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**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 THE HIV MANAGEMENT IN INDIA

ANUJ KAPILASHRAMI

A thesis submitted in partial fulfilment of the requirements for the degree of Doctor
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To my parents: for instilling in me the courage to dream and for giving me the strength to realise it.

Abstract

This thesis aims to deconstruct the monotheism of public private partnerships (PPP) for health and demonstrate the polytheism of practices enabled by it. It contributes to the body of knowledge on PPP in two respects: theoretical and substantive.

At a theoretical level, using a critical enquiry lens, I deconstruct the partnership phenomenon and the notion of shared power within these interactions. This diverges from the traditional problem solving approach intrinsic to 'good' governance literature on PPP, which focuses on how partnerships can be made more effective. The thesis gives a plural account of the rationale and emerging paradoxes and examines the role of structural (institutions and mechanisms) and ideational (ideas and discourse) factors in constituting and constructing the practice of PPPs.

The substantive aim of the thesis is to advance the study on PPP by understanding the contingencies and plurality of practices as a departure from the rhetoric on global health PPPs. Drawing on the case of Global Fund to fight AIDS TB and Malaria (GFATM), one of the three largest global health partnerships, and its country wide operations with respect to HIV and AIDS in India, I also discuss the implications of the discursive practices for the management of HIV and equity in health care. Through a critical examination of the governance mechanisms and arrangements of GFATM it is argued that these have instilled an environment characterised by a proliferation of multiple unaccountable entities which emerge as sites where principles of partnership are subsumed by competition for resources, power and individual and organisational gains. This raises an important question that the thesis attempts to answer: How despite the tensions and ruptures is it possible for the global health PPPs to rise to prominence as a key mechanism in global and national health governance? In response to this, I focus on the role of the development brokers and street level bureaucrats who act at the interface of the global discourse and the local perspectives and create "order" by negotiating dissent, building coherent representations and translating common meanings into individual and collective objectives.

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Abbreviations

AIDS	Acquired immune deficiency syndrome
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
BSS	Behaviour Surveillance Survey
BMGF	Bill and Melinda Gates Foundation
CBO	Community Based Organisation
CCC	Community Care Centre
CCM	Country Coordinating Mechanism
CCSC	Community Care and Support Centre
CDC	Centre for Disease Control
CMIS	Computerised Management Information System
CSW	Commercial Sex Worker
DAPCU	District AIDS Prevention and Control Unit
DANIDA	Danish International Development Agency
DEO	Data Entry Operator
DFID	Department For International Development
FHI	Family Health International
GAO	Government Accountability Office (US)
GAVI	Global Alliance for Vaccines Initiative
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHI	Global Health Initiatives
GIPA	Greater Involvement of People with AIDS
GMP	Good Manufacturing Practice
Gol	Government of India
GPPP	Global Public Private Partnership
HIV	Human Immune deficiency Virus
HR	Human Resource
IPPPH	Initiative on Public Private Partnership
IDU	Intravenous Drug Use/ Injecting Drug User

INR	Indian Rupee
KHPT	Karnataka Health Promotion Trust
LOU	Letter of Understanding
LFA	Local Fund Agent
MDACS	Maharashtra District AIDS Control Society
MSM	Men having Sex with Men
M&E	Monitoring and Evaluation
MPR	Monthly Progress Report
MOHFW	Ministry of Health and Family Welfare
MSACS	Maharashtra State AIDS Control Society
NHS	National Health Scheme
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NGO	Non Government Organisation
OI	Opportunistic Infections
OR	Operational Research
PTE	Peer Treatment Educator
PR	Principal Recipient
PEPFAR	President's Emergency Plan for AIDS Relief
PLHA	People Living with HIV and AIDS
PPTCT	Prevention of Parent to Child Transmission
RCH	Reproductive Child Health
RNTCP	Revised National Tuberculosis Control Programme
SACS	State AIDS Control Society
SGM	Support Group Meeting
SIMS	Strategic Information Management System
SIMU	Strategic Information Management Unit
SR	Sub Recipient
STD	Sexually Transmitted Diseases
SWOT	Strengths, Weaknesses, Opportunities, Threats
TDR	Tropical Disease Research

TRP/ G	Technical Resource Panel/ Group
TCC	Treatment Counselling Centre
ToR	Terms of Reference
UNDP	United National Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNGAS	United Nations General Assembly Session
UNOPS	United Nations Office for Project Services
USAID	United States Agency for International Development
WHO	World Health Organisation

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Chapter 1

Introduction

1.1 Introduction

The Global Fund to fight AIDS TB and Malaria, henceforth referred to as 'the Fund', follows a plethora of global public private partnerships (GPPP) on health also referred to as global health initiatives (GHI). The past decade has witnessed a meteoric rise in the prominence of GPPPs as a key mechanism of global health provision (Utting and Zammit 2009, Widdus 2005, Harmer 2005, Buse and Walt 2002). Three of the largest global health initiatives – the Fund, the US President's Emergency fund (PEPFAR) and the World Bank Multi Country AIDS programme - all include a focus on HIV and AIDS and together provide two-thirds of all external funding for HIV and AIDS (Bennett et al. 2006).

While several of these initiatives are able to increase the scale of resources committed to specific health goals, the evidence base backing this model of organisation is rather limited and inconclusive. Literature focuses either on operational issues such as determinants of successful partnerships (Druce and Harmer 2004, Dowling et al. 2004, Gillies 1998) or on coordination of national programmes and the governance structures (Brugha 2003, Buse 1997, Caines et al. 2003). Little work is undertaken to examine the *meanings* and *practices* generated by these institutional arrangements, the range of

structural and ideational factors underlying these, and the different logics and agendas involved.

One of the aims of my thesis is to redress this deficit. Such examination is useful because it unpicks the complex forces of power and processes that underpin these arrangements and thus, helps to explain the rise in prominence of PPPs as an 'innovative' and 'effective' policy mechanism in global and national health governance. Buse et al. (2009) argue that such analysis is also crucial to facilitate the meeting of health objectives.

The aims and objectives of the thesis are outlined after briefly engaging with the historical background and concepts that are further examined in the following chapters.

1.2 Understanding Public Private Partnerships

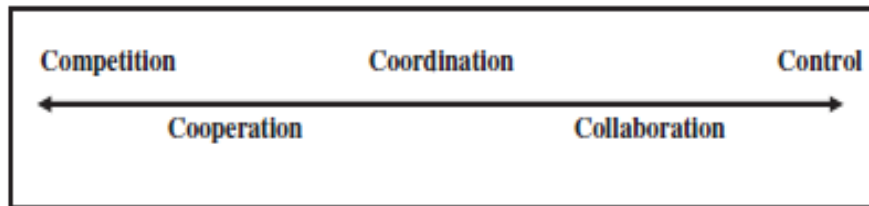
1.2.1 Clarifying concepts and definitions

There is no single comprehensive acceptable definition of partnerships (Gray and Wood 1991, Asante and Zwi 2007, Jamali 2004). The meaning of the expression 'partnership' is often implicit in different terms that are used interchangeably – 'collaboration', 'network', 'alliance', 'mix' - leading to a 'terminological quagmire' (Leathard 1994, Elston 2005, Sen and Davala 2002).

Nijkamp *et al.* (2002) refer to PPP as an institutionalised form of cooperation of public and private actors, which on the basis of their own objectives, work together towards a joint target. Within the health arena, one of the most accepted definitions of global PPPs defines them as:

“collaborative relationships that transcend national boundaries and bring together at least three parties, among them a corporation and an inter-governmental organisation, so as to achieve a shared health creating goal on the basis of a mutually agreed and explicitly defined division of labour” (Buse and Walt 2000a: 550).

Evident in these definitions and other attempts to describe partnerships, is the loose use of the term ‘collaboration’ or ‘cooperation’. However, the operational reality of PPPs in developing countries, as presented in the subsequent chapters, suggests a contrary scenario. Green and Matthias (1997) propose a continuum to assess the inter-organisational relationships (Refer figure 1). Starting with competition, which suggests a scenario where organisations compete with each other and there is limited communication and functional linkage between them, the continuum progresses through cooperation, coordination, collaboration, and ends in control. The control end represents a relationship where one organisation gains full autonomy and control over another (*ibid*). It has been argued that inter-organisational relationships form a continuum of increased structure, decreased autonomy and intensified communication. (Zafar Ullah *et al.* 2006, Begum 2000).



Source: Green and Matthias (1997)

Figure 1: The competition- control continuum

However, as Robinson and White (1997) rightly point out, the debate has largely focussed on ‘complementarity’ and not ‘cooperation’ or conflict between the actors. This, in their view, reduces PPPs to a mechanism through which the state provides an enabling environment for the other social actors. Thus we find an increasing use of metaphors like ‘oversight’, ‘facilitation’ and ‘supervision’ in the context of the changing role of the State from a provider and regulator to a co-provider of services.

Alternative modes of conceiving PPPs, although limited, have begun to emerge. Roy Widdus (2001) and Buse and Waxman (2001) view partnerships as ‘social experiments’ that are attempting to learn how to tackle intractable health problems in better ways. Judith Richter (2003) on the other hand, proposes the term ‘interactions’ in view of her objection to the term ‘partnership’ which disguises unequal power relations between public institutions and private corporations or between institutions in the global north and south or between the non profit and for profit sector. She also argues that lumping together diverse categories of public-private interactions such as fundraising (corporate donations in cash/kind), research collaborations,

negotiations and consultations with corporations and business associations, corporate social responsibility projects, contracting out of services etc. under a common label of PPPs obscures important distinctions (Richter 2004a). More recently, constructivist approaches have been applied to understanding and reconceptualising partnerships. Buse and Harmer (2004), for example, discuss the utility of the application of Hacking's (1999) constructivist framework (Box 1) to reflect on partnerships as a governance mechanism and challenge the assumptions underlying it.

In the present state of affairs 'X' is taken for granted.

X need not have existed, or need not be as it is.

X, or X as it is at present, is not determined by the nature of things, it is not inevitable.

X is quite bad as it is. We would be much better off if X were done away with or at least radically transformed.

Box 1: Hacking's constructivist framework

Substituting PPP in the framework and adding a cautionary note, rather than dismissing the concept, Buse and Harmer (2004) argue that the framework can be particularly useful for assessing partnerships in comparison to alternative global health frameworks. Hacking's framework is a departure from other approaches to examine the partnership phenomenon, for which the starting point is not an analysis of the assumptions or rationale underpinning the phenomenon but the practices which it generates. This thesis builds further on the critical view inherent in this framework and does

not assume, rather questions, the inevitability, and legitimacy of PPPs in general and the Global Fund in particular.

The above understandings suggest the significant variation in the meaning and practice of partnerships where the term is used loosely to refer to almost any kind of arrangement between the 'private' and the 'public'. Partnering has extended to describe a wide range of activities involving an ever-expanding web of relationships between donors, high and low income country governments, NGOs, community members, and corporate and business houses and their representatives (Mitchell-Weaver and Manning 1992, Hall et al. 2005). Tracing these interactions Nishtar (2004) highlights a continuum where transnational / global partnerships with a visible for-profit partner occupy one end of the spectrum while the other end is occupied by informal arrangements between national governments and individual practitioners or an NGO in service provision such as TB control or control of non communicable diseases. Somewhere in the spectrum also lie 'informal and direct' relationships between the civil society and corporate partners (NGOs seeking support from corporate sector) for supporting global programmes (ibid).

1.2.2 Novel arrangements or old wine in a new bottle?

Arguably, PPPs represent a transformation in public-private relations and interactions (Lethbridge 2002, Harmer 2005). This claim has been refuted on many accounts. I summarise the criticism through two main arguments.

The first argument rests on the false and contested distinction between the terms 'public' and 'private' which has historically been critiqued by social movements (Pateman 1989), predominantly feminists and Marxists, as mere social constructions with its roots in patriarchy (Cochran 1999) and economic relations of productions (Waltzer 1984). This distinction is even more contested today, given the blurring traditional boundaries between what constitutes 'public' and what is 'private' (Buse and Walt 2000a, 2000b). If the nation state and the private for-profit corporations were the evidently distinct public and private entities, a series of other institutions such as the multilateral development agencies (like WHO, WB) and international NGOs occupy a space in between them. The dichotomy is further blurred with the business sector/ corporations setting up private foundations registered as trusts and societies (Hellen Keller, Bill Melinda Gates, Global Business Coalition etc.) and setting up public health initiatives as part of their corporate social responsibility. The Handwashing Initiative, set up as a partnership between Unilever, Procter & Gamble, Colgate-Palmolive, and development agencies such as UNICEF, USAID and others, is an example of the latter.

The second argument challenges the novelty of public-private interactions. Historically, the public and private sector, especially if the latter were to include the non-government and non-profit actors such as missionaries, have engaged in both formal and informal relationships and the United Nations and World Health Organisation have had explicit interactions with the

business community. These interactions include: contracting out services, research collaborations, fundraising, corporate social responsibility projects, and negotiations or public tenders for low product pricing (Richter 2004b). In addition, most nation states have collaborated with members of the civil society constituency in generating awareness and providing support structures for services delivered in the public sphere. Richter (2004a) argues that subsuming such widely differing issues under a common label of 'public private partnerships' obscures important distinctions between interactions and creates a false sense of novelty of the PPP approach.

I do not deny that historically, both public and private sectors have enjoyed formal and informal relations in the health sector. However, as Widdus (2001) argues, the division of roles between the public and private constituted "a poorly defined partnership in which the outcomes desired by different parties were never explicitly negotiated". This emphasis on 'explicit negotiation' as the key distinguishing characteristic of partnership from other interactions is also explicated by Jane Nelson (2002) who regards the "shared process of decision making" as the unique feature of this policy paradigm. She argues that the novelty of most strategic partnerships can be attributable to "the partners work(ing) together at all levels and stages, from the design and governance of the initiative, to implementation and evaluation" (Nelson 2002:47)

These understandings render my concurrence with Richter's observation that the novelty about PPPs today is the *framework of thought* underlying the approach (Richter 2004b). This framework of thought, or *ideas*, that inform the discursive understanding of PPP is evident in the current literature across disciplines, which regards PPP as 'inevitable', 'win-win' arrangements desirable to resolve the current global health crisis (Buse and Harmer 2004). Additionally, partnering implies a notion of joint sharing of efforts, risks and benefits by all partners (Reich 2000, Zafar Ullah et al. 2006). Since there is little disagreement on their potential to act as a transformative mode of governance, negative outcomes, if any, are viewed as 'unintended consequences' and attributed to "process-related challenges" which can be overcome by using set of global principles and norms (Nishtar 2004).

This renders an analysis of the thoughts and ideas, which inform the hegemony of PPPs. The ideas that underlie the PPP phenomenon have evolved over time: a period marked by economic, political, and financial crisis. I start by looking at the historical context within which the discursive understanding on PPPs evolved. I discuss the number of key global developments that acted as precursor to this new model of interaction.

1.2.3. Historical development: tracing the global

PPPs were introduced as a new form of governance in a period marked by significant shifts in the political economy of health across nations. The inter-war period (1919 to 1939) witnessed the entry of a number of international

NGOs and private foundations such as the Rockefeller Foundation (Loughlin and Berridge 2002). Despite the proliferation of these non-state agencies, health responses and initiatives remained a mandate of the State and the League of nations. In the post war period (1940s) the idea of “partnership” was mooted at an inter-governmental level. Rooted in the functionalist school of thought, which was sceptical of the ability of the nation States to ensure peace and order and enable public welfare outside its traditional boundaries, the proponents argued for joint working through novel international institutions (Mitrany 1975). The alternative proposed was a “cobweb of diverse and overlapping institutions...that would help to cement processes of growing interdependence among states and societies” (Rosamond 2000:35). However, it wasn’t until the mid 1970s that the phenomenon of PPP (distinct from intergovernmental collaborations) gathered momentum at the international level. The UN special programme for Research and Training in Tropical Diseases (WHO/TDR), created in 1975, adopted the PPP approach between public sector and private companies for drug discovery and development (Nwaka and Ridley 2003).

The start of 1980’s was also marked by a gradual shift from the emphasis on strengthening public health care (and the centrality of the State in development), as highlighted in the Alma Ata declaration in 1978, to the debate on ‘health care financing’. The economic and fiscal crises and the rise of the World Bank in this period was instrumental in shifting the discourse away from state-oriented health care towards a market driven approach to

health sector reforms. The Bank's growing hegemony in defining health and financing international and global health policy and its role in "diffusing knowledge of its neoliberal principles" (Lister 2005) enabled a quest for efficiency and ways to cut public spending on services (Hong 2000). For example, in its report '*Financing health services in developing countries: An agenda for reform*' (1987), the Bank points out to the inability of the nation States to ensure efficiency and equity. The early 1990's thus witnessed a clear move away from the public sector reform, towards the privatisation of public infrastructure, utilities and services including health and education (Lister 2005). This development conveniently overlooked the emerging evidence which questioned the myth that competitive markets facilitate increases in cost containment, equity or efficiency in health care markets (Maynard 1994, Hsiao 1994).

With the introduction of the reforms package in the later part of the 1990s, there was also a gradual shift to a 'modernisation' narrative that emphasised values of social cohesion (Newman 2004) through network building, holistic governance and partnerships. The impact was visible at various levels. At the global level, institutions like WHO, that played a significant role in formulating health policies and prescribing standards of health care, welcomed and encouraged partnerships between the State and the market in financing, provisioning and researching health care (Baru and Nundy 2008). The

Jakarta declaration¹ was the first in the series of global political ratifications to draw upon the ‘widest possible range of resources’ to tackle health determinants in the 21st century, thus seeking the involvement of the private sector in health promotion efforts.

“To address emerging threats to health, new forms of action are needed. There is a clear need to break through traditional boundaries within the government sector, between governmental and non-governmental organisation, and between public and private sectors. Cooperation is essential; this requires the creation of new partnerships at all levels of governance in society” (Excerpt from the Jakarta declaration, WHO 1997)

By the late 1990s, there was a general acknowledgement of the need for multiple sources of health financing and an acceptance of “modified” interpretation of state-market relations. PPPs were now regarded as an important component of health sector reforms and gained legitimacy and visibility in the health sector on the basis of various rationales (rooted in diverse theoretical perspectives) which I further elaborate in the next chapter.

The dominant rationale that emerged was that the “fiscal constraints demanded a prioritisation and restriction of public expenditures”, and that turning to the private sector could “address cost and investment challenge, improve efficiency, understood largely in terms of service provision and

¹ The Jakarta declaration was a product of the ‘Fourth International Conference on Health Promotion: New Players for a New Era’, a meeting held in Jakarta in July 1997 with the objective of leading health promotion into the 21st century.

management at reduced costs, and enhance service quality” (Nikolic and Mikisch 2006).

The proponents of global governance argued that global PPPs promote cooperation between the various stakeholders and facilitate coordination of policies at all levels, from local to global (Brugha 2008, Benner et al. 2002, Spicer et al. 2010). Given the rise of corporations, PPPs were also seen as a means to harness the perceived benefits of corporate resources and expertise, while maintaining public protection of social value (Harmer 2005). In the process, it was argued, the corporate sector could “advance its own cause by embracing the universal values...and weave them into global market relations” (Ruggie 2000). Pharmaceutical companies and businesses thus began to play a significant role in the technical boards of disease control programmes of the WHO and in funding research and product development. Several global health initiatives were launched as partnerships between multiple actors – multilateral (World Bank, UN agencies) and bilateral organisations (Dfid, USAID, EU), international NGOs, pharmaceutical companies (Merck, Smith-Kline), and private foundations (Bill and Melinda Gates, Clinton) - in complex relationships.

The millennium development goals (MDG) further triggered a spate of new alliances and consortia set up to accelerate action to scale up coverage and deliver improved outcomes against the health-related goals. The focus was on increasing aid effectiveness, improving transparency, accountability, and

cooperation in the programs executed by 'typically rival agencies' (Schneider and Garrett 2009). One such attempt to improve relations and coordination between global international health agencies resulted in the formation of the H-8 (health -8: WHO, UNICEF, UNAIDS, UNFPA, WB, GFATM, GAVI and Gates Foundation), health alliance formed to foster cooperation and discuss challenges to scaling-up health services. In September 2007 the world's wealthy governments and private donors created the International Health Partnership, a consortium that seeks to 're-design' the relationship between donors and recipient nations. It promised longer term financial commitments in exchange for commitments from recipients to accountability of every dollar spent at the country level (DFID 2007).

These developments reveal that various discourses and shifts within them have played a role in establishing the necessity of PPPs and thus shaped the rationale on the basis of which participation of specific actors/ institutions has been invoked. Harmer (2005) identifies four such discourses: The *economic* discourse underscores the shift from state-oriented health care of the 1970s (public) to health care financing models and competitive markets of the 1980s (private) to modified markets (public-private) in the 1990s; the *Sociological* focuses on the changing relationship of the state and the market and the move from social to neoliberal democracy, which paved way for a 'third way' of sociological and political thought (Giddens 1998); the *Technological* suggests a shift from the emphasis on broader social-economic determinants of health to a narrow focus on biomedical responses

and technological fixes to global health problems; and the *Globalisation* discourse focusing on the evolution of ideas on global public goods and global health governance. Several other ideas, for example, injecting business like principles to public agencies (*Management* discourse) and participation of the local and affected communities (*International human rights* discourse), played a significant role in defining the PPP policy model.

These overlapping and often divergent ideas together made it possible to establish the inevitability of PPPs, in order to resolve global health problems. A negative consequence of this is that the rationale around a specific PPP is then applied to, and serves as the rationale for, all kinds of public private interface arrangements. PPPs have been variously promoted but usually with no distinction made between the pluralities in its forms and working. Hence, at the outset of this thesis, I outline the global partnership and country level public private arrangements which are the focus of my investigation and describe the context in which these emerged.

1.3 The Global Fund to fight AIDS, TB and Malaria

1.3.1 Background: Infectious diseases in a new light

While the control of infectious diseases has always been high on nations health agenda, the turn of the century (and the decade preceding it) witnessed a growing hysteria marked by a renewed awareness of the rapid

globalisation of these diseases and a greater global will to tackle the 'warfare'². A variety of discourses and arguments have led to its re-prioritisation at both global and domestic levels. These include rapidly growing social inequalities, industrial and ecological change that impacts the distribution and spread of diseases, a re-conceptualisation of some of the infectious diseases as a threat to international security and development and above all, the moral-rational model of 'global public goods' that proposes a re-conception of the benefits of infectious disease control in the developing world for the global community (Tan et al 2003, Price-Smith 1998). Recent reports and research on infectious diseases also highlight the link between the impact of these global shifts on States' capacities for governance and economic growth and an increased threat of inter or intra state conflict.

I adopt the phrase 'cognitive evolution', as proposed by Emmanuel Adler (1997), to describe the series of events that transpired as a precursor to the Fund. These served as a medium for translation of the multiple viewpoints into a common language, thus evoking support of multiple stakeholders. Adler describes cognitive evolution as a process wherein institutional facts are socially constructed and established by "collective understanding of the physical and social world that are subject to authoritative selection process and thus to evolutionary change" (1997:339).

² See Ian Harper (2005) in Mosse and Lewis (ed) 'An Aid effect', for a discussion on the use of the idiom of warfare in disease control programmes. Referring to the TB control programme in Nepal, Harper (pg 137-139) argues that such metaphors structure a public health perception, for example, the tubercle bacillus waging terror on the human populations, and shape its focus and direction.

1.3.2 Cognitive evolution of the Fund

The turn of the twentieth century witnessed a new resolve to scale up the global response to three infectious diseases – HIV and AIDS, tuberculosis and malaria- which were declared as global public health emergencies. A milestone in this global awakening was the launch of the report of the WHO Commission on Macroeconomics and Health³ (WHO 2001). The report that was presented in 2001 marked a culmination of a series of projects undertaken by the World Health Organisation on economics in health policy, systems and services. It was presented as a new ‘global blueprint for health’ to save millions of lives at a small cost relative to large improvements in health and prosperity (WHO 2002).

Commentators welcomed the progressive elements of the report such as its critique of user fees as a means of health care financing and its demand for greater funds for tackling ill health. However, the report was criticised for the implicit shift from an emphasis on poverty and other social determinants of health upheld in the Alma Ata declaration to an exclusive focus on economic productivity (Banerji 2002a). The report was argued to mirror the conceptual and methodological approaches of the World Bank and was regarded as the next step towards widening opportunities for private investment in public programmes and promoting vertical programmes at the behest of donors (ibid). In confining itself to the economic concept of public good and further defining it only in the context of a few of the numerous communicable

³ Macroeconomics and Health: Investing in Health for Economic Development was presented on 20th December 2001 to the Director General of World Health Organisation

diseases, the report presented a narrow perspective on public health. Critics point out that this exclusive focus on only three of the infectious diseases namely, HIV and AIDS, TB and malaria is linked to the potential they carry for expansion of markets for vaccines, diagnostic kits, antiretroviral and other drugs (Banerji 2002b). Such views were reinforced by another blue print entitled '*Scaling up the response to Infectious Disease: A way out of poverty (2002)*' which immediately followed the Commission report. The Commissioners elaborated on how the increased investment in health could be 'well spent'. In providing a 'single road map to scale efforts to control the three killer diseases' it stressed specific interventions and called for 'an unprecedented deployment of communications and marketing strategies to encourage preventive behaviour among more than a billion people at risk' (WHO 2002).

Meanwhile, a series of international meetings played an important role in wielding support and commitment for the policy processes at the global level. The first in this chronology was the G8 Summit at Okinawa (2000) where the leaders of the world's richest countries made ambitious commitments to achieve substantial reduction in the global burden due to the three 'killer diseases' (Brugha and Walt 2001). In the HIV arena specific targets were endorsed for reducing the number of new infections among young people by 25% by the year 2010. Ideas and activities around the creation of a global 'war chest' to fight the three diseases began to converge. This war chest, or

a global health fund, was envisaged as the cornerstone of measures taken to meet these commitments.

Following on from the targets adopted the previous year at Okinawa, the African Summit at Abuja (April 2001) and the UN General Assembly Session (UNGAS) on HIV and AIDS (June 2001) were other key events in mobilising a global response through pledges from respective countries. The UN Secretary General Kofi Annan concluded the UNGAS session with a commitment and call for raising US\$ 7-10 billion annually in new funding for the three diseases. These series of events culminated at the Genoa G8 Summit (July 2001) where countries including US, UK, Japan, the European Union; private corporations; foundations such as the Bill and Melinda Gates among others, committed resources to a global partnership that was officially launched in January 2002, as the Global fund to fight AIDS, TB and Malaria (WHO 2002). For the purpose of this thesis, this global initiative or partnership is referred to as the Fund.

1.3.3 Purpose of the Fund: Examining the public transcript⁴

As evident from the historical developments preceding the setting up of the Fund, the purpose of such an institutional arrangement was to dramatically increase resources available to fight the three diseases- HIV and AIDS, TB

⁴ The term introduced by James C. Scott in his seminal work *'Domination and the arts of resistance: The hidden transcript of subordinate group'* (1992) refers to the surface or public interactions present in the systems of domination between the oppressed and those who dominate (ibid:2), In contrast, the term hidden transcript pertains to "the discourse that takes place offstage, beyond direct observation by power holders" (ibid:4).

and Malaria. Similar to other global initiatives in health, the Fund is constantly evolving and expanding in terms of its outreach, in-country presence and influence. Since its creation in 2002, the Fund has approved funding of US\$ 19.3 billion for more than 572 programs in 144 countries (GFATM 2010). The Fund's contribution is particularly notable in HIV and AIDS for which it has leveraged significant amounts of funding. It provides a quarter of all international financing for AIDS globally, two-thirds for tuberculosis and three quarters for malaria (GFATM 2009).

It serves to attract, manage and disburse funds in order to mitigate the impact of the diseases in countries. The Fund is regarded as a new finance mechanism, a move away from traditional bilateral assistance. The *public transcript* of the Fund sets it apart from other approaches to financing health sector by laying claims on:

1. Country ownership: The Fund operates “only” as a “financing instrument and not as an implementing entity”. Grant proposals submitted to the Fund's global secretariat are developed by recipient countries, thus underscoring a commitment towards supporting ‘country driven’ (and not donor driven) programs that reflect national ownership.
2. Inclusiveness and partnership: It is set up as a partnership between governments, civil society, private sector and the affected communities. The Fund's commitment to the mechanism of public-private partnerships is not only restricted to fundraising and

management at the global level but also extends to operations in the recipient countries. However, the notion of 'partnership' in both these areas – resource mobilization at global level and in-country utilization of those resources - differs considerably with respect to the governance structures, the accountability and information flows, the conflict among interests, and consequently, in the play out of power among 'partners'.

3. No in-country institutional presence: Coordinated through a secretariat in Geneva and a board which comprises of 24 members including nation states, corporate members, and the civil society, the Fund exerts its country presence by contracting a local fund agent (LFA) to oversee progress and ensure the continuity of grants. Structures central to Fund governance in countries include a national coordinating mechanism, CCM and a Secretariat.
4. Conditions precedents and legal provisions essential to signing and/or disbursement of grant: These are conditions that must be achieved by the recipient before disbursements of funds will be made under the grant agreement. These may include: expanding the composition of CCM to include private sector, developing M&E systems to enable efficient reporting on programmatic success, Failure to meet a condition precedent by the terminal date decided by the Fund can lead to termination of the grant agreement.

Finally, 'performance based' funding, with emphasis on achievement of clear and measurable results and timely implementation rather than inputs and processes, is a key organising principle of the fund arrangements. While the Fund claims to be open to supporting a diverse range of activities among the recipient countries, a closer examination of the content and strategies of proposals that are successful in securing a grant suggests certain salient features. Bennett and Fairbank (2003) in a policy research paper developed for the Fund highlight these as follows –

- greater role of the business and corporate sector (and wider 'civil society') in service delivery
- a substantial investment in purchase of drugs, in particular ARVs, purchase of new equipment, strengthening of health systems, and capacity building of human resources.

A recent development in the Fund's operations was that, starting January 2009, its administrative services agreement with WHO was terminated rendering it as a fully autonomous institution. This step was perceived to allow this international financing institution greater independence and flexibility in "shaping its organisational culture, applying its corporate policies exclusively and managing its own administrative services (HR, finance, procurement, administration)" (GFATM 2008). These changes were argued to have additional implications for the policy environment and governance processes in recipient countries.

Figure 2 illustrates the core structures of the Fund governance which will be further elaborated in chapter four. The Fund awards grants to ‘principal recipients’ on the basis of proposals submitted by the country coordinating mechanism (CCM), a structure central to governance of the Fund’s country level operations. Country proposals are reviewed by a technical review panel (TRP) of independent experts and considered for approval by the board members.

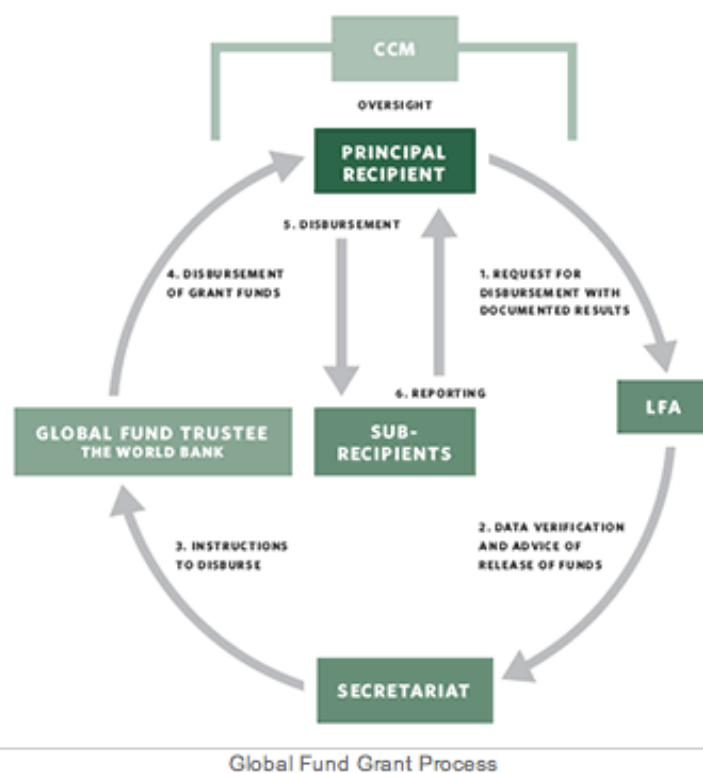


Figure 2: Core governance structures and grant process of The Global Fund

The entire process of bidding, identifying projects and partners and subsequently submitting a country proposal to Global fund is coordinated by the CCM, which is “key to maintaining the Fund’s commitment to local

ownership and participatory decision making” (GFATM 2007a). Once a grant is approved, the CCM is also responsible to ‘oversee progress during implementation phase’.

1.3.4 Critical analysis of the Fund: emerging *hidden transcript*

The magnitude of the funding generated and given to countries and the novelty of institutional arrangements that the Fund claims to operate through has generated an unprecedented interest among the global health practitioners as well as academic researchers. Since its inception, the development with respect to the funding rounds approved and the technical evaluations undertaken have been closely monitored by both national governments and the civil society actors. This is evident from the abundance of websites/ newsletters (the Global Fund Observer) and organisations, for example the Initiative on PPPs for Health (IPPH), dedicated to the analysis and commentary on the Fund.

Much of the debate, however, revolves either around the need for increasing donor commitments to the Fund to ensure sustainability of the grants and the initiatives supported by it or the difficulties in governance of these programmes in resource poor settings. Underlying the debate on sustainability is a growing recognition that donor commitments are insufficient to continue grant cycles (Radelet 2004). Concerns have been raised about the significant gap that exists between the funding raised and that required by countries that bear the largest burden of disease. Sceptics have also raised apprehensions about how and on what priority areas the

limited amount of money will be spent. Another set of criticisms is around the emphasis laid by the Fund on purchase of brand-name drugs (Ford and Hoen 2001). This has implications for equity of treatment since triple therapy from generic manufacturers in India costs five times less than pharmaceutical companies in the west. In the context of the study, the emphasis on procuring only 'good manufacturing practice (GMP) certified drugs' has resulted in procurement difficulties for states/ regions since the drug companies do not cater to small quantities required by the state governments.

Technical evaluations commissioned by the Fund and a few independent studies highlight the system wide effects of the Fund arrangements (Bennett and Fairbank 2003, Hanefeld 2008, Banteyerga et al. 2005). While the Fund's primary goal is towards "increasing coverage of critical and cost-effective interventions", its public transcript also commits to the use of these resources "in ways that contribute to the strengthening of health systems" (GFATM 2009). However, evidence suggests that in view of the relatively large sums of money that the Fund grants and its emphasis on timely and 'efficient' disbursement, there are likely to be significant effects on elements of the broader system for delivering health care within a country (Bennett and Fairbank 2003). These system-wide effects have been traced in terms of potential i) *stewardship* and regulatory challenges to government with involvement of non-traditional actors in policy processes, ii) shifts in distribution of human resources to better funded focal disease programmes

and, iii) *verticalization* of service delivery and development of parallel pharmaceutical distribution, health information and management information systems (ibid).

Notwithstanding the need for a systematic independent evaluation of the Fund processes and outcomes in India, the aim of this thesis is not to undertake an impact assessment of the Fund. The substantive aim of the study, however, does contribute to building the evidence base on the implications of the Fund arrangements for the equity of health systems and HIV management in India. The full scope of the thesis is presented in the next section.

1.4 Aims and Objectives of the thesis

The thesis has two inter-related aims. From a theoretical point of view, the thesis aims to examine and deconstruct the rhetoric on public private partnerships and the notion of shared power within this discourse. Specific objectives are:

- 1.1 To examine the various understandings of public private partnerships and their ability to capture the ambiguities and plurality of interests
- 1.2 To explore and better understand the role of global and local structure, actors, and ideas/ discourse in enabling the development and practice of PPPs
- 1.3 To examine how power mediates the public private interface arrangements and shapes the practices and outcomes

From a substantive view point, the thesis aims to demonstrate the contingency and realities of practices of public private arrangements set off by the Global Fund in India as a departure from its discursive understanding, and consider its implications for the health systems and outcomes. Specific objectives are:

- 2.1 To examine the structures (institutions and mechanisms) of the Fund and the meanings and practices they generate
- 2.2 To understand how the fund regime constitutes the actors and how the actors in turn negotiate the discourse-practice divide.
- 2.3 To consider the system and programme wide effects with respect to equity of treatment and care resulting from the practices.

The Fund arrangements (and public-private interactions) are examined in the context of the national AIDS programme in India. This is primarily because, as evident from table 1 below, HIV and AIDS has received approximately 67% of the grant amount sanctioned by the Global Fund to fight AIDS, tuberculosis and malaria. Moreover, the discourse around the magnitude of the crisis of AIDS and the challenge posed by inequitable access to treatment and care, together, have created opportunities for strategic partnerships and legitimised greater involvement of the private sector in the public health arena.

Table 1: Disease specific Grant details			
	Total Funding Request (USD)	Approved Maximum (USD)	Total Funds Disbursed (USD)
HIV/AIDS (Round 2,4,6,8,9)	1328319626 (66.5%)	772,750,868	343,124,499
HIV/TB (Round 3)	14819772 (0.7%)	14,819,772	14,819,772
Malaria (Round 4,9)	177225133 (8.9%)	101,650,559	47,705,431
TB (Round 1,2,4,6,9)	476391998 (23.8%)	218,972,322	77,272,392
Total	1,996,756,529	1,108,193,521	482,922,094
Source: The Global Fund website (India Portfolio of Grants)			

1.5 India's HIV and AIDS epidemic and the responses

The dominant narratives that establish the 'crises' of the AIDS epidemic are well documented elsewhere (UNAIDS/ WHO 2005, UNDP 2009). Rather than reproducing or reinforcing these, this section presents a brief overview of the contested nature of knowledge, which has shaped the nature of public health response and the complexities highlighted by the political economy of AIDS in India. While in chapter five I describe the key features of the AIDS 'industry' and relate the shifts in the national response to the Fund requirements, I restrict the scope of this section to understand the background against which the Fund arrangements operate.

1.5.1 The dwindling figures

The number of people estimated to be living with HIV and AIDS in India rose from 3.9 million in 1997 to 5.7 million in 2005. The difference was attributed

to an expanding number of sentinel sites and changing methodologies in the calculation of estimates, rendering the task of describing trends in prevalence difficult (NACO 2004, UNAIDS 2006). The national sentinel survey established that the epidemic was largely concentrated in six states: Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu (Refer map in section 3.5.2) where HIV prevalence was 5% among 'high risk groups' and 1% in the antenatal population (NACO 2004, UNAIDS 2006, Amin 2004).

In 2006, however, the estimates arrived at through a more rigorous methodology⁵ "attested to and backed by international agencies namely UNAIDS and WHO" (NACO 2007c), suggested an almost 50 percent reduction in these figures. With a national prevalence rate of approximately 0.36 percent, the numbers amounted to an average of 2.5 million people with HIV and AIDS and were confirmed as the most accurate reading thus far (NACO and NIMS 2006). The impact of this reduction was evident in all the discussions had with the research participants as they highlighted the tensions between the NACO and the civil society organisations. First, while NACO regarded these figures as an opportunity to make claims over the success achieved by the national programme partly attributing the discrepancy to earlier faulty techniques, the civil society organisations were concerned over the retreating commitments of the donor community.

⁵The new estimates were arrived at through a composite methodology using multiple sources: Sentinel surveillance covering all districts in the country, the National Family Health Survey or NFHS 3 conducted in 2005-2006, and a behavioural and biologic assessment focusing on high risk groups in high prevalence states. See NACO online for a more detailed discussion.

Second, a change was observed in the national strategy with the focus shifting from “high prevalence states” to “emerging districts of concern” located in high or low prevalence states (NACO 2007c).

Notwithstanding the dispute around figures and its implications for multiple stakeholders, the sheer numbers affected masks a complex reality which, as also noted by NACO, suggests that India has not one but two epidemics in various stages of progression. As per the previous estimates, heterosexual transmission was argued to be the main mode of transmission accounting for 85% of cases although in regions such as the northeast injecting drug use (IDU) accounted for a majority of the infections (NACO 2004). However, the revised estimates indicated alarming trends: IDU and homosexual route has emerged as important routes of HIV transmission across the country, prevalence among the female sex workers is increasing in the North east region, and there is rising prevalence among ANC clinic attendees in North Indian states (NACO and NIMS 2006).

1.5.2 The public health response

The epidemic in India has been handled primarily in terms of regulation and risk management, although the various interventions have conformed to the internationally recognised best practice models. A brief history of the state response is presented in box 2.

<u>1986:</u>	Formation of the National AIDS Committee (in MOHFW)
<u>1992:</u>	First national AIDS control programme (NACP-I) launched; National AIDS Control Organisation (NACO), the nodal agency programme division set up under MoHFW
<u>1999-2006:</u>	Phase of the NACP launched with focus on targeted interventions through NGOs
2004 :	Free ART launched in the programme: in select hospitals in a phased manner
<u>2007:</u>	3rd phase of NACP launched with focus on multisectoral response, strategic partnerships, strategic MIS and the principle of 'Three Ones' (one action framework, one coordinating authority, one national M&E)
The programme runs through 35 AIDS prevention and control societies and several NGOs	

Box 2: The state response: Timeline and key features

The national response was initiated in 1986 and largely restricted to national surveillance programmes and mass media campaigns focussing on 'risky behaviours' to generate awareness. Despite the timely response, much of this early prevention effort was argued to be inadequate and resulted in stigmatisation of vulnerable populations (Dube 2000, Solomon et al. 2004). In 1991, a renewed commitment arising from a World Bank (WB) loan to the Government of India (GOI) for a national programme for AIDS control facilitated the setting up of the National AIDS Control Organisation (NACO), the nodal agency under the Ministry of Health and Family Welfare (MOHFW), to implement HIV control efforts in India (Solomon et al. 2004). The first phase of the programme made little progress, the failure attributed largely to the lack of political will of the State and poor utilisation of funds (Imam 1994). The second phase of the programme (NACP II) was launched in 1999 with

funding from multiple donors including a five-year loan from the WB, GOI and bilateral agencies. The budget was over USD 392 million, extended for two years and revised upwards to USD 474 million. The World Bank's assistance of USD 192 million amounted to approximately 47 percent of the total earmarked funds (NACO 2007a). The Global Fund was introduced in 2002 and the first grant agreement was signed in January 2003. Subsequently, the programme received increasing contributions from the Fund with its share increasing from 6 percent of the funds earmarked in NACP II to 25 percent in NACP III (NACO 2007a). A landmark achievement in this period was the phased introduction of free antiretroviral treatment at select public hospitals in India in 2004.

The field studies on which the thesis is based commenced when the programme was in its third phase, NACP III. The third phase, launched in 2006, has treatment as its prime focus and seeks to integrate with prevention, care and support initiatives. The programme articulates 'mainstreaming' and 'partnerships' as key approaches to facilitate multi-sectoral response and leverage technical and financial resources of the development partners (NACO 2007b). The Fund is the single largest donor with the funding disbursed for round II, III, IV and VI alone amounting to 44 percent of the external AID component and 25 percent of the total funds earmarked for NACPIII (Refer Table 2).

Sl.No	Source	Amount (RS./billion)
I	Direct Budgetary Support	28.61
II	EAC (External Aid Component)	41.48
(i)	World Bank (USD 295 mill. including Retroactive financing for 2006-07)	13.28
(ii)	DFID(95 mill. Pounds)	8.08
(iii)	GFATM (Round II, III & IV)	8.24
(iv)	GFATM (Round VI)	9.63
(vi)	USAID	2.25
	Grand Total (I +II)	70.09

Table 2: Source of Funding of NACP III

The national AIDS control programme in India is a vertical programme that has added to the burden of the health system which is struggling to meet the demands placed on it (MOHFW 2005). NACO implements the programme through 35 AIDS Prevention and Control Societies in the States (SACS) and works with nearly 700 NGOs, CBOs, bilateral donors and private foundations to carry out targeted interventions (NACO 2007d). The SACS are quasi governmental organisations that receive funding from the NACO (and not the State governments) towards the implementation of the state AIDS programmes. Different components of the national programme include phased ART roll out across the country, targeted infections (TIs), prevention of parent to child transmission (PPTCT), Integrated counseling and treatment centre (developed by merging together voluntary counselling and testing centres and the PPTCT component), blood safety, and care provision.

1.5.3 The battle for ARVs

India is the also the largest supplier of generic ARVs to low and middle income countries, exporting two-thirds of the drugs it manufactures (UNAIDS 2008). With the launch of its first generic drug in 2001, Cipla (an Indian pharmaceutical) unleashed tremendous competition among the big pharmaceutical industries, resulting in a dramatic drop in the price of the drug globally (Liu and Lu 2010). Although, the export and manufacture of generics in India is termed as a turning point for universalising HIV treatment for resource-poor settings (ART being exported to sub Saharan Africa and other regions), it was not until 2004 that the people with HIV and AIDS in India were able to benefit from this development. Prior to that, the treatment was available at unaffordable cost in the private sector (speciality clinics and hospitals) and, on case to case basis, through charitable trusts and NGOs.

1.6 Structure of the thesis

In this chapter I set out the background for the thesis engaging briefly with the different domains that are the focus of this research: the discursive understanding and practice of public private partnerships, the Global Fund to fight AIDS, TB and Malaria, and the HIV and AIDS programme in India. Besides clarifying the concepts and the inherent ambiguities, I examine the discourse and ideas shaping the PPP phenomenon and the historical developments that act as precursor to the set up of the Fund.

Chapter two starts by addressing the first of my theoretical aims which is to examine the different approaches of classifying and understanding PPPs. I argue that none of the approaches adequately account for an analysis of power and information asymmetries that are typical to the arrangements that are investigated in this research. I therefore conclude this section by proposing an alternative *classification framework* to assess public private arrangements across different analytical dimensions. Next, the literature on PPPs is reviewed and the theoretical approaches embedded in different disciplines are examined in order to understand the ideas establishing the inevitability of PPPs and legitimising its practice at both global and country level. An outcome of this exercise is a realisation that there is no grand theory on PPP. The lens of network governance is therefore adopted given its utility in understanding the organisational form that partnerships represent. The third section in this chapter is dedicated to clarifying the various conceptualisations of power. Here, particular emphasis is laid on the structural and ideational (ideas and discourse) dimensions of power and a *conceptual framework* is proposed to explain the third objective within my theoretical aim. I conclude with identifying four broad themes to be further explored in the subsequent chapters.

Chapter three describes the framework adopted for the research design and levels of analysis and substantiates my methodological and epistemic choices. I situate my research design in the four elements of the framework proposed by Michel Crotty (1998): epistemology, theoretical perspective,

methodology, and methods. Crucial to this research is the information generation process and my journey as a researcher. I outline the study sites, the selection criteria and the enablers and disablers in my journey. This chapter is concluded with a discussion on the quality of data, and ethical considerations made.

Chapters four, five, and six are structured mainly around the substantive element of my thesis. Drawing on the primary and secondary sources, these chapters reveal the *hidden transcript* of the Fund, addressing objectives 2.1, 2.2, and 2.3. In chapter four, I discuss the practice of public private partnerships facilitated by the Fund mechanisms as a departure from the *monotheism* (discursive notion) of the Fund, and more generally, health PPP. Drawing on the case of the national AIDS programme I focus on two inter-related aspects. Firstly, I examine the *governmentality* of the Fund and the contingencies of practice i.e. how new alliances produce structures and how these compete with their private and public counterparts to sustain in an environment characterised by power asymmetries and resource constraints (Objective 2.1). Secondly, I seek to understand the plurality of perspectives of the Fund *actors* and the challenges they face in mediating the different worlds of the global discourse and local practices (Objective 2.2). The first aspect examines how ‘partnerships’ are established, negotiated, maintained and challenged. The second aspect is explained through two case studies focusing on the public sector ‘partnership’ arrangements with a civil society consortia and a corporate member.

In chapter five, I seek to understand and illustrate the disciplining regime of the Fund i.e. how the Fund governance reconstitutes the non-state actors at all levels. Drawing on the case of the network of people with AIDS, I engage more deeply with objective 2.2, focusing on a sub-section of the Fund 'brokers' i.e. the actors comprising the 'civil society', and explicate their role in reproducing the discursive construction of the Fund and development. Here, the life of a project cycle and the interpretive communities it creates in the process are the object of analysis. An underlying aim of this chapter is to deconstruct the conceptual understanding of the term civil society and present an analysis of the AIDS 'industry', its constitution, the diversity of interests and power relations operating within, and seek to understand the processes with which claims are made and credibility established.

