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Abstract

This paper investigates state-civil society relations in the Ugandan AIDS response through a critical exploration of the history of Uganda's 'multi-sectoral' and 'partnership' approaches, particularly as it pertains to The AIDS Support Organisation (TASO). It finds that the Ugandan government's reputation for successful prevention campaigns is not necessarily deserved, and that the effectiveness of civil society is limited by an authoritarian political culture. Despite these limitations, however, state-civil society partnership did contribute to the emergence of a relatively effective coalition for action against HIV/AIDS. Donors were essential in encouraging the emergence of this coalition, but have also inadvertently undermined the emergence of strong and independent civil society voices able to hold the Ugandan state accountable.

1. Introduction

Uganda experienced one of the earliest large-scale HIV epidemics in Sub-Saharan Africa, but gained a reputation for a highly effective response to, and strong political leadership on HIV/AIDS. It is often considered a model for addressing HIV/AIDS in resource-poor settings (Youde, 2007: 1). Both the personal leadership of President Yoweri Museveni and appropriate public policy are seen as critical success factors – as is the effective civil society response spear-headed by The AIDS Support Organisation (TASO). Indeed, the relationship between the state, donors and civil society is widely understood as a productive partnership, making up for weaknesses in state capacity where necessary.

This paper critically investigates state and civil society leadership on AIDS in Uganda through the lens of TASO's growth and evolution in the context of a supportive but relatively authoritarian state. A particular focus is on whether TASO has managed to improve service delivery, not only directly[1] – by

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[1] Bukenya (2012) has shown that in addition to direct service delivery, TASO has attempted to build state capacity within the public healthcare system through knowledge and skills transfer, etc.

providing services the state lacked the capacity to provide – but also by 'holding government to account' on HIV/AIDS policy and service provision. It has been suggested that civil society did so in South Africa and Brazil (Nunn *et al.*, 2012), through various approaches including litigative strategies (Meier and Yamin, 2011). The analysis reported in this paper bears out neither a story of exemplary leadership from the Museveni government nor of civil society 'holding government to account'. However, it does illustrate that state-civil society partnership contributed to the emergence of a relatively effective 'AIDS response coalition'. Donors had a critical (but not unambiguously positive) role in the emergence of this coalition.

The research primarily draws on key informant interviews conducted with leaders in civil society, government officials, donor representatives and healthcare workers in Uganda as well as documentary sources and secondary literature. Informants named in this paper were (or still are) public figures and consented to be quoted and named in publications arising from the study.[2]

2. 'AIDS leadership' and coalition-building

Leadership is increasingly seen as critical to curbing HIV transmission and implementing AIDS treatment programmes. This argument is perhaps most closely associated with former UNAIDS Executive Director, Peter Piot (see Piot and Coll-Seck, 2001; Piot, 2012), but the notion of 'AIDS leadership' is complex and under-theorised (Grebe, 2012). It is primarily used in the sense of 'political commitment' from national political leaders, i.e. a willingness to talk about and address AIDS as a policy priority (see for example Bor, 2007), but is also used by Piot and Coll-Seck to refer to the ability of leaders to mobilise society-wide collective efforts. This can be thought of as building 'coalitions'[3] for effective responses and involves both state and civil society leadership (Grebe 2012: 13-24).

Partnerships between civil society and the state, or their absence, have been used to help explain good and poor policy outcomes in Brazil and South Africa respectively (e.g. in Nunn *et al.,* 2012). However, this analysis is too simplistic to enable a sufficient understanding of the AIDS response in Uganda, where

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[2] Informed consent was obtained from all informants. Informants were given the option of remaining anonymous and to provide portions of or their entire interview 'off-the-record' or on a non-attributable basis. In all cases where such requests were made, these have been respected.

[3] For a more thorough elaboration of the theoretical underpinnings of coalitions as drivers of political and policy outcomes see Yashar (1997) and Leftwich and Hogg (2007).

state-civil society partnership, state repression (or the threat thereof), civil society service delivery and the actions of international actors all appear very significant for policy and service delivery outcomes. In poor, aid-dependent countries like Uganda, the role of donors is likely to be very significant. Drawing 'lessons' about the Ugandan experience thus ideally ought to be based on an evaluation of state and civil society leadership as well as the character of state-donor-civil society relations.

The paper starts with a description of the context within which Uganda emerged as an 'African success story' on AIDS and a critical evaluation of state leadership on AIDS. It then turns to the emergence and evolution of TASO before analysing its functioning within the particular institutional and political context of Uganda during the 1990s and 2000s. Particular attention is paid to the opportunities provided and constraints imposed by this context and by the choices of the Ugandan government and donors.

