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SYNERGY IN SOCIAL SERVICE PROVISION: EMBEDDEDNESS AND COMPLEMENTARITY IN FIGHTING HIV/AIDS IN UGANDA

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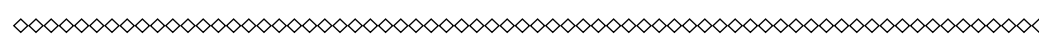

Introduction

Uganda is among the countries that have managed to control the spread of HIV/AIDS despite of the high number of people living with HIV. Uganda is observed to be on the right track towards achieving the 90, 90, 90 Strategy by 2020 (Agaba 2018). The 90, 90, 90 Strategy is an ambitious treatment target that was launched by UNAIDS and other partners. It is aimed at diagnosing 90% of all people living with HIV, provide antiretroviral therapy (ART) for 90% of those diagnosed, and achieve viral suppression for 90% of those treated by 2020. Uganda has registered success in a number of areas, including: reductions in new infections by more than half in five years from 135,000 in 2010 to approximately 60,000 by 2016, in men and women; in children from 26,000 in 2010 to 4000 in 2016, enrolling more than 1 million people on care and support and about 980,954 on antiretroviral therapy (Ministry of Health Uganda 2016; World Health Organisation (WHO) 2018). The reasons why Uganda, a country perceived to be poor, has been more successful in fighting HIV/AIDS than countries such as South Africa and Botswana, considered economically prosperous, remain a matter of discussion. Countries have responded to HIV/AIDS mitigation by providing information and upscaling treatment and prevention. However, these have failed to address the social, economic and power relations which are responsible for individual risks of infection and ability to protect themselves (Kharsany and Karim 2016). The prevalence of HIV among women in most African countries, including Uganda, is higher than that of men due to power relations. Women are unable for example to negotiate consistent use of condoms due to power relations between men and women. Uganda's success is also registered in being able to create harmonious relations between various actors engaged in the fight against HIV/AIDS, a relationship that has been fundamental to Uganda's success in implementing HIV/AIDS policy programmes. Political, social or structural factors play a role in differences between countries about how policy is put into practice (McRobie *et al.* 2017) and ultimately the successes that may be registered in HIV prevention. In this paper, we follow a framework of synergy which looks at the relationship between society and state in fighting HIV/AIDS. We perceive that Uganda's success story can be explained by the general framework of synergy. The study uses secondary data on HIV/AIDS prevention in Uganda.

Synergy as a Framework for Service Provision

Evans (1996 and 1996a) conceptualises synergy as mutually reinforcing relationships between government and groups of engaged citizens. According to Evans (1996a), synergy may take the form of either complementarity or embeddedness. Under complementarity, the activities of civil society complement the activities of government. There is clear division of labour between the two realms. Each may act with relative autonomy in pursuing goals where there is mutual understanding. In Uganda, civil society organisations have for a long time worked independently yet with the knowledge of government about what they are doing in the service sector, especially in health and education. Non-governmental organisations (NGOs) pioneered the service and health support systems for HIV/AIDS patients. Embeddedness requires complex institutional settings to allow sustained relationships

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across the public-private divide. Countries such as Rwanda have developed HIV and AIDS programmes that have enabled them to achieve near-universal access to HIV prevention, care, and treatment. This is because it built a decentralised health sector system, as well as its public policies that permit complementary services from NGOs and government healthcare facilities (Riedel *et al.* 2018). Under embeddedness, the government provides not only inputs and a favourable environment that facilitates the development of private sector, but also co-opts members of civil society into government teams involved in the delivery of goods and services.

The involvement of the state is a strong environmental factor that facilitates the functioning of the public sector, private sector and civil society in service provision in general. Evans (1996a: 1120) argues that effective states create environments which strengthen and increase the efficiency of local institutions and organisations. Similarly, Muriisa (2009) argues that government can coordinate the relationships between the various actors involved in service provision such as those involved in HIV/AIDS-related activities. Both state and non-state actors must work in close partnership for efficient service delivery. Synergy exhibited by the state and civil society in fighting HIV/AIDS was particularly important for making HIV/AIDS visible and making communication and open discussion about HIV/AIDS possible in Uganda (Low-Beer & Stoneburner 2004a; 2004b; Muriisa 2009). How did it work? In the following account, we try to answer this question.

Initial Response to HIV/AIDS: The Role of Government in Uganda

At the heart of Uganda's HIV/AIDS response success story has always been a strong government commitment. At a time when many African governments such as Kenya and Zimbabwe were denying the existence of HIV/AIDS (Fredland 1998; Kayazze 2002), Uganda responded by taking an open stance to the epidemic and was among the first African countries to establish a national AIDS Control Programme (ACP) and the National Committee for the Prevention of AIDS (NCPA). In 2007, the STD/AIDS Control Programme developed a four-year Strategic Plan (2007-2010) with the primary goal of preventing further transmission of STIs and HIV infection and providing support for the mitigation of the impact of HIV/AIDS. HIV/AIDS was placed high on the agenda of the government development programmes, and HIV prevention was integrated in poverty eradication programmes early enough, compared to other African countries (Allen & Heald 2004; Oketcho, Kazibwe, & Were 2001; Okware, Opio, Musinguzi, & Waibale 2001). Uganda is the first country in the world to start a presidential initiative to end HIV/AIDS by 2030 (WHO 2018).

