The Ugandan Journal of Management and Public Policy studies
Volume 2 Number 1 November 2011

Uganda Management Institute

Partnerships as Entities, Agreements, and Venues to Interact: The Case of the Uganda Aids Commission and the Uganda HIV/AIDS Partnership

Rose B. Namara
Uganda Management Institute, UMI
rosenamara@gmail.com

Sylvia I. Bergh
International Institute of Social Studies, Erasmus University Rotterdam, the Hague, the Netherlands
bergh@iss.nl

Abstract

Partnerships as a framework for development have long been used in the delivery of public policy and programmes. However, the literature suggests that the concept of partnership is often uncritically used and partnerships are understood and practised differently in the delivery of public services. Yet there is little research on the discourse, interests and practices of partnership arrangements and the range of structural factors and agendas underlying these relationships. This article is based on a rapid assessment of the HIV/AIDS Partnership in Uganda as coordinated by the Uganda AIDS Commission (UAC) to explore: (i) how actors (and the UAC in particular) understand the concept of partnership in everyday development delivery and (ii) how actors (and the UAC in particular) practise the concept of partnership. Data drawn from in-depth interviews with UAC management and technical staff as well as key policy documents demonstrates that in the HIV/AIDS sub-sector in Uganda, partnerships are understood and practised as an important methodology of conducting HIV/AIDS interventions. By applying the model developed by Kingsley and Waschak to the empirical data, the article shows that the UAC sees the HIV/AIDS Partnership predominantly as a way of bringing together different entities to make a contribution. Intentionally or not, the HIV/AIDS Partnership serves several purposes, including: improving governance and decision-making processes, streamlining HIV/AIDS resource mobilisation and utilisation, enhancing coordination of the HIV/AIDS response at the decentralised government level, and generally contributing to an effective management of the ever-increasing web of actors in the sector. To a lesser extent, the UAC also conceives of the HIV/AIDS Partnership as a venue of interaction for learning purposes, mainly through the Partnership Forum, and as contractual agreements, especially in the management of the Civil Society Fund where civil society organisations compete for service delivery funding.

Key words: Partnerships, HIV/AIDS, Health, Uganda

Introduction

Numerous partnerships arrangements have been developed, ranging from memoranda of understanding between organisations to contracts to define clear roles and responsibilities of actors, around issues such as health, education, research, and even the global War on Terror. However, a look at the literature on partnerships in development suggests that the concept is often uncritically used. This has partly been attributed to New Public Management demands for quick fixes of the (perceived) inadequacy and inefficiency of the public sector in public service delivery. This often led to the engagement of various actors without critical analysis of their motives and capacities. Another explanation relates to the good governance agenda which suggests that partnerships in development are critical to increasing aid effectiveness and accountability. The literature further suggests that partnerships are understood and practised differently in the delivery of public services (Kapilashrami, 2010). This may be a result of different conceptualisations of the concept of partnerships and these differences have implications for development policy and delivery.

This article explores two angles of the concept of partnership: (i) how actors understand the concept of partnership in everyday development delivery and (ii) how actors use/practise the concept of partnership. Does the conceptualisation of partnership determine the way it is practised? Focusing on the Uganda AIDS Commission (UAC) as the main actor in coordinating partnership arrangements in the national HIV/AIDS response, this article suggests that understanding how partnerships have been conceptualised in the HIV/AIDS sector requires careful consideration of the motive and ideology behind such partnerships, the nature of players or potential partners, the contractual obligation of players as well as the relationships and processes in such partnerships. The primary data for this article include policy documents and five interviews conducted by the first author with two members of the UAC's management and three technical staff in the period 26 April to 7 May 2011 (see Appendix 1 for the interview tool). This rapid assessment of the HIV/AIDS Partnerships in Uganda finds that partnerships are understood and used as an important methodology of conducting HIV/AIDS interventions.

The paper is structured as follows: The next section reviews the literature on the concept and practice of partnership, followed by a presentation of the conceptual and analytical framework. Section four sets the context of the case study by briefly reviewing recent developments in the global health and HIV/AIDS sub-sector. The in-depth discussion of the case study is found in section five, while the conclusion in section six summarises the findings and outlines future areas for research.

Literature Review: The Concept and Practice of Partnership

Kapilashrami (2010: 17) notes that the meaning of the concept of partnership is often 'implicit in different terms that are used interchangeably – "collaboration", "network", "alliance" leading to conceptual ambiguity' of what the concept of partnerships really means. According to Fowler (2000), partnership expresses the ideological aspiration of solidarity and mutual interdependence; often the relationship among parties is long-term and not merely about solving a specific problem. Authentic partnerships are premised on solidarity rather than on contracting, mutuality and reciprocity and a degree of similarity, recognised position and function in society, among others. Lister (2000) and Fowler (2000) note that collaboration between agencies should not be assumed to constitute partnership, because partnerships take long to develop.

Although Fowler and Lister do not specify how long it takes for a relationship to qualify to be called a partnership, the mutual solidarity, joint decision and action seem to present minimum characteristics of most partnerships. Lister (2000) considers a successful partnership to include: a) mutual trust, complementary strengths, reciprocal accountability, joint decision-making and a two-way exchange of information; b) clearly articulated goals, equitable distribution of costs and benefits, performance indicators and mechanisms to measure and monitor performance, a clear delineation of responsibilities and a process for adjudicating disputes; c) shared perceptions and a notion of mutuality with give-and-take; d) mutual support and constructive advocacy; e) transparency with regard to financial matters, long-term commitment to working together, and recognition of other partnerships.

