Two minds know more than one.

Public Private Partnership in the battle against HIV/AIDS in South Africa

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Abstract

This study looks into the Public Private Partnerships (PPP) in South Africa. In the western world PPPs have proven an efficient way of managing public services. PPPs can exist on many different policy terrain. In the developing world not many studies have been performed on PPPs yet. The existing literature does state that different challenges in PPPs are in effect in developing countries then in the western world. These challenges can be divided in ethical and technical challenges. These challenges can affect the outcome of PPPs. Another important factor effecting PPPs is the form of governance characterises the different partners. The different forms of governance are: hierarchical, rational goal, self-governance and open systems model.

This study looks into a PPP on health care, in specific HIV/AIDS care. In South Africa HIV/AIDS has taken on pandemic proportions and is a major issue and many different organisations are active in this field. As government only stepped in into HIV/AIDS treatment in 2004 other non-governmental organisations (NGOs) have stepped into the gap to help the community. Many of these organisations are funded by donors from overseas, but donor money never lasts forever. One of these NGOs is the SACBC AIDS Office. The SACBC AIDS Office and their local clinic, the Newcastle Catholic ARV Project, are commencing a PPP with the local Amajabu District Department of Health. How this partnership is going to be structured is not yet clear, but different scenarios have been taken into account.

It became clear that the South African government is a highly hierarchical organisation in all of its levels. Whereas the SACBC AIDS Office is hierarchical but their local clinic fits the rational goal model and the self-governance model in forms of governance. When looked at the partnership itself it is a hierarchical partnership where the government tends to take control. This sometimes causes friction within the partnership because the SACBC AIDS Office and the Newcastle Catholic ARV Project are the ones that always adapt.

When looking at in what way the partnership could be governed more efficient, the SACBC AIDS Office clinic would be allowed to keep its independence. Government is able to procure treatment at lower prices and wants to supply treatment to the area the Newcastle Catholic ARV Project operates. The Newcastle Catholic ARV Project already has expertise and has build up a name in the area. These strength can be combined when government chooses to outsource the service delivery to the SACBC AIDS Office and Newcastle Catholic ARV Project.

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I could not have done this research without the cooperation of the staff at the SACBC Newcastle Catholic ARV Project, a very big thank you to Xolani Kunene, Sister Leo, the nurses, counsellors, ARV monitors, drivers, data capturers, the stock controller, the book keeper and the other supporting staff. Their input has been the major source of information for this study. They all made me feel very welcome in their organisation. Also the sisters and staff from the Primary Health Centre in Pomeroy were kind enough to supply the necessary information and connections, they have helped us to get information from a local hospital and without them we would not have been able to collect this very important data.

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List of abbreviations

AIDS	=	Acquired Immune Deficiency Syndrome
ARV	=	Antiretroviral Treatment or ART's
CRS	=	Catholic Relief Services
COSH	=	Church of Scotland Hospital
DOH	=	Department of Health
DDOH	=	District Department of Health
HBC	=	Home Based Care
HIV	=	Human Immunodeficiency Virus
NDOH	=	National Department of Health
NGO	=	Non-Governmental Organisation
OVC	=	Orphaned and Vulnerable Children
PDOH	=	Provincial Department of Health
PDS	=	Patient Data System
PEPFAR	=	President's Emergency Plan Fund for AIDS Relief
PHC	=	Primary health care clinic
PPP	=	Public Private Partnership
SACBC	=	Southern African Bishops' Conference
SANAC	=	South African National AIDS Council

Introduction

In the western world public private partnerships (PPP), where public parties engage into partnership with private organisations, have proven an interesting addition to the way projects are handled. The strengths of both public and private bodies meet to deliver services in a more efficient way than before. What motivates these partners to come together and supply a service that in the first place is a government responsibility is an interesting subject. What drives both parties to engage in the partnership and what gains are there for both? Where in the western world PPP has become common good, you can find PPPs for instance in infrastructure projects, waste disposal, water treatment, health care, etc (European Commission, 2003), in developing countries the concept of PPP is being introduced now. Most research on PPPs has therefore been performed in western countries, as it is an established phenomenon there. How PPPs function in developing countries is an interesting topic: in what way do they differ from western PPPs and in what similarities can be found? As starting a PPP is an extensive process (European Commission, 2003), do the challenges differ that exist in forming a PPP?

In South Africa, the government is trying to get more efficient service delivery by using PPP on national, provincial and municipal level. The National Treasury of South Africa also started a PPP unit to catalyse the development of PPP in the country (National Treasury of South Africa, 2011). In the South African Health Care many non-governmental organisations (NGOs) are active. They have taken on responsibilities in providing health care to the community and helping the government.

One NGO in particular is engaging into a PPP with the government on providing treatment for HIV/AIDS patients. This specific case is in the starting phase of the PPP where the government and the Southern African Catholic Bishop's Conference (SACBC) AIDS Office will take shared responsibility in providing health care for the local community. This PPP is important and interesting as within South Africa HIV/AIDS has taken on epidemic proportions in the last decades. In order to contain the epidemic, NGOs have taken on responsibilities in helping the government and the community. To get a clearer picture of the history of this epidemic a short introduction on HIV/AIDS and HIV/AIDS in South Africa will be given below.

HIV/AIDS

Human Immunodeficiency Virus (HIV) was first discovered in the eighties (Epstein, 2007). The disease was discovered in the United States. HIV spread itself across the globe and has reached pandemic proportions in Africa. HIV is the cause of Acquired Immune Deficiency Syndrome (AIDS), a disease that affects the human immune system. People suffering from AIDS are especially receptive to many infections like pneumonia and tuberculosis (TB). These diseases can eventually result in the death of the person infected. HIV/AIDS is often transmitted through sexual interaction, mother to child transmission or direct blood contact (UNAIDS, 2006).

There is still no cure for HIV, a cocktail of different anti-retroviral medicines (ARVs) that can slow down the progress of HIV has been used since the nineties. Also medication to prevent mother-to-child transmission is available as well as medication that decreases the chance becoming infected after being exposed to HIV, post exposure prophylaxis (PEP). HIV affects the immune system and this can be retrieved from the amount of CD4 cells active in the blood, testing this amount is called a CD4 count. The lower the value the further HIV has progressed and the larger the chance of people getting sick. ARVs can prevent the spreading of HIV and help raise the CD4 level (SANAC, 2007).

In South Africa the prevalence rate of HIV is one of the highest in the world. The official South African prevalence rate is just over 10 %, this leads to a total number of infected people of 5,5 million (Statistics South Africa, 2010). Per region estimates vary, but for some areas they reach up to 22% of the population, the province of KwaZulu Natal having one of the highest infection rates in the country (SANAC, 2009, Statistics South Africa, 2010). The amount of people who should be on ARVs is estimated on approximately 1,5 million.

The South African Government has set guidelines at what level of CD4 count patients will be set on ARVs. These guidelines assure that every citizen gets the same treatment. ARV treatment is supposed to commence at a CD4 level of <200 cells/m3 (South African National AIDS Council, 2007). When the ARVs are effective the CD4 level will rise and people can stay healthy for longer. Also they can stay productive in the society. For pregnant women and people suffering from other diseases like TB other guidelines are formulated. Pregnant women infected with HIV are at risk of transmitting the infection to their baby, therefore, another regiment of ARVs should be taken in order to prevent mother to child transmission of the virus (UNAIDS, 2006).

The South African Government Against HIV/AIDS

With the decline of apartheid and in the preparation of the new democratic South Africa negotiations were held between the apartheid government and the ANC. Part of these negotiations was the 1992 'South Africa United Against AIDS' conference. The conference resulted in forming the National AIDS Convention of South Africa to gather all the relevant actors in South Africa on the HIV/AIDS terrain. This included political parties, NGOs, trade unions, religious institutions and health workers. *"In practice, this proactive and collaborative multi-sector approach to HIV/AIDS failed to materialise"* (Evensen & Stokke, 2010). After this failure to address the problem, in 1999 former South African President Thabo Mbeki and other statesmen denied the link between HIV and AIDS, which became known as 'AIDS denialism' (Mbali, 2003). HIV infections being more prevalent among the black population made it a sensitive subject to address (Evensen & Stokke, 2010). The criticism on the 'denialism' government policy would often be dismissed as racism (Fassin, 2007).

Because of the 'denialism', there was hardly any government policy on HIV/AIDS treatment. The ideas of a multi-sector approach were never executed and the civil society organisations were not involved in the policy process (Evensen & Stokke, 2010). The Treatment Action Campaign (TAC) took legal actions against the government to force them to provide treatment for people living with HIV/AIDS in 2001. The case was won and it forced the state to make policies on HIV/AIDS treatment. They started the roll-out in 2003 (Evensen & Stokke, 2010). Since then the government has been actively involved in the enrolling of ARVs and HIV/AIDS testing.