According to O'Manique (2004), the response by the government of Uganda in combating the AIDS pandemic, rather than denying its existence, remains unparalleled and unmatched on the African continent. According to the country UNAIDS Representative and the Executive Director of UNAIDS, Uganda has made tremendous progress in the fight against the scourge in a way that had made it a model country for effective response to any epidemic (Agaba 2018; WHO 2018). For Barnett and Whiteside (2002: 116), Uganda's openness about HIV/AIDS on the part of the president of the country enabled the country to succeed in the battle against HIV/AIDS.

With a president committed to responding to the HIV/AIDS challenge, Uganda created an environment that enabled and encouraged the HIV/AIDS prevention and mitigation activities by various individuals and groups – including HIV/AIDS NGOs, faith-based organisations, and private individuals such as herbalists. In addition, the government established agencies like the Uganda AIDS Commission and the National HIV/AID Partnership Forum and various committees such as the District AIDS Coordination Committees (DACCs) that would encourage interaction between different actors involved in fighting the HIV/AIDS epidemic, and between different actors and government agencies and departments.

Political Leadership

The importance of senior political leaders in promoting and sustaining the fight against HIV/AIDS cannot be ignored (Parkhurst and Lush 2004). The commitment of senior political leadership is crucial for the provision of resources necessary for fighting HIV/AIDS (World Bank 2000). To affirm their commitment, political leaders of the world at the 69th UN assembly signed a resolution

to end HIV by 2030 (Uganda AIDS Commission 2015). In Uganda, the fight was championed by the president when other African leaders were denying the existence of HIV/AIDS (Muriisa 2009, 2004). The president of Uganda launched "The Presidential Fast-track Initiative on ending HIV&AIDS in Uganda by 2030", which is the first such initiative in Africa and the entire world (WHO 2018). The initiative proposed five points, including: men's involvement in fighting HIV/AIDS to prevent new infections, acceleration of implementation of Test and Treat and attainment of 90-90-90 targets; consolidate progress on eliminating mother-to-child transmission of HIV; ensure financial sustainability for the HIV response; and ensuring institutional effectiveness for a well-coordinated multi-sectoral response for consideration for ending HIV/AIDS in Uganda (WHO 2018). It is this political commitment of the highest office that enabled Uganda's continuous fight against HIV/AIDS and partly explains the successes registered in HIV/AIDS mitigation.

The Role of Local Governments in Uganda

Uganda has a decentralised administrative structure in which districts are given autonomy in designing their own programmes. In combating HIV/AIDS, the decentralisation policy promotes coordinated partnerships between religious, political and educational institutions and NGOs, in planning and implementing programmes through a central coordinating body at the district level. Initially, the District AIDS Coordination Committee-DACC (UNDP 2002) and later the District AIDS Committee have over time assumed critical roles in responding to HIV/AIDS problem. The formation of these bodies facilitated the formation of a formal structure of communication through which politicians could interact with other actors and monitor programmes in their respective districts.

In Uganda, the decentralised framework allows the Uganda AIDS Commission (UAC) to link up with the politicians at local governments. Lam (1996) provides evidence that the involvement of officials who are part of society in the programme management process increases trust between government and citizens, and such trust leads to improved delivery and management of services and also results in positive reception for messages about HIV/AIDS in communities.

Community Response

The government in Uganda intrinsically has an enabling environment for association and participation (Oketcho *et al*. 2001:14). The participation and engagement of people working in various fields and at all levels is encouraged by the decentralised health reforms involving the creation of AIDS Coordination Committees (ACC) at various levels in the district. Beginning in 1992, the Uganda Aids Commission (UAC) established District Aids Coordination Committees (DACCs) in all districts of Uganda. Within each district, three levels of committees were established: the Sub-county Coordination Committees (SACCS), Parish AIDS Coordination Committees (PACCS) and Village Aids Control Committees (VACCS). The creation of such bodies was meant to facilitate the coordination of HIV/AIDS activities in the districts, but this structure was not fully implemented due to a lack of technical leadership and funding (UAC & NHACP 2002).

Without the above structure in place, the UAC allowed the Chief Administrative Officers (CAOs, also the Administrative Head of the District) to form District AIDS Committees (DACs) in their districts in 2001. The DACs were chaired by District HIV/AIDS Focal Persons appointed by the district CAOs to coordinate HIV/AIDS activities such as training, mobilisation and coordination of different stake holders and the implementation of new programmes such as the recently launched presidential initiative to end HIV/AIDS in Uganda by 2030.