Chapter six focuses on the knowledge-power links, illustrating the process and tools through which the stabilisation of the Fund programme occurs. Following the paper trails and documentation necessary for this exercise, I discuss how the disjuncture between theory and practice, as presented in earlier chapters, is weaved into consensus and success stories. I argue that the system is stabilised and its hegemony maintained through a constant cycle of interpretation - translation of the project rationale into different institutional languages through acts of brokerage and sensitisation of 'beneficiaries into 'activist experts'- and demonstration of success in order to

legitimise the roles of the Fund brokers and make further claims through production of “facts”.

In chapter seven, I summarise the findings and conclude the thesis by reflecting on the theoretical and substantive aim of the thesis. While the theme of system and programme wide effects (Objective 2.3: implications for HIV management) is recurrent in chapters four, five and six, it is further teased out in this chapter in pursuit of a discussion on the implication of the Fund for equity of human resources, treatment, and care.

Chapter 2

Theoretical Considerations on Public Private Partnerships and Power

2.1 Introduction

Building on the description and clarification of Public Private Partnerships presented in the previous chapter, I now analyse the phenomenon in greater depth. The chapter is divided into four sections. The first section examines the different approaches used to clarify and classify the phenomenon of PPP, the global and local dichotomy in the nature of these arrangements, and concludes with a framework proposed to assess the phenomenon across different analytical dimensions. Here, I also summarise the main critique and concerns around PPPs in the public health domain and its implications for governance. The second section examines the theoretical underpinnings of the phenomenon where I view PPPs through the lens of network governance drawing on the theoretical perspectives of public sector management, organisational studies and political science theory. The central argument is that issues of power and accountability are central to the governance of PPPs, which are often used as a descriptor of network arrangements. These are examined in the third section through an in-depth review of the literature on power. Situated in the *structural*, *post-structural*, and *constructivist* paradigm, the discussion argues for striking a balance in the analysis of

power in global health governance by addressing the role of both hegemonic institutions including control over resources (structure) and, ideas and discourse (ideation). I conclude with clarifying the arrangements that are the primary focus of my research and identifying themes for further exploration in the chapters.

2.1 Understanding Public private partnerships

2.1.1 Different approaches/ typologies of PPPs

Different types of partnership are distinguished, based on their purpose, outcomes, partners involved, nature of partnership, and geographical spread (Nishtar 2004, Widdus 2005 and 2001). The various attempts at classifying PPP's can be broadly categorised under: i) Purpose or goal oriented ii) Role oriented and organisational form of arrangements.

2.1.1.1 Purpose oriented

Buse and Walt (2000b) categorise health partnerships into broad categories developed around the goal of the partnership: *product-based* including drug donation programmes aimed at increasing the demand for a particular drug, mostly initiated by a pharmaceutical; *product development based* which is generally initiated by the public sector for research, development and commercialisation of drugs which are not considered lucrative enough by the industry; and *issues/systems based*. The latter is a more eclectic group comprising of partnerships that seek to harmonize approaches of various

actors on a single disease or raise its profile on the global policy agenda, complement government efforts, and tap non-medical private resources for disease control (ibid).

In a similar attempt, Lob-Levyt (2001) identifies three main foci of PPPs in health – products, outcomes, and activities. *Product*-oriented partnerships seek to increase investments in research and development of new drugs and vaccines particularly for diseases that ‘disproportionately affect the poor’. These arrangements legitimise the involvement of pharmaceutical industry along with philanthropic foundations and public sector institution. The Global Alliance for TB drug development, involving Glaxo Smith Kline and other partners, is a case in point. *Outcome*-oriented partnerships are regarded as those initiatives that aim to eradicate or mitigate poverty related conditions such as polio or guinea worm. The global programme to eliminate lymphatic filariasis and ‘Global 2000’ (an initiative of Jimmy Carter, the former US President) are two examples with focus on outcomes. Finally, *activity* oriented partnership is argued as a broad conceptualisation including arrangements that employ private sector mechanisms in the delivery of goods, for example, social marketing of bed nets and condoms (Asante and Zwi 2007).

While these categorisations served an initial analytic purpose, they do not take into account a plethora of PPP arrangements whose description or positioning does not fit into the above categories. For example, the inventory

of global partnerships developed by the Geneva based Initiative on PPPs for Health classified nearly hundred partnerships based on the following broad 'approaches' (categories):

- Product Development (discovery and development of new drugs, vaccines or other health products)
- Improving access to health products (including distribution, donation, subsidising or negotiating prices)
- Global coordination mechanism (for coordinating multiple efforts to ensure success of approaches and health goals), and reporting mechanisms
- Health Services Strengthening
- Public Advocacy, Education and Research
- Regulation and Quality Assurance

This listing revealed the broad remit of health partnerships set up globally to tackle 'priority' health issues. A list of major global health partnerships categorised on the basis of the purpose they serve is given in table 3. These could be housed or owned by the public sector (GAVI, GPEI), orchestrated by companies (Action TB) or by a civil society organisation (Malaria Vaccine Initiative, Mectizan donation programme) (Reich 2002).

	Purpose	Partnerships
1	Product development	Global Alliance for TB Drug Development, International AIDS Vaccine Initiative, Medicines for Malaria Venture, and Malaria Vaccine Initiative
2	Improving access to healthcare products	Microbicide Development Programme, Accelerated Access Initiative, Global Alliance to Eliminate Leprosy , Global Alliance to Eliminate Lymphatic Filariasis, and the Global Polio Eradication Initiative (GPEI)
3	Global coordination mechanisms	Global Alliance for Vaccines and Immunisations (GAVI) , Stop TB, Global Alliance for Improved Nutrition, and the Micronutrient Initiative
4	Strengthening health services	Alliance for Health Policy and Systems Research, Multilateral Initiative on Malaria, African Comprehensive HIV/AIDS Partnerships
5	Public advocacy and education	Alliance for Microbicide Development, African Malaria Partnership, Global Business Coalition on HIV and AIDS (GBC) and Corporate Council on Africa
6	Regulation and quality assurance	The International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use, Pharmaceutical Security Institute, and the Anti-Counterfeit Drug Initiatives

Source: Nishtar S. (2004) Health Res Policy Syst. 2004; 2: 5.

Table 3: Categorisation of public-private partnerships based on the purpose they serve

However, like the previous attempts, this tabulation is not only simplistic but primarily based on the purpose with which the arrangements were entered into. Hence, while the purpose oriented classifications are a useful (and most commonly cited) reference point, the conceptually weak framework for analysis precludes the possibility of a critical engagement with substantive issues related to the interactions inherent in the relationship: transnational and complex nature of arrangements, inter-organisational dependencies and their incentives, geographical/ spatial arrangement, and the institutional environment generated in the recipient country. Each of these aspects, as the discussion will reveal, has implications for power play and accountability.

2.1.1.2 Organisational form and role of partners

A second category of classification emphasises the role of the potential participants and the types of cooperation sought. For example, Gentry and Fernandez (1998) identify three roles: provisioning of services, financing (public, out of pocket or insurance, and services provided by the corporate sector), and regulation and monitoring required to achieve a “minimum outcome”. This classification also called for an examination of incentives that each partner constituency has in performing these roles (Jutting 1999). In a similar discussion, Robinson and White (1997) identify three main processes: determination, financing, and production, which underlie various types of partnership arrangements between government and civic organisations in provision of social goods and services.

An important contribution to this debate is made by Mitchell-Weaver and Manning (1992) who categorise PPPs on the basis of their organizational form differentiating institutional models in relation to the degree to which private interests participate in “strategic decision making in the public interest”. These are : the *elite* model which entails negotiations among relatively equal partners who then exert influence on their respective organisations to achieve partnership objectives through network association; the *NGO* model wherein the state provides the material, financial and organisational resources and delegates the private sector (mostly NGOs) to carry out the programme; and the *quasi-public authority* model in which the state sets up a hybrid organisation possessing both public and private attributes which then provides services and goods or enables the private

sector to enter the market. Buse and Walt (2000) suggest that, in effect, this model creates a favourable environment for private enterprise to provide services which are publicly mandated.

While this classification is critical for understanding the institutional relationships especially with regards to the role of the private sector, it does not cover the range of partnerships that are emerging where either the private 'for-profit' sector is a dominant partner or a hybrid of these diverse organisational forms are in operation. The newer forms of public- private mix arrangements, for example, have 'coupling' as a defining element of partnerships (Bannerman et.al 2005). This masks the strategic role that the private sector actors might have in the interactions. Spatially, a partnership may involve horizontal coupling, i.e. an activity around a function that is common to the interests of all stakeholders (drafting the proposal for the Fund grant or joint development of a new programme) or it may involve vertical linkages whereby, the actors fulfil one or more roles in the value or supply chain (such as the delivery of anti-retroviral therapy in the treatment and care programme). Alternatively, as is the focus of my investigation, a public private mix might entail a combination of horizontal and vertical coupling of tasks for which private sector involvement is invoked.

Most typologies are based primarily on the substantive content of development activities and use the activity or purpose of the PPPs or form of arrangements as its distinguishing feature. This misses important questions

about the institutional structures and governance mechanisms and fails to distinguish relationships on the basis of process outcomes such as accountability. Sen and Davala (2002) adapt Robinson and White's 3x3 matrix to incorporate the element of accountability defined across three elements: rights and access to information, role in monitoring, review and evaluation, and role in key decisions. The typology includes three case scenarios depending on whether the government, the NGO, or both are the producers (ibid). Notwithstanding the significance of examining accountability for the analysis of power, I argue that the plural and complex nature of public private interface arrangements demands a framework with multiple layers of analysis.

2.1.2 Global vs. Country level plurality in the types of PPPs

At the global level one mostly finds complex arrangements of multiple actors including multilateral development organisations like the United Nations, the WHO and the World Bank; bi-laterals like the UK Department for International Development (DFID), the United States agency for International Development (USAID); philanthropic foundations like the Bill and Melinda Gates, Carter, Clinton Foundation; pharmaceutical companies like Merck, Smith-Kline Beecham; International non-governmental organisations (iNGOs) and faith-based groups.

At the country level still greater plurality exists since the global actors are joined by multiple stakeholders in formal and informal interactions. In India,

for example, collaborations between the State and the private sector in health-care date back at least to the post independence era and can be traced through its national health programmes and five year plans (Baru and Nundy 2008, Das 2007, Jeffery 1988). Most of these collaborations saw NGOs in a supportive role for community mobilisation and education along with limited service provisioning. Subsequently, these collaborations extended to the for-profit sector. However, the PPPs of the 1990s can be distinguished from the earlier forms of collaboration in two respects: firstly, while earlier initiatives saw the role of non-state players as peripheral to the programme, the recent ones appear to conceptualise both partners as 'equal' and are arbitrated through a formalised agreement, often a memorandum of understanding (Baru and Nundy 2008). Secondly, with the emergence of global partnerships or initiatives and their vertical interface with state and non-state actors, the older forms are transformed into newer and complex patterns of arrangements. The complexity arises from the transnational nature of these relationships and multiple layers of accountability (Nundy 2005) which emerges as the primary, secondary and tertiary levels of care are vertically integrated between the global, national, state, and local levels.

2.1.3 Evolution of public private interface arrangements in India

Since the inception of the first five year plan (1951-1956), the government elicited support from the 'for-profit' and 'non-profit' sectors in specific vertical disease control programmes. In an analysis of the shifts in forms of collaboration in the subsequent five year plans, Baru and Nundy (2008)

highlight that the private sector involvement largely restricted to community mobilisation and awareness generation in order to create a demand for services and thereby, complement government efforts. These collaborations were primarily observed in family planning, maternal and child health, leprosy and few other disease control programmes where the role of the non state actors restricted to distributing condoms and providing nutrition supplements. A very small proportion of the private providers were involved in providing contraception and abortion services with state subsidies in the form of monetary incentives and devices. It was only in the mid 1980s, following the global endorsements which underpinned the discourse on *reforms*, that the concept of PPPs was explicitly introduced in the Reproductive Child Health (RCH) policy and some disease control programmes through the seventh five year plan (1985-90). These programmes were externally funded, mainly from the World Bank, and laid out the basic guidelines for initiating partnerships. The active involvement of the for-profit sector is a post 1990 development where PPP was outlined as a distinct approach under the aegis of health sector reforms introduced in the early 1990s. The reform process in India has been piecemeal and incremental (Baru 2002) undertaken through the eighth, ninth and tenth five year plans. The plans themselves mirrored the wider shift in the organisation, structure and delivery of health care: from integrated primary health care to primary level care and an extensive preoccupation with single purpose driven programmes (Nundy 2005).

An analysis of PPPs across regions in India indicates a varied experience in terms of both design and outcomes (Annigeri et al. 2004, Venkataraman and Bjorkman 2006, World Bank 2006). Within the health sector, the literature on PPP suggests that the first model of partnership adopted was 'contracting out': outsourcing of a service run by the public sector to the private sector. Substituting hierarchical management structures with contractual relationships between purchasers and providers was believed to enhance transparency of prices, quantity and quality, and competition that will lead to gain in efficiency (WHO 1998). The simplest and most common forms include contracting out of services at the primary level for health education, demand generation through social marketing and limited curative care, and at the secondary and tertiary level for *para* clinical services like diagnostic and laboratory facilities and dietetics.

A second more complex form of PPP includes arrangements such as social franchising and joint ventures. Social franchising combines elements of contracting out and an extensive system of public subsidies in the form of land, diagnostic kits, equipment and devices. One of the pioneering models of this kind is '*Janani*'. Initially set up to address the gap in general services at primary level health care, it now focuses on reproductive and child health services. Evaluation of this programme reveals equity concerns since the programme targets only the middle and low income segments that can afford partial payment. The poorest segment is reliant on subsidies or discounted prices, neither of which is built into the model (Annigeri et al. 2004:24).

Currently, social marketing is another strategy used for supply of condoms, emergency contraceptives, IUDs and other unspecified new contraceptives, STD drugs, tubal ligation and non scalpel vasectomy, bed nets, Iron folic acid tablets, along with other 'socially beneficial health products'. The main arguments put forward in favour of social marketing as a partnership model include its potential to: i) reach out to un-served or under-served population ii) improve coverage and availability by reducing costs, and iii) encourage socially beneficial behaviour (GOI 2001). However, it has been argued that the National Strategy for Social Marketing by the Government of India (GOI) takes the focus away from ensuring equity and minimum standards of quality services (Qadeer unpublished) by proposing 'differential quality and on-payment provision of services'.

A third stage in the evolution of public private partnership arrangements involves private providers in co-provisioning of services in public hospitals. In some cases, the private sector's involvement is restricted to services like diagnostics and drug supply, while in others the entire management and operation of primary health centres has been given to non-governmental organisations (Das 2007). The complexities arise from involvement of several actors and intermediaries across constituencies with multiple and overlapping roles. These arrangements are very dynamic as they continue to evolve to meet changing interests, donor commitments, and commitments of private practitioners, NGOs, and national or state programmes.

Yet another stage of the evolution has involved creating autonomous structures which directly interact with the donors and NGOs for provision of services. Prakash and Singh (2007) refer to this growth of intermediaries as *agencification*. The term implies the “carving out of independent agencies from the state, either through corporatisation or the formation of societies at the state levels” (ibid: 4). These autonomous agencies are registered as a society or trust, which allows them legal and financial independence from the parent body and greater operational flexibility with regards to recruitment, funding, payment systems, and outsourcing services. This trend is argued to result in “diffusion of power and authority” (Baru and Nundy 2008: 66), potentially fragment services, and has implications for the relationships between the State and non-state actors thereby posing a challenge to accountability.

In recent years, literature is beginning to emerge on the experience of simple/linear and complex PPPs that are operational in primary, secondary and tertiary care in India, mainly restricted to the reproductive and child health (RCH) and the revised national Tuberculosis programmes (RNTCP). An analysis of these arrangements reveals that their content and design are largely derived from the guidelines and the strategy documents of the multilateral and bi-lateral agencies, and that the plurality of actors and their roles often results in diffusion of authority and power across the various actors (Baru and Nundy 2006). A closer examination of RNTCP reveals that while it successfully increased demand through active case-detection, the

division of role and responsibilities between the market (private providers) and the state led to a fragmentation of the programme thus affecting its comprehensiveness and effectiveness. Dewan et al. (2006:4) call for the importance of a strong public sector programme (national control) as a critical condition for sustaining partnerships with the private sector and ensuring success. Likewise, Kumar et al. (2005) in their study of a PPP in a district in Kerala attributed its success in improving case detection of TB patients to “a strong local government TB programme with adequate staffing, medication and capacity to monitor the partnership while continuing routine diagnostic and treatment services for most patients” (ibid: 873).

To summarise, there is greater plurality in the forms of public private interactions at country level. Often the evidence and literature fails to account for the variations that exists in the designs across states and rural/ urban areas, process building of these partnerships, and the nature of services for which they were set up (Kumar et al. 2005, Dewan et al. 2006, Uplekar et al. 2001). Evidence, though limited, underscores the need for careful assessment of these arrangements, the role of the partner organisations in relation to the State, and the power and equity implications for health system and programmes.

2.1.4 An alternative view on partnerships: multi-dimensional power analysis

Given the increasing complexity and varied impacts of the public-private interactions, a rigid, flat and linear typification takes the attention away from the full spectrum of arrangements and relationships that are legitimized as partnerships. Moreover, the discursive conceptualisation of public-private interactions within the health sector mostly takes into account large transnational/ global initiatives and leaves out a plethora of arrangements in operation as 'partnership' at the country level.

An alternative view must therefore regard public private interface arrangements across multiple dimensions that may be defined geographically, temporally, spatially, and functionally, with divergent axes of accountability, formality of arrangements, purpose and specific role of the State or other actors in provision, production, procurement, and financing. I propose a preliminary framework for classification which builds on the existing attempts at conceptualising PPPs (Bovaird 2004, Sen and Davala 2002, Mitchell-Weaver and Manning 1992). Central to this framework, is the recognition that power plays a key role in the playing out of public private interactions. I present five dimensions along which a public-private interface arrangement may be defined and assessed. The dimensions are:

1. Geographical and spatial arrangement: pertains to the local or transnational nature of relationships and actors involved. It seeks an

examination of where (the region and the institution) the partnership is housed (physical location of the headquarters and the administration) vis-a-vis where it operates to identify the locus of decision making, agenda setting, governance of structures, and implementation. An important distinction, and an object of analysis, here lies between self-organising, bottom-up partnerships and those externally mandated by a central agency and/or driven by fund flows and top-down formation. This, as suggested, has implications for local ownership and the ideology and interests shaping the policy content.

2. Nature and scope of arrangements: determines the flow of funding, information and accountability and therefore has implications for the power wielded and the ownership developed among various actors. Are the multiple actors vertically integrated, horizontally integrated or defined by mixed arrangements? Horizontal arrangements imply a function which generates interest and invokes participation of multiple stakeholders, for example, joint development of proposal or policy. On the other hand, vertical linkages suggest that the actors fulfil one or more roles in the brokerage chain. Examples of the latter are sub-contracting NGOs to deliver antiretroviral therapy and provide adherence counselling within the HIV and AIDS treatment care programme.
3. Nature of inter-organisational relationships and the partnership environment can be traced on the competition – control continuum proposed by Green and Matthias (1997). The continuum, which is

characterised by decreasing autonomy and intensifying communication, can be a useful tool to assess the different forms taken by organisational relationships and the proposed outcomes.

4. Role of actors and representation of constituency: A deconstruction and assessment of the type of actor organisations involved in the arrangements is essential as it defines the organisational ideology, its structures and relative authority with which they function within the partnership. This determines their relative bargaining position across the three elements identified by Sen and Davala (2002): access to information (knowledge), role in decision making, and role in monitoring, review and evaluation (and arbitration). This demands a distinction between the constituencies and analysis of each of the actors within the 'public', quasi-public, 'private for profit' (business and corporate houses, pharmaceutical companies, independent providers/practitioners) and, the 'private not-for profit' (international NGOs or local movements and NGOs, bilateral or multi lateral donor agencies).
5. Rationale and purpose of the partnership: is particularly useful to assess the congruence between the stated and unstated objectives of the state and non-state partner agencies. Each partnership, as Bovaird (2004) suggests, will have a different rationale and policy objective(s). The objectives could be diverse: improving access to treatment or services, monitoring and evaluating a programme, implementation and delivery, empowering the affected, tackling social inclusion and financial gain. However, often a disjuncture between the

rationale, practice and outcome can be observed. Comparison of the programme outcomes evaluated against the policy rationale gives insights into the often contradictory pathways of policy formulation and implementation. For example, as the subsequent chapters reveal, private sector participation is often invoked on the cited grounds of 'complementarity of roles and services' whereas the project activities result in duplication and competition. An assessment of the success or failure of a partnership must therefore account for these differences and the inherent paradoxes in the rationale. These paradoxes are discussed in the following section.

Making these distinctions and mapping out the partnership along each of the above axes has implications for the analysis of power and accountability since each dimension has particular relevance for the analysis of the structural and ideational sources and characteristics of power: material, resource, ideas and discourse. Such analysis, it is hoped, will also make evident the paradoxes in the discursive understanding of the PPP model.

One such paradox is highlighted in partnerships that focus on a single issue or programme or disease. Within the public sector, a key rationale for partnerships is to set up an organisation which will focus on a specific, often 'neglected', issue to avoid the problems of diffused focus which is typical of public sector agencies. The rationale around setting up of the Fund, for instance, is argued to be an increase in resources and efforts to fight three

major communicable diseases, particularly HIV and AIDS, which disproportionately affect low-income countries. However, as Bovaird (2004) points out, merging services across sectors to meet the holistic needs of the infected and affected (in this case treatment, care, and support services) may often drive in the opposite direction, i.e. might lead to further fragmentation given the multiple needs and agendas.

Another paradox in the rationale underlying the shift to a partnership approach to public issues is the need for improving transparency and accountability in policy processes. However, it has been suggested that the heterogeneity that is both a characteristic and the very rationale of a partnership approach brings fragmentation of structures and processes, which in turn leads to blurring of responsibilities and of accountability (Loffler 1999, Wettenhall 2001, Baru and Nundy 2008). As illustrated in the subsequent chapters, the diffusion of authority and blurring of roles became a challenge for arbitration and for ensuring transparency among actors.

2.1.5 The public-private arrangements under investigation

The public private partnerships that are the focus of my investigation and of interest to this thesis refer to: formal, task oriented and time bound institutional and working arrangements which are invoked by a global initiative, the Global Fund to fight AIDS, TB and Malaria (the Fund). Among the three diseases that the Fund addresses, I trace the arrangements in the context of HIV management in India focusing on the national AIDS

programme. Using the descriptive elements of the five dimensions of the proposed classification framework (Section 2.1.4), I define these as:

Transnational arrangements whose country relationships involve a public sector organisation, the National AIDS Control Organisation or its state divisions, and one or more organisations outside the public domain. The latter includes international and national NGOs, the 'beneficiaries' represented by a network of people with AIDS and the corporate sector represented by business houses and industry led and industry managed non profit entities. While the overarching arrangements are predominantly between the State and actors in the private sector, I also examine sub-arrangements between two or more private sector organisations (as members of civil society consortia). These arrangements are governed at multiple levels: global, where the Secretariat and the Board in Geneva takes key decisions on who, what, and where to fund; the national and sub-national operations are managed through a coordinating body and governance structures that bridge the national to global. Besides a contract between the Fund and national recipients, and Fund guidelines that define the overall partnership structure, the multiple alliances at the country level are not bound by any single legal document that captures the terms and the diverse commitments and motivations. The majority of these alliances, particularly those at the national level, are governed by a Memorandum of Understanding (MoU) and a tripartite agreement that

sets out very minimal terms including a statement on conflict of interests.

2.1.6 Concerns and critiques of PPPs

Since PPPs originally came into prominence around three decades ago, the concept has been contested (Bovaird 1986, Gibelman and Demone 1983) and a subject of 'intensely fuelled debate' (Nishtar 2004). The debates highlight diverse issues related to i) the merits and demerits of PPPs, ii) governance structures and functions of global PPP and their representative legitimacy and accountability, and iii) the processes and the "side" effects or impact on service delivery, sustainability and national priorities (Hanefeld 2008, GAO 2004, Widdus 2005, Brugha et al. 2004, Brugha and Walt 2001, Bennett and Fairbank 2003, Taylor 1997). The debates are summarised below.

PPPs have opened up new spaces and possibilities for the private sector to exercise power and influence in not only delivering care but also establishing norms and guidelines, domains traditionally the mandate of public sector. In the course of generating new resources within the global health arena, PPPs are argued to alter the relative distribution of power among organisations, between public and private sectors, and between the agencies of the global North and the global South (Buse and Harmer 2004). For example, sceptics have expressed concern over the skewed balance between global partners and local beneficiaries since very few global partnerships include

representation from low income countries, where most partnerships operate (Nishtar 2004). The conventional literature on Public Administration suspects PPPs, particularly interactions in which the pharmaceutical industry participates, to dilute political control over decision making and infiltration of for-profit interests (Dukes 2002, Henry and Lexchin 2002, Montaner et al. 2001, Angell 2000).

At a macro level the implications of this power imbalance can be seen with respect to the choice of health problem or country of focus which does not always correspond to the disease burden experienced by the poor, resulting in inequities within the society (Buse and Walt 2000a). Rather, it magnifies the negative effects and elements of aid regimes by distorting national priorities and policies. This observation echoes with the literature on global governance. The Fund, for example, proposes to be an innovative 'architecture for aid', a new form of financing and governance mechanism having the commercial sector as active agents at all levels of policy formulation and translation. This, as argued by Buse and Walt (2000b), may result in pluralisation of decision making bodies and in reshaping relations of power, authority, and legitimacy.

It was also considered that partnerships increased planning burden with time consuming reporting and financial management systems. Few evaluations revealed the procedural burden on the staff that is already overstretched in managing the demands of multiple vertical and externally driven initiatives

(Biesma et.al. 2009, Hanefeld 2009). On the other hand, a more positive conceptualisation of the shift from purely and quasi government to partnerships has been articulated as the opening up of decision making spaces to civil society organisations and previously marginalised groups (Buse and Harmer 2004).

While some examples illustrate the potential of creating a powerful mechanism to address difficult problems by harnessing strengths of different partners, others bring to light complex issues that emerge from different and often conflicting interests and objectives working within different governance structures. Salamon (1995) identifies key implications for the public and non profit sectors in terms of governance. These are:

1. For the non profit sector – potential loss of independence, dilution or distortion of their advocacy role in pursuit of available funds, and the resulting loss in flexibility and local accountability traditionally seen as the greatest asset of the voluntary sector (ibid).
2. For the government / public sector- in a context where decision making is widely dispersed among organisations with diverse set of interests and independent authority and support systems, partnerships pose a challenge for the government in ensuring accountability, exercising supervision, and coordination (ibid). These are argued to have enabled the flow of state resources to private enterprise.

This indicates the potential for partnerships to transform existing relationships, induce conflict, and blur existing boundaries and distinctions. Drawing attention to the “well demonstrated reluctance of the private sector to grow in backward areas”, Baru (1993:965) suggests that the notion of PPPs serving as a mechanism to enhance equity (ensure adequate population coverage) is an ‘eye-wash’. Ferlie et al. (1996) regard the shift from public and private provision to public-private provision as part of the pervasive neo-liberal ideology in health care, an ideological move to a system based on private sector models and markets. This explains the inherently political nature of partnerships.

If power relations are to serve as the locus of analysis of public private interface arrangements, an area that demands careful examination is whether the values of the weaker and marginalised actors are co-opted by the more powerful partner. This has been explored in some depth, although insufficiently, within the debates on global PPPs. For example, questions have been raised regarding suitability of partnering with the pharmaceutical industry particularly for health promotion (Hancock 1998). Recognising the need for discretion, WHO and UNICEF note the need to exercise caution over the selection of private sector partners (Kickbusch and Quick 1998, Bellamy 1999) and have proposed guidelines that single out other players like the tobacco industry and the arms manufacturers. The debate on country level health partnerships demands a similar analysis and discretion.

2.2 Theoretical underpinnings of PPPs

While no single grand theory on partnership exists (Addicott 2006), theoretical perspectives from multiple disciplines have been employed to understand various elements of partnership and shape its meaning. The roots of the ongoing debates on the role of PPP in the development and health process can be traced to the discussions of welfare reforms proposed in the industrialised countries towards the end of the 1970s and 1980s. Around this time a pessimistic view of the post war 'welfare State' became dominant. The new era of administrative and structural reforms proposed by the government of Reagan in the United States and Thatcher in the United Kingdom was characterised by de-regulation, privatisation and budget cuts and led to a strategic retreat of the public sector and the introduction of the discourse on new 'managerialism' towards lowering costs and functioning effectively (Jutting 1999, Kickert et al. 1997). This re-evaluation of the structure and function of government in relation to delivery of public services is largely guided by the theoretical foundations of '*new public management*' (Hood 1991, Moore 1996). Argued as arising from the disenchantment with the performance of traditional public sector bureaucracy, the *new public management* discourse was considered to have at its core – a cutback of public sector expenditure, delegation of services and tasks to the private for-profit sector, and the engagement of the voluntary sector in provision of public goods (Mitchell-Weaver and Manning 1992).

The new thinking, primarily guided by classical economic principles, was concerned with injecting 'business like practices'⁶ into public sector agencies (Shaw 1999) based on the assumption that hierarchical bureaucracy, the organisational form of the public delivery system is inefficient and introduction of market mechanisms can substantially enhance its efficiency (Mills 1995). This inefficiency has been attributed largely to public choice theory, which proposes that bureaucrats and politicians are more likely to serve their own interests or those of powerful interest groups and do not always act in the public interests (Walsh 1995).

A central theme of this neoliberal thinking regards the State as an enabler rather than direct provider of services except in specific identifiable circumstances (Moore 1996, Vining and Weimer 1990). In accordance with this, private sector involvement was sought in view of the benefits of the managerial mode of coordination in a multi provider system (Robinson and White 1997) i.e. managing the institutional and managerial consequences of the mixed economy of care in social sectors like health and education. Over time, the role of the private sector expanded from contracted services and voluntary participation of citizens in the production and provision of public goods and services by local governments to a broader conception involving a range of actors from civic organisations and private sector firms (Warren

⁶ R. Paul Shaw (2004) outlines five features while defining the approach of 'business like practice' which centres around 'costs' of producing the good/service and linking it with expected outcomes in pursuit of 'value for money'; ensuring accountability to stakeholders through rigorous monitoring and evaluation, explicit TOR and incentives linked to performance; and taking regular stock of client needs and satisfaction.

cited in Jutting 1999). As a result emphasis was laid on joint action and mutually outlined goals with a potential for economies of scale or economies of scope. Meanwhile, currents in the management and political science perspectives were emphasising the importance of participatory and collaborative working as opposed to competitive behaviour.

The development of the term 'partnership' can be located in the literature on 'networks' which has been explored in detail through management and organisational studies (Pettigrew and Fenton 2000b, Nohria 1992, Thompson 2003, Benson 1975, Aldrich 1979) and, political and policy science literature (Marsh and Rhodes 1992; Kickert et al. 1999). The following section presents the main discussion on network governance, as a separate mode of governance emerging in response to the dichotomous view of centralised rule (bureaucracy) and multi-actor perspective. In particular, I elaborate on the 'policy network' approach and contextualise it to the focus of the study: public private partnerships in HIV management in India.

2.2.1 Examining key characteristics of different modes of governance: hierarchies, markets, and networks

In his classic article on the nature of firm, Ronald Coase (1937) proposed 'firm' as an alternative governance structure to 'markets' for organising similar kinds of transactions. This work was revisited only in the 1970s when Oliver Williamson (1975) used the lens of transaction cost economics to

distinguish exchanges in hierarchically organised firms as oppose to market interfaces (Powell 1990).

According to this view, market conditions could take any form with monopoly at one end of the spectrum through to perfect competition at the other extreme with the presence of a large number of buyers and sellers, none of which were large enough to have direct control over the market price. Alternatively, hierarchies are organised under a structured regime of command driven by a set of overt organisational rules and procedures. Bureaucratic hierarchies in particular operate through pyramidal organisation with increasing task specification and decreasing (gradation of) power and autonomy as one moves from the top to the bottom of the organisation (Mitchell 1991 cited in Thompson et. al. 1991). Given the high levels of formalisation and routinisation, hierarchies exhibit less flexibility than markets and are believed to destroy innovation and creativity (Lowndes and Skelcher 1998).

This dichotomous view of markets and hierarchies has been subjected to a great deal of scrutiny given its failure to capture the complex realities of exchange across traditional and established boundaries. Scholars instead argued that economic exchanges can be organised across a continuum, with discrete market transactions on one end and centralised firms on the other and various intermediate or hybrid organisational forms scattered in between (Powell 1990). Literature from organisational studies and management

research highlight that in response to the search by both public and private sector organisations for novel methods of coordinating services across pre-existing boundaries, networks or network-based organisations emerged as an innovative organisational form (Pettigrew and Fenton 2000b) based on a decentralised coordinating style, and have since been adopted in the health care sector in both low or middle, and high income countries (an example of the latter being the NHS primary health networks). Indeed, networks have long existed as an organisational form without being explicitly acknowledged as such, both when health systems were primarily hierarchical and quasi-market (post 90 development). As Nohria (1992) suggests, organisations are influenced by their environment which should be viewed as a network of other organisations and the behaviours of actors can be best explained by their position in this network of relationships.

Both the dichotomous and continuum view of markets-networks-hierarchies remains contested. First, critics challenge the myth of 'agentless bueraucracies' and 'pure and perfect market place' (Latour 1993) since firms are increasingly engaging in forms of collaboration that are distinct from the familiar alternative of market contracting as well as the formal ideal of vertical integration (Powell 1990). Second, the continuum view of economic exchange also remains insufficient, as Powell suggests "too quiescent and mechanical" (ibid: 299), and deflects our attention from an array of organisational forms characteristic of global governance today. Neither markets can be viewed as the starting point of exchange giving rise to other

models nor do hierarchies represent an end point (on the continuum) of economic development (Powel 1991: 268).

Thompson and Mitchell (1991) propose network as a flat organisational form where typically 'equal' partners enter into informal relationships that are socially rather than legally binding and are required to adapt administratively, financially, technically and logistically. An ideal network is conceived as one in which formal structures, such as position, geographical location, and market focus, are not significant barriers (Pettigrew and Fenton 2000b). Like partnerships, no single grand theory of network or third party governance exists (Addicott 2006). Definitions, however, focus on informal communication between diverse organisations to coordinate the flow of goods and services, which is achieved from sharing of resources and expertise. This sharing and commonality of resources is believed to reduce uncertainty and enable greater flexibility, capacity, and access to resources and skills that might be external to the organisation (Miles and Snow 1992; Thompson et al. 1991).

Network development may entail entering into newer relationships and the potential breaking of existing relationships. Networks take a variety of forms: centralised or devolved; formalised or loosely structured; utilising existing structures and resources or stimulating newer initiatives (Abbott et al. 2006). While markets are governed by price mechanisms and bureaucracies operate on command, networks predominantly function in an environment

based on relationships. Networks are regarded as more egalitarian, flexible and inclusive although, as Addicott (2006) points out, there can be central and peripheral stakeholders within a network, with variable power. It is argued that in comparison to hierarchies, network arrangements are more suitable for rapidly changing and highly complex environments (Thompson et al. 1991, Pettigrew and Fenton 2000b) since they are more dynamic and responsive as a result of which, new information or knowledge can be easily disseminated, interpreted and acted upon. Literature suggests that the defining characteristics of a network model are: its access to diverse information sources, particularly professional and technical knowledge which is tacit (Ferlie and Pettigrew 1996), the opportunity for knowledge generation and reciprocal learning through sharing and exchange , and team-work and collaboration leading to reduced duplication and diffusion of expertise (Kewell et al. 2002).

2.2.2 Networks in the private and public sector

Pettigrew and Fenton (2000a: 279) suggest that the main driver for network based organisational forms in the private sector is high competition in lieu of which traditional hierarchical structures become redundant, thus prompting “new organisational practices characterised by flexibility, knowledge transferability and horizontal collaboration”.

Emerged as an outcome of the political discourse around government failures, the conventional literature on networks (barring the work of Rogers

and Whetten 1982, Gage and Mandell 1990) has largely ignored the potential of government steering within an existing network of inter organisational relations. The conventional account of networks mostly considers them in the private domain (Marsh and Rhodes 1992) regarding them as 'political oligarchies' that shut out the public (ibid: 265). Fox and Miller (1995) argue for pluralism of discourses and regard policy networks as 'nascent forms of publicly interested discourse in which all affected work together to determine possibilities for next action'.

2.2.3 Networks in the public sector: Policy network

Kickert et al. (1997) define policy networks as 'more or less stable patterns of social relations between interdependent actors which form around policy problems and or programmes'. Interdependency, based on the distribution of resources among various actors, goals they pursue, and their perceptions of their dependency, is the key defining characteristic. Frequent repetition of these interactions, it is argued, enables institutionalisation and formalisation of these processes and rules, the structural features of which then influence future policy process (ibid). Policy networks typically involve a large number of inter-dependent actors - public, semi-public and private- from a particular policy field coming together (or competing) for influence over policy (Rhodes 1997, Kickert et al. 1999a). The government, though passive, may undertake the steering role (Rhodes and Marsh 1992) while the participating actors and organisations are connected through resource dependencies.

The literature on policy network draws together insights from: i) policy science, which analyses public policy processes as complex interactions and ambiguous processes resulting from multiple goals and strategies, and uncertainty of information and outcomes (Cohen et al. 1972, Marin and Mayentz 1991), and ii) political science and organisational theory for the analysis of distribution of power and dependencies in inter-organisational relations (Benson 1978, Rhodes 1996, Kickert et al. 1999, Marsh and Rhodes 1992).

2.2.4 A critical view on Network governance

In this section, the discussion on network governance is summarised and critically reflected upon in order to contextualise it to the focus of the research.

Firstly, networks are proposed as a novel and distinct style of governance in contrast with markets and hierarchies. Given the ambiguities within the distinction, I argue against any stylized models of exchange or coordination. Concurring to the scepticism around the novelty of network (as a third category of organisation form), I argue that both hierarchies and market transactions can have multiple nodes similar to a network whereas network transactions can be managed through firm or market mechanisms. The Fund grant and the public-private arrangements under investigation are cases in point. While the national AIDS programme is located within a bureaucratic structure of governance (the NACO housed within the Ministry of Health), it

represents a mixed form of governance with emerging policy networks for raising funds, monitoring and delivery, and an extensive use of market mechanisms (contracts, compensation, performance based payments, and other exchanges). Moreover, the wider health care context in which the national AIDS programme is situated continues to be dominated by market forces with 82 percent of treatment occurring in the private sector (Das 1997). Here, the transactions occur through a mix of discrete exchanges, administrative fiat, and through networks of individuals or inter and intra organisational relationships among donor and recipient constituencies.

Secondly, the defining characteristics of network arrangements are: reciprocity and interdependence among actors, notion of shared burden and benefits, and access to resources including information and expertise. Kickert et al. (1999) draw our attention to the fact that network management is a departure from the classical management approach where management is seen as a top down activity based on a clear unilateral authority structure. Rather, it entails initiating and facilitating interaction processes between actors, creating and changing network arrangements for better coordination (Scharpf 1978, Rogers and Whetten 1982). It is however, inaccurate to conceive of networks solely in terms of collaboration and harmony. The involvement of multiple stakeholders in common tasks has resulted in the problem of 'multiple hands' rendering the task of defining responsibilities and arbitration difficult (Hondeghe 1998). A body of literature highlights conditions under which networks fail. Some attribute its failure to the design

stage wherein, cultural compatibility is often ignored (Child and Faulkner 1998) while others call attention to managerial faults in its operation leading to ineffectiveness (Miles and Snow 1992). Another group of sceptics suggest that cooperation and reciprocity do not 'insulate practitioners from considerations of power' and each point of contact in a network could be a potential source of conflict as well as harmony (Keohane cited in Powell 1990). Koliba et al. (2009) propose that asymmetrical allocations of material and immaterial resources and power among network actors will influence the structure of administrative authority of the network.

If the 'partnership' model is regarded as a descriptor of the network phenomena, and there is ample evidence to do so, the above necessitates an in depth analysis of power and resource dependencies among various actors engaged in public-private interface arrangements. In order to do this, I first outline the *structuralist* and *critical* approaches to power and examine important concepts that shape the generation and utilisation of power. These approaches are complemented by drawing on current perspective in anthropology of health to analyse power and resource sharing in the PPP policy model.

2.3 Theoretical perspectives in the analysis of Power

Within the wealth of literature on power, three distinctive broad theories emerge: pluralism, structuralism and post-structuralism. Each of these broad perspectives or schools of thought comprises differing conceptualisations of

power and views to understand power relations. Within the *structuralist* framework, for instance, some theories are underpinned by *orthodox* or *neo-Marxist* analyses (Navarro 1998b, 2004) which focus on importance of class analysis in explaining health inequality (Navarro 2000b) or the propagation of neo-liberal ideology through international organisations (Banerji 2002, Berlinguer 1999). Other approaches as applied to health care organisations examine power in relation to conflict, which they suggest arises from professional dominance (Freidson 1994).

However, this chapter does not engage with the three broad 'categories of theories'. It instead focuses on the key characteristics of the debate that can be drawn from the literature on power: a thematic distinction between 'power over' and 'power to' characterised by an overwhelming focus on the conceptual, theoretical and political explication of the former (Stewart 2001). This section considers the main arguments central to discussions of 'power over' in social sciences in the recent decades: Parsons' authoritative political power model (1967a), Giddens' structuration theory (1976, 1979), Foucault's elaboration of disciplinary power and association with domination (Foucault and Gordon 1980, Rabinow ed. 1985), and, Mann's analysis of the sources of social power (1986, 1993), to tease out and provide a more operational account of elements derived from these theoretical perspectives. Subsequently, I discuss the nature of power relations in networks, particularly those relevant to the study, and the prevalence of professional dominance and expertise in the modern world.

2.3.1 Various conceptualisations of power

Parsons (1963, 1967a) conceptualisation of power lays emphasis on the pursuit of collective goals (and mobilisation driven by consensus) as 'facilitative' and seen distinct from 'distributive' approaches that highlight the "hierarchical character of power, and the divisions of interest which are frequently consequent upon it" (Giddens 1997:341), i.e. power by A over B, in relation to the coercive and sectional pursuit of goals. Giddens elaborates on two aspects of power: in the broad sense, power can be seen as the 'transformative capacity of human agency' which refers to the capability of the actor to intervene in a series of events to change their course. In the narrow sense, power is 'relational' and may be defined as 'the capability to secure outcomes where the realisation of these outcomes depends on the agency of others' (Giddens 1976) and can be understood as power 'over' others or power as 'domination' (ibid). The relational aspect of power is further explicated by Lee (1999: 246) who likens power to electricity as "it has the possibility of existence everywhere but can only be identified as it flows from one thing to another".

Explaining the source of power, Giddens argues that in any given social interaction use of power can be understood in terms of "resources and facilities which participants bring to and mobilise...so as to influence or control the conduct of others party to that interaction" (1976:112). In his formulation of the 'structuration theory' Giddens proposes that "power...is generated in and through the reproduction of structures of domination. These

structures are constituted by resources of two sorts- allocative and authoritative” (1984:258). While Giddens in his analysis of social power lays emphasis on structural domination and dependency, he argues that “...actors in subordinate positions are never wholly dependent, and often adept at converting whatever resources they possess into some degree of control over the conditions of reproduction of the system...there exists a *dialectic of control*, continually shifting balances of resources, altering the overall distribution of power” (Giddens 1982b: 32).

Michael Mann in his study of ‘The Sources of Social Power’ (1986) gives valuable insights to the analysis of how power is wielded or acquired (Stewart 2001). Mann’s social analysis departs from the totalitarian view of societies. He instead proposes a conception of societies as “multiple overlapping and intersecting power networks” and can be best accounted in terms of “the interrelations of four sources of power: economic, military, ideological and political relationships” (Mann 1986). These sources of social power, he argues, are organisations’ institutional means of social control for attaining human goals. Thus Mann’s strategic perspective on power is “the ability to pursue and attain goals through mastery of one’s environment” (ibid: 6). He explores this ability through two aspects of social power: distributive, that being exercised over other individuals, and collective, whereby persons cooperate to enhance their joint power over third parties (ibid). The latter of Mann’s proposition clarifies the development of interdependent relationships, which may transcend national, international and transnational boundaries as

is the case with global public private arrangements. However, referring to it as 'cooperation' could be misleading.

A central argument here is: most social interactions and relations have both aspects of power, distributive and collective, exploitative and functional, intertwined and operational. Mann (1986) explains this through his central concept of 'organisational power' stressing the extent to which implementation of collective goals requires the organisation and division of function, thus subjecting it to 'distributive power'. Drawing parallels with the classic elite theory, he proposes that organisational power (and the inherent dominant relations) gains stability as those at the top ensure compliance by exercising control through laws and norms as well as through *organisational outflanking* of the masses at the bottom. The latter are unable to resist or collectively organise because they are embedded within collective and distributive power organisations controlled by others (ibid). In this organisational perspective on power, Mann attributes outflanking to diffused power (distinct from authoritative power), which spreads spontaneously and unconsciously through a social group, resulting in "social practices that embody power relations but are not explicitly commanded" (ibid: 7). Thus, a central feature of diffused power is 'normalisation' owing to which the 'outflanked' subordinates do not deem resistance necessary.

The process of normalisation can be better understood in terms of Foucault's concept of 'disciplinary power'. Foucault delineates distinct modern forms of

domination as those of 'disciplinary power' and 'bio-power' (See Foucault 1980). While the classical 'sovereign' model of power proposed that power may direct, coerce or even repress those subject to it, disciplinary power constructs the subjectivity necessary for the successful operation of a particular regime of power/knowledge. It is this 'subjectivisation' that lies at the heart of the disciplinary model and identifies a distinctively modern power configuration: one which subjugates (to someone else by control and dependence) and makes subject to (tied to identity by a conscience or self-knowledge) (Foucault 1982). Unlike the sovereignty model where domination is expressed through prohibition or punishment of the censured action, in the disciplinary model it inculcates the required action by making it the desired action within the framework of political rationalities and technologies of power (Stewart 2001). Foucault's conceptualisation of power has come under criticism for its denial of normativity of political engagement and resistance (ibid: 20) and failure to acknowledge that collective disciplines can function both as structures of domination and as elements of *agentic* power (See Habermas 1990b, Fraser 1989a). This omission according to Taylor (1986:93) "precludes the possibility of an emancipatory conception of power as human agency".

For the purpose of this thesis, however, the perspective on normalisation of power and practices is crucial for analysing social power relations in networks and in effect, partnership arrangements. Angus Stewart suggests that this distinction enables the possibility of the existence of relationships

that appear as a result of “self evident common interest” but may in fact embody “definitive asymmetries of power” (2001:26).

A separate body of work contextualises the analysis of power in terms of inter-dependency (Pfeffer and Salancik 1978, Pfeffer 1981, Ulrich et al. 1984, Keohane and Nye 1989). *Resource dependency* theorists argue that both internal hierarchies and the distribution of power in external relationships determine resource allocation within organisations and explain behaviour and outcomes (Elston 2005). Developed through the work of Emerson (1962), this perspective proposes that organisations depend for resources on key stakeholders in their external environment and strive to be effective in meeting the goals of these powerful stakeholders. He establishes an inverse relationship between power and dependence by positing that the power of A over B is derived from the dependence of B on A. Hence, dependence on other individuals or organisations will create power in those external resources. This interdependence between actors, although regarded as a key driver for effectiveness (Gulati and Sytch 2007), can lead to conflict and uncertainty (Pfeffer and Salancik 1978). If we assume knowledge or access to information and ideas is power, uncertainty or lack of access to information suggests a lack of power.

This perspective is particularly relevant to the analysis of power in public private arrangements, which characterise relationships of high dependencies between potentially unequal partners with varying degree of control over

resources. I posit that access to and control over resources not only determines power balance within interactions but also determines the very need (appropriateness of these arrangements) and nature of these relationships. The resource dependency theory can thus help us understand: i) who (organisational actors) is sought out for such arrangements and who becomes an asset or a liability in partnership and, ii) the shifting power balance between the different players and their planning, implementing, monitoring roles within partnership arrangements. It can also help us explain the conflict and tensions in network or partnership development, i.e. the factors determining formation of newer relationships and the breaking of existing relationships in successive Global fund rounds. The resource dependency perspective has been critiqued for focusing exclusively on official hierarchies and their functioning and thus denying the existence of informal, less obvious power structures. I acknowledge the limitations of this theoretical perspective and concur that resource dependency theory is too simplistic an explanation for describing a complex phenomena like public-private interactions. Hence, I do not restrict my analysis of power to resources. Instead, I regard resources as one of the many structural factors (others include rules, guidelines and norms) that constitute social practices. Besides, I adopt Lukes (1974) third dimension of power i.e. values, norms and ideologies exercised through all social interactions or the notion of “discourse” to complement my analysis of power and explain the ‘disciplinary regime of the Fund’.

