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Are service-delivery NGOs building state capacity in the global South? Experiences from HIV/AIDS programmes in rural Uganda

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1. Introduction

This paper investigates the role of service delivery NGOs (SD-NGOs) in building state capacity in the global South. Efforts geared to state building have recently received renewed attention, not only from the official development agencies, but also from academic and research institutions (Vom Hau 2012). Although this is a welcome development, SD-NGOs have largely been side-lined from serious analysis in this area, except for instances where they are reprimanded for replacing or encouraging the state to abdicate its responsibilities of providing for citizens (Collier 2000; Wood 1997). This neglect is surprising, especially because in the last 30 years SD-NGOs have been important development players in many Southern countries. It should be recalled that while the state witnessed increased marginalisation at the peak of neoliberalism (1980s-1990s), non-state providers, especially NGOs, entered the limelight as they were singled out by donors to be the favoured alternative in the provision of social services (Bratton 1989; Lewis and Kanji 2009) and consequently their numbers exploded throughout this period in most Southern countries (Brass 2010b; Mercer 1999; Therkildsen and Semboja 1995).

Admittedly the context of development has changed substantially since the mid-1990s. By the late 1990s and early 2000s, the neoliberal policies of the 1980s had given way to the new era of the post-Washington consensus, paying special attention to good governance and poverty reduction (Hickey 2008; Hulme 2008). To guarantee ownership of the poverty agenda, governments of poor countries are encouraged to work in collaboration with other societal actors (Batley and Rose 2011; Lange 2008; Lochoro et al. 2006). These developments have given way to what Fowler calls a consensual mode of development (Fowler 2000). As Batley and Mcloughlin (2010:134) state, 'the case for

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'partnership' is now widely promoted by donors and acknowledged, in principle, by governments and many NGOs'. However, scholarly opinion is sharply divided with regards to the implications of this for NGOs' progressive potential. Whereas NGOs have continued to access large-scale funding from official sources, sceptics feel that this has transformed them from functioning as incubators of alternative development ideas into 'partners' charged with delivering development programmes on behalf of states and donors (Banks and Hulme 2012; Bebbington et al. 2008). Yet, optimistic analysts have watered-down such criticisms by suggesting that even seemingly 'reformist modes of engagement' by development agencies can turn out to be genuine political tactics (Corbridge 2007:201). For instance, collaboration with government could actually allow NGOs to gain access and influence things from inside the state itself (Charlton and May 1995; Chhotray 2008; Lavalle et al. 2005).

This paper explores this debate within the context of an African country, Uganda. Uganda is an interesting case for investigating these issues because of the 'hybrid' character of the state (Tripp 2010). The country is often described as a typical neopatrimonial regime – that combines patrimonial logics and formal, albeit weak, modern bureaucratic features (Hickey 2013). There is an uneasy coexistence of democracy and autocracy (Tripp 2010). Unsurprisingly, Ugandan NGOs tend to opt for the 'non-political' development areas because the state is suspicious of advocacy activities and being outspoken triggers outright harassment and could risk the very survival of NGOs through deregistration (see Section 3). This paper, therefore, asks whether within such contexts service delivery by NGOs contributes to, or rather undermines, the processes of state capacity building. To answer this critical question, the paper draws on an in-depth research project undertaken by the author on a prominent Ugandan NGO called the AIDS Support Organisation (TASO). In particular, the study focused on the 'Mini-TASO Project' – a project where TASO worked with local governments in various rural districts to address the capacity of public health facilities around HIV/AIDS service delivery (see Section 4).

The rest of the paper is structured as follows: Section 2 reviews existing literature regarding the role of service delivery and NGOs in state building. This is to enable developing a conceptual framework to guide the empirical analysis. This section also describes and operationalises the dimensions of state capacity identified in the literature and which form the basis for analysing the impact of our case study NGO. Section 3 then provides a brief overview of the NGO sector in Uganda and its relations with the state. Section 4 describes TASO and its Mini-TASO project (MTP), and the

methodology employed. Sections 5-7 discuss in-depth the implications of the TASO project on state building along the dimensions of state capacity identified in the literature. Section 8 concludes.

2. Service delivery and state building

Understating the role of SD-NGOs in state building has to start with an examination of the role of service delivery *per se* in the state building process. Until recently, studies only made indirect reference to the relationship between service delivery and state building (Van de Walle and Scott 2011). However, since the mid-2000s there has been heightened interest in theorising and empirically investigating the feedback effects of service delivery (Batley et al. 2012). The central point of departure for studies here is the claim in Pierson (1993) that service delivery programmes are not just outcomes of political action, but that they themselves set political forces in motion. In particular, 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 the accountability of states, among others (Brinkerhoff et al. 2012; Devarajan and Widlund 2007; Van de Walle and Scott 2011; World Bank 2004). This section summarises the existing evidence here and pays special attention to the implications of NGOs delivery for the state building processes.

2.1 Service delivery and state bureaucracies

It is claimed that service delivery in sectors such as education and health is central to the development of the state's bureaucratic capacity (Evans 2011). For instance, some observe that the low emphasis placed by colonial governments on education services for the colonised natives is largely responsible for the weak development of modern state bureaucracies on the African continent (Chazan et al. 1999). Theda Skocpol, based on several analyses of American social policies, argues 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). At the local level many service delivery programmes involve collecting data on beneficiaries, their households and communities. Several scholars, following Scott's (1998) analysis, have variously argued that such information greatly enhance the bureaucratic capabilities of states to 'see' and plan for their citizens (Corbridge et al. 2005; Hurrell and MacAuslan 2012).

In what they call the 'recruitment effects' of development programmes, Corbridge and colleagues (2005) draw our attention to the ways through which the practices of those state agents at the frontline of service delivery are modified, mostly 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 in service delivery programmes, such as implementation autonomy and prompt feedback on performance, can attract high levels of commitment from street-level bureaucrats and form the basis for the emergence of capable bureaucracies in 'difficult settings' that are otherwise famous for being the 'world of rent-seeking' (Tendler 1997).

Although not explicitly stated as such, there are many documented case studies of SD-NGOs that work to improve state bureaucracies at different levels. For instance, drawing on her research on Samaj Pragati Sahyog (SPS) – a successful NGO in India, Vasudha Chhotray illustrates how it helped the district to operationalise existing minimum wage laws that had historically been dormant and improve land registrations. SPS also trained bureaucrats and elected political representatives and implemented several development programmes contracted to it by the local state (Chhotray 2008; Chhotray 2013). The effect was that hitherto inert and defunct state institutions, such as panchayats in the SPS operation area, became effective and pro-poor. In a seminal book edited by Edwards and Hulme (1992), *Making a Difference? NGOs and Development in a Changing World,* several contributors illustrate how innovations of NGOs from a range of sectors and country contexts had contributed to building state-capacity through scaling-up their activities within the state. In Kenya, Brass (2011) notes similar developments and concludes that since 2002 NGOs approaches have become institutionalized in the governing processes of public service provision.

Of course there are many challenges that can impinge on NGOs' collaboration with state officials. Batley's (2006) synthesis of six case studies points to the enduring mistrust and rivalry between NGOs and government officials. Besides, in some contexts, NGOs have been accused of undermining the bureaucratic capacity of some governments. It is reported that, at the peak of the neoliberal policy prescriptions in developing countries, entire sections of government ministries or districts were handed over to NGOs to run, especially in health or social services (Dicklitch 1998; O'Manique 2004). This greatly derailed the full development of the government's own bureaucratic capacity. Also some NGOs use huge salary packages to lure good staff from the civil service (Cannon 2000; Fritz and Menocal 2007).

