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From Social Accountability to a New Social Contract? The Role of NGOs in Protecting and Empowering PLHIV in Uganda

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ABSTRACT *Social protection and social accountability initiatives are increasingly promoted as mechanisms for securing a new social contract between states and citizens in developing countries. Evidence from Uganda suggests that* social protection programmes with built-in accountability arrangements *led by non-governmental organisations (NGOs) can enable states and citizens, in this case people living with HIV and AIDS, to 'see' each other in different and more positive ways, and as such can provide clues as to how such interventions can help build a social contract at the local level. This finding helps counter critical concerns that NGOs tend to depoliticise state–society relations and undermine accountability.*

Introduction

> Those days, before the Mini TASO Project, health workers were so bad and looked at us as sinners. This created self-stigma among us patients. Many of us refused to come out to test or seek other medical services because we felt that health workers had turned us into second class citizens. But with the coming of the MTP you can no longer despise people with HIV/AIDS. TASO taught us how to represent and defend our rights. (Male PLHIV, Kamuli, 1 February 2011)

> As staff members at this hospital, our approach and attitudes towards PLHIV clients was not very friendly before the MTP. We used to under look [and] discriminate against PLHIV for the fear that they would infect us with HIV. However after the capacity building by TASO we were able to change our attitudes, we started handling PLHIV as human beings with dignity. This actually improved our relationship with even other patients in the entire hospital. (Female health worker, Kamuli, 21 March 2011)

The role of social protection in reducing the vulnerability of poor and marginal groups has increasingly been framed in terms of the sociopolitical as well as the material gains that such interventions can have. Proponents suggest that social protection interventions can enable the integration of previously marginal groups within communities (Devereux, 2007) and help promote social cohesion more broadly (Hujo, 2009), along with a broader range of 'political feedback' effects including voting habits and regime stability (Barrientos & Pellissery, 2012). More widely, it is claimed that social protection can be a means of extending and improving the 'social contract' between states and citizens (see Hickey and King, this volume), in that it can help render states more legitimate in the eyes of citizens and, where participatory mechanisms are integrated in a more 'transformative' approach (Devereux & Sabates-Wheeler, 2004), it can help enhance the citizenship status and claim-making capacities of local communities.

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Similar claims are concurrently being made for the kinds of social accountability mechanisms that are intended to increase citizen voice and power as a means of making service delivery more effective and responsive. For example, Joshi and Houtzager (2012) argue that social accountability should be conceptualised as a means through which state–society relations are transformed in progressive ways, rather than as a technocratic tool. Such an outcome is more likely to occur, they argue, along with other recent work on the politics of social accountability (Booth, 2012), where interventions do not simply empower 'demand-side' actors; they can also challenge and/or support 'supply–side' actors and institutions to adopt more accountable working practices.

It is difficult to assess the validity of these claims, given that the research base concerning the effects of integrating social accountability mechanisms within social protection interventions remains at an early stage. However, recent survey work on the politics of social protection and service delivery does provide some clues: according to a survey undertaken in Uganda and elsewhere by the Secure Livelihoods Research Consortium (SLRC),[1] citizens said that being informed and consulted about such interventions, and the inclusion of accountability mechanisms through which they could raise grievances, were what counted in terms of improving their perception of state legitimacy (Mazurana, Marshak, Opio, & Gordon, 2014). In short, it is the way in which goods and services are delivered that really counts if service delivery is to act as a mechanism for building state–society relations. This research also found that this effect was not dependent on the character of the agency delivering the services in question: citizens did not mind whether it was the state or non-state actors. This is interesting given the presumption in some work on the politics of social accountability that the prominent role of non-state actors in service delivery may undermine state accountability whilst also tending to depoliticise popular agency through a technocratic approach to promoting citizenship participation (see King, 2015 for a review of these debates).

This paper explores these arguments and debates by examining the extent to which intervention by a non-governmental organisation (NGO) in rural Uganda to protect and promote the rights of people living with HIV and AIDS (PLHIV) both empowered those involved as citizens and changed the approach of the state, and in so doing encouraged the emergence of a new social contract. The following section discusses the theoretical links between social protection, service delivery, and the formation of social contracts, and proceeds to introduce the AIDS Support Organisation (TASO) as the NGO case study, its intervention programme, and the research methods employed to investigate the outcomes of its intervention. The two sections that follow assess the extent to which TASO managed to promote higher levels of state capacity and citizenship, respectively, before turning to the wider question of whether social protection programmes with built-in accountability arrangements by NGOs can help to foster a new social contract between states and citizens.

Accountable Forms of Social Protection and the Social Contract: Conceptualising the Links

The role of social protection and social accountability in extending the social contract involves changes on both sides of the equation (Gaventa, 2002; McGee & Gaventa, 2010): generating increased citizenship status, rights, and participation whilst also improving the developmental capacity and commitment of the state to recognise the rights of citizens and deliver goods/services to them (see Hickey and King, this volume).