In 2007 the South African National AIDS Council (SANAC) presented the 'HIV and AIDS and STI Strategic plan 2007-2011' (SANAC, 2007). This plan contains measures that the government will take to increase the number of people that have access to ARVs. According to SANAC in 2006 around 200.000 people were on ARVs. While an estimate of 511.000 more people should be on ARVs but are not getting or taking them (SANAC, 2007). So a lot of work still needs to be done in reaching the population.

In order to provide the population with medication NGOs have stepped in in this process at the time ARVs were not provided by the government. But as health care ultimately is the responsibility of the government these NGOs will not keep this work up forever. As they will move out, the community

will need to get access to governmental health care and government will have to be able to provide these public goods for the community. In order to be able to do this the government can engage itself into PPPs with the active NGOs to make the transition smooth and be able to learn from the expertise the NGOs have build up in the past years. This calls for collaboration between the NGOs and the government. One of the NGOs in this process of phasing out is the Southern African Catholic Bishops' Conference (SACBC).

The SACBC AIDS Office

"Since 2000 the SACBC AIDS Office has coordinated the response of the Catholic Church to AIDS in South Africa, Swaziland and Botswana, strengthening and building on existing programmes, and helping to initiate new ones" (Stark & Munro, 2005). The SACBC AIDS Office started with 22 clinics to enrol the ARVs. The last few years eight of them have been closed down. From June 2011 another three will be closed bringing the number of clinics the SACBC AIDS Office coordinates back to eleven. The SACBC clinics are funded through the President's Emergency Plan Fund for AIDS Relief (PEPFAR). From 2004 until 2008 they were funded via the Catholic Relief Services (CRS). From 2008 the SACBC AIDS Office receives funding from PEPFAR directly. These funds only last until 2013, after this year the SACBC will have to find other means of funding to sustain their clinics.

The SACBC AIDS Office had connections throughout South Africa because of the Catholic Diocese infrastructure. The clinics of the SACBC AIDS Office were placed in areas where the Catholic infrastructure was strong enough to commence an efficient ARV project (UNAIDS, 2006). Because of this infrastructure the SACBC could relatively easy access more remote areas to start ARV treatment before the government could reach those areas. Next to ARV treatment the SACBC AIDS Office also provides home based care (HBC), support for orphaned and vulnerable children (OVC), hospice services and other health care services.

In 2008 an independent research on the SACBC AIDS Office and its clinics was performed by Brady and Ota, they can give a more realistic view of the organizations strength and weaknesses (Brady & Ota, 2008). These results have been an important source of information for this research. Some of the strengths that came forth in this research are that the management structure is very strong because of the diocese infrastructure, home-based care and community-based adherence mechanisms have been successful in the high rates of adherence to ARVs, the selection criteria for patients that are put on ARVs are the same as the government so patients can be transferred to government clinics when necessary. Also some weaknesses have been found, the ARVs are very expensive and the SACBC AIDS Office has not been able to get access to less expensive medications. Another weakness found is that not all dioceses are equally active and therefore not always participating in the SACBC AIDS Office programs.

The HIV/AIDS problem is very complex and a nationwide problem. Organizations throughout South Africa have to unite in order to call the spreading to a halt. The SACBC Aids Office want to partner up with the South African government in order to continue their services to the infected population. As the SACBC AIDS Office has proven itself being able to provide treatment cost effective to the population in remote areas. For government their working methods can provide a worthy addition to the already existing services the government provides itself.

Problem Definition

A public private partnership between the Provincial Department of Health of KwaZulu Natal, the Amajuba District Department of Health and the SACBC Newcastle Catholic ARV Project is under development. The PPP is necessary to guarantee a sustainable health care system for the patients in Blaauwbosch. Contacts between the organisations exist but are not yet formalized. What this partnership looks like is not yet clear. In what form the partnership will be created and what do the people working at and visiting the SACBC AIDS Office clinics notice of the partnership? In KwaZulu Natal the Noyi Bazi clinic in Pomeroy already works together with government hospitals/clinics. In order to come to a comprehensive report this partnerships will also be taken in to account in this research. For instance, what similarities and differences exist between the different projects and partnerships?

The functioning of these public private partnerships can be of use in the creation of a sustainable public private partnership between the Newcastle Catholic ARV Project and the Amajuba DDOH. Other SACBC AIDS Office clinics throughout South Africa are or will be in a similar kind of process in the time to come. The experience gained from this partnership can be used to manage these processes more effectively. Also the patients of the clinics are relying on the clinic for their medication. The SACBC AIDS Office and the government have a shared responsibility to make sure that these patients are taken care for when the SACBC AIDS Office will no longer provide the medications. As most literature on PPPs is about the situation in the developed western world, insights in the process of PPPs in developing countries can be a valuable addition to the existing knowledge on PPPs. As the context differs, other processes and challenges may exist. In order to provide more knowledge on how PPPs work in the developing world the study of these different partnerships is necessary. Because of the small amount of literature existing on the subject an explorative research can provide new insights to trigger new research.

Goal

The goal of this research will be to gain insight in how the KwaZulu Natal Department of Health, The Amajuba Department of Health and the SACBC Newcastle Catholic ARV Project want the public private partnership to be formally structured. What do they expect from the partnership, which challenges are they encountering and what challenges do they expect to encounter in the future. How do they want responsibilities to be dispersed among the partners? To achieve this goal also the partnership at the Noyi Bazi Clinic in Pomeroy will be mapped.

A derived goal is to gain insight how the formal structure of the partnership is able to use the strengths of the partners and to optimize the services of the partnership.

The results of the research will be used to formulate recommendations to benefit both partners that participated in the research.

Research Question

The following research questions have been formulated in order to achieve the goal of this research:

> How is the partnership between the SACBC and the Health Department of the districts and provincial government of KwaZulu-Natal formally structured and what characterizes the organisations involved?
>
> How can the formal structure facilitate using the strengths of the organizations to optimize the services delivered by the partnership?

Because of the exploring nature of this research, first relevant literature has been gathered and studied. The information this provided was necessary in order to formulate more specific sub questions to help answering the research questions. These can be found in the theoretical chapter of this research. The theoretical chapter will provide information on PPPs and governance models. After the theoretical section the used research methods will be accounted for. In the results the sub questions are answered following an analysis of the gathered data for the research. In the conclusions chapter the research questions are answered and recommendations on future policy are given.

Theoretical Framework

The general information on HIV/AIDS, the South African government and the SACBC AIDS Office in the first chapter has led to a need for information on Public Private Partnerships (PPP). This chapter will give theoretical insights in PPPs and the challenges that may arise. Also information on different forms of governance in partnerships is included.

Public Private Partnerships

This chapter will give more information on PPP. Most of the literature on Public Private Partnership is aimed at partnerships in the western world. Not all aspects of the western knowledge will be applicable in South Africa. First a definition of Public Private Partnerships will be given. A definition is given by Bojovic, she has done research on applying western based knowledge of PPP on eastern European upcoming countries.

The definition of partnership she formulated is : “Partnering involves two or more organizations working together to improve performance through mutual objectives, devising a way of resolving disputes and committing to continuous improvement, measuring progress and sharing gains” (Bojovic, 2006). This definition can be expanded by adding the following definition of public private partnership to it: “Public private partnerships are arrangements between government and private sector entities for the purpose of providing public infrastructure, community facilities and related services. Such partnerships are characterised by the sharing of investment, risk, responsibility and reward between the partners” (Ministry of Municipal Affairs, 1999) . These definitions imply that barriers need to be overcome to create an effective partnership. For the SACBC AIDS Office and the DDOH this can imply that they will have to adjust their ways of working to match the processes.

In general PPPs provide long-term programmes creating more value for money. This is achieved by combining the strengths of both public and private parties to achieve a complementary partnership (Bojovic, 2006). This implies that tasks which have been executed by the public sector can switch to the private sector. These shifts can have a large impact on policymaking and service production. South Africa differs from this view, in the way that the private sector has taken up tasks the public sector has been unable to perform. The SACBC was already active on ARV treatment and testing before the public sector became involved in the Blaauwbosch area. The movement in KwaZulu Natal is not a shift in responsibilities from public to private sector but the other way around. Therefore Bojovic (2006) description does not match with the South African reality. The definition states that a goal of PPPs is to improve services to the public, in this specific case the main goal is to make ARV treatments accessible to the general public.

