powers

\(^{42}\) Personal communication with Dr. Versudha Chhotray, 05/11/12.
to the service provider (agent) vis-à-vis the client and/or politicians who represent citizens (principals) (World Bank, 2004).

Thirdly, even the key proponents of the transformation potential of HIV/AIDS such as Robins (2006) insist that not all HIV treatment experiences can result into transformation of PWAs’ subjectivity and identity in ways that promote social mobilisation. Robins, for instance, indicates that HIV/AIDS treatment in the South African public sector, which is shaped by the conventional doctor–patient dyad and highly technicist and depoliticized modes of biomedical intervention, produces dependent patients who prefer to remain anonymous and isolated from the public domain. Chapter Six (Section 6.2.1) made a similar characterisation of health services in Uganda’s public facilities that did not implement the MTP (and MTP sites before TASO’s intervention as illustrated in Chapter Five). These observations imply that where PWAs exhibited signs of empowerment and engaged in social mobilisation it is because other variables outside the HIV/AIDS condition per se had been brought into play.

According to Robins (2006) it takes conscious efforts on the part of the service provider to promote the conditions for more “collectivist responses” to HIV/AIDS and treatment. Drawing specific examples from programmes supported by the Treatment Action Campaign (TAC) in South Africa, he notes that:

whereas public health practitioners report that most of their HIV/AIDS patients wish to retain anonymity and invisibility at all costs, TAC successfully advocates the transformation of the stigma of HIV/AIDS into a “badge of pride” that is publicly displayed on T-shirts at township funerals, demonstrations, workshops, and other public spaces. It is through these activist mediations that it becomes possible for the social reintegration and revitalization of large numbers of isolated and stigmatized HIV/AIDS sufferers into a social movement and a caring community (2006:314).

This observation is inline with those made in this research. As compared to the care in public health facilities where patients remain isolated, recruitment into MTP allowed PWAs to access supportive communities and nonhierarchial social space in form of MDD groups and other clients’ associations and co-production activities among others. Chapter Seven argued that, compared to mainstream public health services, TASO through the MTP project was not only interested in medical treatment but also concerned itself with
creating empowered PWAs who understand the connections between biomedicine and the wider social world. Thus, this study attributed the differences in political impact among the study sites to differences in opportunities for citizens’ empowerment created in those sites and relations between service providers and service users among other factors as opposed to the particularities of HIV. In Kamuli where MTP created more opportunities for citizen empowerment, PWAs exhibited more confidence to exercise voice, engage in civic activities and political contestation more than those in Masafu that had fewer opportunities. Similarly, PWAs in MTPs performed better in the mentioned areas compared to those in Iganga that had no activities focused at citizen empowerment.

A look at NGOs and people’s movements that have successfully undertaken empowerment and social mobilisation in the global South provides further insights into what might have occurred with MTP. Campbell and colleagues’ (2010) comparative analysis of the South African TAC, which focuses on mobilizing poor people to demand for ART treatment, with two other successful pro-poor social movements: the Brazilian Landless Workers’ Movement that mobilizes for land access and the Indian wing of the People’s Health Movement (PHM) for general health care access, summarised their reasons for success as follows;

- Ability to promote and facilitate critical thinking among the poor which resulted in a conceptualisation of poverty and disadvantage as the result of social inequalities. This created drive and motivation for participation in collective action,
- The provision of education and capacity-building which strengthened the commitment of participants,
- The promotion of strategic horizontal (with civil society) and vertical alliances (with political society) which were crucial for gaining receptivity to movements’ demands among power-holders and building the strength of the movements through numbers.
- All three movements used media presence and strategic moral, legal or economic discourses to gain the moral high ground and mobilise a broad base of support around the issues they are promoting. This created a ‘symbolic value’ for their cause.

Our analysis identified similar strategies. It indicated that service delivery activities such as “transformative” counselling could be important avenues for conscientising service users; co-production, improving the quality of services, and training PWAs in peer
counselling and MDD were important forms of capacity building that enlisted PWA’s commitment; dialogue structures provided useful vertical state-society linkages; and there was some evidence of media engagement in Kamuli. Also, studies in other fields such as micro-finance have indicated that mobilisation of the marginalized into support groups, which are then linked to local government structures, can help to provide transferable skills that can be used by such people to advance their interests in social and political spheres (see, Williams et al., 2011).