Summarising some of these debates, I posit that: power can be conceived in the terms of the ability of an actor (or an institution) to get others to do something by not only controlling material resources and possessing capabilities, but also determining “shared meanings and the creation of inter-subjectivities” that constitute interests and practices (Adler 1997:336). This conceptualisation can be explained by: i) the hierarchical nature of organisational relations as embodied in the rules and norms, and the differential control over organisational resources within hegemonic structures wherein, the goals are heteronomously determined, and ii) normalisation of power and practices. This explanation entails both the coercive and consensus elements of Gramsci’s analysis. Through his concept of ‘cultural hegemony’ in ideology, Antonio Gramsci (1992) gave valuable insights to how power gets normalised. Explaining the absence of a proletariat revolution in Western European countries, he posited that the workers were made to believe that their interests coincided with those of the capitalist class and so, did not revolt.

Thus, a more nuanced analysis of power focuses on both ‘hard’ and ‘soft’ power. While hard power is essentially coercive, Joseph Nye (cited in Harmer 2005) argues that soft power refers to “cultural, ideological and institutional forces”, central to which are the “beliefs and values that set the agenda and the framework of debate” (ibid). If we are to apply the above conceptualisation of power to public private interactions, it is important to examine the ways in which these subjectivities are created and the role

discourse and ideas play in “socialising states and other social actors (in the chain of brokerage) into accepting certain practices and models through their interaction with international actors” (Wendt 1992, Hall 1993).

2.3.2 Role of ideas and discourse

More recent approaches in the analysis of power are increasingly adopting a constructivist analysis which underscores an emphasis on the relational and ideational characteristics of power. This focus on ideas and discourses is not new and rather derives from Foucault’s knowledge-power analysis and Gramsci’s ideological hegemony (Hopf 1998). Furthering the diffuse conception of power which is also central to constructivists’ analysis, Hopf argues that “power is everywhere...and social practices reproduce underlying power relations” (1998:185). He refers to the “power of social practice” which lies in the capacity to reproduce the intersubjective meanings that constitute social structures and actors alike (ibid: 178).

Proposing the two dimensions of her framework on discourse, Vivian Schmidt (2002) suggests that discourse can be understood as “an ideational and interactive component” of public policy making which enables policy and social practice. Discourse is not only a function of transnational economic power (that is arising from hegemonic structure) but one that can bring about “change in the ideas and values of the polity” (ibid: 16). This suggests the transformative potential of discourse.

The **ideational** dimension of Schmidt's framework (2002) pertains to ideas and values which i) justify (the need for) a particular policy model or programme (the cognitive function) and, ii) legitimise practices/ actions and the policy model (normative). For instance, as discussed in Chapter 1, the creation of the Fund was underlined by a combination of discourses: *economic*, around the need for a 'war chest', and *technical* and *globalisation* around the global threat posed by the three infectious diseases. Likewise, in the case of the Global Fund arrangements in India, the involvement of corporate actors was invoked and justified by an economic imperative i.e. cost-effective means to provision of treatment as well as an ethical and moral responsibility of corporations towards their employees. The focus area and intervention (treatment, prevention, or other) within each round of proposal demands a similar justification.

Establishing the *logic of necessity*, however, is not sufficient for the success of a policy model. It must also appeal to the ideologies and interests of various stakeholders. As Schmidt argues, discourse must also show "how the policy serves to build on long standing values and identity while creating something new...more appropriate than the old 'public' philosophy" (ibid: 221). Through its normative function, discourse establishes the *logic of appropriateness* by making references to particular principles (development jargons) adhered to by the State or non-state actors such as sustainability, corporate social responsibility, sector-wide approaches and others.

The **interactive** dimension of the framework focuses on the coordination and communication of ideas in order to translate the policy objective into the multiple interests of the stakeholders. Through co-ordination, it provides a “common language and overarching framework for the construction of the programme” (ibid: 210) where the actors representing specific epistemic communities can put forward, debate and come to consensus on the content and implementation. This purpose is served by the various governance structures instituted through fund arrangements such as the CCM and other close-door consultative workshops and meetings. The communicative function pertains to translating the policy/ programme objectives into different meanings and perspectives to attain the policy goals. Policy actors play a crucial role in this process of sensitisation, communicating back and forth the policy content and outcomes. Long (1992:23) articulates that effective agency, or governance, requires strategic manipulation of actors within different discourses as they become “partly enrolled in the project of some other person/s”. David Mosse (2005) in his seminal work on ethnography of development rightly argues that the success of a policy relies not on the content alone but on interpretive communities and supporting actors who continually recruit support of other actors. There lies a constant need for translating one set of interests into another. Project managers, consultants, and others are able to influence because their instructions can be translated into others’ goals and ambitions. *Subjectivities* are thus being produced in the complex interactions of *discourse*, nation states and other material agents (protocols, statistics, health professionals, drugs), all of which

participate in *stabilising* the system and establishing order (Harper 2005) as though “its representations were reality” (Sayer 1994 cited in Li 1999:298-99). For the purpose of this thesis, I refer these actors or active agents as ‘brokers’ (more aptly, the ‘Fund brokers’), a terminology proposed by Mosse and Lewis (2008). The study of development brokers emerges from actor oriented approaches applied to brokerage, a long standing theme in political anthropology. Works of Bierschenk (1988, 2002), for example, on this theme examines the ways in which actors function as agents actively building social, political, and economic roles rather than blindly conforming to normative scripts. Brokers are seen as intermediaries between development institutions and beneficiary communities, having particular competencies, strategies and careers (Mosse and Lewis 2006). This study views brokers as the interpretive communities who realise development projects through a constant act of tying in supporters and sustaining interpretations (Latour 1996, Mosse 2005a). For the purpose of this thesis, these include the Fund bureaucrats, aid recipients, project managers and workers, and any peripheral actors linked to the process.

The analytical framework proposed by Schmidt (2002) can be a useful tool in examining different pathways in which discourse operates and constitutes practices. Chapters five and six, discuss these dimensions of discourse in further detail particularly with reference to how power is exercised in the operation of Fund arrangements.

2.3.3 Power analysis in global health policy and outcomes

While undertaking an analysis of power relations in the formation of health policy, Alford (1975) proposed the structural interest group theory, a model useful for understanding the structural distribution of power in health care organisations. It suggests that health care organisations must be viewed in relation to the “continuing struggle between major structural interests operating within the context of a market society” (ibid: xiv). He identified three major structural interest groups: “...’professional monopolists’ who control the major health resources, ‘corporate rationalists’ that challenge their power and the ‘community population’ seeking better health care”. These categories are not internally homogenous. Rather, they represent different groups and individuals who also respect autonomy and control over their work and will act collectively if that autonomy is threatened. Though useful, these categories cannot be considered universal given the complex arrangement of actors and the disparate influence they possess owing to their position and expertise within the health policy domain, and the resources they control.

Similar work was undertaken on how particular issues and interests reach the policy agenda. Harrison et al. (2002) argue that issues under investigation in health care mirror underlying power relations within the sector. The most dominant group, in his case the medical profession, determine what is analysed and evaluated, and therefore, what reaches the policy agenda. Lukes (1974) while elaborating on the third dimension of power, proposes that dominant groups/ individuals can prevent an issue from

even reaching the pre-decision stage by manipulating the desires and values of those involved. Likewise, Lewis and Considine (1999) while examining power and influence associated with agenda setting of health policy in Australia, propose that the structural interest approach interacts with the elite model, whereby the corporate elite within a profession are more influential as compared to frontline staffs who have limited influence. It can thus be argued that groups are more politically heterogeneous and thus differentially influential than the *structural interest group* theory allows. This heterogeneity is the starting point for our analysis of interpersonal relationships and power dynamics in network arrangements.

New paradigms of health policy analysis began to emerge in the 1990s with the work of Gill Walt (See Walt and Gilson 1994, Walt 1995) and others who expanded the focus from actors and interests to a multitude of factors: process, content, and context to examine power involved in the development and formulation of policy and its impact on outcomes. A review of literature in this field (Gilson and Raphaely 2007) shows that a very limited number of frameworks and theories exist, and despite the central role power plays in affecting change, it remains under researched. Moreover, there continues to be an overwhelming focus on 'what' happens and not 'why' (Buse and Dickinson 2007).

2.3.4 Analysis of power in PPPs

The literature on global PPPs omits the preliminary work done on analysing the power implications of partnership arrangements. Much of the discussion on who wields power within partnership arrangements can be located on the traditional theoretical distinction made in the analysis of distribution of power: between *elitist* and *pluralist* and *neo pluralist* perspectives (Walt 1994, Buse and Harmer 2004).

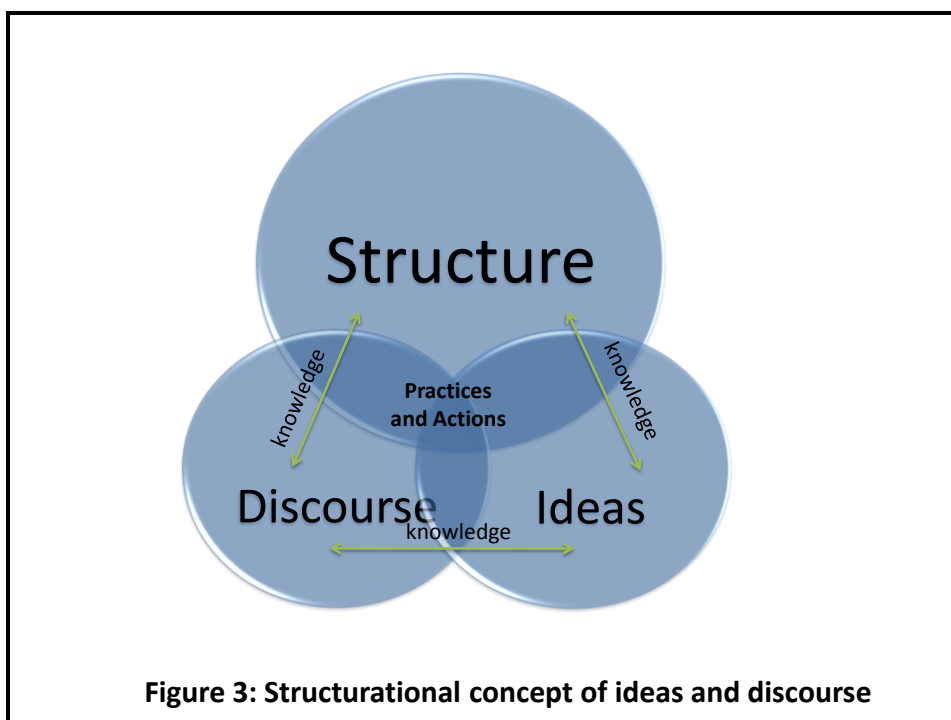
Elitists argue that power is wielded by an elite core of individuals across sectors in the society (Karliner 1999, Utting 2001, Richter 2003). Richter (2003:8) for instance, argues that “high level public private interactions ...are in fact instruments of elite governance which advance the corporate-led neoliberal restructuring of the world”. According to this view point partnerships are dominated by corporate elites and are seen as having the potential to subvert the public services of international organisations such as the United Nations who are seen as flouting their own guidelines in pursuance of global initiatives (ibid).

In contrast, the *pluralist* accounts suggest that partnerships operate in an array of diverse and overlapping interest groups seeking influence and authority, while the arrangements, *per se*, are neutral (Held 1996). This view-point regards the mechanism as one where power is shared and decisions are made through consensus (Walt 1994). *Neo-pluralist* accounts acknowledge that certain pressure groups, particularly the pharmaceutical

corporations have the power to influence and bias the partnership agendas towards their interests (Held 1996). These studies attribute partnership failures to loose and ill-defined governance structures which introduce inefficiencies in decision making, and result in lack of accountability and local ownership (Caines et al. 2003, Feacham et al. 2002, Buse 2003a). Examining power in terms of authority and legitimacy, they argue for amendments to the structure (hosting arrangements and representation on governing bodies) and delivery of partnership model in order to make them more accountable, transparent and equitable (Buse and Walt 2000a, Nishtar 2004, Buse 2004). These approaches are however restrictive in their focus since they exclusively focus on global governance structures which are defined solely in terms of representation in decision making bodies. A range of other aspects through which power mediates these arrangements - *structures and institutions, ideas and discourse, processes and outcomes* - is often overlooked.

As argued in chapter one (Section 1.2.1), although nascent, a third body of work, has begun to emerge and concerns itself with an alternative approach to analysing power relations in partnerships. Using *constructivists* approaches these studies seek to understand the role of ideas and discourse in shaping the practice of global public private partnership and explain its prominence in global governance debates (Harmer 2006, Buse and Harmer 2004, Hastings 1999). My thesis contributes to this development. Schmidt (2002) argues that ideas informing the discourse emerge from the

communities: policy experts, scientists, academics, research institutions and other think tanks or could also be promoted through advocacy coalitions or individuals. While I do concur with the role of communities and actors in communicating ideas that inform discourse, I do not regard this as a linear process and instead, conceive of ideas in structural terms. I emphasise the role of discourse and knowledge in communicating and diffusing the ideas that subsequently inform the practice of PPPs. As I illustrate the structural conception of ideas in figure 3 below, I argue that both discourse and ideas are deeply embedded in and interact with the hegemonic structures which in turn represent ideologies and values in a given economic, political and social context. The structure here is constituted by the rules, norms, and resources governing actors.



Central to this conceptualisation is the strong links between knowledge and power which is highlighted in the studies on authority of private actors in global governance (Cutler et al. 1999a, Hall and Biersteker 2003). As a value laden variable, argues Adler (1997:36), knowledge frequently enters into the creation and reproduction of a particular “social order that benefits some at the expense of others”.

2.3.5 Conceptual framework to understand power at the interface between theory and practice of public-private arrangements

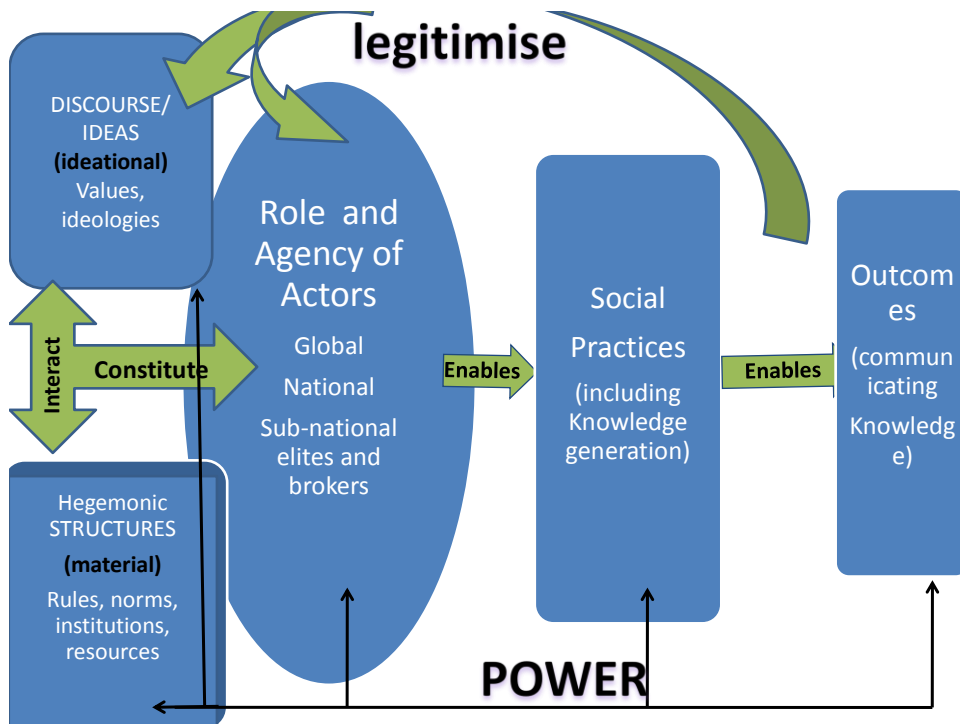


Figure 4: Conceptual framework for analysis

The above framework illustrates the interface between the theory and practice of PPP model. It presents an analysis of how power mediates public-private interactions and how practices and power get normalised within

these. The arrows represent how the actors and their interests, and practices are constituted and constructed through an active process of translation and sensitisation. I propose that discursive ideas and the hegemonic structures (protocols, institutional rules, and resources) in which these are embedded constitute the actors and their interests. These global actors or development brokers, through an act of constant translation of policy objectives into multiple interests, enable the practice of PPPs to generate knowledge and material outcomes. Knowledge acts as a powerful tool in creating 'order'. It serves to legitimise the practices and the outcomes and as a result, reproduce the dominant discourse: the appropriateness and success of the PPP model and the role of brokers in these arrangements. In other words, the actions (or social practices within partnership arrangements) are constrained and enabled by the material (structures) and ideational factors which get produced and reproduced by those very actions.

In this context, power operates at multiple levels. The dimensions I explore further in the thesis are:

1. Power understood in terms of resources, expertise and facilities which actors bring to and mobilise in these complex interactions.
2. Power generated through the reproduction of structures of domination (exclusion from decision making and agenda setting mechanisms) or that exerted through the authority of protocols and guidelines.
3. Power of social practice which embody underlying power relations and, power of control over outcomes (or the capability of actors to

secure outcomes) and the ability to demonstrate those outcomes as knowledge coherent with the dominant discourse.

2.4 Conclusion

In this chapter, I outline and critically engage with the ongoing global and country level debates on Public Private Partnership. Highlighting the conceptual and terminological ambiguities inherent in the term and the paradoxes in the rationale, I propose an alternative framework of classification of 'public-private interface arrangements, henceforth the term which I use in this thesis for the arrangements under investigation.

Following from this, I examine the theoretical underpinnings of PPPs and in particular look at the body of literature under network governance. I do not regard networks as a third form of exchange, distinct from markets and hierarchies and concur with the view that network transactions co-exist with mechanisms of the market and hierarchies. Networks are primarily regarded as voluntary solutions based on reciprocity and sharing of resources, benefits and risks, devised by those working towards similar objectives (Abott et al. 2006). Their creation therefore, by diktat, as is the case with public private interface arrangements triggered by global initiatives such as the Fund in middle and low income countries, can have significant implications for power play among partner organisations as they re-configure and re-invent such arrangements. The resulting conflict, as will be discussed in the subsequent

chapters, has a damaging effect on the programme outcomes as well as the delivery system.

A central concern of this thesis therefore is to unmask the power relations which get reproduced in the practice of country level operations of global health partnerships such as the Global Fund. In doing so, I adopt the critical theory which was developed in direct opposition to the positivist approach evident in neo liberal institutional theorising (Neufeld 1995). *Critical theory* can explore how the interests of a dominant class of transnational elites achieve hegemonic status. It emphasises as much the importance of a 'legitimising ideology' as the material and structural characteristics of power (Hasenclever et al. 1997).

I conclude with a conceptual framework to understand the role of structure and discourse in constituting and constructing practices which currently legitimise and stabilise the PPP model. The literature led me to four broad themes that are identified in the framework and will be further explored in the thesis. These are:

1. The role of hegemonic *structures* (protocols) and *discourse* (ideas and *meanings*) of the Fund in constituting actors and their involvement in public-private arrangements.
2. The role of *interpretive communities* of actors in reproducing the discursive practices and stabilising the Fund system and the national AIDS programme.

3. The discursive practices emerging from an interaction of the three elements: structure, discourse and actor agency and the outcomes it generates.
4. How power mediates at the interface of the different elements of the framework: discourse-structure, actors and their interests, social practices and health outcomes.

Chapter 3

Research Design: Conceptual and Methodological framework

3.1 Introduction

This chapter outlines the research design of the study and gives a reflexive account my research journey. The research design presented in this chapter has been developed with reference to i) the nature and context of the phenomenon under study: health partnerships and the factors (*structure* and *discourse*) influencing their development and consequently, performance, and ii) the research objectives to be addressed. The latter have been outlined in the first chapter and relate to the theoretical and substantive aims of the proposed research. The aim of the study is to examine the *monotheism* of discourse (ideas and *meanings*) and *polytheism* of *practice* around public private partnerships set off by the Global Fund under the national AIDS programme in India and to discuss its system and programme wide effects.

This research does not intend to statistically measure the impact of the Fund supported programme on HIV and AIDS. Nor does it undertake a quantitative assessment of its performance. It instead seeks to gain an understanding of how the partnership model operates, the role of structure and discourse in shaping its practices and the implications it has for the broader health

system. Addressing these objectives also allows a broader reflection on 'partnership' as a policy reform approach in the health sector, the rationale underlying its pervasiveness in the global and national health debates, and the implications it has for health systems: policy coordination, strengthening local systems, and delivering quality and equitable care.

The chapter begins with outlining the approach taken to analyse the public private interface arrangements which are the focus of this investigation, and then discusses the paradigmatic choice justifying the research design and its key elements: epistemology, theory, methodology, and methods. A detailed description of the research journey follows next where I discuss the methods used to collect data, approach to data analysis, and the constraints faced. I conclude with a critical reflection on the ethical implications and the limitations of the study.

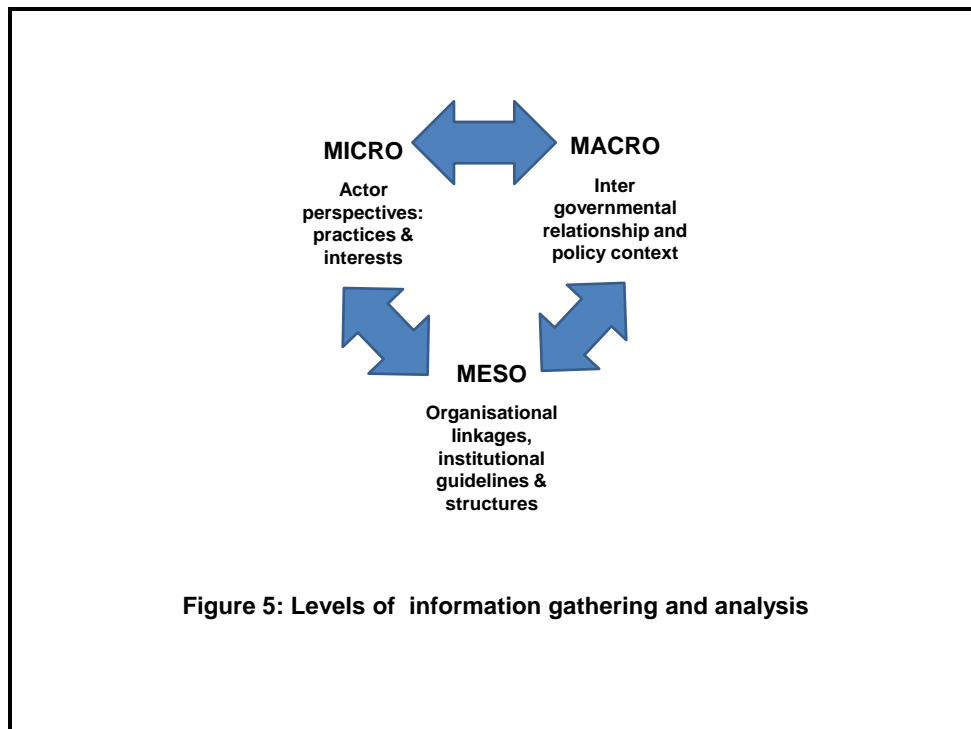
3.2 A multi- level analysis of PPP

From the discussion so far, it is clear that partnership arrangements under investigation can be viewed as a complex process of social interactions between individuals, organisations, and wider hierarchical global and local structures. Hence, an in-depth analysis of a policy approach must take into account the *macro*, *meso* and *micro* levels at which the networks operate and are shaped by (Marsh and Smith 2000, Evans 2001). Evans (2001) argues that contemporary policy making occurs within multi-layered, self-organizing networks. These policy networks are not rigid or determinate

entities. In fact, they are always in a state of becoming (ibid). Their characteristic features: power dependency, processes of exchange, rules of the game, dominant coalitions and others are attributed to the process of social construction. As Benson (1977) argues, this calls for the need to focus on the process through which the network arrangements are produced, and the mechanisms through which it is maintained, reproduced and reconstructed.

In order to study these attributes for global health partnership networks I opted to focus on the Global Fund to fight AIDS, TB, and Malaria, one of the largest global health initiatives and a major player in HIV management in India. Marsh and Smith (2000) propose a 'dialectical approach' which combines *macro*, *micro* and *meso* levels of analysis as an explanatory model for policy networks and their effects on policy outcomes. The model focuses on the interaction between structure, underlying discursive ideas (such as global health, governance or the Fund), and agency (of actors operating within networks) in order to explain policy continuity and change. Adopting this model I undertook the analysis at three levels: *macro* level analysis of the entire gamut of actors in the policy arena, the intergovernmental structures, *meso* level focusing on organisations and interests grouped around a policy sector, and the institutional rules governing them, and *micro* level analysis to examine actor's perspectives and practices defined by their interactions, decision making and motivations. This encompassed multiple sites (activities and institutions in five states) to enable comparisons and

contrasts and rich variation in programmes. Finally, a longitudinal approach to data collection was adopted to examine the dynamicity of the partnership environment over time.



Using the framework presented in figure 5, I analyse the relationship between specific organisations involved in the Fund implementation (and HIV management), the institutional environment created by the policy discourse, and seek to explain the practices of organisations' and individuals enabled by these. Selected organisations represented the wide range of institutions/actors: direct and indirect recipient of the grant and/ or deliverers of the national AIDS programme. These include: i) national government recipient - Ministry of Finance and the National AIDS Control Organisation, ii) national civil society recipients and NGO and corporate sub-recipients who as

members of civil society consortiums implemented programmes in specific grant rounds, iii) independent coordinating and monitoring agencies for the Fund, iv) activity sites and service providers, and v) bilateral agencies who are important stakeholders of the programme and its decision-making bodies. In addition, I also selected institutions that were not direct implementers of the Fund supported programmes but were active players with high level of influence in the HIV arena in the states that were the focus of investigation. This added a greater level of complexity to the study and enabled me to build a complete country-wide scenario.

3.3 Paradigmatic approach

The choice of a particular paradigm or “tradition of enquiry” is underpinned and shaped by one’s background, beliefs and values, the nature of explanation sought, as well as the values espoused by that paradigm itself (Creswell 1998). These values shape the decisions made throughout the process of enquiry: while defining the research problem, developing the theoretical framework, information generation and analysis (Lincoln and Guba 2000).

As the study was primarily exploratory in nature, the study design had to be sufficiently flexible to account for the dynamicity. A qualitative enquiry was chosen to meet the research objectives, given its appropriateness and adeptness in explaining a complex process or phenomenon from a more personal and subjective perspective (Denzin and Lincoln 1994).

3.3.1 The fundamental epistemic tension in social sciences: *Positivism* vs. *Interpretativism*

The development of qualitative inquiry can be seen as counter to the methodologies of the positivist stance that suggests the existence of an overall meaning and a single explanation of reality demonstrable through development of comprehensive theories or grand narratives (Agger 1991) based on “essential truths” (Reed 1995:71). The principles of the positivist stance espouse objectivity based on rigorous data collection, analysis and interpretation to generate knowledge that must be reproducible and generalisable (Edwards 2002). In contrast, the *relativist* paradigm takes an interpretative stance that acknowledges the existence of multiple explanations of reality and actively seeks them to generate a comprehensive understanding of the social world and processes. Coast (1999) suggests that the merit of qualitative enquiry lies in its ability to “aid understanding, provide explanations, and explore issues that are of complex nature”. Emerging from postmodernist tradition, research which draws on qualitative enquiry believes that reality is made up of multiplicity of voices, views, and meanings and that each representation is context and time dependent (Agger 1991, Cheek 1999). Consequently, it adopts an inductive approach to investigation and analysis rather than a deductive or reductionist approach followed by positivists. Buse (1999) argues that investigations that are political in nature must premise on explanations of behaviour. Hence, even at the very initial stages in the design of the research, the complexity emerging from the area

of investigation and the multiple layer of analysis required to examine power and discourse within the partnership environment made the choice of a relativist paradigm appropriate.

3.3.2 Situating partnership literature within the two paradigms

The literature on inter-organisational relationships and partnership networks can be described as falling into these two broad paradigms: *Positivism* or *objectivism*, which is rooted in the modernist perspective of organisations, and the *interpretivist* or *subjectivist* approach to studying partnerships that emerges from the postmodernist tradition. The evolution of sociological organisational theory (or resource exchange) can be traced back to the *positivist* paradigm which views organisation as an object whose dimensions can be reliably measured by an independent observer (Hatch 1997). Using methodologies (statistical techniques and tools) shaped within the *positivist* tradition, much of the research co-related dependent and independent organisational attributes or variables with an outcome of interest in order to arrive at the 'law' that will govern what types of organisational structure best suit the partnership or network model. Critics of this approach have pointed out that many of these studies relied on measurements of poor or unknown validity or reliability (Rogers 1982, Hall 1984); and failed to consider wider environmental influences such as the role of actors, their views and beliefs, and, the processes that might influence those variables (Rosenhead and Mingers 2001).

The *interpretative* or *relativist* paradigm in contrast assumes that all knowledge is mediated by experience. 'Reality' thus gets defined by the individual's subjective experience, although under social and cultural influences (Hatch 1997). Individuals interpret their environment and act on the basis of this interpretation (Bryman 1988). In other words, it is this subjective impression that influences how they behave in a collaborative working environment. This thinking relates to the *symbolic-interaction* strand of interpretative perspective on organisations which considers the actor as the unit of analysis. It assumes that actors are embedded in a social context and are aware of their status within (Cuff et al. 1990). Interaction is then regarded as a constant cycle of interpretation and 'negotiation' among actors as they re-affirm, alter, and replace the social arrangements within which they are bound and act (ibid; Bryman 1988). Studies adopting an interpretative perspective thus attempted to explore the socio-psychological paradigms governing perceptions, conduct and response in inter-organisational settings using qualitative data collection tools which could reveal motivations, understandings and meaning assumed by actors.

Within the *interpretivist* paradigm, however, few studies linked the interpretative determinants (actions, activities, meanings generated, and relationships) with the context of inter-organisational activity (Marsh 1998, Challis 1988, Halpert 1982) or explored how the network's 'structure' and the underlying 'discourse' might influence relations (Fleisher 1991, Reed 1992).

As a result, the interface between the *macro*, *meso* and *micro* levels continues to be a predominantly uncharted territory.

3.4 Research design framework

The framework for this research draws on Michael Crotty's (1998) framework founded on four elements: epistemology, theoretical perspective, methodology and methods. The emphasis laid by Carter and Little (2007) on the need for internal consistency between these elements has guided the conceptualisation and strategy of this research from the outset. They propose a framework, in particular for evaluating the quality of research, wherein they examine the contributions of epistemology, methodology and methods and their interrelationships.

The four elements of the research design framework are defined in conflicting ways in the research literature with differing views over whether a particular paradigm is regarded as epistemology or a philosophical stance. I regard these elements not as fixed, objective categories that have to be adhered to in a 'biblical' sense but as providing the researcher with a systematic guide to view, justify and explain their research. Hence, I feel it is important to clarify and explain my understanding of these elements for the purpose of my thesis.

3.4.1 Epistemology

Epistemology relates to the study of “the nature of knowledge (Schwandt 2001:71), its possibility, scope, and general basis” (Hamlyn 1995:242). In other words, it is a way of “understanding and explaining how we know what we know” (Crotty 1998:3) and could be embodied in several theoretical stances. Given the scope of the thesis that seeks to explore complex nature of the relationship between diverse actors, the influence of structures and discourse on the environment within which they act, and the power issues embedded within, I adopt an *interpretive* stand and the epistemology of ‘*social constructionism*’.

According to the *constructionist* paradigm, ‘truth’ or ‘meaning’ comes into being through our engagements with the world we interpret, and all knowledge is derived from and maintained by these social interactions. Again, constructionism is distinguished from constructivism, the latter focusing exclusively on “individualist construction of meaning” while the former pertains to “the collective generation and transmission of meaning or social phenomenon” (Crotty 1998: 58). This research views social constructionism as an overarching paradigm and ascribes to the views of Denzin and Lincoln (2007:33) that it assumes “*relativist* ontology (existence of multiple realities), a *subjectivist* epistemology (i.e. knower and respondent together generate understandings of the social phenomenon) and naturalistic methodological procedures”. Often, subjectivism has been treated as a third epistemology (distinct from objectivism and constructionism) ascribing it to

the structuralist, poststructuralist and postmodern schools of thought. Michael Crotty (1998) argues that unlike constructivism, in subjectivism meaning is not generated through an interaction between the object and subject, i.e. the object has no contribution in creating knowledge. While I concur that knowledge is shaped by other factors including cultural and religious beliefs, socio-political milieu, “primitive archetypes within our collective unconsciousness” and others (ibid), it is only through the interaction between the subject and object that these forms can be realised. Hence, for the purpose of my investigation, while I draw on critical theoretical perspective to stress on ideational and structural- material determinants and effects of the partnership environment, I do so within the social constructionist paradigm.

3.4.2 Theoretical perspective

Theory refers to the philosophical stance that acts as the researcher’s “lens” to view the social world and its problems. It guides the methodology by grounding the logic and context of the research process (Crotty 1998). The guidance for this research comes from the perspectives and teachings of *critical social* theory (Neumann 1944, Horkheimer and Adorno 1972, Habermas 1973 and 1989). This theoretical perspective is concerned with examining how the construction of knowledge and the organisation (and generation) of power in society broadly, and in institutions such as health care specifically, create and reproduce structures of domination and oppression (Reeves et al. 2008).

Stemming from the work of social theorists in the Western European Marxist tradition, also referred to as the Frankfurt School of thought, *critical theory* emerged in connection with the social movements that identified the varied dimensions of domination of human beings in human societies (Agger 1991). Particularly, it sought to explain the survival of capitalism in terms of deepened ideologies or *domination*, seen as a combination of external exploitation and internal disciplining. Thus, *critical theory* provides both a descriptive and normative basis for social inquiry with the objective of decreasing domination in all its forms.

The proponents of Critical theory proposed new ways of articulating the role of the state and culture in advanced capitalism, which the state actively protects against its own contradictory nature (Agger 1991). In chapter two, I illustrate the political nature of networks and public private arrangements and discuss theories on power as both domination and agency to explicate power distribution in this context. The theoretical concepts discussed will be revisited in the subsequent chapters that discuss the findings. The choice of the theoretical perspective is reflected in the design of the research which takes into account both methodological and substantive categories proposed by Agger (1991). Moreover, critical theory is appropriate for the study design since it is not linked to a specific methodology and can be applied at all the three levels: the *macro* (society and policy context), *meso* (systems and institutions) and *micro* (actor).

3.4.3 Methodology

In literature and practice *methodology* is used very loosely to mean anything from schools of thought to tools of data collection. However, in Kaplan's (1964:23) terms, methodology "helps us to understand, in the broadest possible terms, not the products of scientific enquiries but the process itself". For the purpose of this research, methodology is understood as the description and explanation of the study that guides and justifies the choice of its methods, clarifying their assumptions and outcomes, in other words, a "strategy for enquiry" (Denzin and Lincoln 2000).

The strategy of enquiry for this research disapproves the notion of "methodological fundamentalism" (Carter and Little 2007) and believes that elements of more than one methodology can be combined to clarify the intent of enquiry and the knowledge generated. Advocates of qualitative methodologies stress the richness of qualitative data and arguments on the big picture, and how processes, chronological facts and causal links occur (Miles and Huberman 1994). Given the range of issues to be investigated and the complex ways in which concepts under investigation interact with one another, I adopt *critical ethnography* and an analytic narrative style *case study approach*.

Methods, the fourth element of Crotty's framework (1998), are discussed under section 3.5.4.

3.4.3.1 *Critical ethnography*

Critical ethnography has been used to describe, analyse and reveal hidden agendas from public transcripts, power centres, and assumptions that constrain and repress (Thomas 1993). Informed by the writings of Foucault, critical perspectives in development studies analyse the development *discourse* as a system of knowledge, practices, technologies, and power that orders action within it. This perspective has been evident in the works of James Scott (1990) on the 'hidden-public transcripts'; Escobar's (1995) analysis of the rise of development discourse and practices as instruments of western capitalism to dominate the "third world"; and Fergusson's (1994) ethnographic analysis of a development project in Lesotho in an attempt to understand how the dominant discourse produces depoliticised knowledge, and technical solutions to development problems. Mosse (2005), Lewis (in Lewis and Mosse 2006), and others regard the critical and deconstructive approaches as offering a "diabolic image of the development world" and paying little attention to the "incoherence, uncertainties, and contradictions" (Oliver de Sardan 2004:5). While not abandoning these approaches, they focus on making them *methodical* rather than *ideological* in order to analyse the interface of ideas and relationships in the development arena (Olivier de Sardan 2004, Mosse 2005). This view is critical to the thesis as it builds on (but does not replace) the post-structuralist analysis to examine the complexity of the policy of public-private partnership as "institutional practice", the social life of projects and organisations, and the diverse discourses and interests shaping policy models (Mosse 2004:644).

The study is based on the premise that a critical approach to the 'partnership' model can provide policy makers and managers with valuable insights into the operations and effectiveness of the complex set of "local, national and cross cultural social interactions" (Mosse and Lewis 2006) which can no longer be examined in isolation from the state system, civil society, or wider national and international political, economic, and administrative practices. The Fund arrangements investigated in this research involve interactions between actors of different statuses, goals, and varying resources. Recent works on development draw attention to the *meso* and *micro* looking at actor perspectives, practices and concepts, strategies, and contextual constraints that highlight the *macro* i.e. the broader national and political economy (Bierschenk et al. 2002).

Olivier de Sardan (2005) argues that this multiplicity of interactions gives anthropology (as the discipline) and ethnography (as its methodology) a "privileged empirical pathway" into social reality. This is primarily because contrary to narrow culturalist approaches, this discipline attends to the social processes and negotiations of meaning and identity in heterogeneous social arenas. Development anthropology is increasingly becoming the study of "the global" that is concerned with new forms of transnational connection between "people, information and ideas" in the realm of 'stretching the organisations' beyond the nation-state. The choice of *critical ethnography* is thus appropriate for the context my study is located in.

3.4.3.2 Case study

A *case study* approach has been regarded as a useful methodology to evaluate organisations and complex, real world developments, “with the ‘case’ providing a source of explanations for wider developments” (Keen and Packwood 1995). This approach has been increasingly applied to investigate the nature of public-private interactions, particularly contractual arrangements in the health sector (Palmer 2001, Allen 2000). An investigation of the issues and concepts outlined in chapter one and the themes identified in chapter two, required an in-depth analysis of a variety of aspects (and concepts) related to partnerships such as, the dynamicity and complex nature of arrangements, structural and ideational drivers of the practices, the interplay of power and, the impact of these on the process of partnership development. The partnership agenda (and the arrangements under investigation) was still developing at the time the field studies were undertaken: new partnerships were being forged for forthcoming rounds while a few older ones disintegrated and others continued to operate. A case study strategy was particularly useful as it was able to cope with the evolving context in which partnerships developed, new grant rounds unfolded, and more variables of interest than data points existed (Allen 2000). The *analytic narrative* approach to case-studies was considered appropriate as it allows an engagement with political actors. This approach has been previously applied to evaluate effective aid arrangements (Oliveira-Cruz 2007) and to seek an understanding on “actors perceptions, preferences, their evaluations of alternatives, the information they possess...the strategies they adopt and

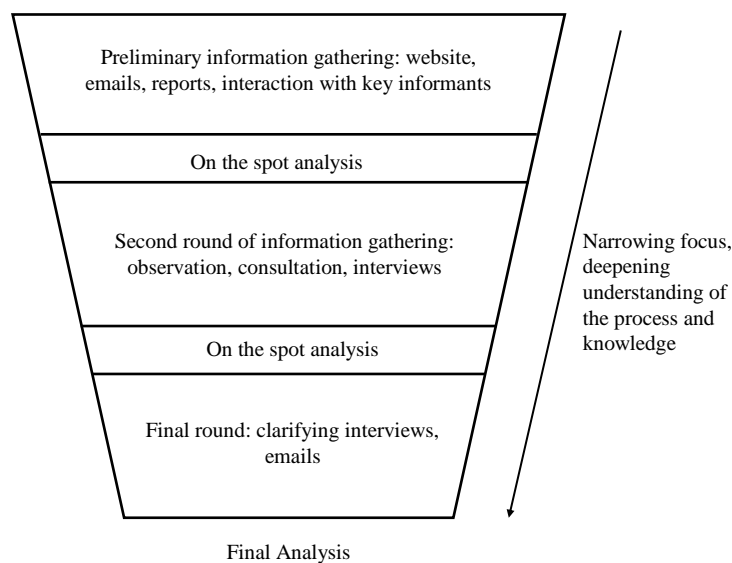
the constraints they face” (Bates et al. 1998: 11). In the context of aid mechanisms, Zinnes and Bolaky (2002) argue that a *narrative approach* not only enables an evaluation of the obstacles to effective mechanisms but also provides a guidance to design the right mechanisms to prevent the opportunism that risk its effectiveness.

A *multiple and embedded* case study design was applied as it allows theoretical propositions to emerge and be tested across sites for greater refinement of analytic generalisations (Miles and Huberman 1994, Keen and Packwood 1995), thus adding an overall robustness to the study (Yin 1994). As Rossi (2004) points out, an embedded case study combines insights into the wider historical, political and socio-economic context with a “thick description” of local developments. This is applicable to the way I use the case study methodology in this thesis, focusing on the Fund and drawing on different partnerships, interventions, and settings.

3.5 Information Generation Process

This research involved an intensive period of field studies, approximately nine months, adopting a layered approach to investigation, covering the country context of national AIDS policy before examining individual programmes operational through the different Fund rounds. As indicated in figure 6, this period was broken down into three phases in an attempt to narrow down the focus of the study and deepen my understanding of the processes. Although the information was generated in three distinct phases,

it was not linear since a linear research plan would have been inappropriate for a research where *meaning and* practices are constantly evolving. Thus, I adhered to an iterative process of praxis, emphasising critical reflection and subsequent action based on this reflection. Writing and reporting were part of the analytic process and contributed to developing my thinking and interpretation (Richardson 2000).



Source: Guijt, I. (1998).

Figure 6: The process of information generation and analysis

The *first phase* in Edinburgh focused on retrieving background information on the Global Fund programmes and public-private arrangements set up under the HIV and AIDS programme in India, and establishing appropriate points of contact. This was undertaken largely through: organisation websites, email communications and, documentary analysis of fund reports and evaluations available on the internet. This exercise enabled me to develop my study tools

such as a semi-structured guide for in-depth interviews, consent forms and to choose techniques such as *mapping* and *SWOT* analysis along with interviews. The *second* phase comprised the bulk of the fieldwork and was carried out between June and December 2007. During this period I was based in Delhi and made frequent visits to the 'field' in different states. The *final* round of information generation was undertaken through a follow up visit to India in November 2008 - January 2009. The second visit allowed me to revisit some of the interview participants and take stock of the rapidly changing environment. During this time I was also able to follow up with actors who were crucial to the Fund scenario but were difficult to access in the previous visit.

3.5.1 Study sites and selection strategy

The research adopts *purposive* sampling undertaken at three levels-national, state and district. The choice of this strategy was in tandem with the methodological approach of the study. Unlike methodologies framed under the positivist paradigm, qualitative enquiry in general, and ethnography in particular, does not aspire for a representative sample arrived at statistically but instead considers the quality of information supplied by thick description of concepts under investigation. The following section describes the selection process and criteria.

At the outset, I undertook a consultative mapping exercise in order to define and clarify the structure of the Fund arrangements in India and the various

associations and interactions taking place along the chain at the three tiers. The exercise involved several visits to the nodal agencies (principal recipients of the ongoing grant round of the Fund) and informal meetings with multiple stakeholders of the programme. I also continued to consult and re-visit the web resources (websites of the Fund, its governance structures, the principal and sub-recipient agencies, and the NACO) to clarify the structure and process of grant making and the Fund operations in India. This exercise revealed different activities that the civil consortia and the government agencies (NACO) were engaged in through the ongoing grant rounds and their corresponding state implementation agencies. This served as the basis for 'sampling' for the investigations at the state and district level.

An unanticipated outcome of this exercise was that it laid bare the complexity and multi-layered environment that the Fund arrangements were located in and needed to be accounted for in the study. When the field studies commenced in 2007, the first four rounds of funding (approved for India) were in operation, round six had just commenced, and the proposal for round seven was being reviewed by the Fund board (For more details on the rounds, refer to table 5: section 4.3.1). Initially, only one round was identified as the focus of enquiry because for the first time in the history of international aid in India, a non state actor (leading a civil society consortium) became a national recipient of the Fund grant alongside the government. The fund has an annual cycle of grant making i.e. new rounds, if approved commence each year while previous rounds continue to be in operation for five years or

more. As a result, the policy environment is very dynamic comprising: visible tensions between earlier collaborations, discontinuing intervention models that were perceived as a source of conflict, cutback of funds/ budgets, emergence of newer arrangements for subsequent rounds, and (re)negotiation of the proposed activities. In fact, from the time I developed my research tools to the time I commenced field work, newer 'partners' had joined the consortia and talks were ongoing to disband some of the ongoing activities. Given this development and constant evolution of 'partnership' arrangements, I modified my strategy to examine the activities of one round but expand the focus to understand the ongoing processes (and negotiations) for the subsequent rounds.

3.5.2 Selection criteria

Subsequent to the consultative mapping exercise, I adopted a *two stage* sampling process. At the *first* stage, sampling was undertaken with organisation as the unit of analysis. Of all the organisations involved in the partnership programme (including the principal recipient, sub recipients and the frontline implementing organisations), a few were purposively identified based on the following criteria-

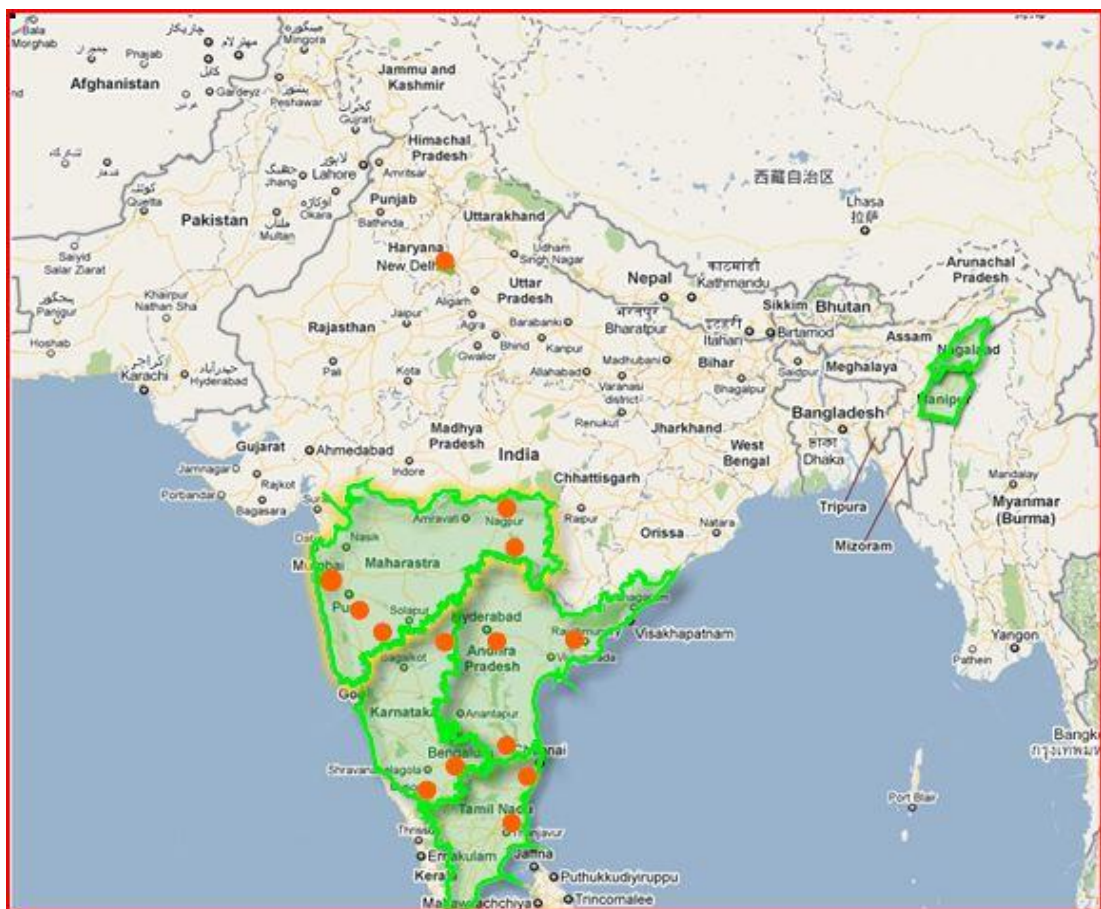
- Role in the partnership – organisations performing key roles and responsibilities at each stage of the policy cycle: proposal development, priority setting, implementation, monitoring and appraisal, as well as entities that served the bridging role between the country mechanism and the global secretariat.