3. State leadership and the making of an 'African success story'

In the late 1970s, North Western Tanzania and Southern Uganda probably constituted the epicentre of the African HIV epidemic (Epstein, 2007). By the mid-1980s many communities were being ravaged by the disease locally known as 'slim' (O'Manique, 2004; Thornton, 2008). The situation was exacerbated by the insecurity and social upheaval of a bloody civil war lasting from 1981 to 1986 that contributed to widespread fear and confusion and rendered any systematic state response nearly impossible.

By the time Museveni's National Resistance Army took power in January 1986, AIDS constituted a public health crisis that could also threaten economic reconstruction and even the stability of the new regime.[4] The Museveni government started responding meaningfully to HIV shortly after coming to power. Prevention campaigns involved the President himself speaking openly about the risks of contracting HIV through sex and featured the so-called 'zero grazing' (partner reduction) and ABC ('Abstain, Be faithful, Condomize') messages. A subcommittee that had been set up by the second Obote

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[4] It has, in fact, been argued that Museveni – whose power base was the army – was shocked to discover that significant numbers of soldiers were HIV-positive. Museveni himself has recounted an incident where a significant proportion of Ugandan army officers sent to Cuba for training tested positive for HIV and Cuban President Fidel Castro personally informed Museveni of the problem (Garbus and Marseille, 2003, cited in Ostergard and Barcello, 2005; De Waal, 2006: 97).

government was upgraded to the National Committee for the Prevention of AIDS (NCPA) in October 1986 and a World Health Organisation mission to Uganda in January 1987 helped draw up a short-term intervention plan and a medium-term five-year action plan. These plans formed the basis of the Aids Control Programme (the first in Africa) and a donor conference in May 1987. The President made a number of high-profile speeches in which he drew attention to AIDS, and in December 1988 he declared AIDS a major national priority, calling for an all-out public education campaign. This openness and willingness to tackle the issue of HIV and risky sex stood in sharp contrast to most African governments at the time (Piot, personal communication, 2010).[5]

But Uganda's status as a 'poster child' for good governmental leadership on AIDS and Museveni's reputation as an exceptional African leader were probably cemented when it became apparent in the mid-1990s that HIV prevalence had started to decline, turning Uganda into the first African HIV prevention 'success story'. What exactly led to the decline in HIV prevalence is uncertain, and there has been considerable debate among scholars about the relative importance of different factors (see, for example, Gray *et al.*, 2006; Green *et al.*, 2006; Merson, 2006; Thornton, 2008; Atzori *et al.*, 2009). Changes in sexual behaviour – in particular reductions in the number of concurrent partners – are generally thought to have played a significant role (Stoneburner and Low-Beer, 2004; Low-Beer and Stoneburner, 2004). This is usually attributed to the prevention campaigns, while Thornton (2008: 33) emphasises the effects of the configuration of sexual networks on HIV trends and Epstein (2007: 160) argues that the many small community-based AIDS groups that were founded during the 1980s and early 1990s deserve much of the credit for changing sexual norms.

The Ugandan government attracted substantial credit for the apparently radical behaviour changes that would explain declining HIV prevalence (e.g. UNAIDS, 1998; 2001). But while it is undeniably due some credit, the degree to which its prevention campaigns shaped the evolution of the epidemic is debatable. Epidemiological evidence calls into question the hypothesis that declines in HIV prevalence resulted primarily from prevention interventions (although this is not to say that those efforts had no effect). While Stoneburner and Low-Beer's (2004) estimates suggested that the incidence of HIV among pregnant women peaked in the late 1980s, modelling the Ugandan AIDS epidemic using data and software from UNAIDS suggests that new adult HIV infections fell after 1983,

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[5] Piot (2012: 175) also describes then-Ugandan health Minister Ruhakana Rugunda's speech at the 1987 World Health Assembly as a 'lone voice' calling on his peers to face the reality of AIDS on the African continent.

well before Museveni came to power, and adult population prevalence reduced from 1988.[6]