Government Procurement of HIV/AIDS Medicine

The introduction of the Highly Active Antiretroviral Therapy (HAART) services in 1996 (Lucchini et al. 2003), brought hope to people affected by HIV/AIDS. However, the high cost of these services and monitoring tests, and lack of qualified personnel, meant that people living in developing countries did not have access to these services, especially the ARVs. In Uganda in 1998, the cost of treatment was US$1,000 per month or US$12,000 annually for brand drugs (Martinez-Jones & Anyama 2002). Considering that about 80% of Ugandans lived on less than US$1

a day (O'Manique 2004), HIV/AIDS treatment was a faraway dream.

Recognising this disparity of access, the United Nations (UN) organisations set out to negotiate a way of making these drugs accessible to people in developing countries. Thus making these drugs cheaper was the starting point. As a result, the UN organisations, governments and non-governmental organisations began negotiating with the major pharmaceutical companies producing ARV drugs for a reduction in their prices. The pharmaceutical companies negotiated with governments on a country-by-country and drug-by-drug basis. According to the Ministry of Health *Annual Health Sector Performance Report for the Financial Year 2000/2001*, continuous negotiation by government reduced the cost of HIV/AIDS drugs by 80-90% (MoH 2001:14). This is confirmed by the findings that between 1996 and 2001, the price of ARV drugs decreased to between 5% and 20% of their price in developed countries (Lucchini ***et al***. 2003).

As early as 1996, Uganda, unlike many other Sub-Saharan African countries, had started the importation of antiretroviral drugs. These drugs were imported and distributed to those who could afford them, through private and government hospitals under the supervision of qualified health personnel. The government commitment to making ARV drugs available to its citizens caught the attention of international AIDS bodies such as UNAIDS. Between 1998 and 2000, therefore, Uganda was one of the countries sponsored in a pilot project under the UNAIDS Drug Access Initiative (DAI) programme (Martinez-Jones and Anyama 2002) to access antiretroviral drugs for all. In order to increase access to the drugs, the government established an advisory board to oversee the implementation of the programme. In addition, a non-profit autonomous organisation, Medical Access Uganda Ltd, was established to import the ARVs and distribute them to pharmacies at subsidised prices. Lucchini and his co-authors (2003) note that in other countries such as Kenya and South Africa, there was no clear commitment of government to facilitate the delivery of ARV drugs, except for preventive use like in the case of prevention of mother-to-child transmission of HIV.

Apart from the DAI project, Uganda is one of the countries that has been active in developing a hybrid mechanism of drug procurement that combines the Accelerated Access Initiative (AAI) international framework with competitive tendering procedures vis-à-vis the generic producers (Lucchini et al. 2003: 190). In 2002, the UN signed an agreement with five pharmaceutical companies (Boehringer Ingelheim, Bristol-Myers Squibb, GlaxoSmithKline, Merck and Hoffman-la Roche) to provide ARVs to developing countries through the AAI. The aim of the programme was to rapidly increase access to ARVs in developing countries. To supplement this, UNAIDS offered technical training to various centres in Uganda in dispensing the ARV drugs. The biggest centre dispensing these drugs is the Joint Clinical Research Centre (JCRC), a non-profit organisation established by the Ministry of Defence, the Ministry of Health and Makerere University to carry out research in HIV/AIDS (Martinez-Jones and Anyama 2002).

Although Medical Access Uganda Ltd was given the exclusive rights to import ARV drugs in Uganda, this monopoly did not apply to the hybrid mechanism. By 2002, JCRC was dispensing generic drugs to patients in regional referral hospitals such as Mbarara regional referral hospital. Similarly, Médicins sans Frontiérs (SMF) was importing generic ARVs directly from pharmaceutical companies and is initiating a HAART project in Arua District of Northern Uganda. As a result of taking away the monopoly rights of provision of ARVs from Medical Access Uganda Ltd, and allowing other companies to provide these drugs, their prices declined significantly. Between September 2000 and February 2001, there was a sharp decline in the price of the eight major types of ARV drugs on the Ugandan market. There has been continuous drop in prices of drugs and the costs of HIV/AIDS treatment in general. By 2013, the Ministry of Health reported that the annual cost of first-line antiretroviral drugs was US$118–137 (McCreesh ***et al***. 2017), more than a 1000% reduction in price compared with the 1998 price.

The reduced prices made it possible for an increasing number of patients to access ARV drugs. Prior to the DAI programme, which ended in 2001, fewer than 400 patients had had access to ARV drugs. However, by the time the programme closed down, about

1,700 patients had received treatment in seven centres (Cains ***et al***. 2003:32). By 2016, 940,000 (67%) people living with HIV/AIDS were on treatment (UNAIDS 2017:43). How did this happen?