2.2 Service delivery and the extension of the state's territorial reach

Drawing on the 19th century history of European state formation, Van de Walle and Scott (2011) observe that service delivery, potentially, impacts on state building through aiding the processes of state *penetrating* of both the centre and the periphery, *standardising* citizen's experience of the state, and *accommodating* alternative centres of power in society. The process of penetration is closely connected to the infrastructural power of the state, particularly as it relates to the spatial extension of state agencies and spread of services (Soifer and vom Hau 2008). The implementation of development projects in the countryside, Ferguson (1990) observes, usually has a 'side-effect' of attracting the state to such periphery areas to establish systems of effective control, such as police posts and local tax collection offices.

The mode of service provision – whether services are contracted out, co-produced or provided directly by government agencies – influences the effectiveness of state penetration. The dominant view is that government agencies should be in charge of service delivery (Eldon and Gunby 2009; Van de Walle and Scott 2011). According to Van de Walle and Scott (2011), public service structures like police posts, hospitals and schools are symbols which help states in the process of 'boundary-building' to differentiate themselves from other socio-political organisations. From this angle delivery through NGOs may undermine this process. However, there are cases where the infrastructural power of the state is 'grounded in the organizational entwining between state and non-state actors' (Soifer and vom Hau 2008:222). Skocpol's (1992) account of the growth of formal schooling in the United States, for example, shows that it was religious communities that built free public schools. Similar accounts are given relating to the development of public water systems in the Netherlands (Lintsen 2002). The work of missionaries in Africa, in spreading education and health services during the colonial and post-colonial eras, also provides a comparative perspective on how non-state actors can expand the territorial reach of the state (Doornbos 1990; Nabuguzi 1995). More recently, Brass (2010b) has claimed that, by situating their programmes in remote areas where the state is 'thin', NGOs are helping to 'broadcast' the power of the state across rural Kenya. All these examples suggest that voluntary agencies can act as a conduit to facilitate rapid spread of service delivery infrastructure into the periphery.

However, such findings have been challenged by observations that in some developing countries NGOs establish parallel structures alongside weak and under-funded government systems which greatly undermines/discourages governments' organisational development (Mohan 2002). In addition, NGOs tend to concentrate in areas that are accessible and/or served with modern

amenities – areas where the state is strong prior to NGOs' interventions – as opposed to the poor and underserved communities, where the state is absent (Dicklitch 1998; Jones 2009).

2.3 Building state–societal ties

Service delivery enhances the state's abilities to build links and coalitions with communities (Eldon et al. 2008). This is because service delivery structures can help in clarifying citizens' expectations of the state, and vice versa, and making these expectations more realistic and manageable, thereby strengthening the social contract around national issues, such as health and education (Cornwall et al. 2000; Eldon et al. 2008).

Additionally, it is claimed that since the efficacy of many service delivery programmes depends on the cooperation of, and coproduction with, the beneficiaries, state officials must devise strategies to enlist this. 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 1996a). 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 1996a:1121). Tendler reports 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 examples relating to improvement of living conditions for the urban poor in the global South.

NGOs have also been instrumental in promoting coproduction within many state agencies especially through spreading participatory approaches. In some countries this has been through establishing formal participatory spaces such as Brazilian Health Councils (Coelho 2007), Health Watch Committees (HWCs) in Bangladesh (Mahmud 2007) and a variety of decentralisation arrangements in other Southern countries. Besides teaching state officials, some NGOs have mobilised and trained citizens to occupy these spaces. However, whether these approaches have redefined state–society relations, is a matter of intense debate (Cooke and Kothari 2001; Hickey and Mohan 2004).

Extrapolating from the preceding analysis, and building upon Vom Hau's 2012 analysis, we argue that each of the four sets of impact discussed can usefully be conceived as representing a specific dimension of state capacity, namely, bureaucratic capacity, infrastructural/territorial reach, and embeddedness, respectively (see Table 1)[2]. Below we explain these dimensions in turn and provide a summary of the effects of NGO delivery on each dimension.

2.5 Dimensions of state capacity

2.5.1 Bureaucratic capacity

Bureaucratic capacity relates to the training, expertise and professionalism of government employees, which determines the ability of states to implement stated objectives (Evans and Rauch 1999; Vom Hau 2012). Among the main structural factors found to enhance the organisational performance of state bureaucracies are training, meritocratic recruitment, availability of standardised procedures and predictable careers (Evans and Rauch 1999; Henderson et al. 2007). Scholars also draw attention to the importance of an 'esprit de corps' – 'a sense of community, shared norms about proper and improper conduct, public esteem and the belief that civil servants are performing an invaluable task' (Vom Hau 2012:6) – in fostering discipline among civil servants. At the local level this could include mundane activities such as developing a customer care culture among frontline staff; and Corbridge et al. (2005) argue that this can be instigated by agencies external to the state.

2.5.2 Embeddedness

Another body of evidence posits that contrary to the general wisdom that state building must rely on formal institutional arrangements, high-capacity states can emerge out of relationships between state and non-state actors. Evans (1995) used the term 'embedded' autonomy to refer to the 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 requires 'much broader, much more 'bottom up' set of state-society ties' (2011:3) that connect the state to civil society. The concept of embeddedness is particularly useful in understanding state building in neo-patrimonial contexts like Uganda, where decisions are made more through deals than rules (Booth 2012). State embeddedness is also popular in relation to coproduction (Evans 1996b), which relates to 'the provision of public services through regular, long-term relationships between state agencies and organised groups of citizens, where both make substantial resource contributions' (Joshi and Moore 2004:10).

[2] 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 2012:4).

2.5.3 Infrastructural/territorial reach

By infrastructural capacity, the study 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 over the state's territory (Herbst 2000).

We can relate the above dimensions of state capacity with the earlier analysis on the role of service delivery in state building to conceptualise how NGOs impact on state capacity. We summarise this in Table 1.

Table 1: Service delivery, NGOs and state building

	Dimension of state capacity		
	Infrastructural capacity	**Bureaucratic capacity**	**Embeddedness**
Service delivery programmes	- Spread of structures, personnel and services across claimed territories	- Skills and professionalism of staff - Resources available for, and from, service delivery	- Dense state-society ties - Coproduction - Participation
Positive contribution by NGOs	- NGOs create structures awaiting state takeover - NGOs provide funding to poorly resources remote government offices - NGO broadcast state power	- Training and mentoring of government staff - Positive experiences from implementing collaborative projects	- Encourages coproduction - Community mobilisation - Supports citizen participation
Negative effects of NGOs	- Discourage government to establish own structures - Fragmented programmes and concentrated in accessible areas	-NGOs are inexperienced and too small to provide meaningful lessons to government -NGOs lure staff from government -Mutual mistrust	- NGO preference for autonomy rather than collaboration - Tokenistic participation

Source: the author

Overall, the discussion in this section makes an appealing claim that through service delivery activities NGOs can influence processes of state building. However, most of the alleged links are often flagged as questions to be explored empirically, rather than being strongly evidenced. Therefore, whether SD-NGOs have a positive or negative influence on state building remains a contentious issue. Our empirical evidence from Uganda is aimed at making a contribution towards settling this debate. Before we embark on this task, we first describe the Ugandan context within which NGOs operate, as well as our case study and research methods.