Social protection is linked to the promotion of citizenship in a number of important ways, starting with the recognition of status that it accords to previously marginal groups. Comparative analysis of the politics of social protection in a range of African and South Asian countries, including the post-Apartheid extension of the social pension to black South Africans, suggests that the expansion of social protection is closely related to the extension of citizenship rights to different categories of erstwhile 'subjects' (Hickey, 2009). Whilst this primarily constitutes an extension of the social rights of citizenship (Leisering & Barrientos, 2013; Marshall, 1963), this form of redistribution and recognition has been identified as encouraging citizens to take up the civil and political rights – and obligations – of citizenship through becoming more active in a range of associational and even

political forms of participation, partly to protect or expand benefits but also in a broader sense (Mettler & Soss, 2004; Skocpol, 1992). Campbell's (2003) study of the impact of US Social Security and Medicare programmes on the political activity of senior citizens illuminates this point. Where such interventions include mechanisms through which recipients gain voice and are supported in exercising their agency (for example by capacity building and conscientisation initiatives), these effects can expect to be deepened. Finally, the material resources that social protection offers may also enable recipients to overcome the transaction costs of being involved in civil and political participation (Campbell, 2003).

The argument that delivering social protection, as a form of social policy (De Haan, Jeremy, & Nazneen, 2002), can help enhance state–society relations also draws on a wider set of debates concerning the role of service delivery in generating increased levels of state legitimacy (Batley, McCourt, & McLoughlin, 2012; OECD, 2008). The key mechanisms for this include the delivery of effective services, which signals the will and capacity of the state to act in a responsive manner, and the promotion of participation and accountability, which can enhance citizens' perceptions of the state (Brinkerhoff, Wetterberg, & Dunn, 2012, 276).

What has been less explored, however, is the extent to which non-state actors can play a role in these processes. For some observers, allowing NGOs to take a leading role in social protection and social accountability interventions is likely to undermine the accountability required for more progressive state–society relations to flourish. NGOs may depoliticise the role that citizens and social movements can play in this process as a result of the technocratic forms of participation they tend to employ, particularly when their involvement in service delivery involves their co-optation by the state. According to Wood (1997), when states 'franchise' service provision responsibilities to NGOs, citizens risk losing the capacity to hold providers to account, as NGOs are accountable upwards to the state and their funders rather than downwards to recipients. Swidler and Watkins' (2009) research in Malawi indicates that service delivery NGOs undermined the agency of their communities by teaching them to be subservient to the powerful – government and international – agencies that fund their activities. Others suggest that NGOs can have a negative effect on the development of voice when they establish parallel service delivery structures that act as exit sites for clients dissatisfied with government services (Di John, 2007; Maclean, 2011). However, recent studies suggest that NGOs can foster responsive service delivery skills in government staff (Batley & Rose, 2011) and help to 'forge more productive linkages between communities and public institutions than states are able to establish on their own' (Cammett & MacLean, 2011, 7). It is further suggested that if non-state actors encourage the coproduction of services between communities and the state, this can result both in citizens becoming more engaged and empowered and states becoming more responsive (Mitlin, 2008; Tsai, 2011).

Researching the Politics of Social Accountability in Uganda

This paper explores these debates through a case study of an HIV/AIDS service delivery project implemented by a prominent Ugandan NGO: TASO. The focus on PLHIV is particularly appropriate given the extent to which this category of people have often been treated as second-class citizens in African countries (as elsewhere), and so provides a test case for how far social protection programmes with built-in accountability arrangements can transform relations between the state and marginal groups.

Uganda offers an interesting context within which to explore these issues. Uganda is typically categorised as a semi-authoritarian state, within which processes of democratisation have been heavily compromised by the continued dominance of the ruling party, the National Resistance Movement (NRM). The NRM has secured itself in power since 1986 through its combination of delivering stability and relatively pro-poor forms of growth, the active repression of political opponents and dissenting voices from within civil society, and the use of state resources to deliver services and protection as forms of patronage rather than as of right (Tripp, 2010). Public services such as the national health system are highly visible social institutions, and thus may play an important role in

influencing public trust and legitimacy in government. In Uganda, although access to basic services such as education and health increased impressively following election-related policy shifts to reduce costs for users in 1997 and 2001, respectively, the quality of service provision remains very low and the government has yet to make any serious investment in social protection, despite donor pressure to do so. NGOs are warned to 'back off politics' (The New Vision, 2012). Hence the majority confine themselves to service delivery activities (Barr et al., 2005). However, the President was also amongst the first African leaders to promote interventions designed to assist PLHIV, a move that has been credited with the rapid decline in the incidence of HIV/AIDS (Parkhurst, 2005; Putzel, 2004).

