Joint fight?

A Public Private Partnership in South-Africa; how do the Southern African Catholic Bishops' Conference and the South African government work together to fight AIDS?

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Preface

Welcome to this master thesis!

It may sound strange to welcome you to a thesis, but as you read this thesis, you might learn about issues related to HIV/AIDS that you have never come across before. The research field around HIV/AIDS is huge. There are many related topics and it would be impossible to tell you all about it in just one master thesis. As I've been immersed in the subject for the last year, I can tell you some things about it though. This year I studied at Utrecht University in The Netherlands and followed the master program 'Social Policy and Social Interventions'. The Social Sciences Faculty gives students the opportunity to perform their master research in South Africa. This is a journey I enthusiastically embarked upon and it has been great. Studying the field of HIV/AIDS has opened my eyes to consequences of this epidemic that I was not yet aware off, especially as it mainly takes place far from my own comfort zone in The Netherlands. Coming to South Africa, meeting the people there, seeing the work that has been done and the challenges that still face the country and the workers in the field have been further eye-opening. I am very grateful I had this opportunity and can truly say it has changed my life. The people I've met will stay in my heart and I want to applaud everybody working in this complex and difficult field, I respect you a lot.

Now please follow me as I try to explain exactly what I've been doing in South Africa and what I have found out. In doing this I will try to make the complicated field of all related aspects around HIV/AIDS a little more comprehensible. But as I've said, it's a huge field, so I can only focus on a small part of the subject and I can only share what I've learned and experienced myself. I am aware that every person has a different story to tell, every region in South Africa faces different challenges and consequences and every country is affected by HIV/AIDS in a different degree and manner. But interestingly none the less. I hope you won't get lost in all the abbreviations and organizational structures that are mentioned (it took a while for me to get it too) but that you will get a sense of the magnitude and far stretching consequences of this disease and can admire the work that is being done daily by many dedicated people in South Africa.

A word of thanks is in place here too, as I could not have done this research nor write the masterthesis without the help of many people. To my supervisor, Trudie Knijn, thank you

for the constant and structural feedback and practical help concerning the stay in South Africa. Sister Alison Munro of the SACBC AIDS Office, thank you for posing the research question and for your help and cooperation. To my co-researcher, Tim Sweegers, thank you for the fun and good times in South Africa and for your understanding and feedback in the research process. To all my friends and family who have supported me in my choice to go to South Africa and have made me feel loved and missed. Thank you to all the new friends I made in South Africa, for making me feel at home and for your love and help. And a big thank you to God, as without Him, my life and anything I do would be purposeless and I could not have done this or any of my previous studies without His help.

Anneke Kleinmeulman

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List of abbreviations

AIDS:	Acquired Immune Deficiency Syndrome
ARV/ART:	Anti-retroviral medicines / Anti-retroviral therapy
CRS:	Catholic Relief Services
DDOH :	District Department of Health
DOH:	Department of Health
FBO:	Faith Based Organization
HAST:	HIV, AIDS, STD and TB
HIV:	Human Immunodeficiency Virus
NCARV project:	Newcastle Catholic ARV project
NDOH:	National Department of Health
NGO:	Non-governmental organization
NIMART:	Nurse Initiated Management of ART treatment
OVC:	Orphans and vulnerable children
PDOH:	Provincial Department of Health
PDS:	Patient Data System
PEPFAR:	The US Presidents' Emergency Plan for AIDS Relief
PHC:	Primary health care
PPP:	Public Private Partnership
SACBC:	Southern African Catholic Bishops' Conference
STD:	Sexually Transmitted Disease
TB:	Tuberculosis
VCT:	Voluntary Counselling and Testing

1- Introduction

In South Africa one of the major challenges is the HIV/AIDS epidemic. To deal with HIV/AIDS is not only a personal challenge to those infected, it is also a national challenge. It affects individuals, families, communities and the entire nation. One of the results of the epidemic is the high rate of orphans in the nation; in 2006 it is believed 300 000 children under eighteen experienced the death of their mother (SANAC, 2007). Another outcome is the high percentage of sick people who are not able to provide for themselves and half of the country's 740 000 deaths in 2006 are believed to be AIDS related (SANAC). The development industry has taken it upon themselves to help the world in general and Africa in particular in dealing with the HIV/AIDS epidemic. Funds and aid are offered to help combat the disease. HIV/AIDS prevention is a major focus of the aid, but so is healthcare to those already affected. One of the organizations involved in this process in South Africa is the Southern African Catholic Bishops' Conference (SACBC). The SACBC has an AIDS Office that is 'the Catholic Church's response to the HIV/AIDS epidemic' (Brady, 2008). Their ministry involves different aspects of which one is the distribution of ARVs (anti-retroviral medicine) to HIV/AIDS affected people. When taking ARVs, it is possible for infected people to live a relatively normal life.

Besides various Non-governmental Organizations (NGOs), like the SACBC, the major actor in South Africa in the HIV/AIDS care field is the government. Its role in dealing with the HIV/AIDS epidemic in the last two decades is not uncontested, the cabinet reign of former president Mbeki and his leaders characterised as 'AIDS denialism' for instance (Evensen en Stokke, 2010). There have been government documents, guidelines and action plans since 1993 (Guthrie, 2006) and the first National Strategic Plan for HIV, AIDS and STI was drafted in 2000 for the period until 2005. However, this plan did not include the provision of ARVs. Only in November 2003 the National Department of Health (NDOH) announced the roll-out of ARVs in its 'Comprehensive HIV and AIDS Care, Management and Treatment Plan' (Guthrie, 2006). They did so after pressure from the Treatment Action Campaign (TAC). The roll-out of the ARV programme has been slow, gaining momentum only towards the end of 2006 (Cullinan en Thom, in Guthrie, 2006). By then, NGOs had already started distributing ARVs.

The SACBC AIDS Office started its first ARV programs in 2004, the number of sites going up to 20 in 2008. Because of the increased provision of ARVs by the South African government and the decreasing funds for the SACBC AIDS Office, the latter is now in the process of re-structuring and/or closing ARV sites. From the original 23, at the moment of writing in June 2011, only thirteen remain and also these thirteen are subject to changes and will eventually close down or be structured to receive drugs from the Department of Health. The SACBC AIDS Office and the South African government work together in this process in order to provide sustainable care for the patients. Because the partnership is between an organization in the private sector and the government of South Africa, it can be typified as a Public Private Partnership (PPP).

This thesis describes the set up and results of a research that has been conducted in South Africa that was aimed at studying this collaboration or partnership between the government of South Africa, in particular the Provincial Department of Health (PDOH) and the Amajuba District Department of Health (DDOH) in KwaZulu-Natal and the SACBC AIDS Office. The Department of Health is the body that is responsible for the ARV roll out in South Africa and in each province any organization involved in this roll out needs to liaise with the Provincial Department of Health if partnerships are to be developed. The SACBC AIDS Office clinic in this area is the Newcastle Catholic ARV Project (NCARV project) in Blaauwbosch which is funded by The United States President's Emergency Plan for AIDS Relief (PEPFAR) (Catholic Relief Services, 2010). Blaauwbosch is situated in the Amajuba District and collaboration between the SACBC AIDS Office and the government in this particular case is with both the PDOH and the DDOH as well as the Provincial Hospitals and the Primary Health Care clinics in the area. More information about this partnership and the funding can be found in chapter two of this thesis. Also in chapter two a theoretical overview of aspects of PPPs is given that have been found in the literature study. These have been divided in formal and informal aspects. The formal aspects are addressed by my co-researcher in his thesis 'Two minds know more than one; Public Private Partnership in the battle against HIV/AIDS in South Africa (Sweegers, 2011) and this thesis focuses on the informal aspects. The focus of this thesis is on the values needed for a successful partnership, on barriers that can exist in PPPs that can have a negative effect on the development of the partnership and on the sustainability of care for the patients, and on the causes of conflicts.

Chapter three lays out the research design and research questions. This is followed by the results of the study in chapter four. The results are descriptive and relate to the values, barriers and causes of conflicts mentioned in chapter two. For comparison reasons another site of the SACBC AIDS Office in KwaZulu-Natal, the Noyi Bazi Clinic in Pomeroy, is described and the way the collaboration between the Catholic Church and the South African government developed there. This clinic is situated in the Umzinyathi district and here the Augustinian sisters have several hundred patients on ARVs which are provided for by the government. A description of this project is also given in chapter four.

On basis of the results, conclusions can be made answering the research question. This will be done in the final chapter, chapter five. A reflection on this research is presented there as well, followed by recommendations for the SACBC AIDS Office and further research in this field.

Problem definition

A PPP can be formed in many ways. It can be between the public provider and for profit companies, to whom a part of the work is outsourced and who have financial gain as one of their goals (Bojovic, 2006), or between the government and a not-for profit organization. In the second case, the motive for the partnership will be different. Most studies about PPPs are undertaken in the Western world and are about partnerships with a for-profit organization. This generates important information, but not all findings are translatable to the developing world. In a PPP there are several possible barriers that can be found that will make the partnership less effective or, if not addressed, can end the partnership prematurely. There are values that need to be present to make a partnership successful and there are often conflicts of interest in partnership of which the causes need to be discerned in order to solve them. In the case under research here, knowledge and insight is needed into the partnership between the Newcastle Catholic ARV project (NCARV project), one clinic of the SACBC AIDS Office, and the Department of Health (DOH) in South Africa about how it developed, what is happening now and what the prospect of the partnership is in the future. In this way, barriers that are present can be addressed to make the partnership more effective, it can be determined if the needed values are present and what relevant causes of conflicts are. It is useful to study how PPPs in the development world are formed and what barriers and conflicts are appearing

there and what values are present, so this research can add to the knowledge of PPPs in the developing world.

According to Goede and El Ansari (2003) research is needed at the local level. Because of the decentralization process in most African countries, the local authority is the place where the health services are being implemented and where the efforts of all actors are being coordinated. The partnership between the SACBC AIDS Office and the government in the ARV roll out and the care for HIV/AIDS patients in the Amajuba district has not yet been the subject of research. The knowledge this research will produce about this specific local partnership, can be used by the SACBC AIDS Office itself, by the DOH involved, by donors and by other partner organizations as well as people interested in ARV provision and PPPs, in order to better address the needs of people affected by HIV/AIDS.