According to the literature on organisational studies, in order to fully understand the concept of partnerships, it is critical to analyse the reasons for forming partnerships and the kind of organisational relations that foster or hinder cooperation and coordination. The need for exchange, for knowledge and technical expertise, and the need for collaboration to secure strategic positions within a field of organisations are some of the reasons why organisations prefer to work in partnerships. Kapilashrami (2010) argues that partnerships may not only form to complement, collaborate and cooperate with each other but also to compete. Partnerships are therefore not always harmonious but conflicts and disagreements may exist in such arrangements. Such motives and conflicts may be understood by exploring how actors understand the concept of partnerships and how they live it.

In public management literature, the term 'partnership' is closely linked to liberal reform agendas, i.e. it is viewed as an all-purpose remedy for many different reform movements in the public sector (Osborne, 2000). According to Teisman and Klijn (2002) in Kingsley and Waschak (n.d.), partnerships are cherished in public management reforms because there is a recognition that: a) for an individual actor to achieve goals requires activities by other actors; b) the resources and knowledge for achieving goals are distributed across multiple actors; c) the systems and processes for development delivery are comprehensive because they are dependent upon the negotiations of participating actors; and d) partnerships enforce accountability standards. Thus the reasons for partnerships in public management are varied.

Partnerships between the public sector and the private sector are commonly forged to enhance the efficiency and effectiveness of policy and service delivery by improving equity, efficiency, quality, accountability and accessibility of services and accelerating capacity strengthening in a relationship where both government and the private sector actors have a certain level of autonomy, share risks and complement each other (Lobina & Hall, 2006; Franceys & Weitz, 2003). Dunaway and Shaw (2010) emphasise that even in private companies the motives of the partners are the driving forces behind any partnership arrangement. In contrast, Buse and Harmer (2004) have labelled partnerships as tools of governance, dismissing the ideology or anticipated benefit embedded in the concept. They argue that the starting point in analysing partnerships should not be their underlying assumptions or rationale but the practices which the partnerships generate. Hence, this paper attempts to understand the partnerships in the case study both by analysing the rationale for and the practices that emerge from the partnership arrangements.

Miraftab (2004) emphasises the importance of the kind of institutions that are involved in a collaborative relationship and the degree of foregone autonomy as human behaviour and actions take place within a socially constructed framework. Institutions establish different kinds of arrangements, such as public-private sector partnerships (PPPs), NGO - state partnerships, NGO - private sector/corporate partnerships, NGO - NGO partnerships, and NGO - beneficiary partnerships. Partnerships can be inter-organisational and cross-sectoral. A common yet distinguishing feature of these different forms of partnerships is a shared governance structure and decision-making process that guide the partnerships (Ahmed & Ali, 2006). Institutional arrangements need not be taken for granted but rather should be questioned to understand who is a partner to whom and how the decisions in such partnerships are made. This is because the way in which partnerships emerge determines the nature of power relations and the complementary role of partners, as well as the level of reciprocity in sharing benefits (Lankatilleke, 1999 in Miraftab, 2004).

For example, some partnerships are said to be dominated by donor-recipient behaviour and power asymmetries and do not portray a sense of mutual accountability (Fernando, 2007).

Indeed, PPPs have been highly criticised as a form of 'privatisation advancing interests of the private sector and the market under the banner of sharing power with the poor and the state' (Miraftab, 2004: 89). Miraftab suggests that once the PPPs are in motion the interests of the community are marginalised. Miraftab attributes this to conceptual inconsistencies, where the concepts of private/public are ambiguously defined with a likelihood of obscuring the distinct vested interests of the partner. Yet there is little research on the discourse, interests and practices of the institutional arrangements and the range of structural factors underlying these relationships, and the different logics and agendas of different partners (Kapilashrami, 2010). This paper aims to contribute to this knowledge gap by focusing on the UAC's discourse and practice with regard to the partnership arrangements in the HIV/AIDS sub-sector.

The Conceptual and Analytical Framework

Kingsley and Waschak (n.d.) provide a useful model of assessing how partnerships are conceptualised and practised. They suggest that partnerships can be viewed as entities, processes, agreements and venues of interaction among actors.

Partnerships as entities. These comprise memberships, boundaries, and formal and informal organising structures designed to achieve specific functions. The success of such structured and bounded partnerships is assessed by analysing the growth and sustainability of such structures. The partners are bound together by a common agenda and thus organise in different structures with defined roles and responsibilities towards the achievement of the goal.