Challenges of Public Private Partnerships

As mentioned PPPs aim at creating more value for money. Every organisation in the partnership has its own area of expertise which they can use to link themselves to other organisations (Zapka, et al., 1993). Also with their expertise they can contribute to the partnership, other organisations can benefit from each other’s expertise (El Ansari, Phillips, & Zwi, 2004, p. 280). Next to benefits there are also challenges to be overcome in order to have an effective partnership. The challenges can be divided in both challenges on the organizational level and challenges at the level of employees.

Nishtar (2004) divides the organizational challenges into two different categories, ethical challenges and operational en process related challenges. The ethical challenges concern macro-social aspects

of national health care reforms, only some of those challenges are applicable to the partnership between the SACBC and the KwaZulu Natal department of Health. The ones that are expected not to be relevant for the partnership between the SACBC and the KwaZulu Natal department of Health have not been included in this list. Below the ethical challenges will be explained.

1. *"Social safety nets"*, PPPs can give the public sector an opportunity to avoid its responsibilities and lead to the decline of social safety nets. This would be a negative side effect of a partnership.
2. *"Conflict of interest"*, partnerships can originate out of the need for organisations to fulfil a social obligation. The main goal of organisations may conflict with this obligation which can endanger the partnership.
3. *"Redirecting national health policies"*, with their influence partnerships can redirect policies. An unwanted side effect of this can be that other running initiatives can come to an end.
4. *"Fragmentation of the health system"*, partnership goals often are short term goals. Low hanging fruits are an effective way to achieve these goals effectively. This does not contribute to building a sustainable healthcare system in less developed countries.
5. *"Contribution to common goals and objectives",* partners often do not have the same goals. Sharing goals and objectives is required for an effective partnership.
6. *"Lack of outcome orientation",* many partnerships only exist on paper and therefore do not contribute to building a sustainable health care system.

Source: (Nishtar, 2004)

In the casus under study the sustainability of the programme is at stake. After years of not taking up responsibility in the Blaauwbosch area, the South African state now joins in by cooperating with the private sector SACBC AIDS Office to provide HIV/AIDS prevention and treatment. The partnership of the SACBC and the government is created to provide medication to a marginalized group that previously depended only on the private sector. With the public sector becoming an actor in the AIDS relief programmes, new goals and interest can change the way programmes have been run. Important is that the public sector and the foreign donors like PEPFAR are funding the projects, but when the PEPFAR grants ceases, the facilities that have been build through these grants should continue to exist. The SACBC and the DDOH will be depending on each other to continue the project.

Key to these ethical challenges is that the forming of a PPP to increase efficiency should not be at the expense of the service delivery to the patients in need.

At the operational and process related level challenges may directly contribute to good or best practices of the PPP between SACBC and the DDOH.

1. *"Governance structures",* in order to effectively distribute responsibilities among the partners the governance structure has to be accurately defined. When governance mechanisms are not defined properly, a PPP can become dysfunctional.

2. *"Power Relationships",* skewed power relationships can become a barricade. In developing countries governments tend to take core responsibility of the PPP. This hinders the participatory process, which should be key in a PPP.
3. *"Criteria for selection",* the selection process is both an ethical and process related challenge. In order to form a partnership with competent partners criteria have to be well-defined. The public sector can often be vague about the screening of potential partners.
4. *"Sustainability",* sustainability is often not incorporated in a PPP.
5. *"Accountability",* In many partnerships it is not clear to whom the partnership is accountable for what and what the criteria are by which the output is measured. This way not all partners can be held accountable for their share in the delivery of goods and services.

Source: (Nishtar, 2004)

These challenges are mainly in effect on the organizational level. The partners have to clearly define the specific tasks both take on in the partnership. As this research focuses on the formal aspects of the partnership these challenges are of significant importance to the research. The partnership between the DDOH and the SACBC AIDS Office aims at sustaining the HIV/AIDS care to the people in Blaauwbosch. When the partnership comes to an end arrangements have to be made so that the facilities will remain. How this will be incorporated in the partnership is not yet clear. In order to know who is responsible for different domains of the partnership, the governance structure of the partnership between SACBC and the DDOH has to be clearly specified. Also the DDOH has not always been an actor in the AIDS relief projects, how do they influence the projects that were already in place and the ones that are founded still?

Also the SACBC projects used to account for their actions to the donors, but how is the accountability arranged within the partnership? Also is the partnership equipped at sustaining the activities after the PEPFAR donations cease?

At the individual level there are barriers to be addressed. El Ansari, et al. (2004) and Hagebak (1982) state that in order for health care nurses to switch their working mode to a partnership these barriers are relevant.

Barriers of *organization*: structures, systems, personnel and communication;

Barriers of *vision*: history, tradition, and absence of clear directives or adequate models;

The different factors that are mentioned above need to be addressed. When these factors are not made compatible to match the partnering organization, personnel will not function properly within the partnership. As the partnership members begin to interact lack of direction and organizational difficulties can occur because of insufficient attention to the barriers. Other problems are the infringements on organizational sovereignty and individual identity and fear of loss of autonomy or the compromise of giving up turf and territory (El Ansari, Phillips, & Zwi, 2004).

Public Private Partnership and Governance Structures

Already mentioned were governance structures as a technical challenge. Governance structures are important factors for making a PPP work. In her research of governance in the UK Janet Newman has defined four different models of governance in organizations (Newman, 2001). These are the following: the self-governance model (towards sustainability), the open systems model (towards flexibility), the hierarchical model (towards accountability) and the rational goal model (towards pragmatism) (Newman, 2001).

These models are orientated on a horizontal and vertical axis. The horizontal axis representing the orientation to change and the vertical axis representing the degree in which power is centralized or decentralized (Newman, 2001). Figure 1 shows the four different models in relationship to each other on the horizontal and vertical axis's.

Starting with the hierarchy model, this model focuses on predictability, control and accountability. In government systems this would be a situation where the government remains in direct control of the policy development and execution. It is characterized by vertical hierarchical lines and bureaucratic power relations. The model focuses on continuity instead of change and has a focus on processes, things have to be done in line with guidelines and the correct process (Newman, 2001).

The rational goal model has shorter timeliness than the hierarchy model but still has a focus on centralization. The main focus is on output, getting things done. Bureaucratic power has been replaced by managerial power. The responsibility for the service delivery is diverted to local managers and service level agreements are used to hold the managers accountable. Accountability will be more on the output and not so much on detailed expenditures (Newman, 2001).

The open systems model is a network-focused model, where the power is dispersed among network partners based on interdependence of each other. Relationships are dynamic and change with the change of needs or challenges. In this form of governance the government is less able to exercise direct control over the policies. Power is highly decentralized and the focus is on change and innovation to create effective policies (Newman, 2001).

The self-governance model is focused on sustainability based upon long time relationships and interdependencies. The role of civil society actors is acknowledged in this model but with a strong focus on partnership between government and civil society actors. The partners can be used as co-producers of health and welfare services next to existing government services drawing onto each other their strengths (Newman, 2001). Partnerships often will not fit into one specific model but fit into two or three different models.

Important in choosing the form of governance is that it suits the goal of the partnership. The different forms can work against each other. For instance an organisation focussed on accountability will have many procedures in order to account for their performance, this will make it harder to be flexible because of all the different rules that have to be altered (Newman, 2001, pp. 113 - 116).

Which forms of governance the SACBC AIDS office and the DDOH represent can influence the outcomes of the process. Also it can have an effect on the partnership as a whole.