To understand causal effects of a particular TASO intervention, named the Mini TASO Project (MTP), this study employed a comparative case analysis of how MTP altered state–citizen relations in two of the districts that it was rolled out in, alongside a control study of a district in which MTP was not present.[2] Our initial investigation discovered that MTP was not rolled out evenly in each district, with key informants identifying Kamuli as a district in which the project had been extended the furthest, compared to others in which implementation was considered by TASO staff to have been 'patchier'. We therefore purposively sought to investigate Kamuli alongside a district in which MTP had been more weakly implemented, namely Masafu, in order to establish if variation in the implementation of MTP had a bearing on performance and outcomes, whilst also including a non-MTP district (Iganga) as a control to offer the full range of possibilities. Retrospective baselines of government capacity to respond to PLHIV were then constructed in Kamuli and Masafu hospitals prior to TASO's MTP intervention, although this was not possible in the Iganga control due to a lack of record-keeping within local government there. In the MTP sites, the study included a temporal element throughout, whereby retrospective questions were asked in order to help identify the situation before and after the MTP intervention, which ran in 2006–2011. The fieldwork was undertaken in November 2010–July 2011 and involved both qualitative and quantitative methods of data collection, namely in-depth interviews (with PLHIV, health workers, district leaders, TASO staff, and other key informants), documentary analysis, observation of service provision, and a small-scale survey of PLHIV service users from the three district hospitals. Here, structured questionnaires were administered to a total of 178 respondents (Kamuli, n = 61; Masafu, n = 71; Iganga, n = 46). As with all such studies, there are methodological limitations to be aware of here, including the fact that the cross-sectional nature of the study does not allow full assessment of impact and sustainability beyond the MTP period, that the retrospective element of the survey is vulnerable to recall bias, and also that the samples for the survey research were too small to allow sophisticated inferential statistical analyses. Wherever possible, steps have been taken to mitigate the effects of these limitations, including the careful triangulation of findings and the use of quantitative data in a descriptive rather than explanatory way.

Towards a New Social Contract in Rural Uganda? The Mini TASO Project

TASO 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 (Grebe & Nattrass, 2009). In 2003, TASO crafted the MTP as a capacity-building programme that involved various training programmes for government health workers, financial support to district hospitals, and supporting citizens to demand their rights and engage in coproduction activities with service providers. The name suggested the intention to transform government hospitals into 'TASO-like' agencies which recognised PLHIV as full citizens and ensured that they received the required treatment in an effective and accountable manner (TASO, 2005). Between 2003 and 2010, TASO annually initiated partnerships with two to four district local governments to transform the HIV/AIDS departments in their main hospitals into Mini TASOs. According to TASO documents (TASO, 2005, 2007) and interviewees, MTPs were established through a three-phase programme that involved site mobilisation, capacity building, and service delivery. The MTP thus constitutes both a protective and a transformative form of social protection (Devereux & Sabates-Wheeler, 2004, p. 10), in that it seeks to both increase the provision of the drugs required to ameliorate

the effects of HIV/AIDS and to challenge disempowering and discriminatory tendencies that have reduced PLHIV to the status of second-class citizens.

Prior to TASO's intervention in 2006, both Kamuli and Masafu hospitals had introduced antiretroviral therapy (ART) programmes in 2005. Government guidelines stated that before a health facility was accredited to provide ART services, it ought to have capabilities in various areas, including: the presence of basic physical infrastructure for the treatment of PLHIV (for example space for counselling and testing, drug storage facilities); qualified personnel with experience in HIV/AIDS management, and the ability to ensure the provision of follow-up care and support for families and communities with PLHIV (Okero, Aceng, Madraa, Namagala, & Serutoke, 2003).

However, TASO's own evaluation of its intervention sites deemed them to have 'inadequate levels of capacity, resources, community mobilization and community involvement' (TASO, 2007, p. 18). The capacity assessment found that these units had neither the social nor the physical infrastructure for providing ART. Our own research confirmed this: in Masafu, one respondent recalled that health workers started providing HIV/AIDS services 'with hardly any basic understanding of the processes involved in this specialised service area' (Male health worker, Masafu, 14 April 2011). Health workers in Kamuli hospital also claimed that, prior to 2006, they lacked the skills in psychosocial work required to educate and provide counselling services to PLHIV. These observations were further confirmed by the findings of a 2008 Uganda Ministry of Health survey, which reported that 'only one third of facilities prescribing ART and/or medical follow up services have a provider trained in ART prescription or medical services and in counselling for adherence to antiretroviral (ARV) drug therapy' (Ministry of Health and Macro International Inc., 2008, p. 187).

Health workers noted that their inadequate skills in mobilisation, counselling, and ARV administration meant that they recruited fewer patients before MTP (Male health worker, Masafu, 14 April 2011). As shown in Figure 1, Masafu hospital only managed to recruit 27 PLHIV on ART in 2005, whereas this increased fivefold to 135 during the first year of TASO's arrival. Similarly, Kamuli hospital registered a steady increase in PLHIV annual enrolment on ART after getting MTP. The fluctuating figures in Masafu arguably reflect the inconsistent implementation of the MTP there that we noted above.