Overall, even though there are certain specificities to this particular case/sector, what this study has offered is an analytical approach that captures this (e.g. how the President's particular interest led to a new 'social contract' being formed between government and PWAs) but which can also be said to capture the politics of others sectors. In the last section, the chapter draws on the earlier discussion to make recommendations for development theory, policy and practice. It also suggests areas that require further empirical analysis.

**8.7 Policy recommendations and suggestions for further research**

The study recommends that development agencies need to pay more attention to the management of public services at the point of delivery. This thesis has argued that poor people’s access to public services needs to be mediated by methods that provide them with opportunities to exercise agency with a view to boosting their self-confidence to act as citizens. Therefore, it is paramount that capacity building initiatives to equip street-level bureaucrats with skills to approach service delivery as potential learning grounds in which a sense of citizenship and rights are developed and strengthened are prioritised. As argued throughout this thesis, SD-NGOs with proven service delivery record can be brought on board to share their experiences in this aspect.

NGOs need to take all the stages of the ‘project cycle’ – from initiation, implementation, monitoring and evaluation to closure – more seriously. Monitoring and evaluation aspects, which were ignored in MTP, had direct implications for funding and sustainability of interventions and their impact (Hulme and Edwards, 1995). A closely related point is that as a good start is important for an intervention, so is a good ending. The study observed that despite being in its strategic plan for the 2008-2012, TASO did not follow
the exit strategy suggested for MTP. The resultant abrupt closure affected service delivery activities like outreaches and home visits that depended on the continued funding and support supervision from TASO. This point is also related to the critique about the ‘short-termism’ embedded in the approaches of many SD-NGOs, something that limits impact and sustainability of interventions (Dicklitch, 1998). Therefore, SD-NGOs need to approach their work with a long-term development perspective if their contribution to development is to be taken seriously. In particular, for NGOs interested in building state capacity, there is need to recognise that state building takes time.

Coming directly from the above, is that in order to advance this long-term perspective to development, NGOs need to have reliable funding sources. The evidence from this study revealed that TASO’s programming was affected by the unpredictability that is associated with external financing. This problem could be minimized by strengthening internal revenue sources with a goal of reducing dependence on international donors and/or governments. However, care is needed here to ensure that alternative funding options do not compromise NGO goals for beneficiary empowerment or catalysing social change (Edwards and Hulme, 1995; Fowler, 2010; Hulme and Edwards, 1997c). Alternatively, NGOs could negotiate for core longer-term funding such as the ‘basket’ funding arrangement in which, as discussed in Chapter Five, a number of official donors were supporting TASO’s strategic plan rather than individual activities. The Dutch government also operated a similar system where selected NGOs, known as co-financing agencies, would receive funding from the state through a four year Programme Funding Agreement (Derksen and Verhallen, 2008; Guijt, 2008).

There is a need to integrate co-production approaches in the delivery of public services in the South. This thesis has demonstrated that co-production in the provision of social services can facilitate the development of good interpersonal relations between state officials and their clients which increases the opportunities for the latter to have their needs addressed (Mitlin, 2008) and allows the state to gain legitimacy (Tsai, 2011). Most importantly, co-production can also provide opportunities for ordinary citizens to learn political skills. This means that co-production should be promoted as a state building and/or citizenship building strategy rather than as a strategy for reducing operation costs.
of government agencies by for instance using ‘expert’ service users as substitutes for technical staff.

Related to co-production, at the local level, the state needs to take on an activist posture in its service delivery programmes. The relative success of community mobilisation programmes like drama and medical outreaches in MTP sites is an indication that the convention facility based approach which turns the state into a passive bystander that only swings into action when contacted by citizens is outmoded. This study has showed that the poor and other marginalised people who have undergone prolonged periods of exclusion are likely to lack the confidence and know-how to seek services without outside help.