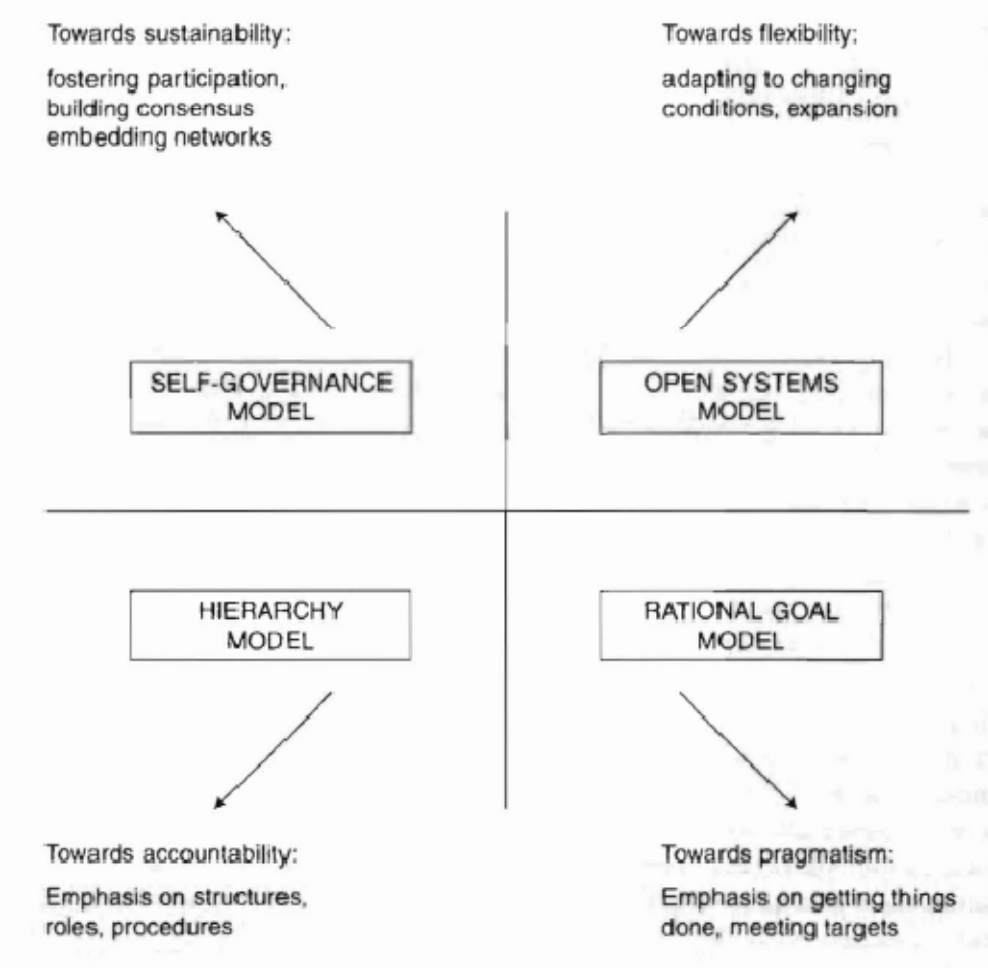


Figure 1: Four models of governance by J. Newman. Source: Newman (2001)

As stated an organization can often fit into more than one of these models. The SACBC AIDS Office for instance is funded by foreign donors, they are obliged to account to these donors, so it is to be expected that there will be a hierarchy model in place. The research from Brady & Ota (2008) on the other hand implies that the different SACBC AIDS Office sites have a high degree of independence. This places the organisation in a self-governance model.

It is expected that the DDOH fits the description of a hierarchy model. The government system in South Africa has a focus on accountability. The experiences with the local government until now suggest that this model fits them best. The different levels of government, going from National, Provincial and District Level all have their own department of Health. They all have their own responsibilities and have to account to the level above them. They have a complex vertical oriented way of communicating. This research will have to make clear in what way the organizations have to adapt their models to each other in order to be able to effectively partner up. This information leads to the following expectations.

Expectation 1: Accounting will not be a problem in the partnership as both SACBC and DDOH are hierarchical organisations. Both organisations are expected to be equipped to do so and will value this process. As they both need to account to either the donor or the tax payer.

Expectation 2: On local level there will be friction in the partnership. The government institutions are hierarchical in all layers where the local clinic is self-governing. They have a higher degree of independence and are able to make decisions at a faster pace than the local government as they have long chains of approval.

Sub Questions

The above theoretical insights have led to the formulating of the following sub questions. In order to be able to obtain answers to the research questions, these sub questions will provide the necessary information to be able to do so.

1. What ethical and technical challenges can be identified in the public private partnership?
    a. How are responsibilities divided between the two organisations, and their departments (for instance testing, laboratories, ARV provisions, level of CD4 counts, treating dying patients).
    b. How do the organisations transfer patients between one and the other?
    c. What measures are taken and could be taken to prevent patients from dropping out or getting lost in the transfer process?
    d. What consequences will the public private partnership have on the number of different functions of jobs at the Newcastle Catholic ARV Project?
    e. How will the clinic be financed until the PEPFAR funding stops and after it stops in order to guarantee a sustainable level of service?
    f. How do the organizations account for their activities? And how can these systems be adapted to match one another?
    g. Which organisation is accountable for what part of the partnership?
2. What kind of governance model, according to Newman (2001), characterized the different organisations in the partnership and what kind of governance model would fit the public private partnership best?
3. What barriers can be identified in the public private partnership?
    a. How will the partnership affect the independence of the Newcastle Catholic ARV Project?
    b. How will the partners communicate with each other and at what level (organisational, individual, etc.)?
4. How can the Newcastle Catholic ARV Project be integrated into the government clinic system?

Methods

This chapter gives a description of the used research method for this study. The theory from the previous chapter has been used to formulate a goal and research questions. These are described below.

Research Methods

In order to answer the research questions research has been conducted in the area of Newcastle, KwaZulu Natal in South Africa. The process of partnering the SACBC Newcastle Catholic ARV Project with the government is very specific. The amount of people involved in this process is limited. Also because of the exploring nature of this research it is important to get depth information and to get new valuable information on PPPs the research is qualitative.

For this research mixed methods have been used. In order to get the necessary information on the local case a document study was performed. Together with observations on site this has been the preparation for semi structured interviews. The findings of the document study and the observations led to specific subjects to question the staff of the clinic through depth interviews about the partnership.

The research was conducted in the Newcastle region in KwaZulu Natal, South Africa, the SACBC Newcastle Catholic ARV Project in Blaauwbosch near Newcastle, the Madadeni Hospital, Amajuba District Department of Health in Newcastle, the Noyi Bazi Clinic at Pomeroy and the Church of Scotland Hospital in Tugela Ferry. The population used for this research were the staff of the Newcastle Catholic ARV Project, the Augustinian Sisters and counsellors at the Noyi Bazi Clinic in Pomeroy, a doctor in the Church of Scotland Hospital at Tugela Ferry, a manager at Keth' Impilo and staff from SACBC. These people were selected as being the key figures in the process after studying the documents and observing at the site. All of them were interviewed on this partnership.

The government facilities in Newcastle were not included in the interviews. It was not possible to get the necessary permissions to conduct our research at the government facilities due to long processes and not being able to get the proper forms. It was not clear which forms where needed and who needed to approve them. Also it has not been possible to receive an ethical clearance from a local university for it is necessary that students must be enrolled at the university to get that clearance. Therefore only observations have been performed during meetings at the District Department of Health and the Madadeni Hospital.

In these meetings all the important information involving the partnership has been written down in reports. Specific points that were looked at were the agreements that were made in the meetings and how the different partners communicated amongst each other. The reports have been bundled in a chronological order to keep a structured oversight in order to analyse the reports and filter out the important events.

The observations at Madadeni Hospital have been conducted in order to get a clear view of the actual process of transferring the patients between the Newcastle Catholic ARV Project and Madadeni Hospital.

The information this has supplied us with is used in this research. Although the patients of the clinic will notice the effects of the partnership between the SACBC and the government, they are not

included in the research. This because this research looks at the organisational level and not into the experience of the individual patients. In total 17 interviews have been held with staff members from different organisations.

In order to be able to focus the interviews on relevant subjects, first key stakeholders have been interviewed. The results from these interviews were used to finalize the interviews for the other employees. For this research the director of the SACBC AIDS Office and the project coordinator have been selected as the key stakeholders. They are the ones that know most about the overall processes in the Newcastle Catholic ARV Project and their information can be used to narrow down the interviews for the rest of the staff. The actual topic list can be found in Appendix 2.

To analyse the interviews NVivo 9 has been used. NVivo 9 is a computer program to analyse qualitative data. Both audio and text can be put into the program. So every interview has been transcribed and put into the program. To extract relevant information different nodes were created. These nodes represent a specific selected subject. From the interviews the relevant quotes on the subject can be selected and linked to the node. This way the relevant information on all the relevant subjects for this research can be bundled. These nodes form the basis for the results. Therefore it is very important that this process is done with precision. To include all the relevant information it has to be included in the nodes. By reading through the interviews and checking if an answer belongs to either one or more nodes this is guaranteed. Because the interviews are semi-structured different questions were asked to the different respondents. Therefore NVivo cannot bundle the data automatically and the bundling of the information is done on own interpretation.

Results

The interviews and observations that have been executed resulted in the following findings. These are divided into the different sub questions that have been formulated in the previous chapter. The results are based on the interviews of the staff of the Newcastle Catholic ARV Project, the Noyi Bazi Clinic, the doctor from Church of Scotland Hospital and a staff member from Kheth' Impilo. Results concerning the government institutions are deductions from observations and based on second hand sources.