- Constituency representation – organisations across the three constituencies: public (state agencies), corporate sector, and the not-for-profit NGO community including international donor agencies.

The HIV and AIDS component of the Fund programme in India was implemented in a phased manner, coinciding with the phase-wise introduction of antiretroviral in the public programme. In the initial rounds, the Fund programme and its corresponding interventions were restricted to six states - Maharashtra, Andhra Pradesh, Tamil Nadu, Karnataka, Manipur and Nagaland - corresponding to the 'high prevalence' category established by the surveillance system, and Delhi. In subsequent rounds, some of these interventions were scaled up to districts with high prevalence in states which were classified as 'moderate prevalence'. However, these interventions (and their corresponding districts) were not included in the study since the nascent stage of their development would not reveal implementation related challenges and the dynamics among partners and among project staff.

Among the high prevalence states, I restricted my selection frame to the four southern states – Karnataka, Maharashtra, Andhra Pradesh and Tamil Nadu. The two north-eastern states (Manipur and Nagaland) were not included because the regional and cultural context and epidemiology of HIV and AIDS in the North-east differs significantly from the southern states. Moreover, the costs of travelling to the north-east and between the different sites were impractical given the limited funds available for the research.

To ensure insights from different contexts and sites of implementation, the field studies were carried out in five states of India, four of which fit the 'high prevalence' category legitimising concentrated presence of donors, and the fourth, Delhi, which houses all ministries, donor agencies and the governance structures of the Fund such as the Secretariat, India country coordinating mechanism and the LFA (Refer map).



The highlighted states in green represent the high prevalent states where Fund programmes were initially implemented. The orange dots represent the districts where intervention centres were visited and the field study was carried out.

Map of India depicting the study sites

Subsequently, I held consultations with key representatives of these organisations and networks at national and sub national level to analyse the structures, arrangements, institutional environment, and actions/practices generated at their interface. Attention was also given to governing bodies and coordinating structures established at different levels in order to understand the translation of the Fund mechanisms from the global to the local. Consultations with main stakeholders enabled me to better understand the coordination, integration, and harmonisation of efforts. These were representatives of the national recipient and sub recipient agencies, members of the Fund governance structures such as the country coordinating mechanism, the Secretariat and the LFA, and other governing structures (such as the project advisory board and management unit) set up by NACO and the civil society consortia for the implementation of the Fund grant.

In the *second* stage, I short listed a few intervention models from an extensive list of services provided at the state, district and *taluk* (block) level. Among the continuum of services provided under the HIV and AIDS programme, I chose treatment and care-support activities in the five states as the focus of enquiry. The criteria for selection of service type were such that: i) enabled comparison across state and non-state services, ii) were crucial to understand the dynamics of *meso level* inter-organisational relations and *micro* level implementation of the partnership, and iii) generated rich information and comparison for the purpose of an in-depth case study. For

example, counselling centres run by both public sector agency as well as the civil society consortia, government run ART centre and corporate ART centre were among the service types examined. The choice for some intervention sites was straightforward as there were only a small number (for example, two care and support centres established in two states). Selection of services (and corresponding intervention site) for investigation was based on the following criteria-

- *Diversity and nature of arrangements*: this criterion related to the type of organisations involved in providing the service, the constituencies they represent, and the nature of their association with the State. Arrangements that represented a wide range and variation of these attributes were identified. For example, direct and indirect recipient NGOs and corporate partners, NACO and its state divisions, network of people with HIV and AIDS were the constituencies included. This enabled an examination of different structures of provisioning and institutional environment specific to a constituency, and the distribution of power within inter-organisational relationships.

- *History, performance, and geographical location*: These criteria enabled the generation of information along multiple axes in order to capture the changing contexts, regional variations, and dynamics of relationships based on the performance of partner organisations. Results of national assessments and appraisals served as an important sampling frame. For example, having access to the results of a national assessment of care and support interventions enabled the selection of both high and poor performing

centres/ organisations to reveal the implication of the Fund governance for service provision. Inclusion of intervention sites that were more recent in the partnership history and those that had been operational for over a year gave insights into the changing mechanisms and different stages of partnership development. I regarded these aspects significant to examine the monitoring and evaluation mechanisms and understand the impact of the structures on aid organisation and the 'partnership' environment.

3.5.3 Research journey: the enablers and the disablers

Before undertaking this research my experience in the health and development sector in India, specifically at the grassroots and policy level, shaped the questions that I (and the organisation⁷ I worked with) sought to answer through action research in health systems. The findings fed back and informed policy advocacy and groundwork. This experience has had a significant bearing on my positioning as a researcher, as it informed my philosophical stance and underpinned the research design, language, the process and the context in which the participants were engaged.

The 'sampling' frame was both a familiar and an unfamiliar terrain, making me both an "insider" as well as an "outsider" to the context. Given my subject positioning as a gender and health activist and the multiple roles I performed as a trainer, researcher, and advocate in all the regions (and most states) in

⁷ I have worked in the capacity of Programme Co-ordinator with a development organisation called *Sama*. It is a gender and health resource centre based in Delhi and implementing training, research and advocacy programmes across different regions in India.

India, I was familiar with: the geo-political context of the area where the study was situated, the nature of organisations under examination, and the bureaucratic hurdles and power relations I could expect to encounter. This took care of the practical aspects of carrying out the field research such as, travel, knowledge of the structure and functioning of health system and the bureaucratic procedures (/permissions) among others. Although each state has its own official language and script, which I do not have proficiency in, most health care providers (barring two respondents) were able to communicate in English or *Hindi*. At these two occasions while interacting with frontline staff (network for people with HIV), I was assisted with translations by other members of staff present. Additionally, my credibility within the health and women's movements in India enabled me to reach out to the members of the civil society who were either directly or indirectly linked with the fund processes.

My work, however, had previously never exclusively focused on HIV and AIDS and this contributed to the unfamiliarity which I mention above. The AIDS landscape, as I elaborate in chapter six, is unique. It involves a wide range of players – governments, international development agencies, academics and researchers, and NGOs and CBOs - working with, or representing specific marginalised groups. The vertical nature of the AIDS programme renders 'penetration' into this industry difficult. Moreover, the critical voice and momentum in India is building up through processes like the People's Health Movement and people's tribunals, and legislations such

as the Right to Information act (2005). The latter attempted to strengthen citizens' voice and influence service provision through more rapid but still formal legal channels. An unanticipated outcome of this is a higher sense of threat (and vulnerability) among the national and local authorities, which has resulted in greater censorship of information. However, the movement of many institutions, which earlier worked on general or reproductive health services, into the AIDS industry worked to my advantage. Taking the familiar leads, I embarked on my research journey, which entailed a constant negotiation of my positioning between the multiple identities: that of a researcher and of an activist. In the course of interactions with the senior bureaucrats at the state division of NACO and corporate representatives, overplaying my research links, institutional affiliation (with an international University), and links with senior member of NACO came handy. On the other hand, having a critical understanding of the politics of health care delivery and grassroots experience enabled me to connect with the sub-recipient NGOs and networks of people with HIV.

Through professional and personal⁸ contacts within the civil society consortia and the nodal AIDS agency in Delhi, I got in touch with partner institutions and their respective state divisions/ teams. A letter of support from two influential authorities (at government and a non-government agency) at the centre implied full cooperation at the state level, and often, assistance with translations, arranging my stay, and facilitating visits to the centres. This was

⁸ My father is the former Director of a key government institution on health. His close ties with some officials in the Ministry were particularly useful to make an entry into the national AIDS agency.

immensely useful for making roads into the civil society component of the Fund programme, particularly the more exclusive corporate sector and the people with HIV. With the State divisions of NACO, however, due caution was necessary. Authorities in these agencies were occasionally in conflict with the Centre over issues ranging from corruption to “under-performance” and “under utilisation” of funds. These, thus insisted in pre-mediating and facilitating my visits to the interventions sites and sub-recipient NGOs. I was aware of the information bias this might result in, given the authority that the bureaucratic state divisions commanded from non state actors. Hence, a flexible approach was required that involved carrying out interviews and observations in a range of formal and informal or unplanned settings. However, due care was taken to protect their confidentiality. This aspect is further discussed under the *Ethics* section of this chapter.

3.5.4 Information sources and methods

Qualitative research is often multi-method in focus (Flick 2002). The combination of multiple methodological practices, empirical materials and observations in a single study adds rigour, complexity and richness to any inquiry (ibid: 229). However the purpose of using multiple methods and triangulation of these is to secure in depth understanding of the phenomenon under examination, rather than to prove its accuracy.

Information sources included: documents, minutes of meetings, field notes of visits and observation, mapping of the Fund arrangements: structure and

functions, and individuals. Each of these sources was valuable and contributed to the development of the narrative presented in the following chapters. I classify these diverse sources under three categories of methods: Documentary analysis, Observation, and Interviews. A detailed account of these methods is given below -

3.5.4.1 Documentary analysis

Institutionally generated information as a data source can be very effective in revealing the culture and operation of institutions (Miller 1997). Documentary analysis has been used in a number of studies on health partnerships (Green 1998, Cooksey and Krieg 1996). In the context of this research, given the Fund focus on performance based grant-making, documentation and reporting had a particular significance as it served as a crucial mechanism to converge the gap between the *public* and *hidden transcript*. Collection of documentary evidence is particularly useful as it allows for a broad coverage and analysis in terms of time period (previous as well as current processes), range of events, and contexts (Yin 2003) in an unobtrusive manner.

In line with the analytic approach, a range of information was gathered through various media to examine the: *macro* historical and political context and discourse underlying the introduction of the Fund, launch of antiretroviral, national AIDS policy, and national guidelines for provision of care, treatment and support; *meso* level institutional guidelines and Memorandum of Understanding (MoU)/ contract agreements, proposals,

minutes of meetings, project reports and budgets; and *micro* level performance oriented records, registers, health cards maintained at the implementation sites. These mostly related to the development of the 'partnership' agenda and the functioning of partnership.

A majority of documents and reports used for the research was collected through personal interaction with participants at various institutions and institutional websites such as, the India Country Coordinating Mechanism (CCM), the Global Fund website, National AIDS Control Organisation (NACO) and others. Documents mentioned by a research participant during an interview or a meeting were requested from the relevant persons within the institution.

Obtaining access to these documents was not an easy process. Documents such as MoUs, proceedings of the CCM were regarded sensitive in nature and not shared. The *Director General* of NACO, for example, declined to share any internal documents and directed me to the official website. At the state coordination units and local intervention sites, while most participants were open to sharing the contents of registers, they were hesitant to give a copy for my records. This restricted the collection of centre specific records (of enrolments and targets) from all centres and thus hindered a comparative analysis of the programme outcomes. However, to the extent possible, I recorded this data verbatim as it was shared at the intervention site, and was able to develop an understanding of the comparative work-load specific to

centres, adequacy of human resources, and other substantive issues that have a bearing on the quality of service provision.

Documentary analysis has its fair share of criticisms, to the extent that some researchers challenge its acceptance as a method (Platt 1981 in May 1997:158). Others raise concern around the lack of rigour in justifying its contribution to the research findings, and challenge the myth that documents are a reflection of social reality (Silvermann 1993, May 1997, Miller 1997). I acknowledge that the content of documents/records can be generated through a controlled or manipulative process where the final product is shaped by decisions related to the social, political, and economic environment (Miller 1997). This was also evident from the minutes of the CCM meetings that I obtained from the website, wherein contested issues and disagreements, divulged during the interviews, were omitted. Since a bulk of the documents reviewed were official publications by the NACO as well as the civil society consortia produced in line with the Fund requirements, they carried the bias of containing misleading and unverifiable information. I therefore do not regard these as neutral artefacts but treat them as official views and a construction of the phenomenon which enriched the study by contributing to the understanding of hidden and public transcripts. Of course, this critique applies to all sorts of information including objective and 'hard' data. This aspect has been covered to some extent in chapter six where the protocols and records are examined for their potential to reproduce the policy rationale.

Bearing these limitations in mind I undertook the documentary analysis throughout the research period in an iterative manner as and when documents were accessed. I adopted Atkinson and Coffey's (1997) approach towards documentary analysis which suggests that documents should be analysed for what they are and what they are used to accomplish, giving careful attention to: their status in organisational settings, values attached to them (ibid) and, interpretative factors such as who they are developed by and for which audience, for what purpose, and what expertise/ knowledge was required to interpret them (Hammersley and Atkinson 1995). For example, the proposal to the Fund for round four appeared comprehensive on paper with clear articulation of roles and responsibilities for each partner. It became evident that this was not clearly a 'true' reflection of the 'partnership' or its practice, which significantly varied from the policies contained in the proposal. However, since it was 'the' official document required by the Fund to generate the contract endorsed by the signatures of all parties, its contents were likely to be shaped by what was desired at the global level and the pressures acting at national and local levels. This process was adopted to analyse the various documents to examine how they relate to (and generate) the themes addressed in the study and to corroborate the findings obtained from other methods.

3.5.4.2 Observations

Yin (2003) suggests the broad scope of observation as a research method in qualitative enquiry. It could range from a 'field' visit (which might be undertaken to study a community or institution) to more structured and formal activities such as meetings and consultation. Observation could be direct or indirect, and participant or non-participant.

For the purpose of the study, participant and direct as well as indirect observation was carried out. *Participant* observation has been defined as one in which "you are not merely a passive observer. Instead, you may assume a variety of roles within a case study situation and participate in the events being studied" (ibid).

Before commencing the visits to the field, I undertook a consultancy with one of the national recipient organisations to develop a concept note for an Operational Research (OR), one of the deliverables of the Fund grant. In order to develop this, I along with three other staff (two from the head office, one from the state office), visited the intervention sites in two Southern states that were also part of my research enquiry. The intervention sites were *district level networks* run by people with HIV. This exercise gave me the opportunity to understand the interventions proposed through the Fund grants, get familiar with network members and also visit the network national head office. It also revealed the operational and programmatic difficulties faced by the network members, which subsequently became an issue for further investigation.

At the national level I had the opportunity to attend both formal and informal meetings that were held to discuss and review programmatic aspects of the national programme. These mostly related to interactions between the NACO and the civil society actors concerned with policy matters related to the Fund arrangements and activities, as well as the areas established as “priorities” within the national AIDS programme. Sometimes the focus was on review of procedures and developing guidelines, and other times on the harmonisation efforts with donor agencies. These meetings enabled me to –

- Map out the organisations involved in the field and familiarise myself with the formal structures and processes (Allen 2000) within the national AIDS programme in general and fund arrangements in particular.
- Clarify the roles, rules and relationships, the nature and processes of interaction of the different partners, and their views on the performance of other partners and events.
- Get useful insights and documents related to the progress of individual activities, and familiarity with internal issues related to conflict of interests among partners.
- Identify participants to be interviewed, meet them in both informal and formal settings and thus establish a rapport with them. The rapport building was facilitated by the legitimacy gained through my presence in such closed door meetings with senior officials of the organisation. This in turn facilitated their willingness to be part of the study.

This rich information generated through regular interactions with individuals contributed to the development of my interview guide as I tried to further investigate the issues that emerged in these meetings.

At the *micro* level, observation was undertaken at the implementation sites. I visited public hospitals that housed the counselling and treatment (ART) centre, sub contracted NGOs running care centres, state coordination units (offices) of individual partner organisations and, state and district level networks of people with HIV. Observations at this level served a different purpose for the study. By observing the routine functioning of the centres, I was able to identify the discrepancies between what people say or claim and what they do or is happening (Mays and Pope 1995). Observation methods are thus particularly suited to study organisational culture, shared norms and values, and functions of the employees (Elston 2005) as they uncover behaviour or routines of which participants might themselves be unaware of (Mays and Pope 1995). For example, the visits to the intervention sites revealed: the excessive burden of reporting and its effect on quality of services provided, competition between local networks to assume counselling role at the public hospitals, and prevalent stigma among the care givers. These issues had not emerged during my interactions at the national level and had to be probed in the interviews.

Detailed notes of the meetings and any informal discussions before or after were taken and written up at the earliest possible. Notes were taken and maintained in a separate notebook along with other details such as date, time and location (Silverman 1998) as well as contentious opinions, important actors to be followed up, and the overall impression of the event. Besides the formal meetings where the content and flow of discussions were taken verbatim, I recorded all the formal and informal interactions using a voice recorder. Subsequent transcription enabled me to verify any missing information in the notes.

Observation as a research method has been criticised on two accounts: i) concerns around validity since observers rely exclusively on their perceptions thus influencing the findings (Adler and Adler 1998) and, ii) involvement of the researcher/ observer might alter the behaviour of the actors (Patton 2002, Allen 2000) or the very nature of relationship under study (Elston 2005). The first criticism, though important, did not have a significant impact on the study since the research is not primarily observational. Observation was instead combined with other methods of generating information and its main purpose was to generate insights to inform the interviews and examine the contradictions. Moreover, similar issues (and description of events) emerged or were recounted back by the participants during the interview, thus verifying the observations and my reflections. Regarding the second concern related to the influence of the observer, it is not entirely possible to know the extent to which my presence altered the proceedings or content of

the event/meeting. Since on most occasions (government meeting on guidelines, the Fund seminar, informal group meetings), I was invited by the organising body, the members either seemed oblivious to my presence or engaged with me in the discussions. The nature of issues that emerged from the meetings seems to suggest that my presence did not make an impact on the few meetings I attended. However, at the implementation level, the presence of another person (especially from a partner organisation with greater authority) did seem to affect the content and the openness with which discussions were held. In such cases, additional methods such as SWOT analysis were used and care was taken to re-visit the institution or gain further clarity through phone or email communications.

3.5.4.3 In-depth interviews

As stated earlier in chapter one and two, a *partnership culture* or environment is defined by the interaction of structure, the discourse, and processes constituted by interactions among the participating actors. *Interviews* are a useful tool to investigate reasons for human actions, perceptions and motivations as they yield rich insights into people's experience, feelings and attitude (May 1997), their interpretation of events (Fontana and Frey 2007) and the significance they attach to their own actions. Legard et al. (2003) emphasise the flexible and interactive nature of interviews which enables them to achieve depth, and the likelihood of creation of new knowledge and thoughts at some point in the research

process. For these reasons, *Interviews* acted as the primary source of information used to develop the case narratives.

For the purpose of this study, 70 in-depth interviews with a total of 94 participants were carried out. A few interviews, especially those held at the service delivery (or intervention) site, were in groups of two or more. Of the 70, four interviewees were *key informants*. As Patton (2002: 321) defines, “*Key informants* are individuals who are particularly knowledgeable about the inquiry setting, and whose insights can prove useful in enabling the investigator to understand what is happening and why”. The four key informants represented the civil society and the government (two from each sector) and were not directly part of the HIV component of the Fund arrangements. However, they were important players in the HIV and AIDS industry (and potential partners for the subsequent grants) or were associated with other components (TB and Malaria) of the Fund grant through the MoH. They provided crucial insights into the history of the Fund operations in India, the functioning of governing bodies, and the relationships between different actors and parties. Moreover, I found KIs particularly useful to verify conflicting claims of other respondents (such as their role in steering the Fund processes in India, performance gaps, and others) and seek information that was sensitive in nature.

Providing a list of all institutions contacted for interviews, organisational affiliations of interviewees’ and their role in the partnership (sub-recipient/

principal recipient, advisory or implementing) was difficult given the multiple levels of analysis, diverse roles played by the actors in the chain of policy process and their multiple institutional affiliations. For example, a CCM civil society member could also be a sub-recipient of NACO for one round and a sub-recipient of the civil society consortium (GO-NGO partnership) for another. Hence, table 4 presents a broad categorisation of the constituency the interviewee represents and their role in the programme. A limitation of this seemed apparent at the time of substantiating the findings with people's opinions/ quotes. Hence, while presenting quotes of research participants, I only present their role or organisational affiliation relevant to the discussion.

	Governing body members (CCM/PR)	Directors and Senior managers (PR and SR)	Project officers (PRs and SRs)	Managers of service delivery points	Front line providers	TOTAL
GO	3	2	6	5 (6)	5 (7)	21 (24)
NGO	6	7 (10)	6 (7)	11 (16)	5 (14)	35 (53)
Corporate	0	2	3	2 (3)	2 (4)	9 (12)
Other	3	2				5
						70 (94)

GO - Government Organisation; **NGO** includes the people with HIV; **Other**- refers primarily to i) Fund bureaucrats (i.e. employees of the institutions set up for the governance of the Fund) and ii) Key informants.

The numbers outside the parentheses are the interviews held while those in parentheses are the number of individuals interviewed. The difference is because on some occasions, interviews were held in groups of two or more.

Table 4: Description of research participants

The pre-testing stage for the interview guide indicated a length of approximately 60 minutes, although the majority of the interactions lasted between 60–90 minutes duration while the longest carried on for 150 minutes. Participants engaging in lengthy interactions often provided the

historical and political context of their work (which added to the richness of information), before focusing on the Fund arrangements.

Both *semi-structured* and *unstructured* interviews were carried out. A *semi-structured* interview is characterised by “predetermined questions” whose order and content can be modified according to the investigator’s perception of appropriateness (Robson 2002). This format gives flexibility to both the interviewee (to elaborate on answers and themes they consider relevant) and the interviewer (to clarify responses, and omit or add additional questions). These interviews were held with the help of an interview guide that was developed prior to commencing the second phase of field studies and subsequently modified with each round of interviews taken. The draft guide is included as annexure in appendix 1. The questions were open ended to avoid limiting the field of enquiry and enable respondents to answer at length and in detail. Since the nature and scope of the research was very broad, analysing the ‘partnership’ culture at three levels, a diverse range of actors were interviewed. Hence, the interview guide only served the purpose of suggesting broad themes of interaction and its contents were modified according to the constituency the respondents represented and their involvement with the Fund arrangements. In addition, on many instances (particularly at the intervention sites) I had informal discussions with the respondents, often in groups of two or three. These *unstructured* interviews were relevant since the nature of enquiry not only focused on the national or state level partnership arrangements but also the intervention: its history,

operational issues, infrastructure and institutional mechanisms, targets, tensions, reporting and monitoring, and other issues that the respondents wanted to flag. Robson (2002) describes the *unstructured* approach as an informal interaction where “the interviewer has a general area of interest and concern but allows for the conversation to develop” and issues to emerge.

As mentioned earlier, the interviewees were identified using a *purposive* approach and *snowball technique*. *Purposive sampling* refers to a process by which respondents are intentionally selected with the purpose of generating information that is relevant to the outlined aims and objectives (Green and Thorogood 2004). It entails selecting respondents for known characteristics (May 1997) such as the sector they represent, the level of seniority and so on. Unlike the sampling strategies adopted in quantitative enquiry embedded in the positivist paradigm, these are not determined by statistical representativeness (Britten 1995). The research aimed at capturing a broad range of perspectives on the practices of partnerships and also how different constituencies (government, non-government, and corporate) viewed these arrangements and their role in developing them. In order to generate this information from multiple perspectives, respondents (who were often not known to me) from across these sectors had to be interviewed. Hence, the *snowball* technique where key informants or other respondents suggested other key stakeholders who were crucial to the development or functioning of the public-private arrangements (of the Fund) in India was used. The choice of interviewees was guided by two aspects: First, at the *macro* and *meso*

level the main unit of analysis was organisations that were part of these arrangements (as national recipients or sub recipients, members of civil society consortia and others). Hence, the interviewees were often the senior members of the organisation and the programme team. In most cases, a separate team (comprising of managers, officers and coordinators) and project office was dedicated to the Global Fund rounds. These acted as the interview site. Second, actors (within organisations or independent) who had a significant role to play in how the partnership processes developed or unfolded were individually pursued. Often these names emerged in the interviews and informal discussions held with respondents. Respondents identified through these two techniques were directly involved with the Fund arrangements and/ or some stage of the 'partnership' cycle: its development, execution, or review.

The interviews were conducted face to face, in person, either individually or in groups of two or three. The first few interviewees were people I had contact with through my work prior to starting PhD. Among these, two interviewees (each representing the government and the non-government sector) were immensely useful in putting me in contact with key stakeholders. These interactions provided important background information and policy developments that shaped my ideas. They were kept informed on my progress through emails as I further developed the research idea. As mentioned in the *research journey* (section 3.5.3), they also facilitated the interview process at the sub-national level by issuing a letter to the

respective State authorities requesting (or rather commanding) support for my research. Hence, conducting the initial interviews was an easy and insightful process.

All the interviewees were contacted through email (and phone calls) and sent the relevant information on the research beforehand (See section 3.6 for a discussion on Ethics). In some cases, as and when requested, the interview guide and concept note was also sent. The response rate of those contacted was extremely good. Only one person in the government, the Director General of NACO explicitly refused to meet or be interviewed in spite of several emails and phone calls. All other potential respondents agreed to an interview. On few occasions, while the potential participants agreed for an interview in principle, it did not materialise due to time constraints on their side. This was particularly the case for the bilateral and multi lateral partners given their travel schedules.

3.5.5 Information management and analysis

Interviews were recorded through a voice recorder. Permission for recording was sought in the introductory letter, consent form, as well as prior to the interview. I explained to the interviewees that the sole purpose of recording was to ensure reliability and minimise information loss. In some contexts, particularly at the intervention sites, I did not consider recording appropriate since the interviewees (health providers) were carrying out their routine jobs which included counselling and other routine check-ups. Recording these

interactions did not seem ethical as it involved vulnerable individuals who were outside the remit of the study. Here, I took detailed notes in the register. Some local units / centres (such as network of people with AIDS) had maintained internal safeguards with regards to information sharing and disclosure. There was a sense of scepticism and insecurity on how the information regarding the project outcomes (that was obtained through their records) could be misused.

After each interview, I read through my notes (which I took irrespective of whether or not the interview was recorded) and marked issues that required further probing and my impressions of how the interview process had gone. Subsequently, I personally transcribed all the recorded interviews. This was a very time consuming process since majority of the interviews were longer than an hour. Hence, selective transcription i.e. transcription relevant to the themes of analysis and development of the narrative was undertaken to save time.

Like in most qualitative research, the analytical process began during data collection wherein the information gathered is analysed and shapes the tools and subsequent collection process (Pope et al. 2000). The process of “*sequential* and *interim* analysis” (Miles and Huberman 1984) has already been indicated in the illustration under the earlier section on *Information generation* (page 18). This strategy has the advantage of allowing the

investigator to re-visit and refine questions and pursue emerging areas of inquiry in greater depth (Pope et al. 2000).

This research adopts an *inductive (constructionist)* approach to analysis. According to this approach, analytic categories used to describe and explain the social phenomena under study emerge from the data rather than being defined *a priori* through a framework approach (Glaser and Strauss 1967, Charmaz 2006). However, the broad themes included in the interview guide were informed by theoretical perspectives on power and literature on networks and partnership arrangements, thus introducing a *deductive* element to the study design. Coast (1999) argues for a combination of these two approaches to obtain in-depth insights as one complements the other. The format and the content of the interview guide were broad enough to accommodate unfamiliar terms, themes, and ideas.

The analytical process involved the following steps: *familiarisation* with the data, development of *themes* and *categories*, *mapping* of the range and nature of phenomena, *analytic induction* i.e. iterative testing and re-testing of theoretical ideas on the data (Bloor 1978), and development of *narratives*.

First, information generated both formally (transcripts and field notes) and informally (surroundings, policy debates, other media) was assimilated and gone over several times to identify the main thematic categories. For example, a recurrent theme identified was: the tensions (and competition)

between the government and non-government intervention sites that were meant to operate in collaboration. The interviews were then mapped for the relevant information around the theme. A *narrative approach* was adopted wherein the emerging theme formed the description of the narratives that were written as 'emerging stories'. These stories centred on particular incidents or themes such as types of behaviour or nature of relations between the partners, and were particularly useful in making 'sense' of the information. Using *constant comparison* method (Charmaz 2006) I continued to examine the narratives for additional links, commonalities and contrasting perspectives and account for those in the final case studies. By adopting this approach I was attempting to develop a coherent interpretation or picture of the whole 'story' by bringing together and understanding the different narratives scattered across the information assembled. The final process of writing up the narrative also brought together (*triangulated*) different information sources, and adopted an iterative process of testing and retesting of theoretical ideas and assumptions (*analytic induction*) and making general inferences. These narratives were subsequently used to present the research findings in the later chapters.

3.5.6 Quality

Evaluating rigour and quality in qualitative research and the most appropriate means to do so has been a pressing issue by the evidence-based medicine movement (Carter and Little 2007) and within the social science research community. The issue of 'reproducibility' i.e. the extent to which the findings

or the explanations of the “truth” can be reproduced in another setting (or by another researcher) has been crucial to qualitative research (Green and Thorogood 2004). The case study approach in particular has been criticised for its “microscopic” view and inability to generate findings that can be generalised to other settings, given the small number of ‘cases’ it deals with. Moreover, as Pawson and Tilley (1997) suggest, as the descriptive baselines of a case increase, its ‘representativeness’ reduces. This, as argued, further affects the possibility of generalising the findings to other situations.

Harrison et al. (2001) on the other hand argue that some of these concerns can be dispelled by a conscientious collection of data about the case, its context, processes, and an adequate analysis. Likewise, Yin (1994) proposes that general applicability arises from the methodological qualities of the case and the rigour with which the case is constructed. He further points out that in a *case study* methodology, generalisation of results is made to theory (*analytical* generalisation) and not to populations (statistical generalisation) (ibid). In line with this view, this study seeks to achieve conceptual or theoretical *generalisability* for a similar set of arrangements and structures in operation.

In order to establish the “domain to which a study’s findings can be generalised” (Yin 2003: 34), and ensure dependability, transferability, and credibility, which according to Denzin and Lincoln (2007) and Lincoln and Guba (2000) substitute reliability and internal or external validity in qualitative

research, I pursued some of the actions suggested by Yin (2003) and Silverman (1998). A conscious effort was made to transcend checklists and be systematic in planning, implementing and reviewing the research process. The process has endeavoured to be inclusive, reflective and flexible to encompass the diversity that exists in qualitative research practice. Possible regional differences were taken into account by selecting cases in different states and urban/ rural districts among those demarcated as high prevalence.

The constructionist epistemology significantly shaped the methodology adopted in the study and, thus the analysis of the information generated. I maintained a comprehensive account of the information generated and the analytical process followed. Multiple sources of information were used and triangulated to develop analytic case narratives. In line with this, detailed records of my experience in the field, observation of meetings were maintained and used as important data source in analysis. Concurrently, combining data generated from observations, in-depth interviews, group interviews and participants' reflections on their transcript has served dual purpose- enriching information and checking for accuracy.

3.6. Ethical considerations

A policy or systems focussed research is perceived to have less severe consequences posed to individuals as compared to bio-medical research undertaken with patients or end users. However, there are important issues

of power and control that may impact on individual's dignity (Cassell 1980) and professional conduct. This research demanded particular attention to ethics not only for its potential impact, direct or indirect, for the well-being of individuals but also the process related issues arising from interactions between the researcher and the researched.

The work of feminists and other critical ethnographers have been crucial in highlighting the ways in which various identities- professional (work experience) and personal (with respect to gender, ethnicity and race) - might influence and shape research encounters, processes, and outcomes (Gould 2004, Mohammad 2001). In section 3.5.3 where I describe the enablers and disablers of my research process, I briefly engage with my position as an activist-researcher (from my earlier leanings) and the merits and demerits of being an 'outsider' in the organisation of the Fund, the object of analysis. These aspects had a significant role in how I, as 'the' researcher, was read and interpreted by the research participants and therefore, a subject of ethical consideration that required reflection throughout the research process. This ongoing negotiation of ethics which, as Harper (2007) suggests, involves moving between a number of sites and subject positions, of the researcher and the researched, in practice is a clear disjuncture from the tick-box approach adopted by research ethics committees. Rooted in strict bio-medical and bio-ethics perspective, the latter is argued to underplay i) the significance of researcher's life experiences, ideological affiliations, and

complex identities (Hopkins 2007) and ii) the lived experience of phenomenon in specific contexts.

In line with this view, a careful consideration of ethical issues was made prior to the primary research based on which, approval was sought from the Research Ethics Committee of the Queen Margaret University. Working towards an ethical approval, however, demanded a stated allegiance to the four basic *prima facie* tenets upheld in health research: Autonomy (ensured by informed consent and confidentiality and avoiding deceit on the purpose of the research); *Beneficence* and *non-maleficence* (the objective being to improve interventions and minimise harm to the vulnerable populations); and Justice. Standard research protocols were followed to provide information on the purpose of the research (Refer appendix 2), and ensure consent and confidentiality for all respondents (Refer appendix 3). These protocols are expected to reduce the possibility of harm arising from comments, opinions and criticisms of senior colleagues, partner organisations and others. The process of collection of information, its analysis and write up, however revealed several ethical moments divorced from these ideals of research.

Firstly, the extent of honesty and transparency regarding research objectives as implied through the information sheet to participants is questionable given the changing nature of inquiry during the research process. Such a practice assumes that the researcher, especially in ethnographic research, knows precisely the potential direction or outcome of the research process (Harper

2007, Kelly 2003). Despite their limitations in mirroring the research content, these protocols served an important purpose in the project initiation phase. Given the exposure of the Fund bureaucrats and brokers to the technical and bio-medical perspectives in which ethical debates are grounded, most of the research participants in both public and private sector agencies demanded the “information sheet” or “concept note” prior to the meeting.

Secondly, these protocols are restricted to the researched. Conducting observations and interviews in health care (clinical) settings often implied the providers were interviewed while they undertook their routine clinical and administrative duties such as counselling, consulting or diagnosing patients, and administering drugs. Interviews were often held in informal settings often in the presence of the beneficiaries i.e. people with HIV or other staff who were not part of the study. Given the nature of the provider-user interactions and the chaos at the public hospitals, ensuring an informed consent of these passive research participants (who were not directly related to the research) was not possible. Here, care was taken to reduce the potential harm (and maintain the autonomy of this group) by not digitally recording the interviews, taking photographs of the interaction or by informally sharing the broad perspective on the study, which was still in the process of getting defined. Another ethical moment emerged during the interactions with the people with HIV, not as beneficiaries but as providers of a service and sub-recipients of the Fund grant. These active members of the Fund organisation, which has

various forms of denials built into its structure (Cohen 2001), fear inquiry into the everyday practice of political expediency.

Thirdly, as with traditional ethnography, access by an 'outsider' in health care research is heavily dependent on researcher's prior relations with the host case study (Pettigrew 1997), the degree of trust established, and the participant's status and authority. In other words, contacts with influential insiders shaped the staff readiness to give time simply because they wished to please their superiors. Often, this resulted in discontent within junior staff who were deputed to accompany me at the expense of their duties and workload. In order not to add to their workload and without undermining the senior officer's authority, on suitable occasions, I would relieve the junior staff ensuring that the seniors remained unaware of the arrangement.

Fourthly, the main concern with regards to ethics emerged during the writing stage. Ethical codes and guidelines seem insufficient with respect to questions around where the researcher's primary obligation lies while the researcher grapples with the potential harm caused to the people if information is suppressed vis-a-vis the damage to the careers of certain individuals. Although attempts were made throughout to ensure confidentiality, the scale of interventions, and the nature and area of investigation (the Fund programmes implemented in partnership between the government and the civil society) renders it difficult to invisibilise the organisations/ players involved. Names of respondents have not been used

when presenting their quotes. However, a good understanding of the Fund organisation in India and the actors involved might reveal the identities of certain research participants and individuals who have been crucial when negotiating access with gatekeepers and making arrangements to interview. A conscious decision was also made to identify the few senior bureaucrats who did not agree to be interviewed since it provided insights into important dimensions of the research and enabled an analysis of authority in hierarchies.

3.7 Literature review

A systematic and iterative approach was taken to review the literature related to the main concepts presented and discussed in the thesis: Public private partnerships and global health initiatives, GFATM, and power.

The purpose of the review was to enable a critical understanding on i) the historical shifts in health care delivery and financing and the evolution of public private partnerships ii) the discourses (and the theoretical foundations backing them) on the basis of which current partnership approaches/models are designed, and iii) different theoretical approaches and explanations of power and the extent to which power is examined in the analysis of health policy and reforms. Finally, the review was also undertaken to present and discuss the current debates on PPP at both global and local level, summarise the key issues emerging from the country level experience of the Global Fund, and identify public and hidden transcripts from the published and unpublished literature.

In order to meet these objectives, a comprehensive review of the literature was carried out. First, an initial search for the historical beginnings and trends of 'partnership' was made so that the theoretical foundations upon which it emerged could be identified. Here terms such as "public private", "partnership", "mix", "collaboration" and "interactions" were used to identify relevant material. Next, text book literature on these different disciplines was reviewed. The searching strategy involved: consulting of new institutional economics, organisational studies, public administration and health governance literature through text books and papers; following up of relevant material in reference lists of books and papers reviewed; consulting with experts in the area; and consulting of some internet sources (WHO – www.who.int and the World Bank – www.worldbank.org). A similar exercise was undertaken to get familiar with the literature on "power" and its analysis in health policy.

The first step for the review was the QMU library catalogue and e-journal database, following which, SCOPUS, PubMed and other databases were used. These databases were searched for refereed journals, books and chapters, manuscripts, and conference papers. Published articles that were deemed to be opinion pieces, editorials, and reviews were also included. The unpublished or grey literature was accessed using search engines such as Google and visiting websites of global health initiatives and other organisations/ newsletters such as Avert, ODI and Global Fund Observer,

which monitor their progress. eTheses and EThOS were other repositories accessed (and found useful) for PhD thesis produced by students at QMU as well as other institutions in UK.

3.8 Conclusion

In order to meet the objectives set out in the introductory chapter, this research combines the methodological approach of critical ethnography and an analytic narrative style case study. In this chapter I justify the research design and engage with its key elements: epistemology, theory, methodology, and methods while presenting a reflective account of the research journey followed to undertake a multi-level analysis of PPPs. The subsequent chapters discuss the findings of the research.

Chapter 4

Understanding the contingencies of practice and plurality of perspectives

“There is no such thing as equal partners. In any partnership, not just with government, even with others, we are always made to feel as the ‘dalit’ [the untouchable]” – a ‘partner’ NGO

4.1. Introduction

In the previous chapters I discuss the different theoretical perspectives on partnerships and network arrangements and clarify my methodological approach to the research. I argue that the literature on partnerships gives little attention to the tensions between the global discourse and local practices of PPP and the role of structure and discourse in shaping the practice of these arrangements. Chapter 3 highlights the deficit in the evidence base on policy approach, which ignores the interface between the *macro*, *meso* and *micro* levels. Drawing on the primary research, the following three chapters address this gap by focusing on the interaction between global institutions and structures, policy environment and processes and their local outcomes. The findings are presented as an “embedded” tale (Rossi 2004) that reflects on the wider historical, political, and socio-economic context while presenting a “thick description” of local developments.

This chapter engages with the country level processes and polytheism of practices resulting from the Fund grant and briefly discusses its possible implications for local management of the HIV and AIDS programme. Two inter-related aspects are examined: Firstly, the “contingencies of practice” of Fund arrangements (and public private interactions), i.e. how alliances are formed and how new structures are produced and sustained in an intensely competitive environment, and secondly, the emerging disjuncture between the global discourse and social reality. Amidst disjuncture, I seek to address the “plurality of perspectives” (Mosse 2004b:80): the current challenges faced by the actors and the rationalising narratives generated around them.

Corresponding to the above objectives, the chapter is divided into two main sections: first, I examine *partnership formation and management* i.e. the processes and purpose with which organisations come together, the kind of arrangements they enter into and the structures they create. Here, I describe in detail the *governmentality* of the Fund (objective 2.1). Coined by Michel Foucault, the term *governmentality* - ‘deliberations, strategies, tactics, and devices employed by authorities for acting upon a population to ensure good’ - has been variously interpreted. As argued by Rose (1996: 328), there is an emergence of “a range of rationalities and techniques that seek to govern... through regulated choices made by autonomous actors in the context of their particular commitments to families and communities”. Taking a broad view, I refer to *governmentality* as the organised practices (rationalities, ideologies, techniques, protocols) through which subjects are governed. Hence, the

object of analysis in this chapter is: the structures and institutions set up for the Fund, their constitution and functioning, and the practices enabled by these structures. I also discuss the role of the intermediary actors or the “Fund brokers” in mediating the different worlds of the global discourse and local contexts (objective 2.2). The second section of this chapter relates to *partnership dynamics* and *disruption*. Here, I analyse the lives of the structures and the textures and tensions of their operation through two case studies which capture the power dynamics between different stakeholders, the resulting friction at the implementation sites, and the structural factors underpinning these phenomena. The two case studies elucidate two different sets of public private interactions: between government and non-profit NGO constituency, and between the government and the business or corporate sector.

4.2 Partnership Formation and Management

4.2.1 Description of application and grant making process

The Board of the Fund holds a funding ‘round’ every nine to twelve months. The round begins with a call to invite countries to submit a grant proposal for the three focal diseases. This annual bidding process presents itself as an opportunity for various stakeholders to enter into new relationships, form new entities and participate in the national level policy processes. It also facilitates movement of leading international organisations into India and large national organisations from other fields into the HIV and AIDS industry. Stakeholders

representing diverse constituencies (and organisations) come together into arrangements referred to as 'partnerships'. The entire process of bidding, identifying projects and partners, putting together a country proposal and subsequently submission to the Fund is coordinated by the country coordinating mechanism (CCM), which as described in chapter one (section 1.3.4), is responsible for overseeing the application process and progress during the implementation phase (GFATM 2007a).

The country proposal is often developed by paid consultants, individuals who are believed to have the ability and expertise to work effectively in the context of extensive and complex application procedures. These individuals are sought out and much of the grant preparation process is turned over to them. The resulting proposal passes through several rounds of closed door and informal negotiations that bypass formal structures and channels like the CCM. In the process, certain intermediary actors or 'brokers' become key to successful bids and applications. Similar to the observation made by Bierschenk and colleagues, these actors (individuals and organisations) who specialise in "the acquisition, control, and re-distribution of funds", play a crucial role in the "irresistible hunt for projects" and in managing the diverse interests (Bierschenk et al. 2002:4). The final country proposal is then ratified by the CCM, often within hours, and usually handed in person in order to meet the deadline to the Global Fund secretariat in Geneva (Interview notes).

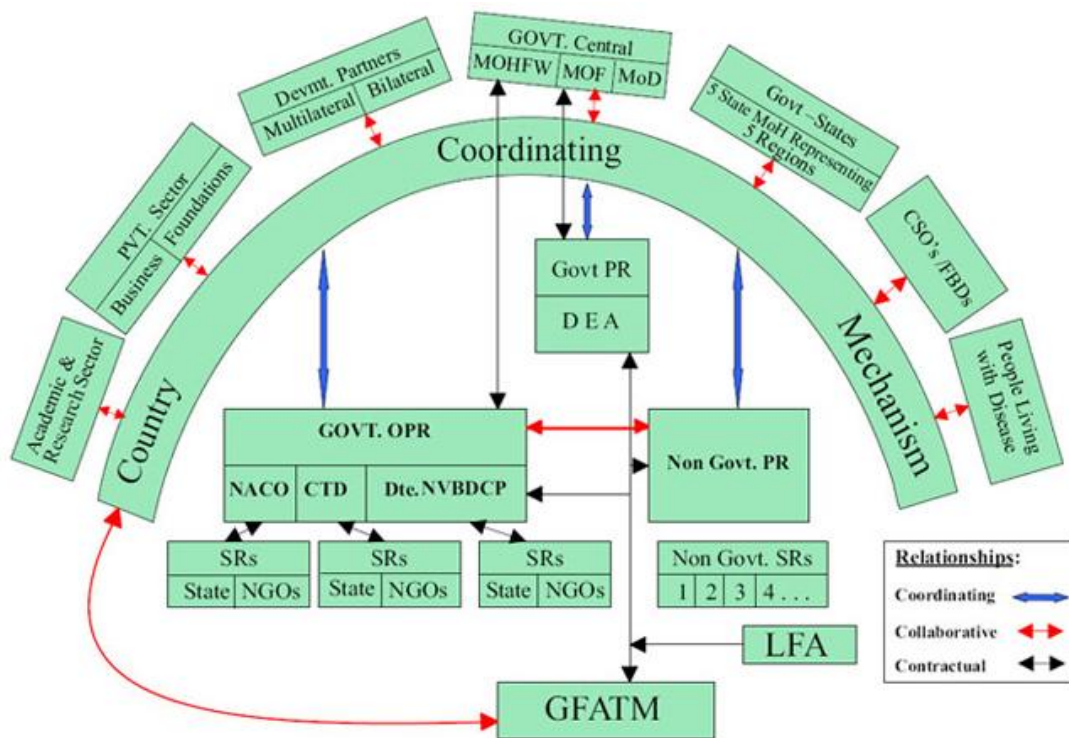
The country proposals are reviewed and assessed by the Technical Review Panel of the Fund and a decision is made. Once the country proposal is approved, the grant is given to the principal recipient/s (PR), the institution legally and primarily responsible for receiving, distributing, and monitoring the funds to implement programmes. The PR is often a government department or agency although increasingly a private organisation (an NGO) is taking up that role. In India, until Round four, the Ministry of Finance was the main PR with NACO⁹ as the operating PR. In the subsequent rounds, NGOs and educational institutes have played a similar role along with NACO. A list of PRs for the Fund rounds is provided in table 5 in section 3.1 of this chapter. Each grant is approved for an initial period of two years, following which a rigorous assessment of the progress is made. Based on a satisfactory report and recommendation by the assessor, the grant is renewed for a further three years.

4.2.2 Governmentality of the Fund

The governance model adopted by the Fund for its country operations includes: i) the board or the **Country Coordinating Mechanism (CCM)**, generally comprised of a broad range of stakeholders who represent diverse constituencies. These include the centre and state government, civil society including faith based organisations and people affected with the disease, development partners- bilateral/ multilaterals, private business sector and

⁹ As described in Chapter 1, NACO is an acronym for National AIDS Control Organisation, a division of the MoHFW and the nodal agency for formulation and implementation of HIV and AIDS policy in India. It operates through 35 state specific HIV/AIDS prevention and control societies.

medical associations, and academic/ research institutions, ii) the **Secretariat** responsible for the management, and iii) the **Local Fund Agent (LFA)**, usually a private agency, assigned as an independent auditor to oversee progress and verify information submitted by the grantees on the basis of which, grant is renewed. Consulting firms such as Price Waterhouse Coopers, KPMG and institutions like the Bank and UNOPS have served as LFA in different recipient countries. The role and experience of the LFA is further examined in chapter six. An interaction of the above structures, as depicted by the India CCM is shown in figure 7.



Source: India CCM website

Figure 7: Governmentality of the Fund (Structures and relationships)

4.2.2.1 India CCM

In accordance with the eligibility criteria of the Fund, the India CCM was set up in 2002. This was soon after the launch of the Fund at the G8 summit in Okinawa and the first announcement of its call for proposals in January 2002. A respondent who was actively involved in the initial setting up process, both at the global level in Geneva and in India, described the process as follows:

“The closing date for the proposals was February 28, 2002. Hence, all proposals [at the country level] were to be in by the 22nd. In order to meet this deadline, the MoH [ministry of health] put together 16 names to get the CCM going, ...[these were] mainly friends of friends.”

History, Constitution, and Representation

The ad-hoc manner in which the CCM was initially set up and the arbitrariness of its ongoing proceedings was a recurrent theme of concern in all interactions had with non state actors. At this stage, the CCM primarily comprised of the NACO and representatives of central and state government who presided over the meetings and had voting rights. The representation of the civil society was minimal and tokenistic, restricted to two NGOs who were engaged in HIV prevention and care programmes with partial assistance from the government. Chaired by the health Secretary, this committee submitted the first India proposal to the global secretariat.

“We didn’t have a clue on how we entered the CCM. But once we were in we felt stupid because partnership means getting other people involved. We were supposed to be representing all the NGOs in the drug field. So we had to actually start developing partnerships in order to not feel guilty about it.”
(Former CCM member, NGO representative)

The first civil society consultation was held in August 2002 on the initiative of an independent agency, which emerged from the ‘Massive Effort Campaign’ launched in Switzerland in 2001. With its India office set up primarily to “catalyze the emergence of a global movement against AIDS, tuberculosis and malaria” (website), the agency played both communicative and facilitative roles in orienting or “sensitising” (Rossi 2006) the different stakeholders to the Fund processes and enabling negotiations between them. For this purpose, a series of workshops was organised with assistance from the Global Fund regional directors, one of which focused on the role, structure, and function of the CCM. However, as a key informant reported, *“the GOI and its related departments for HIV and TB were absent in all these consultations”*. The informant attributed their absence to either the *“we know enough, others need to be oriented”* attitude prevalent among the government bureaucrats or a sense of threat they had begun to face with the increased involvement of the civil society.