Further conceptual work and research into service delivery impact on politics is needed. The analytical field of ‘politics of service delivery’ has lately received attention from scholars addressing a wide range of issues such as service delivery in conflict and fragile states (Brinkerhoff et al., 2012; Van de Walle and Scott, 2011), the political impact of non-state social welfare provision (Cammett and MacLean, 2011) and some looking at the political implications of specific services such as cash transfers (Hurrell and MacAuslan, 2012). These studies have helped to firmly make the claim that social service delivery does produce politics. However, other questions remain unanswered. For instance, does impact vary according to service type or not? How long does it take for the effects to emerge? Can the effects of a particular programme be sustained after its implementation? Therefore, future research should investigate these issues.

Lastly, another area that will require further investigation, at the local level, is the assessment of the effectiveness of those people who use the experience acquired from service delivery programmes to join active politics. In the case of MTP, it would be interesting to find out whether they promoted the agenda of their group (e.g. PWAs), whether they intend to continue participating in active politics and at what level, and whether their involvement has had any effect on the attitudes of other group members towards politics.
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## Appendix 1: Research Matrix

<table>
<thead>
<tr>
<th>Research questions</th>
<th>Indicators</th>
<th>Sources of data</th>
<th>Methods of data collection</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Question 1:</strong> What impact has the Mini-TASO project had on the capacity of the state to deliver health services?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **1.1 Impact on bureaucratic capacity** | Availability of required personnel Skills and expertise of health workers in handling PWAs  
Performance on key health outputs. Availability of effective M&E systems | - Health workers  
- Service users  
- TASO  
- Project reports  
- Service users  
- TASO  
- Hospital/health department evaluations  
- Health workers  
- H/U administrators | - Semi-structured interview with health workers; service users; and TASO officials  
- Documentary review  
- Semi-structured interviews with health workers; service users; and TASO officials  
- KI with local politicians; ministry of health |
| **1.2 Impact on embeddedness** | Partnerships with other CSOs  
Degree of service users' involvement in hospital activities  
Other stakeholders’ involvement  
Number and types of decision making structures | - Project reports  
- H/U administrators  
- Health workers  
- H/U management  
- Health workers  
- Service users  
- TASO  
- Project reports  
- H/U administrators  
- Service users  
- TASO | - Documentary review  
- Semi-structured interviews with health workers; service users; and TASO officials  
- KI with local politicians; ministry of health  
- Semi-structured interviews with health workers; service users; hospital admin; and TASO officials  
- Direct observation  
- KI |
| **1.3 Impact on infrastructural capacity** | Availability and effectiveness of strategies for the territorial reach of | - Project reports  
- H/U administrators | - Documentary review  
- Semi-structured interviews with health workers; |
<table>
<thead>
<tr>
<th>Research questions</th>
<th>Indicators</th>
<th>Sources of data</th>
<th>Methods of data collection</th>
</tr>
</thead>
</table>
| Question 2: How has the Mini-TASO project impacted on state legitimacy? | 2.1 Impact on the loyalty and confidence of service users in state delivered services | Congruence between citizens needs and preferences with programme deliverables | - Project documents  
- Health workers  
- Service users  
- TASO | - Documentary review  
- Semi-structured interview with health workers; service users; and TASO officials  
- Service user survey; FGDs |
| | Service users’ perceptions about the quality of services (including attitudes towards health workers) | - Service users  
- Health workers  
- TASO | - Semi-structured interview with health workers; service users; and TASO officials  
- Service user survey  
- Direct observation |
| | Service users perceptions about government facilities and services | - Health workers  
- Service users  
- TASO | - Semi-structured interview with health workers; service users; and TASO officials  
- Service user survey; FGDs |
| | User’s confidence in other state structures e.g. local councils | - Service users | - Semi-structured interviews with service users  
- Service user survey  
- Documentary review |