Challenges

For this research certain challenges that Nishtar described in PPPs in developing countries were expected to occur. These can be divided into ethical and technical challenges. The ethical challenges are: declining social safety nets, conflict of interest, redirecting national health policies, fragmentation of the health system, contribution to common goals and objectives and lack of outcome orientation (Nishtar, 2004).

The following technical challenges were expected to occur: governance structures, power relationships, criteria for selection, sustainability and accountability (Nishtar, 2004).

Ethical Challenges

The information gathered for the research has led to information on the above mentioned ethical challenges. This paragraph will state the results gathered on each one of the challenges.

The challenge of declining social safety nets, where governments can avoid responsibilities because of the partnership is not appearing in this setting. Where the government has avoided responsibilities in supplying medication until this point they are taking their responsibility now. They have agreed to supply medication for the Blaauwbosch patients and the patients from Madadeni that go to the Rosary Clinic in Blaauwbosch. "*Because we don't get money now from America. So they are transferring those who are from Osizweni, Madadeni, other places, but they are keeping Blaauwbosch ones. And the ones that are from Madadeni that are using Rosary Clinic. They can stay here."* (Respondent 2), "*Nothing is formalized yet, but there is a letter of commitment from the Department Of Health, that states from last Friday, the first of April, that they would start providing ARVs."* (Respondent 8). This challenge seems not to be in place in this specific situation as government is taking on more responsibilities then before instead of outsourcing it's services.

Government, the SACBC AIDS Office and the Newcastle Catholic ARV Project all share the same goal, to provide health care to the community. As funding becomes from PEPFAR comes to an end the SACBC AIDS Office requires to find a solution to providing ARV treatment to the patients. "*And so the treatment is now available in the public sector so the responsibility is now more on the DOH even than it was when it wasn't providing it, you know."* (Respondent 7). So they have a common interest to keep providing treatment for the patient and fulfil their moral and ethical obligation.

The forming of the partnership between the Newcastle Catholic ARV Project and the DDOH has been a slow process. Where the Newcastle Catholic ARV Project and the SACBC had to adapt to the wishes of the DDOH. The Newcastle Catholic ARV Project has taken on a government responsibility at Blaauwbosch to provide ARVs to the community there while the government was not doing this. The government will after a year of negotiations start to take their responsibility for those patients by providing treatment for them. However the terms for this partnership are made by the DDOH. Also in

exchange for the partnership they ask for resources such as a car, a driver, 10 counsellors and gazebo tents. As one of the staff members mentioned: "*And the relationship between us and them, it's always like we have to beg. We are the ones who ask, come down. Because they have all the powers, they are the people"* (Respondent 14). Also at the lower level government does not always participate with the Newcastle Catholic ARV Project: "*It depends on the doctor you meet or the nurse you meet. Because I had to escort my patient to the hospital. And they just say: "You have lots of money, you go to private sector then at the last moment you come here." We have to tell them they don't pay money"* (Respondent 2). The government seems to be making its own plans where other actors have to adapt to. It doesn't appear to be that the partnership is redirecting the national health policies. Whereas the government is shaping the policies of the Newcastle Catholic ARV Project, *"We signed an agreement with the NDOH to say that we would not go onto others. … Number one we can't afford it, it's a different regimen and things and number two, it's breaking the agreement that we have with the government."* (Respondent 7).

Technical Challenges

Some of these findings also correspond with the challenge of skewed power relationships. The DDOH makes the frame for the partnership and decides what will and will not be part of the partnership. "*So there are different models which means that we have to be very flexible, we don't say 'one size fits all' and we don't say 'you have to do it like this', we do it whatever makes sense for that particular province. We will be the flexible one, to jump whatever way needs to be jumped. So we have to be on the ball all the time to see what makes sense."* (Respondent 7), "*And the relationship between us and them, it's always like we have to beg. We are the ones who ask, come down. Because they have all the powers, they are the people"* (Respondent 14), "*Personally, what I am expecting is somebody from the District or Madadeni to tell me that this is where we put the drugs, we must wait for this door to be opened to get the ARVs."* (Respondent 8). In the partnership the SACBC AIDS Office and the Newcastle ARV Project have to wait for government to take action in order for them to be able to move forward.

The SACBC AIDS Office works according to the governmental guidelines when it comes to ARV regimes to make an eventual transfer from patients easier. "*We signed an agreement with the NDOH to say that we would not go onto others"* (respondent 7). "*The other advantage of that is that we can move patients from catholic sites into the government sites without changing their medication"* (respondent 7). At the Newcastle Catholic ARV Project they have deviated the government guidelines in some cases. This has proven to be a problem for the sustainability of these patients. The government has stated they do not have these regimens at their disposal so they will not take these patients from the Newcastle Catholic ARV Project.

However in the discussions at the DDOH the sustainable character of this partnership has been made clear by trying to integrate the Newcastle Catholic ARV Project with the Rosary Clinic, including the integration of the Rosary Clinic's TB treatment program. So when the SACBC really shuts down the funding to the Newcastle Catholic ARV Project it will be easier to take over the services by the DDOH. Also the patients that will be initiated at the Newcastle Catholic ARV Project will be registered at the Madadeni Hospital so they can be referred to any other government clinic easily because they are already in the government system.

In the current situation the Newcastle Catholic ARV Project accounts for its finances to the SACBC AIDS Office. The SACBC AIDS Office also looks into the timesheets from the clinic staff, to make sure the staff actually reports their activities correctly.

Also the Newcastle Catholic ARV Project accounts its progress to the Catholic Relief Services (CRS). As they were the first PEPFAR recipients they have build a Patient Data System (PDS) to capture all relevant data on the patients digitally. Every week a back up of the PDS is send to CRS which they analyse.

Already the Newcastle Catholic ARV Project delivers statistics to the DDOH. "*Because they also set their own target of about 180 000 to be tested and they are pushing a campaign to go to school and test. So that's why they need us,… so they need NGOs like us, who can come and count, but over and above, they need numbers and we can provide them. If our 800 patients go to their list, they've added 800 patients immediately, just like that. So that will show when they report to the province, so for them, numbers are important*" (respondent 8). The DDOH needs to know how many patients the Newcastle Catholic ARV Project treats so they can give more accurate estimates on the prevalence rate in the district.

Within the partnership a new important actor arises. The Madadeni Hospital need to be included in this network. They will be responsible for ordering the ARVs for the Newcastle Catholic ARV Project. They also have to account for the medication they disperse to the PDOH. The Newcastle Catholic ARV Project will have to register every new patient directly at Madadeni Hospital so they can send the proper regimen of ARVs for that particular patient to the Newcastle Catholic ARV Project.

As the accounting mechanisms are already in place at the government and the Newcastle Catholic ARV Project accounting for the partnership is not expected to pose a problem. Within the collaboration the data necessary for accounting will be shipped to other organisations but the infrastructure is already in place. As the Newcastle Catholic ARV Project uses a Patient Data System (PDS) in which all relevant data about a patient is stored. By supplying the government with this data the accounting can be covered.

Governance

As mentioned in sub question 2 organisations can have different forms of governance. These forms of governance can characterise an organisation. In the interviews and observations the different forms of governance that characterise the organisations involved became clear.

The Newcastle Catholic ARV project consists of a clinic funded through the SACBC AIDS Office by PEPFAR. The observations show that the clinic is an independently working organisation, able to adapt to the local situation. As shown in the organogram in Appendix 1 the clinic has few hierarchical levels. The SACBC AIDS Office is responsible for the clinic, in the clinic the project coordinator is in charge of the day to day activities. Above the project coordinator is the board to which the project coordinator has to account his actions, also "*Constitutionally the policies are the responsibilities of the board."* (Respondent 8). The project coordinator is then responsible for implementing these policies and reporting the status of this to the board. The SACBC AIDS Office has embedded it's clinics into the local community and tries to adapt the clinics to the local conditions. This also goes for the partnership with the government, *"So there are different models which means that we have to be very flexible, we don't say 'one size fits all' and we don't say: 'you have to do it like this', we do it*

whatever makes sense for that particular province. We will be the flexible one, to jump whatever way needs to be jumped. So we have to be on the ball all the time to see what makes sense." (Respondent 7)

The clinic has a high degree of independency from the SACBC AIDS Office. They account for the spending of the money but are free in how they want to run the clinic and adapt the clinic to the local situation, as long as they spend the money accordingly to the goal of ARV provision. So when the project is in need of equipment or supplies they can quickly place an order and purchase what is needed. Also within the clinic it is easy to get things done quickly, lines between the coordinator and the staff are short. *"If I want to do something, I just go to Xolani"* (Respondent 14). Also the staff has a degree of own responsibility in organising the work, *" The coordinator doesn't care which of us does what task, as long as it gets done"* (Respondent 14). These characteristics place the organisation in both the Rational Goal model as in the Self-Governance Model. The organisation tends to work pragmatic according with the guidelines. The work needs to be done properly but is not complete bound to very strict regulations and policies that prevent the organisation to act when circumstances change. Therefore the organisation is able to make decisions quickly and can anticipate fast on changing circumstances.