The interviews and survey findings reveal that, before MTP, relations between health workers and patients were tense and characterised by 'mutual mistrust' in both hospitals (Focus Group Discussion (FGD) with MTP service providers, Masafu, 24 January 2011). Patients claimed that health workers would blame them for being HIV positive and some PLHIV reported incidents of physical harassment by staff (Male PLHIV, Kamuli, 1 February 2011). Acknowledging some shortcomings in retrospect, health workers reflected that their attitude flowed from inadequate awareness of the disease and how to

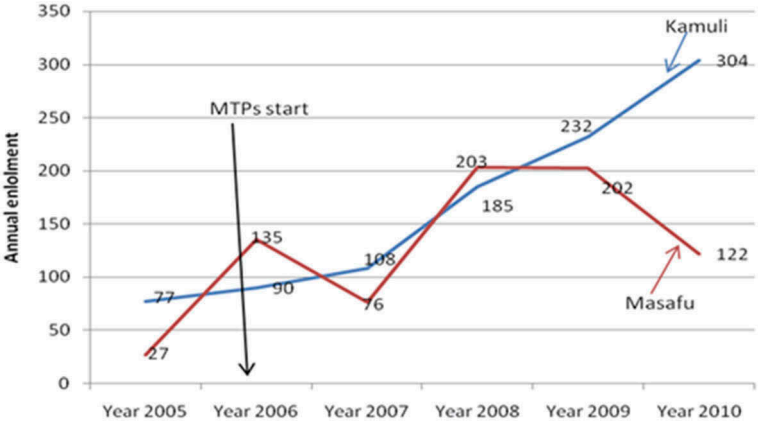

Figure 1. Annual enrolment of PLHIV on ART in Kamuli and Masafu.
Source: *author's calculations based on ART registers*

deal with PLHIV (Interviews with two female health workers, Kamuli, 14 January 2011 and 21 March 2011). In both Kamuli and Masafu, capacity to deal with PLHIV was limited to the central district hospitals, with no outreach programmes for those in remote parts of the district. This reflects the more general lack of 'infrastructural power' in Uganda (Hawkins, 2014), which means that many rural dwellers rarely 'see the state' (Jones, 2009). Given these conditions, it is not surprising that our survey found PLHIV critical of the quality of services available to them prior to MTP. On eight selected indicators about service quality – staff responsiveness, privacy in consultations, opportunity to discuss concerns with health workers, the quality of explanations received, drug availability, waiting time, number of days services were available, and the hours of service – PLHIV in both study sites rated services as below average on six. It is against this background that TASO oriented MTP towards working on the 'supply side' before building citizens' capacity to make demands of the hospital staff.

Did MTP Build State Capacity and Change the Way in Which the State sees PLHIV?

There was consensus among respondents in our MTP districts that the project increased the capacity of government hospitals to deliver HIV/AIDS services. Between 2005 and 2010, the number of PLHIV receiving treatment in Kamuli increased from 334 to 4,152, and from 256 to 2,113 in Masafu. This translates into an annual percentage increase in PLHIV enrolment of 71 per cent and 53 per cent for Kamuli and Masafu, respectively.[3]

MTP provided each participating health facility with UGX 50 million (~GBP 15,000) per annum. This is a significant financial contribution considering the small operational budgets for health facilities in local governments in Uganda. For example, mini hospitals, which offer services to a catchment population of 100,000, receive up to UGX 12 million per annum (Parliamentary Committee on Health, 2012). Around 20 per cent of the MTP budget was reserved for purchasing drugs (Interview with male TASO HQ official, Kampala, 28 January 2011). Before this, health workers would advise patients to buy medicines from private providers, a move that had negative implications for state building, in that it effectively means telling PLHIV to stay away from essentially irrelevant public facilities (Interview with health workers' FGD, Kamuli, 24 January 2011, Kamuli). This finding is corroborated by Nazerali, Oteba, Mwoga, and Zaramba (2006), who observe that, in Uganda, hospital attendance is greatly determined by the availability of drugs. The reliable provision of drugs is also central to citizens' expectations of a functioning health system (Nazerali et al., 2006), with drug availability shaping the perceptions of patients about the trustworthiness of government employees in the health sector (Ssengooba et al., 2007).

As shown in Table 1, whereas 84 per cent of our sample of PLHIV in Kamuli felt that there was poor availability of drugs before TASO arrived, this overall judgement had been reversed by 2011, with roughly the same proportion then claiming that the drugs supply was good. Progress in Masafu was more limited, although still significant, with a switch from 83 per cent registering a negative view regarding the pre-MTP situation to nearly 58 per cent holding the opposite view by the end of the

Table 1. Clients' perception of drug availability

		Drug availability		
Facility	Period	Poor (%)	Fair (%)	Good (%)
Kamuli	Pre-MTP	83.6	14.8	1.6
(n = 61)	2011	4.9	9.8	85.2
Masafu	Pre-MTP	83.1	15.5	1.4
(n = 71)	2011	4.2	38.0	57.7
Iganga	2006	19.6	60.9	19.6
(n = 46)	2011	17.4	67.4	15.2

intervention. In Iganga, our control, the majority of respondents felt that drug supply is just 'fair' in their facility, with marginal changes occurring over a five-year period.