| Question 3: How has the Mini-TASO intervention influenced the citizenship status of beneficiaries? | 3.1 Impact on patients social trust | How service users gain access to scarce materials like drugs | Service users  
Health workers | - Service user survey and Semi-structured interviews |
| | Service user’s opinions about the fairness of service delivery systems e.g. selection criteria fairness. | Project documents  
Health workers  
Service users | - Service user survey  
- Clients leaders FGDs  
- Semi-structured interviews with clients |
<p>| | 3.2 Has the project | How to service users express their | - Project reports | - Semi-structured interviews |</p>
<table>
<thead>
<tr>
<th>Research questions</th>
<th>Indicators</th>
<th>Sources of data</th>
<th>Methods of data collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenced the ability of service users to express voice?</td>
<td>dissatisfaction at the health facility?</td>
<td>- Health workers</td>
<td>- Service user survey; FGDs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Service users</td>
<td>- Direct observation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- TASO</td>
<td>- Documentary review</td>
</tr>
<tr>
<td>Formal and informal channels for receiving and managing complaints at health units (How are they accepted, avoided, resisted, deflected?)</td>
<td>Hospital administrators, Health workers, Service users</td>
<td>- Service user survey</td>
<td>- Semi-structured interviews with clients, health workers, TASO, local politicians</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Service user leaders FGDs</td>
</tr>
<tr>
<td>Health workers’ responsiveness to complaints and suggestions of the different categories of service users</td>
<td>Health workers, Service users</td>
<td>- Direct observation</td>
<td>- Semi-structured interviews with health workers</td>
</tr>
<tr>
<td><strong>3.3 Impact on civic and political participation</strong></td>
<td>Service user membership in civic/community groups</td>
<td>Service users</td>
<td>- Service-user survey</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Semi-structured interviews with clients</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Direct observation</td>
</tr>
<tr>
<td>Money, time and other contributions made by service-users towards solving community problems/issues</td>
<td>Service users</td>
<td>- Service-user survey</td>
<td>- Semi-structured interviews with clients, TASO and local politicians</td>
</tr>
<tr>
<td>Nature of engagement with political leaders</td>
<td>Service users</td>
<td>Service-user survey</td>
<td>- Semi-structured interviews with clients, TASO and local politicians</td>
</tr>
<tr>
<td></td>
<td>Politicians</td>
<td></td>
<td>- KI</td>
</tr>
<tr>
<td>Engagement in political activities e.g. elections.</td>
<td>Service users</td>
<td>Service-user survey</td>
<td>- Semi-structured interviews with clients, TASO and local politicians</td>
</tr>
<tr>
<td></td>
<td>User-politicians</td>
<td></td>
<td>- KI</td>
</tr>
</tbody>
</table>
Appendix 2: NVivo screenshot for bureaucratic capacity

In kiwoko we didn’t have counselors. But now because of the intervention of TASO we have over 12 counsellors, those ones stationed in the HIV department then most of the nurses based in the hospital have been trained.

Reference 1: 0.39% Coverage

Then children and adolescent counseling was also given from Jinja. It was the nurses. Then also the still the nurses, they took them for nutrition and then also prevention of HIV.

Reference 2: 0.32% Coverage

For Pallisa Hospital Many health workers were trained in HIV/AIDS counseling. I think About 15.
1. a) Residence:
Name of village: ____________________ Sub-county: ____________________ District: ____________________

2. Respondent’s socioeconomic background:
2 a) Age (in complete years): ________
2 b) Sex: 1: Male [    ];  2: Female [    ]
2 c) What level of education did you attain?
None [    ] 00; Attended Primary [    ] 01; Completed Primary [    ] 02;
Attended O’level [    ] 03; Completed O’level [    ] 04;
Attended A’level [    ] 05; Completed A’level [    ] 06;
Attended tertiary [    ] 07; Attended university [    ] 08;
Other – specify __________ [    ] 88.