Several such orientations, at national and sub-national levels, were held at the behest of international agencies to enhance familiarity with the fund

processes and criteria, encourage participation of the corporate sector and NGOs, and ensure successful country level applications. These meetings acted as sites for “sensitisation” of the senior management of predominantly the non state actors into the prevailing discourse on the Fund (establishing the relevance of the global crisis and the partnership mode of working), encouraging them to “express their problems in conformity” with it (Bierschenk 1988). These orientations also emerged as an opportunity for the national NGOs and networks to mobilise and form alliances to lobby for greater representation in the CCM and to receive direct funds from the Fund as co-principal recipient to the government.

In early 2004, following an evaluation of the CCM commissioned by the Global Fund, the Fund brokers and bureaucrats¹⁰ were quick to translate the findings into the ‘policy need-of-the-hour’ to enable a more formalised and ‘representative’ constitution. By this time significant mobilisation had occurred among the non-state actors. International organisations had set up their operations in India, a few large national organisations working on general or reproductive health had begun to chart the AIDS landscape, and there was a growing interest of local champions in the Fund processes. The sensitisation set off at the CCM or national level was being reproduced at sub-national levels and as a result, network formations of people with HIV, facilitated by their international counterparts, were demanding a stake in the

¹⁰ The term Fund bureaucrat is used for the employees of the structures/institutions set up exclusively for the execution of the Global Fund grant in India. These structures – the CCM, the CCM secretariat and the Local Fund Agents- are discussed in section 4.2.2. Although these actors are also regarded as Fund brokers, the latter is an eclectic group comprising implementers and those affecting the governance of the Fund from outside.

process and challenging the legitimacy of the existing members. This led to friction among non-state actors as apparent in the quote below.

“Because we were chosen [as a CCM member], there was a great problem. There were many rivalries...Somewhere in 2004 AIDS alliance formed an entire group of NGOs and started challenging... At a meeting [they asked] ‘How did you guys enter the CCM? How can one NGO in Delhi represent the entire country? Now we must choose from different regions, zones.’ There was no thought given to the process at all.” (Former CCM member, NGO representative)

However, the Fund’s emphasis on greater involvement of the civil society and an expanding lobby of “sensitised” government and non-government bureaucrats stimulated three subsequent meetings that were hosted by the government in 2003 and 2004. The informal meetings revealed two noteworthy developments with regards to the grant making process in India. Firstly, when the CCM was reconstituted in early 2004, the president of a prominent network of people with HIV was elected as the vice-chair of the CCM. Secondly, for the first time a NGO was nominated as the second principal recipient (alongside NACO, the government recipient) for the national AIDS component of the Fund grant. The civil society representation however, still fell short of the Fund mandate.

In 2006 the Global Fund launched its guidelines for CCM. The board required the CCM to have: i) a balanced composition ensuring adequate representation of stakeholders, and ii) formal documentation of the process to ensure transparency in the selection of non-government representation. A restructuring plan for the India CCM was developed with a view to ensuring compliance to the board requirements (CCM Secretariat 2006). According to the Secretariat coordinator, a “sophisticated process of web based selection” was employed under the guidance of a CCM sub-committee, comprising mainly of government and donor representatives. The official rationale for this process was that members be selected by their own constituency, although the rule applied only to the NGO constituency, whereas the induction of other members continued in a non-transparent manner. The process involves formation of an electorate by inviting NGOs, which meet the criteria set out in the Fund guidelines, to register online. Once the documents are verified and an electorate formed, the members are asked to self nominate as representatives to the CCM. This is followed by an online voting procedure to identify the civil society representative on the CCM.

This selection process is facilitated by an external agency (Global Policy Alliance for the first reconstitution and UNAIDS for the second) in coordination with the CCM Secretariat. Although the model was designed to ensure democratic nomination/election of members, the process was fraught with problems. The medium of electronic voting was reported to exclude local and community based organisations working with people with HIV in remote

districts. Organisations operating locally or with small funding were particularly excluded since they did not meet the criteria of structure and scale, measured primarily through the turnover. Although the research participants interviewed regarded the system of nominations necessary, many were unaware of the modalities while some also referred to incidents of proxy voting.

“Eight NGOs were identified and 122 were to elect them... I think the 122 are not members, nor are they on the board....I like the concept [online voting] very much. You apply for membership. Once you are approved, then your name will be put up for selection, I don't know by who or how”. (An elected member)

“I think it was a very democratic process although it was a little surprising that somebody had already cast a vote on our behalf. My vote was already there, even before I logged in”. (An elected member)

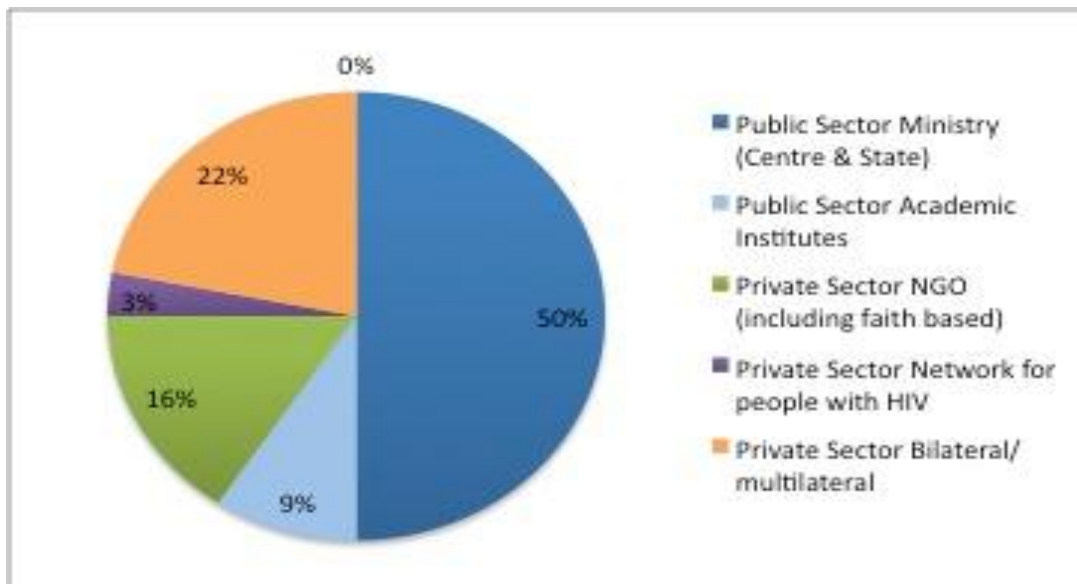
A second round of restructuring was held in 2007 since only four out of eight seats allocated for the civil society were filled on completion of the earlier round. However, this time the process was facilitated by UNAIDS which, at this point, also hosted (and was responsible for the functioning of) the Secretariat of the India CCM. The shift, as shared by a key informant, was in the light of the arbitrariness of the previous voting exercise. This attempt also failed to fill up the vacant posts. A key informant attributed this failure to poor

management of the process and the proximity of the Secretariat to the conducting agency. Commenting on the process the informant observed “*There was no arbitrator, the conductor became the judge. As a result, there was significant time gap between the announcement, election, and final results.*”

Despite two failed attempts to fill the eight civil society seats in the CCM, narratives of the Fund bureaucrats unequivocally upheld the democratic and inclusive nature of the selection process crediting the Fund for “enabling civil society participation at such a prominent scale at the national level” (Notes from informal discussions).

Decision-making and information asymmetries

Despite the growing numbers of the civil society members, the national AIDS agency or NACO was regarded as having a dominating role and presence in the CCM. The figure below presents a constituency-wise breakdown of the CCM in 2007. Given the constant restructuring of the CCM and the censoring of information on the minutes of the proceedings available online, compilation of this information was difficult. The exercise, however, revealed the loose configuration and high turnover of membership, particularly within the public sector since bureaucrats were either represented by their subordinates or their successor (on two years tenure). The impact of the frequent turnover of the public sector employees is discussed further in section 7.4.3.



Source: Compiled from minutes of the CCM meeting

Figure 8: Composition of India CCM

Figure 8 reflects an imbalanced representation among the constituencies. Due to a reported conflict between two powerful business foundations (for a membership in the CCM), the corporate/ industry seats were vacant. However, senior management of Price Waterhouse Coopers were among the invited members who did not have voting rights.

In view of the skewed representation, clear information asymmetries were reported. The inclusion of NGO members in the CCM did not transpire into treating them at *par* with other members given the well-defined authority of 'expertise' within the CCM. Reflecting on the lop-sided constitution of the governing board and consequently the decision making processes, a respondent observed:

“If you take the two principles: one vote per entity and conflict of interest into account, decision making is clearly lopsided. Government occupies 18 of 34 seats through its various entities. Academia is also represented by government owned institutions. So, people who are voting and leading discussions are the government...The NGOs have strings attached to them as majority receive funds from the government. The externals like UN agencies, WHO, and bilateral could balance but among them there is clear dissonance between what is said at the headquarter level and actions by their counterparts at the country level.” (Senior Fund bureaucrat)

Clear information asymmetries were observed with respect to notifying dates of meetings, selecting members, identifying proposals and defining programme priorities. Most NGO respondents reported the arbitrariness and non-transparency within these procedures. Independent technical review committees set up for reviewing applications and proposals were reported as dominated by bilateral/multilateral organisations like the USAID, DFID, the Bank and the UN agencies, leaving little scope for participation of NGOs.

“It [call for proposals] is very erratic. Earlier it was advertised around the deadline for submission. Even now the advertising is very late. They will suddenly say whoever wants to apply should submit and that too not everyone will be made aware of.” (Sub recipient NGO, former CCM member)

Processes of agenda setting and decision making too were firmly grounded in these professionalized and hierarchical settings where power was wielded through the control of information and exclusion of the members further down in the chain of command.

“...Conflict of interest operates differently for different groups. For instance, when our application was being discussed at the CCM, we were asked to leave the proceedings...no one questioned NACOs presence at the meeting although they were also bidding for the proposal.” (Senior management, Principal recipient)

“As partners we had to start CCC [care centre]. They[NACO] want it 10 bedded, they tell us the place where to have it, they pass a rent of 4000/- when in reality it is 30000/- pm. They call all the ‘experts’ together, sit in air conditioned rooms, earn in dollars and draft something which makes no sense. What makes them think people will work for this? There is no such thing as equal partners. In any partnership, not just with government, even with others, we are always made to feel as the ‘dalit’ [the untouchable].” (NGO sub-recipient, former CCM member)

Most respondents representing the NGO constituency were unaware of the country programme focus and ongoing interventions as part of the grant. They expressed disconnect between the official purpose and the actual

functioning of the CCM, particularly in relation to its role in monitoring and 'overseeing', which was regarded negligible.

"I have been in the CCM for well over a year. I don't know the activities that are happening across the country. I don't see a consolidated picture, probably that could be because we haven't been there from the beginning."

(CCM member, NGO representative)

"For a meeting [to ratify the proposal] at 3pm, proposals are received at 1pm. How do you respond?The document is not 30 or 40 pages. It runs into so many pages and there is so much of back referencing. If the proposal has to reach Geneva by the 2nd, CCM meeting is held on the 29th of previous month. Then you are told if you don't endorse it now, how will we submit? GFATM asks for 50 copies or something online and a few hard copies. So, half a day goes in printing. Each time a person has to be flown to Geneva to make sure that the 3pm deadline is met." (Senior Fund bureaucrat)

4.2.2.2 The Secretariat

Some of the problems with regards to the functioning of the CCM were attributed to a dysfunctional secretariat.

In September 2005, an independent India CCM secretariat was set up. Prior to this it was located within NACO. The secretariat is staffed with a coordinator who, under the supervision of the Joint Secretary of Health and

Family Welfare, is responsible for smooth management and operation of the CCM. The remit of the coordinator is very broad. It includes: management of CCM processes, technical and organisational support to the committees, facilitation of performance oversight by the CCM, liaison with the various levels of the Fund bureaucracy in India (Local fund agent, and government and non government PRs). Additionally, it is responsible for tracking the downward disbursement of funds i.e. from the Fund Secretariat to the principal and sub-recipients, and upward financial and physical reporting (CCM Secretariat, TOR 2008). The Terms of Reference also explicates the facilitative role of the coordinator in preparation of position and policy papers on key public health aspects of HIV and AIDS, TB and Malaria epidemics. The public transcript of the Fund bureaucracy, therefore, regards the secretariat as the nodal agency accountable for the management of the Fund bureaucratic as well as institutions in India. Given its pivotal role in the Fund operations, the secretariat came under critical scrutiny in the interactions with research participants.

“It [the secretariat] is ad-hoc...used to be pretty much the baby of NACO. Other two diseases [malaria and tuberculosis] did not have access or control over it. It excluded all interactions with other stakeholders. When it came out of NACO into UNAIDS in 2007 it was like jumping from the frying pan to the fire. The situation worsened despite very efficient coordinators in place.”

(Key Informant 4)

“If we adhere to the governance model of the Fund, the secretariat should do the business of the fund in India. But it is a goof up, the coordinator is treated like a clerk. They are told to get the job done: letters to be written, minutes to be taken, postage to be stamped. The CCM should be functioning like the board and supervise the Secretariat. But the members consider it as their baby, neither do the job nor delegate it.” (Key Informant 3)

A result of the lack of control over the secretariat’s functioning was the high turnover of the national consultant or the coordinator of the secretariat was reported. Within the two-year span of the study, four consultants had been recruited, each lasting three months to a year.

An analysis of the *governmentality* of the Fund demonstrated that both the cognitive and coordinative function of Schmidt’s discourse framework were operational given the multi-actor system and environment generated by the Fund grant. It also reveals the potential of these mechanisms to act as sites of power, and at times contestation. Power was wielded at two levels: firstly, through control exercised by ‘direct agency’ resulting in conflict of interests among the various stakeholders. Secondly, through “diffused agency” (Crawford 2003:145) by controlling the agenda setting and information around what gets discussed, proposed and implemented.

The practice of Fund *governmentality* often resonated with the discursive practice of development, which Escobar (1997:87) argues, engineers “who

can speak with what view points, authority, and according to what criteria of expertise”. The *professional* and *technical* experts (the international donor community and few heads of international organisation and heads of disease control programmes) dominated the technical review committee and authorised interventions by a non-transparent process which valorised their technical skills and reinforced the difference between the ‘developed’ and the ‘developing’ worlds.

As suggested by Buse and Harmer (2004: 54), this distribution of power has significance for perception of ownership of the partnership by the respective partners and consequently, determines their commitment to it.

4.2.3 The ‘marriage’ of multiple stakeholders and plural interests

4.2.3.1 Rationale and Motivations

The NGO constituency involved in the Fund arrangements was articulate in expressing their reasons for entering into partnership arrangements with the government. For most, it served as a “window of opportunity” to have a say in country wide processes and policy decisions, expand their outreach in India and bring their interventions to scale, establish their credibility in the AIDS industry, and ensure sustainability of their organisational work. While reflecting on the collaborations with the corporate sector, the NGO constituency reproduced the Fund discourse on ‘industry participation’

making frequent references to the enhanced role of the business associations in health partnerships globally.

The public sector bureaucrats involved with the Fund governance unequivocally regarded partnerships with the corporate sector as an opportunity to ensure “additional funds and manoeuvrability in reaching out to people” (Notes from interviews and meetings). However, collaborations with the NGO sector at the national level were not considered desirable. Unlike the earlier public private interactions where NGOs were funded (contracted out for specific services) by the state, the government representatives felt that the new PPP model, only provided more power to these unaccountable entities and was not conducive to effective functioning.

“There is definitely a need for PPPs at the grassroots or implementation level. Also, in planning, monitoring, evaluation research, technical expertise like TRG set ups, we need to involve individuals or organisations. But I am not in favour of PR level GO-NGO partnership...you have organisation conflicts, duplicate administrative costs, and makes foreign contribution essential.” (Senior public sector bureaucrat, Principal recipient)

Despite power imbalance within the Fund governmentality, and friction at the implementation site, the actors expressed views consistent with the dominant development discourse (and the rationale underpinning official policy decision) on the Fund and public-private partnerships. All the narratives

echoed the dominant discourse discussed in chapter one upholding the technocratic and managerial discourses establishing, in the process, inter-sectoral working (public and private) as 'necessary' and external finance mechanism such as the Global Fund ('war chest') as an inevitable solution. The non-government Fund bureaucrats in addition maintained that the problems with the functioning could be attributed to "poor governance which they equated with corruption, leadership, and autocratic mode of public sector functioning".

4.2.3.2 Reconciling various interests: Developing the country proposal

Below are three separate accounts of the preparatory phase of the country proposal prior to submission to the Global Fund secretariat. These accounts highlight the varied experiences of stakeholders in negotiating respective programmes and budgetary allocations.

"The initial expression of interest was for 30 million, for 30 partners to work in ten states- some for technical support but mostly for implementation. It was cut down to 20 million and we lost all states except three. Then the work really started with NACO. We had some random meetings with other PRs and government sub-recipients for the grant where the head of NACO delegated areas for each. The other recipient's proposal was completely changed and they were given some partners who were ours. It was all very messy, nothing was done in writing." (Non-government Principal recipient 1)

“..The [Consortium’s] current proposal was accepted by the technical group. When it came to the CCM, main issue was over the PRship [NGO becoming a principal recipient]. On the budget, the CCM felt it was impossible to give a sum of 54 million to an NGO. Instead, NACO demanded the sum to purchase ARV drugs.10 million was what they suggested for our work. We negotiated since it was impossible to carry out all the tasks in so little. In 5 hours time this was brought to 18.2 million as the deadline for it to go to Geneva was the following day.” (Non-government Principal Recipient 2)

I don’t understand the process through which the CCM puts together the country proposal. For Round 7, 141 proposals were received for HIV and AIDS component alone. A consortium down south [India] had put up a proposal on the theme of workplace policy. It was very unique and the technical committee had selected it. But it was dropped from the final list [that was circulated for ratification]. I don’t know the background but it said workplace topic was removed because the corporate sector and Ministry of Labour didn’t give the proposal on time. (CCM NGO representative)

The above accounts highlight the arbitrary and authoritarian manner in which the final country proposal is put together: in informal and closed door settings where public sector agency, mainly the NACO, is seen overtly dominant. It also reflects token participation of different constituencies in the coordinating mechanism which is often bypassed when taking crucial decisions. The

underlying authority of NACO was prominent in all non government narratives even though they were aware that much of the decision making took place in technical committees where the deliberations were dominated by development agencies and NACO had little or no role.

Negotiating the bureaucratic hurdles is common to all the above accounts. They differ, however, in their relative bargaining position within the hierarchical organisation of the Fund. The legitimacy derived from this bargaining position, as the quotes below suggest, was a determinant of the organisation's success in the "negotiations". The first account is of an international NGO operating at the country level. The international status and visibility, and representation in the Global Fund board (in Geneva) gave it a competitive advantage over other stakeholders in the bidding and subsequent negotiations. While describing the preparatory phase, the respondent gave insights on these privileges and how these facilitated the formation of partnership.

"With a member of staff sitting on the board of the Global Fund, our advocacy profile within India increased substantially. We get to play both our national and international card. Though international, our FCRA¹¹ status allows us to raise funds from foreign sources. Global Fund came up when we were looking at our resource mobilisation strategy. With previous experience of

¹¹ Foreign Contribution (Regulation) Act, enacted in 1976 in India, regulates the acceptance and utilisation of foreign contribution by associations. Voluntary organisations in particular are mandated to have FCRA status in order to receive funds from foreign agencies/ sources. The registration is granted to associations with proven track record of functioning for at least three years, thorough security vetting of the activities and antecedents of the organization and office bearers.

being on the CCM of other countries, we knew of the politics but success in delivering the fund meant a lot of money over many years. We did an analysis of the previous round that India did not qualify for and got in touch with groups thinking they will apply again...We invited the main competitors to be our partners before the official call for application came out.”

(Non government principal recipient 1)

The second narrative is of a national level NGO that had support of prominent players in the AIDS industry in India. Although less visible at the international level and less familiar with the AIDS landscape, the organisation, with a former senior government bureaucrat as its Director, had good rapport with the government and a strategic presence in Delhi. Non-government partner organisations reported this as the single most important criterion in selecting the organisation to represent the civil society consortia as the principal recipient. A contrasting experience is shared in the third narrative of a CCM member wherein, a local organisation with insufficient clout and connections was unsuccessful in its bid for the grant and received no communication about the grounds on which its application was rejected.

Partnerships developed as a result of the forced marriage between unequal partners failed to generate consensus on the shared understanding and rationale for different components of the project and the role of partners. As a result, the approved grant invoked little ownership and participation giving rise to projects that were beyond the local implementation capacity of not

only the national agency, NACO but also other implementing partners who had little control on the programme. This aspect shall be explored in further detail in the subsequent section.

4.2.3.3 Peripheral stakeholders, core actors

Besides partnerships arising from the Fund, there is a visible trend of multiple structures created as partnerships between state governments and donors such as the Bill and Melinda Gates Foundation and USAID. A comprehensive understanding of the dynamics of operation of the Fund necessitates an understanding of these additional power centres within the AIDS industry in India. Cases for discussion here are the Karnataka Health Promotion Trust (KHPT) and the Avert Society in Maharashtra. KHPT is a partnership between State AIDS Society (the state division of NACO) and University of Manitoba, the chief executive agency for the Gates Foundation's HIV prevention project, set up in 2003 (KHPT 2008). The Avert Society, referred to as "an agency of the Government of Maharashtra, funded and jointly administered by the state government and USAID", was set up to "support the GOI to reduce the negative impact of HIV and AIDS in India" (Avert Society 2004). Reflecting on the genesis of these agencies while discarding the *public script* emerging in their websites, a key informant articulated that these structures emerged "in response to the reluctance of bilateral and other donors to fund governments directly" (Key informant 3). The reluctance was primarily attributed to bureaucratic hurdles and mismanagement associated with the state governments. Subsequently,

independent entities were registered as trusts or societies, often chaired by senior government bureaucrat, and served as an alternate channel of receiving aid. This view was confirmed in a few other interviews.

“USAID was planning to come to India. They asked for bids. NACO would have been ideal [recipient] but it was refused, as USAID knew that it is a big tunnel and USAID did not want to lose control on the programme. They said we will give the money if you set up a trust instead. That is how KHPT was formed. The trust is chaired by the Principal Secretary of the State.” (NGO sub recipient)

The respondent also referred to the agency as being an offshoot of the Bill and Melinda Gates Foundation.

“It was a project of Gates foundation. When the project was completed and the government refused its continuation, the entire team got sucked into KHPT. Because KHPT was an Indian entity it couldn’t get the funds directly. So, Gates foundation routed the funds through a US based institution. University of Mannitoba won the bid and KHPT became the implementing partner.” (NGO sub recipient of the Fund)

The creation of these parallel agencies, or what has earlier (section 2.1.3) been referred to as *agencification*, not only affects the channels of aid flow but also re-configures the skills and expertise valued in development

practice. It promotes the development of a cadre of *brokers* who, as we shall see in the following discussion, as active agents and skilled professionals aware of the funding modalities and having the required technical “expertise” for successful grant making, emerge as a threat to the public sector employees. This cadre not only includes fund recipients who act at the interface of the global development rationales and the local contexts and perspectives, but also development workers in the project chain (project officers, programme managers, review consultants) joined by implementers/providers who Michael Lipsky (1980) refers to as “street level bureaucrats”. The latter category represents the local populations who “express its needs to the structures in charge of aid and the external financiers” (Bierschenk et al. 2002:4) and translate the project objectives into locally coherent rationales.

4.2.4 The divorce...

While the two agencies (KHPT and Avert) were initially set up with the patronage of the state governments, they subsequently emerged as large parallel organisations competing for the same resources, programmes and funding. Their links with international institutions, primarily educational and research institutions enable better access to technical expertise, global mechanisms, and standards of practice. With improved access to information regarding policy developments, technical know-how, and better ability to mobilize human and financial resources, they often outbid state agencies. One of the states experienced a crisis when in a recent move by NACO all

community care centres that were contracted out to NGOs, were shifted from the ambit of the State AIDS society to one of these agencies. Since the AIDS society had been implementing the programme since 1999, this move increased the friction between the two parties and resulted in care centres having no funds for several months. Concerned NGOs approached the State AIDS society for renewal of the grant but were refused on the grounds that there was no clear notification from the national body on the mechanisms of this shift.

“March 2007 is till when we got the grant. Now we don’t have any funds. State AIDS society told us that they will not be getting funds from NACO to run care and support programmes. We have been running on loan. Now a USAID project implemented by KHPT has taken care of some components. But we have no idea of how to move forward....We have only 33 patients now, we took a slow approach in the last few months as we fear we may not be able to continue.” (NGO running a care centre)

While there was no specific rationale provided for this move, subsequent meetings with the stakeholders emerged as battlegrounds for shifting responsibility. Different accounts within KHPT and NACO suggested a perceived failure and redundancy of state society in managing the programme. However, employees of the State AIDS society reported wider systemic and structural issues such as severe shortage of human resources, and a high turnover of senior management staff resulting in negligible

institutional memory. Reflecting on the performance gaps, a senior officer at the State AIDS society highlighted the high turnover of Project Directors¹² at the state level.

“between 2006 and 2007 alone four directors changed and the present one is on additional charge”. (Senior project officer, State division of NACO)

This trend is not restricted to the sub-national level (states or districts) but also visible at the national level in the different national disease control programmes.

“In the last 4 yrs I have worked with the 3rd Director General of NACO and probably the 7th head of malaria division. In a system like this how do you improve matters? Lot of people tell me that DG NACO is a punishment posting. They are always trying to get out of it.” (Senior Fund bureaucrat)

Both government and non-government respondents were in agreement that this high turnover led to increased bureaucratic hurdles and delays since each Director had to be re-oriented to the programme intent, objective, and Fund requirements. On the other hand, non-governmental agencies particularly those with strong international ties, were regarded as being well resourced to meet the increasing demands of the Fund and other donors.

¹² Nodal person at the State AIDS Control Society, usually a senior Indian Administrative Service (IAS) official appointed by the state administration.

“There are some advantages in having KHPT implement the programme. They pool in resources from several grants like USAID, Gates Foundation, other state and national resources... pay more to staff and have more senior people monitoring the programme. For implementing ‘Targeted Interventions’ and ‘Care and Support’ programmes they have 60-80 well qualified people - field supervisors, regional and zonal managers, team leaders, and project director. We have only one finance officer, one implementing officer and a technical support unit to monitor all the programmes. In round 2 we had 500 counselling centres but no support staff as there was no money for infrastructure and human resources”. (Senior project officer at the State division of NACO)

The structural barriers also include differential workload and salaries in the public health and private sector agencies, which leads to an internal drainage of human resource.

“...There is also a funding difference. For instance, drop-in-centres supported by state AIDS society receive 200,000 INR per year. Through Avert they run on a budget of 600,000 INR per year. This is a huge difference”. (Senior project officer, Network of people with HIV)

The impact was felt most at those implementation sites where multiple projects with differential incentives and work environment created a competitive environment and discontent among project staff.

“Introduction of KHPT project is almost unlawful. Careful planning should have been done on the impact of this on our project. Pay scales cannot be matched. Despite a degree and years of experience, I get ...[nearly half the salary] that their project staff in our network draws. S/he is planning to move to state level, I will try to get a transfer to that post.” (An employee of network of people with HIV commenting on different projects implemented in the district)

4.3 Partnership Dynamics and Disruption

4.3.1 Life and dynamics: textures and tensions within micro processes

Ambiguity surrounding both the concept of partnership and the *governmentality* of the Fund, and the ad-hoc manner in which relationships were developed around the call for proposal resulted in lack of clarity and uncertainty around individual and partner roles. In this context, projects emerged as sites of contested power where, as we shall see in the following section, actors competed for more resources, better incentives, autonomy and legitimacy from different quarters.

Table 5 below presents details on all grants approved for India for different rounds. Each round is for a period of five years implemented in two phases. The grant is initially given for two years and following a review, renewed or

extended for another three years. The rounds commence in sequence but run parallel, so much so that at any given time, up to five rounds are running simultaneously, each with a different objective, partnership arrangement and funding. At the time the field work was undertaken, India awaited decision on the eighth round of Global Fund grant while funds from the first round remain unutilised.

Rounds	Component	Principal recipient agency	Sub-recipient/partner agency	Activities	Grant start date	Funds approved (in million \$)
Round 1	TB	Department of Economic Affairs (GOI)				
Round 2	HIV&AIDS	Department of Economic Affairs (GOI)	State AIDS Societies (treatment) and Sub contracted NGOs (prevention and care)	Prevention of mother to child; public-private ARV delivery	May-04	92.7
Round 3	HIV / TB	Department of Economic Affairs (GOI)	State AIDS Societies	Reducing TB morbidity in PLHAs and preventing further spread of TB, HIV in high prevalence states	Jan-05	14.82
Round 4	HIV&AIDS	Department of Economic Affairs (GOI)	National AIDS Control Organisation and State AIDS Societies (treatment)	ART delivery in 6 high prevalence states and Delhi	Sep-05	122.67
		Population Foundation of India (Civil society consortium 1)	Confederation of Indian Industries, Network of people living with HIV, Freedom Foundation, Engender health society	Access to care & treatment in high prevalence states	Apr-05	18.2
Round 5	Not approved for funding					
Round 6	HIV&AIDS	Department of Economic Affairs (GOI)		Expanding access to ARV, testing and counselling (all states), community care centres	Oct-07	214.17
		Population Foundation of India (Civil society consortium 2)	Catholic Bishops Conference of India, Constella Futures India, Network of people with HIV	Promoting access to care and treatment (8 northern states)	Jun-07	30.6
		India HIV/AIDS Alliance (NGO consortium 3)	5 NGOs in Andhra Pradesh, Delhi and Tamil Nadu	Scaling up care and support services for children	Jun-07	14.38

Round 7	HIV&AIDS	Department of Economic Affairs (GOI)		Strengthening systems (human and institutional) capacity	Jun-08	87.8
		Tata Institute of Social Sciences		Strengthening institutional capacity for counsellor training institutes		
		Indian Nursing Council		Strengthening institutional capacity for nurses training		
TOTAL FUNDS APPROVED FOR INDIA						595.34
Table 5: Details of GFATM grant rounds in India						

Source: Compiled by the author using information from the Global fund website. The green highlighted area represents the focus of investigation in the research

The Principal recipient and Activities columns illustrate the shifting allegiance of partners and disjointed activities. Programme components proposed in each round stand isolated from previous rounds. However, considerable overlap can be observed between activities of different partners and institutions created. Either new concepts of care and support were introduced or previously established concepts modified to demonstrate 'innovation', a recurrent and striking feature with respect to the Fund activities in all narratives. A case in point is round four where an NGO led five member civil society consortium proposed a series of care and support interventions focusing on six high prevalence states. It had deliverables corresponding to counselling, care, follow up and network building for people with HIV. Prior to the Fund's entry, 10 bedded community care centres were being run by NGOs, independently or aided by the government. The consortium instead proposed a "more comprehensive understanding of care and support" through 50 bedded centres. Three such centres were to be set up in the first two year phase of round four.

However, once the grant was approved, the consortium faced difficulties in setting up these centres and in enrolling support of all stakeholders, particularly the NACO, for the 'comprehensive care' model. In the subsequent round, therefore, while the proposal for scaling-up its activities to other states of India was accepted (and the NGO was re-inducted as the PR for the next round), the consortium, which now comprised of newer partners, witnessed a gross reduction of its activities. The comprehensive care model was abandoned and the consortium was given the responsibility for setting up a fixed number of care centres on the lines of the earlier 10 bedded government model. Meanwhile, another Delhi based international agency leading an independent consortium became the third recipient for that round with proposed focus on children.

“Round 6 is different from Round 4. Although it is an expansion [of our work] from high prevalence states to vulnerable states, certain components have been changed. The TCC and comprehensive care centre are withdrawn. Instead, NACO’s model of care centre is endorsed. What constitutes ‘comprehensive’ is debatable. Our partner organisation [responsible for the comprehensive care component] has a fair perspective on it and plays an advisory role internationally but others differ in their view point”. (Senior project officer, Civil society consortium)

Justifying their decision to modify the interventions proposed by the NGO consortium, a senior public sector bureaucrat argued that multiple

interventions were leading to duplication and as a result, the national programme lacked uniformity.

“If other partners are implementing a scheme which we are also implementing, there should be some uniformity. That is why we developed official guidelines for CCC which should apply to everybody. Across the country, CCC should receive the same level of assistance irrespective of which pocket the money is coming. Project is the same, so why should there be a difference?” (Senior public sector bureaucrat, Principal recipient)

Reflecting on the impact of having multiple interventions and providers within a national programme, a senior bureaucrat in the state division of NACO expressed, *“all these separate rounds and overlaps between them lead to confusion and chaos at the implementation level”*.

While previous rounds remained open, new ones continued to be developed around each call for funding without generating consensus or apparent learning building on previous rounds. Not surprisingly though, there were simultaneous discussions on integrating and synergising different rounds in accordance with the *harmonisation* principle of the Fund.

“Although I don’t think there is a clear possibility there, the Fund is considering maximising its impact with respect to the resources going into the field. These are proposals which have been approved and already in

place. There cannot be a direct linkage between round one to the present because all the rounds are radically different from each other. I don't see how you can actually connect them". (NGO, national committee member)

4.3.2 Partnership rupture

4.3.2.1 Issues of disengagement and disruption

The grant from the Fund mandated the setting up of a range of different models and sites for service provision, often as *deliverables* of each phase, in the identified states. Round four in particular marked a significant shift in the fund organisation and governance at the country level. In prior rounds the government was the sole recipient of the grant with the NACO as the main implementing agency, or operational principal recipient. As described earlier, the Fund's demand for a stronger representation of the civil society in the India CCM compelled the endorsement of a NGO led civil society consortium as the second principal recipient for the grant.

The *public transcript* for round four (evident in the proposal approved by the Fund) reflected a complementary effort by different stakeholders including the corporate sector (companies and business houses), government, NGOs and network of people with HIV. The government's mandate is to provide treatment while the civil society component is aimed at improving the access of people with HIV to treatment, providing care, and support. The government component included (1) ART roll out centres housed mainly in

select public hospitals and, (2) 10 bedded community care centres that were sub-contracted to NGOs. The consortium led programme included a number of service delivery points, trying out different models of palliative care, support, and adherence education. These included (1) positive living centres, (2) treatment counselling centres, (3), setting up district networks of people with HIV, (4) 50 bedded care and support centres and, (5) corporate run treatment centres. The first three components were the mandate of the network of people with HIV. The main objective was to strengthen the *demand* (by generating awareness through community based interventions) and *supply* (providing counselling, palliative care, and other support services) and address the gap by linking the two.

However, in practice, the link between different components was very weak and activities developed as multiple service delivery points with little demarcation of roles and increasing conflict among interests. Each partner set up separate project offices, both nationally and in target states, with its staff organised into specialised “divisions” dealing with sectoral activities. The focus, as revealed in the discussion with the co-ordinators at the project offices on their perceived roles, was to ‘oversee’ progress and gather support of the stakeholders. This enabled the project managers to gain legitimacy for activities by developing appropriate ‘professionalized’ accounts and rationales for them. Different views on the project, its rationale and significance implied increasing disagreements on competency of partners and the perceived value that other components added to the programme.

These became constant sources of distrust and tension between government and non-government partners. These issues are further teased out in the following case study in the context of the round four activities of the Fund programme.

Case Study 1: A tale of two centres

An observable locus of this tension was the interface between the civil society consortium run treatment counselling centres (TCC) and government run Anti Retroviral Therapy (ART) roll out centres in public hospitals. In the proposal to the Fund, the TCC was envisaged to cover the gap between treatment centres (supply end) and communities accessing them (demand end). The proposed intent was to minimise dropout rate and strengthen treatment adherence by providing 'post ART adherence' counselling on clinical and non-clinical aspects, and engaging in community outreach and follow up through the district level networks run by people with HIV. However, in the rush to hand in the proposal (which has been elaborated in section 2.1 of this chapter) there remained several unresolved issues where a consensus was not reached. These included agreement on where the centres would be located, who the TCC staff would be accountable to, how the counselling undertaken at the TCC will complement (and not duplicate) the ongoing counselling at the ART centre, and how documentation and reporting burden would be shared between the two centres.

A strong resistance to the NGO activities was observed among the public sector bureaucrats, mainly the senior officers at the national and state divisions of NACO and providers at the public hospital where the centres were located. Drawing attention to the abundance of counsellors and other staffs at various government prevention and treatment set ups, the bureaucrats argued that TCC added little value to the programme.

“Rather than using VCTC [voluntary counselling and testing centre] counsellors which are more in number, you want to depend on some TCCs and expect them to go to the field which they hardly do. Some places you have TCC counsellors, other places you don’t. It is leading to confusion. I visited few centres... they just depend on our information to write reports and are not actually going out to do any outreach.” (Senior bureaucrat, State division of NACO)

The general opinion of these stakeholders was that the network of people with HIV, the implementing agency for TCC, was interested only in demonstrating numbers to the fund. A senior medical officer and ART centre in charge claimed:

“...these organisations were not doing anything worthwhile but are forced upon us. They got funding, started networks and are only interested in building those networks.”

A senior project officer at the State division of NACO reported that consortium activities such as treatment counselling were overburdening patients, mandating them to visit two or three counsellors in a single visit to the hospital. The respondent clarified:

“these patients are often poor and come from distant villages. They are unable to complete these time consuming procedures”.

The consortium members, on the other hand, highlighted the strong resistance that NGO initiatives faced from the public sector employees, mainly the front line providers and administrators. Directing to issues operating at the micro level, the consortium members argued that medical officers and counsellors at the ART roll out centre were not cooperative. On grounds of confidentiality, they often did not share names and records of patients with the project workers in TCC. Lacking the vital information essential to enrol patients into district level networks, the project workers (in this case, the employees of the district network for people with HIV) reported their inability to follow up patients and/or undertake counselling to ensure adherence to treatment. Fearing non-performance and inability to demonstrate impact to the Fund, they devised various strategies to increase enrolments. These included providing free nutrition package, accompanying people with HIV for testing and treatment, developing a new cadre of outreach workers: *peer treatment educator* to follow up people in the communities, among others.

“Sometimes there are ego problems with doctors but mostly counsellors. They don’t give lists or information on the patients. They don’t allow us to sit in the treatment centre... But we have to maintain targets. A network member stands outside the treatment centre and...brings them to TCC. That’s how we get our clients. We cannot give individual counselling because there are more than 300 follow ups every day. We link them to our networks instead”.

(A project worker and network member, Consortium led TCC)

Examining the roots of disharmony: the macro factors underlying the textures and tensions within the micro processes

Underlying the varied conflicting accounts of the description of the environment in which service provision occurred were issues of control and authority: lack of a clear chain of command, lack of clarity on roles and work division, and above all, the authority of the Fund protocol. The tensions seemed to threaten the administrative and professional legitimacy of the actors derived from the power and resource asymmetries between state run and consortium run centres.

There was a growing resistance to TCC activities because the public hospital and ART centre staff felt that even though they were technically more qualified and trained than the network TCC staff, the latter were better rewarded in terms of salaries and enhanced working environment (computers, separate office and counselling space).

“They started saying ‘we don’t want the TCC. They are making our lives miserable. Whose computer is it? Is it the doctor’s or the counsellor’s? If I don’t have one, how can the counsellor?’ The computer is there to manage and enter the data. These are petty issues but they do come up. If there is good mutual understanding, symbiotic relationship occurs otherwise it [the partnership] is a parasite”. (Senior officer, network of people with HIV)

This friction can also be attributed to the failure to address accountability and hierarchy issues arising from the burden of procedures and technical reporting. The Fund’s reporting protocol demands a large quantum of information and statistics in forms such as consolidated reports, forms/patient cards and documentation registers. Visits to public hospitals revealed that on an average, 250-300 patients visited treatment centres daily. Most counsellors and other support staff (social worker, pharmacist, data entry operator) were expected to complete this task alongside their primary responsibility of counselling clients individually and in groups to encourage treatment adherence and improved lifestyle. As a result, most provider-user interactions observed at the centres were restricted to information sought in the form.

As stated earlier, commenting on the value added by the network of people with HIV, the public sector (NACO and its state divisions) bureaucrats claimed that the TCC staff was preoccupied with documentation at the cost

of their primary responsibility of outreach. In response to this, a state officer of the consortium expressed:

“Of course that’s happening...A funding agency asks how many people are counselled. If I’m paid 8 or 10K per month, I have to show some work. If the system is not set in place and there is no coordination, I will definitely write up. But in some places, counselling is also happening”.

The *authority of the protocol*, and the resulting bureaucratic burden, pre-occupied staff at the service delivery points with record keeping, data entering, and report generation. At the same time, it reinforced *professional* hierarchies which regarded the people with HIV suitable for clerical work of maintaining records and not qualified enough for jobs like counselling. Evidently, the global discourse around *greater involvement of people with AIDS* (GIPA) had not penetrated the implementation level. As a result ART-TCC interface emerged as a site where power could be exercised in order to legitimise one intervention over another.

“Some ART centres consider the TCC staff subordinate and want to control and use them for their own work...assisting doctors, filling registers, performing menial jobs. When they do not comply they decided they will not let them be in the premises.” (Senior officer, Civil society consortium)

One of the factors most commonly mentioned was the “mindset” or “attitude” of the staff at the public hospital and ART centre.

“It is a question of mind set. TCC is a place where we have 3 counsellors to support the treatment roll out. The whole issue is with the medical officer at the public ART centre. If his mindset is positive, things are working very well. Places where TCC has failed, the onus is more on medical officer than the counsellor. They have not tried to integrate it into the system.”

(Senior officer, Civil Society consortium)

Public ART roll out centres and network run treatment counselling centres that were able to arrive at some level of understanding and work harmoniously had reached a consensus that the ART in-charge (usually the head of the speciality in the public hospital to which the treatment centre is attached) would hold the chain of command and delegate responsibilities. This often implied that TCC counsellors would share the burden of completing register entries of patients coming to the treatment centre.

The senior project officers and managers of the consortium play an important role in achieving the state of “harmony” or acceptance of the status quo. Mediating between the discursive construction of partnership and the differing local perspectives, they present the public sector bureaucrats and service providers as having a particular mindset that leads them to manipulate their environment in order to gain authority and serve their

interests. While this authority was resisted at one level, an internalisation of and compliance to the State's authority was also observed among the non-government respondents at another level.

"I don't blame SACS [state division of NACO] for this. The attitude of the TCC staff should change. Even though it is a separate entity with separate finances, they should not feel that they are different. You can't get patients if you don't work in coordination. The medical officer is the head of the centre. When you are placing the consortium's counselling centre under the government treatment centre, what is the problem in accepting their directions?" (Project officer, Civil Society consortium)

The ad-hoc marriage of arrangements between different stakeholders at the centre and its top-down and vertical implementation was counterproductive to the programme. The factors outlined above and the resulting conflict between the public hospital staff (medical officers and counsellors) and the employees of the consortium led counselling centre (TCC in-charge and counsellors) contributed to chaos at the antiretroviral roll out site. This had significant impact on the quality of counselling, follow up, and consequently adherence rates.

Case Study 2: The business sector and HIV

Another ambitious component of the Round 4 project proposed by the civil society consortium was involvement of the corporate sector, businesses and

industries. The corporate representative in the consortium was responsible for facilitating the setting up of ART roll out centres by private companies. Under round 4, it was given a deliverable of 10 such treatment centres. This raised the profile of the project and the consortium considerably with the Fund, and as reported was the basis on which the proposal was accepted. The slow progress however, became a point of contestation in the partnership.

Initial efforts and constant dialogues with companies made little progress and proved resource intensive since the companies were not willing to make a long term investment. Hence, once the grant was received the corporate representative entered into negotiations with the NACO to provide antiretroviral free of cost to companies.

*“The first two years we did not have any deliverables to show. Other partners do not understand that it is not only the centre but the entire process behind it. Putting a positive person on ART increases the longevity of life. This implies an increase in **n** number of years of commitment. In order to make industries take up this cause we need to cut the **n** barrier. With such state-of-the-art centres established and tests provided, it is not possible to also provide drugs.”* (Corporate representative, Civil society consortium)

Eventually the terms were re-negotiated such that targets were met at a lower cost to companies and the resulting burden shifted to public sector

resources. As per the new agreement entered with the NACO, the government provides anti retroviral and opportunistic infection drugs¹³ for the general population while companies cater to their workforce and contributed to the infrastructural costs.

The corporate representative's decision to "bring NACO on board", as shared by a respondent, was based on two factors. First, as explained above, reducing cost to companies, and second, to facilitate the process of setting up centres which required accreditation from the national body. Getting approval from the national AIDS organisation meant not only bypassing some of the bureaucratic hurdles experienced at the state level, but as reported by a company respondent, also resulted in treatment reaching out to a higher number of people. Prior to getting the NACO on board, only clients presenting with severe symptoms were being put on ART.

"Since NACO is giving drugs, we have gone for more patients. When we started with our own drugs, not all were given antiretroviral. Earlier, only those who had less than 6 CD4 count, were immediately put on anti retroviral". (Project officer, Corporate centre)

However, new 'partnership' also meant newer issues of conflict between the two constituencies. Conflicting accounts emerged for the decision making process and the delay in achieving the deliverables by the corporate sector.

¹³ At the time of field studies, provision of lab reagents was also being negotiated with the NACO.

The corporate social responsibility department and the company nodal officers were unaware of the negotiations that occurred in the higher management who, despite repeated attempts, I did not get access to. In spite of the lack of information (and transparency), rationalising accounts were subsequently developed for the decisions taken with regards to the location, management and other aspects of the centre. These decisions and their implications for the programme are discussed below.

The two corporate ART centres that were operational during the study were stand alone i.e. not attached to company hospitals, a decision reported to be taken by companies to protect themselves from any repercussion of the programme such as compensation issues arising from an AIDS related death in the company hospital. One of the centres was independently registered as a trust and was situated outside the compound, on the main highway. The other centre, functioning under the company's name, was set up as an independent unit in proximity to the company hospital.

“Companies set up trust to do corporate social responsibility only because if they do it under Industry's name then in case of a health programme...if you gave a drug and the patient reacted and died, one has to compensate. I feel that industries fear a lot of things that are not likely to happen. In reality, no one is saying that since you started the ART centre it is your responsibility to compensate if someone dies because everyone knows that HIV is a disease

is terminal and therefore it is only a matter of longevity.” (Senior management, Partner Company)

The human resource and management considerations were responsible for the initial lag phase in setting up and running the company ART centres. In addition, corporate representatives attributed this delay partly to the interference by the NACO in identification of sites, and communication gaps between the centre and the state divisions of NACO.

“When NACO team came to do the assessment of the centre they had a big objection to the centre not having in-patient provision. They did not have clarity on how a company hospital works. It took us a lot of time to convince the district officials that the centre will only work on an out-patient basis and patients will be referred to the district hospital which has good facilities. Keeping the people with HIV in the hospital becomes an industrial relation issue.” (Corporate representative, civil society consortium)

“...there is a big gap between the NACO and its state societies. NACO decides on a centre but the SACS are often not willing to set up, they do not see the need...the link is very weak”

Moreover, a high level of competition was observed between the two service delivery points - government ART centres in public hospitals and corporate

ART centres - as both constituencies needed to demonstrate 'numbers' in their respective programmes.

"We identified a charitable trust hospital to set up a corporate centre. When we were about to sign the MoU, NACO rang us to tell we should not go ahead because they are setting up theirs in the same district. However, the hospital in-charge of the district said he is not interested in setting up the centre and did not want to get into this hassle with NACO. We went back and forth but till the end the district officer did not know why the centre was being imposed on him." (Corporate representative, consortium member)

"The problem is that the government is due to start an ART centre in the district. So, numbers will definitely be a challenge. But we will focus on giving good quality services (lifestyle change, counselling etc.). Once we get the reagents from NACO, all patients will be tested here. We could use our skills and motivate them to come here for ART... after all that is a government hospital. The clients will start ART wherever there is good service."

(Project officer, Corporate centre)

This also induced a dual system of 'free' and 'paid' services under the same programme since corporate centres charged a subsidised amount for HIV testing, laboratory tests and CD4 counts while at the public hospitals, this was free.