Purpose of the research

There are several purposes to the research that has been undertaken on the partnership between the SACBC AIDS Office and the Department of Health (DOH) in KwaZulu-Natal. It is not yet clear what this partnership entails. The initial research request of the director of the SACBC AIDS Office, Sr. Alison Munro, was to evaluate the collaboration between the Department of Health and the Church in the KwaZulu-Natal province. In the e-mail contact there has been between the researcher and staff of the clinics before travelling to South Africa, it became evident that it was not clear if there is a real partnership or just occasional contact between the two organizations. The first purpose of the research was to create an overview of the collaboration between the Provincial DOH, the District DOH and the ARV clinic of the SACBC AIDS Office in this respective site of the KwaZulu-Natal province. After this overview was created it was possible to conduct in depth research at the site concerning the informal aspects of the partnership. The purpose of this is to give the SACBC AIDS Office information on the barriers concerning the organization, attitude, vision and ignorance that are present, on the presence of the needed values in a partnership and on the causes of conflicts on the basis of which recommendations can be made to improve the collaboration. A third purpose is to add to the body of knowledge about PPPs in the developing world, as this research focuses on HIV/AIDS care in the KwaZulu-Natal province in South Africa and the information that is discovered can be useful for further research at other sites in similar areas.

2- Theoretical framework

Because the research will specifically look at the role the SACBC AIDS Office plays in the distribution of ARVs to HIV/AIDS infected people, this theoretical overview will first give some information about HIV/AIDS in general and in South Africa specifically and about ARVs. Paragraph 2.2 focuses on the Government of South Africa and its response to HIV/AIDS. After that information will be provided about the SACBC AIDS Office and Faith Based Organizations (FBOs). Finally, as the research is about a Public Private Partnership (PPP), paragraph 2.4 will explain what a PPP is and give an overview of concepts regarding PPPs that are useful in evaluating the informal aspects of the collaboration between the SACBC AIDS Office and the Department of Health (DOH).

2.1- HIV/AIDS and ARVs

Human Immunodeficiency Virus (HIV) was first mentioned in global media when it was found among the gay community in the United States of America in the '80s (Epstein, 2007). Where the disease comes from is still unknown, though there are several theories about it. When HIV progresses far enough, it will cause Acquired Immune Deficiency Syndrome (AIDS) and patients will contract diseases like tuberculosis and because of their failing immune system, tuberculosis or other diseases will cause the death of the patient.

According to Campbell (2008) HIV/AIDS is the chief cause of death and illness in sub-Saharan Africa. The official HIV prevalence rate according to the Government of South Africa in 2010 was 10.5 per cent, which is the percentage of the population living with HIV. In South Africa, that would mean there are 5.24 million people infected with HIV. Of these 5.24 million, 1.6 million people age fifteen and over and 183 000 children are in need of ARVs (Statistics South Africa, 2010). The prevalence rate increased slightly over the last decade, coming from 9.4 in 2001. But it is important to note that the prevalence rate differs in each province and the KwaZulu-Natal province is said to have one of the highest prevalence rates in the country, over 25% (Statistics South Africa, 2010; SANAC, 2008).

In the past decades there has been a lot of effort to find a cure for HIV/AIDS. This has not yet been found. What has been found is a specific combination of medicines that will help most infected people to be able to live a relatively normal life. These medicines are called

antiretroviral medicines, abbreviated ART or ARV (in this thesis, the abbreviation ‘ARV’ will be used). When people infected with HIV/AIDS have a CD4 count lower than 200, treatment with ARVs can begin (SANAC, 2007). The CD4 count shows the amount of white antibodies in someone’s blood and tells how far the disease has progressed, as HIV affects the immune system. The ARVs will improve the patients’ well being, so they will gain weight and feel stronger and often are able to return to work if they were sick. In 2007 the threshold set by the government is 200 cells/m3. This has been adapted in 2009 for four groups of people; pregnant women, children, people with a combination of HIV and Tuberculosis (TB) and people that are multi drug resistant (SANAC, 2009). For these groups, ARV treatment should begin when the CD4 count becomes less than 350 cells/m3 and children under the age of one should start ARVs irrespective of their CD4 count.

The government in South Africa promised in 2003 to provide ARVs to all its citizens in need of them (Epstein, 2007). A constraint in the national ARV roll out is the limited resources of personnel in the government hospitals and clinics and the limited reach of these facilities. In 2003, only three provincial hospitals in the country started providing ARVs and this has slowly expanded to other provincial hospitals and to local clinics. A number of NGOs have been providing ARVs before 2003 or at places where the government did not yet provide. One of them is the SACBC AIDS Office. They started in 2003 and have been able to reach people in areas that have little or no access to the government hospitals or clinics, because of the distance and transport difficulties. Since patients usually have to pick up their new stock of medicine every month and also adhere to support from counsellors, access to a clinic nearby is essential. Epstein concluded in 2007 that fewer than 60 percent of South Africa’s health facilities were able to perform testing and counselling for AIDS and clinics were understaffed and unequipped (Epstein, 2007).

2.2- Government response to HIV/AIDS in South Africa

An important event in the politicisation of HIV/AIDS in South Africa was the conference held by the African National Congress (ANC) and the apartheid government in 1992 entitled ‘South Africa United Against AIDS’. It resulted in the formation of the National AIDS Convention of South Africa, which gathered together a number of key actors including political parties, trade unions, non-governmental organisations (NGOs), religious institutions

and health workers. However, according to Evensen (2010) who gave an overview of the political response to the HIV/AIDS epidemic in South Africa between 1994 and 2005, in practice, this proactive and collaborative multi-sector approach to HIV/AIDS failed to materialise.

At first the government did not take responsibility for the treatment of HIV/AIDS infected persons. In 1999 the former president, Thabo Mbeki, even openly questioned if HIV was the cause of AIDS and gave voice to the idea of suspicion of a conspiracy to justify the market in anti-AIDS drugs (Epstein, 2007; Nattrass, 2006). In 2002 the Treatment Action Campaign sued the government over its refusal to offer ARVs in public maternity clinics and won the case. Research showed that the occurrence of HIV in children could be halved if infected mothers would receive medicines when delivering their babies. But the distribution of the medicines was stopped by the Ministry of Health as some AIDS dissidents questioned this (Epstein, 2007; Nattrass, 2008). The government considered how it could comply with the court order to provide the medicines. In the meantime in Asia the competition to manufacture affordable ARVs had led to lower drug prices. At the end of 2003 the Ministry of Health finally launched a program to make ARVs available to all AIDS infected people in South Africa (Nattrass, 2008).

It is a huge challenge to provide the ARVs to the people who need them and to keep them on the treatment. According to the National DOH 230 000 people received ARVs in 2006. As there were about 540 000 people who did not receive treatment yet, the National DOH stresses the roll out is still a work in progress and in the most recent Strategic Plan, the 'HIV and AIDS and STI Strategic plan 2007-2011' (SANAC, 2007) a number of measures are pronounced to expand the roll out like strengthening the health care system and focusing on specific target groups. The most recent estimated number of people receiving ARVs according to an article in the South African Medical Journal is 568 000 in 2008, which would still only cover 40.2% of the ones in need of it (Adam and Johnson, 2009). Of these ARVs, 79.9% is provided for by the government.

Nattrass, who is director of the AIDS and Society Research unit at the University of Cape Town, emphasizes in her work the slow progress the government in South Africa has made in the roll out of ARVs. She notes that by March 2006 fewer than one third of the originally planned number of people, as mentioned in the operational plan of 2003, were on

ARV treatment (Nattrass, 2008). Not only has the government been slow, a large portion of the ARVs that have been provided, were funded by outside donors. At the end of 2005, 53.9% of the public-sector patients on ARVs were part funded by external donors, of which the largest is PEPFAR (the U.S. President's Emergency Plan for AIDS Relief) (Nattrass, 2006).

2.3- The Southern African Catholic Bishops' Conference AIDS Office

The SACBC AIDS Office's description of itself is: 'The AIDS office of the SACBC coordinates the Catholic Church's response to the HIV epidemic and supports numerous church service programs throughout South Africa, Botswana, and Swaziland. It has been functioning like this since 2000, strengthening and building on existing programmes, and helping to initiate new ones.' (Munro, 2010). The SACBC AIDS Office coordinates the work of about 100 home based care projects in Southern Africa, some of which have become treatment centres. Initially, these treatment centres received their PEPFAR funding through cooperation with the Catholic Relief Services (CRS), but now the SACBC AIDS Office receives the funds directly from PEPFAR. In collaboration with the AIDSRelief Consortium, led by CRS, the SACBC AIDS Office has coordinated the ARV programming for some twenty three sites providing ARV therapy in South Africa (UNAIDS, 2006). One of the areas of work of the Catholic Church in South Africa is the expansion of the access to ARVs. According to UNAIDS (2006), expanding access is possible where the infrastructure of the Faith Based Organizations (FBOs) is strong and where there are collaborative efforts with governments and donors. The benefits of FBOs are that they have networks with outreach capacity. The SACBC AIDS Office has been one of the "pioneers" in gaining access to ARVs in South Africa and in building capacity among its partners so that these medications would be administered in the most responsible manner (UNAIDS, 2006).

In 2008 the Georgetown University evaluated the SACBC AIDS Office. In this evaluation the structure and development of the SACBC AIDS Office is described with its strong and weak points (Brady, 2008). The strengths of the AIDS office are; a strong management structure through the local parishes of the dioceses; the possibility to respond to unique local needs through access to larger funding and technical assistance structures; the presence of a strong, flexible, responsive, persistent and involved leadership that keeps the projects on task and adheres to the mission, vision and values of the organization. Also a few

challenges have been found. Consistency in the level of activity within the dioceses can be improved, as some dioceses are more active than others. This is partially due to the resources in the area and the remoteness of the locality. Diocesan coordinators and committees continue to need training and more support in what is expected of them at the local level. Sr. Alison Munro is the leader of the Office and has provided centralized coordination as the Office has established itself and made efforts to scale up. This is a strength but can make it more difficult to establish new leadership and mentor the next generation of leaders. Finally, efficiently translating successful or best practices from one project to another, is the third challenge. This last challenge is one that the current research intents to address.