3. NGOs and the state in Uganda

NGOs represent one of the fastest growing sectors in Uganda but they enjoy an uneasy relationship with the state. In particular, those NGOs that play a 'watchdog' role on issues such as corruption, activities of the military and/or oil – issues that Ugandan authorities consider no-go-areas for civil society – are harassed to 'back off politics'.[3] The persistent ones have had their operating licences

[3] The New Vision: 'Back off politics, minister tells NGOs'. http://www.newvision.co.ug/news/631584-back-off-politics--minister-tells-ngos.html. Accessed 2 June 2012.

withdrawn: In 2012, Oxfam GB and the Uganda Land Alliance were warned that their operating licences would not be renewed because they had produced a critical report on state-orchestrated land grabbing in the country,[4] while the Advocates Coalition for Development and Environment (ACODE) was singled out by the President as promoting 'foreign interests' with regard to Uganda's nascent oil sector. These developments should not be surprising, given that the Ugandan state has both democratic and authoritarian features of which the latter is predominant (Tripp 2010).

However, as discussed further below, the state tolerates and sometimes encourages NGOs in the 'no-political' development areas probably because the state's ability to deliver public services, especially in the health, education and agriculture sectors is largely weak (Wild et al. 2012). This has historical roots, including the colonial experience and the destruction caused by the political upheavals that punctuated the first half of Uganda's post-colonial period (Bukenya 2012). However, since President Museveni's government captured state power in 1986, it has managed to stay longer than its predecessors because of a comparatively better approach to state–society relations underpinned by development policies such as decentralisation, poverty reduction programmes and the handling of HIV/AIDS. Since 1986 his government has focused on 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, received high priority, with Museveni himself spearheading the government's awareness campaigns, thereby giving the response the much needed 'political will' (Putzel 2004). When antiretrovirals (ARV) become available in the early 2000s the government, with the support of international donors, committed itself to scaling up antiretroviral therapy (ART) through its decentralised health system (Richey and Haakonsson 2004). Acknowledging its limitations in addressing the pandemic single-handedly, the state welcomed SD-NGOs and other non-state actors to operate as key stakeholders in this area (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.

4. TASO and the Mini-TASO Project: An empirical investigation

As already noted, this papers draws on the work of a Ugandan service delivery NGO called The AIDS Support Organisation (TASO). 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 2007:2). From a mutual group

[4] The New Vision: 'Uganda may eject Oxfam over land grab claims'. http://www.newvision.co.ug/news/630965-uganda-may-eject-oxfam-over-land-grab-claims.html. Accessed 12 May 2012.

comprising 16 volunteers whose initial aim was to provide emotional support and encouragement to members infected and affected by the HIV infection, TASO has grown into one of the largest HIV/AIDS service NGOs in Africa (Grebe and Nattrass 2009; TASO 2008). Its HIV/AIDS management approaches are widely regarded as models worth emulating globally (Danida 2007; Garbus and Marseille 2003; Museveni 2004).

TASO directly operates 11 service branches across Uganda. In addition to these, TASO had a project called the Mini-TASO Project (MTP), in which it created units which were operated indirectly through existing government hospitals. It is this MTP that is the focus of this paper.

Alongside the political context discussed above, understanding TASO's strategy towards the Ugandan state requires us to look at the circumstances surrounding its origin as an NGO. TASO was formed at a time when Uganda was 'at the height of ignorance about HIV infection and when hospitals were not very receptive to HIV-positive patients' (ACC/SCN 2001:14). During this time, the public treated people living with HIV (PLHIV) in Uganda as second class citizens and many considered them as social deviants, who were being 'punished by God' for their promiscuity (Monico et al. 2001). Some were ostracised and it is claimed that even public health workers stigmatised patients they suspected of having HIV/AIDS (Ssebbanja 2007). It was because ofsuch stigmatising care given to Christopher Kareeba, the husband of the founder of TASO, Noreen Kareeba, that she decided to form an HIV/AIDS support group in early 1987, which afterwards transformed itself into the NGO known as TASO (Ssebbanja 2007:5). Rather than confronting government to force it to improve services, TASO's initial activities focused on sensitising staff in public hospitals to change their attitudes, so that service delivery recognises the needs of PLHIV (ibid). After observing that such an ad hoc approach was having less impact, TASO sought to develop a systematic programme through which 'to provide more support to government hospitals to run dedicated HIV/AIDS clinics and share our skills in diagnosis and management of common opportunistic infections' (TASO 2002:28). The resultant project came to be known as the Mini-TASO Project (MTP).

A Mini-TASO is a government health facility (typically a district hospital) whose 'capacity is built by TASO to offer comprehensive quality HIV services to its catchment population' (TASO 200:2). The project focused on enabling TASO, a highly regarded NGO, to support government health-workers and hospitals through various training programmes, providing financial resources of approximately 50 million Uganda Shillings (henceforth UGX). annually, and empowering citizens to engage in coproduction activities with service providers. The official start of MTP is 2003 and the project ended

in 2010. In each of its eight years of existence, TASO would initiate partnerships with two to four selected districts to transform their main hospitals into Mini-TASOs.

Mini-TASOs that were five years or more were selected for this research. Five years is a long enough period for impact to occur (Mcloughlin and Batley, 2012). Our methodology emphasised depth over breadth: hence two Mini-TASOs of Kamuli and Masafu (out of the 13 eligible) were identified for detailed investigation, while a non-MTP hospital of Iganga was picked to provide a comparative view point. This also means that our findings are only applicable to the specific study sites and therefore not meant to be generalised.Fieldwork was done between November 2010 and July 2011 and data collection consisted of qualitative and quantitative methods. The former involved interviews (with PLHIV, health workers, district leaders, TASO staff and other key informants), review of documents and observation of service provision. The latter was a small-scale survey of service users of public health facilities (i.e. PLHIV) from the three districts of Kamuli, Masafu-Busia and Iganga. Apart from comparing Mini-TASOs with a control site, Iganga, the study included a temporal element (retrospective questions) in both the small-scale survey and in-depth interviews. The control and temporal element helped in ascertaining the extent to which observed changes were attributable to the intervention. In particular, the temporal element helped in reconstructing the situation before TASO's intervention in the study sites, as explained below, to create what De Vaus (2001:61) calls a 'pseudo *before* measure'.

What follows is an examination of the extent to which the project impacted on state capacity to deliver health services. It does this by investigating the impact of MTP on the dimensions of state capacity explored in the earlier sections of this paper – namely, bureaucratic capacity, embeddedness and infrastructural power.

5 Mini-TASOs and the bureaucratic capacity of the state

This subsection identifies and assesses the impact of MTP activities on the bureaucratic capacity of targeted local governments to deliver HIV/AIDS and health services generally.