In 2003, the government negotiated with various organisations regarding the provision of ARVS in various districts and centres. In 2004, Uganda implemented the Presidential Emergency Plan for AIDS Relief (PEPFAR), which was President Bush's five-year plan to address the problem of AIDS in developing countries. The programme in Uganda focused on making ARV drugs available to patients free of charge in selected hospitals. About 2,700 HIV/AIDS patients received the drugs at 11 referral hospitals and 11 district hospitals throughout the country. This was a joint programme initiated by JCRC, the Ministry of Health (MoH) and the United States Agency for International Development (USAID), and is still being run by the MOH.

Apart from negotiations to access ARVS, the government has been involved in the procurement of condoms to be distributed through health units and NGOs. The Ministry of Health procured about 150 million condoms between 1997 and 2000 (Garbus & Marseille 2003: 90). In 2002, over 50 million condoms were distributed and the government projected that about 80 million would be distributed in 2003. In 2015 about 240 million condoms were procured. Condom use and behaviour change are among the reasons why HIV/AIDS intervention has been successful in Uganda (Low-Beer and Stoneburner 2004a to c). Condom use in 2016 stood at 60% and 45.5% for males and females respectively (UNAIDS 2017). It should be noted, however, that government recognition of the NGOs and other actors involved in condom distribution – "a multi-sectoral approach to condom education and distribution" (Ministry of Health Uganda 2016) – made this exercise successful.

It should be emphasised that the government relies on the health units (government hospitals and other government health establishments) for the implementation of various health programmes. However, these units are understaffed, lack essential drugs and very few people visit them because they lack the funds to enable them to access healthcare services (Garbus & Marseille 2003; O'Manique 2004; and TASO 2002). The lack of resources and facilities requires involving other actors in the delivery of services. In the following section, we discuss aspects of the role of NGOs in the fight against HIV/AIDS. The discussion focuses on the services of NGOs as autonomous service providers well recognised by government for their service.

The Role of Civil Society in Fighting HIV/AIDS in Uganda

In Uganda, there has been a peaceful co-existence of civil society and the government in the fight against HIV/AIDS. Civil society organisations work with people at the grassroots. The exclusion of such organisations from policy debates and/or the relief arena contributes to the failure of the government to transmit messages about HIV/AIDS to the people. Civil society involvement is a precondition for successfully combating an epidemic such as HIV/AIDS, which affects all social and economic forums. Civil society organisations have been instrumental in making society realise and accept the HIV/AIDS reality and cooperate in fighting HIV/AIDS. On the cooperation of society, Steven Friedman wrote:

> It is simply impossible for any government to fight Aids on its own: society must co-operate not only by changing attitudes and behaviours, but also in its willingness to support and help those who live with the virus or are orphaned by it. The key goal of political leadership in the three countries (Uganda, Thailand and Cuba) was to rally society around the battle against AIDS. The government needed to take the lead, but its task was to get everyone who could contribute to a solution to work together to achieve it. (Friedman 2000)

In Uganda, NGOs have been instrumental and pioneered the fight against HIV/AIDS. The relationship between NGOs and government has been harmonious. Policy proposals have always developed through a cooperative process, with no major opposition from either the government or civil society. For example, HIV/AIDS NGOs in Uganda were viewed as channels through which counselling and care, and HIV/AIDS messages on behavioural change, could reach the communities. The government of Uganda provided a stable environment in which

NGOs could evolve and coexist with the government in the fight against HIV/AIDS (Putzel 2004:27). This kind of cooperation made it possible to send the right messages to communities and people at the grassroots in Uganda.

NGOs and Fighting HIV/AIDS in Uganda: Complementarity in practice

The development of HIV/AIDS NGOs in Uganda followed a pattern that has a global outlook. HIV/AIDS organisations emerged as a distinct group as a result of a grassroots need. People infected with HIV and AIDS or affected by the diseases felt a pressing need to respond to the exclusionary practices society had adopted. This was also as a result of limited government support to fund HIV/AIDS activities. Uganda funds only about 5% of the HIV/AIDS programmes, with the rest coming from the donor community. According to O'Manique (2004:139), in 1992 "the public sector [in Uganda] contributed approximately $2 per capita per annum to health, the lowest in the region". HIV/AIDS appeared in Uganda at the time when Uganda was implementing the neoliberal policies of restructuring of the public sector with increasing privatisation of services, leaving many patients with no services at all, thereby making them fend for themselves. This came in the way of solidarity organisations through which care and support for one another could be accessed. It is out of these initiatives that the first ever HIV/AIDS NGO – The AIDS Support Organisation (TASO) was formed (Muriisa 2009).

TASO which started in a sitting room of one HIV/AIDS-infected person in collaboration with 15 other members. It is now a nationwide organisation, operating 11 service centres and mini-TASOs operating in partnership with missions and government hospitals (TASO 2018). TASO operates 22 outreach clinic sites in public health facilities, where clients receive a comprehensive package of care and support services. Through the outreach programme, TASO operates mobile health clinics, where clients receive medical services such as counselling, nutrition advice, and care and support.