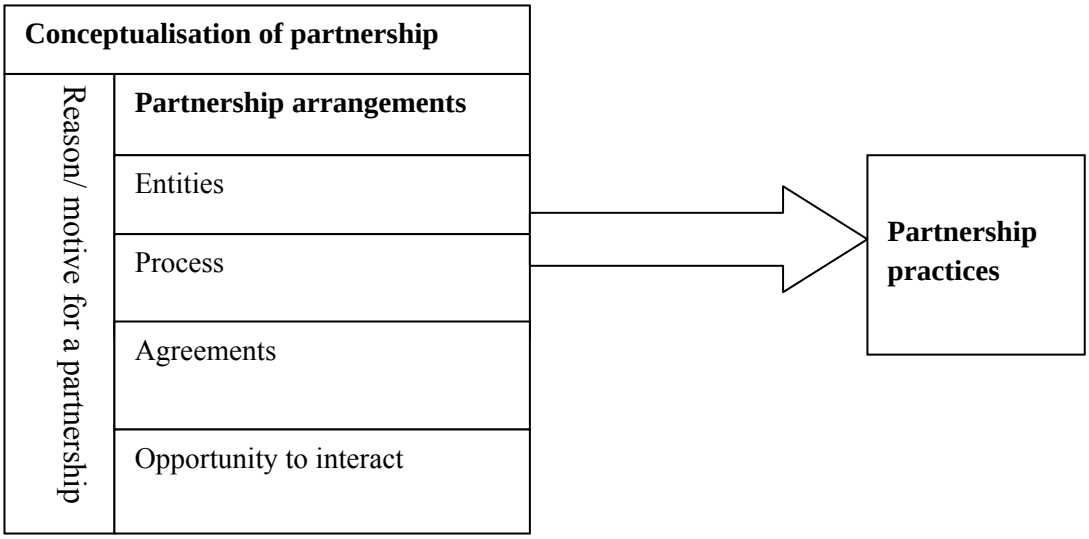
Partnerships as processes. These consist of relationships that are built up over time to enhance levels of trust and cooperation towards a certain goal, often working together in an organised way to reach mutual goals which would be hard or impossible to reach by the effort of one institution alone. Parties share roles and activities, resources and work procedures to achieve the intended goal. The scope and boundaries of such partnerships are often unpredictable and their success is largely dependent on adherence to the chosen process by the partners.

Partnerships as agreements. These have contracts with goals aimed at improving performance in a given undertaking. Each organisation has specific clear roles of responsibility and is accountable for carrying out these activities and responsibilities. Likewise, Phang (2007) equates public-private partnerships to a formal business arrangement between public and private actors, regulated through contracts.
Often the structure of contractual partnership arrangements varies from contract to contract and adherence to the terms and conditions of the contract is very critical to the partnership's success.

Partnerships as a venue or opportunity to interact. This is where there is an opportunity to bring together individuals, often with diverse multiple expertise and with similar interests, to address issues of importance to the partners. The structure of such a partnership is loose; it is communication and the sense of community that make such partnerships work. This is in line with Widdus' (2005) view of partnerships as social experiments where parties attempt to learn how to interact and handle certain issues better.

Although Kingsley and Waschak's (n.d.) model emphasises complementarities and cooperation among actors, rather it provides a useful tool for analysing how partnerships are conceptualised and practised. This paper utilises a modified Kingley and Wschak' model (see Figure 1 below) to analyse partnership arrangements in the health sector and specifically the HIV/AIDS Partnership programmes, focusing on the Uganda AIDS Commission, to assess how it understands and practises the concept of partnerships in coordinating the national HIV/AIDS interventions. The analytical framework enabled the researchers to detail the rationale behind partnerships, the kind of partnership arrangements, the related practices as well as the factors underlying such practices. The framework assumes that the way partnerships are conceptualised in the HIV/AIDS programmes determines distinct practices of such partnerships.

Figure 1: The analytical framework



Source: *Authors' own creation for purposes of analysis*

Partnerships in the Global Health Sector and the HIV/AIDS Sub-Sector

The history of partnerships in the health sector dates back to the 1970s. The welfare reforms in Europe and the subsequent fiscal crisis of the 1980s saw a shift away from state-oriented health care towards a market-driven approach to health sector reforms. Similarly, in developing countries there was a deliberate, mainly World Bank-supported, shift towards the privatisation of public infrastructure, utilities and services, including health and education, and towards the use of multiple sources of health financing (Lister, 2005; Kapilashrami, 2010). One such source are the global public-private partnerships (see below), which are seen as a key mechanism of global health provision (Utting & Zammit, 2009). From an economic point of view, the global PPPs are meant to address cost and investment challenges through modified private-public markets, improve efficiency, and enhance service quality (Nikolic & Mikisch, 2006).

The major global health partnership initiatives include the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the United States President's Emergency Plan for AIDS Relief (PEPFAR), the GAVI Alliance (GAVI, formerly the Global Alliance for Vaccines and Immunisation), the Joint United Nations Programme on HIV/AIDS (UNAIDS), and the World Bank's Multi-Country HIV/AIDS Program for Africa (MAP), among others. They all focus on HIV/AIDS and together provide two-thirds of all external funding for HIV/AIDS (Bennett et al., 2006). These initiatives are said to increase the scale of resources committed to specific health goals (Kapilashrami, 2010), improve capacity in terms of staffing and retention of workers in the health sector (Heward et al., 2007), and increase access, improve equity, and raise the quality of health services (Patouillard et al., 2007). However, Naimoli (2009:3) shows that the global health partnerships are faced with a number of challenges including: 'forging a common vision and approach, governance, balancing pressure to move money with incremental learning, managing partner roles and relationships, managing the "value for money", risks, and capacity building'. Kapilashrami (2010) argues that one negative consequence of the global partnerships has been the 'one size fits all' rationale around PPPs, usually with no consideration of the pluralities in context and the shape and workings of such partnerships. Indeed, the global partnerships seem to be largely driven by efficiency principles and risk focusing on a single disease or interventions, rather than a comprehensive approach to achieve equity and 'health for all'. Périn and Attaran (2003) show that there have been numerous shifts in health policy since the 1960s, yet health needs in developing countries have remained constant. They argue that 'donors back health policies that mirror their own domestic political or economic ideologies' (ibid.:1218) and are not related to recipients' health needs. Périn and Attaran (2003) therefore call for locally-owned dialogues and partnerships with donors rather than top-down interventions. As we will see, our case study seems to fit this approach.