The SACBC AIDS Office provides services to HIV/AIDS infected persons via education, support groups, home-based care, hospice programs and in the roll-out of ARV medicines. In this roll-out of ARV medicines, there can be collaboration between the government and the SACBC AIDS Office, as the government has agreed to provide ARVs and is in the process of making these services available across the country. Since many FBOs, including the SACBC AIDS Office, were already working with patients infected by HIV/AIDS since 2000, the patients that are taken care of in the private sector, need to be transferred to government care. This transition process is a work in progress and determining how the partnership is being formed, is one of the purposes of this research. Another element of the need for collaboration is the limited funds the SACBC AIDS Office receives. The continuing growth of the number of patients on ARVs stretches the funds they have and the PEPFAR funding will stop in June 2013. The collaboration with the government is therefore not only optional, but essential for the continuation of the treatment of the patients already on ARVs.

There are several strong points of FBOs according to a study performed by the Global Health Council in several African countries. The intention of their report was to examine the role of FBOs in the HIV/AIDS combat, since their role is not uncontested due to the freedom of religion principle and the stance the Catholic Church in general has taken on condom use (Global Health Council, 2005). FBOs are considered to play a substantial role in the provision of clinical, home-based care for people living with HIV of which the quality of care and services is considered high. Besides that, FBOs offer spiritual/social support for affected/infected people via counselling, preparation for death and guidance against stigma

(Global Health Council). The WHO reports that one in five organizations involved in HIV/AIDS programming is an FBO. This makes them an important partner in the battle against HIV/AIDS. UNAIDS (2006) calls for 'partnerships of key social groups, government service providers, non-governmental organizations, community-based groups and religious organizations'. Also PEPFAR gives high profile to the role of FBOs to the extent of allocating a significant level of funding for FBO activities in the fifteen countries receiving PEPFAR aid. In this regard, whether or not their role is contested, the Catholic Church in South Africa is involved in the care for HIV/AIDS infected people and has been able to do so with support of funders like PEPFAR who recognize there is a part they can play. Studying how the Catholic Church and the government work together to provide HIV/AIDS care is important.

2.4- Public Private Partnerships

2.4.1- Introduction

Public Private Partnerships (PPP) have been studied at large in western countries, in particular in Europe. Such studies either focus on the cooperation between (local) governments and private companies, or on the cooperation between public services and their (recently) privatized and/or outsourced facilities (Bojovic, 2006; Börzel and Risse, 2005; European Commission, 2003). In this study however a reverse public private partnership is under study; it concerns the relationship between a private service, offered by a Faith Based Organisation (FBO), the SACBC AIDS Office, and the South African government that is in the process of integrating this service into its public health services. Therefore theories and concepts that are developed to study PPPs in the context of the European tendency to outsource public services cannot on a one to one basis be applied to the current study of the public private partnership in the domain of healthcare in South Africa's province KwaZulu-Natal. Moreover, this PPP is not yet crystallized; will it be a real PPP, in which both partners cooperate on an equal basis, or will it be a transition from private to public health care in which the district and provincial government gradually take over both the purchasing and the provision of health care for HIV/AIDS patients?

However, barriers and possible causes of conflicts that seem universal can be taken into account in the current research to see if they do apply to the PPP between the SACBC AIDS Office of the Catholic Church and the Provincial and District Departments of Health

(PDOH and DDOH) in South Africa. Moreover, some PPP studies focusing on health care in South Africa use the more general definition of PPPs. For instance, in a study on 'Public health nurses' perspectives on collaborative partnerships in South Africa', El Ansari, Phillips and Zwi (2004) use the following definition of Butterfoss (Butterfoss et al., 1993): '*Partnerships are interorganizational synergistic working alliances, banded together for a common purpose or goal*.' The first step towards a partnership is collaboration. Collaboration is a process that may end in a partnership, characterized by the combination of influence and power (El Ansari, Phillips and Zwi, 2004). For collaboration to occur there needs to be a belief in the creative potential of joint working toward purposive change.

Another description is taken from Bojovic, who has done research on PPPs in western states. It gives clear descriptions of ingredients for partnerships that are universally applicable. The concept was encapsulated in the following definition: "*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 shows the purpose of a partnership: improving performance. Partners need to resolve disputes and measure progress. The purpose of the collaboration between the SACBC AIDS Office and the DOH will have to be determined and also if disputes have been resolved and progress is being measured. The last characteristic is taken into account by my co-researcher in his thesis (Sweegers, 2011). PPP is partnership between public and private organizations. Bojovic (2006) mentions three advantages for both sides. The western approach of Bojovic can be detected in the first two advantages as she assumes the shift is from public to private service provision. Firstly, the partnership allows government to maintain an active role in developing policy initiatives. In the current study the question is not if the partnership allows the government to maintain an active role; it is only recently taking an active role. Questionable is whether the government allows the private partner an active role. The second advantage Bojovic mentions is that the partnership provides a means for the private sector to complement, rather than replace government. Also this assumption has to be reversed; it is not clear yet if the private partner wants to maintain an active role to complement the government's role. Finally, a PPP according to Bojovic (2006) encourages a valuable exchange of skills and experience between two sectors. To be able to experience this

advantage of exchange of skills and experience, the collaboration would have to be a real partnership and would have to be organized in such a way that benefits are possible. In this, it is important to see if there is room for an exchange to occur between the SACBC AIDS Office and the South African government.

PPP's contain both aspects of formal cooperation and informal work-relations. The focus of this study is on informal work-relations, such as individual behavioural (personal) factors (Tonder, Havenga and Visagie, 2008). These authors found that the causes of conflicts, which are important as they often influence the effectiveness and the duration of a partnership, could be divided in these two main categories. They added a third, which is the communication processes, an often overlooked factor. The communication process is of importance both in the structural and in the individual behavioural factors. Individual behavioural factors concern the people working in both of the organisations that this research is about. For good collaboration to occur, there need to be a number of shared values present (Bojovic, 2006).

2.4.2- Aspects of Public Private Partnerships

Values

The work of Bojovic (2006) 'Public Private Partnership as a last resort for public procurement' gives an overview of the many aspects of PPPs with values that need to be present in successful partnerships. These values are:

- openness and trust
- integrity and fairness
- mutual support

Unfortunately these values are not expanded upon in the work of Bojovic, they are just taken as one dimension of successful partnerships in her study about changes in the way public services are delivered (Bojovic). There is a lot of literature available on trust in organizations though, often approaching trust as one component of social capital (Costa and Peiró, 2009). Social capital in this respect describes a set of resources that is important in relationships within organizations and between organizations. As organizations become more and more focused on external relationships new organizational forms like networks are emerging that demand social capital. Trust is considered as one of the core components of social capital

(Costa and Peiró). It is needed to develop cooperation and to coordinate expectations, interactions and behaviours among individuals. In earlier work Kramer (1999) approached 'trust' in organizations from a psychological angle. He states that trust relates to the uncertainty regarding the motives, intentions, and prospective actions of other persons and entails a state of perceived vulnerability or risk. Openness about the motives, intentions and prospective actions is needed so trust can develop. Panteli and Sockalingam (2005) add that in inter-organizational arrangements, trust is positively related to conflict resolution. A key prerequisite for trust is familiarity with the partners.

Tan and Lim (2009) bind the values of trust and integrity together. They draw from the work of Mayer et al. (1995) who named the trustee's ability, benevolence and integrity as the three most prominent factors of trustworthiness. Tan and Lim did a qualitative research to test this and found that integrity is indeed positively related to trust. Integrity in this respect refers to the extent to which a person feels the trustee adheres to a set of principles that the truster finds acceptable (Mayer et al., 1995). Researchers believe that employees put more trust in co-workers who are perceived to have integrity, because these co-workers can be expected to act with honesty, consistency, and justice (Tan and Lim, 2009). This can be translated to inter-organizational relationships, as Delbeke et al. (2010) summarize that perceived organizational justice can increase the trustworthiness of organizational authorities. When an organization is perceived as trustworthy, that reduces fear of exploitation and provides an incentive to cooperate (Delbeke).

The aspect of mutual support pertains to assistance. It is closely related to reciprocity, which will be discussed a little later. In a collaboration, alliance partners are expected to share their skills, expertise and competencies for mutual benefit according to Panteli and Sockalingam (2005). Miller, Perry and Thomson (2007) deducted from literature and interviews that the concepts of importance to a PPP are *governance, administration, organizational autonomy, mutuality* and *norms.* The norms are further divided in reciprocity and trust. Only the norm of reciprocity was not found statistically relevant, but they think this is due to the way they have performed the research and that the concept is still relevant. Mutuality has to do with interdependence between the organizations in a partnership. There must be mutual benefits based on either differing interests, which would mean the organizations complement each other, or on shared interests. The partnership between the

NCARV project and the DOH is based on the last; shared interest. This means in the partnership they form concerning the delivery of care for HIV/AIDS patients, they should have a similarity in mission, commitment to a similar target population, and/or professional orientation and culture (Miller, Perry and Thomson, 2007). In earlier work, Thomson found that the second factor, commitment to a similar target population, is the most important factor that holds collaboration together. The results of the study by Miller, Perry and Thomson are that mutuality in collaboration is manifest in partner organizations that (1) combine and use each other's resources so all benefit, (2) share information to strengthen each other's operations and programs, (3) feel respected by each other, (4) achieve their own goals better working with each other than alone, and (5) work through differences to arrive at win–win solutions.