5.1 Bureaucratic capacity for delivering HIV/AIDS services

There was consensus among respondents in this study that the project enabled targeted local governments to increase access to HIV/AIDS services. The claim was that TASO, through the Mini-TASO project, enhanced the ability of targeted facilities to deliver HIV/AIDS services. Table 2 summarises the main outputs from Mini-TASOs in the study sites. Overall, during the project period,

the number of PLHIV receiving treatment in Kamuli increased from 334 in 2005 to 4152 at the end of 2010. In the same period, PLHIV in Masafu-Busia increased from 256 to 2113. This translates into an annual percentage increase in PLHIV enrolment of 71% and 53% for Kamuli and Masafu-Busia, respectively.[5]

Additionally, because of TASO's intervention, public hospitals were providing a more diversified package of HIV/AIDS services, combining prevention, care and treatment strategies (see Table 2), which experts recommend for effective programmes (TASO 2007; UAC 2007; WHO 2009). In contrast, several key informants noted that the situation in Iganga mirrored that in most non-MTP hospitals, where the conventional doctor–patient dyad and highly technicist modes of medical practice rule. Most 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 wellbeing (Prince 2012; Robins 2006). As discussed throughout this paper, the performance of Mini-TASOs can be attributed to the fact that bio-medical approaches were accompanied by social mobilisation, outreach and psychosocial activities, even though some of these were not sustained after project funding. The proceeding subsections trace specific project interventions that could have facilitated this performance.

Table 2: HIV/AIDS service-related outputs in the study sites

	2005[a]	**2006**	**2007**	**2008**	**2009**	**2010**
PLHIV adults in care (cumulative)						
Kamuli	334	830	1443	2502	3412	4152
Masafu-Busia	256	400	732	1093	1506	2113
Iganga [b]					2726	2704
Children (1-14 years) in general care (cumulative)						
Kamuli	6	28	83	167	235	321
Masafu-Busia	8	33	45	97	163	206
Iganga					63	78
PLHIV served in outreaches [c] **(annual)**						
Kamuli		621	771	842	1121	652
Masafu-Busia		100	257	216	356	244
Iganga						

[5] Besides dispensing of drugs to PLHIV, however, most of the other HIV/AIDS-related activities here were introduced with MTP and therefore had no baseline with which to be compared.

MDD community awareness (annual)						
Kamuli		1342	5440	7358	8806	1987
Masafu-Busia		858	2035	2961	3203	663
Iganga						
Counselling sessions (annual)						
Kamuli		2766	5274	6340	7406	6876
Masafu-Busia		1395	2766	2220	3900	2279
Iganga [d]						

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

Notes

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

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

[c]Outreaches are mobile clinics organised by hospitals to reach patients in distant communities.

[d]Iganga hospital health workers claimed that they give counselling to their PLHIV clients. However, because this aspect is not catered for by the Ministry of Health reporting system, they do not keep records about it. This is also the reason why Kamuli and Masafu-Busia did not document it prior to 2005.

5.2 Mini-TASOs and availability of medical supplies in public facilities

This subsection looks at MTP's attempt to address the challenge of unreliable supply of essential drugs in the targeted facilities, which is one of the main barriers to health care access in Uganda (Ministry of Health 2008). In all Mini-TASOs, PLHIV and health workers explained that the erratic supply of medicines, especially the prophylactic drug Cotrimoxazole (Septrin), was a major challenge prior to TASO's intervention. Through the annual UGX 50 million 'seed grant' to Mini-TASOs, there was an allocation of around 20% of the total budget reserved for purchasing such drugs.[6]Health workers reported that, prior to TASO's intervention, they would advise patients to buy medicines from private providers and this had far-reaching implications for state building. Some respondents argued that telling clients to buy from private providers encouraged them to stay away from what they considered to be irrelevant public facilities.[7] This finding is corroborated by Nazerali and

[6] Interview with male TASO HQ official, 28 January 2011.
[7] Interview with health workers' Focus Group Discussion, 24 January 2011.

colleagues (2006), who observe that, in Uganda, hospital attendance is greatly determined by the availability of drugs. Thus, the reliable provision of drugs is also central to citizens' expectations of 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 (OECD 2012; Ssengooba et al. 2007). Indeed, one respondent in Iganga hospital associated the stock out of drugs in the hospitalto 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!'[8] Therefore, by providing a budget allocation for drugs, TASO was able to restore the confidence of service users in state facilities (see Table 3).

According to Table 3, whereas 84% of PLHIV 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 was only fair in their facility, with marginal changes occurring over a five-year period.

Table 3: Clients' perception of drug availability

Facility		**Drug availability**		
		Poor	Fair	Good
Kamuli (n=61)	Pre-MTP	83.6%	14.8%	1.6%
	Current	4.9%	9.8%	85.2%
Masafu (n=71)	Pre-MTP	83.1%	15.5%	1.4%
	Current	4.2%	38.0%	57.7%
Iganga (n=46)	Five years ago	19.6%	60.9%	19.6%
	Current	17.4%	67.4%	15.2%

Note: Current denotes the time of fieldwork.

It is important to note, however, that drug supplies were not sustained beyond the project's lifetime. Soon after MTP had wound up, clients and health workers stated that their hospitals were re-experiencing drug stock-outs. One service user had this to say:

[8] Interview with male PLHIV, Iganga, July 2011.

> My problem, as I have already told you, is the absence of some drugs. There is no consistency in the availability of drugs. Take for example the previous three months: we did not have any Septrin. When TASO was still here it would give us money for a buffer stock.[9]

Table 3 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 paper, namely, several of the strategies the project promoted had a short-term orientation.

5.3 Human resources management

As far as human resources are concerned, the study finds that Mini-TASOs addressed two closely connected challenges in government hospitals, namely, staffing shortages and inadequate skills among existing staff.

5.3.1 Training of government health workers

Most of the health staff in government facilities that TASO selected for the project lacked the technical skills, such as antiretroviral therapy (ART) administration, and the psychosocial skills, including proper communication with patients, required to manage HIV/AIDS (Bukenya 2012). Drawing on its experience as the pioneer HIV/AIDS psychosocial NGO in Uganda, TASO sought to address these through its home-grown training programmes. Apart from giving health workers technical knowledge, this training was meant to change attitudes, especially the stigmatising tendencies among government staff observed earlier.[10] As illustrated below, to TASO, effective HIV/AIDS management calls for building relationships of trust between service providers and their clients.[11]

In both Kamuli and Masafu-Busia, most health workers who attended TASO trainings attested that their attitudes towards PLHIV and HIV/AIDS work changed for the better. As exemplified by some of the responses below, government staff started 'seeing' their clients as NGOs did:

> 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.

[9] Interview with male PLHIV, Masafu-Busia, 11 April 2011.
[10] In particular, participants in the health workers' FGD (held on 24 January 2011) invariably referred to TASO's training programmes as very inspirational.
[11] Interview with male former TASO HQ official, 6 May 2011.

> 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.[12]

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 PLHIV but we would just under look them. [However] after the training by TASO we were able to change our attitudes towards PLHIV and [started] handling them in a better way… This actually improved our relationship with the PLHIV.[13]

For service users, whereas 82% and 80% of them in Kamuli and Masafu-Busia described the responsiveness of staff in the pre-MTP era as poor, many claimed that MTP reversed this situation, with 90% and 96% reporting it to be good, at the time of fieldwork, in Kamuli and Masafu-Busia, respectively. Thus, as Corbridge et al. (2005) would predict, TASO, an external agency helped government staff to acquire an organisational culture that is more closely associated with NGOs, regarding PLHIV as citizens who deserved humane treatment.