Partnerships in the HIV/AIDS Sub-Sector in Uganda

Uganda subscribes to the three global principles (the 'Three Ones') in its efforts to coordinate the national HIV/AIDS response. The 'Three Ones' include: one national HIV/AIDS coordinating authority with a broad-based multi-sectoral mandate; one HIV/AIDS action framework which provides the basis for implementation by all partners; and one agreed country-level monitoring and evaluation system (UAC, 2011). Uganda established the Uganda AIDS Commission (UAC) in 1992 as a corporate body with the overall function of planning and coordinating all HIV/AIDS policies and programmes (UAC, 2007). UAC is responsible for developing the national HIV and AIDS strategic plans and the national performance frameworks as well as ensuring that such guidelines are implemented through coordinated efforts. Partnerships are thus seen as a tool for enhancing coordination of the HIV/AIDS

national response and are embedded within the 'Three Ones' framework. As emphasised by one of the respondents:

> We [UAC] would not [be able to] fully coordinate and oversee HIV/AIDS interventions unless we have this partnership in place. UAC is a lean commission, with limited staffing. Even when you look at our budget, government contributes about 20 per cent. So the HIV/AIDS Partnership has enhanced our coordination. The partners are able to reach where UAC may not physically reach (UAC 2007: 2).

Thus it seems that partnerships have enhanced coordination and increased resources and the visibility of UAC efforts in planning and coordinating the national response. However, its broad mandate means that other actors involved in HIV/AIDS programmes in the country are necessarily operating on the terrain of UAC, an indication that there may be an inherent unequal structural power relationship between UAC and other players.

To better fulfil its coordination tasks, UAC works in a partnership called the HIV/AIDS Partnership. The need to establish the HIV/AIDS Partnership was realised in 2001. UAC conducted an institutional analysis and performance assessment which concluded that UAC was not able to fulfil its mandate as desired. It was realised that not many of the institutions that ought to have participated in coordinating and overseeing HIV/AIDS interventions were active and even receptive to UAC's call. As such the UAC established the multi-sectoral HIV/AIDS Partnership mechanism in 2002 to facilitate the participation of a wide range of institutions.

According to UAC, the HIV/AIDS Partnership has been conceptualised as a method of doing coordination and carrying out oversight responsibilities. The HIV/AIDS Partnership aims to 'minimise duplication, maximise potential for synergies, harmonization, learning and peer support and pool efforts for scaling up the response' (UAC, 2006: 4-5). As one official emphasised:

> To us, partnership is a method of doing work. This method has got elements like having a common agenda that allows all to participate to the extent that is possible; that ensures that the set standards and guidelines are followed; that allows for joint resource mobilisation and mechanism that allows players to agree and disagree and share resources. UAC alone, we cannot manage; it is a way of improving our working (ibid: 2).

The HIV/AIDS Partnership has thus multiple reasons behind its existence: efficiency, potential for networking and support, learning, and scaling-up of the national HIV/AIDS response. One of the main aims of the partnership is to implement the National HIV/AIDS Strategic Plan 2007/8-2011/12 (referred to as NSP; UAC, 2007), which, among others, sets the targets of decreasing Uganda's annual HIV incidence by 40 percent by 2012 (i.e. a decrease in the number of annual new HIV cases from 163,000 to 100,000) and of substantially increasing access to HIV/AIDS services in the country (increasing the number of people with access to antiretroviral treatment to 240,000 from 91,500). The plan emphasises the ABC method (Abstinence, Be faithful and use Condoms) and focuses on cost-effective prevention programmes (UAC, 2007).

Discussions with UAC officials show that some of the common processes of the HIV/AIDS Partnership include:

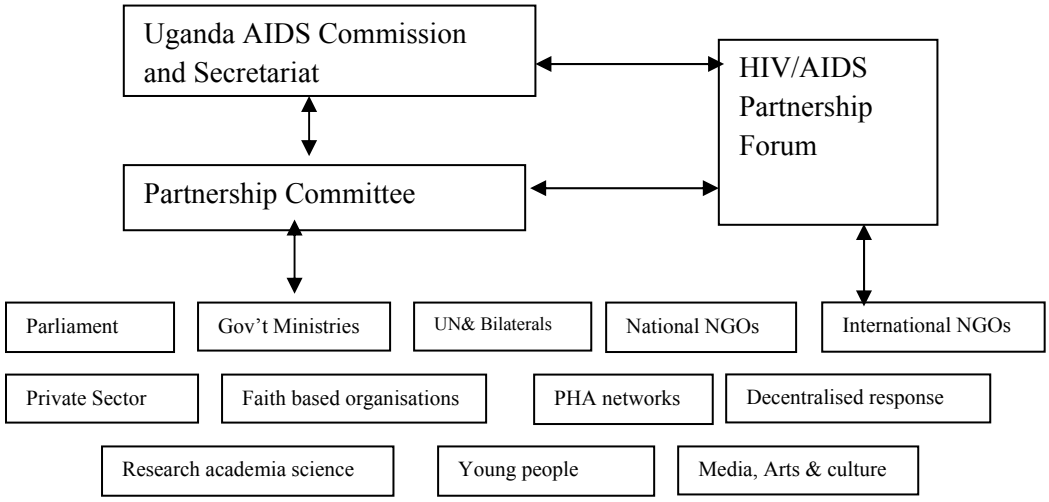
- Conducting joint planning and priority setting.
- Setting guidelines towards better quality delivery of the national response.
- Holding various meetings, seminars, and workshops on several aspects of the purpose of the partnership.
- Holding monthly and annual coordination meetings.
- Documenting how coordination is happening and the results of such coordination.