The government organisations are much more hierarchical, in the District Department of Health (DDOH) meetings it became clear that their process is complex because all of the different vertical levels in the organisations. The National Department of Health (NDOH) is on top of the hierarchy, then comes the Provincial Department of Health (PDOH) and under that are the Provincial Hospitals and the DDOH. Also when requesting interviews at the DDOH and Madadeni Provincial Hospital the clearance had to be given at provincial level, but with authorization from the DDOH. At the DDOH a District Manager is in charge, in the case of Amajuba District this is Mrs. Tshabalala.

In the stakeholders meetings at the DDOH Mrs. Tshabalala requests for different goods from the NGOs that are involved in the HIV/AIDS treatment in Amajuba. Explaining that the money is available at the DDOH but the need is urgent and their supply chain is very long because of red tape. This makes clear how bureaucratic the governmental Health Departments function. A central buying division is active within the department of Health.

Within the partnership the DDOH is also a hierarchical party. "You can't force them to do what they maybe or not totally are ready to do. You do what you can and you accept when they are ready. In some sites they said they would start at such or such date and they did. In some sites they said we won't start with all your patients this month, but we will take 200 and in another case they said they would take 75 per month. So whatever they say, you go along, knowing that is part of good patient management into the future, responsible use of donor funding cause the donor funding is limited and knowing that PEPFAR will be supporting the South African DOH into the future, but in a different way." (Respondent 7).

According to the ARV program manager from the PDOH the budget for ARVs at the government is made up yearly. Local government cannot endlessly put patients on ARVs. They have to stick to the budget that has been assigned to them by the provincial and national departments.

In order to be able to act quickly to changing circumstances in the area of ARV treatment it would be wise to utilize the strengths of both the government and the SACBC AIDS Office. As the government

is able to procure medication at a low price and has the means and responsibility to do this they will be a suitable long term partner in the ARV provision. The SACBC Newcastle Catholic ARV Project works independently and has proven it can provide cost-effective treatment. In order to keep doing this the Newcastle Catholic ARV Project should not be fully integrated into the hierarchical system of the South African Department of Health but remain an independent Self-Governing institution under the umbrella of the government. This will make them able to do the work necessary without being bound by long chains of decision making, which characterizes the rational goal model. This means that within the partnership three quadrants of the governance model will be represented. Both the existing governance models will remain intact but with a new structure of hierarchy.

Partnership Process and Barriers

This chapter will gave a description of how the partnership has come about and which barriers were encountered. The information used for this chapter have been the documents supplied by the SACBC and the Newcastle Catholic ARV Project, the observations of the meetings at the DDOH and Madadeni Hospital and the interviews.

A partnership between the Newcastle Catholic ARV Project and the DDOH has been suggested in August 2010. "… the province has identified Rosary clinic as one clinic that has high numbers of people with HIV or that are tested positive here" (Respondent 8). The Rosary Clinic in Blaauwbosch at present and at that time does not provide ARVs and does not initiate patients on ARVs. "So the District felt like we should be initiating instead of Rosary Clinic because we are already there. They thought it would be duplicating of services if we initiate and they initiate" (Respondent 8). The DDOH was supposed to supply ARVs to the Newcastle Catholic ARV Project in November 2010 already as was agreed upon in August 2010. This never started back then and has never been formalised in writing and because of the District Manager left this agreement was never finalised. Apparently arrangements are depending on specific persons and when they leave the process comes to a standstill and has to start all over again.

On 17 February 2011 the DDOH sent an e-mail stating they will pay for the medication of newly initiated patients by Newcastle Catholic ARV Project and that they will take over the already initiated patients from the Newcastle Catholic ARV Project into the government clinics to supply their medications. Effectively this means the Newcastle Catholic ARV Project will have to down refer its patients to Madadeni Hospital. Down referring is the process of transferring the patients to another facility.

In the stakeholders meeting on 9 March 2011 at the DDOH the procedures around the partnership were discussed. The Newcastle Catholic ARV Project will down refer its patients to government clinics through Madadeni Hospital. Down referral forms will be filled in for every patient to be transferred stating all the important data about the patient, general and medical information. This will be send including a pink prescription chart per patient, this contains the information about the used ARV regiment for each individual patient so that the pharmacy can send the proper medication to the clinic. Also copies from the first lab results of the patients have to be included, also called the base line results. A maximum of 40 patients may be down referred to Madadeni Hospital every week. In the meeting no agreements are made on how the forms will be send to Madadeni Hospital, also it is not clear where the ARVs will be stored and how and when they will reach the Newcastle Catholic ARV Project. In return for this deal the DDOH requests some resources from the SACBC and the

Newcastle Catholic ARV Project. *They asked us to buy a car, supply a driver for a car, 10 lay counsellors and 9 gazebos (tents), because they got that impression from Kheth 'Impilo that NGOs can buy for government* (Respondent 8).

There has not been any contact between the Newcastle Catholic ARV Project and Madadeni Hospital and Rosary Clinic between the meeting on 9 March and the starting date of the transfers on 1 April. When the transferring process commenced there was not a clear system. The sister in charge started filling in the transfer forms and to deliver them to Madadeni Hospital in person. The maximum of 40 patients was not reached. Most of the weeks the maximum is not reached at the SACBC side. On the government side this process has had some problems. About 40 files that were sent to Madadeni Hospital were lost for a time. On another occasion the Hospital did not accept the files stating for a reason they were understaffed and were not able to take these extra files from the Newcastle Catholic ARV Project. Also the first 5 patients that were transferred to Madadeni Hospital were sent back to the Newcastle Catholic ARV Project by the government clinic where their medication should have arrived. Here both an organisational barrier and a barrier of vision are in effect. On the one hand the communication between the different organisations is minimal, without further consultation the process is started and not everybody is informed of the agreements. On the other hand there is a lack of directive, the organisations involved are not properly instructed on what is happening so clinics don't know of the existence of the partnership and don't accept patients. Basically the staff at the government clinics is not aware of what is expected of them.

It has become clear that most communication between the different partners is verbal. When something is not clear or when extra forms are needed, the person who might know the answer is contacted either in person or over the phone. The agreements that are made in the meetings at the DDOH are made verbally and follow meetings are planned between specific partners but not every follow up meeting actually takes place. As there is no memorandum of understanding or written agreement the terms of the partnership can be interpreted differently between the different partners.

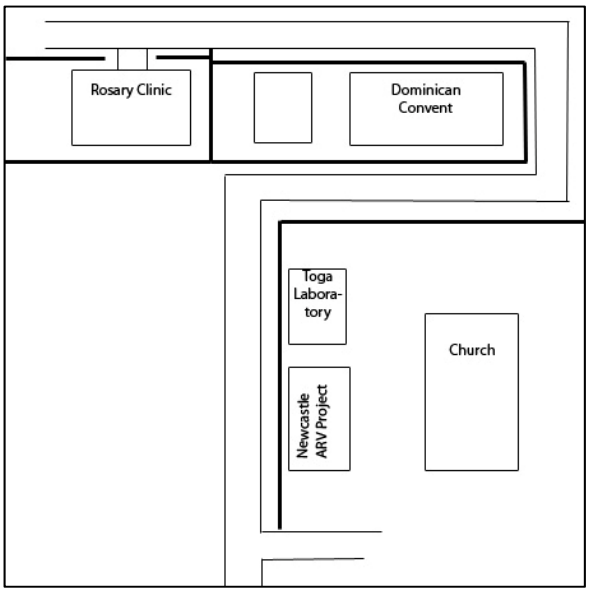
A letter from the District Manager about the transfer process to every stakeholder including all the government clinics never reached the clinics. This letter stated the government clinics must not send the patients back to the Newcastle Catholic ARV Project because they are supposed to be transferred into the government system. Here a communication issue arises. As there is no communication between the Newcastle Catholic ARV Project and the local clinics it is hard to check if the patients are actually transferred successfully. As arrangements are made in the stakeholders meetings to move forward, on the operational level these agreements don't seem to take effect.

Referring back to the organisational barriers of El Ansari, et al. (2004) this can be seen as a barrier. In the partnership communication takes place at the organisational level in stakeholders meetings. The government clinics are represented by the Madadeni Hospital and the DDOH but information does not effectively reach the clinics involved. For the partnership to work all the stakeholders need to be aware of the agreements being made, otherwise the partnership will not reach its full potential.