Furthermore, the new relationship with NACO also affected the ongoing partnership among the consortium members resulting in friction within the principal and sub-recipient relationship. This was primarily because, as shared by a consortium member, much of the negotiations were undertaken bypassing the principal recipient NGO and its authority.

“While it was earlier agreed that antiretroviral will be procured by the companies, they [the corporate sector] have expressed their reluctance in doing so. They are negotiating with NACO directly to provide antiretroviral for the general population while they cater only to their workforce. Therefore the corporate component has been much delayed. And since it is a component of our programme, the non-performance is reflecting on the entire program.”

(Senior officer, civil society consortium)

As the corporate component stood at the time of the research, it seemed to contradict the main rationale behind involvement of the commercial sector in the partnership as it shifts the cost burden onto the public sector while adding no additional value to the programme. Firstly, while companies do invest in setting up and running costs (infrastructural and staff salaries) of the centre, this investment is tiny in comparison to the recurrent costs of drugs and reagents the government is expected to bear. Secondly, the observed staff to patient ratio in the treatment centres in public hospital and corporate sector was disproportionate. The centres in the public hospitals that I visited had on an average 1500 (and in few cases over 3000) people on ART enrolled

catered to by one to two medical officers, a pharmacist, a staff nurse, a counsellor and a lab technician. However, in most centres few posts were vacant, thus adding to the workload. In contrast, the corporate centres had adequate staffing, a beautiful infrastructure but very low patient load (Refer photo 1 and 2).



Photo 1: Public ART centre



Photo 2: Corporate ART centre

“Right now there is only one person on ART, that too on 2nd line. So, not getting free ART will not dismantle the programme.”

(Project health worker, corporate centre)

Moreover, the corporate centre model does not align with the model of public antiretroviral roll out where centres are housed in and attached to district or referral hospitals ensuring access to inpatient services required prior to and post treatment such as testing and pre test counselling. This implied that if the patient accessing the corporate centre was in an advanced stage and required treatment or admission, s/he would be referred to a private clinic or the government hospital despite the physical barrier to access.

“We do not have ICTC [testing and counselling centre] service in ART. It is in a rural hospital 2 kilometres away, or at a centre 20 kilometres away, or at the district hospital. We don’t intend to start it. For HIV testing we were

depending on these people from day one of the programme. That's how working with government was from the beginning.” (Project worker, corporate centre)

4.4. Discussion: Points of departure

In the course of implementation of the Fund rounds, transition from one to another marked a shift in allegiance of ‘partners’ as their importance and value to the partnership and, others’ dependency on them grew or lessened. Given the performance oriented nature of the Fund, efficiency in absorbing funds and demonstrating results became the primary aim and was seen as a significant factor shaping the relationship between organisations. New organisations were partnered to make up for the lag phase in meeting deliverables for each quarter of the project period, while existing partners broke away to form newer and independent alliances in successive rounds. Of the five organisations that came together to form the NGO consortium in Round 4, only two continued to partner in Round 6.

The shifting allegiance can be attributed to the competitive environment triggered by the Fund *governmentality*, a result of which is the emergence of several parallel and competing projects aspiring for the same pool of funds, clients and legitimacy. The evidence presented in case study 1 (under section 4.3.2) suggests that neither funds nor activities of each grant round have surety of sustenance. In this environment of uncertainty and competition, organisational and individual survival becomes paramount.

Pfeffer and Salancik (2003) argue that one of the key determinants of organisational survival is its ability to acquire and maintain resources. The process of developing the country proposal, as described earlier, substantiates this argument. Organisations with better access to information and technical 'expertise', greater visibility, and links *outflanked* local groups in securing grants. However, once the grant is approved, maintaining and acquiring further resources in order to ensure sustainability are dependent on the demonstration of success or effectiveness.

The Fund governmentality renders an organisation effective if it is able to manage the demand of timely and structured reporting as well as the needs of the dominant partners. The decisive force directing which organisations continue to partner in successive rounds and which fall out, is the perceived value and legitimacy its activities are able to generate among the influential stakeholders. The network for people with HIV, for example, was a valued partner for the consortium in round four since it had seven of the nine deliverables that were the consortium's mandate. Hence, even though some of its activities (such as the TCC) were disbanded, the network was again partnered with in round six while others discontinued.

The performance based disbursement of funds has led partners to focus exclusively on demonstrating their effectiveness by meeting extensive and rigid reporting requirements of the Fund. At the service delivery sites, which are characterised by high patient load, poor infrastructure and lack of human

resources, this exclusive focus on documentation has manifested in a lack of quality services such as counselling and over-stretched the capacity of already weakened systems.

An effect of the fragile and uncertain environment presented in the case studies is that constituencies collaborating on one front are competing on other, making claims on their achievements and counter claims on the other's ability to deliver quality service. In the absence of a proper supervision system worked out, it further triggers an environment where all attempts for coordination and evaluation present themselves as battlegrounds for shifting responsibility for non-performance. The following quote by a senior programme manager explains the consequence of this lack of supervision, calling for more integration of services.

“The question arises when the government says treatment adherence rate is very low. If the country has a programme with so many people and offices, then why is adherence so low? One counsellor or outreach worker cannot make all the difference. A concrete system is required. And unless the programme is integrated it will not be so. How long can you run a parallel system? Where are the community health workers from other programmes? Why cannot they be given the responsibility of supervision? We need someone closer to the population, taking care that drugs are being taken correctly”

4.5 Conclusion

The chapter illustrates how the Fund institution (structures and processes), has led to creation of new and unaccountable organisations which take a life of their own, competing with each other for resources such as funds, patients, and drugs. It argues that this new and 'potentially vertical financing mechanism' (Brugha et al. 2004) instils an environment where the ideas shaping the discursive notion of public private partnerships are subsumed by competition for resources and increased tensions between different stakeholders over individual roles, control of funds and legitimacy.

Processes of decision making are increasingly situated within this complex and hierarchical setting. Partnership arrangements are forcibly (and centrally) developed and actors are brought together, in an arbitrary manner, in response to the yearly launch of the Fund rounds. These arrangements are forced upon sub national levels without clarifying the intent and addressing power dynamics and resource allocation among partners. As a result, in this context, partnership arrangements act as an instrument for expanding technocratic control, advancing organisational interests, co-opting critical discourses, and shifting, if not contradicting the purpose with which they were initially set up. The *public transcript* of the Fund, as described in chapter 1, abdicates its role in the country level operations. However, as observed in this chapter, the structures and ideas with which the Fund operates in India significantly regulates the environment in which the programme is 'steered' thus conditioning its operation as well as effects.

Multiple structures or *frankenstein's monsters*¹⁴ are created in the pursuit of programmatic goals and deliverables. Once created, structures break away and in an attempt to survive in an intensely competitive environment make claims on their achievements and counter claims on their partner's ability to deliver. In this state of chaos (despite fragmentation, resistance and compliance), the Fund brokers (including the aid recipients, Fund bureaucrats, project managers and workers) are constantly creating "order". They construct and manage the partnership milieu by enrolling and juxtaposing both human *actors* and non human *actants*. The brokers build coherent representations by *translating* the protocol of the Fund, and the *technocratic* and *neo-liberal* discourses underlying it, into individual and collective objectives. The legitimacy of their own role is derived from and dependent upon the conformity of multiple stakeholders to the dominant discursive construction of the partnership phenomenon.

This chapter is in agreement with Crawford's (2003) analysis of how "partnerships are permeated by relations of power" (2003:145). It illustrates how power is wielded through the control exercised by direct as well as diffused agency. The latter operates through the creation of subjectivities by having exclusive governing structures, controlling agenda setting, and maintaining information asymmetries.

¹⁴ I use this terminology in a forthcoming paper as a representation of the contingencies of the practice of global discourses in development. I argue that once institutions and programmes are brought to life, the drive for identity and sustainability overpowers the initial rationale with which they are set up, a case of development run amok.

Chapter 5

Re-emerging and translating ‘Civil Societies’:

Examining the interpretive communities

“Big agencies want to do everything, everywhere. The small have no role.

And there are too many overlaps.” -Project officer, State division of NACO

5.1 Introduction

In the previous chapter, I discuss the contingencies of practice and plurality of perspectives on the public-private Fund arrangements operational at the country level. Despite the tensions and conflicts visible in the practice, the Fund, as a model of public private partnerships is gaining prominence in global and countrywide health financing and provisioning debates. The previous chapters suggest that this is due to the interaction between the structural and ideational factors that shape its discursive understanding and constitute the actors and their practices. In this chapter, I focus on the interpretive communities, which are described earlier as playing an important role in stabilising the Fund order.

The Fund lays claims on transforming country level governance given its stipulation of greater involvement of the ‘civil society’ in setting priority and

managing grant processes. This decision could be partly seen as resulting from a growth in the scale and policy influence of the civil society globally, underlying which, was a growing mass resistance to an 'undemocratic functioning of government bureaucracies'. As discussed in chapter one, the setting up of the Fund was also partly legitimised by a mobilisation around the demand for a greater participation of the international community of people with HIV.

Despite the shared enthusiasm for a participatory mode of governance, not only does 'civil society' remain loosely defined and poorly understood, the evidence base examining its organisation and claims to legitimacy, continues to be thin. In this chapter, some of these claims and processes are examined in the light of a growing presence of 'civil society' in the country level processes of the Fund in delivering the national AIDS programme.

Unpicking this central idea around which the discursive notion of the Fund is built, I examine how it is used to legitimise the involvement of certain influential actors, and promote and obscure certain practices and interests within the Fund programme. Referring back to the first and second theme identified in chapter two (role of ideas and protocol in creating the interpretive communities required for stabilising the Fund system), I examine the constitution of actors, the diversity of interests and power relations within, and the processes with which claims are made and credibility established.

5.2 The role of the ‘civil society’ in global governance: a development discourse

In recent years, civil society organisations have come to play a prominent role in global health governance (Loewenson 2003, Dodgson et al. 2002, Frenk et al. 1997). Their growing involvement in global health initiatives has facilitated their role in decision making, through membership in consultative forums and, in implementing programmes as a direct recipient of grant. Their increasing share within the aid market is accompanied by a growing legitimacy that has enabled their movement beyond support services into the realm of provision and financing.

The AIDS ‘industry’ in particular has opened up spaces for active participation and mobility of the non-state actors at large, and the ‘affected’ communities specifically. The fight against HIV and AIDS mobilised tremendous financial and political support and also marked a shift in investments in health, from infrastructural support to funding disease specific initiatives with emergency, short-term goals, and often unsustainable results (Schneider and Garrett 2009). Policy papers, mission statements, guidelines and numerous other documents of international development and national government agencies unequivocally seek civil society representation and participation in disease control programmes.

The meaning of the term civil society has always been fuzzy. Salemi (2006: 103) refers to it as a “heterogeneous list of institutions and practices in

the public arena including media, universities, labour unions, civic and professional associations, social movements, religious institutions and NGOs in all their forms”.

Although the civil society remains loosely defined, the rationale for its involvement is built on three premises – i) wider and more democratic representation of people’s voices (particularly those affected) within structures of global governance ii) comparative edge over the government in delivering services given its outreach and presence in the very ‘communities’ the programmes target (Doyle and Patel 2008) iii) balancing out the growing influence of markets and reinforcing public interest roles of states (Labonte 1998). Apparent from the above rationales is the rhetoric around the concept that sees civil society as essentially a ‘good thing’, whose promotion can enable ‘democratic’ and ‘good’ governance. This is expected to enhance efficiency and accountability, balancing the power of the state and the private sector (Fisher 1997).

A significant body of literature exists around the piecemeal attempts of policy models and approaches to decentralise governance and devolve power to the civil society. Likewise, evaluations of the Fund and other global health initiatives suggest that the State continues to play a dominant role in policy making and implementation in most developing countries. These tools and observations establish what Schmidt (2004) refers to as the *logic of necessity* or need for a greater involvement of civil society (Bhattacharya and Dasgupta

2009, Winters 2008:11) at the global and national levels. However, little analysis is undertaken on the type of organisation whose involvement is sought at the policy level, the kind of organising and expertise required from them, and, the processes of political action with which their claims are accepted or rejected.

In this chapter I seek to address these gaps situating the findings within the broad framework (as outlined in chapter 1) that has informed the development of this research. Specifically, the chapter seeks to address the following questions.

1. How does the Fund re-constitute civil society actors (i.e. specific formations, configurations and expertise required) in the AIDS 'industry'?
2. How do the actors in turn reproduce and legitimise the rationales and practices?

The chapter is divided into three sections. In the first section the characteristics that define the AIDS 'industry' are explicated with particular reference to the social actors that constitute the landscape. The disciplining regime of the Fund is discussed next by drawing on the case of a network of people with HIV and AIDS. The case study examines the path followed by a project cycle and the subjectivities and interpretive communities it creates in the process. In the final section, I examine the impact of the Fund

governmentality on the 'civil-society' by drawing on case narratives of two organisations with varying degrees of power and agency within the AIDS and the development industry, highlighting the strategies they adopt to 'negotiate' in an environment of intense competition.

5.3 The nature of AIDS *industry* and a growing 'civil society'

The term 'industry' is increasingly used to refer to the HIV and AIDS sector. This is primarily based on the development of an unprecedented private-public industrial complex around a single disease (Rennie and Mupenda 2008) characterised by fluctuating figures (as discussed in chapter one: section 1.5.1), escalating prominence within donor agendas¹⁵ (MacKellar 2005) and a disproportionate worldwide spending. Global spending on AIDS has witnessed a stupendous growth and was estimated at USD 19.8 billion in 2009, twice that of the total spending in 2007 (Kaiser Family Foundation 2009). Another striking feature of the industry is the multitude of players seeking a share in these resources— national governments, international development agencies (multilateral and bilateral), academics and researchers, and non government and community based organisations (NGOs and CBOs) working with or representing specific 'communities' that are labelled or, have begun to self identify, in the course of their interactions with the AIDS industry (See Khanna 2009), as "high risk" or "vulnerable

¹⁵ Also see Gomo, M. (2009). *HIV/AIDS- A booming industry*. Gomo, an independent development communicator in Zimbabwe and South Africa, refers to the industry as the most lucrative and fertile sources of donor income. He also highlights concerns related to the size and over prioritization of the AIDS industry as a stand-alone "business" disconnected from the wider public health system.

populations”. These include, for example, Men having Sex with Men (MSM), Drug Users (IDUs) and Commercial Sex Workers (CSWs). The business sector which was earlier seen as an adversary to fair pricing of drugs including ARV and ensuring universal access to affordable medicines, has now witnessed a transition in its role: from supplier of drugs to a ‘partner’ in expanding access to medicines, building new markets through infrastructural support, and prevention and treatment programmes (Caines et al. 2004, Kettler et al. 2003). There is yet another cadre that the industry serves: the cadre of ‘consultants’ or brokers who circulate in the industry based on the ‘expertise’ sought. In the previous chapter, I briefly examine and discuss the role of these brokers in facilitating Fund processes in India and translating the project rationale into different institutional language (section 4.2.2.1). I build this argument further in this chapter.

These diverse players, as active agents in the industry, are organised in a particular fashion, speak the same language seen as emerging from the intersection of the language of the market (contracts, efficiency, performance indicators, and consumption) and the political language of “communities”¹⁶ (Rose 1996:331), plagued by acronyms around interventions and services (TI, ICTC, VCTC, ART), governance mechanisms (CCM, TRP, TRG) and the ‘risk’ communities (CSW, MSM, IDU). This enables their movement within the industry (across and/or within constituencies and nations) to more

¹⁶ Nikolas Rose (1996: 331) regards the language of community as a significant (morally invested) thought of contemporary political rationalities exemplified through the vocabulary of community care, community workers or the idea of at risk ‘communities’ (gay, drug users, sex workers) carrying particular genes.

influential and rewarding positions or employment opportunities. The findings of my research substantiate the above statement. For example, a few senior managers of Fund projects and other international partner institutions who were interviewed were former public sector bureaucrats. There were also instances of project staff (outreach workers, counsellors, social workers) at various levels in the programme chain circulating among development projects and organisations.

Literature and field experience highlight the emergence and growth of the AIDS *movement* as one of the most distinctive features of the AIDS politics and industry. Historically, several movements, particularly the feminist health movement, have been at the forefront of challenging the bio-medical hegemony over patient's bodies, putting patient-provider interaction centre stage of medical ethics. The AIDS movement, however, is argued to be the first social movement to engage with bio-medicine in a manner that has transformed the affected or the "victims" into "activist experts" (Epstein 1996). Shaped around an identity based on the embodiment of the illness, the movement is highly significant for the cultural redefinition of interactions between medical or technical 'experts' and patients or 'lay' consumers. The AIDS movement therefore cannot be regarded as merely a "disease constituency" advocating for affordable treatment and more resources but, as Steven Epstein (ibid:8) puts it, an "alternative basis of expertise".

The movement(s) itself is broad based and includes organisations or networks that work with and represent 'communities' stigmatised on the basis of either getting tested positive (people with HIV) or engaging in practices defined as "high risk" in the bio-medical and epidemiological understanding of the epidemic.

Finally, the national AIDS programme, like in many other middle and low income countries, is a vertical disease control programme with a separate organisational structure, administration and budget provisions, enjoying a certain functional independence from the broader public health system. The control lies with the National AIDS Control Organisation (NACO), an agency of the central government, which is responsible for formulation of the national policy and guidelines, technical guidance, evaluation research, procurement of test kits, drugs, equipment such as the cd4 machines and others. As described in chapter one, the national policy is implemented in states by the State AIDS Control Societies, which enter in an agreement with the NACO through a Letter of Understanding (LoU). The state divisions are officiated by senior bureaucrats who are deputed by NACO for brief tenures. In recent years, a striking feature of the national programme has been the 'territorial divide' within states whereby provision is not restricted to a defined territory of the public sector. Instead, clear physical and geographical demarcations can be seen, where agencies set up with foreign aid (such as those described under the concept of agencification), are responsible for provisioning in a particular region.

“In Maharashtra there are three types of services [provider] and districts are divided between them - MSACS [Maharashtra State AIDS Society], Avert, a USAID collaboration, and MDACS for Mumbai district. Some districts...are managed by Avert and the rest are managed by MSACS. Drop in Centres and CCC [Community Care Centres] which is the care and support component is divided [among the two agencies].” (Senior bureaucrat, State division of NACO)

“To prevent duplication, Avert and BMGF [Gates Foundation] earmarked districts and were told to look after the programme for seven districts each. BMGF has a few districts especially for targeted interventions with sex workers etc. Avert has nine care centres and a lot of care and support projects. Avert will now be a technical support unit for Maharashtra while MSACS will only be the implementing agency.”(Senior project officer, State division of NACO)

These developments are an outcome of a parallel and growing trend of what has earlier (in chapter two) been described as ‘agencification’ of state entities. As discussed in chapter two and four, these structures compete with the state and other non-state actors for the same resources (financial, human and other) and programmes. With better access to skills and expertise, a relatively small scale of operations, and greater operational flexibility, they tend to outbid the State agencies in receiving grants and demonstrating

effectiveness. An outcome of this, discussed in the previous chapter, is the birth of multiple projects running on different pay scales within the network of people with HIV. This has enhanced the re-distribution and re-organisation of actors within the network and produced friction between the government and non-government agencies. Another manifestation of this divide could be observed among the state employees who reported a sense of loss of control over programmatic outcomes since the parallel agencies had a bigger mandate and thus wielded more power.

“Big agencies want to do everything, everywhere. The small have no role. And there are too many overlaps. KHPT [a partnership between Gates Foundation and State AIDS Society] is implementing in 18 districts, State Society in 9 districts. So, clearly they have an upper hand. Some NGOs get direct funding from them, so they don’t feel accountable to us, do not share reports.” (Senior project officer, State division of NACO)

Having described the AIDS industry and the trends/ developments that characterise it, I now discuss how the Fund governmentality mediates these spaces and the intersubjectivities it creates among actors in this course.

5.4 The disciplining regime of the Fund

In this section I examine one of the many non-state actors involved in the Fund programme whose presence has great significance for re-defining the role of ‘civil society’ in India: the network of people with HIV. While currently

several independent networks of people with HIV exist in India, the focus of my investigation was a network that has high visibility at both national and international forums and is an important stakeholder in the national processes triggered by the Fund.

Registered in 1997 on the initiative of 12 men and women tested positive, the network currently has a presence in 22 states and 235 districts in India and a membership of 129,000 people with HIV. With its president as a distinguished member of national consultative committees and the country coordinating mechanism of the Fund, the network has a strategic presence in different Fund rounds through partnerships with NACO (as a sub-recipient of its state divisions) and as a valued partner in the civil society consortium. The crucial role played by the network in the consortia in different Fund rounds (four and six) has been discussed in the previous chapter. Through these alliances it implements prevention programmes and undertakes outreach work to ensure treatment adherence and support to people with HIV. As part of the latter, it is mandated to set up networks for people with HIV, in a phased manner, in each district of the states. My field studies involved visits to ten network offices (four state-level and six district-level) and a few of their interventions across four southern states in India.

A senior board member of the network described the structure and function of the network as depicted in figure 10 below. The Network operates at three levels: i) a national secretariat or country office which is responsible for

“effective implementation of project deliverables” (Network website accessed in 2009) and national and global advocacy, ii) state level coordination units with the mandate of network building and developing good referrals, and finally iii) the district and *taluka* (block) level units which are responsible for service provision to the people with HIV and for outreach work in the communities. The district level units are central to the network’s claim on achievements and acts as the basis on which the network and its partner agencies establish their credibility with respect to both the funding agency as well as the community.

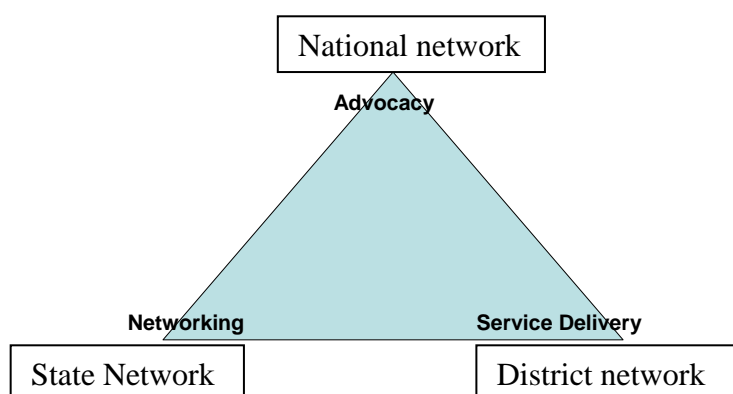


Figure 9: Structure and function of the Network of People with HIV
Source: As explained by a network member

5.4.1 Interventions at the District Level Network

District level networks (DLN), as the name suggests, are set up in districts across India as one of the deliverables of the network’s Fund project. These

are independent units which are meant to serve as the first point of contact for people with HIV and AIDS. They act as the main service delivery point for the network offering a range of services including counselling (primarily to encourage testing and ensure adherence to treatment), organising support meetings for people with HIV, providing nutritional supplements and making referrals to ART, care and support centres. The district networks are usually established in a busy part of the town/district, often in the vicinity of the public hospital where the ART centre is located.

Formally registered as societies (under the Society Registration Act), each DLN has a separate governance and organisational structure which comprises of a board and project staff varying with the number of projects implemented. The infrastructure usually comprises of four or five rooms, each run as a dedicated unit, distinguished by the Funder's name mounted on a nameplate at the entrance of each room, for the respective funding agency whose project is being implemented (Notes from observations). The number of projects run by a single DLN varies depending on its rapport with the state division of NACO and funding agency, which impacts on its ability to attract funding. Typically, most DLNs I visited had on an average five to six projects being implemented. Of these, the Fund, with simultaneous rounds operating, had a prominent presence. For example, round four and six funding for NGO consortium led Access to Care and Treatment (ACT), round two funding channelled through state division of NACO for prevention of parent to child transmission and drop in centres. In addition, several other

funding agencies have directly funded the network for projects ranging from micro credit or income generation programmes to strengthening the network's involvement in India CCM of GFATM. These are: HIVOS, Elton John Foundation, Gates Foundation, US Centre for Disease Control (CDC), Danish International Development Agency (DANIDA), Canadian International Development Agency (CIDA), GlaxoSmithKline Positive Action, Family Health International (FHI), Concern Worldwide, UNDP among others. The figure below gives a glimpse of the virulence¹⁷ of interventions triggered by the AIDS virus at one of the sites I visited.

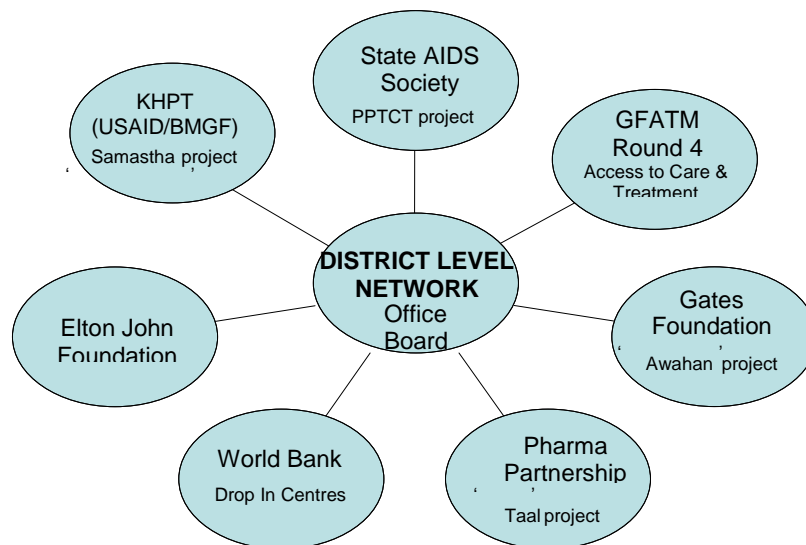


Figure 10: District level network- site of multiple projects and funders

¹⁷ The term 'virulence' has been used to demonstrate both the severity and degree of infectiousness of the Fund interventions and the nature of subjectivities created by it.

5.4.2 New opportunities and complex configurations: A shift from critical to institutional

With the Fund's emphasis on inclusion of the 'voices of the affected community', participation of the people with HIV in the partnership has become key to successful bids. The networks therefore emerged as convenient sites for much of the development work around HIV and AIDS. The Fund opened up possibilities of engaging with 'beneficiaries' as 'activist experts' and thus, gave a boost to the presence of institutions representing them and their activities. As a result, the network's outreach expanded from national to sub-national (state and district) level with 102 networks set up in the districts of select (high prevalence) states within the first two years of the Fund's operations in India.

"In most states GFATM round four has been the first funded project for the DLNs. Before the Fund project, a few DLNs had set up their board but did not have any projects to run. The Fund has built the capacity of the DLN, and also led all other funders to focus on them. Now, even the SACS [State AIDS society] is sourcing outreach projects to them."

(State project officer, civil society consortium)

The sheer number of networks established suggests a quantum leap in reaching out to the people with HIV and, as a result, in improving their access to care and support services. The outreach work undertaken by the network staff was also reported to provide people with HIV a point for

redressal of grievances with respect to unavailability of drugs, quality of treatment and other violations of their rights. However, district networks have also emerged as units running multiple projects with multiple funding sources and significant overlaps in their activities. Table 6 below presents the interventions/ activities (listed in the first row) carried out through different projects (listed in the first column) at one district network I visited.

	Training & Capacity Building of network staff	Network building	Counselling (pre-test & follow up)	Community awareness/ Support Group meetings	Outreach services	Referrals	Strategy development (GIPA, advocacy)	Others
1. GFATM 4 – Population Foundation of India	X	X	X	X	X			Nutritional support; children's education
2. GFATM- State AIDS Society (PPTCT)			X	X	X	X		
3. USAID- Karnataka Health Promotion Trust	X	X		X		X		
4. HIVOS	X	X					X	
5. BMGF+ FHI (Avahan)	X						X	MIS development
6. State AIDS Society (Drop In centre)			X	X		X		
6. CDC	X		X	X				Micro credit programme

Source: Compiled from field visits and network website

Table 6: Project activities implemented at a district network

The table illustrates the escalating prominence of the network in donor agendas and the disproportionate funding received by projects at one network site. A noteworthy observation here is that most activities are linked with sensitising of activists into project officers or street level bureaucrats.

These include network building activities such as development of the capacities of network staff, enrolment of new members, drafting strategies for advocacy, infrastructural support among others. A few projects are designed specifically to build capacities with respect to the Fund mechanisms, for example, strengthening the network's involvement with the CCM and other national processes. Moreover, a clear overlap can be seen among projects whereby service oriented activities such as support meetings, pre and post test counselling, and referrals, were supported by more than one funding agency. A consequence of managing these multiple demands of the different funding agencies was that a single intervention was recorded and reported under different projects.

“There is a lot of duplication of enrolment. Same person is enrolled in two or three records or under projects. Sometimes there are 2 different identities of the same person.” (Senior member, network of people with HIV)

Concerned with the impact of this trend on the network, a senior member of the network pointed out, *“Project driven network units can be threatening to the overall objective of the programme. Somewhere in filling the forms to meet enrolment numbers and maintain records, the network has diverted from its objectives and lost its vision. Most networks are worried only about getting new funding.”*

This view was expressed more strongly by a public sector bureaucrat at the state level while highlighting the duplication of activities the networks give rise to.

“Ultimately from the programme point of view, output to society is very less. There is a lot of wastage of resources. For instance, trainings- same person gets different trainings even though it is not relevant to their task.

(Senior officer, state division of NACO)

5.4.3 Translating the discourse through the Fund brokers: Sensitisation of the ‘beneficiaries’ into ‘activist experts’

The district network acts as the site where the project ‘beneficiaries’ are enrolled as supporters and ‘sensitised’, serving both ideational and interactive dimension of the Schmidt (2004) framework. The need and appropriateness of the project were established by its ability to role out further projects. The objectives of the Fund programme were reinforced by translating them into a common language and endorsement of the ‘beneficiaries’ through support group meetings and counselling sessions. The network board and the project employees- DLN officer, social worker, peer counsellor and others - through a series of orientation meetings, learned to reproduce the project rationalities (and significance of working in partnership) and encourage people with HIV to “express their problems in conformity with the prevailing discourse”, what Bierschenk (1988) refers to as “sensitisation”.

In accordance with the above argument, the level of awareness of project objectives, rationale and deliverables among the DLN project officers was high. Each respondent had a good understanding of the deliverables, the monthly and quarterly progress reports and the significance of reporting through computerised management information system (CMIS) for the Fund project as well as other projects being implemented at the district network. The network members were highly receptive to such knowledge and, as evident from the case study presented below, used it to manipulate the environment to achieve locally relevant outcomes and establish their credibility.

Case Study 3

Community outreach work undertaken through the district networks, as mentioned earlier, acts as the basis on which the i) network's involvement is sought and, ii) partner organisations (the civil society consortium, in this case) made claims on successive rounds of funding. The network carried out much of its care and support work through its peer education strategy implemented at district level.

At the inception stage of the Fund round four programme in April 2005, the network identified master trainers from among the district network pool (primarily the district network officer) for further training. The master trainers were imparted a four to five day training by a partner organisation of the civil society consortium. Subsequently, people with HIV who were on ART were

identified and after a three day training program conducted by the Master trainer, qualified as Peer Treatment Educators. Each peer educator was allotted certain number of people with HIV, including those on ART as well as drop outs, to be reached with treatment education on adherence and other services like counselling and referrals. Other responsibilities of the peer treatment officer included: generating awareness in the community, and mobilizing people with HIV to participate in monthly support meetings at district network. The project had a provision for each peer educator to receive a monthly honorarium of INR 400/- towards travel and other incidental expenses in relation to their work (Quarterly Progress Reports of member organisations).

However, the PTE model on which treatment adherence (and by default the entire care and support component) rested, failed to generate results. The project staff attributed the failure to several factors. Firstly, an adequate number of people with HIV taking ART could not be identified to be counselled or enrolled in the network. Failure to enrol was ascribed to factors such as conflict at the public health facilities (as described earlier in chapter 4) and stigma and discrimination prevalent in the community. Secondly, peer educators were not willing to work in their own vicinity for the fear of being identified as positive and thus, discriminated against. These factors were reported as hindrance to the achievement of “optimal” performance. In view of this, “strategic shifts” were made to the strategy of peer treatment education from July 2006 (sixth quarter of Phase 1 of the programme)

onwards. In the revised strategy, a new cadre of Treatment Outreach Worker (TOW), not necessarily people with HIV, was recruited in the district networks, trained as master trainer and expected to further train people with HIV as prospective peer educators. The peer educators were no longer allotted people with HIV to follow. Instead, they had to conduct three to four sub-district/*taluka* level support group meetings each month under the supervision of outreach coordinator. Issues like treatment education, adherence, nutrition, and other supportive services/information were expected to emerge/ be discussed in these meetings. Moreover, a cost cutting exercise was undertaken whereby the honorarium of INR 400/- was withdrawn to “promote volunteerism” (PFI 2007).

While the revised strategy was being implemented, the project observed a high turnover of the existing peer educators. As on September 2006, only 30 percent of trained peer educators remained. In view of the shift in the strategy, the roles of peer educators were not clear at the service delivery level. Initially, each person with HIV on treatment was expected to be met at least once a month in order to ensure adherence to treatment regime. However, as per the new strategy, a monthly meeting of not more than 20 to 25 people with HIV was expected to achieve similar results. Further, there was no clarity on who could be covered through the group meetings: those who had recently started ART or old cases (Findings of the evaluation exercise).

“We have a target of 30 enrolments per month. How do I ensure that number? To get peer educators for training programmes is another challenge. There is no per diem, so how can we motivate them to come for four days?” (Project officer, district network)

Realising the delay in meeting the deliverables, the network's partner organisation (also the principal recipient for the civil society consortium) was quick to commission a special study to “review the existing approach and provide inputs to strengthen it”. While I was involved in the initial stages of conceptualising the study, a leading social science institute was contracted for the purpose of carrying out the research. The institute held consultative workshops in each of the six high prevalence states with multiple stakeholders including the peer educators (functioning as well as the drop-outs). The outcome of the consultation was an operational research study report, one of the deliverables of the Fund. Some of the issues that emerged from these are listed below.

Firstly, remuneration emerged as the most critical issue for all participants. The field visits were both physically and financially demanding for the peer educator due to long distance travel and inaccessible areas. The withdrawal had greater significance for women peer educators, particularly those who had lost or were caring for their sick husbands. While several participants upheld the spirit of volunteerism, a few peer educators vehemently opposed its implementation to peer education component. A peer educator expressed,

“Voluntary social work is meant for elites, not for us. It does not fill our bellies”.

Secondly, the remaining peer educators were overburdened as there was a shortage of trained staff, lack of medicines, skills to handle complex issues and resources (including transportation). Their discontent was compounded since other NGOs and networks had a provision for fixed salary to their outreach staff. This resulted in frustration and de-motivation and consequently, low accountability and a high turnover.

Thirdly, there was escalating power politics and autocracy among other “professional” members (i.e. the new cadre of TOW) of the network who, as reported, did not treat the peer educators with dignity. This not only affected the motivation of remaining peer educators but also the solidarity amongst people with HIV. Moreover, it impacted programme output (with a significant drop in the adherence rates) as peer educators were a crucial link between the network and the clients.

Discussion: Reproducing rationalities

The experience of peer educators and the rationalities developed in the process reveals the chain of “translation” that occurs at the interface of global aid mechanisms and local struggle for credibility.

At first sight, sensitisation takes place at the interface between the aid giver (in this case, the Fund) and the receiver (the consortium members) where the authority of the protocol and the underlying ideas is established. The previous chapter discusses this in greater detail referring to this interface as sites where alliances are forged between influential partners, interdependencies are established and ideas are packaged into projects and sold to the partner and implementing organisations as innovations. Peer education approach, for example, was not new. It was earlier implemented as ‘targeted intervention’ within the national AIDS programme whereby individuals from vulnerable communities such as MSM or drug users were trained. These in turn ‘educated’ their peers. Local NGOs working with these marginalised groups were mostly contracted by the government for this purpose. Responding to the ‘innovative’ and ‘GIPA’ stipulations of the Fund, the approach was re-packaged and thrust on the state and district networks for implementation. This was primarily to ensure treatment adherence, an objective around which the consortium programme was structured. However, unlike other “high-risk” communities, since these were not localised populations from which ‘clients’ could be identified, the peer educators strategy failed to meet enrolment targets given to them.

“The Peer treatment educator concept worked for ‘targeted interventions’ because these are specific localised communities, so outreach activities can be undertaken. The same concept is applied to this project but to a much dispersed population that comes to specific service delivery points. So, most

of the time peer educators don't know how and where to meet their targets from." (Project officer, Network of people with HIV)

Moreover, since peer educators were the only link between the networks and the clients, the success of the program depended solely on how integrated they were in the national and state networks. The revised strategy however, failed to address the substantive issues: power hierarchies within the network, motivations for peer educator, and the wider stigma prevalent in the community.

The training workshops, reviews, and operational research serve as the second site for translation. The project officers are sensitised into their official or institutional role, enabling them to reproduce political rationalities even though it ran counter to their local experience. For example, despite the firm commitment to "for PLHA¹⁸ by PLHA approach", the peer educator posts (similar to that of project officers) were opened to non HIV positive people, often the reputed members of the community. Ideas embedded in the human rights discourse were woven together with ideas emerging from technocratic programmes whereby, the peer educators must be 'sensitised' to alter their mindset to work voluntarily, 'speak out'¹⁹ in the communities, and others.

¹⁸ People living with HIV/AIDS is the common term used by the network members as well as partner agencies. In the thesis however, I use the phrase people with HIV instead. The phrase 'for PLHA by PLHA' is used as a strategy to involve the infected as the provider of services.

¹⁹ 'Speak out' is a common term used in the AIDS industry. It refers to the practice of disclosing one's HIV status in public. Projects and interventions at the grassroots are increasingly facilitating 'speak out' sessions in the community with the understanding that the person who has disclosed will act as a role model for other people with HIV/AIDS, thus address stigma in the community.

Finally, at the end of the translation chain, are the very 'beneficiaries' the project seeks to empower. Peer educators, the product of a three day training programme, similar to other project officers of the network, were highly receptive to and reproduced the knowledge gained at the orientation meetings. They unequivocally endorsed the strength of peer education approach to combat stigma and discrimination in their community in spite of it being the very reason for their inability to enrol clients or for not serving in their own communities.

"The PTE [peer treatment education] programme proved extremely beneficial to tackle issues related to stigma and discrimination."

"It has helped in removing HIV/AIDS related fears and instilling faith and hope for a better life. This had been possible due to the knowledge we gained in the trainings and the referrals we could make for care and support services." (Peer educators at the consultation meeting)

Even though the behaviour and practices of the 'beneficiaries' is regulated at the first instance, they subsequently learn to manipulate the environment to achieve locally relevant outcomes and establish their credibility. Nearly two years into the project (April 2005 to March 2007, when the study concluded), the consultation participants mutually re-established the need for –

- Re-introducing the remuneration to peer educators and providing an increment for achievement of minimum targets;
- More comprehensive training for a longer duration (equivalent to that of master trainers), and provision of refresher training courses and modules;
- Developing an efficient system of reporting to increase peer educator's accountability and orientation on basic documentation and reporting skills; and
- Provision of day care shelter, nutrition, livelihood support and income generation opportunities to peer educators.

These decisions subsequently transpired into further project plans, proposals, and funding opportunities.

5.4.4 Translating figures into achievements and gaps

An innovative and distinct feature of the Fund programmes in India is its claim to technology centred management of information or statistics. Each network office is provided with computers that have a management information system (CMIS) installed and a network officer who undergoes training to handle the software. Besides the computerised input, the employees are required to maintain extensive documentation in the form of registers and forms for every interaction undertaken and each activity performed. This implies that at any given point, the project staff in the network unit were maintaining between six and seven registers: a master

register of all people with HIV enrolled, record of every individual counselled (separate records for those taking ART and those who are not), all support meetings organised, peer educator trainings held and their minutes, each person followed up on treatment, peer educator's working registers, and other similar records. Information from all these registers is then entered into cumbersome databases (on computer) accessible to the state and national network office, and the partner agencies. Additionally, progress reports are generated at the end of each month both by the state and the network head office, collating the information from different districts, to be submitted to the Fund every quarter.

A common complaint of all respondents (in network offices as well as other service delivery centres) was the excessive burden of paperwork and reporting linked to the Fund's activities and deliverables. To handle all this workload, there were a total of at least five employees within the Fund project at the district network: network officer, social worker, peer counsellor, outreach worker and accountant. During my visits to the DLN, a majority of staff was found absent, leaving one or two individuals to manage the records alongside their other responsibilities including home visits, counselling and other provisions. Moreover, given the multitude of projects functional at the network office, there was an abundance of training programmes²⁰ to build the capacities of the project officers at all levels. These take up a considerable

²⁰ A variety of "training and capacity building" programmes as mandated by different funding agencies and NGOs took a considerable staff time. Training content ranged from project orientation to advocacy and institutional development. Several international agencies- Futurz plus, Engender Health, Insa India and others – have capacity building as their primary role in the partnership.

time from their working hours. Despite the thrust on capacity and skill building, respondents revealed that the workforce and their capacities were not sufficient to cope with the scale of interventions the network was engaging with. This also emerged as a barrier in effective documentation.

“All are NGOs working in two or three districts. Suddenly we are expected to cover so many more districts and achieve high targets. Earlier there were very few district networks, mainly supported by Gates Foundation. Through the Fund we have MoU with 22 districts in our state and four more this month. This is the scale we are talking about. The staff at the State network is also not adequate to support and supervise.” (Senior member, State network of people with HIV)

“Much of the time the majority of the staff is away on trainings. Only I am left to do the record keeping. Others have very poor education levels and no skill. So, the entire burden of record keeping is on me.” (Project officer, district network for people with HIV)

Being responsible for a majority of the deliverables of the civil society consortium (in Fund round four), the network was also the *target* of the interventions of other members of the consortium. As a result, besides meeting the demands of the state network offices, the Fund project officers at the district network had to respond to increasing demands of the consortium partners. These included participating in training programmes, a deliverable

of an international NGO partner; making subjects (people with HIV or peer educators) available for operations research studies to be conducted by a NGO partner. These deliverables, although regarded unrealistic, had to be met.

“It was very hectic. By the time we started one study, the concept of the next study was sent. As per mandate...[a partner organisation] has to do all these 8 operational researches in the first phase of the programme.” (Project officer, network member civil society consortium)

At other instances, the staff such as the counsellor and outreach worker complained of not finding time to perform their primary duties because they are required to fill in for other staff and complete documentation while they are away on training programmes. As most respondents pointed out, the stress on reporting and evaluation is linked to the ‘performance based’ nature of the Global Fund grant. The project staffs, particularly the outreach workers, is under constant pressure to meet the deliverables or outputs against which the performance is measured. For instance, reported monthly targets included “30 new enrolments”, “four support group meetings per *taluka* (block)”, “1000 peer treatment educators trained by 2010” among others. As a result, various strategies were adopted by the staff to meet the targets. These included providing added incentives like nutritional support or employees of the TCC coercing people with HIV to visit the network while they came for testing.

“Prior to opening the TCC [an intervention by the network] in the public hospital, we [the district network] had 30-40 clients every month. After TCC the number has increased to 70. They [the TCC staff] convince the PLHA to visit the DLN during lunch hour. We provide lunch and sometimes staying facility. That is how we get our clients.” (Project officer, District level network)

“DLN [District level network] people do only one thing: increase their membership. One of their founders is a doctor who is popular for treating PLHA. So he refers to their pharmacy and the DLN does not inform them of the free medication provided at the government centre.” (Member of an independent network of people with HIV)

Pressure to meet targets in a competitive and uncertain environment that has resulted from the creation of several ‘monster-like-projects’²¹ has led the different constituencies in making counter-claims on the achievement of outcomes of one project vis-à-vis the other. The formats, registers and operational research studies thus become crucial sites for establishing the organisational relevance to the Fund as well as employees competence in the project. Both in turn translate to making claims on the next cycle of the grant and legitimise the re-organisation of key people in the project cycle.

²¹ The nature of this term has been teased out in the previous chapter. The term relates to the proliferation of several independent units/ structures in response to the yearly rounds of the Fund. Once established, these units grow out of their shelf life and strive to attain sustainability and make claims on the limited resources

Thus, the process of translation is not unidirectional i.e. it does not begin at the interface of aid givers and ends with recruiting the 'beneficiaries'. Rather, the system is maintained through a constant cycle of interpretation: translating the meaning of a project in different institutional languages (top to bottom) and at the same time translating back the significance of the project (bottom upwards) by using tools such as progress reports and operational research (OR) studies and organising *speak out* sessions in an attempt to illustrate the reduced level of stigma. In the process, the Fund brokers render the "beneficiaries" to the development apparatus and simultaneously reinstate the legitimacy of their own role and ease organisational access to the Fund revenue (Neubert 2000:256).

5.5 Towards sustainability

In this environment of fierce competition and multiple project sites established, maintaining organisational sustainability i.e. the ability of an organisation to constantly seek new funds and projects becomes imperative. Since the district networks rely only on project funding, which on average lasts for two to five years, the network board is on constant lookout for new funders and projects.

"Sustainability of DLNs will be an issue unless they start a self supporting mechanism. Each office, like a community based organisation, has to individually fund itself. They should not be dependent on ACT [Fund programme] alone." (Senior governing member, Network for people with HIV)

5.5.1 Multiple 'partnership' models for delivery of ART

Case Study 4: 'Partnering' with a pharmaceutical company

Taal is an initiative of the network set up in partnership with a pharmaceutical company, to dispense antiretroviral and opportunistic infection drugs at subsidised costs. Since the *public script* behind its creation was to fill in the treatment deficit created by the over burdened public health systems and unaffordable private sector, the network's website refers to it as "a partnership to bail out persons in private ART facility".

"We want people to use the government services but they are apprehensive to go and get medicines from the centre. There is a long waiting period and they have to go many times to get all tests done. So, we started the pharmacy in January 2006 because at that time there was a shortage of medicines. Emcure gives us drugs at rock bottom prices. We add 5-10% extra for our maintenance costs and sell it for 250/- when the market price is 419/-." (Senior member, State network of people with HIV)

"Basic reason [for preferring Taal over government services] is confidentiality and time. You have to wait at least 2 to 3 hours for drugs in government hospital whereas I deliver it in 15 minutes. Also I retain privacy. Diagnosis of HIV is a big hurdle. People don't know their sero-positive status leave alone CD4 count...And there is stigma which is why they are not ready to come for

treatment. Behaviour of government doctors is really bad. So when they don't have any money, only then they go there.” (Project officer, State network of people with HIV)

“We offer entire package...we also have a positive living centre [another service point run by the NGO consortium], so a doctor is available to visit. For CD4 count, x-rays, blood report and other tests we have established links through them and with one of the private clinics. But people prefer to get CD4 done from government itself because outside it costs around 570/- while in government it is free.” (Project officer, Network of people with HIV)

The model, although heralded as a ‘one-stop-treatment-shop’ providing treatment literacy, all types of counselling, peer support and referrals, was dependent on either the public or private health facility for laboratory tests and hospital admissions (inpatient facilities). Bureaucrats and project officers at the state divisions of NACO and the medical staff at the public ART centres resented this initiative and expressed concern over the duplication of effort and potential deception of patients who were being charged for a service that is provided free in the public hospitals. A senior bureaucrat in the state division of NACO expressed:

“They [the network of people with HIV] have started their own drug distribution centres, their own opportunist(ic) infection treatment, their doctors... But for investigations, or when the patient is unable to afford, they

send them to public health facility. Why the need to duplicate? They should add to the programme. Our need is to encourage institutional delivery, partner testing and counselling and, tackle stigma and discrimination. That is what needs attention.” (Senior bureaucrat, State division of NACO)

Case Study 5 – Graduated cost recovery model: An NGO-GO ‘partnership’

Under round two of the Fund grant, NACO, the principal recipient of the grant, entered into an arrangement with a leading NGO working on HIV and AIDS to offer low cost drugs through price negotiations with the pharmaceutical company. The hidden transcript that emerged from the interviews revealed that the partnership was commissioned in accordance with the recommendation made by the Technical Review Panel (TRP) of the Fund in Geneva, to address the lacunae on the basis of which the proposal for round two was initially rejected. Addressing the protocol, the CCM put together a NGO consortium to deliver part of the mandate. The consortium comprised of three agencies: two pioneering organisations in the field of HIV and a quasi governmental institution (autonomous body under Government of Maharashtra). While the latter was meant to be the lead agency for the project, it was unable to handle the wide scope and demands (with respect to documentation) of the project. A decision was therefore made, by virtue of which, the funds were channelled to the three agencies via the government instead of directly from the Fund.