The norms identified by Miller, Perry and Thomson (2007) are as mentioned reciprocity and trust. These two are closely related conceptually. The partnering organizations usually have an ‘‘I-will-if-you-will’’ mentality, based on reciprocity. The problem is that developing trust takes time and repeated interaction. If there is trustworthy behaviour over time, partners may be less focused on the ‘I-will-if-you-will’ reciprocity and more on longer term commitments. Personal relationships are important because they can supplement formal organizational role relationships by creating a psychological contract between the partners, making a partnership sustainable over time. Reciprocity and trust are expressed in issues as:

- experienced trustworthiness of the other organization
- organizations taking advantage of the others
- being able to count on the partner to meet its obligations
- meeting your own obligation, even if the other organizations do not
- does the partner try to get the upper hand?
- developing long term personal relationships (Miller, Perry and Thomson).

Causes of conflict

Several authors emphasize the presence of all sorts of conflicts in PPPs. These conflicts have a negative effect on the sustainability of the PPP, can cause the PPP to end prematurely or can make the PPP less effective (El Ansari, Phillips and Zwi, 2004; Omobowale et al., 2010; Tonder, Havenga and Visagie, 2008). Work in the field of organizational conflicts is the

article of Tonder, Havenga and Visagie about 'The causes of conflict in public and private sector organizations in South Africa' (Tonder, Havenga and Visagie, 2008). They gave an extensive overview of all sorts of possible causes of conflicts and use the categorization between structural and personal factors. The causes of conflicts that pertain to personal factors are:

1- differences in knowledge, beliefs or basic values
2- competition for position, power or recognition
3- a drive for autonomy
4- personal dislikes
5- differing perceptions or attributes brought about by the organizational structure (e.g. different role structures, heterogeneity of the workforce, differences in goals, diverse economic interests, loyalties of groups, and value discrepancies).

Here again the importance of compatible values is seen as well as the character and skills of the persons involved in the partnership. The first and fifth set of conflicts relate to characteristics of the organisation, in the sense that the knowledge, beliefs and basic values of personnel in an organization will reflect the vision and values of the organization itself. It is possible that the beliefs and basic values in the NCARV project of the Catholic Church are different than those in the public hospital and Department of Health. The second, third and fourth sets of conflicts relate more to the person representing the organization in creating the partnership as the one that has most contact with the other organization. When the person in charge of the partnership is pursuing his or her own aspirations for power etc., it will distract from the purpose of the partnership and may, as mentioned, end the partnership prematurely (Tonder, Havenga and Visagie, 2008). The fifth set of conflicts come out of the organizational structure, but is reflected in the workforce of the organization. In the organization there may be more or less horizontal levels and more or less hierarchy, leading to a different level of autonomy of the personnel and to different ways of communication and approaching managers in the organization (Omobowale et al., 2010). Gender and race differences in the workforce of partner organizations can be an obstacle when the personnel has to work together. Different overall goals of the organizations can cause a conflict when the goals of the organizations and its staff are conflicting with the goal of the partnership (Omobowale et al., 2010). Besides the goal of the organizations and the partnership, the motive for the

partnership is part of this possible conflict too. When motives are dissimilar, that will be reflected in the choices made, in the effort put into the partnership and the dedication to it. Next, the group loyalty may not be directed at the partnership, but at another goal, such as the desire to keep the organization as it is, or to their own people, in this case to colleagues and patients. The loyalty of the staff at the NCARV project could be with their patients and not with the partnership. And finally, value discrepancies between the two organizations may create difficulties when choices have to be made and priorities set and can make working together of staff difficult. It is important to find the sources of conflicts in order to solve them (Tonder, Havenga and Visagie, 2008).

The number one source of conflict according to the personnel questioned by Tonder, Havenga and Visagie originate in managerial practices that are perceived as racially informed abuses of power (workplace discrimination would be illustrative). Adapted to the current research, this would imply differences in race of the staff and of the representatives of the organizations in the partnership is a possible cause for conflicts. The second major source of conflict identified is inadequate and ineffective resources, being physical resources and ineffective staff. Changes in work demands associated with changes in technology, e.g. innovation, and management practice is the third major cause of conflict.

Tonder, Havenga and Visagie focused on organizations as such, trying to bridge the gap between the literature available about conflicts from macro economics and political perspectives and the (lack of) knowledge available about conflicts at the micro organizational level. Because they focus specifically on the South African context and on both public and private organizations, their findings are expected to be relevant to the present research for this masterthesis. The list of sources of conflicts they identified will now be used to see if these are also present in the PPP that is the object of this research.

Barriers

El Ansari, Phillips and Zwi (2004) focus in one specific article on the view of public health nurses' perspectives on partnerships. In their studies, they found barriers for partnerships. For health professionals to transform their working arrangement to a collaborative mode, four sets of barriers need to be addressed (Hagebak, 1982, in El Ansari, 2004):

(A) barriers of organization: structures, systems, personnel and communication;

(B) barriers of attitude: political considerations and conflicts, and turf guarding;
(C) barriers of vision: history, tradition, and absence of clear directives or adequate models;
(D) barriers of ignorance: lack of awareness of problems and potential solutions.

For A), personnel and communication are relevant to the personal factors in a partnership. Member and leadership skills and expertise need to match the other organization to ensure a successful partnership (El Ansari, 2004). Furthermore, El Ansari also mentions the importance of communication, just like Tonder, Havenga and Visagie (2008). Communication should be efficient, ongoing between all the collaborating partners and stakeholders. Collaboration is about relationships, dialogue, negotiation and shared objective. The second barrier, of attitude, is not explained in detail, but can be understood using the work of a different author. Turf guarding means that often an organization wants to protect its own turf and not give away territory to other organizations so it won't lose its influence or work (Nishtar, 2004). Especially for the government's involvement in the partnership, it needs to be clear it is really interested in the partnership and in the common goal and is not just participating out of political considerations. C) relates to the vision of the organizations for themselves and for the partnership on the short and on the long terms, what is the partnership trying to achieve? Barrier D) speaks for itself, if no one is aware of potential problems, they cannot be addressed and prevented. Potential problems are competing priorities and interests, operational understanding and role clarity (El Ansari, 2004).

The study of El Ansari focused on the perspective of the *public* health nurses and found these barriers are often present and need to be addressed in order to have a fruitful partnership. In the current research the participants are people, including nurses, working in the *private* sector and it can be determined if these barriers are present in the partnership that is being formed between them and the government.

3- Research design

3.1- Research questions

Given the information about aspects of Public Private Partnerships (PPPs) mentioned in the previous chapter that relate to the informal or personal aspects in the collaboration between the government and the Newcastle Catholic ARV project (NCARV project), the following overall research question is formulated:

Which of the values, causes of conflicts and barriers related to Public Private Partnerships are present in the partnership between the Newcastle Catholic ARV project and the Provincial and Amajuba District Department of Health in KwaZulu-Natal, South Africa, and which should be addressed to improve the partnership?

The following sub questions focus on the different aspects:

1. What values that are needed for a fruitful partnership to occur (Bojovic, 2006) are present in the partnership and which could be strengthened?

2. What are the conflicts between the partners and which causes of conflicts based on the work of Tonder, Havenga and Visagie (2008) can be identified?

3. Which of the barriers as mentioned by El Ansari, Phillips and Zwi (2004) are present in the formation of the partnership and need to be addressed?

3.2 -The subject of the research

This research gives insight into the collaboration between the governmental Provincial and District Departments of Health (PDOH and DDOH) and the NCARV project, which is a private ARV clinic of the SACBC AIDS Office, in KwaZulu-Natal, South Africa. The collaboration is about delivering ARVs and giving support to HIV/AIDS affected people and can be typified as a Public Private Partnership (PPP). The focus of this research is at the informal or personal behavioural aspects of the partnership.

The development of the NCARV project and the collaboration between them and the PDOH and DDOH are studied as they have occurred in the past and during the time of the research. Additionally another clinic of the Catholic Church in KwaZulu-Natal has been visited in order to describe and compare the different ways of collaboration between the government and the clinics of the SACBC AIDS Office. The research aims to find out which values needed for a fruitful partnership (Bojovic, 2006) are present, to see if there are conflicts between the partners and what the causes of these conflicts are and to see if barriers for the partnership exist and which should be addressed.

3.3 -Place of the research

The two sites of the SACBC AIDS Office that are part of this research are the 'Newcastle Catholic ARV project' (NCARV project) which is located in Blaauwbosch, and the 'Noyi Bazi Clinic' in Pomeroy.

The first clinic, in Blaauwbosch, is purely an ARV clinic, where people can get tested for HIV/AIDS, get counselling and receive ARVs when needed. At this site, there is collaboration between the NCARV project in Blaauwbosch and the Amajuba District Department of Health in Newcastle. To execute the agreements in the partnership, there is contact between the NCARV project, the Madadeni Hospital in Madadeni and the local clinics in the Amajuba District. Additional to the local contacts, there is contact between the SACBC AIDS Office in Pretoria and the KwaZulu-Natal Provincial Department of Health in Durban.

The second site, in Pomeroy, is a Primary Health Care Clinic that the Augustinian sisters run with their staff and where they also provide HIV/AIDS counselling and testing and distribution of ARVs when indicated. Here, the partnership is between the Noyi Bazi clinic in

Pomeroy, the public Church of Scotland Hospital in Tugela Ferry and the Umzinyathi District Department of Health.

The two sites are both located in KwaZulu-Natal. They do however fall under different health districts, these are the Amajuba district and the Umzinyathi district. Where possible, government sites in both districts have been visited. They are located in Newcastle, Madadeni and Tugela Ferry.

3.4- The research and its methods

The total period for the research lasted from February till July 2011. In this period the NCARV project has been visited often for observations and interviews. The Noyi Bazi clinic has been visited twice.

On basis of the literature a topic list was made for the target group of the interviews. A qualitative approach has been chosen because of the explorative character of the research. In semi-structured interviews there are opportunities to go in depth into subjects that arise during the interview and the interview questions and order can be adapted when necessary on the basis of the answers of the respondent (Boeije, 2006). The interviews were focused on the values that are needed for fruitful collaboration, the possible barriers in the partnership and possible conflicts and its causes. The categories for the interviews were: general information; services provided to patients; attitude towards HIV/AIDS patients in both organizations; differences between the two organizations in workforce, communication, training and services; conflicts between the organizations and causes of them; the development of the collaboration and the motive for it and expectations around the collaboration in the future (see Appendix I). In total seventeen interviews were conducted in the two sites. These interviews were first transcribed word by word and were analyzed using the software programme for qualitative research Nvivo 9 which gave the opportunity to categorize the relevant concepts such as the values people have concerning the testing and adherence to the ARV program of patients, the attitudes towards personnel of the other organization and the patients, the appreciation of each other's skills and conflicts of interest.