2 d) What is your marital status?
1: Married (mono) [    ];  2: Married (poly) [    ]; 3: Separated/divorced [    ];
4: Widowed [    ];  5: Never married [    ]; 88: Other – specify __________ [    ]

2 e) What is your religion?
1: Catholic [    ]; 2: C.O.U (Protestant) [    ]; 3: Moslem [    ]; 4: SDA [    ];
5: Orthodox [    ]; 6: Pentecostal (Born again) [    ];
7: Atheist [    ]; 88: Other – specify ______________________ [    ]

2 f) What is your occupation?
1: Employed Govt [    ]; 2: Employed private Co. [    ]; 3: Peasant [    ];
4: Casual labourer [    ]; 5: Business/ self-employed [    ];
88: Other – Specify ______________________ [    ]

3 a) Which health facility is closest to your home?
........................................................................................................................................................................
........................................................................................................................................................................

3 b) If not the same as MTP, what is the main reason you do not go to the nearest facility?
Inconvenient operating hours ................. [    ] 01
Bad reputation .................... [    ] 02
Don’t like the personnel ................. [    ] 03
No medicine .................... [    ] 04
Prefers to remain anonymous ............... [    ] 05
It is more expensive ................. [    ] 06
I was referred .................... [    ] 07
Other (specify) .................... [    ] 88
Don’t know .................... [    ] 99

3 c) When did you register with [name of MTP] health facility?
4. a) Have you heard about the mini-TASO program?
   a) No 1 [ ]
   b) Yes 2 [ ]

4. b) If yes what does the Mini-TASO do?

……………………………………………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………………………………

4. c) Can you tell me the ways in which it has benefited you?

……………………………………………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………………………………

4 d) Which of the following statements is closest to your view? Choose Statement 1 or Statement 2.
Statement 1: In _________________ Project I am more attracted by the quality of care than drugs.
Statement 2: In _________________ Project I am more attracted by the availability of drugs than the quality of care.
   a) Agree with 1 [ ] 01
   b) Agree with 2 [ ] 02
   c) Agree with both [ ] 03
   d) I don’t know [ ] 99

5. a) What services do you receive from this project/facility?

<table>
<thead>
<tr>
<th>No.</th>
<th>Type of treatment</th>
<th>Date started</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Septrin</td>
<td>[ ]</td>
</tr>
<tr>
<td>2</td>
<td>ARVs</td>
<td>[ ]</td>
</tr>
<tr>
<td>3</td>
<td>Counselling</td>
<td>[ ]</td>
</tr>
<tr>
<td>4</td>
<td>Food supplements</td>
<td>[ ]</td>
</tr>
<tr>
<td>5</td>
<td>Treatment for other illnesses (not PWA)</td>
<td>[ ]</td>
</tr>
<tr>
<td>88</td>
<td>Others specify</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>I don’t know</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

5. b) How did you gain access to these services?

<table>
<thead>
<tr>
<th>No.</th>
<th>Access Method</th>
<th>[ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Another client connected me</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>I have a friend/relative in the hospital</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Passed through a local politician</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Paid some money</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>The hospital announced</td>
<td></td>
</tr>
<tr>
<td>88</td>
<td>Others specify</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>I don’t know</td>
<td></td>
</tr>
</tbody>
</table>

5. c) Do you pay for the services you get from this project?
c) No 1 [ ]

d) Some times 2 [ ]

e) Always 3 [ ]

5. d) How much do you pay for each of the services?

<table>
<thead>
<tr>
<th>No.</th>
<th>Type of treatment</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Septrin</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>ARVs</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Counselling</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Food supplements</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Treatment for other illnesses (not PWA)</td>
<td></td>
</tr>
<tr>
<td>88</td>
<td>Others specify</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>I don’t know</td>
<td></td>
</tr>
</tbody>
</table>

5. e) What are the terms of payment?

a) Official (receipted) 1 [ ]
b) Token of thanks 2 [ ]
c) Not official but necessary to get services 3 [ ]

6. a) How would you rate the quality of services provided by _____________ project?

