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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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Abstract

Service-delivery NGOs are often attacked for abandoning the pursuit of ‘alternative development’ in favour of ‘technocratic’ and ‘depoliticised’ forms of development. Yet some commentators argue that these organisations, through their ‘technocratic’ interventions, can in fact have progressive impacts on political forms and processes. In this paper we investigate this debate through the lens of state capacity building in the global South. Primary research into the ‘Mini-TASO Project’, a programme by Ugandan NGO TASO to support government health workers and hospitals in improving HIV/AIDS service delivery, reveals that NGOs can have a constructive impact on four aspects of state capacity – bureaucratic capacity, embeddedness, territorial reach, and legitimacy. The paper finds that within its project areas TASO strengthened the bureaucratic ability of government hospitals to deliver HIV/AIDS services, made people living with HIV (PLHIV) visible to the state, increased the state’s embeddedness within society through co-production, and enhanced state legitimacy in the eyes of beneficiaries, due to increased accessibility to life-saving services and improved patient–provider relationships. However, the impact of the programme on the infrastructural reach of the state in rural Uganda was not sustained beyond its implementation. The overall conclusion of this paper is that service delivery by NGOs is not merely a technical activity: it can actually be an avenue for building more effective states.

Keywords

NGOs, service delivery, state capacity building, HIV/AIDS

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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 towards state building have recently received renewed attention, not only from the official development agencies, but also from academic institutions, of which the Effective States and Inclusive Development (ESID) Centre is a clear example (Hickey, Forthcoming; Vom Hau, 2012). This is a welcome development, especially in sub-Saharan Africa, where, due to the legacies of colonialism, inexperienced leadership in the immediate post-independent period and the resurgence of neoliberalism in the 1980s, the state building project has made limited progress (Crook, 2010; Mkandawire, 2010).

SD-NGOs have largely been sidelined 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; Marcussen, 1996; Mercer, 1999) 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). Moreover, to guarantee ownership of the poverty agenda, governments of poor countries are encouraged to take the lead in the formulation and implementation of policies, albeit in consultation with other societal actors (Batley and Rose, 2011; Lange, 2008; Lochoro et al., 2006; Pender, 2001). The mode of development that emerged out this is consensual development (Fowler, 2000).

As Batley and Mcloughlin (2010, p. 134) state, “the case for ‘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, Hickey and Mitlin, 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 strategies or tactics (Corbridge, 2007, p. 201). For instance, collaboration with government could actually allow NGOs to gain access and influence things from inside the state itself (Batley, 2011; Charlton and May, 1995; Chhotray, 2008; Lavalle, Acharya and Houtzager, 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). Uganda is often described as a typical neopatrimonial regime – that combines patrimonial logics and formal, albeit weak, modern bureaucratic features (Hickey, 2013). Although liberal democracy was introduced in 1996, elections are widely considered to be marred by gross irregularities, the opposition is usually harassed, the regime tolerates high levels of corruption, and it often limits freedom of speech and association (Tripp, 2010). With this uneasy coexistence of democracy and autocracy, unsurprisingly, Ugandan NGOs tend to opt to work in the 'non-political' development areas. 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 important question, the paper draws on the author's earlier PhD research, which focused on a prominent Ugandan NGO called the AIDS Support Organisation (TASO) (see Bukenya, 2012). TASO worked with local governments in various rural districts to address the capacity of public health facilities around HIV/AIDS service delivery through the 'Mini-TASO Project' (see detailed discussion on this in Section 5).

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, with the view of developing a conceptual framework to guide the analysis. Section 3 builds on this by describing and operationalising the dimensions of state capacity identified in the literature and which form the basis for analysing the impact of our case study NGO. Section 4 then provides a brief overview of the NGO sector in Uganda and its relations with the state. Section 5 deals with the description of TASO and its Mini-TASO project (MTP), the methodology employed and an introduction to the study sites. Sections 6-9 discuss in-depth the implications of the TASO project on state building along the dimensions of state capacity identified in the literature. Section 10 concludes.

2. Service delivery and state building

Analytically speaking, 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. Both of these areas are nascent fields, however: until recently, studies only made indirect reference to the relationship between service delivery and state building (Van de Walle and Scott, 2011, p. 9). However, since the mid-2000s there has been heightened interest in theorising and empirically investigating the so-called feedback effects of service delivery (Batley, McCourt and McLoughlin, 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, Wetterberg and Dunn, 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 enhances 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). It is, for instance, observed 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). By independence few skilled Africans were available to competently occupy the top positions of the civil service in their countries. Chazan and colleagues illustrate that in Kenya and Tanzania only 10 per cent of the civil service personnel were Africans at the time of independence (1999, p. 43). Comparable statistics are reported in Uganda (see, Furley, 1988; Kabwegyere, 1974).

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/or plan for their citizens (Corbridge et al., 2005; Hurrell and MacAuslan, 2012).

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

...because of the official efforts made to implement new policies using new or existing administrative arrangements, policies transform or expand the capacities of the state. They therefore change the administrative possibilities for official initiatives in the future, and affect later prospects for policy implementation (1992, p. 58).

In what they call the "recruitment effects" of development programmes, Corbridge and colleagues (2005) draw 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, p. 9). Comparable observations are made by Tandler (1997), especially in her case study of the preventive health care programme in Brazil. To Tandler, 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. These analyses therefore serve to account for the emergence of capable bureaucracies in 'difficult settings' that are otherwise famous for being the 'world of rent-seeking' (Tandler and Freedheim, 1994; also see Crook, 2010).

Although not explicitly stated as such, there are many documented case studies of 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 SPS judiciously applied acquiescence and resistance tactics to help the district 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 illustrated how NGOs' innovations from a range of sectors and country contexts have been scaled up within the state.

In Kenya, Brass (2011) notes that since 2002 the Kenyan government, through different line ministries and provincial administrations, sought to reach out to NGOs to encourage them to engage in the policy-making process and in service delivery. She argues that although this trend can partially be explained by donors' insistence on state–civil society collaborations, the view of most commentators is that this is a deliberate strategy by the Kenyan government to improve its development record, following “decades of hierarchical control [that] led to a decline in public service provision, a crumbling economy and massive corruption under Moi” (2011, p. 217). Brass claims that this has involved hiring NGOs' leaders to head various government departments and that:

NGOs now sit on government policymaking boards, development committees, and stakeholder forums; their strategies and policies are integrated into national planning documents; and their methods of decision-making have, over time, become embedded in government's own. NGOs have become institutionalized in the governing processes of public service provision (2011, p. 218).

Rather than being evidence of state co-option of NGOs or NGOs “hollowing out” the state (Wood 1997), the involvement of NGOs is illustrated by Brass (2011, p. 217) as “democratizing” development processes within Kenyan government agencies. 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. In Kenya, Okello (2010) reports that ex-CSO leaders who joined government, such as the Commissioner of Kenya National Commission for Human Rights, had come to conclude that changing how government works is a frustratingly slow process. This amplifies Edwards and Hulme's suggestion that the decision for NGOs to work with government “must be based on an assessment of the ‘reformability’ of the structures under consideration” (1992, p. 18).

Those positive examples notwithstanding, NGOs have been accused, in some circles, of undermining state capacity. 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). Although anecdotally stated, some add that NGOs use huge salary packages to lure good staff from the civil service – something that greatly derails the full development of the governments' own bureaucratic capacity (Cannon, 2000; Fritz and Menocal, 2007).