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 Mini-TASOs. 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 than with serving 'in order to satisfy the client'.[14] Another respondent noted that 'the problem here is that one counsellor could be responsible for about 100 clients, which means that they can't effectively offer quality care'.[15] A related challenge 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'.[16] 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

[12] Interview with male health worker, Masafu-Busia MTP, 22 December 2010.
[13] Interview with female health worker, Kamuli hospital, 21 March 2011.
[14] Interview with female PLHIV, Kamuli, 21 March 2011.
[15] Interview with male PLHIV, Kamuli, 1 February 2011.
[16] Interview with female TASO Central Region official, 6 December 2010.

active service at the hospital.[17] 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 government Medical Officers received an annual salary of $3,500, compared with $1,750 for Registered Nurses (African Health Workforce Observatory 2009:45).

5.3.2 The 'motivation' of government health workers

The study observed that the introduction of Mini-TASOs increased the workload of the already stretched staff in public hospitals. Health workers had to combine HIV/AIDS activities with attending to patients in the outpatient department and/or doing ward rounds. Moreover, as explained later, MTP introduced 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.[18]

Thus, within the annual budget to Mini-TASOs, there was an allocation of UGX 5,000 per workday (roughly $2.5) to motivate[19] health workers who picked extra work. To the poorly paid health workers, such allowances were a huge incentive – for example, in a month some would collect an additional 15% equivalent of the nurse's salary. Hence, as one respondent noted, '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'.[20]

Incentivising health workers, however, had some drawbacks. For example, patients claimed that motivating health workers in the AIDS clinic distracted their attention from citizens with other non-AIDS ailments. However, this claim was denied by some health worker respondents who argued that they first attended to patients in the outpatient department and/or used their '*offs*'[21] to serve at the

[17] Interview with female health worker, Kamuli hospital, 14 January 2011.
[18] Interview with female TASO Central Region official, 7 March 2011.
[19] Health workers often referred to allowances from TASO as their 'motivation' for doing extra work.
[20] Interview with male health worker, Masafu-Busia, 22 December 2010.
[21] Being 'off' is slang used to refer to days/hours when a health worker is supposed to be off-duty, having completed his/her shift.

HIV/AIDS department.[22]Moreover, the motivation depended on TASO's funding. It is reported that when this funding stopped, activities of MTP, 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'.[23]

The introduction of allowances had other negative implications for state capacity. Some analysts argue that 'quick returns' in the 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, such incentives are difficult to sustain. 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 TASO withdrew, the clinic almost collapsed. Otherwise everything else was positive.[24]

This is in agreement with observations made in Section 2 on the short-term and unsustainable nature of NGO programmes.

5.4 The creation of HIV/AIDS departments

As noted above, all hospitals targeted by MTP lacked a dedicated office space for activities like counselling, which is a crucial aspect of bureaucratic capacity required for effective HIV/AIDS service delivery. Both patients and health workers concurred that this state of affairs negatively affected people living with HIV (PLHIV). 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 …'.[25] The lack of office space also perpetuated the practice of focusing on dispensing drugs, thereby leaving patients' psychosocial needs unattended.[26] In an apparent attempt to enlist the attention of the state to PLHIV, therefore, TASO funded or pressed local governments to create separate HIV/AIDS departments in all hospitals that implemented MTP.

[22] Interview with male health worker, Kaberamaido MTP, 18 May 2011.
[23] Interview with male health worker, Masafu-Busia hospital, 24 January 2011.
[24] Interview with male health worker, 1 March 2011.
[25] Interview with male staff, Kamuli, 2 March 2011.
[26] Interview with female health staff, Masafu hospital, 27 December 2010.

Departmentalisation implies that PLHIV were made a separate category of patients, distinct from those suffering from other ailments, such as malaria and measles. 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'. [27] Following Corbridge and colleagues (2005), this can be interpreted in terms of helping PLHIV citizens to become more visible to the state; and with this clearer 'view' the state started providing services that corresponded to their needs. Some patients claimed that creating a separate department helped to push HIV as a priority in their hospitals.[28]

The state's visual capabilities were improved further when TASO handled issues of records management in Mini-TASOs. It introduced several data forms to help health workers to collect information on PLHIV, trained records clerks, funded the establishment of records storage facilities, such as computers, filing cabinets, and supplied clients' files. These apparently technocratic interventions had visible impacts, because, as already noted, MTP sites kept far more data on their service delivery activities compared to Iganga hospital, where the project was not implemented (see Section 5.1). Moreover, the effects of some of these interventions also spilled into improvements in other dimensions of state capacity, such as infrastructural power (discussed in Section 7). In Kamuli, for instance, when data showed that MTP was serving fewer children compared to adults, health workers started to make home visits, which increased the visibility of child citizens:

> 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.[29]

This could explain why Kamuli had more children on care compared to other sites (see Table 1).

Nonetheless, turning HIV/AIDS clinics into separate departments or causing PLHIV to be regarded as a 'special' category of citizens was to some extent disadvantageous. For instance, it was reported that there was a section of PLHIV who were better served when HIV/AIDS services were integrated in outpatient department, because they did not want to be openly identified by members of the public as AIDS suffers. Therefore, as Scott (1998) would argue, enhanced visual powers of the state came at the expense of citizens losing their privacy. Yet, specialized services for PLHIV obviously led to quality services and conveyed state efficiency.

[27] Male respondent, 1 January 2011.
[28] Interview with male PLHIV Kamuli, 10 February 2011.
[29] Interview with female health worker, Kamuli hospital, 14 January 2011.

6. Mini-TASOs and the external embeddedness of the state

As observed in Sections 2, one of the established positions in the literature on state building is that high-capacity states emerge out of bureaucratic reliance on formal and/or informal relations with actors in civil society. This study observed that the specific avenue through which MTP activities influenced ties between the state and civil society was coproduction.

6.1 PLHIV as service co-producers with government

The study established that before the implementation of MTP, involvement of service users in activities of government hospitals was generally minimal, as even co-financing of services through user fees had been abolished in 2001 (Ssewankambo et al. 2008). However, avenues to enlist direct engagement of PLHIV 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 sought to promote some of these aspects in government hospitals. For instance, for each MTP, TASO facilitated the formation of one MDD group (with 15-20 PLHIV) and it trained a similar number 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.

As Campbell and Cornish (2010) note, a major role played by peers is their ability to reach socially marginalised 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 were also a conduit through which many villagers started accessing medical services from the state. By helping the government agents to reach deep into the villages where they had no previous contact, it can also be argued that co-producing with PLHIV facilitated state penetration.

However, some scholars have pointed to the adverse forms of coproduction, which serve to promote the neoliberal agenda of slimming public expenditure (Mattson 1986; Mitlin 2008). There is a fear that involving PLHIV in service delivery may compromise service quality and might discourage

hospital administrators from bringing in more qualified health workers. Interviews with senior officials in the different Mini-TASOs showed that some had become comfortable with using PLHIV as a substitute for technical staff to provide services.[30]

Generally, several respondents talked of progressive improvements in their relations with health workers in particular and the respective health facilities in general. One of the PLHIV 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 PLHIV 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.[31]

Respondents' evaluation of health workers and the quality of services was further measured through their 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). Whereas over 96% of respondents in Kamuli and 73% in Masafu-Busia expressed willingness to pay, in Iganga only 32% reported the same. Therefore, if we take willingness to pay as a proxy 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 observations, impact appears to be greater where the project was fully implemented, for example in Kamuli, where PLHIV were already contributing some user fees, respondents were more willing to pay compared to Masafu-Busia.