“Organisation Y [one of the three members of the NGO consortium] fell grossly short of being able to handle this project. So the net result was that though it was originally supposed to be a consortium led initiative, because they were unable to take anything forward, we finally decided that the respective organisations will work directly with NACO.” [Project officer, sub recipient NGO consortium]

However, the launch of the cost-recovery initiative was delayed considerably. The delay, in part, was at the proposal acceptance stage by the Global Fund, and subsequently, in the release of the funds from NACO to the respective agencies. This was soon followed by central government’s decision to introduce free antiretroviral through the national programme.

“When the proposal was put in, it was considered a very unique strategy because at that time antiretroviral was considered frightfully expensive. What it meant was that we would get into negotiations with pharmaceutical companies and have clients recruited at various levels: from those who pay the price at which the drugs are negotiated to those who will get them free. But by the time the project actually came through and the money was released, one and half years had gone by and few months later the government announced its free roll out.” (Senior management, member of NGO consortium)

The decision itself was, as it emerged from the interviews held with key informants, a politically motivated move by the government to garner support before the elections.

“Sushma Swaraj [the then health minister] launched this in April 2004, was more of an election gimmick. The elections were round the corner. The first round of polling was 10th April and she announced it on 1st April.”

(Senior bureaucrat, Fund governance)

“I also discovered that it was more of a political thing because the idea was the ministry comes out with something substantial before elections...It was a topless policy because there was absolutely no planning as to how the government will go about it. The minister’s statement was that by April 2005 we will have 100,000 people on ART. The Planning Commission asked where she is going to get the money or how will she reach out? That question was never answered.” (Senior management, NGO consortium)

The decision however posed as a major hindrance for the organisation in achieving its deliverables for the round two of the Fund and thus impacted its performance. As part of the review exercise undertaken at the end of phase one (i.e. second year of implementation), the targets were re-negotiated with Global Fund and brought down to “a more realistic level”. However, the Fund did not agree to an altogether suspension of this component from the country’s mandate. As a result, the organisation adopted a two pronged

strategy: (i) to 'sell' the cost recovery model by making counter claims on the quality of drugs and treatment provided in the public health facilities, and (ii) to look out for alternative partners to bid for the next round of the Fund.

“Government roll out became a big challenge for this particular project. Why would anyone come here and pay for drugs when there is a free roll out? So this is an ongoing challenge. But we have tried to do our best and managed to achieve numbers simply by focusing on issues of quality.”

(Senior management, recipient NGO)

“The project is formally supposed to end next year and we are now more or less on target in terms of the numbers, although the challenges continue to persist. Because of the free roll out, there is tremendous pressure on NACO that they somehow need to get numbers. So the focus continues to be more on increasing numbers in the government roll out rather than looking at any of the other alternatives, which are all similar initiatives.”

(Senior project officer, NGO consortium)

5.5.2 Social Mobility²²

The presence of multiple donors funding different projects facilitates movement of personnel within and outside the network. The movement is particularly stark in case of the Fund, which as described in earlier chapters,

²² Social mobility in this context is described as the movement or opportunities for movement between different social groups in terms of security of employment, income, opportunities for professional and social advancement at workplace or in community.

has rounds commencing every year, with different objective, partnership arrangement and funding. The Fund, therefore, legitimates parallel projects under one umbrella programme. This implies that an organisation A which partners with B in one Fund round is also able to undertake a separate set of activities (with different fund and salary structures) through partnership with a third organisation C, in another round. This directs the movement of personnel from one to another organisation and/ or project thus reinstating 'professional' and 'social mobility' as the defining and organising principle of the AIDS industry (Khanna 2009). This mobility is highly asymmetrical, to the detriment of projects running on lesser funds, grassroots advocacy groups, and finally the public health sector since they lose their human workforce and considerable investments in training and capacity building, orientation to the monitoring mechanisms, and the use of technology. Influential and resourceful stakeholders such as the corporate sector, internationally funded NGOs, and independent institutions which are an outcome of the partnership arrangements have drawn senior bureaucrats from the state divisions of NACO. The personnel who move from public bureaucracy into international bureaucracies prove an asset for managing the Fund projects owing to their relations with the state government employees and the authority they command at the intervention sites where they continue to be regarded as representing the government.

"Because I was a senior officer at SACS previously, I knew most officers there. So, coordinating with them wasn't a problem and the introductory part

was very smooth. Only thing that changed on my resume was that I was now on the other side of the table.” (Senior project officer, civil society consortium)

Likewise, recruiting former network employees ensured community acceptance, credibility through their experience in outreach work in the community and greater involvement of people with HIV (GIPA). In the context of the network this mobility manifested at two levels:

i) External or outward mobility from the network to Indian operations of international partner agencies, corporate service centres, or to higher positions in competing networks of people with HIV.

“Positive women’s network [an independent network operating at a smaller scale] persons have gone out from here. The president of our board had gone for training when she was offered a better job by their president to set up new networks. They offered good salary etc.” (Board member of a district network)

ii) Internal mobility within the network was observable in senior management (state and country office) and at the level of implementation (district office). Movement within the district network- a site of multiple programmes and funding agencies, disparate technologies, working environment, and rewards- was more common.

“Pay scales [of different projects] cannot be matched. Despite a degree and years of experience, I get half of what the other project staff in our network draws. The coordinator of that project is planning to move to state level, I will try to get a transfer to that post”. (Project officer, district network)

5.6 Discussion and Conclusion

Impact on the ‘civil society’: widening or shrinking spaces?

The AIDS epidemic has given voice as well as visibility to non-state actors as organisers, planners, implementers, and advocates. From the very onset of the epidemic, they have been at the forefront of promoting prevention, care and treatment. Their contribution has ranged from addressing stigma and generating awareness in the communities to importing ARV drugs when none existed as part of the national programme. For example, a local organisation which started the first care and support unit in India in mid 1990s (with subsequent assistance by the NACO), began importing antiretroviral for its clients in 2000, four years prior to its introduction in the programme. However, earlier the programme was structured around a centralised state that sought out NGOs to play an active role in addressing the epidemic in the community. In doing so, these non-state actors extended the state authority. The entry of the Fund and the authority of its protocol, which mandates civil society involvement as principal recipient, have transformed this equation.

Firstly, the imposition of global structures and ideas on local systems facilitates a reconfiguration of non-state actors around newer forms of expertise and power centres. This is made possible as the Fund facilitates the entry of organisations that enjoy a certain level of credibility owing to one or all of the following attributes: 1) their access to resources, which includes expertise of Fund brokers, to translate 'innovative' project ideas into successful bids, 2) their international standing and links with the government, and 3) their ability to generate support of the 'beneficiaries' (in this case, the people with HIV). These organisations include international organisations whose registration as Indian entities and national organisations whose movement into the AIDS industry can be traced around the same time as the entry of the Fund. On the other hand, some local and community based groups remain at the mercy of the government for minimal grants to run care centres or provide ad-hoc group counselling at the treatment centres. Failure to maintain computerised records or detailed registers is understood as a marker of 'inefficiency' and 'non-performance' and often results in the withholding of these small grants leading to a closure of activities. This aspect is further explored in the following chapter (chapter six). While some networks have come into being in the wake of the Fund, the existence of many others is threatened. Often, the latter include women's networks and other marginalised and grassroots groups who remain in the periphery of the spaces that global initiatives like the Fund create. Their invisibility from the Fund arrangements limits their visibility in the industry and thus their ability to make claim on country wide resources. In order to sustain in such

competitive environment, they therefore ally with the workforce at the public hospitals who are already hostile to the more prominent network's activities or the Fund partners. They establish their credibility by providing counselling and other outreach services voluntarily and make counter claims on the work of more prominent networks.

This necessitates a re-visit of our understanding of the 'civil society'. The Fund's particular strength is regarded as "boosting the engagement of NGOs and faith-based agencies, bringing them into planning structures and enabling their access to significant funds" (Biesma et al. 2009). However, exposing the *hidden transcript* demands critical questions to be asked: Who are the actors that are involved and, as a result, empowered through these arrangements? How do hierarchies get reproduced through these interactions? Can country wide operations of associations of the business sector (Global Business Coalition, Confederation of Indian Industries, Pharma companies) and the bilateral and international agencies be treated at par with local and grassroots groups undertaking advocacy and prevention activities and working with the marginalised communities since the start of the epidemic? Yet, it is the former and not the latter which has visibility in the Fund governance. Of the latter, only those actors who are able to conform to the 'ethos' of the AIDS industry are able to have a stake in the national processes. Amore and Langley (2004) have argued that the term 'civil society' enables a dishonest creation of an idealised space where a large collection of individuals and organisations are assumed to pool their interests

to secure optimal outcomes. In agreement and on the basis of the evidence presented in this chapter, I argue that this notion of civil society underplays differences and power relations between various institutions and confers spurious legitimacy on policy decisions and the actions of international agencies and global governance strategies. This results in reinforcing rather than challenging the 'democratic deficit' of the international systems (Anderson and Rieff 2004, Seckinelgin 2003).

Secondly, it has increased inequities within the programme and as a result, dissatisfaction among health workers and other actors in the industry across the different constituencies: public, private-for-profit and not-for-profit. The apparent transition from critical to increasingly technical discourses, in order to fit in with formalised models and frameworks of mainstream development agencies, has also changed the very nature of 'expertise' that was earlier rewarded. For instance, the cadre of community workers who are the main links with the community (responsible for generating awareness on treatment through community education and home visits, strengthening links with the community) are encouraged to work voluntarily whereas employees with professional degrees (in social work and management) and computer skills are increasingly sought to fill up network positions. Moreover, the environment of inequities instilled through different pay scales for the same activity under differently funded projects within the network has also resulted in increasing discontent among workers. This has led to a high project-

specific turn over (peer counsellors and other employees) and thus impacted the actual links with the community and follow up.

Finally, as David Mosse (2004) argues, success of policy models is not inherent but depends upon stabilization of particular interpretations/narratives. The more the interests that are attached to a particular policy interpretation, the more secure and stable the policy approach becomes. Evidently, as case studies 3 and 4 suggest, within the AIDS industry the 'civil society' constituency acts as the "interpretive communities" that are needed to socially sustain the discursive model of partnerships and reproduce all its underlying *ideas* on volunteerism, greater involvement of people with HIV, and other. The success also arises from, as Bruno Latour (1996:78) argues, "their ability to continually recruit support and impose their growing coherence on those who oppose them".

Chapter 6

Knowledge production, translation and management: Examining the Monitoring and Evaluation mechanisms of the Fund

“...People cannot even fill registers and they are computerising everything.

They are making us run before we learn to crawl!”

– Senior M&E officer, State division of NACO

6.1 Introduction

The performance oriented protocol of the Fund makes the disbursement, management, and utilisation of the funds an integral and, as highlighted in the previous chapters, exhaustive component of the grant cycle. In this context, the process of production and translation of ‘knowledge’ gains significance for its ability to demonstrate effectiveness. In this chapter I discuss how the interpretive communities created by the Fund protocol utilise this knowledge to legitimise the project rationale and practice in order to make justified claims over further resources and stabilise the Fund organisation.

Several systems and mechanisms are therefore set up to ensure regular generation and translation of ‘facts’ on deliverables to enable reporting by the chain of brokers within the Fund system. These operate at different levels: i) the global secretariat which monitors and reviews the country performance

through 'Local Fund Agents' (LFA) and independent country wide evaluations of the programme, ii) India CCM which has the mandate of 'oversight' of the national programmes for the three focal diseases, and where officers in-charge of the respective programmes present the progress; iii) separate M&E division and project offices of national recipients who monitor the sub-recipients, their data collection and reporting systems.

However, the task of monitoring the performance, and consequently the process of production and translation of knowledge, is impeded by several difficulties arising due to asymmetrical flow of information and power, multiple levels of international and national bureaucracy, and conflicting interests operating within the partnership environment. Another challenge is the weak capacities in resource poor settings further constrained by high turnover of human resources in a highly competitive environment of public and private provision. This aspect has also been highlighted by previous research (Guinness 2005) in the area of HIV and AIDS in India. These difficulties are compounded in time-bound evaluations of health partnerships by difficulties of attribution of specific contributions of the different actors to specific outputs (Oliveira-Cruz 2007). Attribution is impractical since outcomes result from long term efforts, multiple interventions and investments, and endogenous and exogenous determinants, and are accounted for using country's national systems. Thus, several factors determine the implementation of the AIDS programme and service delivery in a complex multi-funded terrain. This interplay of factors and the resulting difficulties in attribution to specific

intervention is also acknowledged in other studies on global health. Biesma et al. (2009) thus call for the need for assessing value for money through donor-specific measurements of performance.

These challenges in producing knowledge and utilising it to rationalise practices and representations make it imperative to carry out an analysis of how knowledge acts as a determinant of social relationships and organisational cultures within the partnership environment. As Bina Desai (in Lewis and Mosse 2006) articulates, “actors produce knowledge, and knowledge makes actors”. In the context of the Fund, the actors in their role of ‘brokering’ the delivery and management, strategically employ (and demonstrate) certain types of knowledge to legitimise their professional identities while moving or negotiating between organisations. Knowledge thus becomes an essential resource in negotiating differences and presenting the tensions of daily practice as stories of success.

This knowledge-power-practice link is the object of analysis of this chapter. I seek to understand how conflicting perspectives and the disjuncture between theory and practice are turned into consensus when presented upwards in the chain/hierarchy of the Fund. The various motivations for the Fund brokers and the ways in which they manipulate their environment to balance official realities with ground realities are examined and its possible implication for the programme is discussed. At the outset, the policy and tools adopted for monitoring and evaluation of the Fund programme are explicated. This is

followed by an examination of monitoring practices as a departure from the official transcript.

In the previous two chapters, I discuss partnerships in practice or the *Fund governance on the ground* and examine the characteristics of the *interpretive communities* created by the Fund and the role they play in stabilising the system. This chapter examines the Fund protocol (or mechanisms) in further detail and discusses the process of stabilising the discourse i.e. how knowledge is generated, translated, and managed and how ground level practices are manipulated to stabilise the AIDS programme and the Fund system.

Similar to the previous two chapters, the evidence for this chapter was drawn from a combination of information sources: interview data and notes from direct observation of the operations at the implementation sites, district visits and monitoring structures such as state coordination meetings. In addition, I referred to minutes of CCM and state coordination meetings, reports and other documentation related to NACP III, GFATM score cards, evaluation reports and statistical information gathered from the centres. Finally, I also made use of informal accounts and documents (e.g. emails, letters, presentations) as provided by key informants and NGO representatives.

6.2 Knowledge production and translation tools

6.2.1 Financial Management and audit system of the Fund

The Fund operates on an independent Local Fund Agent (LFA) based financial management and audit model whereby an independent agency with a country presence is contracted to “oversee, verify and report on grant performance” to enable the Fund board to take funding decisions. The LFA regards itself as the “eyes and ears of the Global Fund in the field” with its mandate restricted to “*ensuring the utilisation of the funds as per the original proposal and monitoring the monitoring of PRs*” (India LFA). In the first two years of the Fund operations in India, the World Bank was the LFA. Subsequently the Bank was replaced by the United Nations Office of Project Services (UNOPS) which established its India operations as it embarked on this role. Based on desk reviews of the reporting of the national recipients, the LFA assesses the progress on both financial and physical targets for each quarter and reports to the Fund. The Fund in turn approves or terminates future grants based on the reporting. The role of the LFA as perceived by the partner agencies and the challenges faced in implementing the Fund protocol is further discussed in section 6.4.1.2.

6.2.2 National and sub-national monitoring systems

Since the national AIDS programme in India is a vertical programme, the guidelines on services and monitoring systems have constantly evolved in accordance with the principal funding agency supporting the programme or a

particular component of it. Constant shifts in the policy guidelines and in effect reporting tools and formats, can be observed. Moreover, as clarified earlier, the fund operates through multiple recipients who lead specific programmes on prevention, care, treatment, or support with varying focus and objectives. This compounds the task of co-ordinating and streamlining the disparate indicators into a single national M&E framework.

6.2.2.1 The national programme and policy

The national AIDS control programme (NACP) is currently in its third phase. The first phase (1992-1999), which was launched with a World Bank credit of USD 84 million, focused on prevention of HIV transmission. The second phase (1999-2006) of the programme saw a scaling up of testing and counselling services alongside provision of palliative care and support services. Multiple donors funded the programme in this phase, and World Bank's assistance of USD 192 million amounted to approximately 47% of the total earmarked funds (NACO website, Funds and Expenditures). The Global Fund was introduced in 2002 and the first grant agreement was signed in January 2003. Subsequently, the programme received increasing contributions from the Fund with its share increasing from 6% of the funds earmarked in NACP II to 25% in NACP III (NACO website). A landmark achievement in this period was the phased out introduction of free antiretroviral treatment in 2004.

With the Bank as its single largest external donor, monitoring and evaluation (M&E) was an integral component in the NACP II with a separate budget provisioned for it. The M&E strategy had two major components: national Behaviour Science Surveillance for general population and high risk groups which was held twice, in 2001 and 2006, and the Computerised Monitoring Information System (CMIS). Additionally, periodic evaluations of targeted interventions and programme support units were undertaken through an external agency.

Although the amount and types of information being collected grew substantially during NACP II, primarily due to the involvement of newer funders and partners, the information remained largely un-utilised. Firstly, the biggest challenge reported in the study and highlighted in the evaluation of NACP II, was the limited use of CMIS at various levels as it was highly dependent on the technical capacity at the reporting units (Paithankar 2008). Secondly, the utilisation of the data generated through the system was grossly inadequate. A lot of information was collected but data analysis, sharing of information to partner organisations and feedback was very limited rendering the CMIS as a one way reporting system. Given these lacunae, and a growing complexity of the policy environment with increasing involvement of stakeholders, the policy framework and M&E approaches underwent several changes.

6.2.2.2 *Aligning the national systems with the requirements of the Fund*

The revision exercise can be seen in the context of the ongoing grant evaluations and the processes triggered thereafter. The pressure generated from the “recommended time bound actions” made by the Fund in its end of phase 1 evaluation of round two and round four led to a re-formulation of the M&E framework in accordance with the criteria of the Fund. The renewal of phase 2 was made contingent to the actions taken upon the recommendations made. These included an upward revisions to the targets in view of the underutilized funds.

Excerpts from grant scorecards²³:

“The most serious concerns with this Program have been the conservative target setting considering ...the significant under-utilization of grant funds. Programmatic achievement has been strong to date with a very significant budget under-spent...the results to date have been achieved with approximately one third of the funds available for phase 1. This indicates that the grant should have achieved far greater programmatic delivery. Therefore, as a condition to continued funding a substantial upward revision of the targets in line with the phase 2 budget is required prior to phase 2 grant signing.” (Grant Score card for phase one of round two)

“Suggested time bound actions:

²³ At the end of phase 1 (i.e. at month 23 of the grant implementation) of one grant, the Global Fund secretariat prepares a report card, or *grant scorecard*, which contains an analysis of the performance in that phase and a recommendation to the Board on funding for the remaining years of the proposal. The Board takes a decision to go with one of the four recommendation categories: ‘Go’, ‘Conditional Go’, ‘Revised Go’ and ‘Not go’

By 31 December 2007, the PR shall deliver to the Global Fund an operational plan for M&E of the Program, taking into account the national M&E operational plan of NACPIII.

By 31 December 2007, the PR shall integrate Global Fund financial management and recording needs in the computerised financial MIS". (Grant Scorecard for phase two of round four, government recipient)

The involvement of an NGO as a national recipient in round four, in particular, raised several issues around the decision to streamline multiple programme indicators into a single M&E framework. In 2004, WHO, jointly with CDC and as part of its 'three ones principles', facilitated the formation of a UN working group for M&E. The concept paper, entitled "revisions to the NACO CMIS", resulting from the deliberations of the group formed the basis of the NACP III process (WHO/India 2009). The NACP thus witnessed a transition from a stage where there was little focus on indicator based reporting on programme performance, to a stage where M&E became the core component of the policy.

6.2.2.3 Revised M&E framework

The field studies for my research commenced when the programme was nine months into its third phase. NACP III (2006-2011) sought to integrate prevention efforts with care, support, and treatment initiatives. The strategic objectives of the third phase laid emphasis on strengthening infrastructure, systems, and human resources in the above programmes at all levels-

district, state and national. Acting upon the Fund recommendations and acknowledging the limitations in the NACP II, in the third phase, NACO sought to institutionalise the monitoring and evaluation strategy. The subsequent deliberations of technical committees, presided by multilateral and bilateral partners as well as the Fund bureaucrats, led to the creation of 'Strategic Information Management System' (SIMS). It entailed an elaborately defined organisational structure (Figure 11) called the Strategic Information Management Unit (SIMU) at the state level and District AIDS Prevention and Control Unit (DAPCU) at the district level and a national plan developed in accordance with accepted international standards.

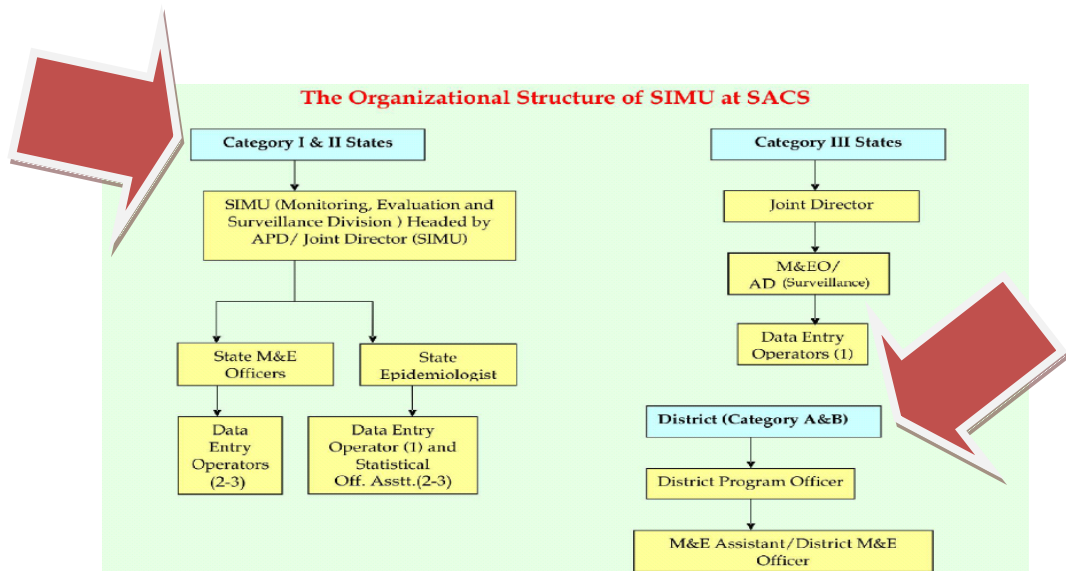


Figure 11: Organisational Structure for M&E

The M&E strategy, as per the operational plan for the SIMS, outlines a comprehensive process (Figure 12) and an indicator framework (Figure 13), which account for the externally set goals and objectives of the SIMS.

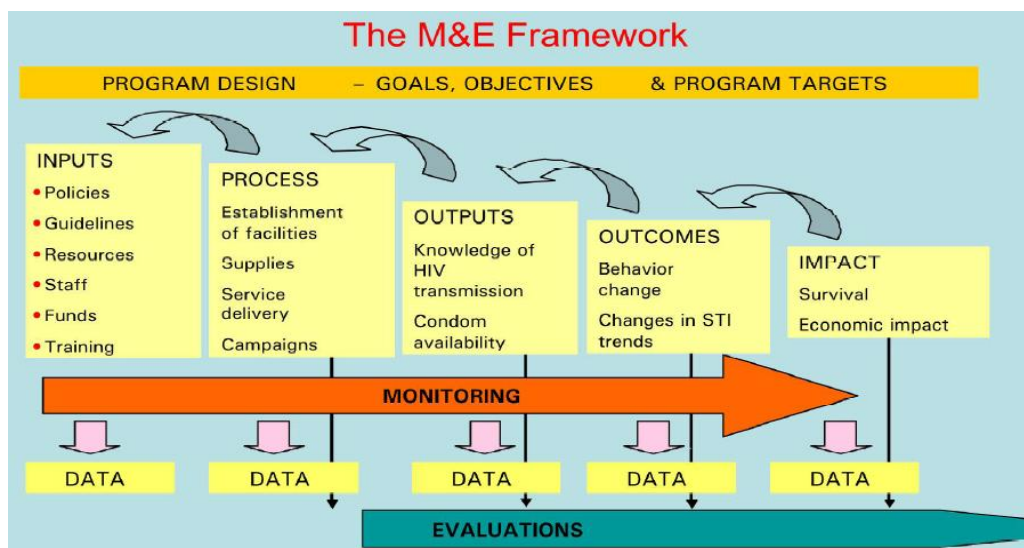


Figure 12: National M&E framework (process)

In theory, the conceptual framework aimed at “simplifying data collection to a set of key indicators while providing programme managers regular in-depth reports” (NACO 2007e). It also attempted to address the gap in NACP II by emphasising analysis and utilisation of the information collected. In this process, a list of 157 indicators was prepared to be reported on at various levels and from multiple sources. Similarly, the single M&E framework and the revisions to the MIS of NACO, other donors, and NGOs claimed to generate “a more complete picture of all activities related to HIV and AIDS in India” (WHO/India 2009).

	Purpose	Primary User	Level	# of Indicators
I. Annual Core Indicators	Assess overall programme impact	NACO International agencies and donor partners	Outcomes and Coverage outputs at National & State level	19
II. Monthly Report	Monitor service Statistics and infrastructure for services	NACO	Inputs and outputs	32
III. Dashboard	Provide snapshot of state programme performance against targets	SACS PD and DAPCU District level	Inputs and Outputs at State &	18
III. Programme Management Indicators	Identify areas requiring more operations management	Reporting Unit Managers; SACS technical officers; PSU	Inputs and Outputs at District & reporting unit level	98 (~ 5 per programme area)

Table 7: Indicator framework for NACP III

However, in reality, SIMS continued to largely draw on the earlier version of the CMIS and no changes were observed in the way data was either collected or analysed. The indicators continued to be largely input/activity oriented and there was a lack of uniformity in indicators of programmes, states, and partners. In the six months period of field studies in 2007, no initiative towards improving staffing for monitoring and evaluation or building their capacity was reported.

6.2.3 The CMIS

At the heart of the national monitoring system for HIV and AIDS lies the computerised management information system or the CMIS which is designed to routinely collect and facilitate the analysis of the inputs and the outputs of the programme. CMIS facilitates decentralised data entry and generation of standardised monthly reports at multiple reporting sites. Once

uploaded in the system, the data can be retrieved at multiple levels of management, enabling the generation of different types of analysis reports (SIMS, NACP3), thereby ensuring transparency in the process. The study participants reported several difficulties and limitations of the current reporting system. These are outlined in the following section.

6.3 The Process: Knowledge generation and interpretation

To enable data generation, extensive monthly and quarterly reporting formats are developed for the service delivery sites and sub-recipients to report back on. Information is collected through a series of standardised data collection tools (registers, patient cards, registration forms) which are specific to the different types of reporting units or intervention sites. For example, different formats exist for treatment centres, community care centres, district level networks and others. This *data* is then entered into the CMIS and made available to the sub-national and national offices of the respective organisation. The data from the national databases then becomes part of complex databases in Geneva, where the figures on manipulation help the international bureaucrats and technical experts to make sense of the movement of national programmes towards international goals.

Each reporting unit is also required to generate its monthly progress report based on the MIS records. These monthly reports go to the respective state offices where reports from all districts are compiled and forwarded to the NACO. The flow of information was found to be asymmetric since the district

and state offices did not have the complete countrywide picture of the performance of the national programme. Additionally, there was little scope for communicating the limitations and challenges faced by the officers at the district level. In comparison, in the civil society consortia, there was greater scope for a two-way discussion between the programme management and the implementing team although this could also be attributable to the small scale of operations. The civil society consortia followed a reporting format similar to that of NACO although it varied with each partner and the indicators it reported on. For instance, the network for people with HIV, with its state and district level offices had a governance structure similar to that of the NACO (the government recipient). Hence, the information flowed through a similar channel i.e. from the service units (such as the TCC, care and support centre) to the district office, from the district to the state network office and eventually to the national office. The corporate partner, on the other hand, accessed information directly from the company head office, which in turn received the information from the human resource manager and the in-charge of the company run treatment centres.

6.3.1.1 Challenges in the knowledge production exercise: Implications for service delivery and providers

As a departure from the rhetoric on technocentric responses, the knowledge production exercise was fraught with several problems. Firstly, as highlighted in chapters four and five, the majority of the staff at the service delivery units such as the treatment centres, the counselling centres and the district

networks, reported being over burdened with the task of filling up an increasing number of registers. At most centres, this high patient and paperwork load translated to a diversion of the employees from their primary responsibilities, leaving little scope for doctor or counsellor-PLHA interaction. This gap was acknowledged at various levels.

“At the ART centre the doctor is very busy because of the patient load. When a PLHA walks in, the doctor has hardly anything to talk with him at a comfort level. So, the patient talks and the doctor just writes [entering the patient form]. Then you have the counsellor who is in a very different state, filling up patient cards and managing the queues. Also there are the NGOs who claim to be doing work with PLHAs adding to this chaos.” (Senior project officer, civil society consortium)

Most ART centres I visited conformed to this description. Peer educators and outreach workers from multiple non government and community based organisations undertook “group counselling” addressing stigma and discrimination while the people with HIV watched over: the counsellors completing patient registration, the pharmacist or nurse counting pills and assisting doctors with patient cards, and the doctor-PLHA interaction, which restricted to seeking information sought in the forms. (Observation notes)

Secondly, poor infrastructure including space constraints (in public hospitals), power shortage, and the limited support for software were reported as major hindrances to the generation of information through the CMIS.

“In our country there are power shortages and few centres run on no or intermittent power supply. We have computerised the system, want experienced data entry operators, but sometimes you don’t have protection from virus and other such problems. So, the whole system crashes.” (Senior project officer, State division of NACO)

“...look at all the mess. Since we started in ...there are thousands of records of patients. Who can search for any record in this mess? And NACO keeps changing the format, increasing the size. The new formats are very cumbersome and there is no space for storing the formats and client information.” (Senior medical officer, public ART centre)

Thirdly, as highlighted earlier, there was high turnover of data entry operators and trained M&E officers. The difficulty of recording was compounded by the reported poor capacities of the existing project workers.

“Capacities are there but turnover may be high. These are contractual posts so people are always looking for security of better job. You cannot hold a training every other day. So there may be a lapse in trained staff.” (Senior bureaucrat, State division of NACO)

“Most people lack the capacity. Even with simple registers they fumble. ART [treatment roll out] M&E is totally paper based recording and it’s not happening perfectly. I have seen 90% incomplete registers. They [data entry operators] have to fill twice, once on the cards and then the registers. But dual entry doesn’t take place. And cohort is also there in the registers but transposing from that to excel sheet and analysis is something they are unable to do.” (Senior M&E officer, State division of NACO)

The difficulty arising due to weak infrastructure and capacity of the staff was compounded by the lack of standardised protocol for the service delivery centres. Given the constant shifts in reporting formats, the absence of any national protocols standardising the functioning or staffing of service delivery centres resulted in further chaos. In the year prior to the commencement of this research, operational guidelines for human resources, drugs and equipments, and routine functioning of the centres were being developed. While the field studies were undertaken, various experiences of the imposition of these guidelines on the states and districts emerged.

“For 3 yrs there were no instructions. The operational guidelines have just come out in April. Meanwhile, they [the staff at the ART centre] have adopted a flow. Someone else fills the registers, data entry operator and the pharmacist does the counselling work. How do you expect the order to change suddenly?” (Senior M&E officer, State division of NACO)

“..Only in the last one year we are coming out with modules, guidelines for centres, performance based reporting formats, quality care etc. Someone should be held responsible otherwise this system will collapse.”

(Senior M&E officer, State division of NACO)

Finally, flaws with the system of monitoring were reported at the sub national level. The M&E officers reported difficulty in measuring and validating the adherence rates and lost to follow up figures, indicators key to the Fund programme which is increasingly structured around finding and effectively treating infective patients. Treatment adherence in particular, emerged as both a concern as well as a contentious issue across all interviews. From a programme point of view, the non-government actors expressed their discontent with the existing review processes since it did not provide an explanation for the poor outcomes.

“GFATM has set up targets, deliverables...all that is fine. We started centres, enrolled PLHA, trained the service providers and worry about QPRs [Quarterly Progress Reports] to go to GFATM. This is all the service part, which is wonderful. The question arises when the national programme says that treatment adherence rate is very low. The country has a programme, so many people working on it. Then why is treatment adherence low?”

(Senior management, civil society consortium)

On the other hand, the state monitoring team pointed out that a fundamental flaw with the MIS system was that it did not allow the generation of knowledge on treatment adherence and defaulters. A senior M&E officer in-charge of the programme highlighted that the system was primarily based on cumulative numbers and thus, prohibited a cohort analysis of the situation.

“The monitoring mechanism itself is faulty ...We generate a list of indicators based on monthly reports. It could be fascinating for programme managers but as a doctor you would like to know what happened to patient x or y... It does not capture that. It only captures how many patients you have got. The numbers are increasing but we don’t have a cohort analysis.”

In one of the four states where the research was conducted, an independent initiative was carried out locally whereby cohort analysis was undertaken for two sites for a period of one year alongside the usual MIS data generation. However, the attempt, although successful in generating useful data, was withdrawn as it added to the existing workload of the employees at the implementation sites.

“The problem is overloading of these centres. DEOs [data entry operator] start complaining that they are already overloaded. In one centre there are 180-200 outpatients every day. Even NACO was initially keen on implementing it but now they say that the staffs don’t have the capacity, we haven’t trained them adequately.”

A paradoxical state of affairs thus emerged. On the one hand there was resistance from the NACO to alter the standard protocol to enable a cohort analysis at the reporting sites on the grounds of poor capacities. On the other hand, however, in compliance with the Fund demands of constant revisions of the M&E strategy, it sanctioned a framework of 157 indicators under the revised strategy (SIMS).

“This is the fourth version of MIS being tried. Earlier there was no system of monitoring done, only PLHA registered, data entered and captured. As days pass we are forcing difficulties and newer methods, constantly refining and re-refining old reporting tools.” (Senior M&E officer, State division of NACO)

6.3.1.2 Impact of changes in the M&E strategy

The most visible impact of the shifts in the M & E strategy adopted at the centre was on the reporting formats. These underwent several changes. The implementation team at the service delivery units (the reporting sites), particularly the treatment roll-out centres, reported difficulties in keeping pace with these changes. The treatment centre in-charge, usually the head of community medicine or another department within the hospital, felt this necessitated a constant re-orientation of the staff which, given the case load at the treatment centres, was not plausible.

Critically reflecting on the paradox highlighted earlier and attributing the failure partly to the lack of comprehensive trainings, a senior M&E officer stated:

“We need to train doctors, nurses, counsellors, DEO. Like having a mock ART centre. Give a card, fill the register, and at the end design monthly reports, cohort etc. But in this push for computerisation, trainings have got lost. People don’t keep registers properly, or even enter data completely. They are making us run before we learn to crawl. They cannot even fill registers and you are computerising everything!”

The result of the poor infrastructure, capacities, and lack of trained human resources was the reported poor quality of data generated through the CMIS. This emerged as a grave concern across various interviews with the Fund bureaucrats such as the LFA, regional coordinators and others. Moreover, no attempts were made to incorporate data from other agencies and components of M&E, the very rationale on which the new framework was developed. The CMIS was unable to account for changing priorities and information requirements over a period of time. Research participants including the state level senior monitoring officers were largely unaware of the information from other sources like sentinel surveillance, BSS and operational research. These remained disintegrated and thus unutilised for the purpose of planning and management of the programme (Notes from informal meetings and interviews).

6.4 Knowledge translation and production of order

In this context of a ruptured system of generating knowledge, other mechanisms played a crucial role in bringing together the official representations with the ground realities, acting as the interface between the project staff and the Fund bureaucrats. These mechanisms: periodic reviews and supervision visits, country wide evaluations, and operational research (OR) studies, served a dual purpose. While they enabled the translation of the different discourses and contradictions into a common language to be presented to an outsider, they also acted as the basis on which the roles of these very outsiders or the Fund bureaucrats could be established.

6.4.1 Periodic reviews and site visits

6.4.1.1 Experience of M&E officers

A cadre of Fund brokers which specialises in fixing the ruptures comprises of M&E officers (State or regional coordinators) appointed by the NACO or the NGO principal and sub recipients. The mandate of the M&E officers is to *“monitor the progress of the programme in respective states, facilitate joint working and coordination among partners, and consolidate the figures from various reports”* (Notes from informal meetings). However, different narratives brought to light the dilemma of these project officers who on one

hand acted as the 'field experts' for their region, available for all evaluation visits by the donor agencies, and on the other, had little knowledge of and control over work procedures and progress made on activities. They remained excluded from the centralised decision-making and at the same time were regarded as 'outsiders' by the State officials as well as the non-State partner organisations.

There was a high imperative for the local authorities and project officers to manipulate the knowledge generated and misreport on the programme outcomes. This can be attributed to the mismatch between the system capacities (with respect to workforce, capacities, infrastructure) and the scale of interventions required by the Fund activities, the stress on performance measured solely on cumulative figures, and the growing competition resulting from multiple providers. In this context, the cadre of project officers operating out of the state office were seen as a potential threat as they could leak the incidents of misreporting to NACO as a result of which the State divisions of NACO could lose the grant (and programme) to its private counterpart. These officers often found it difficult to bridge the official reality (public transcript) with the ground realities (hidden transcript) due to the sanctions laid by the State authorities on field visits undertaken or information shared with the higher authorities.

"There is a regional coordinators meeting called by the NACO which I am not allowed to attend by the Director [of SACS]. He scrutinises and tempers with

all the documents- minutes of previous report, agenda, my presentation, and what I am reporting- before they can be included in the presentation. If the documents are not cleared, it implies I can neither participate nor present.”
(Senior M&E officer, deputed by NACO)

The information sanctioned in particular related to the poor treatment adherence and other outcome indicators related to the programme which formed the very basis of interventions such as treatment, counselling in all its forms (pre test, post test, adherence), outreach work, and others. The officers were aware of and reported instances of manipulating adherence data by reducing the ‘lost to follow up’ figures and by increasing the ‘number of reported deaths’.

“Even I will be concerned if the adherence level is so low. It should be more than 80%, if it is something like 55%, it is reason for concern. This is what I mentioned in some of the slides in the presentation.” (Senior M&E officer deputed by NACO)

Likewise, in the civil society consortia, the imperative on each partner organisation to project or demonstrate high levels of performance resulted in a lack of transparency among partners on the ground realities. The project officers coordinating the initiatives at the state level reported little or no coordination among partner organisations of each or successive rounds and had limited awareness of the progress and performance of partners. Given

the lack of transparency and the ill-defined hierarchies, all attempts at coordination at the state level emerged futile.

“We have a quarterly MIS review meet where all districts are called to bring their registers so that we may finalise our quarterly progress report. Of the four partners, we get monthly progress reports of only one partner. Also, we don’t know what is going on in the corporate arena. If a consortium is considered as one unit, why hide information?” (State coordinator, civil society consortium)

The coordinators often reported a lack of authority to question or seek clarification on the non-performance of their partner organisations. In due course, coordination offices at the state level reached an understanding (rather, were instructed by the senior authorities at the head office) to only “participate and oversee” the activities of the partner organisation. Moreover, financial monitoring was kept outside the mandate of the state offices given the “sensitivity” of the matter (Meeting notes).

“At least the State level MPRs [monthly progress reports] should be shared with us. It includes numbers- on ART, not on ART, SGMs [support group meeting] held, members participating, referrals made etc.. That is all the information we need, nothing confidential. As the managing partner of the consortium, I have to present the numbers. I have brought to the notice of the

PMU [project management unit], hopefully they will take action.” (State coordinator, civil society consortium)

The state coordinators appointed by the managing partner of the civil society consortium, therefore, found it difficult to access relevant information necessary to report to the senior authorities in the head office of the organisation.

“I’m not satisfied with the reports and formats. Where ever I go, books are put in front of me: these many PLHA enrolled, these many counselled, these many support meetings conducted. I would like to see the quality of counselling, and know the process. To what extent has the concept of support meetings been understood or do they simply gather a few people, say a few words and give them travel allowance?” (Project coordinator, civil society consortium)

The problems of asymmetric communication and legitimacy due to competition and power hierarchies among project officers and project workers were intensified by *time*. Time was particularly a hindrance for the M&E officers in the state divisions of NACO for whom reporting duties in the Fund project were additional to other projects implemented under the umbrella of the national AIDS programme. These include targeted interventions, care and support, antiretroviral roll out and others. This overworked cadre reported difficulty in taking time out to make visits to the

respective centres or reporting sites and thus restricted itself to desk review and compilation of the figures reported.

“Periodic sitting may not be possible because we have one ART centre in each district, a total of 24 centres. As per the operational guideline frequency, I will have to visit 12 in one month, which is not possible. Initially I was very enthusiastic-12 in first month, then 8, 7, 3 and then zero. If I had a backup person to do the office work, I could tour.” (M&E Officer, state division of NACO)

This finding corroborated with the narratives of the partner organisations who reported a lack of supervisory visits from either NACO or its state divisions.

“Even SACS have no control over ART centres. Last year nobody bothered to visit. The first ART centre was established in 2005. Till January 2007 none of the SACS officers bothered to visit any of the TCC [counselling centre] or ART [treatment] centre.” (Project coordinator, civil society consortia member organisation)

The discontent with the reporting protocol of the Fund and the inherent asymmetric communication was visible at the different levels of the Fund operations. Having discussed the practice of monitoring at the sub-national levels, in the following section I examine the utility of these reporting

mechanisms by focusing on the national monitoring mechanism of the Fund: the local fund agent (LFA).

6.4.1.2 Experience of the Local Fund Agent

The LFA follows the quarterly reporting format of the Fund and is responsible to ensure that physical and financial achievements are reported along with explanations on justifiable delays, if any, within 15 and 45 days respectively of the end of each quarter.

The monitoring task of the LFA was constrained by a reported lack of flexibility in the Fund guidelines. The Fund policy does not have the provision of undertaking field visits or attending co-ordination meetings, thus restricting the monitoring format to desk reviews of reports submitted by the national recipients. Moreover, the disconnect between the working of the CCM and the LFA averted the possibility of sharing the challenges in the grant cycle between the two. This, in LFA's view, contains the possibility of effectively monitoring the progress and performance of the grant.

“Biggest handicap with the functioning of LFA is that GFATM doesn't encourage field visits. We are supposed to do only desk review. I ask the PR to show the reports from district, state and the country level to verify the consolidate figure they arrived at. If somewhere some figures are fudged, there is no way to know. I can only catch arithmetic discrepancy. I think GFATM is penny wise pound foolish.”

In the absence of field visits, the LFA often adopted informal checks through informal discussions with the recipients to identify the problems.

“Whatever came to our notice, we reported. And primarily on the basis of desk review we did not notice very much. Meetings are not the recognized format of the bank. They are my initiative. If I meet the programme officer over a cup of tea, there is a tendency to talk. Things you may not be able to catch otherwise, comes up.” (Senior bureaucrat, Fund governance)

When the World Bank was the LFA, it overruled the Fund’s policy and continued to utilize its own monitoring strategy which included a considerable period of 2 to 4 weeks spent by the review team in the field. Subsequently, United Nations Office for Project Services (UNOPS) was appointed as the LFA in 2003 and the field visits were dropped from the mandate. However, there was a growing discontent among the LFA globally with respect to the desk review format. Following a South East regional meeting of the Fund in Cambodia in 2005 where the LFAs resented the desk review format, the Fund issued instructions allowing a one day field visit per state for “data verification”. This implied that the LFA could choose one district in a State identified by the Fund to visit and verify the records as per the timeline issued by the Global Fund.

“We were free to choose the district but in a state like UP which has 70 districts, you may or may not be able to catch something. Still lot of improvement was noticed even with one visit. Global Fund decided the time table. We were given instructions like visit one district in each state. Instructions came separately for HIV and TB.”

The visits were regarded particularly useful as they allowed the LFA to get explanations for the poorly maintained reporting systems. However, without further notice from the global secretariat the field visits were suspended in a year's time.

“We got instructions in 2005 and 2006 and made the visit. Suddenly after 2006, no instructions came. There has been no visit in 2007.”

The LFA articulated the challenges in reporting on grant performance, and the disappointment with the Fund's ignorance of the contextual factors. The discontent was also related to the resulting inadequate compensation for the time devoted to the monitoring exercise.

“...programme... [x] is in a clear mess. They are not able to give any information. Global Fund keeps shouting for the reports. So, we send it as it is...Chapati aadhi bani hai to aap adhi khaiye [if the bread is half baked, eat it half baked]. Then they point out gaps in the information. We have been working on this report for more than 3 months with more than 5 times the

man-days sanctioned. But Global Fund says that if we sanction 20 man-days for the task and you take 50, it is not our fault. I don't know whose fault it is!"

Lying at the heart of the Global Fund monitoring mechanism, the LFA serves as a crucial link in the knowledge verification process as well as between the Fund Secretariat and the country recipients. Since the grant is awarded and renewed based on the LFAs recommendation, it has a vital role in maintaining the grant cycle, re-enforcing the rationale and thus contributing to the cognitive function of Schmidt's (2002) framework on discourse to stabilise the Fund system (and organisation of the grant).

Maintaining the myth of a stabilised system

Despite the LFA being crucial to the stability of the Fund system in India, it was also a point of particular instability and anxiety for the national AIDS programme. This is because any departure from the official representation or reality at the level of LFA implies disruption of the grant cycle and threatens the stability of the Fund organisation. On such occasions, the authority and recommendations of the LFA were found overruled. At one such instance, the LFA's decision to not renew (in effect withdraw) the grant for the second phase of a Fund round led to much uproar within the global secretariat. The reason for the poor assessment of the programme was the underachievement of targets and underutilisation of funds.

“Physical targets have not been met and money has not been spent. You made a commitment that you will achieve the following in two years. And the shortfall is not 5 or 10% which GF is willing to condone if you stick to the overall schedule of IPS for 2 years on the understanding that you will make good progress. But the shortfall is 25-30%”

“For one activity, we gave B2. All hell broke loose. Global Fund was very upset. The mail said, “How can you say no to India?” I think because it is a reflection on their performance. When two years back they thought India could get the grant for 5 years, how could they accept after two years that there are problems?”

The facade of the monitoring mechanisms set up by the Fund revealed itself in the arbitration process that followed the LFA's decision. The global secretariat in Geneva sent a team of three consultants to Delhi who had several sittings and deliberations with NACO and state representatives followed by field visits. Subsequent to the 15 day visit to India and reconciliation of reports, the grant was approved after a little over four months.

“Lots of efforts went into it and the grant was finally released after a lapse of 4 to 5 months. If GFATM can afford to pay for three persons to travel all the way, stay and go to the field for 10 days in India, why can't they sanction 5 to 10 days to LFA for the visits?”

6.4.1.3 Recipients view of LFA

The respondents in most cases viewed the LFA as the “puppet” or the “direct arm” of the Fund and as a “foreign entity not well aligned with the national government system”. There was much cynicism among the secretariat staff and members of the CCM regarding the technical competence of the LFA. In their view, the LFA lacked the necessary technical knowledge of the programmes and this slowed down the grant making process.

“LFA has the financial capability but do not know enough about health sector. They play the role of national auditors but do not have enough knowledge of the country context. This delays the verification process.” (CCM member)
(Secretariat employee)

Besides lacking programmatic skills, the Indian LFA was reported to have limited interaction with national recipients and negligible engagement with multi-stakeholder processes. Discussions with LFA also revealed that the interactions were limited to government recipients within the three focal diseases and the LFA was inadequately informed of the non-government national recipients’ activities.

“NGO consortium was not involved at all at the national level. Whatever they are involved in is at the lower level, I was not to interact with them. If someone sends me communication, it is a different matter. I have had no interaction with them till the time I was asked to take field visits in states.”