<table>
<thead>
<tr>
<th>Item</th>
<th>Pre-TASO situation</th>
<th>Current situation</th>
<th>Change in last 2 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Poor = 1</td>
<td>Fair = 2</td>
<td>Worsened = 1</td>
</tr>
<tr>
<td></td>
<td>Good = 3</td>
<td></td>
<td>Same = 2</td>
</tr>
<tr>
<td></td>
<td>I don’t know = 99</td>
<td></td>
<td>Improved = 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Don’t know = 99</td>
</tr>
</tbody>
</table>

1. Responsiveness of the staff
2. Availability of drugs
3. Cleanliness
4. Time you wait to receive services
5. Ability to discuss problems or concerns with the provider
6. Amount of explanation you received about your problems
7. Privacy from having others hear your consultation
8. Availability of medicines at this facility

9. The hours of service at this facility

10. Number of health workers

6. b) Considering such service quality, would you be willing to pay for these services?
   a) Yes 01 [ ]
   b) No 02 [ ]

6. c) Who do you think has made the quality of services in this hospital the way it is?
   1
   2
   3

7 a) In your experience:
What are the things that you consider important to you that the hospital started doing with the coming of the Mini TASO project that it was not doing before?
........................................................................................................................................................
........................................................................................................................................................
.............

7 b) In your experience:
What are the things that you consider important to you that the hospital stopped doing with the coming of the Mini TASO project that it was doing before?
........................................................................................................................................................
........................................................................................................................................................
.............

7 c) In the last 12 months has this project ever had to go without medical personnel or medical supplies for some time, say six months or more?
   1. No [ ] 2. Yes [ ] 99. I don’t know [ ]

If yes what course of action did you take?

<table>
<thead>
<tr>
<th>No</th>
<th>Responses</th>
<th>Tick</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I kept quiet because I had no choice</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>I just moved to another health facility</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>I approached hospital management to find out why</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>I reported the issue to the local government political leaders</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>I asked a member of service user committee</td>
<td></td>
</tr>
<tr>
<td>88</td>
<td>Others specify</td>
<td></td>
</tr>
</tbody>
</table>

8 a) In the last 12 months, have you ever been dissatisfied with the approach/services of a particular health worker?
   1. No [ ] 2. Yes [ ] 99. I don’t remember [ ]
8 b) If yes, how did you react when you were not satisfied with a health worker at this facility?

<table>
<thead>
<tr>
<th>No</th>
<th>Responses</th>
<th>Tick</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I just kept quiet because I had no choice</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>I just moved to another health facility</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>I brought the issue to the attention of hospital management</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>I informed my local government/municipal political leaders</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>I informed a member of service user committee</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>I informed the concerned staff that I am not happy</td>
<td></td>
</tr>
<tr>
<td>88</td>
<td>Others specify</td>
<td></td>
</tr>
</tbody>
</table>

8 d) Would your response have been different before the coming of MTP?

a) Yes 1 [ ]

b) No 2 [ ]

c) I don’t know 9 [ ]

Give reasons

……………………………………………………………………………………………………………………………………………
……………………………………………………………………………………………………………………………………………
………………

8. e) Have you ever experienced or heard of clients being reprimanded because of complaining about the quality of services?

1. Never seen or heard [ ]

2. Heard about it [ ]

3. Experienced it [ ]

99. I don’t know [ ]

When and what happened?

……………………………………………………………………………………………………………………………………………
……………………………………………………………………………………………………………………………………………
………………

9 a) Do patients in this facility participate in planning and management of activities?

Yes [ ] 01; No [ ] 02; Not sure [ ] 03

9 b) If yes can you tell me how patients’ involvement and participation has affected this hospital’s performance?

……………………………………………………………………………………………………………………………………………
……………………………………………………………………………………………………………………………………………
………………

9 c) How much attention does this hospital pay to what patients think when it decides what to do:

Not much [ ] 01; a little bit [ ] 02; A great deal [ ] 03

9 d) Did the situation improve, became worse or remained the same with the coming of MTP?
01 Remained the same [ ]; 02 Worsened [ ]; 03 Improved [ ]; 99 I don’t know [ ]

10 a) Do you have patients/clients/service uses’ leaders in this project?

a) Yes 1 [ ]
b) No 2 [ ]
c) I don’t know 99 [ ]

10 b) Type of leaders and selection

<table>
<thead>
<tr>
<th>No</th>
<th>Type of leaders</th>
<th>Year of establishment</th>
<th>How are they selected?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

10 c) What is their work?