7. Mini-TASOs and the state's infrastructural power

The architects of MTP had great concerns about the limited spatial spread of HIV/AIDS services in rural Uganda. In particular, they were aware that the then Government of Uganda plan for health sector infrastructure improvement, through the health sub-district structure, was largely ineffective. This was attributed to constraints in rural facilities, such as limited resources, staffing and inadequate skills for service delivery, which were 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

[30] Interview with male health worker, Kaberamaido MTP, 18 May 2011.
[31] Interview with male PLHIV leader, Kamuli hospital, 21 March 2011.

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. Kamuli had two outreaches in Kidera and Bugaya sub-counties, Masafu-Busia had one in Lunyo sub-county, while Iganga hospital did not operate outreaches at all.

However, outreach results from our investigations were rather disappointing. The study established that, rather than being focal points for building the capacity of lower health facilities, outreaches were merely points where PLHIV 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), they could not work collaboratively with the health workers from Masafu-Busia MTP during outreach. According to one of the staff in Mbehenyi, 'they would serve their PLHIV and we would also concentrate on our malaria and the usual outpatient department'.[32] This suggests that no mentoring or sharing of ideas was taking place as TASO officials might have wanted. In fact, by the time MTP 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 the Mini-TASO project failed to improve the capacity of rural health facilities through outreaches, this does not mean that PLHIV in remote communities missed out on accessing services. On the contrary, and as summarised above in Table 2, 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 access services directly from the faraway Mini-TASOs.[33] 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 PLHIV and the latter 230 PLHIV (see figures in Table 2). 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 PLHIV contributions from user fees.

[32] Interview with female health worker, Mbehenyi HC II, 20 April 2011.
[33] Various interviews, with clients in Mbehenyi, Masafu Busia, 20 April 2011; with male health worker, Masafu-Busia hospital, 24 January 2011; and with male TASO Northern Region Official, 16 May 2011.

8.Conclusion and way forward

What is emerging from the foregoing analysis is that MTP's record in building the capacity of the local state for HIV/AIDS service delivery had varied impacts across both the different research sites and dimensions of state capacity. In the targeted health facilities, 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 PLHIV citizens to become more visible 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 public hospitals to 'see the poor as citizens'. However, the achievements were temporary – happening as long as the MTP project was running. In addition, because of its time and budget constraints the project did not find a lasting solution to problems of inadequate staffing and 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 PLHIV, as more people gained access to life-saving services and patient–service provider relationships improved.

The experience of MTP shows that NGOs can help the state to build avenues for engaging constructively with society. NGOs can teach government staff, such as health workers, how to mobilise their clients; encourage them to participate in service delivery; and how to invite them into decision-making spaces like staff meetings. Therefore, if only sustained for the long term, Mini-TASOs and similar programmes in which NGOs collaborate with the state in delivering services can usefully be seen as theatres of politics, where 'the development of state capacity and legitimacy' play out (Batley et al. 2012:131).

References

ACC/SCN 2001. Nutrition and HIV/AIDS *Nutrition Policy Paper no.20.* Geneva: ACC/SCN

African Health Workforce Observatory 2009. Human Resources for Health Country Profile Uganda Geneva: WHO.

Banks, N. & Hulme, D. 2012. The role of NGOs and civil society in development and poverty reduction. *BWPI Working Paper 171.* Manchester: Brooks World Poverty Institute.

Batley, R. 2006. Engaged or divorced? Cross-service findings on government relations with non-state service-providers. *Public administration and development,* 26**,** 241-251.

_____. 2011. Structures and strategies in relationships between non-government service providers and governments. *Public Administration and Development,* 31**,** 306-319.

Batley, R., McCourt, W. & McLoughlin, C. 2012. Editorial: The Politics and Governance of Public Services in Developing Countries. *Public Management Review,* 14**,** 131-144.

Batley, R. & Mcloughlin, C. 2010. Engagement with Non-State Service Providers in Fragile States: Reconciling State-Building and Service Delivery. *Development Policy Review,* 28**,** 131-154.

Batley, R. & Rose, P. 2011. Analysing collaboration between non-governmental service providers and governments. *Public Administration and Development,* 31**,** 230-239.

Bebbington, A. J., Hickey, S. & Mitlin, D. C. (eds.) 2008. *Can NGOs make a difference? The challenge of development alternatives,* London: Zed Books.

Booth, D. 2012. Development as a collective action problem: Addressing the real challenges of African governance. *Synthesis report of the Africa Power and Politics Programme.* London: Africa power and politics.

Brass, J.N 2011. Blurring Boundaries: The Integration of NGOs into Governance in Kenya. *Governance***,** 209–235.

Brass, J. N. 2010a. NGOs in Kenya: Increase State Legitimacy or Undermine Popular Support? *SSRN eLibrary*.

Brass, J. N. 2010b. *Surrogates for Government? NGOs and the State in Kenya.* PhD Political Science, University of California.

Bratton, M. 1989. The politics of Government-NGO Relations in Africa. *World Development,* 17**,** 569-587.

Brinkerhoff, D. W., Wetterberg, A. & Dunn, S. 2012. Service Delivery and Legitimacy in Fragile and Conflict-Affected States. *Public Management Review,* 14**,** 273-293.

Bukenya, B. 2012. *Can NGOs Build States and Citizenship through Service Delivery? Evidence from HIV/AIDS Programmes in Rural Uganda.* PhD Development Policy and Management, The University of Manchester.

Cammett, M. & MacLean, L. 2011. Introduction: the Political Consequences of Non-state Social Welfare in the Global South. *Studies in Comparative International Development (SCID),* 46**,** 1-21.

Campbell, C. & Cornish, F. 2010. Towards a 'fourth generation' of approaches to HIV/AIDS management: creating contexts for effective community mobilisation. *AIDS Care,* 22**,** 1569-1579.

Cannon, C. 2000. NGOs and the state: a case study from Uganda. *In:* PEARCE, J. (ed.) *Development, NGOs, and Civil Society.* London: Oxfam GB.

Charlton, R. & May, R. 1995. NGOs, politics, projects and probity: a policy implementation perspective. *Third World Quarterly,* 16**,** 237 - 256.

Chazan, N., Lewis, P., Mortimer, R. A., Rothchild, D. & Stedman, S. J. 1999. *Politics and Society in Contemporary Africa,* Colorado, Lynne Rienner Publishers.

Chhotray, V. 2008. Political entrepreneurs or development agents: An NGO's tale of resistance and acquiescence in Madhya Pradesh, India. *In:* BEBBINGTON, A. J., HICKEY, S. & MITLIN, D. C. (eds.) *Can NGOs make a difference? The challenge of development alternatives.* London: Zed Books.

_____. 2013. How Samaj Pragati Sahyog Works the State and Why it Succeeds. *In:* NARAYANAN, N. C., PARASURAMAN, S. & ARIYABANDU, R. (eds.) *Civil Society in Water Governance in South Asia.* New Delhi: Sage Publications.

Coelho, V. S. P. 2007. Brazilian Health Councils: Including the Excluded? . *In:* CORNWALL, A. & COELHO, V. S. P. (eds.) *Spaces for Change? The Politics of Participation in New Democratic Arenas.* London: Zed Books Ltd.