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

Drawing on the 19th century history of European state formation, Van de Walle and Scott (2011) observe that one way through which service delivery, potentially, impacts on state building is through aiding the process of state *penetration* of both the centre and the "periphery. Penetration means "the ability of the government to act directly upon the population by its own agents, instead of through intermediate local bigwigs" (Van de Walle and Scott 2011, p. 10). Public works, such as roads and railway networks, and the presence of state agents, such as army personnel, tax collectors and school inspectors, are particularly crucial for penetration. The process of *penetration* is closely connected to the concept of the infrastructural power of the state, particularly as it relates to the spatial extension of state agencies and spread of services (Soifer, 2008; Soifer and vom Hau, 2008). It is argued that the failure of colonial governments to invest in building infrastructural capabilities in most parts of sub-Saharan Africa laid a shaky foundation for successor postcolonial states to exert control over territories they claimed to own (Englebert and Tull, 2008; Fritz and Menocal, 2007; Herbst, 2000).

Ferguson (1990) provides another interesting avenue through which service delivery programmes could extend the infrastructural capacity of the state. The implementation of development projects in the countryside, Ferguson argues, 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 – matters in determining 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, public service structures like police posts, hospitals and schools are symbols which helped European states in the process of 'boundary-building' to differentiate the state from other socio-political organisations. However, there are cases where the infrastructural power of the state is "grounded in the organizational entwining between state and nonstate actors" (Soifer and vom Hau, 2008, p. 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. According to Lintsen (2002), up to the end of the 18th century, the "battle against water" was mainly in the hands of the local communities, with more than a thousand different organisations in some way or another involved in Dutch public works. He notes that:

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

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. In several African countries, the competition between the different denominations led to a rapid extension of service delivery structures into the periphery and they were sustained until states assumed responsibility for them (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. Here NGOs assist the state in creating organisational presence in remote areas, by putting on the ground activities that locals consider to be under state jurisdiction.

However, such findings have been questioned by observations that in some developing countries NGOs set up parallel structures alongside weak and under-funded government systems and that this greatly undermines/discourages governments' organisational development (Mohan, 2002). In addition, NGO programmes tend to be small and fragmented, with only a few able to operate programmes that cover whole regions, let alone countries (Bebbington, 2004). Relatedly, NGOs tend to concentrate in areas that are accessible and/or served with modern amenities – areas where the state has been strong prior to NGO intervention – as opposed to the poor and underserved communities, where the state is absent (Dicklitch, 1998; Jones, 2009).

2.3 Building state–societal ties

Another aspect of state building that can potentially be influenced by service delivery is the state's abilities to develop links and build coalitions with communities (Eldon, Waddington and Hadi, 2008). It is argued that service delivery structures can help to clarify citizens' expectations of the state, and vice versa, and making these expectations more realistic and manageable, thereby strengthening the social contract around national issues, such as health and education (Cornwall, Lucas and Pasteur, 2000; Eldon, Waddington and Hadi, 2008).

Some have argued that since the success of many service delivery programmes depends on the cooperation of 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, p. 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, p. 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 spreading participatory approaches within the state. In some countries this has been through establishing formal participatory spaces, where citizens are invited to contribute towards defining the package of what is provided and how services are delivered, 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. In Bangladesh, for instance, Mahmud (2007) reports that Nijera Kori (NK), an experienced NGO, played a key role in helping the government to mobilise and train villagers into HWCs, which were more ‘successful’ compared to those mobilised by state agents. However, whether these approaches have redefined state–society relations is a matter of intense debate (Cooke and Kothari, 2001; Hickey and Mohan, 2004).

2.4 Garnering support for the sitting government

Closely related to facilitating state–society ties is the observation that service delivery generates support for the ruling government and state institutions more generally. There are numerous channels through which this is possible. Several scholars argue that public services such as national health systems are highly visible institutions, and thus may play an important role in influencing public opinion on government (Eldon, Waddington and Hadi, 2008; Gilson, 2003; Kruk et al., 2010; Rockers, Kruk and Laugesen, 2012). Visibility is critical for regimes with tenuous legitimacy. In the aftermath of colonial rule, the most popular programmes undertaken by many African leaders were the visible ones, such as bureaucratic Africanisation, building of schools and hospitals, land re-distribution, nationalisation of companies owned by foreigners and elaboration of state-owned parastatals (Chabal, 1994; Ndegwa, 1998). In such contexts, service delivery “signals the will and capacity of the state to act on behalf of citizens in a responsive and accountable manner, generating enhanced support for the state in return” (Eldon, Waddington and Hadi, 2008:1).

However, others have implicitly played down the emphasis on visibility, arguing instead that what people care about most is the quality of the outputs. Rockers and colleagues (2012) suggest that what matters in the health sector, for instance, are not the inputs, such as budgetary allocation; rather, it is the quality and responsiveness of the system and health outcomes in form of improved health. Employing multilevel regression models to cross-national data from 38 low- and middle-income countries, these scholars find that individuals who reported a higher technical quality of health care were significantly more likely to trust the government (2012, p. 427). Quality is intimately connected to people’s experience at the point of delivery (Gilson, 2003). In Nigeria, Eldon and colleagues (2008) compared the

delivery of health services in the state of Kaduna and Enugu. They found that in the former, most respondents claimed to have more confidence and trust in the state's Ministry of Health, due to the improvement in their experiences with providers at the point of delivery. Meanwhile, in Enugu state, where health services were reported to be of poor quality, inequitable and fragmented, and unrelated to community priorities, citizens' perceptions of the state's Ministry of Health and the state government as a whole were generally negative and they felt that the state had little commitment either to good services or to the population (Eldon, Waddington and Hadi, 2008).

It is not clear, however, how these effects play out in contexts where the responsibility for service delivery is not a monopoly of state agencies. It is possible that "people affected by an intervention change their views [in relation to] the organization that delivers it" (Hurrell and MacAuslan, 2012, p. 261). Indeed, Hurrell and MacAuslan (2012, p. 261), drawing on their analysis of social protection programmes in Kenya, found that it is non-state providers, rather than the state, that gained "symbolic power", where delivery was spearheaded by the former. Meanwhile, Brass (2010a) did not find a negative effect of NGOs on state legitimacy, noting that: "it seems that in fact the people give loyalty [to the state] regardless of who gives services" (Brass 2010a, p. 17). Others suggest that even where the state lacks capacity to deliver directly, non-state providers can serve to enhance state legitimacy if there are deliberate strategies to present government as responsible for organising the (well executed) contributions of other actors (Batley and Mcloughlin, 2010). Tsai (2011), drawing on evidence from local governments in China, shows that state legitimacy could be boosted if non-state actors promote 'co-production' with the state. This is because, in part, co-production increases face-to-face interactions between state and non-state actors and encourages local officials to build better relationships with citizens (ibid). To Cammett and MacLean, whether or not provision by non-state actors affects state legitimacy is "context specific and depends on the particular relationship between the state and NSPs" (2011, p. 8).