Besides increasing drug supply in targeted sites, TASO's intervention helped public hospitals to respond to two challenges in government hospitals: namely, staffing shortages and inadequate skills among the existing staff. As discussed earlier, the health staff in government facilities lacked technical skills, such as ART administration and psychosocial skills. Efforts by TASO to address these capacity gaps through training programmes were seen by main health workers as enabling them to 'see' PLHIV as citizens in need of special care, in much the same way that TASO did. A senior health worker in Kamuli hospital reflected the sentiments of most of those interviewed at the facility, noting that:

> 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 [. . .] we started moving to the wards to look for our clients, counsel them – to provide them with the psychosocial support, give them information regarding HIV and Positive Living. This actually improved our relationship with the PLHIV. (Female health worker, Kamuli, 21 March 2011)

Generally, health workers claimed that the training and mentoring from TASO reduced their tendency to negatively 'construct' PLHIV as 'sinful' and treat them as second-class citizens (Gilson, 2003; Schneider & Ingram, 2007). Whereas 82 per cent and 80 per cent of the clients in Kamuli and Masafu, respectively, described the responsiveness of TASO in the pre-MTP era as poor, by the time of fieldwork, this judgement had been completely reversed (see below).

TASO's strategy for addressing inadequate staff capacity in the targeted public facilities involved a form of 'coproduction', which Mitlin (2008) defines as citizens and states working together both to extend basic services and as a strategy by and for grassroots groups to secure political influence. 'Expert' service users were mobilised to help the state perform a number of roles required to extend ART provision, from undertaking sensitisation campaigns and mobilising and organising fellow clients during clinic days through to offering health education training, sorting files, packing drugs, and recording the triage details of fellow service users. Health workers acknowledged that this greatly relieved their workload and extended the capacity of their facilities to protect PLHIV from their disease (health workers' FGD, 24 January 2011; observations at MTP clinics, 11–15 April 2011). This form of 'peer-group-led' coproduction is increasingly recognised as a successful strategy for helping public officials to reach socially marginalised groups (Campbell & Cornish, 2010). For example, the use of music, dance, and drama by the peers employed by MTP was proving so effective in mobilising PLHIV that health workers started pairing with drama groups and using the occasions to undertake testing for HIV amongst those attending the shows, and encouraging those testing positive to start accessing medical services. Between 2006 and 2010, the average annual reach of such community awareness campaigns in Kamuli was 4,900 people, while that of Masafu was 1,900; by way of comparison, the majority of Ugandan NGOs reportedly have an average reach of less than 500 people annually (Barr et al., 2005).

MTP targeted another important dimension of state capacity by supporting public facilities to record and store patient details. Although this form of file keeping is characterised by some critics as a form of 'surveillance' that modern bureaucratic states use to governmentalize their subjects (Rose, 1999), coproduction scholars note that marginal groups themselves now undertake their own surveys to ensure that they are rendered legible to the state and thus seen as citizens with valid claims for recognition and redistribution through service delivery (Mitlin, 2008). TASO introduced several data forms to help health workers collect information on PLHIV, and ensured that every Mini TASO hospital had a trained records clerk, records storage facilities such as filing cabinets, and a computer. These interventions had visible impacts: our observations revealed that MTP sites kept far more data on their service delivery activities for PLHIV when compared to Iganga hospital, where the project was not implemented, and in Kamuli there was a 'spillover' effect, whereby the capacities developed by MTP were used to improve records management hospital wide (Male staff, Kamuli, 27 June 2011).

When data showed that the number of clients attending clinics was increasing, MTP administrators increased the number of clinic days from one to four days a week, and a new appointment system was designed to allocate specific types of patients to each day, with Fridays designated for records management. PLHIV leaders observed that this helped to reduce the congestion of patients at the clinic (Female PLHIV, Kamuli, 22 April 2011) and also introduced a structured and more reliable format for state–citizen interactions in Kamuli MTP, a move associated with the development of more 'impersonal' and universalist forms of state provision based on the rights of citizenship rather than personalised negotiations through a patron–client rubric (Corbridge, Williams, Srivastava, & Veron, 2005).

Did MTP Increase Levels of Citizenship Status, Rights, and Participation?

Beyond the advances in the citizenship status and rights of PLHIV discussed above, MTP sought to promote this further in two main ways: namely, the promotion of associational life among PLHIV and the creation of participatory spaces.

MTP Approaches as Participatory Social Accountability

The participatory spaces that TASO introduced at its MTP sites were designed to empower PLHIV to hold service users to account and provide a basis for wider forms of collective action. Various participatory structures were introduced, including clients' representative committees and also client staff meetings, which enabled citizens to be 'invited inside the governmental apparatus itself' to influence programmes that directly affect them (Ackerman, 2004, p. 451). Implementation varied across MTP sites, as Table 2 reveals, with more mechanisms operational in Kamuli than Masafu, although both had significantly more participatory mechanisms than in the Iganga control.