Possible Forms of Partnership

The partnership has not yet been formalized, but the interviews and observations have led to a number of different scenarios of the partnership. How the Newcastle Catholic ARV Project can be integrated into the government system, as mentioned in sub question 4, will be further explained in this chapter. In order to get a clear image of how this would actually look like, a graphical image of the current setting has been included.

Figure 2: Current situation at Blaauwbosch



At the moment the Newcastle Catholic ARV Project has a park home on the premises of the Blaauwbosch Catholic Church. The government clinic "Rosary Clinic" is located around the block, the walk from the Newcastle Catholic ARV Project to the Rosary Clinic is about 10 minutes. All the premises are closed off by fences, you can only walk around the premises and can enter them on one entry point only. The organisations are operating independently from each other and are providing different services which complement each other. When a patients from the Newcastle Catholic ARV Project needs to be screened for TB, he/she will be referred to the Rosary Clinic. "*…patients who screen for TB and come back with their results from the government clinic, because we don't do TB here."* (Respondent 1). Integration of the clinics will be hard in this setting as they are physically separated. In the stakeholders meetings both partners have mentioned this is an unwanted situation. Also with the patients experience in mind this scenario is not wanted as they will need to walk a long distance between the two facilities. The current situation is displayed in figure 2.

With the above information in mind other forms of integration need to be found. Two different scenarios have been mentioned. One is to create a gate between the two facilities and the other is to move the entire park home to the premises of the Rosary Clinic. When looking at integrating the Newcastle Catholic ARV Project into the government health services three different options can be explored.

The first option is to have the government take over the staff of the Newcastle Catholic ARV Project and fully integrate them as a government division. Effectively this will be the end of the partnership as from that moment the Newcastle Catholic ARV Project as a partner will not exist anymore. Benefits from the partnership will then no longer be available. The experience from the staff will remain but from then on they will be bound to strict government guidelines and restrictions.

The second would be that the government will supply the medication and laboratory tests for the Newcastle Catholic ARV Project. The SACBC will have to pay for the staff to keep the clinic running. As Brady and Ota (2008) mentioned, the SACBC is not able to procure less expensive ARVs whereas the government is. So in supplying the community with medications, costs can be cut because of these

less expensive medication and the government does not have to invest in starting a new ARV clinic as they will utilize the already existing one.

The third option is a form of partnership that in the western world is often used for public private partnerships, called outsourcing (European Commission, 2003). Outsourcing on its own is not a form of PPP, but with the government supplying less expensive medication this scenario exceeds normal outsourcing. The government can also choose outsource the service by paying the Newcastle Catholic ARV Project or the SACBC AIDS Office to do the work. As mentioned in the chapter on governance the different governance models can enhance each other's performance. In this way the integration will be minimal but the sustainability is guaranteed as government supplies the means and the SACBC the expertise. The government and SACBC AIDS Office can make agreements on the level of service to be expected by the Newcastle Catholic ARV Project. In this situation both the organisations strengths will be utilized to provide better service to the community.

Noyi Bazi Clinic

In Pomeroy there already is a PPP active. The Augustinian Sisters there run a primary health centre for the local community. They are the only facility in the area that has a fixed building. The government uses mobile clinics to reach the more remote regions around Pomeroy. As there is no government clinic available but there is a need for HIV/AIDS treatment, the Church of Scotland Hospital (COSH) from Tugela Ferry is in a partnership with the Noyi Bazi Clinic.

The COSH supplies the Noyi Bazi Clinic the HIV testing material. The government is paying for the entire treatment program but the Sisters there execute a part of the work and they have their own counsellors to test new patients, also a counsellor from the government is working at the Noyi Bazi Clinic. At the moment patients are not yet being initiated at the Noyi Bazi Clinic but at COSH. This is because the Augustinian Sisters have not yet been trained in initiating treatment. In the future these trainings will be given and patients from Pomeroy will not have to make the journey to Tugela Ferry to start their treatment. Once patients are stable they will be transferred to the Noyi Bazi Clinic where they will receive their ARV treatment from the clinic.

In this partnership the Noyi Bazi Clinic is the executing partner and the COSH the funder and in the end responsible for the result. Big difference with the Newcastle Catholic ARV Project is that the Sisters in Pomeroy do not get paid and the staff at the Newcastle Catholic ARV Project does. This makes for a different financial background of the partnership. The Noyi Bazi Clinic can suffice with the delivery of medication as they do not charge wages for themselves whereas the Newcastle Catholic ARV Project will need means of paying its staff.

When looking at this partnership and comparing it to the scenario's that have been mentioned in the previous chapter, the COSH has already outsourced a part of its HIV/AIDS treatment for Pomeroy to the Noyi Bazi Clinic.

Conclusion and Discussion

This chapter will hold the main findings of the Study. Also the research questions that have been formulated before this study was executed will be answered. Recommendations for the PPP between the SACBC AIDS Office and the DDOH will be stated and recommendations for further research can be found in the end of this chapter.

The PPP that has been the focus of this research is a work in progress. Many things have not yet been decided or formalised. Willingness from both sides to succeed seems to exist but the process has been slow as it was already supposed to start in August 2010, which was not achieved. Since April 2011 the PPP has started with the Newcastle Catholic ARV Project transferring its stable patients to the government clinics. Even though the transferring process has started by now, still no agreements have been formalised. So how the different responsibilities will be divided is not clear and can still be open to changes. Decisions about the process are being made at the meetings with the DDOH or when problems arise between the different actors. These decisions are often ad hoc and a set plan on how to get this partnership started has not been made. In order to work more effectively these issues should have been addressed earlier on in the process to prevent problems from arising.

When looking at the governance models that Newman (2001) describes, the two partners, the Newcastle Catholic ARV Project and the DDOH do not share the same forms of governance. Where the DDOH is strongly hierarchical and focussed on accountability the Newcastle Catholic ARV Project is hierarchical but also fits into the self governance model and rational goal model. From the SACBC AIDS Office and the donors side the Newcastle Catholic ARV Project has to account for their activities and spending, but in executing their work they are relatively free to operate within a set framework by the SACBC AIDS Office. Where government is slow to react to changes because of red tape the Newcastle Catholic ARV Project can adapt to new situations more quickly. These features enhance each other, the government can profit of the expertise, good practices and adaptability of the Newcastle Catholic ARV Project in setting up an initiating site while the SACBC AIDS Office still funds the Newcastle Catholic ARV Project through PEPFAR. When this funding stops, government can take its responsibility at an operating initiating site in Blaauwbosch. In order to get the most out of both partners, after the PEPFAR funding has stopped, it would be efficient to let the Newcastle Catholic ARV Project keep its independence. This can be achieved by outsourcing the ARV provision by the government to the Newcastle Catholic ARV Project, where the DOH funds the Newcastle Catholic ARV Project to perform the task. The government can be a long term stable partner where the Newcastle Catholic ARV Project can use its strengths as being an organisation that is able to adapt quickly to changing circumstances and are less bound to the strict regulations that exist in the government systems. This system of PPP has proven its value in many situations in Europe (European Commission, 2003). It may also prove a valuable addition to the Health Department in the Amajuba District. This scenario guarantees the sustainability of the program as the partnership will no longer be depending on external donors.

The findings on governance are in line with expectation 1: Accounting will not be a problem in the partnership as both SACBC and DDOH are hierarchical organisations. Both organisations are expected to be equipped to do so and will value this process. As they both need to account to either the donor or the tax payer.

Some of the challenges that were expected to be present at this partnership have not been found and some others have. The most important challenge is the skewed power relationships. The government takes control of the partnership and sets request to the SACBC AIDS Office and the Newcastle Catholic ARV Project where they are not in a position to do so themselves. In a way this undermines the concept of a partnership, as the definition that was found is "*Partnering involves two or more organizations working together to improve performance through mutual objectives, devising a way of resolving disputes and committing to continuous improvement, measuring progress and sharing gains*" (Bojovic, 2006). Most of the gains are for the government, the SACBC AIDS Office and the Newcastle Catholic ARV Project are able to phase out ethically responsible and the government will get free labour, expertise and other goods they requested to perform a task that is a government responsibility in the first place. The experienced skewed power relationship may pose a threat to the PPP in development. In the scenario of outsourcing services government is not expected to interfere with the way the work is executed.

The above findings also correspond with the pre-formulated expectation 2: On local level there will be friction in the partnership. The government institutions are hierarchical in all layers where the local clinic is self-governing. They have a higher degree of independence and are able to make decisions at a faster pace than the local government as they have long chains of approval.