Extrapolating from the preceding analysis, and building upon Vom Hau's (2012) work for ESID, it is argued that each of the four sets of impact discussed above can usefully be conceived as representing a specific dimension of state capacity, namely, bureaucratic capacity, infrastructural/territorial reach, embeddedness and legitimacy, respectively (see Table 1). In the next section, we explain these dimensions in turn and provide a summary of the effects of NGO delivery on each dimension.

3 State capacity and its dimensions

State capacity is a multidimensional concept that captures the "the ability of states to apply and implement policy choices within the territorial boundaries they claim to govern" (Vom Hau, 2012, p. 4). State capacity is conceptualised as consisting of: a) the bureaucratic capacity; b) external embeddedness (Evans, 1995; Evans and Rauch, 1999; Henderson et al., 2007); and c) the infrastructural power of the state (Mann, 1984; Soifer and vom Hau, 2008; Vom Hau, 2012). As discussed below, whether legitimacy is a separate dimension of

the state capacity or merely an indicator of it is a contested issue. We briefly explain these concepts below in turn.

3.1 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, p. 6) – in fostering discipline among civil servants. At the local level this could include mundane activities such as developing a customer care organisational culture among frontline staff; Corbridge et al. (2005) argue that this can be instigated by agencies external to the state.

3.2 Embeddedness

Another body of evidence posits that contrary to the general wisdom that state building must rely on formal institutional arrangements, high-capacity states 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, p. 3) that connect "the apparatus of the state, administrative and political, to civil society" (2011, p. 10). The concept of embeddedness is particularly useful in understanding state building in neopatrimonial contexts like Uganda, where decisions are made more through deals than rules (Booth, 2012; Unsworth, 2010). 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, p. 10).

3.3 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).

3.4 State legitimacy

State legitimacy refers to “the degree to which citizens regard the state as the appropriate political authority and the extent to which states can elicit citizen compliance without coercion or the threat of force” (Cammett and MacLean, 2011, pp. 5-6). There are two main perspectives on the relationship between legitimacy and state capacity building. The first, as articulated by Migdal (1988), is that legitimacy is a key determinant of state capacity. According to Vom Hau, the ability of state organisations to implement policy effectively is shaped by ideological consensus of citizens regarding “what constitutes legitimate political authority within a given territory” (2012, p. 14). The second perspective is that legitimacy is an outcome of enhanced state capacity. Legitimacy that emanates from the state’s ability to undertake “effective and equitable service delivery” is called “performance” legitimacy (Levi, Sacks and Tyler 2009, p. 358; OECD, 2008, p. 17). The concept of performance legitimacy is the most relevant for this study, because it provides us with a window for measuring how citizens value the goods and services delivered by NGOs vis-à-vis their evaluation of performance of the state.

It is important to note that the different dimensions of state capacity, as outlined above, are closely connected. For instance, a professional bureaucracy without roots in society may fail to implement public programmes (Soifer and vom Hau, 2008; Vom Hau, 2012). Similarly, Soifer (2008, p. 234) argues that the infrastructural power of the state “determines how far into society a bureaucracy, no matter how professional [and embedded], can reach”.

Relating the above discussion with the analysis in Section 2 helps to conceptualise how NGOs impact on state capacity. We summarise this in Table 1.

Table 1, and indeed the literature in Section 2, make an appealing claim that NGOs through service delivery 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 filling this research gap. 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.

Table 1: Service delivery, state building and NGOs

	Infrastructural capacity	Bureaucratic capacity	Embeddedness	State legitimacy
Service delivery programmes	<ul style="list-style-type: none"> - Spread of structures, personnel and services across claimed territories 	<ul style="list-style-type: none"> - Skills and professionalism of staff - Resources available for, and from, service delivery 	<ul style="list-style-type: none"> - Dense state-society ties - Co-production - Participation 	<ul style="list-style-type: none"> - It affects citizens' perception that the state has a right to govern and its actions are desirable, proper or appropriate.
Positive contribution by NGOs	<ul style="list-style-type: none"> - NGOs create structures awaiting state takeover - NGOs provide funding to poorly resourced remote government offices - NGO broadcast state power 	<ul style="list-style-type: none"> - Training and mentoring of government staff - Positive experiences from implementing collaborative projects 	<ul style="list-style-type: none"> - Encourages coproduction - Community mobilisation - Supports citizen participation 	<ul style="list-style-type: none"> - Enhanced citizens' support when NGOs' programmes increase the visibility of the state - NGOs help the state deliver services in quantities and quality desired by citizens
Negative effects of NGOs	<ul style="list-style-type: none"> - Discourage government to establish own structures - Fragmented programmes and concentrated in accessible areas 	<ul style="list-style-type: none"> - NGOs are inexperienced and too small to provide meaningful lessons to government - NGOs lure staff from government - Mutual mistrust 	<ul style="list-style-type: none"> - NGO preference for autonomy rather than collaboration - Tokenistic participation 	<ul style="list-style-type: none"> - NGOs promote their own visibility and/or discredit the state - Presence of NGOs interpreted as weakness of the state

Source: author

4. NGOs and the state in Uganda

In Uganda, NGOs represent one of the fastest growing sectors: from under 500 NGOs in 1992 (World Bank, 1994, p. 21), their number skyrocketed to 2,655 in 2000 and to approximately 4,000 in 2003 (Wallace et al., 2004, p. 18). Recent estimates put the figure in the region of 10,000 (Grover, Burger and Owens, 2011; NGO Forum, 2011) and the sector is described as “still growing” (Wallace et al., 2004). Despite this proliferation, Ugandan NGOs enjoy an uneasy relationship with the state. Those NGOs that play a ‘watchdog’ role on issues such as corruption, activities of the military and/or oil – issues that Ugandan

authorities consider to be no-go-areas for civil society – are harassed. NGOs are ‘advised’ to ‘back off politics’.¹ The persistent ones have had their operating licences 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,² while the Advocates Coalition for Development and Environment (ACODE) was singled out by the President as promoting ‘foreign interests’ with regard to Uganda’s oil sector. These developments should not be surprising, given that the Ugandan state has both democratic and authoritarian features – with the latter being predominant (Tripp 2010). However, the state tolerates and sometimes encourages NGOs in the ‘no-political’ development areas.

Meanwhile, the state’s ability to deliver public services, especially in the health, education and agriculture sectors, has been described as 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, has historically 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) became available in the early 2000s the government, with the support of international donors, committed itself to scaling up antiretroviral therapy (ART) service provision 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.

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

As already noted, this paper 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 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 Natrass, 2009; TASO, 2008). Its HIV/AIDS management approaches are widely

¹ 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.

² 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.

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.