The community outreach approach has increased the number of clients who have access to TASO services. Since its inception TASO reports that it has served 300,000 individuals and about 1,000,000 households, and supported about 300,000 orphans and vulnerable children with different services, including nutritional support, therapeutic support, and provision of scholastic materials and paying of school fees (TASO 2018). TASO is providing ARVs to over 50,000 clients across the 11 service centres in the country. On average, 75% of clients receive their ARVs through Community Drug Distribution Points (CDDPs). TASO makes sure that there is drug adherence through community and homecare visits. In addition, TASO ensures that there is limited duplication of services by closely linking with other service providers (TASO 2018).

Other than providing services to people infected with HIV/AIDS and their relatives, TASO paved the way for, or even facilitated, the founding of other service organisations: for example, Uganda National Association of AIDS organisations – UNASO (an umbrella organisation for organisations engaged in HIV/AIDS activities) – AIDS Information Centre (AIC), Positive Men's Union (POMU), and National Community for Women Living with HIV/AIDS in Uganda (NACWOLA). Through its community-based programme, TASO mobilises communities to create an environment conducive to HIV prevention and care and support for people living with HIV. Through homecare visits, TASO provides chemotherapy and aromatherapy to bedridden AIDS patients. TASO mobilised and trained over 6,000 volunteers for offering minimum community education on HIV prevention, care and support services (The AIDS Support Organisation – TASO 2018). In addition, the rapid HIV test, whose results are immediately available, enables TASO to "test and treat" clients immediately (WHO 2015). The counselling that precedes HIV testing and the post-test counselling put the client in position of acceptance of positive HIV status.

Multi-sectoral Approach-embeddedness and Complementarity

A multi-sectoral approach is one that goes beyond prevention to focus on all aspects of the epidemic, including treatment, policies and programmes to mitigate the impact of HIV/AIDS and developing policies that will change the societal factors that

influence long-term susceptibility and vulnerability to HIV/AIDS (Barnett & Whiteside 2002). The multi-sectoral approach combats AIDS on a number of fronts, involving various government ministries, and civil society organisations, such as local and international NGOs, the business sector and individuals. This remains a central government approach, and may explain Uganda's success in fighting HIV/AIDS.

As early as 1986, the Ugandan government set up the Sexually Transmitted Diseases/AIDS Control Programme (ACP) to fight HIV/AIDS through information dissemination, blood transfusions and epidemiological surveillance. The ACP was established under the Ministry of Health. By 1991 the HIV/AIDS programme was fully incorporated into six public ministries: Defence, Education, Information, Labour and Social Affairs, Local Government and Health (UNDP 2002)**.** The rationalisation of the HIV/AIDS programme in the public sector began in 1993 with the appointment of programme managers in various ministries, such as Education and Sports, Defence, Information, Labour and Social Affairs, Local Government, Gender and Community Development, Agriculture, Justice, Finance and Economic Planning, Internal Affairs (Police and Prisons) and Health (UNDP 2002). This approach was a forerunner, since, as mentioned earlier, other African countries were still denying the existence of the disease on the continent.

In 1992, the Uganda Aids Commission (UAC) was established under the Office of the President by the Parliamentary Statute No. 2 of 1992 to coordinate HIV/AIDS activities and to harmonise different stakeholders' initiatives in the fight against HIV/AIDS. The commission was appointed on a five-year tenure, which could be renewed or suspended, and its role was to coordinate the multi-sectoral response to HIV/AIDS. Owing to its work, the Uganda AIDS Commission has remained the main central coordinating body in the fight against HIV/AIDS in Uganda. By 2015, the commission had coordinated the HIV/AIDS fight and HIV/AIDS and had succeeded in reducing new infections among adults and children (Ministry of Health Uganda 2016). Of particular importance for this paper is the composition of representatives to the commission, who are drawn from religious organisations, different government ministries, other civil society organisations and the medical profession (UNDP 2002). This involvement of various categories of people increased the exchange of knowledge about HIV/AIDS, as well as participation and popular acceptance of government programmes. The UAC was intended to ensure harmonisation of intervention, to foster collaboration, to establish effective linkages between various agencies, and to facilitate the sharing of experiences (Oketcho *et al.* 2001:15).

In order to coordinate activities and effective programme implementation, the UAC developed a National Strategic Framework (NSF), the purpose of which is to relate the fight of HIV/AIDS to national development goals, and to facilitate and integrate the participation of all stakeholders in the planning and management of HIV/AIDS activities and bringing together all stakeholders under one umbrella and to guide them how to act with respect to priority setting (Oketcho et al. 2001). The UAC developed a National HIV/AIDS Strategic Plan, 2007–2011, whose aim was to provide for universal access services (UAC 2007). The 2011–2015 strategic plan pledged *a population free of HIV and its effects*. Both plans emphasised the continuity of the multi-sectoral approach as a mode of fighting HIV/AIDS in Uganda.