Another element of the research are the observations made by the researcher at the NCARV project itself, the hospitals visited and the stakeholder meetings at the DDOH that

were held during the stay in South Africa. Three hospitals were visited and two stakeholder meetings to which the researcher was allowed took place during the months of research.

Alongside the observations and the interviews, documents about the collaboration have been studied. These documents include all communication between the NCARV project and the DDOH about the collaboration from May 2010 until May 2011.

On basis of the document analysis, the observations and the interviews, the results concerning the three aspects of PPPs of this research were analysed and structured in order to answer the research questions.

3.5 - Relevance of the research

Scientifically this research is interesting, as it adds to the body of knowledge about Public Private Partnerships in South Africa and tries to identify if barriers and relevant types of conflicts of informal aspects of PPPs exist in this specific location. It also looks at the values present in the organizations, like trust, to see if these factors contribute to the partnership or not. In this way, the research aims to fill in a knowledge gap about PPPs in the developing world regarding values, causes of conflicts and barriers in collaboration that have been identified mainly in the western world, to see if they pertain to PPPs in a developing country as well.

The research also has societal relevance. In the introduction it was stated that up till now, not much is known about the development of the collaboration between the SACBC AIDS Office and the government in South Africa. The collaboration started approximately in 2005 and has had different developments over time in different parts of the country. To begin evaluating the collaboration, on invitation by Sr. Alison Munro of the SACBC, this research has focused on the collaboration in the KwaZulu-Natal province. Studying this collaboration will give clarity to the organization itself (and its personnel at the different sites), to donors and to the Department of Health. In the battle against HIV/AIDS there are a lot of people and organizations involved, of which many may be interested in this research, especially since its aim is to identify the possible barriers and challenges in this collaboration. Knowing this will be a further instrument in making the ARV roll out more effective, reaching more people.

3.6 - ISS-viewpoint

This research is part of the graduation program of the Interdisciplinary Social Science study programme. The research takes place in South Africa, which can be labelled as a developing country, and combines social science in general with the more narrow social science field of developmental studies. In the literature review political as well as social and specifically health care dimensions related to HIV/AIDS have been studied. All of these aspects are of importance to the research and studying only one aspect, like health care, would give a narrow picture of the subject. One contribution of interdisciplinary studies is the fact that different viewpoints and approaches in research are taken into account to create a comprehensive picture.

The research is focused at the partnership between organizations, the meso-level, which has a sociological angle. Organizational sociology mainly has been used to learn about the relevant aspects in Public Private Partnerships. To this the psychological aspects of personal factors is added, as it also looks at interactions between staff of two organizations, attitude towards patients and it takes into account the psychological effects of the partnership for the patients and the staff of the NCARV project.

The interdisciplinary approach can also be found in the diverse methods being used, not only interviews, but also observation and document analysis have been used in order to complement each other.

4- Results

In this chapter the empirical findings of the research will be presented. The first part will describe the partners and the partnership as one of the aims of the research was to create an overview of the collaboration. This will be followed by results structured according to the factors of Public Private Partnerships (PPPs) mentioned in chapter two; advantages of PPPs, values, causes of conflicts and barriers and it will be discussed if these factors are present and contributing to the partnership or not.

4.1 – The SACBC AIDS Office and the NCARV project

4.1.1- The beginnings of the NCARV project

The Newcastle Catholic ARV project (NCARV project) is one of the sites sponsored by the AIDS Office of the Southern African Catholic Bishops' Conference (SACBC). The Catholic Church has been active in development work in South Africa for a long time, setting up churches, schools, hospitals, health clinics and so on. The SACBC consists of several departments and offices, one of these offices is the SACBC AIDS Office. The Office has a director, Sr. Alison Munro, and several employees. The AIDS Office coordinates the work the Church does concerning HIV/AIDS, this includes Tuberculosis (TB) related work, Home Based Care work and assisting orphans and vulnerable children (OVCs). Since 2004 there has been a partnership with PEPFAR to enable the SACBC AIDS Office to provide ARVs to patients, which is done at a number of sites that the AIDS Office coordinates. In total there were 23 sites of the AIDS Office providing ARVs in South Africa in 2008, but since then several sites have been closed down and patients transferred to DOH services. There are a number of reasons for this, a major one is the expected decrease in the PEPFAR funding and the possible end of the funding in 2013.

The SACBC AIDS Office started providing ARVs after they received outside funding, first from Cordaid (a Dutch NGO) and later from PEPFAR in 2004. At that time, the government was just starting the process of a national ARV roll out. They only provided ARVs at tertiary hospitals (big hospitals in the cities) and then slowly moved towards provincial and district hospitals and later to local clinics. Because the sites of the SACBC AIDS Office were already active in the communities, they encountered a lot of HIV/AIDS related problems, like sick people and orphans, and started providing Home Based Care for

those people. When the money to buy ARVs became available, the sites that were equipped to provide them where trained in ARV care. One of those sites is the NCARV project.

This clinic is situated in Blaauwbosch. The land in Blaauwbosch is privately owned by landlords and the government involvement has been marginal, it is not even on official maps. Blaauwbosch is about half an hour drive from Newcastle, which is the central town in the Amajuba District. A Dominican sister that has lived in and around Blaauwbosch for over 40 years was involved in setting up a Primary Health Care clinic (PHC). This is the Rosary clinic and it was taken over by the government in 2005, a process which took over five years. In October 2004 this sister was approached by the SACBC AIDS Office to set up an ARV clinic in the area. The Newcastle Catholic ARV project was started, choosing the name 'Newcastle', since that is the municipality Blaauwbosch falls under. In daily communication with the community the name 'Impilo entsha', meaning 'new life' is used, or it is just referred to as the ARV clinic at the Catholic Church. Awareness was raised in Blaauwbosch and surrounding areas about HIV/AIDS and Voluntary Counselling and Testing (VCT), trying to get more people to test. After testing positive, the patients were taken to a doctor's practice in Newcastle where they were put on ARVs. As mentioned, it is only an ARV clinic, and not an Primary Health Clinic (PHC). Patients that are suspected to have TB or another illnesses are referred to their nearest PHC clinic.

The SACBC AIDS Office decided it was better to have the clinic closer to the people and with assistance of PEPFAR in 2007 a park home was acquired and placed on the grounds of the Catholic Church in Blaauwbosch. In the park home there is a waiting room, three office spaces, a counselling room, two nurses' rooms and an air-conditioned store room. The numbers of patients on ARVs at the NCARV project has increased over the years and has reached a number of over 800 patients at the beginning of 2011. Besides the number of patients on ARVs, there are also patients that come for regular testing while their CD4 count is still high (every six months) and new people come to get tested often. These people come not only from Blaauwbosch, but also from Madadeni and Osizweni, the townships nearby, and other towns like Dannhauser and Utrecht which are further away.

4.1.2 How the ARV clinic works

In the first few years of its existence campaigns were coordinated so the community would know about the ARV clinic in their proximity. In the Blaauwbosch area there is no government clinic providing ARVs. Radio interviews and other local media were used to get the word out. Now that the clinic is well known, people come to get tested by themselves. A big part of the work is to test people for HIV/AIDS. Counsellors talk to people to explain to them about the disease and about the test. Then a test is performed and the result is known in fifteen minutes. After the test people get more counselling, explaining to them the need to protect themselves when they are negative and encourage them to get tested every six months, and explaining to them more about the next steps if they are positive. When people are eligible for ARVs (having a CD4 count lower than 350, being pregnant, or having a lot of sicknesses because of the disease) they have to go to adherence training. Adherence is a very important subject, if people stop taking the ARVs once they feel well again, or because they don't want their family seeing them taking the drugs, there is a chance the ARVs won't work any more, that is that resistance develops. Another part of the training is explaining about the side effects. At first, people will always have some side effects, and may even get sicker than they were. They have to stick to the ARVs in order to get better. There is a doctor that comes to the clinic two days a week to see the patients that need to be put on ARVs, the ones that may have to change their regimen and other patients that are sick. When patients are on ARVs, they have to come to the clinic every month to collect their new monthly supply. While they are in the clinic, they meet with both counsellors and the nurses to see how they are doing, if there are any side effects that the doctor should know about and they are weighed.

The 'patient monitors' are an integral part of the work in the NCARV project. Each of the monitors has about 50 patients in his or her own locality that they are responsible for. They go out and visit the patients at least once a month to see how the patients are doing, encourage them to disclose about their status to their family and friends and to see if they are taking their pills correctly via a pill count. Monitors also go out in the community visiting people in their homes to ask new people to get tested. They explain about HIV/AIDS, because there is still a lot of ignorance and stigma. People that live close to the monitors also come and visit them on their own. The monitors are very involved and regard the patients as family.

Most of the monitors were voluntary workers at the Catholic Church before the clinic was opened.

Some quotes from the monitors interviewed:

Respondent 10: *'The treatment has so many side effects, when you start treatment, most people they get sicker and lie down. At that particular time, they need support. We get people to talk and get a solution and take action and we help them always to take treatment, to make new decisions, to take new life, take treatment.'*

Respondent 10: '*I explain that when you are HIV positive, you need to change your lifestyle. One partner, protected sex, healthy food, diet, exercise, always visit the clinic, if you're sick you must get to the clinic, because there are so many opportunistic diseases that go together with HIV. Some listen, others I continue to tell them.'*

Respondent 11: *'I work nicely with my patients. We are like a family. I feel sad if I lose someone, because they are like my family. They listen if you talk to them, but you can't change people, you don't stay with them 24/7. But if you say something, next time she will remember that you had told her. You have done your work. And you explain to them, the healthy food is not expensive, they must plant, small gardens to keep healthy.'*

Respondent 2:

(I) 'Nowadays do you still go door to door?'