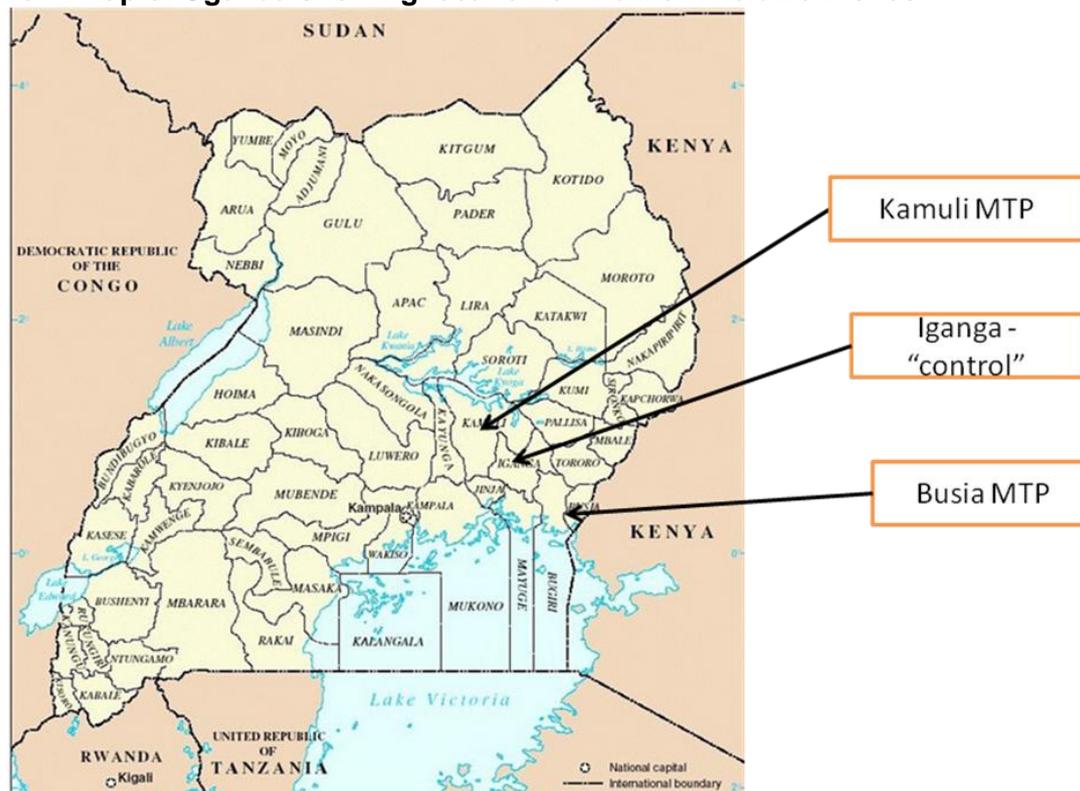
Alongside the political context discussed above, understanding TASO's strategy towards the Ugandan state requires us to look at the circumstances surrounding its origin as an NGO. TASO was formed at a time when Uganda was "at the height of ignorance about HIV infection and when hospitals were not very receptive to HIV-positive patients" (ACC/SCN, 2001, p. 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, Tanga and Nuwagaba, 2001). Some were ostracised and it is claimed that even public health workers stigmatised patients they suspected of having HIV/AIDS (Ssebhanja, 2007). It was because of such 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 (Ssebhanja, 2007, p. 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)(ibid)(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, p. 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, 2005:2). The project focused on enabling TASO, a highly regarded NGO, to support government health-workers and hospitals through various training programmes (see Appendix 1), providing financial resources of approximately Uganda shs.50 million 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.

To ensure that 'mature' projects (old enough to have registered impact) were studied, the research considered Mini-TASOs of five years or more. 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 (see Figure 1). 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 while 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, p. 61) calls a "pseudo *before* measure".

Figure 1: Map of Uganda showing location of the main fieldwork sites



Source: UN Cartographic Section: <http://www.ugandamission.net/aboutug/map1.html>

5.1 Kamuli and Masafu-Busia hospitals before TASO's intervention

Prior to TASO's intervention, both Kamuli and Masafu-Busia hospitals had introduced antiretroviral therapy (ART) programmes. Although Government of Uganda guidelines were not specific on numbers, they stated that before a health facility is accredited to provide ART services, it ought to have capabilities in various areas, including:

- a) the presence of basic physical infrastructure (space for HIV counselling and testing, clinical assessment, drug storage and laboratory);
- b) qualified personnel with experience in HIV/AIDS management; and
- c) the ability to ensure the provision of follow-up care and support for families and communities affected by HIV (Okero et al., 2003, p. 5).

These aspects are closely linked to the dimensions of state capacity identified earlier. This is in the sense that whereas the availability of skills in counselling, ART management and working space are akin to bureaucratic capacity, follow-up care and support for families and communities is a combination of embeddedness and infrastructural/penetrative capacity. Relying on their recollections, key informants stated that the reality on the ground at the time they started ART programmes sharply contrasted with official policy prescriptions. They did not have the necessary preparations for provision of ART in terms of personnel training, laboratory equipment or having a well-organised AIDS clinic. We briefly expound on this claim below.

5.1.1 Bureaucratic capacity within study sites

In terms of bureaucratic capacity, when the government supported Masafu-Busia to introduce antiretroviral therapy it trained only one staff. According to a senior medical officer in this hospital, this did not support large-scale service provision.³ Although the situation in Kamuli hospital was comparatively better, here too only three clinical officers and two nurses had been trained by the Ministry of Health to provide HIV/AIDS services.⁴ Paradoxically, however, even the so-called trained health workers claimed that they lacked psychosocial skills and that this limited their ability to educate and provide counselling services to service users.⁵ Although patients' enrolment on ART is influenced by many factors, health workers argued that it was primarily because of their inadequate skills in mobilisation, counselling and antiretroviral therapy administration that they recruited fewer patients before the Mini-TASO project.⁶

According to Figure 2, in 2005 Masafu hospital only managed to recruit 27 people living with HIV (PLHIV) on antiretroviral therapy (ART). When TASO came in 2006, enrolment jumped to 135 patients, indicating a 400 per cent increase from the previous year. Similarly, Kamuli hospital registered a steady increase in annual enrolment of PLHIV on ART after becoming a Mini-TASO.

For their part, several service users claimed that before TASO they received inadequate advice concerning treatment at the time they were enrolled on ART. This was exemplified by this respondent in Masafu-Busia: "I started getting treatment and then when I improved, I stopped taking drugs. This is because during those days, health workers would not tell us the importance of taking drugs consistently".⁷ The issue is that, during this time, health workers concentrated on the technical aspects of dispensing drugs, thereby ignoring the psychosocial needs of their patients. Both Masafu-Busia and Kamuli hospitals had no dedicated space for conducting counselling, which is crucial in addressing the psychosocial needs of PLHIV.

³ Interview with male health worker, Masafu hospital, 14 April 2011.

⁴ Interview with female health worker, Kamuli hospital, 21 March 2011.

⁵ Interviews with various health workers in Kamuli (various dates in March 2011).

⁶ Interview with male health worker, Masafu hospital, 14 April 2011.

⁷ Interview with male PLHIV Masafu hospital, 20 April 2011.