Figure 1: Epidemiological model for Uganda showing new adult HIV infections and adult HIV prevalence rate (1974-2004) with major political developments.
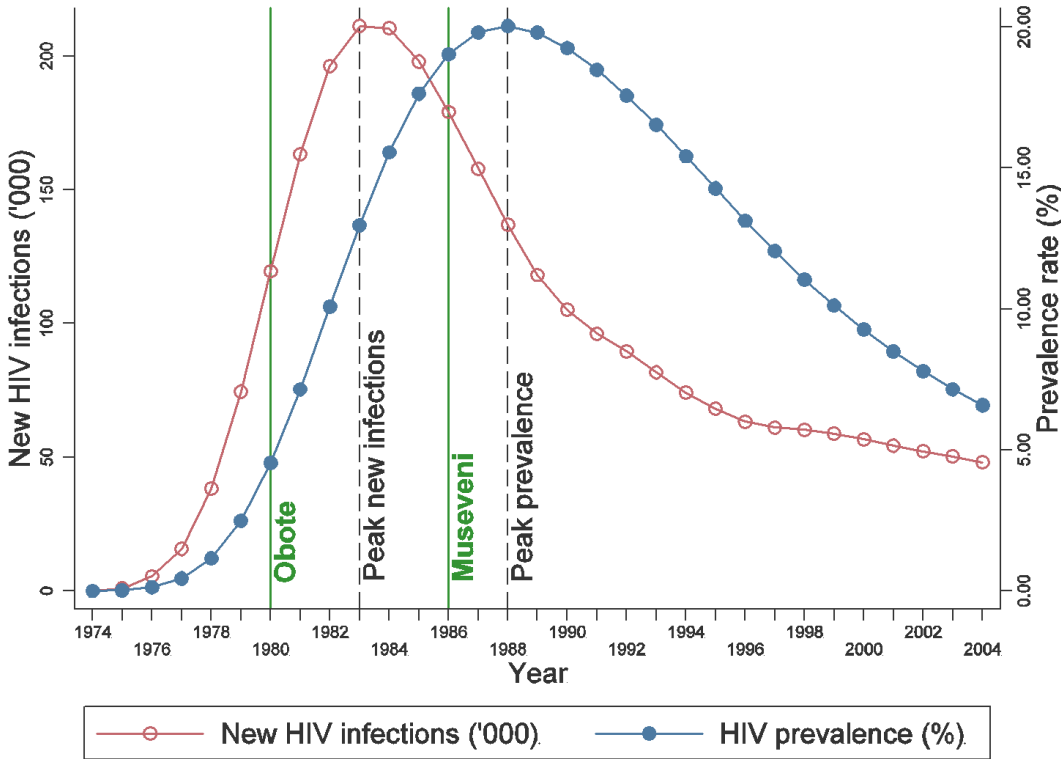
Source: Own estimates using Spectrum/EPP 2011 (UNAIDS, 2011) and reported fully in Grebe (2012: 186-194).

It therefore seems more likely that large-scale behaviour change resulted from the visibility of illness and death (both of which had started to increase markedly by the early 1980s) than from the 'zero grazing' and ABC campaigns.

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[6] The estimates reported in Figure 1 were produced using UNAIDS's Epidemiological Projection Package (UNAIDS, 2011) and HIV surveillance data from Ugandan antenatal clinics, with adult HIV prevalence estimates calibrated using national seroprevalence survey data from the Uganda HIV/AIDS Sero-Behavioural Survey 2004-2005 (Ministry of Health [Uganda] and ORC Macro, 2006). The full set of estimates produced by the model show that AIDS deaths continued to rise until 1995, and the fall in the HIV prevalence rate is explained by demographic changes and deaths exceeding new HIV infections. The model is reported fully elsewhere (Grebe, 2012: 186-194).

While the Ugandan state took the lead in HIV prevention, it could draw on existing home-grown prevention responses from community groups, particularly in the rural areas which formed the epicentre of the epidemic (see Epstein, 2007). By 1988 it was seeking to integrate the efforts of government and civil society (including NGOs, faith-based and community-based organisations), eventually resulting in the 'multi-sectoral approach' of the 1990s (Thornton, 2008: 131). The state possessed extremely limited capacity to provide health services (there were few hospitals and even fewer that had the resources to provide good services). As a result, AIDS services in Uganda were pioneered by civil society, most prominently in the form of TASO, which was founded in 1987 by a small group of volunteers and a few passionate healthcare workers (see next section). The government embraced and encouraged these efforts. TASO founder Noerine Kaleeba describes being brought into high-level policy-making and says that the 'terrain had been set' for civil society to respond to AIDS (personal communication, 2010).