Collier, C. 2000. NGOs, the poor, and local government. *In:* PEARCE, J. (ed.) *Development, NGOs, and civil society.* Oxford: Oxfam.

Cooke, B. & Kothari, U. (eds.) 2001. *Participation: The new tyranny?,* London: Zed Books.

Corbridge, S. 2007. The (im)possibility of development studies. *Economy and Society,* 36**,** 179 - 211.

Corbridge, S., Williams, G., Srivastava, M. & Veron, R. 2005. *Seeing the state: Governance and Governmentality in India,* Cambridge, Cambridge University press.

Cornwall, A., Lucas, H. & Pasteur, K. 2000. Introduction: Accountability through Participation: Developing Workable Partnership Models in the Health Sector. *IDS Bulletin,* 31**,** 1-13.

Danida 2007. Strengthening Uganda's response to HIV/AIDS. Programme document HIV/AIDS support 2007-2010. *104.Uganda.78.* Copenhagen: Danish International Development Agency (Danida), Ministry of Foreign Affairs.

De Vaus, D. 2001. *Research Design in Social Research,* London, Sage.

Devarajan, S. & Widlund, I. (eds.) 2007. *The Politics of Service Delivery in Democracies. Better Access for the Poor,* Stockholm: Swedish Ministry for Foreign Affairs.

Dicklitch, S. 1998. *The elusive promise of NGOs in Africa: lessons from Uganda,* New York, St. Martin's Press

Doornbos, M. 1990. The African State in Academic Debate: Retrospect and Prospect. *The Journal of Modern African Studies,* 28**,** 179-198.

Edwards, M. & Hulme, D. (eds.) 1992. *Making a Difference? NGOs and Development in a Changing World,* London: Earthscan/Save the Children.

Eldon, J. & Gunby, D. 2009. States in Development: State Building and Service Delivery Final Report. London: HLSP.

Eldon, J., Waddington, C. & Hadi, Y. 2008. Health System Reconstruction: Can it Contribute to State-building? : Health and Fragile States Network.

Englebert, P. & Tull, D. M. 2008. Postconflict Reconstruction in Africa: Flawed Ideas about Failed States. *International Security,* 32**,** 106-139.

Evans, P. 1995. *Embedded autonomy,* New Jersey, Princeton University Press.

_____. 1996a. Government action, social capital and development: reviewing the evidence on synergy. *World Development,* 24**,** 1119-1132.

_____. 1996b. Introduction: Development strategies across the public-private divide. *World Development,* 24**,** 1033 - 1037.

_____. 2010. Constructing a democratic developmental state: potentialities and pitfalls. *In:* EDIGHEJI, O. (ed.) *Constructing a democratic developmental state in South Africa: Potentials and challenges.* South Africa: Human Sciences Research Council.

_____. 2011. The Capability Enhancing Developmental State: Concepts and National Trajectories. *UNRISD-KOICA Conference.* Seoul, Korea 13, October, 2011

Evans, P. & Rauch, J. E. 1999. Bureaucracy and Growth: A Cross-National Analysis of the Effects of 'Weberian' State Structures on Economic Growth. *American Sociological Review,* 64**,** 748-765.

Ferguson, J. 1990. *The anti-politics machine: 'Development,' depoliticization, and bureaucratic power in Lesotho,* Cambridge, Cambridge University Press.

Fowler, A. 2000. NGDOs as a moment in history: beyond aid to social entrepreneurship or civic innovation? *Third World Quarterly,* 21**,** 637 - 654.

Fritz, V. & Menocal, A. R. 2007. Understanding State-Building from a Political Economy Perspective: An Analytical and Conceptual Paper on Processes, Embedded Tensions and Lessons for International Engagement. London: Overseas Development Institute.

Garbus, L. & Marseille, E. 2003. HIV/AIDS in Uganda. *Country AIDS Policy Analysis Project.* San Francisco, CA: AIDS Policy Research Center, University of California San Francisco.

Grebe, E. & Nattrass, N. 2009. Leaders, Networks and Coalitions in the AIDS response: A comparison between Uganda and South Africa. *Research Paper 03.* Cape Town: The Developmental Leadership Program.

Green, E. C., Halperin, D. T., Nantulya, V. & Hogle, J. A. 2006. Uganda's HIV prevention success: the role of sexual behavior change and the national response. *AIDS and Behavior,* 10**,** 335-346.

Henderson, J., Hulme, D., Jalilian, H. & Phillips, R. 2007. Bureaucratic Effects: `Weberian' State Agencies and Poverty Reduction. *Sociology,* 41**,** 515-532.

Herbst, J. 2000. *States and power in Africa: Comparative lessons in authority and control,* Princeton, Princeton University Press.

Hickey, S. 2008. The return of politics in development studies I: getting lost within the poverty agenda? *Progress in Development Studies,* 8**,** 349-358.

_____. 2013. Beyond the Poverty Agenda? Insights from the New Politics of Development in Uganda. *World Development,* 43**,** 194-206.

Hickey, S. & Mohan, G. (eds.) 2004. *Participation: From Tyranny to Transformation? Exploring New Approaches to Participation in Development,* London: Zed books.

Hulme, D. 2008. Reflections on NGOs and Development: The elephant, the Dinosaur, Several Tigers but No Owl. *In:* BEBBINGTON, A. J., HICKEY, S. & MITLIN, D. C. (eds.) *Can NGOs make a difference? The challenge of development alternatives.* London: Zed Books.

Hurrell, A. & MacAuslan, I. 2012. The Political Implications of Cash Transfers in Sub-saharan Africa. *Public Management Review,* 14**,** 255-272.

Jones, B. 2009. *Beyond the state in rural Uganda,* London, Edinburgh University Press.

Joshi, A. & Moore, M. 2004. Institutionalised Co-production: Unorthodox Public Service Delivery in Challenging Environments. *Journal of Development Studies,* 40**,** 31 - 49.

Lange, S. 2008. The Depoliticisation of Development and the Democratisation of Politics in Tanzania: Parallel Structures as Obstacles to Delivering Services to the Poor. *Journal of Development Studies,* 44**,** 1122 - 1144.

Lavalle, A. G., Acharya, A. & Houtzager, P. P. 2005. Beyond Comparative anecdotalism: Lessons on Civil Society and participation from Sao Paulo, Brazil. *World Development,* 33**,** 951-964.

Lewis, D. & Kanji, N. 2009. *Non-governmental organizations and development,* London, Routledge.

Lintsen, H. 2002. Two Centuries of Central Water Management in the Netherlands. *Technology and Culture,* 43**,** 549-568.

Lochoro, P., Bataringaya, J., Tashobya, C. K. & Kyabaggu, J. H. 2006. Public-private partnership in health: working together to improve health sector performance in Uganda. *In:* TASHOBYA, C. K., SSENGOOBA, F. & CRUZ, V. O. (eds.) *Health Systems Reforms in Uganda: Processes and Outputs.* Kampala: Institute of Public Health, Health Systems Development Programme, Ministry of Health.

Mahmud, S. 2007. Spaces for participation in health systems in rural Bangladesh: the experience of stakeholder community groups. *In:* CORNWALL, A. & COELHO, V. S. P. (eds.) *Rights, Resources and the Politics of Accountability.* London: Zed Books.