(R) 'Not door to door, but I still visit families now. We just have problems, sometimes we find the patient is hungry, there is nobody working there. So it is so hard to take the treatment. But we are lucky we have the church here, we have St. Vincent, if there is some money we do buy for that patient. But if we don't have there is nothing we can do. You just give them what you have at home.'

Besides testing people, preparing them for ARVs and monitoring them once on the treatment, the NCARV project provides transport for patients that are sick or live far away, not only to

their clinic, but also to the doctor or hospital when needed. When they receive extra funding they are able to buy food and give food parcels to poor patients. They also try to help patients to receive a disability grant from the government. The three nurses working at the clinic do most of the work with the patients, they are well trained and have experience with ARVs. Recently, they went on a training called NIMART, training nurses to initiate patients on ARVs, which will take work pressure off of the doctors in South Africa who are in short supply.

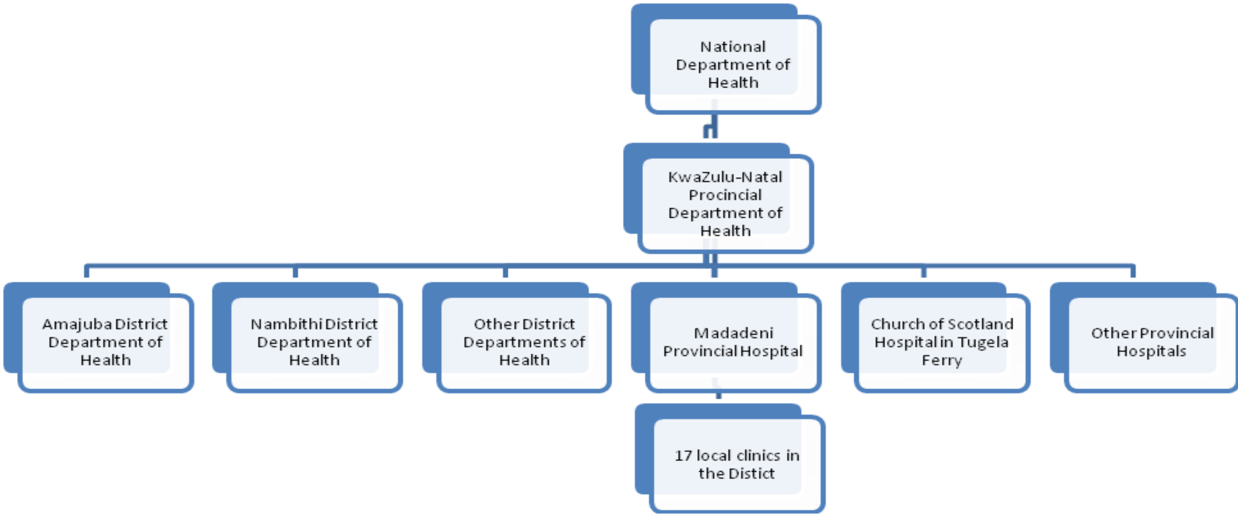
4.2 The government in South Africa

The South African government is made up of various 'layers'. The national government is the highest authority, then there are nine provinces, each having their own ministers and departments like the Department of Health. In each Province there are numerous Districts. The lowest level of government is that of the municipality, which is made up by one major or several small towns. The Districts all have their own government departments, including a Department of Health, which is concerned with HIV/AIDS care. It is unfortunately not always clear which level of government has the authority to decide on certain issues. The SACBC AIDS Office often deals with the Provincial Department of Health (PDOH), but the actual 'on the ground' arrangements have to be made with the District Department of Health (DDOH). But they cannot decide on their own, the DDOH is in constant communication with the PDOH, which in turn may need National DOH's approval for certain arrangements. This is one reason for decisions to go slowly in government. It takes a long time to get something approved and for people to be able to start acting on it.

Another complicating issue in this respect is the fact that the public hospitals are Provincial Hospitals. They fall under PDOH responsibility and receive their orders from them. So even when an organization has an understanding with the DDOH, they have to wait till the PDOH has informed the hospitals. The hospitals in their turn have the responsibility to inform the clinics in their area. Since South Africa is a very big country, there are a lot of Primary Health Clinics (PHC) in the different towns. In this particular case, there is a Provincial Hospital in Newcastle and a Provincial Hospital in Madadeni (the major township in the area). In Madadeni there are seven clinics and in Osizweni there are four (Osizweni is a township near Madadeni). Blaauwbosch is located between these two townships and has only

one PHC, the Rosary clinic, which does not provide ARVs. A picture of the DOH government structure is given in figure 1.

Figure 1: *Government structure of Department of Health*



4.3 ARVs

Since 2004 the national government in South Africa has begun the roll out of ARVs. At first these were distributed in a few tertiary hospitals. An extensive visit to one of the doctors in charge was paid to the Church of Scotland Hospital in Tugela Ferry. Originally set up as a private hospital, it has been a government hospital since 1978. This hospital had already begun providing ARVs to about 100 patients via a Canadian pilot project and the staff were trained, so they asked the government after its announcement to start the roll out of ARVs (see introduction) if they could start with the roll out from government funds in 2004. In the beginning there were only three hospitals in the whole country that provided ARVs. Slowly the other hospitals have begun treatment and now the country is in a phase to start initiating at the clinic level. In the Amajuba District, where the NCARV project is located, of all seventeen government clinics thirteen provide ARVs at the moment.

To start someone on ARVs is a very complex matter. First of all people need to come to be tested. This can nowadays be done in most PHC clinics and in specially created ARV

clinics in the towns and villages. In remote areas there is often no PHC available, though sometimes the government visits these areas with mobile clinics. The SACBC AIDS Office clinics also employ monitors and home based care workers who go out into the communities to encourage people to test. Once someone is tested HIV positive, the blood results will have to be determined. There is pre- and post-test counselling, explaining what HIV is, how you acquire it, what to do if you are indeed positive etc. The blood is sent to a laboratory and the results come back in a few days. These results consist among others of the CD4count and the viral load; how much of the virus can be found in your blood. Up until recently in South Africa patients with a CD4 count lower than 200 cell/m3 were eligible for ARVs. In the private sector this has been changed to a CD4 count of 350 and below and the government has officially also adopted this level for the categories of patients listed in the introduction, but in daily practice the Madadeni Hospital and the government clinics in the proximity of the NCARV project still use the 200 cell/m3 level, often because this is when people present themselves.

As mentioned in the paragraph 4.1.2, people can start ARVs when they have finished an adherence training and seem motivated to adhere. ARVs in general have many side effects. The nurses and doctors must take care of their patients so they will see the side effects and if necessary the regimen must be changed. This is a very labour intensive job. The government is in the process of training the staff in their clinics to initiate new patients on treatment. Some clinics do provide ARVs, but only to stable patients. In the Amajuba District the government has acquired the help of an NGO called 'Kheth'Impilo', meaning 'choose life', to assist them with human resources at the PHCs. Roving teams (mobile teams going to different ARV sites) have been formed that consist of a doctor, a nurse, a pharmacist and a counsellor, they go on specific days a week to various clinics in the District and they initiate and monitor patients on ARVs. It is possible that the staff of the NCARV project will be part of these roving teams in the future; see more about possible scenarios in paragraph 4.4.2. Kheth'Impilo takes part in the quarterly stakeholders meetings at the DDOH and these meetings are scheduled more often when needed, as during the research period when the NCARV project was in the process of transferring their patients to government clinics. Kheth'Impilo itself is PEPFAR funded, like the NCARV project.

There are several regimens of ARVs. People are usually put on one of the first two regimens, called Regimen 1a or Regimen 1b, unless there are reasons to put them on another regimen. The doctor is the one who decides on the regimens. At the government facilities there are two lines of regimens available, meaning if the ARVs in the first line become inefficient (people develop a resistance against them), they can be put on a second line. The doctor in the Church of Scotland Hospital mentioned his concern for one of the drugs in Regimen 1a which causes a lot of side effects. He tries to put all his patients on a replacement drug, but officially the drug is still part of the regimen. The South African government has agreements with several producers of ARVs in the world and they buy the drugs there at a special price. In order to make the replacement drug part of the regime, negotiations have to be made with the producing companies and this will take time. In the NCARV project they are able to change regimens more easily, because the drugs are bought by SACBC AIDS Office from its suppliers. In the NCARV project some patients have been put on other drugs than the ones used in the government facilities as the doctor felt this was needed, although this is not encouraged by the head office of the SACBC AIDS Office. Officially, the SACBC AIDS Office has an agreement with the NDOH to only provide ARVs that are offered at government facilities, so there is sustainability for the patients when they need to be transferred. When the SACBC AIDS Office was made aware that patients in the NCARV project were put on special drugs, they reminded the doctor and the staff that this violates the agreement with the government. This is off course a difficult issue, patients are only put on a different regime when there are reasons for it, like side effects, and these drugs are available in the world, just not via the government in South Africa. This poses a problem for the staff concerned; doctors and nurses have professional discretion but are bound to managerial decisions.

4.4- The Partnership

4.4.1- General information about the partnership

Several respondents have emphasized there has always been a partnership between the SACBC AIDS Office and the South African government, because it is not possible to be involved in healthcare without one. This means the SACBC AIDS Office has been in contact with the Department of Health from the start. However, this does not mean that all (local)

partners are aware of such a partnership. Because of the way the government is set up in South Africa, it is possible that the SACBC AIDS Office has an agreement with the National Department of Health (NDOH) without that being known at the District level. In this specific case the SACBC AIDS Office has been talking to the Provincial Department of Health (PDOH) in KwaZulu-Natal with formal agreements made in 2007. At the time of writing, this agreement needs to be renewed and is in the process of being rewritten. The Project Manager of the SACBC AIDS Office who coordinates several sites is in contact with the PDOH and comes over to Newcastle whenever there is a need to talk to District. In everyday practice the contact between both organizations is between the local Project Coordinator of the NCARV project and the DDOH. So the partnership between the SACBC AIDS office and the South African government exists at various levels. At the legal level, the partnership is between the SACBC AIDS Office in Pretoria and the National Department of Health. At the organizational level there is contact between the SACBC AIDS Office in Pretoria and the Provincial Department of Health in each of the nine provinces in the country where the SACBC AIDS Office has ARV sites. These contacts are at the highest organizational levels. At the lower local organizational level, there is contact between the SACBC ARV sites themselves and the District Department of Health of the District they are situated in.