Despite the questionable assumptions underlying the Ugandan government's prevention 'success story', it did indeed provide leadership in two important ways: (1) by ensuring AIDS featured prominently on the national agenda, and (2) by building partnerships with civil society on prevention and care, and coordinating the work of a diverse set of actors, first through the NCPA and later through the national AIDS Control Programme and the Uganda AIDS Commission (UAC). This institutional framework and Uganda's 'multi-sectoral approach' – including its failings – will be analysed in greater detail in the sections that follow.

By the mid-2000s, Uganda was performing significantly better than expected (and better than most of its peers, most notably the much wealthier South Africa) in the provision of antiretroviral treatment, even if this progress was largely funded by donors and implemented by civil society organisations like TASO. Using a novel approach, Nattrass (2008) shows that Uganda performed significantly better than expected when regressing the country's highly active antiretroviral therapy (HAART) coverage on its level of development, external resources, social characteristics, burden of disease and other predictors. She speculates that this may be related to 'political leadership'. But while suggestive, this study was at too aggregated a level to distinguish between the contributions of government and that of civil society in determining the success of the AIDS response.

4. TASO's birth and evolution: from volunteer network to professional service delivery organization

In early 1987, a group of 16 men and women (the majority of whom were HIV-positive) started meeting informally to share experiences and support one another in coping with the impact of HIV/AIDS on their lives (Ssebanja, 2007: 1). Most were HIV-positive or had loved ones who were ill with or had died from AIDS. This included Noerine Kaleeba, the group's leader, whose husband Christopher had died of AIDS shortly before.[7] As the group grew, it formalised its structure and programme of 'living positively'. Kaleeba, a charismatic and energetic individual, was principal of the School of Physiotherapy at Mulago Hospital and became TASO's first director. She cites as motivation for the founding of TASO 'a feeling of anger and frustration at the stigma and isolation of people with HIV and … the fact that families were abandoning their loved ones' (personal communication: 2008).

Medical services for AIDS patients were extremely limited. Dr Elly Katabira, a physician who had come across AIDS while working in Britain, was shocked to find large numbers of AIDS patients in Mulago Hospital when he returned to Kampala in 1986. He set up an outpatient clinic in late 1986 and opposed proposals for a segregated inpatient ward.[8] In 1987, Katabira had been put in touch with the fledgling TASO and became a key figure in their integration of social support and community-based services with medical services. At the time no life-saving treatment for HIV/AIDS was available, and the founders were responding primarily to the human tragedy caused by widespread stigma and discrimination, both within the healthcare system and the wider community, which condemned patients to lonely and undignified deaths. They strove to enable patients to 'die with dignity' (Ssebanja, personal communication, 2008).

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[7] The previous year, she had visited Christopher in England where he had become ill and been diagnosed with AIDS. In a remarkable interview for the PBS documentary 'The Age of AIDS', she describes how she travelled to Geneva to meet Jonathan Mann, director of the WHO's Global Programme on AIDS (see *The Age of AIDS Parts 1 and 2*, 2006). Her relationship with Mann would later prove valuable as TASO sought to mobilise international support. She brought Christopher back to Uganda, where he died in January 1987.

[8] He was concerned that segregating AIDS patients would exacerbate stigma and discrimination by marking AIDS as a 'deadly and shameful disease' and that a service outside the mainstream would not be sustainable (Katabira, personal communication, 2008). A highly-regarded physician and prominent advocate of a human rights approach to HIV/AIDS, he served as president of the International AIDS Society from 2010 to 2013.

TASO reached out to communities by visiting neighbourhoods to identify patients and running training workshops on caring for the ill at home. It tackled stigma and discrimination by talking openly about AIDS and even the then-chairman of the AIDS Control Programme attended one of its AIDS sensitisation workshops (Ssebanja, 2007: 17). The rapidly expanding organisation obtained office and counselling space at Mulago hospital, helped set up an HIV testing service and day-care clinic in Masaka and provided advice to healthcare workers. Initially it focused on providing counselling and psychosocial support, but increasingly responded to the weakness of the Ugandan healthcare system by providing medical services itself. Eventually TASO would operate 11 service centres throughout the country, administer Uganda's largest antiretroviral treatment programme, provide care to over 100,000 clients per year (TASO, 2014) and establish a number of 'mini-TASOs' in rural state facilities to help build capacity (Bukenya, 2012).