This last point seems to be the weak point in the partnership. Although the UAC established the multi-sectoral HIV/AIDS Partnership mechanism to provide an opportunity for all stakeholders to participate in the coordination of the national response (UAC, 2007), there seem to be no clear documented coordination techniques nor a clear assessment of the contribution of the partnership as a whole to the overall HIV/AIDS response. Until recently, it seems that the focus has been on the process of the HIV/AIDS Partnership more than on measuring the concrete contributions the partnership has made to achieving the national goals.

It was only in 2009 that UAC adopted the Joint AIDS Review (JAR) to review the performance in the coordination, implementation, and demonstration of results of HIV/AIDS programming and implementation. According to information received from UAC (pers. comm. from K2 at UAC received on 7 July 2011 and citing the *UAC Institutional Review Report*, 2011), the JAR draws almost entirely upon existing documentation to the extent possible and aims to ensure that the analysis and conclusions are linked to relevant government processes.

In order to deepen our understanding of the discourse and practice of the HIV/AIDS Partnership, we now apply our conceptual and analytical framework presented above to the data collected in the interviews and from key policy documents. The main finding here is that partnerships in the HIV/AIDS sub-sector in Uganda seem to be predominantly viewed as collaboration among entities, i.e. the first type of conceptualisation in the Kingsley and Waschak (undated) model. Figure 2 presents the structural arrangement of the HIV/AIDS Partnership. UAC provides the secretariat for the HIV/AIDS Partnership in the country, and also serves as the seat of the country coordinating mechanism for the HIV/AIDS component of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GAFTM). The Uganda AIDS partnership structure is comprised of the Partnership Committee and twelve Self-Coordinating Entities (SCEs, also called clusters). Interviews with UAC officials indicate that these entities were invited to become partners with regard to the UAC's coordination and oversight mission. The SCEs are expected to collectively contribute to the management and coordination of the response, share experiences and identify gaps and then share these with other stakeholders through the Partnership Committee and the Partnership Forum (see below for more on these two institutions). Owing to the critical role of some institutions, such as the UAC, UNAIDS, the Ministry of Finance, Planning and Economic Development (MoFPED), the Ministry of Health (MoH), and the Ministry of Gender, Labour and Social Development (MoGLSD), they are viewed as independent permanent partners on the committee rather than being represented as one of the self-coordinating entities.

Figure 2: The Uganda HIV/AIDS Partnership structure



Source: *UAC, 2007: 32 (Figure 3). Notes: The twelve boxes represent the SCEs. PHA stands for 'People living with HIV/AIDS'. The arrows indicate the communication relationships.*

The partnership structure was said by interviewees to have increased conformity to national policies and programmes. UAC does not employ sanctions or force on other players to operate within the national AIDS policy framework, so conformity and harmonisation with HIV/AIDS policies seem to be automatic. This was partly attributed to the consultative nature of formulating the national HIV/AIDS policy and plan. According to one UAC official:

> The structure of the partnership has kept most players in the sector informed of what is going on about the national guidelines and required standards. The representatives of the sector mobilise and consult their members without UAC interference. Maybe that is where there is weakness because we [UAC] do not control operations of the clusters (Ibid:1).

The HIV/AIDS Partnership requires the different entities to articulate their contribution to the national response and show their contribution so as to be recognised as 'part of the club'. Interviews with UAC reveal that even those institutions, including service deliverers and donors, that may have been operating outside the national AIDS plan often make an effort to work in close collaboration with UAC in subsequent years when their contribution is not recognised in the national annual HIV/AIDS reports.

The tension between collaboration and autonomy observed earlier with regard to partnerships in general is also evident here. Structurally, peers are different but seek to work in harmony to deliver the HIV/AIDS national response, suggesting that partnership is the idea of solidarity in diversity. Solidarity and the need for peer support are highlighted as important aspects of the HIV/AIDS Partnership structure. To achieve solidarity as well as maintain the autonomy of different partners, the HIV/AIDS Partnership established the (informal) Inter-agency Coordination Committee in 2009/2010. As one official noted:

> The Inter-agency Coordination Committee brings together the non-state partners, who often discuss and agree on their agenda before meeting the state actors. This has made the non-state partners to move into partnership meetings with harmonised voices. As such then the partnership meetings become avenues for negotiation. For instance through the Inter-agency Coordination Committee, the non-state partners were able to negotiate for the 'principal recipient role' for the Global Fund and it was accepted (K2 – see below for more details).

The Inter-agency Coordination Committee is viewed by the interviewees as one of the most important outcomes of the partnership. It is an operational initiative of the SCEs to organise their interaction with other partners in the Partnership Committee. It has enhanced recognition of players as independent players and minimised the chances for the state's co-optation of non-state partners.