..........................................................................................................................................................................................................................................................
..........................................................................................................................................................................................................................................................
...........

10 d) How much have your representatives/leaders helped to make the hospital pay attention to what you clients think:

Not much [ ] 1;  a little bit [ ] 2;  A great deal [ ] 3

Please give me specific examples of issues that leaders of clients have managed to address

..........................................................................................................................................................................................................................................................
..........................................................................................................................................................................................................................................................
...........

11 a) In the last five years, have you contributed your time towards helping this hospital to achieve a specific development goal?

No [ ] 1
Yes [ ] 2
I don’t know [ ] 9

Please give reasons for your answer:

..........................................................................................................................................................................................................................................................
..........................................................................................................................................................................................................................................................
...........

11 b) In the last five years have other clients in this hospital contributed time toward helping this hospital to achieve a specific development goal?

No [ ] 1
Yes [ ] 2
I don’t know [ ] 9
Please give reasons for your answer:

12 a) Has your contact with this project enabled you to become a member of any groups, organizations, or associations? (Probe: which group he/she belongs to and code in the table below).
   a) Yes [    ]  
   2 No [    ]

12 b) Do you consider yourself to be active in the group, such as by attending meetings or volunteering your time in other ways, or are you relatively inactive? Are you a leader in the group?

<table>
<thead>
<tr>
<th>Name of organisation</th>
<th>Type of organisation</th>
<th>Degree of participation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Degree of participation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leader</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Very active</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Somewhat active</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Not active</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

12. c) Do you think that by belonging to this group you have acquired new skills or learned something valuable?

<table>
<thead>
<tr>
<th></th>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No 2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If yes please specify

13) I am going to name some institutions in this district. As far as you are concerned, would you say you have a great deal of confidence, only some confidence, or hardly any confidence at all in them?
### District Local Government

How has your MTP experience affected this?
Worse 01; Same 02; Better 03

### Sub-county Local Government

How has your MTP experience affected this?
Worse 01; Same 02; Better 03

### Local/village councils

How has your MTP experience affected this?
Worse 01; Same 02; Better 03

### Government Schools

How has your MTP experience affected this?
Worse 01; Same 02; Better 03

### Local Police

How has your MTP experience affected this?
Worse 01; Same 02; Better 03

### NGOs (mention the most active)

How has your MTP experience affected this?
Worse 01; Same 02; Better 03

### Government Hospitals

How has your MTP experience affected this?
Worse 01; Same 02; Better 03

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14. Did you stand during the 2011 local council elections?
No [ ] 1  Yes [ ] 2  I don’t know [ ] 9

15. Have you seen a fellow service user standing for the 2011 local council elections?
No [ ] 1  Yes [ ] 2  I don’t know [ ] 9

16. Have you seen a fellow service user campaigning here for the 2011 local council elections?
No [ ] 1  Yes [ ] 2  I don’t know [ ] 9

16. Whom did you vote for president in the February 2011 elections?

-THE END-
### Appendix 4: Key Informant Interview Guide

1. **What do you know about the Mini TASO project?**

2. Please comment on how the mini TASO affected your participation in health unit affairs and service delivery.

3. Please mention things that you consider important to you that the hospital started doing with the coming of the Mini TASO project that it was not doing before.

4. Please mention things that you consider important to you that the hospital stopped doing with the coming of the Mini TASO project that it was doing before.

5. **How did the project affect the ability of the health facility to deliver services to its catchment population?**

6. **How did the project affect the availability of medical supplies in this facility?**

7. **Did the Mini TASO project affect the way service users are represented in the decision making structures of this facility?**
   - If yes how?

8. **Is there any difference in the way hospital staff handled/treated service users in the period before and after the Mini TASO project?**
   - Give personal examples

9. **Has the Mini TASO project influenced your attitude towards health workers?**
   - Give personal examples

10. **Has the Mini TASO project put in place any new accountability mechanisms in this health facility?**
    - How effective have they been?