In Kamuli, the general PLHIV meetings took the form of 'citizen juries' (Corbridge, 2005; Goetz & Gaventa, 2001), whereby politicians, government health workers, PLHIV, and sometimes members of the press were brought together in a space through which state officials could receive feedback from citizens and be held to account by them for their actions and inactions. MTP thus offered a means 'for bringing the citizen and the state into [. . .] unmediated encounter that offers each party an undistorted sighting of the other' (Corbridge et al., 2005, p. 44), providing structures capable not only of more effective service delivery but also increased and improved levels of state citizen interaction, which promotes citizenship and the pro-poor orientation of service providers (Bruns, Filmer, & Patrinos, 2011; Williams, Thampi, Narayana, Nandigama, & Bhattacharyya, 2011). In Kamuli MTP, PLHIV were able to use these mechanisms to influence how the hospital functioned, including the institutionalisation of a bespoke HIV/AIDS department. After several complaints about the inadequate attention given to PLHIV, the medical superintendent attended the PLHIV's committee meeting of 29 May 2010 and informed members that:

> we came to a conclusion to let the Mini TASO become a separate department and be provided with separate staff [. . .] Since it has become a department, it will run like any other department [. . .] So if someone does not come to duty, he/she will attract disciplinary action like any other

Table 2. Distribution of dialogue structures in the study sites

Dialogue structure type	Kamuli	Masafu	Iganga
PLHIV/client representative committee	Yes	No	No
Client welfare committee meetings	Yes	No	No
Staff meetings with drama members	Yes	Yes	No
Staff and peer counsellors meetings	Yes	Yes	Yes
General PLHIV meetings	Yes	No	No

> person who fails to come to duty in other departments. Any misconduct on a TASO clinic should be handled like any from other departments (Interview with Male health official, Masafu, during the PLHIV's committee meeting, 29 May 2010).

Further complaints from PLHIV caused the medical superintendent to issue a circular warning to all Kamuli hospital staff about their negligence and absenteeism. This finding is consistent with research suggesting that 'bottom up' forms of social accountability can lead to improved levels of oversight which have greater enforceability (Brett, 2003; Goetz & Jenkins, 2001). For some PLHIV, such communications sent a strong signal that their deliberations in participatory spaces were causing the hospital to listen to their concerns, with one PLHIV leader noting that because 'clients' issues are raised in meetings and the medical staff are made to know about clients' concerns, they have changed their ways and in most cases [our concerns] are handled well' (Interview with a male PLHIV, Kamuli, 7 February 2011). However, such mechanisms are clearly far from perfect, with other respondents arguing that:

> When we have meetings with health workers they give us time to give our reports. Sometimes they take on our suggestions [but] other times they do not [. . .] Sometimes when we speak about certain things the problem becomes worse. (Interview with a male PLHIV, Kamuli, 1 February 2011)

The spaces for interaction between health workers and service users were advantageous in another way. Service users were invited to engage in activities that allowed them to gain insights into the working environment of health workers as well as their roles and expectations. Such opportunities have the potential for enabling the two sides to search collectively for solutions to challenges rather than fight about them (Wild & Wales, 2015). As elaborated in later sections, it may be that the most important outcome of social accountability mechanisms is to enable these forms of dialogue, rather than promoting voice per se (Fox, 2015), with dialogic processes offering a basis for improved forms of state–society relations in support of building a wider social contract.

Promotion of Associational Life

Our findings suggest that PLHIV who benefitted from MTP were more capable and willing to relate to and work with one another than those receiving treatment from standard health facilities. In line with other research on this dynamic (Bebbington, 2008; Moore & Putzel, 1999; Tendler, 1995), our evidence shows that contact with the state stimulated PLHIV to create new or join existing groups, associations, and networks. In Kamuli, 64 per cent of the respondents said that their contact with MTP had encouraged them to join local groups, compared to 56 per cent in Masafu. The rate of group-joining was significantly lower in Iganga, at 24 per cent, where TASO had no intervention, reinforcing the sense that the differential effects across our three districts reflect the extent to which the MTP intervention was actually implemented in each.

The music dance and drama (MDD) groups introduced by MTP encouraged further associational activity amongst participating PLHIV members. In each MTP, membership per group ranged between 15 and 20 PLHIV, with slightly more female participants than men. Group members testified that the group exposed them to new experiences, including the opportunity to travel beyond their own villages or districts, for example to annual regional drama festivals, where several Mini TASOs and TASO service branches competed (TASO, 2008, 2010). Participating in these claimed spaces (Cornwall, 2002) enabled PLHIV to learn from wider experiences of how provision for PLHIV was unfolding in other parts of the country, and, in line with Gaventa and Barret's (2010) overview of participation and accountability initiatives, extend their horizons in broader and empowering ways. For example, PLHIV members talked of how group interactions offered opportunities for them to enhance their ability to speak in public: 'For me I did not know that I would ever stand in front of people to talk about myself. But, through drama, that is exactly what I started doing [. . .] I even became the chairman

of PLHIV in my subcounty of Kitayundwa' explained one respondent (Interview with a male PLHIV, Kamuli, 7 June 2011).