Indeed, our case study shows how the HIV/AIDS Partnership viewed predominantly as entities can contribute to good governance among partners, especially government and non-government entities**.** Through the Partnership Committee, which is comprised of government and non-government actors, strategic decisions regarding the HIV/AIDS national response are made. The members of the Partnership Committee include representatives of the ministries, self-coordinating entities, and donor partners. The committee works through sub-committees and technical working groups such as Monitoring and Evaluation, Information and Advocacy, Prevention and Resources Management. Some agencies have permanent seats on the Partnership Committee including UAC, UNAIDS, and the ministries mentioned earlier (MoH, MoFPED, MoGLSD). The committee is the backbone of the partnership mechanism, with monthly meetings to clearly articulate and make decisions regarding the national response. The partnership thus provides a formal and representative forum for interaction between different entities (UAC, 2007). This confirms the observation by Ahmed and Ali (2006) that partnerships take different forms but the common distinguishing features are a shared governance structure and decision-making process. Most importantly, discussions with UAC officials indicate that working in committees promotes a good governance ethos, such as accountability and exchange and free flow of information among partners.

This increases efficiency and the use of available resources, including at sub-national levels. As one UAC official noted:

> Through the HIV/AIDS Partnership, we have managed to get actors in this field to often make reference to the overarching AIDS policies and national plan. We have also managed to increase access to donor funding. We have also managed to make donors fund district plans and budgets. We have asked donors to tell us exactly what they fund in given districts and they have also tasked districts to clearly show the use of funds (K2).

This is in line with Buse and Harmer's (2004) claim that partnerships are also governance tools. Partnerships can strengthen accountability and complementarity between partners, even within the public sector, and help to bring sub-sectors closer to each other (Lobina & Hall, 2006).

Another (at least initially very promising) result in the governance arena is that the partnership is used to streamline aid effectiveness through organising resource mobilisation and utilisation. UAC sees the partnership as a catalyst to provoke a larger discussion of and commitment to the HIV/AIDS sub-sector among partners. The HIV/AIDS Partnership is 'important in pooling resources and creating linkages that enhance the HIV/AIDS strategic information flow within and amongst partners in the response at national and district levels' (UAC, 2007: 33). To this end, the Partnership Fund was set up in 2002 as a major source of funding for the HIV/AIDS coordination and management efforts of UAC, SCEs and other national level stakeholders. Several donor agencies (including the national development cooperation agencies of the UK, Ireland, and Denmark) have contributed to the fund. The fund's quarterly report of January-March 2011 (by Deloitte Uganda Ltd.) shows that a total of UGX 6.1 billion (USD 2.6 million) has accumulated in the fund in the form of grants. The fund grew by 41 percent from UGX 3.6 billion in 2009 to 6.1 billion at the end of 2010. The Partnership Fund covers the costs of the coordination activities of most of the SCEs, but also those of line ministries and special organisation development projects approved by the Partnership Committee, such as the National Aids Support Assessment, Medium Term Review and Joint Annual Review of the NSP and the UAC Institutional Review. However, according to the report cited earlier, only 26 percent of the fund has been disbursed. This may be attributed to operational challenges that emerged when the new financial management agent (Deloitte Uganda Ltd.) appointed in 2010 as well as to reported inadequate technical capacity of the sub-recipients to access, utilise, account for and apply for new funding from the fund. Moreover, as of 31 March 2011, no new funding had been injected in the Partnership Fund, implying that upon disbursement of allocated amounts this year, the fund balance is likely to be exhausted unless replenished with new partner pledges (pers. comm. from K2 at UAC received on 7 July 2011). In other words, the sustainability of this fund is in doubt and this may have serious implications for the partnership's strength as well.

A more encouraging example is the Country Coordinating Committee (CCC) which was established in 2006 to effectively manage the Global Fund to Fight AIDS, Tuberculosis and Malaria (GAFTM). Through the HIV/AIDS partnership it has been agreed that there are two principal recipients to the Global Fund, i.e. the Ministry of Finance and the CCC. As one UAC official noted:

> The Country Coordinating Committee is one avenue through which government and other stakeholders have managed to focus on three health related components all at once, i.e. HIV/AIDS, tuberculosis and malaria. This helps to focus the Ministry of Health's effort and the financing efforts. It helps to set the right priorities and guidelines for these health issues. The Ministry of Finance is the principal recipient but it has been agreed that eventually this role should be taken over by Ministry of Health, because the Ministry of Finance is not an implementing ministry (K 3).

The CCC has enabled partners to develop a common focus on health financing and to develop guidelines for fund utilisation.

In 2007, another fund was established under UAC, namely the Civil Society Fund (CSF), to support the goal of ensuring that the civil society provision of prevention, care, treatment and support services to HIV/AIDS and orphans and vulnerable children is harmonised, streamlined, effective and in support of the government's national strategic plan, national priority action plan and other national plans and policies. Currently, USAID, the UK's DfID, IrishAid, Denmark's DANIDA, Italian Cooperation and Sweden's SIDA have made contributions to the fund (see CSF, 2011). The fund has brought on board several other actors to participate in service delivery and the coordination of the national response. Grants have been disbursed for civil society activities in the areas of HIV prevention, AIDS care and support, and orphans and vulnerable children. As one UAC official noted:

> One good result of this partnership has been the creation of the Civil Society Fund. Donors have been convinced to pool their resources and establish a fund, where organisations delivering HIV/AIDS-related services can compete for funding (K1).

This implies that partnerships may be able to mobilise previously untapped resources and actors from the local, regional, or international levels to supplement government efforts.

Finally, as already indicated briefly above, the HIV/AIDS Partnership has been used to enhance decentralisation. The Local Government Act of 1997 mandates local governments to directly manage and monitor the delivery of services, including those for HIV/AIDS, within their areas of jurisdiction. The government has adopted an institutionalised coordination mechanism for the management of HIV/AIDS in local governments, involving technical and political leaders.