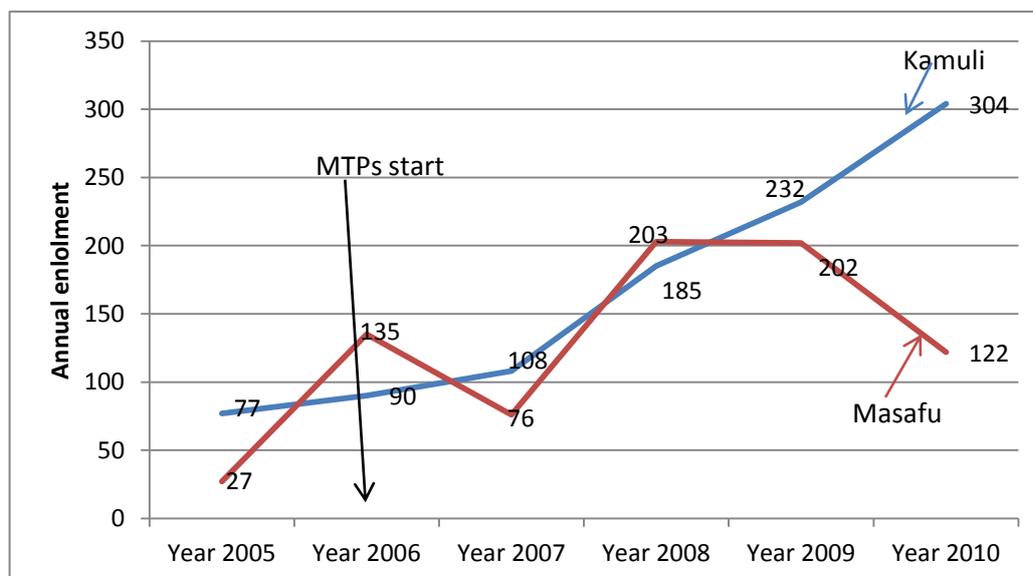


Figure 2: Annual enrolment of PLHIV on ART in Kamuli and Masafu-Busia

Source: Authors' calculations based on antiretroviral therapy registers.

5.1.2 Bureaucratic embeddedness

Health workers in both sites had limited ability to create “dense sets of interactive ties” with service users, families and communities constituting the hospitals’ catchment area. It is reported that before the project, health worker–patient relations were tense and characterised by “mutual mistrust”.⁸ (Some PLHIV respondents claimed that instead of providing services, health workers would blame them for their condition of being HIV positive: “those days, health workers looked at us as sinners. This even created self-stigma among patients. People refused to come out to test”.⁹) Apart from being antithetical to the development of trusting worker–patient relations, which is the bedrock of effective health services (Birungi, 1998; Gilson, 2003; Goudge and Gilson, 2005), PLHIV emerged from such relationships as second-class citizens. However, health workers defended themselves by stating that their poor attitudes were not deliberate, but because they lacked knowledge, skills and other resources to enable them serve their patients professionally.¹⁰ Another example of weak embeddedness is reflected in the absence of links between these hospitals and non-state actors, such as NGOs or service users’ organisations. Similarly, it was indicated that PLHIV did not have membership groups to bring them together with each other and/or with the state.¹¹

⁸ Focus group discussion with MTP service providers, 24 January 2011.

⁹ Interview with male PLHIV, Kamuli, 1 February 2011.

¹⁰ Interviews with two female health workers, Kamuli hospital, 14 January 2011 and 21 March 2011.

¹¹ Interview with male PLHIV, Kamuli, 10 February 2011.

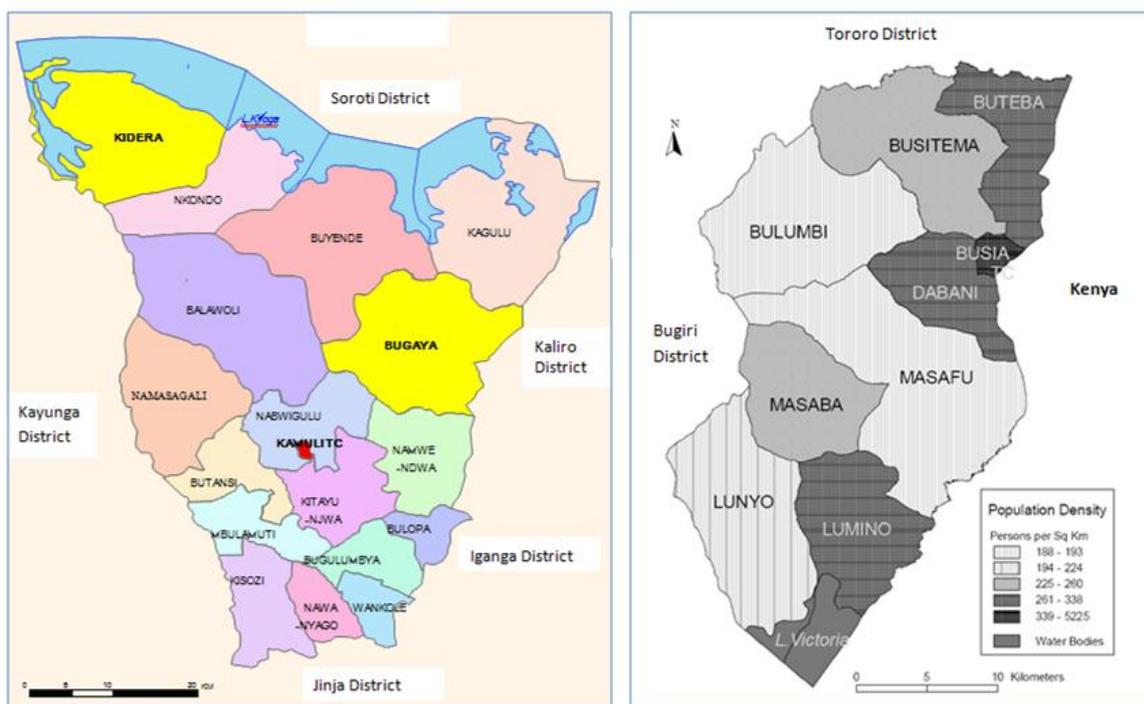


Figure 3: Maps showing sub-counties in Kamuli and Busia districts

Note: On the left is Kamuli District (Kamuli DLG 2009), the mini-TASO was located in Kamuli Town Council (TC) while its two outreach centres were in Bugaya and Kidera sub-counties. Busia District is on the right (Busia DLG 2011), the mini-TASO was situated in Masafu sub-county with one outreach centre in Lunyo sub-country.

5.1.3 Infrastructural/territorial reach

Both sites had a tenuous reach into the community before TASO's intervention. As explained below, there were no community programmes, such as visiting patients in their homes for monitoring purposes, nor any outreach to cater for communities far away from these hospitals.¹² Although the Government of Uganda Health Sub-District (HSD) structure dictates that the highest facility in the district, such as the district hospital, has the responsibility for supervising and offering technical support to the lower facilities, a combination of staffing shortages and inadequate skills meant that Masafu-Busia and Kamuli hospitals were unable to fulfil their supervisory obligations. This would have enabled PLHIV to receive services from the rural facilities nearer to them. Therefore, PLHIV far away from the district hospitals, especially the poor, had difficulties in accessing health services. For instance, PLHIV on the fringes of Lake Victoria in Lunyo sub-country, Busia district, would need to pay transport costs of about US\$5 per month for the 30 km journey to Masafu hospital.¹³ Given the socio-economic status of most PLHIV, which Bukenya (2012) describes as poor, such costs were beyond reach for many. The same was true for PLHIV in Kidera sub-county in Kamuli district (see Figure 3). Thus, whereas those citizens near the hospitals

¹² Interview with male health worker, Masafu hospital, 4 January 2011.

¹³ Several interviews with PLHIV in the area, 20 April 2010.

would 'see' the state, albeit in rough encounters, many of those far away would rarely glimpse it at all (also see, Jones, 2009).

Having established the pre-existing capacities in the study sites, the paper now examines 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. The paper will also analyse how the changes introduced by TASO influenced state legitimacy.