According to Cornwall and Coelho (2006, p. 8), it is through participating in such activities that 'citizens cut their political teeth and acquire skills that can be transferred to other spheres'. Campbell and Cornish (2012, p. 853), drawing on the case of the Sonagachi project for sex workers in India, illustrate how the opportunity to be involved in peer education activities gave sex workers the 'ability to "speak" – at public events, [and] to the media', which in return enabled them to learn 'how to negotiate with police and politicians'. Similar is Williams et al.'s (2011) report of a participatory programme called Kadumbashree in the Indian state of Kerala, where the involvement of formerly marginalised women in neighbourhood groups and state activities enabled them to gain visibility in the public sphere. In the case of MTP, some drama members similarly used their newly acquired confidence and public speaking experience to venture into politics (see below), and thus transcend the 'technocratic' realm of project-level participation for a more political form, and showed how local associations can be effective routes for citizens' empowerment in 'semi democratic' political contexts in the south (Benequista, 2011; Gaventa & Barret, 2010).

The 2011 local elections in Uganda offered a window through which this research could track the political effects of MTP. We found that a greater number of PLHIV contested subcounty council elections in Kamuli in 2011 than in Masafu MTP, where the project was not implemented as thoroughly. We could not identify any contestants in Iganga, and the two PLHIV experts who worked at this facility said that none of the clients had contested (Interview with a male and female expert PLHIV, Iganga hospital, 20 May 2011). Although clearly not conclusive, this evidence tentatively supports claims that service delivery and social protection programmes can be a means for building political skills of citizens (Nyamu-Musembi, 2010).

Discussion: Towards a Deeper Social Contract?

According to the OECD (2008, p. 17), a social contract emerges from a dynamic interaction of four factors: the expectations that a given society has of a given state; the capacity of the state to provide services; the willingness of political elites to direct state resources and their capacity to fulfil social expectations; and the existence of political processes through which the bargain between state and society is struck, reinforced and institutionalised. These are all mediated by the existence of political processes through which the bargain between state and society is struck, reinforced, and institutionalised. To at least some degree, the participatory accountability structures promoted by MTP were engendering some of these processes with a view 'of reaching a state of dynamic equilibrium between the expectations of society and state capacity to meet these expectations' (OECD, 2008, p. 17). Excerpts from the minutes of such meetings revealed that clients and health workers, together with the local political leaders, candidly discussed issues of drugs availability, conduct of particular staff, and government commitment to service delivery. Where MTP was more fully implemented, as in Kamuli, PLHIV developed new and often improved 'sightings' of the state as a result of the changes in health workers' attitudes towards them, the manner in which they were being handled during service provision, and through the different avenues that were established to have direct interactions with health workers and other state agents. From the qualitative interviews, several respondents talked of progressive improvements in their relations with health workers, in particular, and the respective health facilities, in general. One of the 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 (Male PLHIV leader, Kamuli, 21 March 2011)

Table 3. Service users' perceptions on attention of hospital to their concerns

	Attention by hospital			
Facility category	Not much	A little bit	A great deal	Total
Kamuli (n = 60)	10 (16.7%)	13(21.7%)	37 (61.7%)	60 (100%)
Masafu (n = 70)	35 (50%)	7 (10%)	28 (40%)	70 (100%)
Iganga (n = 44)	35 (79.5%)	4 (9.1%)	5 (11.4%)	44 (100%)

Quantitative data, although limited, helps to support these qualitative observations that PLHIV's trust in health workers during service delivery had improved. Our mini survey measured the perceptions of PLHIV about the responsiveness of the hospitals. When respondents were asked how much attention they thought their respective hospitals paid to what people like them think before they decided what to do, Kamuli MTP performed better than other sites (See Table 3).

From Table 3, 62 per cent of the PLHIV in Kamuli and 40 per cent in Masafu reported that, since the MTP intervention, their hospitals were paying 'a great deal of attention' to what they think, while only 11 per cent of the PLHIV in Iganga, where TASO had no intervention, felt the same. A majority of PLHIV (80%) in Iganga thought that their facility did not pay 'much attention' to them, but only 17 per cent and 50 per cent in Kamuli and Masafu, respectively, felt the same. These data suggest that, where the MTP was fully implemented (in Kamuli), state–society interactions became regularised, which made citizens feel that the state was interested in listening to their concerns.

Respondents' evaluation of the hospital and its quality of service became clear when we assessed PLHIV's willingness to pay for the services they received from the respective health facilities. Brinkerhoff et al. (2012) argue that people's confidence in the quality of public agencies is reflected in their willingness to pay for the services delivered there. According to Figure 2, whereas over 96 per cent of respondents in Kamuli and 73 per cent in Masafu expressed willingness to pay, the figure was only 32 per cent in Iganga, providing further evidence that the effects observed here are in line with the level of MTP presence in the different sites, and that the intervention tended to greatly improve levels of confidence and trust in the state amongst PLHIV.