Mann, M. 1984. The autonomous power of the state: Its origins, mechanisms and results. *Archives Europeennes de Sociologie,* 25**,** 185-213.

Mattson, G. A. 1986. The Promise of Citizen Coproduction: Some Persistent Issues. *Public Productivity Review,* 10**,** 51-56.

Mercer, C. 1999. Reconceptualizing State-Society Relations in Tanzania: Are NGOs 'Making a Difference'? *Area,* 31**,** 247-258.

Ministry of Health 2008. Access to and use of Medicines by households in Uganda. *Report of a survey conducted 2008.* Kampala: Ministry of Health.

Mitlin, D. 2008. With and beyond the state – co-production as a route to political influence, power and transformation for grassroots organizations. *Environment and Urbanization,* 20**,** 339-360.

Mohan, G. 2002. The disappointments of civil society: the politics of NGO intervention in northern Ghana. *Political Geography,* 21**,** 125-154.

Monico, S. M., Tanga, E. O. & Nuwagaba, A. 2001. Uganda: HIV and AIDS-related Discrimination, Stigmatization and Denial. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS).

Museveni, Y. K. 2004. Political Commitment and Accountability. *XIV International Conference on AIDS and STDS* Bangkok, Thailand

Nabuguzi, E. 1995. Popular initiatives in service provision in Uganda. *In:* SEMBOJA, J. & THERKILDSEN, O. (eds.) *Service provision under stress in East Africa: The state, NGOs and People's Organizations in Kenya, Tanzania and Uganda.* Kampala: Fountain Publishers.

Nazerali, H., Oteba, M. O., Mwoga, J. & Zaramba, S. 2006. Medicines – driving demand for health services in Uganda? *In:* TASHOBYA, C. K., SSENGOOBA, F. & CRUZ, V. O. (eds.) *Health Systems Reforms in Uganda: Processes and Outputs.* Kampala: Institute of Public Health, Health Systems Development Programme, Ministry of Health.

O'Manique, C. 2004. *Neoliberalism and AIDS crisis in Sub-Saharan Africa: Globalization's pandemic,* New York, Palgrave MacMillan.

OECD. 2012. Case Studies on Development Co-Operation and Accountability:Uganda, Peru, Mozambique and Mali*DCD/DAC/RD(2012)9/RD2.* Organisation for Economic Co-operation and Development (OECD).

Parkhurst, J. O. 2005. The Response to HIV/AIDS and the Construction of National Legitimacy: Lessons from Uganda. *Development and Change,* 36**,** 571-590.

Pierson, P. 1993. Review: When Effect Becomes Cause: Policy Feedback and Political Change. *World Politics,* 45**,** 595-628.

Prince, R. 2012. Humanitarian interventions and the moral economy of suffering and survival: An ethnography of biopolitics in Kenya today. *Biopolitics and Humanitarian Citizenship Workshop.* The University of Manchester.

Putzel, J. 2004. The politics of action on AIDS: a case study of Uganda. *Public administration and development,* 24**,** 19-30.

Richey, L. A. & Haakonsson, S. J. 2004. Access to ARV Treatment: Aid, Trade and Governance in Uganda. *DIIS Working Paper 2004/19.* Copenhagen: Danish Institute for International Studies (DIIS).

Robins, S. 2006. From 'Rights' to 'Ritual': AIDS Activism in South Africa. *American Anthropologist,* 108**,** 312-323.

Scott, J. 1998. *Seeing Like a State: How Certain Schemes to Improve the Human Condition Have Failed* New Haven, Yale University Press.

Skocpol, T. 1992. *Protecting soldiers and mothers: the political origins of social policy in the United States,* Massachusetts, The Belknap press of Harvard University press.

_____. 1995. *Social policy in the United States: Future possibilities in historical perspective,* New Jersey, Princeton University Press.

Skocpol, T. & Amenta, E. 1986. States and Social Policies. *Annual Review of Sociology,* 12**,** 131-157.

Soifer, H. & vom Hau, M. 2008. Unpacking the Strength of the State: The Utility of State Infrastructural Power *Studies in Comparative International Development (SCID),* 43**,** 219-230.

Ssebbanja, P. K. 2007. *United Against AIDS: The story of TASO,* Oxford and Kampala, Strategies for hope trust and TASO.

Ssengooba, F., Rahman, S., Hongoro, C., Rutebemberwa, E., Mustafa, A., Kielmann, T. & McPake, B. 2007. Health sector reforms and human resources for health in Uganda and Bangladesh: mechanisms of effect. *Human Resources for Health,* 5**,** 1-13.

Ssewankambo, E., Steffensen, J. & Tidemand, P. 2008. Local level service delivery, decentralisation and governance: Acomparative study of Uganda, Kenya and Tanzania Education, Health and Agriculture sectors. *Uganda case report.* Institute for International Cooperation (IFIC) and Japan International Cooperation Agency (JICA).

TASO 2002. The AIDS Sopport Organisation (U) LTD Strategic Plan 2003-2007. TASO.

_____. 2005. The MINI TASO/CBO Strategy. Kampala: The AIDS Sopport Organisation

_____. 2007. The AIDS Support organisation (U) LTD Strategic Plan 2008-2012. TASO.

_____. 2008. TASO Uganda Limited 2007 Annual Report. Kampala: The AIDS Support Organisation.

_____. no date. TASO health system strengthening approach. Kampala: The AIDS Support Organisation

Tendler, J. 1997. *Good government in the tropics,* Baltimore and London, The John Hopkins University Press.

Therkildsen, O. & Semboja, J. 1995. Introduction: A new look at service provision in East Africa. *In:* SEMBOJA, J. & THERKILDSEN, O. (eds.) *Service Provision Under Stress in East Africa: The State, Ngos and People's Organizations in Kenya, Tanzania and Uganda.* London: John Currey

Tripp, A. M. 2010. *Museveni's Uganda: Paradoxes of Power in a Hybrid Regime,* London, Rienner publishers.

UAC 2007. Moving Toward Universal Access: National HIV & AIDS Strategic Plan 2007/8 – 2011/12. Kampala: Uganda AIDS Commission, Republic of Uganda.

Unsworth, S. 2010. *An Upside Down View of Governance,* Brighton, Center for the future state, Institute of Development Studies.

Van de Walle, S. & Scott, Z. 2011. The Political Role of Service Delivery in State-Building: Exploring the Relevance of European History for Developing Countries. *Development Policy Review,* 29**,** 5-21.

Vom Hau, M. 2012. State Capacity And Inclusive Development: New Challenges And Directions. *ESID Working Paper No. 02.* Manchester: Effective States and Inclusive Development Research Centre (ESID).

Wild, L., Chambers, V., King, M. & Harris, D. 2012. Common constraints and incentive problems in service delivery. *Working Paper 351.* London: Overseas Development Institute (ODI).

WHO 2009. Priority Interventions: HIV/AIDS prevention, treatment and care in the health sector *Version 1.2.* World Health Organization (WHO) HIV/AIDS Department.

Wood, G. 1997. States without Citizens: The Problem of the Franchise State. *In:* HULME, D. & EDWARDS, M. (eds.) *NGOs, States and Donors: Too Close for Comfort?* London: MacMillan Press Ltd.

World Bank 2004. World Development Report 2004: Making services work for poor people. Washington DC: The World Bank.