6 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 other health services more generally.

6.1 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 per cent and 53 per cent for Kamuli and Masafu-Busia, respectively.¹⁴

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 technician 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.

¹⁴ 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.

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						
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.

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

^bIganga 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.

^cOutreaches are mobile clinics organised by hospitals in distant communities.

^dIganga 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 that Kamuli and Masafu-Busia did not document it prior to 2005.

6.2 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 per

cent of the total budget reserved for purchasing such drugs.¹⁵ 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.¹⁶ This finding is corroborated by Nazerali and 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; Ssenkooba et al., 2007). Indeed, one respondent in Iganga hospital associated the fact that the hospital was out of stock of drugs with corruption. He lamented that "corruption is too much in this hospital, even after you have seen a lorry entering with consignments they will tell you drugs are not there!"¹⁷ Therefore, by providing a budget allocation for drugs, TASO was able to restore the confidence of service users in state facilities (see Table 2).

According to Table 3, whereas 84 per cent of PLHIV in Kamuli felt that there was poor availability of drugs before TASO, their opinion after implementing MTP changed, with 85 per cent, at the time of fieldwork, claiming that drugs supply was good. Similarly, for Masafu-Busia, 83 per cent 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:

My problem, as I have already told you, is the absence of some drugs. There is no consistency of drug availability. Take for example the previous three

¹⁵ Interview with male TASO HQ official, 28 January 2011.

¹⁶ Interview with health workers' focus group discussion, 24 January 2011.

¹⁷ Interview with male PLHIV, Iganga, July 2011.

months: we did not have any Septrin available. When TASO was still here it would give us money for a buffer stock.¹⁸

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 per cent) compared to Kamuli's (85 per cent). 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.

6.3 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, inadequate skills among existing staff and staffing shortages.

6.3.1 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 (Bukonya, 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.¹⁹ Apart from giving health workers technical knowledge, this training was meant to change attitudes, especially the stigmatising tendencies among government staff observed earlier.²⁰ As illustrated below, to TASO, effective HIV/AIDS management calls for building trusting relationships between service providers and their clients.²¹

In both Kamuli and Masafu-Busia, most health workers who attended TASO trainings attested that their attitudes towards HIV/AIDS work changed for the better. As exemplified by some of the responses below, 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. 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.²²

¹⁸ Interview with male PLHIV, Masafu-Busia, 11 April 2011.

¹⁹ See Appendix 1 for details of the different training modules and the number of people who were trained per study site.

²⁰ In particular, participants in the health workers' focus group discussion (held on 24 January 2011) invariably referred to TASO's training programmes as very inspirational.

²¹ Interview with male former TASO HQ official, 6 May 2011.

²² Interview with male health worker, Masafu-Busia MTP, 22 December 2010.

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

Our attitude towards clients ... was not very friendly... We used to have many 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.²³

For service users, whereas 82 per cent and 80 per cent 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 per cent and 96 per cent reporting, at the time of fieldwork, it to be good in Kamuli and Masafu-Busia, respectively. Thus, Corbridge et al. (2005) would predict, an external agency TASO 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".²⁴ Another respondent noted that "the problem here is that one counsellor could be responsible for like 100 clients, which means that they can't effectively follow them up".²⁵ 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".²⁶ In Kamuli, for instance, at the time of fieldwork, of the 12 people trained by TASO at the start of MTP, less than half were still in active service at the hospital.²⁷ 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, p. 45).

6.3.2 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 brought on board new activities, such as extra data collection, home visiting, and community sensitisation, among others. These were perceived as extra work by

²³ Interview with female health worker, Kamuli hospital, 21 March 2011.

²⁴ Interview with female PLHIV, Kamuli, 21 March 2011.

²⁵ Interview with male PLHIV, Kamuli, 1 February 2011.

²⁶ Interview with female TASO Central Region official, 6 December 2010.

²⁷ Interview with female health worker, Kamuli hospital, 14 January 2011.

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.²⁸

Thus, within the annual budget to Mini-TASOs, there was an allocation of UGX 5,000 per workday (roughly \$2.5) to motivate²⁹ 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 per cent 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”.³⁰

This arrangement, however, had several drawbacks. First, there was a risk of distracting the attention of government health workers from citizens with other ailments. Although several respondents claimed that health workers first attended to patients in the outpatient department and/or mostly used their ‘offs’³¹ to serve at the HIV/AIDS department, others argued that the urge to make money affected their attention to the HIV-negative patients.³² One health worker in Masafu-Busia rhetorically expressed this point:

At the hospital, other patients used to suffer indirectly because the number of staff was kind of reduced. Like me, I would spend most time in the field on HIV/AIDS activities. So if another patient came in at the hospital and needed my attention, he/she would not get me.³³

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”.³⁴

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

²⁸ Interview with female TASO Central Region official, 7 March 2011.

²⁹ Health workers often referred to allowances from TASO as their ‘motivation’ for doing extra work.

³⁰ Interview with male health worker, Masafu-Busia, 22 December 2010.

³¹ 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.

³² Interview with male health worker, Kaberamaido MTP, 18 May 2011.

³³ Interview with male health worker, Masafu-Busia, 20 April 2011.

³⁴ Interview with male health worker, Masafu-Busia hospital, 24 January 2011.

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.³⁵

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

6.4 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 ...".³⁶ The lack of office space also perpetuated the practice of focusing on dispensing drugs, thereby leaving patients' psychosocial needs unattended.³⁷ 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.

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".³⁸ 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: "the presence of this department helped to remind the hospital management that HIV is part of the services they were supposed to provide. You know, they used to think that HIV was not a priority to them ...".³⁹

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 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

³⁵ Interview with male health worker, 1 March 2011.

³⁶ Interview with male staff, Kamuli, 2 March 2011.

³⁷ Interview with female health staff, Masafu hospital, 27 December 2010.

³⁸ Male respondent, 1 January 2011.

³⁹ Interview with male PLHIV Kamuli, 10 February 2011.

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, with a view to 'capturing' these children in their homes:

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.⁴⁰

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 'seen' as a particular category of citizens was disadvantageous to some. For instance, it was reported that there was a section of PLHIV who were better served when HIV/AIDS services were being handled in outpatient department, because they did not want to be openly identified by members of the public as AIDS sufferers. Therefore, as Scott (1998) would argue, enhanced visual powers of the state came at the expense of citizens losing their privacy.

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

As observed in Sections 2 and 3, 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 identified two specific avenues through which MTP activities influenced ties between the state and civil society, namely, co-production and through 'dialogue structures'. These are discussed in turn.

7.1 PLHIV as service co-producers with government

The study established that before the implementation of MTP, involvement of service users in government hospitals was generally minimal, as even co-financing of services through user fees had been abolished in 2001 (Ssewankambo, Steffensen and Tidemand, 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 Natrass, 2009; Ssebhanja, 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.

⁴⁰ Interview with female health worker, Kamuli hospital, 14 January 2011.

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. According to data in Table 2, between 2006 and 2010, the average annual reach of such community awareness campaigns in Kamuli was 4,900 people, while that of Masafu-Busia was 1900. This performance is impressive, considering that the majority of Ugandan NGOs (which are considered by some to have a comparative advantage over state agencies in community mobilisation) reportedly have an average reach of less than 500 people annually (see Barr, Fafchamps and Owen, 2005, p. 663).