TASO's founders drew heavily on pre-existing interpersonal networks to build the movement. Personal friends and acquaintances, especially those formed within the Mulago teaching hospital, formed the core of the young organisation (Ssebanja, 2007). The group quickly drew in like-minded individuals and created links with outside actors. These included donors and charities (ActionAid was an important early supporter), AIDS activists and AIDS service organisations in other countries, like the UK-based Terrence Higgins Trust, from whom it obtained support and information. It is notable that Kaleeba and several other founders were educated professionals with significant social capital, comfortable in elite circles and able to hold their own among policymakers. The importance of personal ties during early movement-building is confirmed by frequent references to a 'family spirit' in the recollections of founders (personal communication, Kaleeba, 2008; P. Ssebanja, 2008). Dense interpersonal networks characterised by relationships of trust, domestic and transnational elite networks – including what Keck and Sikkink (1998) term 'activist networks' and interlinkages with professional and governmental networks – and deliberately constructed partnerships enabled TASO to mobilise support and gain influence. This 'network of influence' (see Grebe, 2012) acted as the scaffolding by means of which a coalition for an effective policy and programmatic response to AIDS could be built in Uganda.

But movements and the broader coalitions they form rarely remain static. As will be shown in the next section, TASO's evolution was shaped by the demands of its institutional context, including limited political space for activism. It was able to adapt to its circumstances and cope with an influx of resources and the intensifying demands of large-scale service delivery in part by formalising its structure and operations. Its leaders decided early on to build formal systems – it appointed professional managers and donors like USAID invested heavily in the

development of its technical capacity and managerial systems (Ayers, personal communication, 2008). These choices enabled it to become the successful service delivery organisation it is today, but were probably incompatible with the requirements of leading in civil society and of 'holding government to account'. This is lamented by some of Uganda's most prominent activists, like the International HIV/AIDS Alliance's Milly Katana:

> '[TASO] has lost the crowd. …TASO is riding on the back of its history… Of course it's the biggest – outsiders trust it, value it, they give them more money and they are expanding services, which is great. But to me that doesn't mean that they are leaders' (Personal communication, 2008).

5. Uganda's 'multi-sectoral partnership approach'

The Ugandan government realised that HIV required a society-wide response, and its efforts to encourage civil society through a 'multi-sectoral' approach found their clearest expression in the 1992 founding of the Uganda AIDS Commission. It presided over a very weak healthcare system without the capacity to care effectively for the deluge of AIDS patients. The country had just emerged from a long period of economic mismanagement and war that had decimated its infrastructure and economy. If the government were to stand a chance of successfully dealing with the impact of AIDS, it would need both international partners and local partners. TASO was not an activist movement representing AIDS patients and embracing it may have seemed a low-risk strategy to the Museveni government. TASO was provided with facilities at Mulago hospital (and later at hospitals throughout the country) and Noerine Kaleeba was appointed to the committee in charge of the AIDS Control Programme, apparently at the behest of President Museveni himself.

Putzel (2004: 26) attributes the willingness of the Museveni regime to tackle AIDS head-on to several factors, including that it listened to medical experts, a desire to 'put the epidemic beyond partisan politics' and a 'firm coalition behind the President's HIV/AIDS campaign'. But the literature and interviews with key informants suggest two further critical factors: First, HIV/AIDS in the military represented a very real threat to the new government's power base (De Waal, 2006). Second, the new National Resistance Movement (NRM) government under Museveni's leadership was heavily reliant on donors and needed to legitimate itself in the eyes of both the international community and the Ugandan public. Tumushabe (2006: 8) has argued that the Ugandan 'success

story' on HIV/AIDS became a critical 'approval and marketing issue' for the government.

While the Ugandan government adopted a relatively open stance, and a sense of partnership characterised its relationship with civil society from early on, its motives were not necessarily entirely noble. Furthermore, political space for civil society activism is severely constrained: political and civil rights are weak[9] and, despite the reintroduction of competitive elections, the political system is perhaps best described as a form of 'electoral authoritarianism' (see Van de Walle, 2013) characterised by patronage-based 'neopatrimonialist rule' (Rubongoya, 2007), presidential and party dominance (Mwenda, 2007; Golooba-Mutebi and Hickey, 2013) and intolerance towards political opposition.[10] TASO's focus on delivering services to those with HIV (rather than the political mobilisation many AIDS movements in other countries chose – notably the Treatment Action Campaign in South Africa) probably reflects *both* the need to step in where the state was unable to provide the required services *and* a 'political opportunity structure' that limited its ability to pursue vocal activism (see Scholte, 2004: 229).