The partnership at the ARV site for this research, the NCARV project, consists of a few written agreements, local contact and head office contact. In the Amajuba DDOH there are several people involved with the partnership between them and the NCARV project; the ART coordinator, the HIV, AIDS, STD and TB (HAST) coordinator, the Orphans and Vulnerable Children (OVC) coordinator and the District Manager. In May 2010 an agreement was written that the Province would start providing ARVs to the NCARV Project from November 2010. If they would, that would mean the SACBC AIDS Office would no longer need to spend money on ARVs, freeing the limited funds for other purposes. That agreement was not lived up to. One reason for that being the absence of a District manager at the DDOH who could make final decisions on what and how to do this. The SACBC has been patient and has kept on providing the ARVs to their patients up until this time (June 2011). Another agreement to provide the drugs from April 1st 2011 was made in at the beginning of 2011. The SACBC AIDS Office has made changes in their budget in anticipation of this agreement

coming into effect and does not have a budget allocated to the NCARV project to buy ARVs after April 1st.

During the research period, which lasted from February till June 2011, observations about the processes in the partnership could be made first hand. There have been four meetings with the stakeholders at DDOH since February, one to which the NCARV project was not invited due to miscommunication, which demonstrates the inefficient communication between the partners. But not a lot of concrete steps towards one of the scenarios for the partnership were taken. The NCARV project has started to transfer out some of their patients to government clinics in April, which was also part of the agreement, but until now they have not yet received any drugs. The down referral of patients is done by sending the patients file to the Madadeni Hospital, which should in turn inform the government clinics about the patients being transferred. At the end of the data collection in May there had been more than 100 files of patients sent to the Madadeni Hospital. In the mean time the Project Manager of SACBC AIDS Office that oversees the NCARV project resigned, he had to be replaced up by somebody else. This person had to come up to speed regarding the process and this meant a delay on the SACBC side. An important factor to understand the partnership are the different scenarios for the NCARV project to transfer out their patients and/or to receive drugs from government, they will be explained in the next paragraph.

4.4.2- Scenarios for the NCARV project

The main reason for the SACBC AIDS Office to transfer out their patients is the possible end of the PEPFAR grant they currently receive by 2013. They have already closed ten of the 23 ARV clinics that were in place and the transfer of patients to government has happened in many ways. In general, there are three scenarios. One scenario is that the government has their own ARV clinic or PHC close by that can from then on provide the care and treatment for HIV/AIDS patients. In these cases, the SACBC AIDS Office will downrefer their patients to that government clinic and the SACBC AIDS Office clinic will cease to exist. Another scenario is that the government will provide the ARVs. The PEPFAR grant is not finished yet and when the government provides the drugs, the SACBC AIDS Office has more money left for their staff and other associated costs. Besides ARV care, they also provide TB care, Home Based Care, aid to Orphans and hospices. The third scenario is for the government to take

over the SACBC AIDS Office clinic and its staff. This staff is well trained and experienced and the government often needs more staff.

For the NCARV project, there are a number of specific scenario's that are possible and that have been mentioned. The first would be for the government to provide the ARVs. The result would be that the clinic would stay as it is, where it is and with the staff it has, the only thing changing is the place the drugs come from. A problem with this scenario would be that some patients are on regimens that the government does not provide. A benefit of this scenario is that the SACBC AIDS Office can stop spending money on ARVs (which are very expensive) and redirect their funds. The District and Province have already agreed to do this, they would start to provide ARVs in November 2010 and later committed to April 1st 2011, but have not lived up to this yet. As a consequence, the costs for the ARVs that are still provided for by the SACBC AIDS Office were not budgeted for. It is a major challenge for the SACBC AIDS Office to 'juggle with the funds and keep all balls in the air', according to one of the respondents, especially when funds change or when a partner does not live up to its agreement. This is a reason why the SACBC AIDS Office emphasizes to its clinic in Blaauwbosch to downrefer patients, the financial year ended in May 2011 and there is no budget for ARVs in the next year. The SACBC AIDS Office will make internal budget arrangements in this regard.

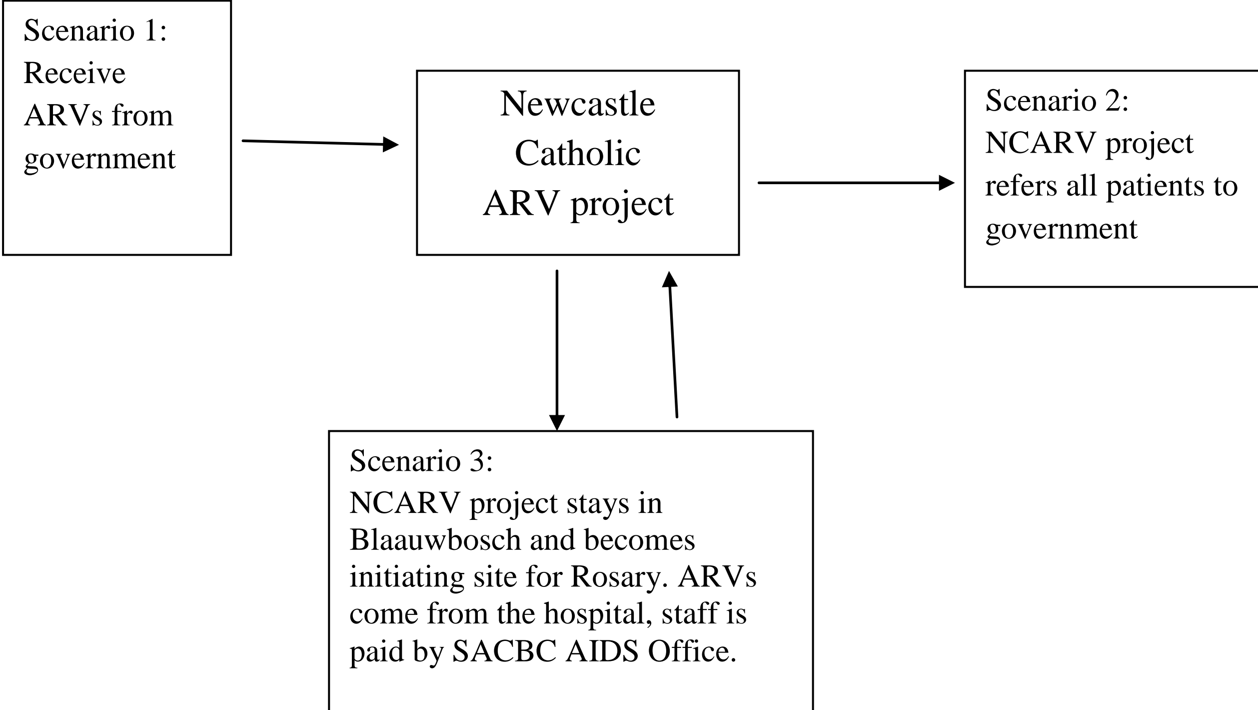
This leads to the second scenario; the NCARV project refers all patients to government clinics. When the project started, there were no ARVs available in the area. Now the Madadeni Hospital and most clinics in the townships provide ARVs, so people can go there to collect them. Unfortunately there are several challenges with this scenario. First of all, the government has to accept the patients. That problem has in theory been solved, the DDOH had agreed in 2010 to accept SACBC patients. But this information has not reached the clinics. Several patients have gone to government clinics after referral and have been sent back. The clinics said they knew nothing about it and they did not have drugs for them. To downrefer a patient involves paperwork. A downreferral form has to be filled out with patient data alongside a 'pink prescription card' for the current regime. All of this is sent to the Madadeni Hospital, which is the 'hub' for the ARV care. In the Hospital it goes to the pharmacist, who has to order the drugs and send a list to the respective clinics concerning the number and names of the patients that will go there and the kind of drugs they need. A

challenge in this scenario is the time it takes for this process to be completed. After the first 40 files were sent to Madadeni Hospital in April and May 2011, the transfer letters were not sent to the pharmacist, hence the drugs were not ordered. Neither were the clinics informed, so the patients were told to go back to the NCARV project, which in turn did not have any ARVs available for these patients as well. The staff of the hospital claimed their work load is too high, they can only handle 40 patients per week, so the total process of transferring most of the over 800 patients will take over 20 weeks. In this time, the NCARV project still has to take care of the patients and provide the drugs for them, unless the government provides the drugs in the mean time. There are also challenges on the SACBC side. The downrefer process was not very organized. Not all the nurses knew who to downrefer. Patients with an odd regime were down referred as well, although the NCARV project had been informed in March 2011 which regimens were and were not available at government facilities. The NCARV project did not have lists prepared stating which patient would be going to which clinic though that could have been done before hand.

One more scenario is for the NCARV project to remain the ARV clinic in Blaauwbosch as the PHC, Rosary, is not initiating yet. This means the staff will treat the Blaauwbosch patients only and initiate new people who test positive. To do this there will have to be close collaboration between the PHC and the NCARV project. Patients that have been tested positive in Rosary clinic will have to be told to go to the NCARV project for initiation. This has been agreed upon in principle at the end of 2010, but until this day has not come into effect. The Rosary clinic sends HIV positive patients to the Hospital or to other clinics, e.g in Osizweni. In this scenario all the patients of the NCARV project that do not live in Blaauwbosch will be down referred to other clinics and the NCARV project or Rosary clinic will receive drugs from the government. Challenges are the actual downreferral process (as mentioned above), the communication between Province, Hospital, District, Rosary and NCARV project which is not optimal and how to receive the ARVs from the government. Officially, the ARVs need to be stored in a government facility and there needs to be a pharmacist to dispense the drugs, who is currently not employed by the NCARV project. The NCARV project will have to find out if they will receive the ARVs themselves or that they will be stored at Rosary and who can dispense them. Then there is a practical challenge to this scenario. Right now, the Rosary and NCARV clinic are not far apart, but they are separated

by literal fences. People would have to walk for about ten minutes to go from one facility to the next. This is not regarded as optimal by both the government and NCARV project. The park home of the NCARV project could be relocated to Rosary ground or gates could be made in the fences, which will reduce the distance to three minutes. So far, no decisions have been made about this and the situation stays the same. The NCARV project could have done some work preparing theses options, asking companies how much relocating will cost. For a park home to be secure, a concrete ramp would have to be build and this could have been looked at already. The time it takes to make a decision about the park home is long, in the meantime, the patients already have to go from Rosary to the NCARV project and back. These three scenarios have been sketched in figure 2.