However, scholars have sounded caution about some of the adverse forms of co-production, which serve to promote the neoliberal agenda of slimming public expenditure (Mattson, 1986; Mitlin, 2008). 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.⁴¹ 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.

7.2 Embeddedness through 'dialogue structures'

TASO encouraged Mini-TASOs to copy mechanisms, such as clients' representative committees, that are used by its service branches to maintain close relations with their communities. However, because TASO avoided being branded 'political', it did not make the adoption of these mechanisms mandatory.⁴² Table 4 outlines the distribution of mechanisms which were established in the different study sites. For the purposes of simplicity, the study collectively termed them 'dialogue structures'.

Table 4: Distribution of dialogue structures in the study sites

Dialogue structure type	Kamuli MTP	Masafu-Busia	Iganga
PLHIV/clients representative committee	Yes	-	-
Clients welfare committee meetings	Yes	-	-
Staff meetings with drama members	Yes	Yes	-
Staff–peer counsellors' meetings	Yes	Yes	Yes
General PLHIV meetings	Yes	-	-

⁴¹ Interview with male health worker, Kaberamaido MTP, 18 May 2011.

⁴² It is through such flexibility that MTP implementation varied across sites.

According to Table 4, Kamuli had five dialogue structures, compared to Masafu-Busia's two, while the two PLHIV volunteers in Iganga claimed that they only took part in departmental meetings. The study argues that dialogue structures acted as avenues for balancing citizens' expectations of the state and vice versa. This is an important aspect of state building, for it points to the process of building a *social contract*⁴³ between the state and citizens. According to the OECD (2008, p. 17) a social contract emerges from a dynamic interaction of four factors:

- a) expectations that a given society has of a given state;
- b) state capacity to provide services;
- c) elite will to direct state resources and capacity to fulfil social expectations; and it is mediated by
- d) the existence of political processes through which the bargain between state and society is struck, reinforced and institutionalised.

When closely examined, the 'dialogue structures' in Kamuli, especially general meetings, were engendering processes "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 some of the meetings will illustrate this point.

In the service user's meeting on 30 January 2010, deliberations of members enabled them to understand the structural constraints that prevented the hospital from having enough drug stocks for clients. In this meeting, one female PLHIV had "lamented over the on-and-off stock-outs of Contrimoxazole and sometimes antiretroviral drugs in Kamuli District Hospital and other health facilities in the district and said that something had to be done in order to rectify the situation". In response, the chairperson of PLHIV reported that:

he had talked to the Project Coordinator about the stock-outs and was convinced by the explanation that the stock-outs were nationwide. [He added] that the management of the hospital was very mindful of the situation and everything possible was being done to minimise the stock outs.⁴⁴

Another example of how these mechanisms helped to align citizens' expectations with state capacity was recorded in the General Meeting of 25 April 2009, where the District Secretary for Health was the "Chief Guest". After her remarks, beneficiaries were requested to raise their concerns. One male PLHIV took to the floor and asked the official: "what is the contribution of government towards the welfare of [PLHIV] in addition to that [support] offered by TASO?" According to the meeting minutes, the Chief Guest answered that "Government already contributes in terms of staff, infrastructure, and drugs, e.g. ARV, etc". When another PLHIV got his chance to speak, he requested that the district should consider

⁴³ Social contract is understood here to refer to a dynamic agreement between state and society on their mutual roles and responsibilities: OECD. 2008. "Concepts and Dilemmas of State Building in Fragile Situations: From fragility to resilience." in *OECD/DAC Discussion paper*: Organisation for Economic Co-operation and Development

⁴⁴ Service users' meeting, 30 January 2010.

empowering health centre IIIs and IVs “to administer ART in a bid to reduce congestion at the district hospital [MTP]”. The Chief Guest’s response was that the decision to grant lower health centres powers to deliver antiretroviral drugs came from the central government (Ministry of Health) and urged PLHIV to be patient; “Rome wasn’t built in a day. Hopefully, this will be achieved in the long run” she reportedly informed them.

These vignettes show that such channels of communication enabled the state to hear citizens’ concerns and citizens in return understood what the state was doing about their situation. This was in part verified through the quantitative data. When respondents were asked in the mini-survey as to how much they thought their respective hospitals paid attention to what people like them think before they decide on what to do, Kamuli MTP that had regularised dialogue mechanisms performed much better than other hospitals (see Table 5).

Table 5: Service users’ perceptions on attention of hospital to their concerns

Facility category		Attention by hospital			Total
		Not much	A little bit	A great deal	
Kamuli	Count	10	13	37	60
	% within facility category	16.7%	21.7%	61.7%	100.0%
Masafu-Busia	Count	35	7	28	70
	% within facility category	50.0%	10.0%	40.0%	100.0%
Iganga	Count	35	4	5	44
	% within facility category	79.5%	9.1%	11.4%	100.0%

From Table 5, 62 per cent of the PLHIV in Kamuli and 40 per cent in Masafu-Busia reported that 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 per cent) 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-Busia, respectively, felt this. This data suggests that where the MTP was fully implemented (in Kamuli), state–society interactions became regular, which made citizens feel that the state was interested in listening to their concerns.

8. 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 current Government of Uganda investment in health sector infrastructure improvement, through the health sub-district structure, was largely ineffective. This is attributed to constraints facing rural facilities, such as limited resources, staffing and inadequate skills for service delivery, which are akin to challenges that existed in MTP sites before TASO’s intervention. The main strategy TASO proposed to address the spatial gap in service delivery was to make these otherwise moribund rural facilities operational, through the concept of “medical outreaches”. TASO assumed that monthly visits by staff from the nearest MTP to “provide HIV related services

at these facilities would lead to capacity building ... in HIV/AIDS management in the long run” (TASO, no date, p. 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, the 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 per cent of the expected number), they could not get time to see what the health workers from Masafu-Busia MTP were doing during outreaches. According to one of the staff in Mbehenyi, “they would serve their PLHIV and we would also concentrate on our malaria and the usual outpatient department”.⁴⁵ 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, p. 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.⁴⁶ 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.

9. Mini-TASOs and the legitimacy of public hospitals

As observed in Section 2, the literature suggests that one of the key sources of state legitimacy is the effective provision of public goods and services, provided at levels of quality, quantity and equity satisfactory to most citizens. The discussion so far suggests that MTP, its weaknesses notwithstanding, bolstered the performance of the targeted government health facilities, as reflected in the numbers of people served in various service categories (see Section 6.1). Moreover, through this project, TASO maintained the state in the driver’s seat to steer service provision. Section 2 suggests that it is important to portray the state as responsible for development programmes and one would expect that this

⁴⁵ Interview with female health worker, Mbehenyi HC II, 20 April 2011.

⁴⁶ 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.

enabled it to claim the credit associated with the project. This section, therefore, investigates the impact of MTP activities on citizens' confidence in the state.