11. **Has the Mini TASO project changed the way beneficiaries of various projects (e.g. ART drugs) in the facility are selected and monitored?**
    - How?

12. **Has the Mini TASO project impacted on the way you are organised as service users?**
    - What existed before the project, how has it changed?

13. **How do you react when you are not satisfied with services at this facility?**

14. **Are there any negative outcomes associated with the Mini TASO project?**
Appendix 5: Research approval letters

The AIDS Support Organisation
TASO (U) Ltd.

The AID Support Organisation
TASO Headquarters, Mulago
P.O. Box 10443, Kampala
Tel: 041 352 580
041 332 581
Fax: 041 541 288
Email: mail@taso.uganda.org

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26th November 2010

Badru Bukunya
The University of Manchester.

Dear Badru,

RE: PERMISSION TO CONDUCT RESEARCH IN TASO
Greetings from TASO Uganda!
Following review of your research proposal entitled “The Politics of building states and citizens through service delivery: What role for NGOs?”, the committee has granted you permission to go ahead and collect data in regions of TASO Central, Eastern and Western Region. While at the TASO center, please ensure you observe the TASO values and not to interrupt the smooth flow of the service delivery. This approval is valid until 26th November 2011. After which you will be required to make a request for extension to the Chairperson TASO IRC in case of continuation with research.

It is a requirement by the institution that you submit a copy of your report findings after completion of your research and inform the institution whenever findings are to be presented in fora not agreed upon earlier by the two parties.

The institution may call upon you to make presentations of research findings in various fora.

Sincerely,

Mr. Mwesigwa Robert
Chairperson, TASO Institutional Review Committee (IRC).

CC: Regional Manager, TASO Central Region
Regional Manager, TASO Eastern Region
Regional Manager, TASO Western Region
Your ref: 

Our ref: SS.2458

Date: 01/12/2010

Mr. Badru Bukenya  
C/o TASO  
P.O Box 10443  
Kampala

Dear Mr. Badru,

RE: RESEARCH PROJECT, “THE POLITICS OF BUILDING STATES AND CITIZENS THROUGH SERVICE DELIVERY: WHAT ROLE FOR NGOS?”

This is to inform you that the Uganda National Council for Science and Technology (UNCST) approved the above research proposal on November 30, 2010. The approval will expire on September 30, 2011. If it is necessary to continue with the research beyond the expiry date, a request for continuation should be made in writing to the Executive Secretary, UNCST.

Any problems of a serious nature related to the execution of your research project should be brought to the attention of the UNCST, and any changes to the research protocol should not be implemented without UNCST's approval except when necessary to eliminate apparent immediate hazards to the research participant(s).

This letter also serves as proof of UNCST approval and as a reminder for you to submit to UNCST timely progress reports and a final report on completion of the research project.

Yours sincerely,

Jane Nabbuto  
for: Executive Secretary  
UGANDA NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY
Secretary to the Ethics Committee  
Room 2.004 John Owens Building  
Tel: 0161 275 2206/2046  
Fax: 0161 275 5697  
Email: timothy.stibbs@manchester.ac.uk  

ref: TPCS/ethics/10099

Mr Badru Bukonta  
PhD Student, Institute of Development Policy & Management,  
University of Manchester  

5 July 2010

Dear Badru,

Committee on the Ethics of Research on Human Beings  
Bukunya, Hickey, Musinguzi: The politics of building states and citizens through service delivery: what role for NGOs? (ref 10099)

I write to confirm that your project was reviewed by the Committee at its meeting on 24th June and has been given ethical approval.

This approval is effective for a period of five years and if the project continues beyond that period it must be submitted for review. It is the Committee’s practice to warn investigators that they should not depart from the agreed protocol without seeking the approval of the Committee, as any significant deviation could invalidate the insurance arrangements. We also ask that any information sheet should carry a University logo or other indication of where it came from.

Finally, I would be grateful if you could complete and return the attached form at the end of the project or by June 2011.

We hope the research goes well.

Yours sincerely

[Signature]

Dr T P C Stibbs  
Secretary to the Committee