Indeed, several Ugandan AIDS activists and civil society leaders have argued that TASO generally failed to lead in civil society and, in particular, failed to support efforts to hold government to account (personal communication, Katana, 2008; Were, 2008). In contrast with more militant Ugandan AIDS activists, TASO leaders displayed a general unwillingness to acknowledge conflict with government or serious failures in governmental leadership during interviews. This seems to reflect a fear that open criticism would undermine TASO's partnership with the Ugandan government and consequently threaten service delivery (which is predicated on access to hospital infrastructure, etc.). Several activist informants (outside TASO) interpreted TASO's relative meekness as fear of losing access to state healthcare facilities and of threatening their partnership with healthcare authorities. This belies the conventional wisdom about Uganda's 'openness' and 'partnership approach'.

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[9] Freedom House political rights and civil liberties ratings for Uganda varied between 4 and 6 over the period 1986 to 1995. Ratings are on a 7-point scale with 1 representing most free and 7 least free. Uganda was classified as "partly free" throughout the period (Freedom House, 2014).

[10] For example, after Museveni's former physician Kizza Besigye ran for president in 2001, Museveni's campaign was characterised by open violence and intimidation, with Besigye fleeing into exile after the election and after the February 2011 elections, during which Museveni again defeated Besigye, brutal state repression met peaceful 'walk to work' protests over fuel prices, in which several people died and Besigye was arrested so violently that he had to be hospitalised in Kenya (Izama and Wilkerson, 2011: 64-65). More recently, the opposition mayor of Kampala was arrested repeatedly.

In recent years, governmental leadership on HIV/AIDS is perceived to have declined in quality and vigour. A number of respondents indicated that President Museveni seemed to have 'withdrawn' from the struggle, while others worried about shifts towards less progressive government policy on AIDS. Developments causing widespread concern included increased hostility to condom promotion, a proposed law that would criminalise deliberate HIV transmission and most recently the promulgation of the discriminatory Anti-Homosexuality Act.[11]

A puritanical and socially conservative agenda is not new in Uganda, and elements of it can be discerned even in the early discourse on HIV/AIDS from Museveni and his government. De Waal (2006: 98-105) points out that the lauded 'ABC' message of the Ugandan government has always been a mixed and inconsistent one, often tailored so as to please or avoid offending specific audiences. On numerous occasions the president has attacked condom promotion, especially to young people. The first lady, Janet Museveni (an outspoken 'born-again' Christian), has been particularly vigorous in her condemnation of condom promotion, telling an audience in the United States that 'giving young people condoms is tantamount to giving them a license to go out and be promiscuous; it leads to certain death' (Museveni, 2004).

In the mid-2000s, the United States became (by far) the largest funder of Uganda's AIDS efforts through the President's Emergency Plan for AIDS Relief (PEPFAR). As an initiative of the Bush Administration, it came encumbered with policies rooted in a conservative religious agenda (such as reservation of funds for faith-based groups and abstinence-based prevention programmes). As

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[11]At the time of the fieldwork for this study the Anti-Homosexuality Bill had not yet been introduced. The bill was introduced by Member of Parliament David Bahati in October 2009 as a private member's bill. While same-sex relationships were already criminalised in Uganda (dating from British colonial rule), the bill would exacerbate repression and discrimination by introducing two new offences, 'the offence of homosexuality' carrying a penalty of life imprisonment and 'aggravated homosexuality' (defined to include homosexual acts with a minor or by a person who is HIV-positive), which would carry the death penalty. Despite strong condemnation from various quarters, including Ugandan lesbian, gay, bisexual and transgender activists and international human rights organisations, the bill received substantial support from the Ugandan public and in the Ugandan media. Criticism of it was framed as 'Western interference' and as a battle over Uganda's moral self-determination (Sadgrove *et al.*, 2012: 105). The bill and the wave of homophobic sentiment expressed in the wake of its introduction seem to have tapped into a stridently socially and sexually conservative agenda in Uganda, which enjoys both public support and has powerful backers in the Museveni regime. The bill was eventually passed (in slightly less draconian form, which dropped the death penalty provisions) in late 2013 and signed into law in February 2014, to widespread international condemnation.

Epstein (2007: 185-201) shows, this conservative religious agenda found fertile ground in certain sections of Ugandan society, in particular a number of conservative church groups and the first lady, who led a backlash against condom promotion programmes. By 2008, this constituted a significant worry for civil society leaders, including the former director of TASO, Dr Alex Coutinho, who obliquely criticised the Museveni government by referring to its approach as 'anti-condoms and a little bit pro-abstinence' and argued that Museveni had to be brought back to the forefront of HIV prevention efforts (personal communication, 2008).