Specific recommendations to be made after this study are that the in the case of future partnerships with other DDOH's and provincial hospitals the communication between the partners should be more frequent. In order to make a pre scheduled plan in partnering up, some challenges need to be addressed before they occur. Responsibilities between the different partners need to be formalised so that each actor knows what is expected of them. Both partners have the same goal in the partnership, to provide treatment for the community, but when some of the actors are not aware of their duty patients can be rejected at the clinic they are supposed to go to. This undermines the trust between the partners but also the trust patients have in the partnership.

Newman (2001) and her governance model made clear that in a partnership, the different models need to be taken into account. As they can enhance each other and the different organisations can benefit from each other's strengths. An effective way to do so, according to the European Commission (2003), is to outsource a part of the service delivery process to an outside partner, where the SACBC AIDS Office can deliver services in a cost effective way and the government can procure ARVs at a much lower price than the SACBC AIDS Office. This way both partners can benefit from each other and service delivery to the patients is maintained in a sustainable manner.

This research has given new insights in how PPPs can originate in South Africa. The complexity of how organisations and government try to form a partnership have been visible. Private organisations encounter barriers in working with the government. For further research it is important to include the government. In this study the government was not participating, therefore no interviews representing the view of the DDOH or Madadeni Hospital could be included. It is still very interesting to know how the government operates and what is their view on PPPs in ARV provision. This information can help in forming more effective partnerships in the future as it is not yet clear what really motivates them to participate in the partnerships and what binds them not to.

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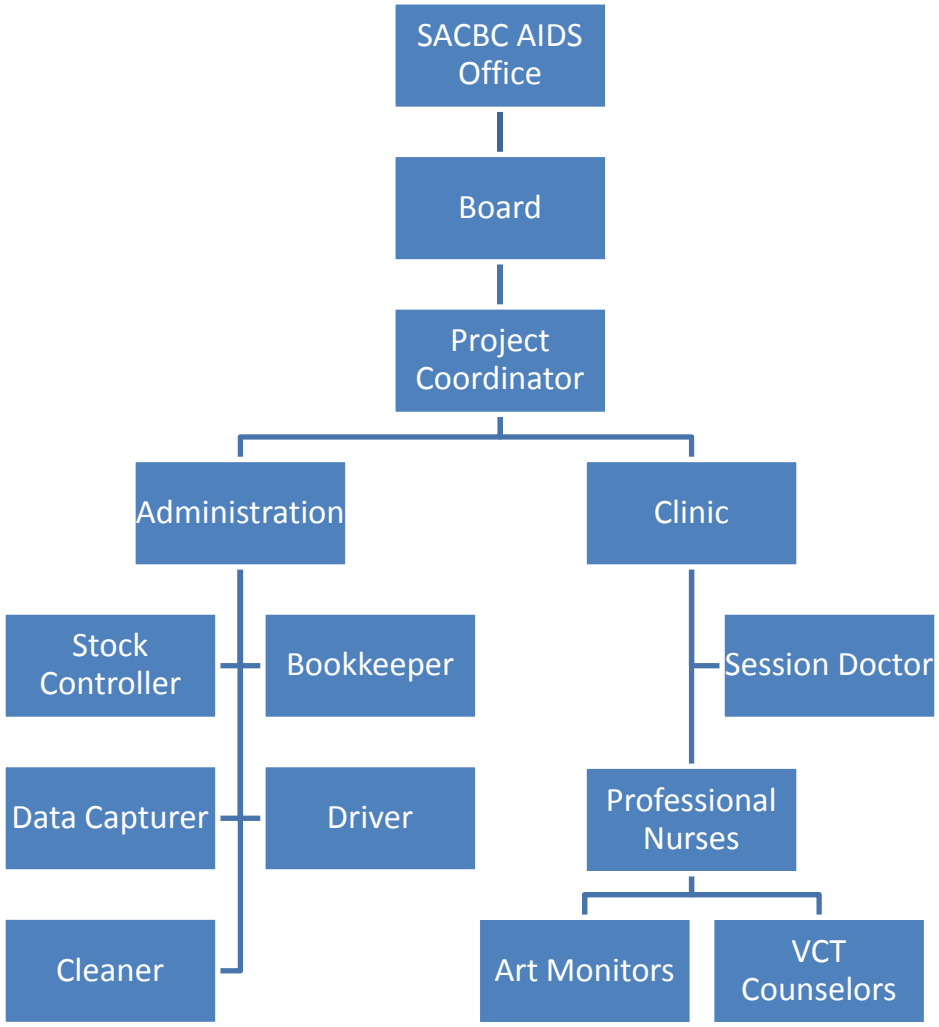
Appendix:

Appendix 1: Organigram Newcastle Catholic ARV Project

Appendix 2: Topic List Interview

Organogram Newcastle Catholic ARV Project



Topic List

Introduction
Thank you for taking the time for this interview. I would like to tell you who we are and inform you about the subject and purpose of the interview. We are asked by the SACBC AIDS Office in Pretoria to look into the collaboration between the clinics in the KwaZulu-Natal province and the Provincial and District Department of Health with regard to the distribution of ARVs and the treatment of HIV/AIDS infected patients. Both of us study at the University of Utrecht in the Netherlands. This is our master research which is our final assignment in finishing our study. Whatever you say in this interview will be kept anonymous in the analysis and the report. The report we will write about this research will be used for our master thesis and it will be sent to Sr. Alison Munro of the SACBC AIDS Office. If you would like to know about the results, please contact her.
If at any time during the interview you want to ask something for clarification or you need a break, please say so.
If it is all right with you, can we record it? This is purely done for transcripts and will not be given to anyone else.

General questions
What is your name?

Since when have you been working for this clinic?

What is your job in the clinic?

What kind of training did you have?

Where did you grow up?

What was your family composition when growing up?

To which ethnic group do you relate yourself?

Organisation
What services relating to HIV/AIDS care does your organisation deliver to the patients?

How do you get people to come to the clinic to get tested?

How are your organisations activities financed?

How will the activities be financed in the future?

What effect will the collaboration/partnership have on the financing of the clinic?

How do you account for your activities?

To who do you account for your activities?

Partnership
Can you explain how the partnership has come about?

What does it entail specifically?

How are you being informed about this partnership?

What is your organisation responsible for in the partnership on the subjects of HIV testing, HIV prevention, laboratory tests, ARV provision, adherence monitoring, treating of terminally ill patients? / How are the different tasks in relation to HIV/AIDS care divided among the organisations?

What agreements have been formalised in writing?

Have there been disagreements in organizing the partnership? How have they been overcome?

What do you notice of the partnership in daily practice in the clinic?

How is the communication organised between the DDOH and the clinic?

Do you have personal contact with anyone from the DDOH?
If so, with whom, how often and what about?
What is your opinion of the communication between the organisations?

According to you, what is the motive for and purpose of the partnership?

What are benefits of the partnership for both organizations?

Do you think it has improved the dispensation of ARVs?
In which regard/ why?
For whom?

How do you see the partnership developing in the future? Especially beyond June 2012?

What possible scenarios/models of partnership could there be?

What is the organizational relationship between the clinic, the DDOH and the hospital?

Who is in charge of the partnership?

To whom will you be accounting for your activities within the partnership in the future?

How will you account for the activities within the partnership in the future?

Logistics
How do you store your patients data?

How is the transfer of patients from the hospital and government clinics to your clinic and vice versa arranged?

Who is (will be) in charge of the referrals?

What are the criteria for referring a patient?

Is the referral system well arranged according to you?

What can be improved?

What measurements are taken to make sure patients do not drop out of the ARV programme?

How is the supply of ARVs arranged?

Is the supply of ARVs arranged well?

Is there anything that can be improved in the supply?

Approach
How do you feel treated by people from the hospital?
(if relevant)

How do you feel treated by people working for the DDOH?
(if relevant)

How can you describe your attitude towards the staff at the hospital and the DDOH?

How would you describe the attitude of you and your colleagues towards HIV/AIDS patients?

How would you describe the attitude of the staff at the hospital and the governmental clinics towards HIV/AIDS patients?

Challenges
In your opinion, do you think patients prefer to come to this clinic instead of others?
Why?

What could be hindering the partnership with the government?

What could be hindering the provision of funds or ARVs from the government?

What do you think is needed to further improve the partnership with the hospital?

And with the DDOH?
(if relevant)

How will this partnership affect the independence of the clinic?

What do you think, will be the effects of the partnership on the number of jobs at the clinic?

Finalising
Is there another subject you would like to mention about concerning the ARV distribution and the partnership with the government?

Thank you for your time