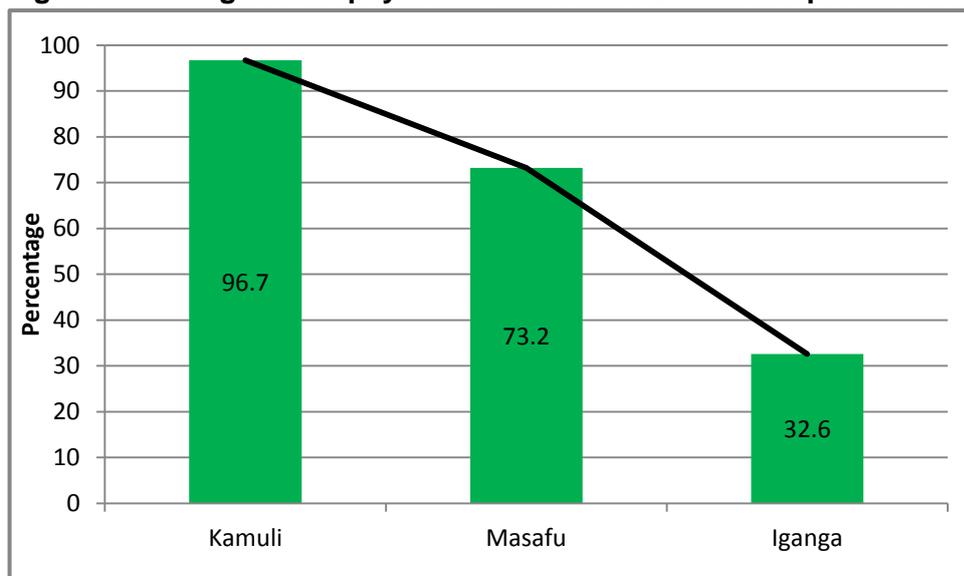
Following Corbridge and colleagues (2005), this study envisaged that PLHIV would develop new and perhaps improved 'sightings' of the state as a result of the changes in health workers' attitudes towards them, the manner in which they were being handled during service provision, and through the different avenues that were established to have direct interactions with health workers and other state agents. From the 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.⁴⁷

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, Wetterberg and Dunn, 2012). According to Figure 4, whereas over 96 per cent of respondents in Kamuli and 73 per cent in Masafu-Busia expressed willingness to pay, in Iganga only 32 per cent reported the same. Therefore, if we take willingness to pay as an indicator of people's trust in public agencies, then Kamuli would be the most trusted hospital, followed by Masafu-Busia. Additionally, and in line with our earlier 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.

⁴⁷ Interview with male PLHIV leader, Kamuli hospital, 21 March 2011.

Figure 4: Willingness to pay for health services in the respective study sites



10. Discussions 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. 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" (Corbridge et al., 2005, p. 150). However, the project did not find a lasting solution to problems of inadequate staffing and unreliable medical supplies in government hospitals. This is mainly because MTP was time-bound, yet most activities depended on the continued availability of funding. 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 findings strongly suggest that the effects were attributable to MTP. Although better results were discernible in Kamuli and Masafu-Busia than in Iganga (which did not implement the project), the results in Kamuli were stronger than those in Masafu-Busia, as the project was more thoroughly implemented and supported in the former.

However, wider state-society relations also matter in explaining the results here. As reported earlier, at the national level, President Museveni put special emphasis on HIV/AIDS upon capturing state power in 1986. The President's charismatic directness in addressing HIV/AIDS placed it high on the development agenda, which in turn encouraged constant and candid national debate and media coverage of aspects around this epidemic (Green et al.,

2006). These developments might explain the seriousness with which some government hospitals in rural Uganda undertook TASO's HIV/AIDS project. This echoes Booth's (2012) observation that state organisations can perform effectively – even in patrimonial settings – when they benefit from strong, top-down authority and leadership carried through to the level of implementation. Moreover, the international community has also been supportive of pro-HIV/AIDS interventions, as signified by the generous funding programmes such as the United Nations' Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and United States' President's Emergency Plan for AIDS Relief (PEPFAR).

According to the evidence presented on state legitimacy, enhanced capacity of the state to deliver services can increase citizens' trust in state agencies, especially those that are directly responsible for the delivery. Service users' higher confidence levels in state agencies in Kamuli compared to Masafu Mini-TASO and Iganga suggest a relationship between the levels of performance of state agencies and the level of trust that they can attract from citizens (Brinkerhoff, Wetterberg and Dunn, 2012). In addition, and as Kruk and colleagues (2010) suggest, the process of building state legitimacy is multi-layered, starting from reworking the micro dynamics of the provider–patient interaction, followed by the overall relationship between health facilities and communities in their catchment area and then upwards to peoples' general perception of government.

This paper also gives important insights into the politics of coproduction. Coproduction activities with PLHIV boosted the bureaucratic effectiveness of Mini-TASOs, increased state legitimacy, and extended the reach of government programmes in the communities. This suggests, therefore, that the argument advanced by some that the desirable organisation arrangement of the state is a centralised bureaucracy which can directly penetrate society and put citizens in unmediated encounters with the state (Houtzager, 2005; Houtzager and Pattenden, 2005; Van de Walle and Scott, 2011) may not be appropriate in some contexts. As suggested by Booth (2011), in some contexts effective service delivery systems tend to be those embedded in social relations – combining professional standards with local moral economy. To Mitlin (2008, p. 353), an effective state sometimes

needs to negotiate with local citizens to ensure their participative involvement, not only with respect to individual changes in behaviour but also because some things can most effectively be managed locally, with citizen engagement.

In view of these observations, what ESID could do is to undertake systematic investigations to establish the extent to which coproduction is an important component for effective service delivery within its case study countries and then trace backwards the factors that both gave rise to and perpetuate such delivery arrangements.

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/or invite them into decision-making spaces like staff meetings. All of these offer opportunities for improving state–society relations and inclusive development. This study indicates that acquiring the

capacity to 'see citizens like an NGO' is an essential part of the state's repertoire in terms of social service delivery. Once public agencies improve on this aspect, citizens become more willing to seek services from them and to coproduce with them. However, further research is needed to establish whether "seeing like an NGO" offers analytic value in contexts outside HIV/AIDS.

Overall, the theme running throughout this paper is that Mini-TASOs and other 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, McCourt and McLoughlin, 2012, p. 131). Our evidence suggests that service delivery is not a technical activity, but rather could also be a means for building effective states. It is therefore concluded that service delivery activities of NGOs should not be marginalised as merely an "adjunct to activities arbitrarily defined as 'more' political; nor should it be dismissed as a distraction from these more important 'political' missions" (Charlton and May, 1995, p. 241). Research programmes like ESID can go a long way in deepening our understanding of the politics of SD-NGOs by providing systematic comparative evidence from various developing countries' contexts.

Appendix 1: Mini-TASO capacity-building programmes

No	Training	Duration	Target per MTP	Actual Kamuli	Actual Masafu/Busia
1	Project planning and management (PPM)	2 weeks	10	10	10
2	HIV/AIDS counsellor training	6 months modular	20	12	10*
3	Monitoring and evaluation principles and practices	1 week	5	5	5
4	Principles and practices of antiretroviral therapy (ART)	1 week	30	12	10*
5	Management of opportunistic infections	1 week	20	12	10*
6	Training for community trainers (TOT)	Modular 6 months	10	2	2
7	Peer counselling training (for PLHIV)	2 weeks	20	20	15
8	Counsellor supervision	1 month modular	3	2	0
9	Resource mobilisation and advocacy	1 week	5	5	5
10	MDD group members trained in message development, communication skills and advocacy	2 weeks	15	15	15

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

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