6.4.2 Operational Research

Operational Research (OR) studies emerged as another important tool by which the brokers could stabilise the discursive practice of the Fund and disguise the disjuncture behind coherent accounts that demonstrate performance. The Fund “strongly encourages” proposals with an integrated operational research component (WHO/GFATM 2008) and has extensive protocols for the applicants to ensure its integration at the proposal development stage. The rationale behind the significance of OR studies is built on its ability to *“identify solutions to problems that limit program quality, efficiency and effectiveness, or to determine which alternative service delivery strategy would yield the best outcomes.”* [ibid]

The proposals were thus found to have a strong component of OR studies with as many as seven (and sometimes up to 12) studies sanctioned for a single national recipient in the first two year phase of the programme. The frequency and ambitious target of OR studies emerged as a cause for concern. Executing the role of a consultant to develop the concept note for one such OR revealed to me the vicious development cycle (complex of events) that is set off by the imperative to demonstrate effectiveness even before the programme could get off the ground. The cycle typically involved commissioning a consultant with research “expertise” (in this case, myself) to undertake situational analysis of the identified problem. This exercise, carried out through site visits and a series of focus groups, established the need for

researching the identified topic. Once the problem was established, a study was commissioned, in this case to a leading research institute, which further justified the utilisation of allocated resources. The results, which failed to generate new learning or change practice, were published with emphasis on best practice models. The representation of these models was in conformity with other global discourses around HIV and AIDS such as speak out sessions, GIPA and peer education strategy. Contrary to the discourse of the Fund which regards OR as *“the science of better”*, the practice of research neither enabled improvements to the existing programme nor led to alternative strategies for better outcomes. Nevertheless, it served as an important resource that enabled the presentation of ongoing tensions and ruptures of daily practice as stories of success.

6.4.3 Country wide evaluation

An important component of the national monitoring systems is the independent evaluation of specific programme or intervention. This component also serves as a means to fill the lacunae emerging from the knowledge generation and translation process. Both the Fund as well as the NACO undertakes independent evaluations of the grant and specific programme activities respectively. In the following section I describe the evaluation process of the care and support programme with respect to its implementation site: the Community Care Centre (CCC).

6.4.3.1 Case Study: Community Care Centres

In India, the concept of CCC evolved from community based institutionalised care and support services initially set up by a leading national non-government organisation in early 1990s catering primarily to intravenous drug users. The success and international recognition received by these centres led the government to adopt this model of care and support as part of the national AIDS strategy. Subsequently, under its care and support programme, the NACO identified care centres that were run by local NGOs or Christian missionary groups and gave additional grants to cover the costs of 10-20 beds. By 1999-2000 the centres became recognised as the SACS (state division of NACO known as State AIDS Control Society) run care centres. Launched officially by the NACO in 2002, these centres came to be referred as the community care centres or CCC and grew in numbers with the NACP III setting the national target of one CCC in each district.

Owing to the arbitrary nature of the grant making and the absence of separate guidelines until 2007, the CCCs developed as a highly plural concept in most states. While a few care and support centres were large institutions (50 bedded hospitals) run by missionary groups with funds from multiple sources and partially supported by the state divisions, a few 10 bedded centres were set up primarily for this purpose.

“The role of CCC has constantly evolved under the NACP [national AIDS control programme]. Previously they were like stop gap arrangement but now

they have a much bigger role once patient is put on antiretroviral. As per guidelines they are responsible for outreach, adherence and treatment of OIs.” (Senior M&E officer, State division of NACO)

“Earlier we had low cost care and support centres whose partial costs such as human resource, food and nutrition were covered by SACS. Now all are developed into CCC. These are huge institutions and infrastructure, 20 and sometimes up to 50 bed-hospitals as well.” (Senior programme officer, State division of NACO)

In a contrasting perspective, a public sector bureaucrat viewed CCC as being reduced to “hospices for terminally ill patients” (Notes from informal meetings with a senior bureaucrat). Thus, there was wide variation in the respondents’ perception of the structure and function of the CCCs. One of the four States under investigation followed a different format for care centres. The State government distributed the funds sanctioned for one CCC among four different organisations running care and support centres. Run on a smaller budget, these centres primarily focused on providing palliative care and nutritional support to the people living with HIV.

“Situation was very different here. They [the State AIDS Society] thought NGOs may not be able to handle so much money. So they split the 16-17 lacs [hundred thousand] into four sums of 4.2 lacs and gave the existing centres. Some were Christian missionary leprosy centres which could

function with this amount because they had their own funding.” (Senior M&E officer, State division of NACO)

“We followed a different system from NACO- a low cost AIDS care and support centre. Previously the CCCs were not treatment specific but now their role has changed. NACO has instructed taking them as centre for treatment adherence counselling. Until December 2007, the centres were run for 4 - 5 lacs [hundred thousand] each, now all are being upgraded to 16 lacs per annum. From January 2008, it will be under GF round 6. (Senior officer, State division of NACO)

This diversity was however ignored in the nationwide evaluation of CCCs which was undertaken in 2006-2007. An independent agency, a US based marketing research company with its operations in India, was contracted for the purpose of assessing the 250 registered CCCs against a standard protocol developed on the basis of the Fund guidelines. The outcome of the evaluation was to determine whether the centre would continue getting government funds.

6.4.3.2 Experience of the evaluation

The performance appraisal that followed was termed as ‘ad-hoc’ and an ‘eye-wash’ by different respondents. Firstly, the process and the tools, the latter comprising of an exhaustive check-list and site visits, seemed divorced from

the plural contexts in which the CCCs developed and did not involve any interaction with the care givers.

“Have you looked at the instrument, the evaluation sheet? As per that, if you have the human resource policy in place, all the documentation in the check list and not a single client then you will get an A. There is no mention of service delivery. Nothing is asked about the quality of services or clients.”

(Senior management, NGO running CCC)

“The man didn’t even come to the head office. We have a separate accounts department here. Accounting or HR policy is in the head office not in the site office because every six months or so the site office is demolished or has to be moved. So the assessors just reported that the organisation does not have a policy. All the things they said we didn’t apparently have, we were ready to show. We got some B or C.” (Senior management, NGO running CCC)

Other criteria used to assess performance included bed utilisation and the turnover of clients in the care centres. Inclusion of these criteria was in accordance with the Fund’s stipulation, which regarded these as a marker of efficiency of the CCC. The requirement, as reported by the project officers’ in-charge of CCC, was that each client could not avail of the in-patient service for more than ten days.

“They say there is no turnover [of clients]. Arey, us bacche ki ma nahi hain. Woh beemar hai aur padha hai to usko utha ke kahan laoge [that child does not have a mother. If he is unwell and lying there, where are you going to send her]?” (Senior bureaucrat, State division of NACO)

A project worker at one of the CCC I visited described the process of registration and the thorough screening a person with HIV was subjected to on arriving at the CCC. The screening enabled an assessment of the severity of the condition and an estimate of the duration the patient might stay for. Narrating one such instance, the project worker shared that a child, despite her terminal condition, had to be referred out after 14 days of her stay. The reason cited was that “the two beds, used by the child and the accompanying person, could not remain occupied for that long” (Project worker, CCC).

In contrast however, the head of a large NGO also implementing CCC as one of its many project, shared instances where the same client was registered under different names to avoid successive interrogations from the Fund and its implementing agencies.

Secondly, the research participants involved with the evaluation reported a high incidence of malpractices. Different sources revealed that the appraising team, in order for the centre to secure a high grade, placed demands of bribery.

“... the appraising person did not visit our CCC in its current location, which was nearer to the ART centre as per the instructions of the SACS. Instead...they demanded a sum of Rs.50000/- to visit the new location and to give a good grade in the appraisal. We refused....Our centre has been graded “D”, which contradicts our past and present performance.” (Excerpts from a formal complaint to NACO by a CCC in-charge and national committee member)

“During our informal inquiries with other CCCs we learnt that the Rapid Appraisal form and observation guide could be accessed prior to the appraisal by giving Rs.50000. Those who paid were asked to fill the forms on their own instead of formal appraisal.” (Senior management, CCC)

Despite the flawed processes, the outcome of the evaluation became a determinant for future funding or termination of the centres. Funding was discontinued for poorly performing centres (which received a grade below B), centres graded B were asked to continue subject to a re-submission and evaluation of the proposal, and the rest were terminated. This resulted in high levels of discontent within the NGOs as well as the State divisions of NACO. Among the poorly graded centres, those that were neither politically connected nor had alternative sources of funding (unlike those associated with missions), faced the threat of perishing. At the time the study was conducted, few CCCs had been running without funds for several months

and were struggling to get alternate funding in order to sustain the running costs of the programme.

“We have been partnering with the government on care home since 1999-2000. In 2007 they decide to change the policy of how they implement TI [targeted interventions]. It is November and we are still to be paid for the period between Feb to June 2007 because that’s the time they decided to freeze everything for the assessment. After June they will decide who they work with and who needs to beg them for fresh funds.” (Senior officer, NGO running care centre)

The upheaval was greater among the CCCs (and the state society they were accountable to) that were functioning on a low-cost model but being assessed on similar criteria as others. The issue was raised at the national technical resource group meeting for CCCs by a member who also headed one such low cost care centre. With the pressure generated through individual complaints and on the initiative of some proactive state divisions of NACO, few centres were re-evaluated while the rest terminated. Among the latter are the two oldest organisations who were pioneers of the community care model in India.

“Recently when NACO visited I took them for a visit to two poorly graded centres. Grading sometimes depends on our attitudes and the person who is evaluating. Now they have modified the grading as B1, B2. Those that were

apex centres of excellence from which other centres have been learning got B2. So, in our State NACO has approved B1 to continue.” (Senior bureaucrat, State division of NACO)

“I am not happy with grade B [centres] being terminated. At least they should have shared with us the reason for grading them low, given them a feedback, give them some time. CCC guidelines earlier were not clear-cut. Some were 10 bedded and others 40 bedded. There was no uniformity. So, they cannot be blamed.” (Senior officer, State division of NACO)

A senior project officer in the State division of NACO expressed her dissatisfaction with the M&E system and its mandate of generating results in the short duration of a project cycle.

“By the time the centres are set up and pick up, 12 months is over. At least give it two years, performance will show only in the 2nd year.”

Discussion on the case study

The country-wide evaluation of Community Care Centres brought to light the common but insufficiently stressed *modus-operandi* that the global development aid apparatus lends itself to and thrives on. Local small scale and often ‘innovative’ initiatives are sought out and introduced to the aid market (public and in effect foreign funds), in the process getting modified in structure, content, and scale as per grant and donor requirements. For

example, the care centres were constantly restructured, from 10 to 50 bedded centres and from a single site to multiple sites across states. Meanwhile standard protocols are devised in accordance with global stipulations and 'best practices', against which the performance of these initiatives is monitored and assessed. Conformity to these extraneous tools, which usually differ from the very intent and rationale of the initiative, thus becomes the basis on which the initiatives are either terminated or granted life. This process not only kills 'innovation' but also creates an environment that promotes opportunist behaviour of the street level bureaucrats (the project workers, evaluators and others). While on one hand the autonomy of the project officer seems subservient to the *authority of the protocol*²⁴, on another, the *agentic* power (Habermas 1990b) drawn from their relative bargaining positions enables them to manipulate these protocols and respond to the needs of the community. In a competitive and uncertain environment, the brokers use the M&E tools to generate knowledge that demonstrates their effectiveness and helps them to attain short term goals such as bribe or renewal of grant or secure position, authority and international repute.

Knowledge thus becomes an essential resource serving both cognitive and normative functions of the ideational dimension of discourse proposed by Schmidt (2002). It ensures i) a justification of the rationale for the next grant

²⁴ See Haper (2005) for a discussion on the authority of the protocol. Examining the health worker-patient interface in the public TB clinic, Harper illustrates how the authority of the protocol (and its strict diagnostic categories) gets stabilised and defers the autonomy of the staff to make more individualist decisions (ibid: 134).

proposal, ii) demonstration of achievement of physical and financial targets, iii) the legitimacy of the roles of development brokers, and finally, iv) the 'peaceful' co-existence of ground realities and official representation within the prevailing discourse.

6.6 Conclusion

The chapter highlights the tensions that arise from the bridging of different normative worlds: the hegemonic protocols of the Fund described in terms of the monitoring and reporting tools, and the field practices of their implementation. The dynamics also reveal the covert manner in which the authority of the protocol, and the discursive practices it enables, stabilise the national AIDS programme and the Fund system.

Firstly, the harmonisation exercise and other implicit tools such as the Fund reporting protocol, M&E plans and M&E systems strengthening, and performance based frameworks, has led to a rather contrary trend. Instead of streamlining its M&E requirements with national priorities and systems, the Fund has enabled a re-structuring of country systems in accordance with international priorities. This has resulted in the birth of a new monster: an extensive framework, new system (SIMS) and series of monitoring and reporting tools at the national and sub-national level dedicated to the production and translation of knowledge to stabilise the Fund governance and the national AIDS programme.

Secondly, these M&E structural arrangements also demonstrate problems which are characteristic of aid delivery and development i.e. problems associated with effective monitoring and regulation. The evidence presented in the chapter reveals the general tendency among the actors in the Fund brokerage chain to pass the responsibility to the level below. While the brokers at each level (global, country, state and district) were proactive in demonstrating performance drawing on the various Fund protocols and securing their positions, none seemed to care about the consequences of 'passing the buck' for those below in the hierarchy. As a research participant rightly stated, the chain of accountability and systems set off by the Fund was characterised by 'NIMTOO' (not in my term of office) syndrome. This implied that officials did not want to take the risk or blame and were happy to maintain the status quo by refusing to acknowledge the obvious disruptions that were emerging.

Thirdly, a direct impact of the rigid "performance based criteria" which is implicit in the evaluation tools and grant score cards is the preoccupation of the already overburdened staff with preparation of multiple reports to report on the extensive requirements. Given the multiple competing interests, this compounds the problems of information and power asymmetries and gives the Fund brokers an incentive to manipulate the knowledge produced and present the tensions of ground reality as official stories of success. Doing so, enables claim on resources, position and authority. The overwhelming pressure resulting from the 'performance based' disbursement condition and

rigid mechanisms of the Fund has also compounded the problems related to low absorptive capacity of countries. The latter is partially attributable to poor budgetary allocations, interests-based as oppose to need-based funding, and multiple/ parallel and incompatible donor funds. This finding has also been highlighted in other studies (Brugha et al. 2005, Stillman and Bennet 2005).

Chapter 7

Discussion and Conclusion

7.1 Introduction

This chapter draws together the various inter-related elements of my research: global health initiatives, country level public private partnerships (PPP) as institutionalised practice, the role of structural and ideational factors in constituting these, the importance of analysis of power relations, and the implications for the management of HIV and AIDS. I discuss my arguments and conclude the thesis in three sections with reflections on: i) the theoretical aim of the thesis ii) the substantive aim, and iii) the system and programme wide effects with respect to HIV and AIDS in India.

7.2 Reflections on the theoretical issues raised by the thesis

The inevitability and legitimacy of the practice of PPPs, as argued in the thesis, is derived from the discursive construction of public-private arrangements which regards partnerships as inevitable, 'win-win', resource pooling strategy and thus, a desired solution to the current global health crisis. This understanding on PPPs broadly emerged from the marriage of two strands of theoretical considerations that I discuss in chapter two as:

- a. New public management discourse and the arguments related to pooling of resources and improving the efficiency and effectiveness of a 'dysfunctional' public health system, and
- b. Network governance which, seen as a departure from market mechanisms and hierarchical forms, highlights the egalitarian and democratic nature of network arrangements and the notion of shared decision making within it.

This thesis is a departure from such discursive understanding and rhetoric on partnerships in global and national health governance. I argue for a careful examination of the plurality of interests and power asymmetries across the five dimensions of the multi-dimensional framework presented in chapter two (2.1.4) while evaluating a public-private mix arrangement. I also seek a rejection of the rhetoric on global PPPs on two grounds. These are elaborated below as I draw on the focus of my intervention: the case of the Global Fund to fight AIDS, Tuberculosis and Malaria.

Firstly, the rationale behind the Fund is predominantly financial, i.e. to increase resources available globally to fight the three 'neglected' diseases namely, tuberculosis, malaria, and HIV and AIDS. Arguably, the budgets of WHO and other multilateral and bi laterals are inadequate to address the health sector priorities and goals for countries that disproportionately bear the burden of global health inequities and consequently, diseases. Likewise, at the country level, budget allocations to the health sector (both systems

and disease-specific) continue to be deplorable in most middle and low income countries. In India the national health budget as a proportion of the gross domestic product (GDP) is on a downward trajectory and currently stands at less than 1% in contrast to private health expenditure of over 5% of GDP (Duggal 2009). Health care and systems research also highlight the deficit areas such as inadequate drug supplies and infrastructure, distribution and availability of human resources, and poor quality of primary health care services including routine immunisations among others. However, like most GPPPs, the Fund neither addresses the local priorities nor targets the efforts towards raising health budgets and increasing overall resources in the health sector. Instead, they continue to reinforce the *technocratic* discourse and a myopic focus on specific diseases, products, and interventions.

Notwithstanding the role of GPPPs in dictating national priorities as argued in the thesis, I do not completely negate the value added by them. This can be seen with respect to increasing the visibility of certain diseases by generating 'additional' resources for them, and specifically with respect to HIV and AIDS, facilitating access to antiretroviral therapy and accelerating the scale of its provision. Over the years, the Fund has significantly increased the total aid flow in the area of HIV and AIDS (Gorgens-Albino 2007, Oomman 2007) which no longer remains "neglected" or "under resourced" (McKinsey 2005). On the contrary, in India, the thrust of donor interests is evident from the annual budget outlays (GOI 2010). The excerpts from the union budget for the health sector for the year 2010-2011 indicates the attention that HIV and

AIDS as a single disease component receives both nationally (5 percent of the total health budget) and as a share in external aid (31 percent of the total aid) (Duggal 2010). The Global Fund alone contributes 25 percent of the budget outlays for NACP III (NACO 2007a).

The link between the primary rationale of the Fund and the rationale behind its institutions and mechanisms in recipient countries is contested. In other words, the discursive construction of the Fund establishes it solely as a financing mechanism thus attributing the negative outcomes to either governance failure of recipient countries or difficulties of aid delivery. It establishes the logic of necessity by channelling 'additional' resources for HIV and AIDS, in particular ART, and reinforces the logic of appropriateness by - i) upholding principles of 'partnership' (egalitarianism, democratic decision making) and civil society representation, and ii) setting off a chain of brokers who perform the coordinative and communicative roles translating the policy objectives to multiple interests and ideologies (as discussed in chapter four, five, and six). In this process, however, it sets off contradictory processes of competition-collaboration, fragmentation-assimilation thus both constituting and constructing the practices and outcomes.

Secondly, although, the public private interactions set off by the Fund regime occur within multiple overlapping 'policy' networks, these do not however conform to the common conception which regards policy network as: stable patterns of social relations with interdependent and largely equal actors

(Kickert et al 1997, Thompson et al. 1991). Instead, as we have seen, these networks are complex configurations characterised by divergent interests and shifting allegiances, asymmetrical allocations of material and immaterial resources, and mediated by both overt and covert forms of power (relations) among network actors.

The evidence presented in the thesis unmask these power relations which are reproduced in the country level practices of the Fund arrangements. Deviating from either purely constructivist or purely structural accounts, I emphasise as much the importance of a 'legitimising ideology' as the material and structural characteristics of power (Hasenclever et al. 1997). Power mediates the institutionalised and discursive practice of PPP at various levels and in various forms: the disciplinary power (Foucault 1980 in Rabinow ed. 1985) of the Fund protocols whereby the required action is made the desired action through normalisation and by reproducing the structures of domination and, agentic power of the Fund brokers. Power, I argue, is both embedded in and wielded through hegemonic structures of global governance (structural factors), the ideas-discourse (ideational factors) and the actor's interface with these (agency of actors). However, the myth of "partnership" and the ideas informing the discourse- shared decision making, benefits, and risks- perpetuate this ongoing exercise of power.

One of the central arguments presented in the thesis renders this dominant discourse on partnerships as 'mythical' and rhetoric, one which masks any

possibility for the expression of progressive political agency that lie imminent within the real fabric of the political economy.

7.3 Reflections on the substantive issues raised by the thesis

Contrary to the monotheism of the PPP policy model which highlights the *collaborative* and *complementary* nature of public and private interactions, the evidence presented in the thesis unmasks the polytheism of practice, the power struggles and the resulting *competition* at the *meso* and *micro* processes.

The Fund supported initiatives and practices emerge as sites where multiple unaccountable agencies compete for resources, power, and individual and organisational gains. The literature on PPP more generally, and the Fund in particular, disregards the uncertainties and in-coherences that arise from the contradictory forces in operation. For instance, the complicity of locally powerful actors (such as the NACO, international or large national NGOs and the corporate) and their manipulation of the rules in order to establish their authority behind subservience to neoliberal donor paradigms (Mosse and Lewis 2006) or the strategies of the marginal actors (such as the district network for people with HIV and implementing partners) who struggle to balance the legitimacy gained from their role in the Fund arrangements and that derived from their links with the community. The resulting tensions form the sub-text for the analysis undertaken in Chapter four, five, and six as I focus on the conflicts and compromise, diverging and converging interests

and the diverse interpretations the discourse is continually subjected to through the practice of PPIs. The disjuncture between policy goals and actual practice, I argue, emerge out of the interaction between externally imposed *hegemonic* structures and agendas and the strategic interactions and interpretations of local and transnational actors acting locally.

Power, gets wielded at various levels. First, as discussed in chapter four, the hegemonic structure of the Fund (mechanisms, protocols, the policy networks such as the CCM, TRP, and the environment it generates) is dominated by what Cox (1997:60) refers to as “loose elite network of influentials and agencies” who share similar ideas and beliefs, and collectively, perform the function of Fund governance. The policy networks in the context of the study include the CCM, the civil society consortia and other national consultative and decision-making forums. Within these networks, power is wielded by i) virtue of membership ii) suppression of information, use of engineered information, spread of misinformation, and lack of effective evaluation procedures, and iii) on the basis of professional and technical expertise, which is largely understood in the context of successful grant application and demonstration of success in achieving programme targets. Hence, while the public sector (the NACO and its state divisions), is an important actor controlling the decision making process at national and sub-national level, it often acts on the knowledge and endorses the decisions taken by transnational actors. The latter gain legitimacy by establishing the dominance of increasingly technical and bio-medical discourses and

managerial systems as demanded by the performance-oriented-nature of the Fund. On the other hand, even though local community based groups are increasingly represented in such networks (as implementers and occasionally in advisory roles) they remain *outflanked* or peripheral to the domains of technical and professional expertise.

The result of this is that a particular class of transnational and national elites often wields power in these arrangements. The focus on 'transnational elites' is a departure from the orthodox Marxist (and in effect structuralist) unit of analysis, the State. This focus stems from a recognition that States function as peripheral actors within, what Keohane and McGrew (2002) propose as, a global constellation of networks comprised of multiple actors at multiple levels of interaction.

“Liberal global governance sutures together the divergent interests of corporate, national, technocratic, and cosmopolitan elites, crystallizing in the process a nascent transnational capitalist class whose principal objective is widening and deepening of the global capitalist project.” Held and McGrew (2002a:63)

I discuss the role of the transnational elites in “co-opting potential leaders of subaltern social groups” (Cox 1996:130) and assimilating and domesticating the voices from the margins by adjusting them to the policies of the dominant

alliance. The case of the network for people with HIV presented in chapter five illustrates this point.

Adopting the terminology of “intellectual fascism” proposed by Vincent Navarro (2002), Banerji (2006) explains how the elite (or ruling class) in both rich and poor countries form a nexus which enables them to impose *technocentric* prescriptive programmes to subserve their political and communal interests. In the chapters four and five, I discuss that this imposition is made possible through what Foucault refers to as the act of normalisation undertaken by the cadre of intellectual brokers and bureaucrats implementing this agenda. An examination of the nature of non-state actors whose participation is invoked in Fund arrangements is undertaken in chapter five. The analysis reveals that under the Fund regime the presence and activities of international NGOs (iNGO) is regarded as a proxy for political action and ‘civil society’ in the country. These iNGOs, in turn, gain legitimacy from coordinating efforts (through training and capacity development) to “build” civil society and ensure GIPA, thus expanding their representation in the national and Fund governance.

7.4 Broader reflections on equity in health care and systems

The introductory chapter outlines the questions and ideas that guide the conceptualisation of this research. An important and rather implicit aim of the thesis relates to the third theme identified from the analytical framework (see figure 5): the practice of PPIs and the outcomes it generates. Since the Fund

represents a new model for addressing global health and providing development aid, the processes and policies through which the Fund supported initiatives operate have significant implications for equity of the health system as well as specific programme related outcomes. Looking specifically at HIV and AIDS, which has brought to the fore the linkages between health and wider socio-economic factors of inequity and inequality (Parker 2000), I discuss the implications for delivery of and access to quality treatment and care.

7.4.1 Fragmentation of delivery and accountability systems

The evidence presented in chapter four suggests the Fund has fostered a growing number of vertical initiatives which results in fragmentation of the delivery system and duplication of services offered by the public sector, private sector corporations and the non profit sector. While it is the case that the resources made available enabled wider access to ART, the amount of funding has created a *defacto* parallel public health system, better funded and equipped than the existing one. This finding also corroborates with the results of multi-country studies on global health initiatives (Brugha et al. 2004, Grace 2004, Brugha et al 2005, Stillmann & Bennett 2005, Oomman et al 2007). Each initiative once created, assumes an identity of its own with independent programme management systems, mechanisms and actors, which interact in loose network arrangements while competing with each other for control over resources (funds, clients, drugs) and legitimising their roles. As illustrated in the case studies in chapter five, different

constituencies provide anti-retroviral treatment under the national AIDS programme (through different rounds of the Fund grant): public sector hospitals, corporate ART centres and the non-profit sector (network of PWHA and other NGOs). They compete with each other for clients to demonstrate efficiency in absorbing funds and achieving results and make counter claims on the performance of the other.

Despite the multi-provider environment instilled by the Fund and the increasing role of the private sector in decision-making, the administrative burden and patient load is disproportionately high for the public sector. There has been a substantial increase in the demand for health services particularly with respect to treatment of opportunistic infections. Multiple service delivery points and consequently a substantial increase in the number of people tested and undergoing treatment has led to congestion at the secondary and tertiary levels of the public sector since the initiatives in the private sector do not provide the complete range of services. A mismatch between the demand and supply of services can be observed.

Secondly, the shift from a purely state managed programme to a public-private mix constitution of the CCM, an entity where the majority of the programme related decisions are made, has further diluted the regulatory role of the State. In the absence of a regulatory framework the existence of multiple providers within the national programme has led to difficulties in ensuring accountability and arbitrating in case of failures. Each node (actor)

in the chain of brokerage set off by the Fund (in translating the Fund/programme objectives into multiple interests and demonstrating the success to maintain the Fund cycle) maintains its legitimacy by passing the buck and ignoring the difficulties and disruptions at the implementation level. The monitoring mechanisms thus serve as a medium to generate knowledge to demonstrate effectiveness while evaluations present as an opportunity to shift responsibility for non-performance.

Another effect highlighted in chapter 6 is sustainability of the fund supported initiatives. While multiple actors and initiatives are set off by the Fund, those run by the subordinate groups on limited funds and technical expertise face the threat of extinction. Since these initiatives provide essential services such as care and support to people with HIV, the closure of the initiatives has had a significant impact on equity of care delivered.

7.4.2 Duplication of services

As the evidence illustrates, the multiple initiatives led by the Fund brokers have overlapping objectives which result in duplication of services provided. In chapter 4, I illustrate the impact on counselling where, due to the high administrative burden generated by the activities of the Fund, counsellors in the public sector are unable to counsel the patients. The gap, instead of being corrected, serves as a justification for newer projects, independent structures, and recruitment of a new cadre of employees (peer counsellors, treatment adherence counsellors, pre ART and post ART counsellors) in the

private sector. As illustrated by the case of the civil society consortia, this response does not tackle the difficulties faced by the counsellors in terms of the paperwork and documentation. It rather subjects the new cadre of counsellors to similar problems and conflicts over resources and authority.

7.4.3 Human resources

In the light of the evidence, it can also be concluded that the Fund arrangements have a detrimental impact on the health system as they actively deplete the pool of skilled human workforce and reconfigure the expertise and knowledge valued within the health sector. Ironically, external country evaluations of donor programmes and global health initiatives including the Fund highlight a shortage of trained and qualified staff as a significant barrier to health systems development in general and scale up of the antiretroviral treatment in particular (Grace 2004, Brugha et al. 2005). All the same, as highlighted in chapter four and five, these problems are often induced or aggravated by the Fund activities and the public private mix. I discuss these problems under three headings: availability and mobility; workload and motivation; and training and skills building. The effects on the human resources are discussed below.

7.4.3.1 Availability and mobility

By inducing an environment characterised by resource and power asymmetries and competition between diverse stakeholders, the Fund facilitates movement of the health workforce. While much of the migration of

health personnel observed was from the public (state divisions of NACO and other public sector agencies) to the Fund supported initiatives run by industrial or corporate component and NGOs, movement was also observed within the private sector i.e. from local networks to bilateral and international agencies, from one project to a better funded project within the same agency, and from other disease programmes to HIV and AIDS. This results from multiple overlapping projects and activities which poach qualified staff by offering better incentives and higher salaries. As a result a high turnover was observed in projects run under the national AIDS programme. The turnover was particularly high among senior officers at the state level. The observation of Fund-induced migration corroborates with findings from other studies undertaken in Ethiopia, Malawi, Kenya and others (Banteyerga et al. 2005, 2006; Mtonya et al. 2005, Donoghue et al. 2005a, Drew and Purvis 2006).

Another observable trend is that organisations which earlier focused on addressing broader health issues and reproductive health needs are moving into the AIDS industry and re-allocating priorities to follow the Fund money. This trend was also visible among international actors who are expanding their operations to newer regions and countries on the basis of the Fund regime.

7.4.3.2 Workload and motivation

The Fund induced activities have caused workload which is additional to the existing responsibilities of the public sector workforce. The human personnel

in the state divisions of NACO had multiple projects to report on and monitor and received no additional incentive or remuneration for the extra work due to the Fund activities. On the other hand, programmes run by large non state agencies, who received direct funds (as a national recipient) from the Fund, had separate provisions for human resource at higher salaries and limited responsibilities. These agencies also operate with multiple sources of funding (corporate companies, bilateral, other donors) and are thus able to attract more qualified and experienced health workforce from the public sector. This staff leakage to the private sector thus exacerbates the problems arising due to inadequate staffing and budget restrictions in the public health sector.

Moreover, the difference with regards to the workload and the workplace environment of the public and private sectors working 'jointly' on the programme was stark, particularly at the facility level. These inequities among the constituents of the same programme led to dissatisfaction and demotivation of human personnel, as highlighted in the interviews held with the service providers.

7.4.3.3 Training and skills building

The evidence demonstrates how the discursive ideas around Fund governance and public private arrangements are continually translated into the interests of multiple stakeholders to justify and legitimise its practice. The stakeholders' claim on future funding is dependent on how successfully the programme activities reach out to and invoke participation of the

beneficiaries, in this case, people with HIV. The involvement of the 'disease constituency' i.e. infected (and affected) community in interventions which are founded on overtly bio-medical discourse, further necessitates a sensitisation process to enable their transition into health workforce who serve as the crucial link between the Fund and the community and at the same time are also able to talk as entrepreneurs striving for results. Likewise, local NGOs while being key to enable the tokenistic representation of the civil society in governance bodies are continually dismissed for their lack of expertise and skills.

In this context, training programmes (and similar mechanisms to build capacities) act as a crucial site for sensitisation. Thus, heavy investments are made in orienting national and sub-national stakeholders to the Fund systems, guidelines and processes and in writing successful grant applications to secure a grant from the Fund.

The Fund focused training programmes and those provided by other donor agencies were not streamlined leading to duplication of efforts. Multiple workshops with similar focus are conducted by various organisations. At the level of implementation, the trainings focused exclusively on software (CMIS), documentation, and providing information on HIV to enable counselling. None of the trainings content provided skills that could be transferrable to other disease programmes. Likewise, a clear shift could be observed in the focus of the capacity building programmes of the network of

people with HIV, which moved away from advocacy and campaign skills to building management capacities.

Hondeghem (1998) highlights that a consequence of the shift from the Weberian bureaucracy to a public sector characterised by business-like managerialism is the transition of public servants to public entrepreneurs striving for results which takes precedence over the means to achieve them. In the context of the public-private mix provision with even greater emphasis on (and funds tied to) measuring performance and efficiency in relation to specific targets, outcome measures and results, this effect is not restricted to public sector alone.

Concluding remarks

Contrary to the discursive understanding of global PPPs and global governance, I argue that these effects are not 'unintended'. The Fund arrangements like other 'partnership' and 'network based' approaches serve as an effective instrument to extend technocratic control and advance the interests of transnational elites while concealing the agency of outsiders (Cooke and Kothari 2001, Mosse 2001). They achieve cognitive and social control by manipulating local elites, co-opting critical discourses and thus, contributing to widen and deepen the global neo-liberal agenda under the guise of autonomy of the people and the nation State.

Over the last eight years, the national AIDS programme has witnessed constant changes with the growth of the Fund, which claims to be 'a new architecture of aid'. However, as illustrated in the thesis, this new *governmentality* is inherently contradictory in its operation. On the one hand, under the rubric of health sector reform, the Fund reflects a conglomeration of diverse discourses (and rhetoric) on 'good governance', 'decentralised implementation', 'greater participation of the civil society' including the private sector and people with HIV to make the health system and services more efficient and responsive to local needs. Yet, on the other hand the practice of Fund governance represents a shift to highly bureaucratised and centralised system (around the State and bi/multilateral-controlled CCM) with an exclusive focus on information systems that are increasingly defined by globalised interests. The rise of such a technocratic and vertical programme mirrors the rise of neoliberal reform process, its associated discourses, and elite interests.

Many might argue that the new form of aid is better than the 'chaos' before, characterised by multiple providers, low diagnosis and treatment rates, and lack of standardised information on the 'epidemic'. However, the myth of 'order' created by the Fund *governmentality*, I suggest, conceals the agendas and interests that the discourse is established to serve. It also conceals the undesirable effects with respect to the quality and equity of treatment and care and the damaging effects on the components of the health system behind huge webs of complex statistics. In an ethnographic account of the

DOTS programme in Nepal, Ian Harper (2005:144) argues that this 'attempted stabilisation of the system can significantly marginalise patients and deny their agency' and contribute to 'structural violence' (Farmer 1998) in administering the programme.

7.5 Are the findings generalisable to all PPPs and all regions?

The study examines only one of the several global health partnerships/initiatives, namely the Global Fund to fight AIDS, TB and Malaria and the public private 'partnerships' it invokes at the country level. This might lead to doubts on the generalisability of the findings to i) all global and country level public-private partnerships, and ii) all GFATM recipient countries. I have a number of responses to this.

First, the aim of the thesis is to deconstruct the policy rhetoric on PPP and examine power in the discursive understanding and practice of public private interface arrangements. The thesis demonstrates that power mediates the phenomenon at multiple levels and interfaces: ideas and discourse, structures and institutions, actors and interests, and social practices. Together, these act to maintain the hegemony of the transnational capitalist class within the development and AIDS industry and eliminate the very possibility of an alternative conceptualisation of public and private interactions. Second, I argue that the practices of a policy model, PPP in the

case of the thesis, is both constituted and constructed by structural and ideational factors. This implies that contrary to the espoused view of the Fund and its proponents, the structures and institutions (and the implicit and explicit rules, conditionalities) of the grant constitutes the actors and their interests, enable the practices, and thus shape the outcomes. Third, these practices and the knowledge that the actors generate legitimises the i) discourse on the inevitability or necessity of the Fund, the public private 'partnerships', and many other sub-texts (involvement of certain actors and certain kinds of expertise: the international agencies, corporate and business houses, people with AIDS), ii) the structures including the coordination, monitoring and evaluation mechanisms, grant agreements, and iii) the role of actors within the partnership environment.

To this extent, the covert and overt forms of controls operating in the discursive notion of partnerships and the intersubjectivities created (as identified in the framework) can be applied to all contexts which are largely defined by the donor-recipient relationship and the involvement of the non-state actors in financing and delivering health services.

However, I recognize that the scale and scope of economies have an impact on these power asymmetries and determine the system-wide practices and consequently their effects. A caveat to the generalisability of the findings therefore lies in the scale and scope (magnitude of operations and diversity of contexts) that the Global Fund operations face in the context of India,

which sets it apart from its African, south Asian and other counterparts. Although these regions have their own complexities with regards to donor monopoly and aid dependence especially in fragile states, which have other implications for power, sustainability, and inequities, the structural dominance is subject to less normalisation and interpretation given the smaller number of actors, vertical interventions, and regional differences in health care delivery and systems. India, in contrast, is far more plural and diverse in terms of interests of the state and non-state actors and their involvement in delivering health care, the regional contexts and priorities, and interventions designed to address these. Given this diversity, attempts at incorporating universal principles of harmonisation and coordination such as the three ones, one national CCM to coordinate all Fund activities and others are deemed to fail. This necessitates further research to examine the role of the Fund structure, the underlying ideas and discourse in shaping practices and outcomes in other Fund recipient countries.

As established in the thesis, a plethora of arrangements are referred to as partnerships and far greater plurality exists in country level public private interface arrangements. Addressing these was beyond the intent and scope of this thesis. This thesis limits itself to examining public private arrangements set off and co-ordinated by the GFATM. However, the framework proposed in chapter two can serve as a useful tool and be further tested to examine different global and country level arrangements and their power implications.

7.6 Contribution of the thesis

This thesis examines the operations of public private partnerships or global health initiatives as a departure from its discursive understanding (and development rhetoric). In doing so, it makes a significant contribution to the challenge of conceptualising the relationship between global policy models and initiatives and the practices and material outcomes they are expected to produce and legitimise.

The limited empirical evidence of country level effects of global health initiatives, such as the Fund, relies heavily on impact assessments and evaluations commissioned or conducted by the Fund. This, on one hand, as Biesma et al. (2009) argue, may affect the validity of the findings. On the other hand, the largely uncritical perspective evident in these studies, contribute to reproducing the rhetoric on partnerships. Moreover, the evidence base is restricted to impact assessments largely conducted in sub-Saharan Africa or countries with high aid dependence and donor monopoly, so much so that sustainability of the country level programme emerges as the overarching concern. Thus, my thesis is the first systematic examination of the operations of the Fund in South Asia.

Another significant feature of the thesis is its theoretical contribution. Building on the nascent *constructivist* attempts to examine the policy discourse, the thesis merges structural/critical approaches to health policy with actor oriented approaches which focus on the ways through which development

meanings are produced and negotiated in practice (Long and Long 1992). Thus, while it questions the larger political economy of inequality and power/ domination in which 'global governance' is located, it also examines how the hegemonic policy model gets transformed into social and political trajectories of brokers and translators who are constantly enrolled. Drawing attention to the nature of discourse, the thesis reveals the role of these brokers in reproducing the system, and gives insights into the social processes and practices that are silenced or concealed behind the attempted stabilisation of the Fund system.

As I reject the inevitability of PPPs, I argue for the possibility of conceptualising public and private interactions in alternate terms in order to avoid duplication and further fragmentation of the health systems. While this thesis does not propose alternative organisational forms, it sets agenda for future research and policy discussions to seek equitable alternatives and/or strengthen earlier channels of funding. This agenda for change should not be restricted to the Fund but should engage with other such organisational forms and relationships at global, national and sub-national level.

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Appendix 1

Draft Interview Guide

I. Background & History of the partnership

1. Describe your role and association with the GF (Rd 4, 6 and 7)
 - History and process of involvement with the fund- changes between the rounds and process of renewal
 - Key stated objectives and commitments(*health systems development, equity, gender*)
 - Designated responsibility by the contracting agency; CCM; other partners
2. Process of awarding the i) grant ii) contract (Competitive bidding/ tender; direct negotiation; any other)
3. Who in the organisation have been key in initiating and managing the programme (i.e. identifying the funder, negotiating the contract, developing the proposal & overseeing the project)?
4. Different relationships within the partnership programme and objective function and institutional arrangement of each

OR

Draw/ map out your organisation's association (formal and informal) with other stakeholders – CCM/ PRs/ SRs/ planning & implementing bodies - describing the nature of relationship. for instance, contractual or collaborative- any other

II. Governance

Decision making

5. Constitution of the decision making bodies like CCM, PAB, NACB- representation of all constituencies across sectors, states and districts
6. Process (of negotiation, compromise and conflict of interest) involved in decision making around -
 - development and review of proposals (identifying activities and sites)
 - budget allocation and financial outlays

- nomination and selection of PRs, SRs/implementing agencies
- review of programme implementation (performance-non performance of actors) and subsequent action

Communication

7. What information systems have been established for communicating key decisions (incl. information on call for proposals and grant making) from CCM members to constituencies and, concerns of constituencies to CCM?
8. Ways of disseminating information to all concerned parties at the Proposal development, bidding (for sub recipients) and grant making stages
9. Systems and processes through which efforts of partner organisations are coordinated- purpose and frequency of coordination meetings
10. Any consultative process/coordination meetings (at the central and state level) with other state specific HIV & AIDS programmes and donors/ multilateral-bilateral funded programmes?

Institutional arrangements/ structures (including M&E)

11. Formal agreements OR good practice norms and informal controls that exist within the institution- how are these exercised?
12. Any written TORs/ by laws/operational guidelines and procedures – DO they clearly specify -
 - i. roles and responsibilities of all coordinating bodies
 - ii. conflict resolution
 - iii. performance assessment criteria and penalties for non-performance
13. What measures are taken to ensure adherence by all parties to GF rules or guidelines? Are these outlined in the contract with sub contracted constituencies?
14. Mechanism for review and assessment of performance –
 - Internal performance monitoring (PR level)
 - Performance evaluation by CCM
 - M&E frameworks across and within the organisation – process of developing the national framework and MIS and sharing with other stakeholders

15. How are deliverables ensured? Any reward-penalty systems set up in case of breach of contract?
16. What are the strengths (if any) and constraints(if any) in the present M&E system? What specific problems do you face, if any, in reporting back?
17. Has there been any experience of disputes/ conflict of interests? How would you expect these to be resolved? What measures are put in place to deal with differences?

BUDGET/ Financial disbursement

18. Process of negotiation with the funder/ contracting agency for the setting of the budget
19. Are the funds adequate for provision of the services mandated by the contracting party? What are the additional costs, if any?
20. Is there any other source of financial (or other) contribution to the programme? If so, provide details.
21. What are the implications of i) over/under spending ii) delay in disbursement for the organisation and/or programme? Can the unspent money be utilised for other items related to the project?

Free word association – one word to describe the -

- a) Partnership's policy environment (decision making processes)*
- b) Management of Global Fund & CCM*
- c) Relationship with sub-recipients, NACO, CII, PFI*

III. Perceptions of the partnership, its performance and impact

SWOT analysis of the partnership. Write on stickies and prioritise. Some guiding questions-

22. What according to you are some significant outcomes of the programme?
 - i. Has it enhanced the quality (incl efficiency) and equity of service provision? How?

- ii. Has the target/ beneficiary group (number or people, spread, population types etc.) changed overtime in the project period? How?
 - iii. Has the change affected the quality of services and existing delivery systems (including drug supplies, management & distribution)? In what way?
23. Has this change been fed back and accounted for by the CCM in deciding the inputs & priorities of the programme? If so, how?
24. Has the programme built/enhanced the capacity of your organisation and the staff? In what way? Is it adequate?

*Impact of the programme on distribution, skills, motivation, time and routine activities of staff/ health workers. **Explore costs of reporting and managing the information systems/visits***

25. What is the funding (/contracting) agency required to do under the contract? Has it failed to meet any of the requirements? In that case, have you been able to address this?
26. What are the gaps (if any) in an efficient governance of the partnership-constraints (capacity/funds etc.) faced in meeting the programme objectives and reporting on them. How have you/do you intend to address the gaps?
27. Pressure faced in meeting the programme objectives and reporting on them - how is slow progress/delays and inefficiencies, non performance of other partners dealt with?
28. What further inputs from the partners you seek essential?

Guiding questions for CCM members

33 members (Ref : Rd 6 proposal) as per new constitution Aug 04-06

I. Your role and delegated responsibilities within –

- The CCM
- Partnership programme

II. About the CCM

Background information (not for all respondents)

- Employees (full/ part time)
- Proportion of the private-public and civil society constituencies within CCM?
- Regularity/ frequency of meetings held? (quarterly/ bi monthly/ monthly etc)

Specific Questions

COMPOSITION (and representation)

- How are the members identified and brought on board?
- Representation of your constituency (Academia-NGOs/CBOs-commercial/business enterprise-the beneficiaries/target group) in the CCM?
- Perceived representation of all constituencies (public-private; governmental-NGOs, advocacy-CBOs) actively involved in fighting TB, malaria, HIV&AIDS? And regions-states/ districts?

PARTICIPATION & COMMUNICATION

- Do all members have prior access to key documents (minutes, disbursement reports, reviews, disbursement and other decisions)?
- How are decisions communicated i) within the CCM and, ii) to other stakeholders?
- Is information related to i) call for proposals ii) decisions taken (including information on approved proposals) made available to all interested parties? How is this ensured?
- Levels of participation of your constituency and concerns related to-
 - Setting the agenda for the meeting
 - Developing the proposal for the Global Fund
 - Overseeing implementation

- Evaluating the functioning of the CCM

GOVERNANCE / MANAGEMENT

- Written TORs/by laws/ operating procedures/ guidelines for-
 - i. defining roles and responsibilities vis-à-vis other coordinating bodies
 - ii. mechanisms for decision making and conflict resolution
 - iii. selection of chair, vice chair
 - iv. ethical behaviour/ code of conduct for members
- How are key decisions around nominating PRs, SRs; reviewing proposals and overseeing program implementation made?
- Is there a transparent process to ensure inputs from a broad range of stakeholders (members and non-members) and constituencies in the proposal development? Is it documented?
- How is participation within the CCM assessed and documented? Are there plans to improve?
- Comments on
 - Processes to address conflict of interest
 - involvement in the decision making, in reaching consensus, assessing CCM
 - Value given to the contributions and involvement of your constituency
 - Documentation available to inform your constituency of decisions taken in the meeting

Coordination between other development partners (WB, UNAIDS, Dfid, USAID etc.) ensured? Frequency of coordination meetings at the central and the state level- how is input from a broad range of stakeholders (members and non-members) and constituencies while developing the proposal ensured?

How is integration with the existing government interventions/ services ensured?

Appendix 2



Queen Margaret University
EDINBURGH

Information sheet for participants

My name is Anuj Kapilashrami and I am a postgraduate research student at the Institute for International Health and Development at Queen Margaret University in Edinburgh, UK. I am undertaking a research project titled “Public private partnerships and governance: implications for health systems and outcomes” as part of my PhD.

The study attempts to examine the governance mechanisms adopted by the country level partnerships of Global Public-Private Partnership (Global Fund) and how these impact on the health systems and outcomes. This will be undertaken in the context of specific partnership projects implemented with the objective of scaling up access to HIV&AIDS treatment and care in India. It is hoped that the findings from this research will enable a nuanced understanding of public-private partnerships and raise crucial governance issues related to partnerships.

If you agree to participate in the study, you will be requested to share your opinion and respond to questions related to the project planning, implementation and outcomes of the project. I would also like to observe the functioning of the centres established for care, treatment and counselling of people living with HIV&AIDS. I would appreciate very much if you felt able to contribute towards this research either through individual interviews, or through your activities in community groups you may be part of.

Information gathered will be anonymised with no names being quoted at any stage. Should you wish to withdraw at any stage or choose not to respond to a question, your decision will be respected. The results may be published in a journal and/or presented at conferences.

If you have read and understood this information sheet, your questions have been answered and you wish to participate in the study, please proceed to the consent form.

Thank you.

Contact details of the researcher: Anuj Kapilashrami
PhD student,
Institute for International Health
&Development
Queen Margaret University
Edinburgh EH12 8TS

Email: akapilashrami@qmu.ac.uk

Ph: +44 (0)131 317 3493

Should you wish to contact an independent person (in India and in Edinburgh) who knows of the project but is not involved in it, please contact them at the details given below.

Advisor (in India)

(In UK)

Dr. Imrana Qadeer

Prof. (Retd.)

Jawaharlal Nehru University

C4 Safdarjang Development Area

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Appendix 3



Queen Margaret University
EDINBURGH

CONSENT FORM

Study title: Public private partnerships and governance: implications for health systems and outcomes

I have had the information form explained to me / read and understood the information sheet and this consent form. I have had an opportunity to clear doubts regarding my participation.

I understand that I am under no obligation to take part in this study and that I have the right to withdraw from this study at any stage without giving any reason.

I understand that by signing this form, I would consent to:

1. My participation in the interviews/ discussions/ other activities initiated by the researcher in pursuit of the information
2. The recording (audio/ written) of the information shared by me
3. The publishing (or other forms of dissemination) of parts of the information shared and the results of the study

I agree to participate in this study.

Name of the participant: _____

Signature of Participant: _____

Signature of researcher: _____

Contact Details of the researcher:

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Institute for International Health and Development
Queen Margaret University
Edinburgh

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Should you wish to contact an independent person (in India and in Edinburgh) who knows of the project but is not involved in it, please contact them at the details given below.

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(address to be confirmed)

In UK

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