Within the multi-sectoral framework, HIV/AIDS activities were decentralised and embedded in the different ministries responsible for designing programmes for implementation. The 2018 guidelines for mainstreaming HIV and AIDS provide guidance on how all government ministries and agencies will mainstream HIV and AIDS into their programmes as a strategy for ending AIDS by 2030 (Uganda AIDS Commission 2018).

State-NGO Relations

Existing literature about the NGO-state relationship indicates that governments in many developing countries fear that the existence of NGOs may erode state political power and threaten national security (Hulme and Edwards 1997). Others such as Jamil (1998:10) suggest four distinct ways in which NGOs relate to government. Of particular interest to this paper is cooperation where NGOs relate to government through consultation and

collaboration. Consultation implies that the both NGOs and government advise each other on development issues, and collaboration implies partnership. This kind of relationship may be likened to the embeddedness and complementarity already discussed.

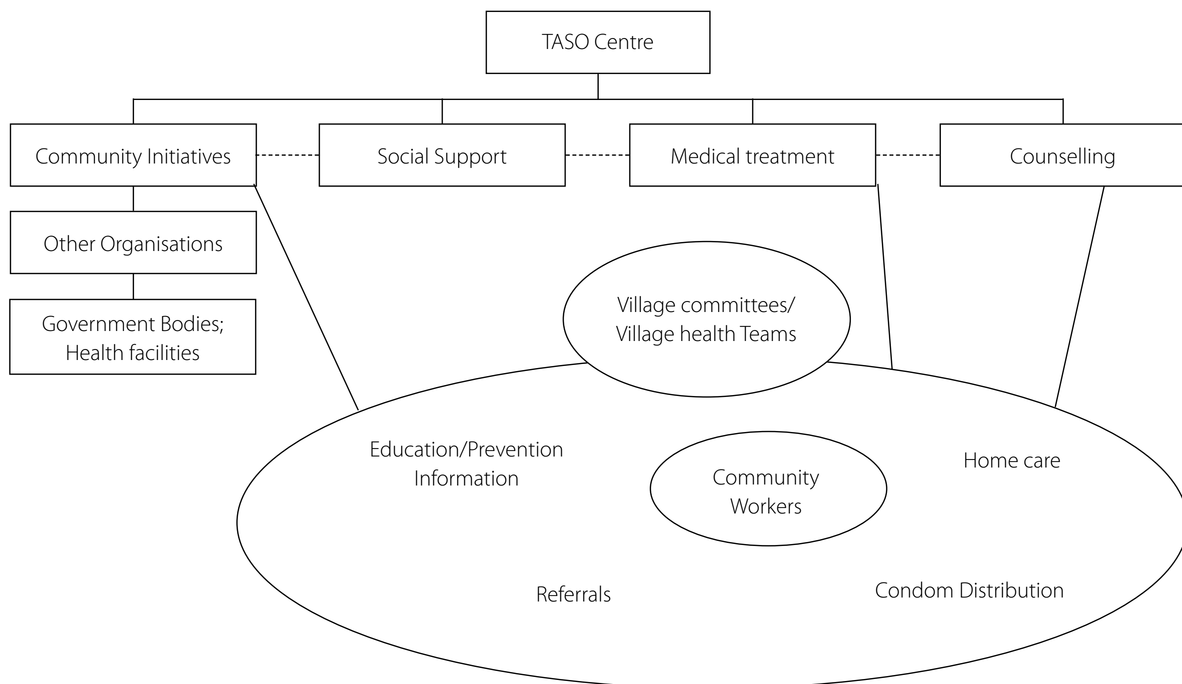
With respect to service organisations such as TASO, the government of Uganda, as already pointed out, set up partnerships and recognised their importance in development, and has therefore opted to allow their contributions in the mobilisation and delivery of services. In this model, complementarity and embeddedness may be observed. This is the government providing a favourable environment for the formation of HIV/AIDS NGOs and NGOs operating independent of government. Here, the role of NGOs such as TASO in fighting HIV/AIDS is well recognised. In other respects, government works directly with NGOs. For instance, NGOs work hand in hand with government on the same programme using existing government structures. It should be mentioned, however, that with regard to other forms of NGOs, especially those engaged in advocacy and human rights, conflict and confrontation characterise the form of relationship. However, as the main concern is with service organisations, issues regarding NGO advocacy will not be focused on. In this section, we explore how the NGOs relate to the government with respect to the HIV/AIDS problem.

The government of Uganda recognises the importance of partnership with NGOs in order to fight HIV/AIDS. There is widespread recognition that no single actor (individual, organisation or state) can successfully solve the HIV/AIDS problem without involving others (MoH, 2003; and TASO 2002). Recognising the potential of the state, NGOs have focused on developing synergistic relations rather than working in isolation. TASO (2002:5), for example, notes that political goodwill and support are vital for the success of HIV/AIDS service delivery. Muriisa (2009) found that the government of Uganda provides a favourable environment for the functioning of HIV/AIDS organisations. There is widespread recognition on the part of the HIV/AIDS organisations that they need interdependent relationships with the government. The nature of the state-NGO relationship is symbiotic and is enacted in a reciprocal way. In this respect, the NGOs have created linkages with the state at both administrative and operational levels.