The Problem of Financial Sustainability

The evidence presented so far suggests that social protection projects with built-in accountability mechanisms can indeed help extend social contracts between states and citizens in developing countries, and that NGOs, contrary to some criticisms, can play a positive role in this process. Importantly, however, the MTP was terminated in 2010. Our interviews with senior TASO staff

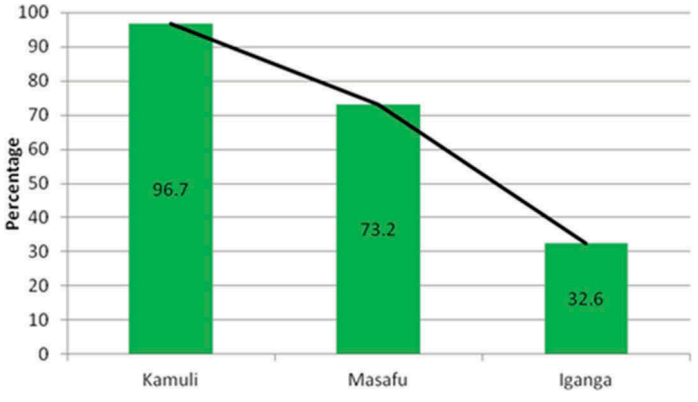

Figure 2. Willingness to pay for health services in the respective study sites.

suggested that the agency struggled to secure further financial backing for MTP from its main international funders because it was channelling funds to government agencies and thus running contrary to the expectation that the Civil Society Fund would primarily benefit Civil Society Organisations (various interviews with current and former TASO employees, Female TASO Central Region official, Kampala, 19 May 2011; Male former employee of TASO, Kampala, 23 April 2011; Male TASO HQ official, Kampala, 13 July 2011). This problem was compounded by the fact that TASO had not undertaken an official evaluation of the MTP despite external recommendations (Scott et al., 2005) and an internal commitment to do so (TASO, 2007), and thus lacked the evidence base required to persuade funders of its success.

This move reflects the dangers of relying on NGOs as the primary agents of progressive change, not because of anything inherent in their institutional character but in relation to the vagaries of NGO financing and because of the limited and time-bound nature of their interventions (Wild & Wales, 2015). Unfortunately, we currently lack the longitudinal evidence required to explore other critical aspects of sustainability, including the extent to which the processes observed here were maintained beyond the lifetime of the MTP intervention.

Conclusion

From the foregoing analysis, it is evident that TASO used the MTP to 'work on both sides of the equation' (Gaventa, 2002); that is, on the one hand, to 'civilise the state' and, on the other, to empower citizens to engage the state to improve service delivery. These effects were consistently deeper and more extensive where MTP had been implemented more fully. 'State civilising' attributes of MTP, such as health workers' shadowing, training, and financial facilitation, enhanced the ability as well as the commitment of government hospitals to deliver increased quantity and quality of HIV/AIDS services. Indeed, the state, especially in areas where MTP was fully rolled out, boosted its legitimacy as a result of meeting citizens' valued needs. On the part of PLHIV citizens, the MTP supplied resources in the form of training, ARV drugs, and actively enlisted their participation in service delivery. These, along with improved levels of service delivery from health workers, enhanced their self-worth. In turn, PLHIV gained confidence to engage in civic and political activities. Social protection programmes with built-in accountability arrangements can therefore provide useful forms of state society linkage, offering opportunities through which marginal groups can start to build a sense of citizenship, creating 'a series of sites where ordinary people might come to see the state in ways they have not done before' (Corbridge, 2007, p. 197). Our findings thus reinforce the growing sense that how programmes are designed and delivered is fundamental to their effectiveness, and that social accountability mechanisms may be less important in terms of enabling citizen 'voice' per se than though bringing stakeholders together from across the state–citizen divide to discuss and understand each other's interests and problems and build relationships of trust (Fox, 2015).

Overall, the experience of MTP supports claims that social protection interventions can potentially offer a route for integrating previously marginal groups within communities (Devereux, 2007), for promoting social cohesion (Hujo, 2009), and for building citizenship. Citizenship building works in a 'snowballing' fashion here, whereby enhanced citizen engagement in one area strengthens the possibilities of successful engagement in other areas. In MTPs, citizen action, whether through contentious action, MDD activities, or engaging in coproduction, left behind key transferable skills that some PLHIV used to engage in other activities, such as direct politics. This finding corroborates the wider sense that 'the journey from silence to a sense of citizenship [occurs] in many small steps' (Benequista, 2011, p. 8).

Lastly, notwithstanding the vagaries of NGO financing and short lifespan of their projects, it is worth noting that such actors can also play a role in helping states to see marginal groups as rights-bearing citizens in need of protection, and so help at least to some extent to reveal a pathway through which more progressive forms of social contracts can be promoted.

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Notes

1. SLRC is a multinational study that has undertaken similar analyses in countries like Sri Lanka, Nepal, and South Sudan (details available at http://www.securelivelihoods.org/publications.aspx).
2. In total, MTP was implemented in 13 districts in Uganda
3. 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.

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