Under this arrangement, AIDS committees (comprised of technical teams) and taskforces (comprised of politicians) have been established at all local council levels. The AIDS committees develop technical issues, activities and policies on HIV/AIDS and submit them to AIDS taskforces for review before submission to councils for adoption and inclusion in their development plans and budgets. The decentralised governance and coordination of the HIV/AIDS national response has enabled the local players to own the national response and demand better service delivery. As one of the respondents noted:

> There are some district committees and AIDS taskforces that have confronted their Members of Parliament on HIV/AIDS funding and policy issues. The decentralised coordination has also regulated donors, who now see it fit to fund District Development Plans. The question during partnership meetings has been, how do we work with districts? Some have supported the development of District AIDS Plans, but some have funded the integrated activities of the districts (K3).

It is clear from this discussion that the HIV/AIDS Partnership is perceived and used as a tool for managing the ever-expanding number of actors in the HIV/AIDS sub-sector and as an alternative governance structure to exclusive public-sector management.

Apart from conceiving of the HIV/AID Partnership as collaboration between entities, it can also be viewed as a venue for interaction (the fourth type in the Kingsley and Waschak model), since it is also aimed at enhancing learning. For example, the UAC has put in place the Partnership Forum, an annual event of all stakeholders at national and sub-national levels that attracts politicians, policy-makers and technical experts to share information on the status of the epidemic and response and agree on the national priorities for action (UAC, 2011). According to UAC, the benefit of such interaction has been the documentation of some of the best practices, the replication and scaling-up of some of the strategies to benefit the majority of the population, and the appreciation of the role of different players. As one UAC official noted:

> When we meet in the annual Partnership Forum, one is able to know what the media is doing, what the academia is doing, who has what resource and who can collaborate with whom on a given aspect. We are able to share our coordination work plans and reports and appreciate some of the guidelines by sharing experiences (K2).

Similarly, the annual District AIDS Partnership meetings provide a key opportunity for joint dialogue between policy-makers, technical representatives, community representatives and other stakeholders in local government. The aim of these meetings is to broaden participation in sharing information, knowledge and experiences on HIV/AIDS.

Besides conceptualising partnerships as entities and opportunities to interact, at least one part of the HIV/AIDS Partnership is predominantly viewed and practised as a contractual arrangement**,** namely the management of the CSF mentioned earlier. The steering committee of the fund is chaired by UAC with representatives from various ministries (MoH, MoFPED, and MoGLSD), donors and civil society and is responsible for the oversight of the fund. The day-to-day operations of the fund are coordinated and managed through three contracted agents, i.e. a financial management agent (Deloitte Uganda Ltd.), a technical management agent (Chemonics International), and a monitoring and evaluation agent (also Chemonics International; see CSF, 2011). Thus funds are managed under the agreement nature of partnership by private for-profit entities. The contractors have specific roles and responsibilities to perform in order to contribute to the national HIV/AIDS response. The structure of the partnership under the CSF has been designed to allocate risks to the partners who are best able to manage those risks and thus minimise costs while maximising performance. UAC has remained with its regulatory role as other institutions are also facilitated to make a contribution. However, the goal of having the private sector in a partnership is to profit from its capacity and experience in managing businesses. Further analysis of the partners' performance in managing the CSF is beyond the scope of this paper but would be useful for enhancing our understanding of the HIV/AIDS Partnership as agreements in practice.

Conclusion

In summary, the evidence presented here shows that under the HIV/AIDS programmes in Uganda, partnerships are conceptualised and practised as an important method of doing work. As such, activities, including joint planning and meetings, are routine aspects of the method. The HIV/AIDS Partnership is seen by UAC predominantly as a way of bringing together different entities to make a contribution. Twelve Self-Coordinating Entities (clusters) as well as other members with permanent seats on the Partnership Committee participate in coordinating and overseeing the national response. Intentionally or not, the HIV/AIDS partnership serves several purposes, including: improving governance and decision-making processes, streamlining HIV/AIDS resource mobilisation and utilisation, enhancing coordination of the HIV/AIDS response at decentralised government level, and generally contributing to an effective management of the ever-increasing web of actors in the sector. To a lesser extent, the UAC also conceives of the HIV/AIDS Partnership as a venue of interaction for learning purposes, mainly through the Partnership Forum, and as contractual agreements especially in the management of the Civil Society Fund where civil society organisations compete for service delivery funding.

This article thus used the model developed by Kingsley and Waschak (n.d.) to reveal the interactions between the conceptualisation of partnership and how it is practised by one of the main actors in Uganda's national response to the HIV/AIDS challenge, namely the UAC. We would argue that 'partnership as processes' is the type of conceptualisation in the model with the least analytical power and could be subsumed under the other three types.

Areas for further research include extending this analysis to the other actors involved (i.e. how do they conceptualise the partnership?), and then comparing the predominant conceptualisations across actors. Another major area of research would be to assess (qualitatively or quantitatively) the contribution of the partnership arrangement to achieving the NSP. A final step would then be to link these two areas of research by looking for causal linkages between partnership conceptualisations and concrete contributions.

References

Ahmed, S.A. & Ali, S.M. (2006). People as partners: Facilitating people's participation in public-private partnerships for solid waste management. *Habitat International*, *30* (4), 781-796.