Praise for Uganda's relatively open and enabling attitude to civil society, and its multi-sectoral partnership approach, must therefore be tempered by acknowledgement of its authoritarianism, a cowed civil society and prevention policies undermined by a socially conservative agenda.

The custodian of Uganda's 'multi-sectoral' partnership approach and the body charged with coordinating the AIDS response, the UAC, was widely seen as being under the control of and serving the interests of the Museveni government. The UAC exercises its coordination role through a Partnership Forum (an annual meeting of stakeholders from all sectors) and a Partnership Committee, which meets regularly and makes decisions regarding issues such as resource allocation. The Partnership Committee also acts as the Country Coordinating Mechanism for the Global Fund and controls a joint Civil Society Fund (often referred to as a 'basket fund'), through which pooled donor contributions are disbursed to civil society organisations.

Sectors are organised into 'self-coordinating entities' (see Figure 2) that are supposed to develop joint policy positions and present these to the Partnership Committee on behalf of their constituencies. While there are twelve such entities, the primary function of the partnership mechanism is to coordinate the work of international, domestic and faith-based civil society organisations, donors and government. At the district level there exists a similar set of structures known as District AIDS Coordination Committees, with representation from the political leadership of the district, government departments, local civil society organisations, the private sector and people living with HIV/AIDS.

Figure 2. 'Partnership mechanism' of the Uganda AIDS Commission
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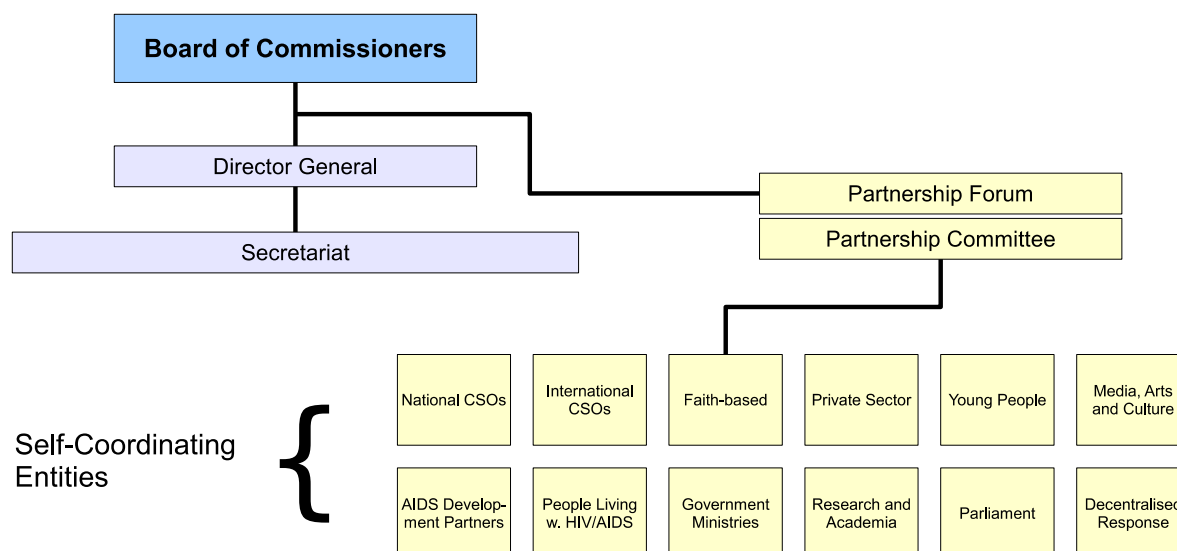
The Director General of the UAC at the time of the fieldwork for this study (Dr David Apuuli) argued that these structures were uniquely able to foster cooperation and coordination in the HIV/AIDS response because the Ugandan government is compelled by law to meet and come to joint decisions with donors, civil society and other stakeholders (personal communication, 2008). In reality, however, neither the UAC nor its partnership mechanism is independent of government. All commissioners are appointed by President Museveni, its Director General was described by independent civil society leaders as highly protective of the President's interests and the UAC itself seen as ineffective in discharging its coordinating function (personal communication, Katana, 2008; Were, 2008; Mworeko, 2008). The creation of the Civil Society Fund was widely perceived as an attempt to gain control over donor funds for civil society in order to deny resources to organisations critical of the government, a fact that activist Beatrice Were argued was central to the UAC's failings (personal communication, 2008).