At the administrative level, government and NGOs plan some of the HIV/AIDS activities together. For example, celebration of International AIDS Day activities are jointly planned and participated in by government and HIV/AIDS CSOs. We have already argued that NGOs plan together with government by involving representatives in various committees for programme implementation. The involvement of the people's representatives on government committees not only increases the legitimacy of the programmes, but also promotes a trusting relationship between government and citizens.

At the operational level, organisations sign memoranda with government authorities committing themselves to provide various services and use the available health facilities. Thus, TASO operates in health facilities owned by the government. As already indicated, many of TASO's outreach activities are done in government health facilities, which are also used as mobile clinics (Muriisa 2009). Health workers in government facilities also help in mobilising people to access health services offered by TASO. At the local level, TASO seeks the assistance of local leaders to mobilise the population for their drama presentations. In the following figure the above relationship is illustrated.

Figure 1: TASO-Initiated Community Participation in HIV/AIDS Activities



Adapted from: TASO and MOH (1995: 77)

The Relationship between Government and Faith-Based Organisations (FBOs) in Fighting HIV/AIDS in Uganda

Religious and faith-based organisations are one category of civil society organisations involved in the multi-sectoral strategy that plays an important role in mobilising communities for behaviour change. The focus of this section is on how the government recognised and facilitated the involvement of religion and religious leadership in fighting HIV/AIDS.

Uganda is a religious country and predominantly Christian. According to the 2014 national Census, Christians of all denominations made up 85.1 percent of Uganda's population, which comprise Catholics (39.3%), Anglicans (32%), Pentecostals (11.6%), Seventh Day Adventists, (1.7%), Baptists (0.3%), Orthodox (0.1%) and other Christians (1.4%) (UBOS 2016). The rest of the population are Muslims (13.7%), traditionalists and non-religious (0.1% and 0.2% respectively).

Faith-based organisations have been important for delivering HIV/AIDS messages and healthcare delivery in Uganda. The involvement of religious groups in the fight against HIV/AIDS strengthened the trust people had in government and its agencies. The legitimacy of discussing HIV/AIDS, which had been considered a sin-related disease, became successful with the involvement of religious groups. The involvement of top church leaders in the Uganda Aids Commission broke the myth about HIV/AIDS being considered as a disease affecting immoral people and transmitted through immoral behaviour.

The introduction of HIV/AIDS discussions into the religious gatherings and functions served, in the first instance, to legitimise and acknowledge the presence of the disease among the congregation and encourage acceptance of the problem. The inclusion of religious leaders as part of the team fighting HIV/AIDS was one way of overcoming the cultural and religious tendencies to view people with HIV/AIDS as immoral social deviants. This was part of the move to make a collective attack against HIV/AIDS.

In addition, since HIV/AIDS had been identified as a sexually transmitted disease, behavioural change was necessary to combat its spread. Open discussions about sex involved touching issues related to people's personal life, and religious beliefs. Involving religious institutions not only legitimised such discussions, but also limited opposition from religious leaders (Putzel 2004). Most public officials had hesitated to address issues related to sex and sexuality because of opposition from religious leaders and interest groups who regarded such issues as matters of individual behaviour and not for public discussion (Putzel 2003). It is important to note, however, that the Anglican Church did not openly support or criticise the use of condoms in HIV/AIDS prevention. Thus, the key messages embodied in the AIDS campaign slogan – Abstain, Be Faithful and use a Condom (ABC) – have been modified by the church: for example, "love carefully" has been replaced by "love faithfully". Such a substitution implies the recognition of the presence of HIV/AIDS amongst their congregation, which facilitates the discussion of HIV/AIDS and sex-related matters in the church.

Religious Fundamentalism and the AB Approach to Fighting HIV/AIDS

Fundamentalist movements have grown up in both the Anglican and the Catholic churches that are vehemently opposed to the use of the condoms in fighting HIV/AIDS. The fundamentalists focus on abstinence until marriage (AB) as the only acceptable approach. This approach has evolved particularly in the Charismatic and Pentecostal sects, and has government support. The programme targets the youth, who are brought together for prayer meetings. With the recent involvement of the first lady, the wife of the president (Mrs Janet Museveni), who called upon the youth to maintain their virginity until marriage, the AB strategy is still a catch word for the religious fundamentalists (Human Rights Watch (HRW) 2005).

It is not unusual to hear that religious groups are preaching about the dangers of failure to abstain from sex. The two moral principles (abstinence from sex until marriage and fidelity) constitute pillars of Christian morality. Nevertheless, the approach of religious fundamentalists to fighting HIV/AIDS needs a closer look and a critique.