Bennett, S., Boerma, J.T., & Brugha, R. (2006). Scaling up HIV/AIDS evaluation. *The Lancet, 367* (9504), 79-82.

Buse, K. & Harmer, A. (2004). Power to the partners?: The politics of public-private health partnerships. *Development, 47* (2), 49-57.

Civil Society Fund (CSF). (2011). Home page and *About Us*. Retrieved from: http://www.csf.or.ug/ and http://www.csf.or.ug/about.aspx respectively.

Dunaway, W. M. & Shaw, G. L. (2010). The influence of collaborative partnerships on private sector preparedness and continuity planning. *Journal of Homeland Security and Emergency Management, 7* (1), Article 47.

Fernando. S. Udan. H. (2007). *Uneasy Encounters: Relationships between Dutch Donors and Sri Lankan NGOs*. PhD Thesis, Amsterdam: Amsterdam Institute for Metropolitan and International Development Studies of the Universiteit van Amsterdam.

Fowler, A. (2000). Introduction: Beyond partnership: Getting real about NGO relationships in the aid system. *IDS Bulletin, 31*(3), 1-13.

Franceys, R. & Weitz, A. (2003). Public-Private community partnerships in infrastructure for the poor. *Journal of International Development, 15*(8), 1083-1098.

Heward, S., Hutchins, C., & Keleher, H. (2007). Organizational Change- key to capacity building and effective health promotion. *Health Promotion International, 22* (2), 170-178.

Kapilashrami, A. (2010).*Understanding public private partnerships: the discourse, the practice, and the system-wide effects of the Global Fund to fight AIDS, tuberculosis, and malaria*: *A case of HIV Management in India.* PhD thesis submitted to the Institute for International Health and Development, Queen Margaret University, UK.

Kingsley, G. & Waschak, M. R. (undated). *Finding Value and Meaning in the Concept of Partnership*, Georgia Institute of Technology, Retrieved from http://hub.mspnet.org/index.cfm/14546.

Lankatilleke, L. (1999). Resource as prerequisite: Who's participating in whose process? *Community and resource management*. Nairobi, Kenya: Community Development Programme, United Nations Centre for Human Settlements.

Lister J. (2005). *Health Policy Reform: Driving The Wrong Way? A Critical Guide to the Global 'Health Reform' Industry*, Enfield, England: Middlesex University Press.

Lister, S. (2000). Power in partnership? An analysis of an NGO's relationship with its partners. *Journal of International Development, 12*(2), 227–239.

Lobina, E. & Hall, D. (2006). Public-Public Partnerships as a catalyst for capacity building and institutional development: Lessons from Stockholm Vatten's experience in the Baltic region, Paper presented at IRC and UNESCO-IHE Symposium on *Sustainable Water Supply and Sanitation: Strengthening Capacity for Local Governance*. Delft, The Netherlands, 26-28 September 2006. Retrieved from: http://www.irc.nl/page/31026.

Miraftab, F. (2004). Public-Private Partnerships: The Trojan Horse of neoliberal development? *Journal of Planning Education and Research, 24*(1), 89-101.

Naimoli, J.F. (2009). Global health partnerships in practice: taking stock of the GAVI Alliance's new investment in health systems strengthening. *The International Journal of Health Planning and Management, 24*(4), 3-25.

Nikolic, I. A . & Mikisch, H. (2006). Public -Private Partnerships and collaboration in the Health Sector: An overview with case studies from recent European experience. *Health, Nutrition and Population (HNP) Discussion Paper*. Washington D.C.: World Bank.

Osborne, S. (2000). *Public-private Partnerships for Public Services: An International Perspective*. London: Routledge.

Patouillard, E., Goodman, C., Hanson, K., & Mills, A. (2007). Can working with the private for-profit sector improve utilization of quality health services by the poor? A systematic review of literature. *International Journal for Equity in Health, 6* (17), no page numbers.

Périn, I. & Attaran, A. (2003). Trading ideology for dialogue: an opportunity to fix international aid for health? *The Lancet, 361,* 1216-1219.

Phang, S-Y. (2007). Urban rail transit PPPs: Survey and risk assessment of recent strategies. *Transport Policy, 14* (3), 214-231.

Teisman, G.R. & Klijn, E-H. (2002). Partnership arrangements: Governmental rhetoric or governance scheme? *Public Administration Review, 62* (2), 189-198.

Uganda AIDS Commission (UAC) (2006). *Structural and Institutional Framework of the Uganda HIV/AIDS partnership: Addendum to the Proposed Longterm Institutional Arrangements for the GFATM Programme on HIV/AIDS in Uganda*. Kampala, Uganda.

Uganda AIDS Commission (UAC) (2007). *National HIV & AIDS Strategic Plan 2007/8-2011/12, Moving Towards Universal Access*. Kampala, Uganda. Retrieved from: http://www.aidsuganda.org/IRC/documents/nsp.pdf.

Uganda AIDS Commission (UAC) (2011). *About Us* (Basic information on the UAC) and *The Uganda HIV/AIDS Partnership*. Retrieved from: http://www.aidsuganda.org/about_us.html and http://www.aidsuganda.org/partnership.html respectively.

Utting, P. & Zammit, A. (2009). United Nations-Business partnerships: Good intentions and contradictory agendas. *Journal of Business Ethics, 90*(1), 39-56.

Widdus, R. (2005). Public-Private partnerships: An overview. *Transactions of the Royal Society of Tropical Medicine and Hygiene*, *99* (1), 1-8.