The unwillingness of large civil society organisations like TASO to openly criticise the government, the UAC or their major donors (most significantly PEPFAR) seems to confirm that these fears were not entirely unfounded.

Donors have substantial influence on policies and programmes in countries that are heavily dependent on foreign aid (Mayhew, 2002). This is particularly true in Uganda, where the majority of spending on AIDS-related programmes are financed externally and even state agencies like the UAC and programmes in the Ministry of Health rely on foreign donors for the bulk of their funding. Over the

period 2003/4 to 2008/9, external financing accounted for 84-98% of HIV/AIDS expenditure (Lule and Haacker, 2012: 250). TASO is the major provider of medical services to HIV/AIDS patients, including the vast majority of antiretroviral therapy, and obtains all of its funding from international donors.

The influence of donors may serve to broker effective AIDS response coalitions or to inhibit their formation. Their clout in Uganda has allowed donors to push for an inclusive partnership approach (between government and civil society) and for an enabling environment that would allow civil society to participate effectively in the AIDS response. But, paradoxically, in the process donors helped inhibit the development of a vocal and independent civil society sector capable of exerting pressure on the state and holding it accountable.

The influence of donors is felt in a number of ways: through direct conditionalities imposed on the receiving state and choices over which programmes and organisations to fund, but also more subtly through the competition over resources between the state and civil society as well as within civil society. The clout of donors is demonstrated by the resolution of a disagreement between TASO and the government over who was to provide the bulk of antiretroviral therapy, which was decided in TASO's favour largely because this was the preference of PEPFAR (Coutinho, personal communication, 2008).

In situations where civil society is not well-developed or the political culture and institutions inhibit openness and broad participation in policy formulation and implementation, the potential for donors to broker inclusive coalitions is particularly significant. Keck and Sikkink (1998) describe a 'boomerang pattern' of influence, in which civil society organisations can obtain leverage over the state in situations where direct channels between it and the state are blocked. International allies (usually Northern NGOs, but sometimes intergovernmental organisations or donors) can bring pressure to bear from outside, either directly or via Northern states. De Waal (2006: 58-59) argues that this pattern is responsible for much of the success of AIDS activism in Africa, where domestic activists have been able to exploit transnational networks comprising international NGOs, intergovernmental organisations (including those of the UN system such as UNAIDS) and, crucially, donor governments, as a means of leverage over their own governments. The Ugandan state's lack of capacity in the late 1980s, and its resulting dependence on donors and civil society organisations to provide public services, was arguably the primary factor in its adoption of a partnership approach.

However, the fieldwork conducted for this paper also points to significant risks associated with powerful donors. Donors may dominate the agenda, inhibiting open engagement and limiting the ability of domestic actors to build 'locally-appropriate coalitions' – in Leftwich and Hogg's (2007) terminology. The Bush Administration used financial assistance to advance a particular ideological agenda in alliance with sections of the domestic elite. Many civil society leaders reported that donors were overly concerned with maintaining their partnership with the state, and consequently failed to support, and even actively (if inadvertently) undermined, the development of an independent and critical civil society sector.

6. Concluding thoughts

While serious conceptual and analytical difficulties attach to the notion of leadership, effective 'AIDS leadership' can be meaningfully described as *the mobilisation of coalitions around AIDS prevention and treatment*. A broad coalition that includes civil society, the state and the international community has helped Uganda to mobilise one of the more effective AIDS responses in Africa. It has performed admirably in providing antiretroviral treatment, even if the effectiveness of its prevention efforts has sometimes been exaggerated.

The choices of individuals, including political leaders like Museveni and civil society leaders like Kaleeba, were arguably as important as broader institutional factors in shaping Uganda's AIDS response. The theoretical construct of 'networks of influence' stand at the nexus of agency and structure, and is therefore useful for thinking about the processes involved in building coalitions for an inclusive and vigorous response. But the history of TASO also demonstrates how political and institutional context shaped the choices of individuals and constrained opportunities for coalition-building.

Weak state capacity left the Museveni government little choice but to pursue an 'open' and supportive policy with respect to civil society, but an authoritarian political culture that discourages open criticism and dissent has limited the ability of civil society to hold the state accountable and influence policy. Donors may inadvertently have undermined the independence of civil society. However, their power has also at times provided a lever for exerting influence over the state and probably limited the extent and intensity of state repression.

This research demonstrates that state-civil society partnerships – undergirded by effective civil society organisations, a supportive state and donor pressure – can help establish effective AIDS response coalitions. However, enhancing state accountability under authoritarian regimes remains a formidable challenge.

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