In its religious teachings condemning sin, the fundamentalists criminalise all other programmes which have proved successful in Uganda and other parts of the world such as Thailand. For example, it condemns condom use, implying that this promotes immorality, exposes individuals to high risk of infection and therefore should be avoided. Thus, the programme fails to address both cultural and social issues that have led to the increased spread of HIV/AIDS. In addition, the approach individualises the problem of HIV/AIDS, and this may heighten blame and stigmatisation. It portrays HIV/AIDS as a self-inflicted punishment, and the acquisition of HIV/AIDS as a matter of personal choice. This approach is not visible only in Uganda, but is what dominated the United States of America's fight against AIDS in the 2000s. Hellen Epstein's work points out that Christians were opposed to the continued funding of HIV and AIDS programmes because they considered HIV to be self-inflicted by homosexuals and also believed that HIV was "God's judgement on promiscuity" (Epstein 2007, 186). As such, 1 billion of about 15 billion US dollars planned for HIV/AIDS activities was earmarked for HIV prevention programmes that encouraged sexual abstinence, and those that received funding were modelled on programmes that strictly promoted abstinence only until marriage (Epstein 2007). In Uganda, the approach dominated much of the fight against AIDS in the 2000s as well. Messages such as abstain and be faithful were emphasised and these have deeper implications, since those who acquire HIV are blamed for their failure to abstain and to be faithful. Ultimately, such an approach meant that those with HIV/AIDS would most likely be isolated and stigmatised, and lose their social identity. This remains a challenge to the efforts to fight HIV/AIDS. Indeed, Epstein (2007) points out that the evaluation of programmes that were founded on the abstain-only-until-marriage approach were found to have failed and were bound to fail if applied in Africa. The success of Uganda's programme was thus not based on abstinence only, but on a combination of other programmes, including the use of condoms (Epstein 2007) and the social approach of openness and the social support system that has long existed in the country (Muriisa 2009).

The use of condoms has been effective and, in combination with other approaches, condom use has contributed to the decline of HIV/AIDS prevalence. Deemphasising the use of the condom, as was the case with the abstain-only-until-marriage programme, is therefore likely to lead to more HIV/AIDS infections. The programme does not address the socio-economic factors that promote sexual vigilance. Poverty, gender and cultural practices, such as widow inheritance, which facilitate the spread of HIV, are ignored. Without addressing these problem areas, it is unlikely that women can negotiate relationships based on abstinence and faithfulness (Wilson 2004: 848). The narrow focus of religious fundamentalists, who vehemently opposes condom use (C), leads to the creation of stigmatised individuals. The Ugandan success story in fighting HIV/AIDS may be reversed by this life philosophy (Sekabira 2005). Already, the HIV situation in Uganda since 2005 has changed, and there has been a significant increase in the prevalence rates – up to 7.6% for females and 4.7% among males (Uganda 2017).

It is important to note that much as religious fundamentalism posed a challenge to the fight against HIV, this position has since shifted, as more open discussions about HIV/AIDS are now visible, although still inclined towards abstinence. There is less condemnation and more welcoming of people living with HIV and AIDS into the congregation. Moreover, there is increased recognition of what the churches and other religious groups are doing in the fight against HIV and AIDS, and they are part of the multi-sectoral approach promoted by Uganda. Instead, the increasing spread of the HIV virus is attributed to the abandonment of ABC (abstinence, be faithful and condom use) strategy. Other explanations for the increase may be the stability of lives and reduction in deaths due to increased access to ART and increased hope of life with the introduction of ART, being less fearful of the deadly HIV virus and AIDS, thus making young men and women change their sexual behaviour (Ninsiima 2012).

Conclusions

The purpose of this paper was to discuss synergy as a model of service delivery in fighting HIV/AIDS in Uganda. The underlying argument is that synergy provides a framework which explains the way Uganda has allowed independence and mutuality in fighting HIV/AIDS. Uganda provides not only an environment where HIV/AIDS is fought but also provides direct support to individuals and organisations fighting HIV/AIDS. The role of the government in providing political leadership, mobilising funding and establishing an enabling environment not only for the operation of NGOs but also for the participation of other actors, including individuals, in the fight against HIV/AIDS, was identified as important an contribution to the success registered in Uganda with regard to fighting HIV/AIDS. The discussion also revealed that the government has been instrumental in forming partnerships between itself and NGOs through the establishment of formal institutions of collaboration. These institutions enable NGOs such as TASO not only to engage with other actors, but also to work closely with government.

The discussions in this paper have shown that there are strong synergistic relationships between government and HIV/AIDS NGOs in the fight against HIV/AIDS. Embeddedness is observed at the organisational level, where inter-organisational communication and collaboration have been strengthened. Complementarity is observed in the form of coproduction as well as individual/independent HIV/AIDS programmes. The paper concludes that without synergy, the success of the fight against HIV/AIDS in Uganda could not be registered.

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