Figure 2: *Scenarios for the Newcastle Catholic ARV project*



The director of the SACBC AIDS Office explained that at the local level the scenarios of partnerships can differ. It is according to what is possible. One example of a local scenario is described below.

4.4.2 b An example of a local partnership: the Noyi Bazi clinic

One example of a local partnership that has already crystallized is the partnership between the Catholic Noyi Bazi clinic in Pomeroy and the government Church of Scotland Hospital in Tugela Ferry, both in the Umzinyathi District in KwaZulu-Natal. The Hospital is a subdistrict hospital, one of four in the Umzinyathi District. In the catchment area of the hospital there are fifteen Primary Health Clinics (PHC), of which the Noyi Bazi clinic is one. Patients in the area go to the hospital when needed and are referred back to the clinic for long term care with diseases like diabetics, high blood pressure and HIV/AIDS. In the Hospital they started with Home Based Care (HBC) for HIV/AIDS patients in 1998. In 2000 they started providing Prevention of Mother to Child Transmission (PMTCT) and in 2004 ARV treatment started. They were the first hospital in South Africa to start with ARVs provided for by the government and were able to do so, because they already were on a trial for ARV provision from Yale with 100 patients. Now they have 7000 patients on ARVs in the whole catchment area. First the patients go to the local clinics, receive three pre-test counselling sessions, called literary sessions, are screened for TB and get blood tests for their CD4 count. Then the patients file goes to the Hospital. The doctor in the Hospital sees the patients, sometimes just for ten minutes because all the preparatory work has already been done, and initiates the patient on ARVs. The patients come back to the Hospital after the first two weeks on ARVs, then after another two weeks, then after one month and when they are stable at that time, they are referred back to the clinics together with a pink prescription card that prescribes ARVs for six months. All children under the age of twelve remain at the Hospital as well as all complicated cases. Right now, the Hospital is in the process of starting NIMART (nurse initiated treatment) at the local clinics.

The Noyi Bazi clinic in Pomeroy was set up about 40 years ago by Augustinian sisters. The area in and around Pomeroy is very rural. A few years ago the sisters had the intention to either shut down the clinic or hand it over to the government, but they have been asked to stay in the area, until the government is able to build a PHC themselves at some point in the future. The staff consists of three Augustinian sisters that are professional nurses that receive no salary from government, two enrolled nurses that are employed by government, two ARV counsellors that receive their stipend from the Global Fund via the SACBC AIDS Office and

one ARV counsellor employed by the Hospital. The majority of the drugs come from government, about 80%. The other 20% is procured via private means or special donations.

In the Noyi Bazi clinic there are about 200 patients on ARVs. The ARVs come prepacked to the clinic every month, delivered by the Hospital, and a few nurses come to see the patients and to give them the ARVs. In the Noyi Bazi clinic there is a HIV/AIDS department where three counsellors offer counselling and testing. They started testing in 2003. Before that they only provided counselling, people would have to go the Hospital for their blood tests. The government asked them to test as well and now they test and take blood samples, a car comes and picks up the blood every day. They started dispensing ARVs in 2005. The CD4 count of 200 cells/m3 is used to determine the moment of initiating, except when a patient has TB, then they can receive ARVs even when their CD4 count is higher. Currently about 20 patients are tested per day.

For the Noyi Bazi clinic to receive government drugs and to be able to provide ARVs, the doctors in the Hospital were involved together with the District Manager of the Umzinyathi Department of Health to get special permission from the Provincial Department of Health (PDOH). This process took some time and the District Manager wrote several motivational letters to get approval to send drugs to an NGO. The Province approved and this has led to the current situation where the Noyi Bazi clinic receives drugs from government and is considered and treated as one of the fifteen clinics in the area. In return, the Noyi Bazi clinic supplies the PDOH with statistics.

This example shows a Catholic owned clinic can work closely with government in providing care for HIV/AIDS patients. When both partners are dedicated to it, it is possible to receive permission from the PDOH to provide the NGO clinic with drugs and for the staff of both organizations to work together. The government benefits from this scenario, since the set up of the clinic including all the needed materials was done by the Catholic Church and also most salaries are paid for by them. The Catholic Church benefits, as they now receive most drugs from government and have a good relationship that will aid the eventual transfer of patients in the future when the government does build a PHC in the area themselves. But it did take time and effort from the government staff and an involved District Manager of the DDOH to achieve this.

4.5 -Results structured by aspects of PPPs

4.5.1- Advantages

As mentioned in chapter two, Bojovic (2006) mentioned three advantages for both partners in a PPP. Firstly, the partnership allows the government to maintain an active role in developing policy initiatives. In chapter two it is explained that in this case, this advantage should be reversed, the question is whether the government allows the private partner an active role. In the research it became evident that the government allows the SACBC AIDS Office an active role and even requests them to maintain their active role, because the government doesn't have enough resources to do all the work themselves. This means the SACBC AIDS Office can continue their work in HIV/AIDS care, though the way they do it will be different from the past because of the more active role played by the government. Since PEPFAR is redirecting its funds towards government, this gives the South African government more resources to act their part. It also needs to be mentioned that NGOs like the SACBC AIDS Office have set an example in the development of treatment and care for HIV/AIDS patients that the government can follow in the development of policies.

The second advantage needed to be reversed as well, it was not yet clear if the private partner wanted to maintain an active role to complement the government. The staff at both the SACBC AIDS Office in Pretoria and the NCARV project in Blaauwbosch made it clear they still see there is a part to be played by them and they want to be involved in the HIV/AIDS care. It is specifically the goal of the SACBC AIDS Office to assist the government until the government is ready to take on all of the work themselves. The future role of the SACBC AIDS Office is dependent on donor funding.

Finally, a PPP according to Bojovic (2006) encourages a valuable exchange of skills and experience between two sectors. To be able to experience this advantage of exchange of skills and experience, the collaboration would have to be a real partnership and would have to be organized in such a way that benefits are possible. The research needed to determine if there is room for an exchange to occur between the SACBC AIDS Office and the South African government. Unfortunately, this advantage has not been much made use of until now. The work done by the SACBC AIDS Office is appreciated, but the good practices are not taken over yet. One example of this is the Patients Data System (PDS) that the SACBC AIDS Office uses and helped develop. Nationally, the government facilities do not have a PDS, the

ones that are being used differ in the provinces. At the Amajuba District, there was talk about getting the PDS of the SACBC AIDS Office, but now the Province wants to buy their own PDS. The data of the patients at the NCARV project cannot be digitally transferred to the Hospital and clinics, because they do not have a PDS. The nurses at the NCARV project are well trained and experienced in providing ARV care and their expertise, as well as the experience of the counsellors and monitors, could be put to better use as well, which is not being done yet. There is no transfer of knowledge between the NCARV project and the government facilities in the area. If the staff of the NCARV project would be part of the roving teams in the area and asked to train other nurses and counsellors in the area, there would be an exchange of skills.

For a successful PPP, it would have to be based on a shared interest and the best interest for a sustainable partnership would be a commitment to a similar target population according to Miller, Perry and Thomson (2007). The two organizations of this PPP do have a similar target population, so an important ingredient for a sustainable partnership is present.

Concluding on the advantages of this particular PPP: the government and private actor can and are both willing to have an active role in the care for HIV/AIDS patients and if attention is given to a transfer of skills, the third advantage can be made use of.

4.5.2- Values

The presence of the three sets of values needed for a fruitful partnership mentioned in chapter two will be discussed now.

- Openness and trust

Relating to trust, Kramer (1999) said openness about the motives, intentions and prospective actions is needed so trust can develop. Both organizations are only open to a certain degree.

Respondent 14: '*They do not tell us everything, but then again, we won't tell them everything we are doing either.*'

Each of the two organizations has their own agenda. This is not a good basis for trust. Additionally, the government has not lived up to its agreements to provide the ARVs as to date, which further complicates the trust issue. Trust and openness need to be developed more

and both partners have to work on showing their trustworthiness. Developing trust takes time and repeated interaction, according to El Ansari, Phillips and Zwi (2004). While the partnership is still being formed, there are opportunities to develop more trust in the future. For trust, also personal relationships are very important. Since the staff at the government facilities changes often, it is hard to build a good relationship, demonstrated from the next quote:

Respondent 7: '*I won't say disagreements but sometimes what I would call, not everybody understands where this thing is going. So sometimes you might have, even the Province saying; yes, we'll help you, and the District saying 'we haven't heard about that, we are not ready for that.' It's that kind of thing, it's not so much disagreement as lack of understanding by all of the same information I would say. Until you get everybody, and then again, like I said, people leave and move away and then you sit with someone who doesn't know anything*.'

This is a point that should be taking into consideration in creating new partnerships at other SACBC AIDS Office sites, trying to invest in personal relationships.

- Integrity and fairness

These values are closely related to trust. A person finds someone with integrity when the trustee adheres to a set of principles that the truster finds acceptable. In the partnership the principles between the two organizations do not conflict in principle, all wanting to help HIV/AIDS patients and 'putting people first' (the mantra of the DOH). However, some respondents wonder if the patients sent over to government will be treated well and they think the government staff have a different work attitude and are less committed.

At the NCARV project, the patients that come there are regarded as family. The staff treat the patients well, and think this is one of the reasons patients choose to come to their clinic instead of a government clinic nearer by. In a way, patients are being spoiled, as respondent 3 says:

'*We attend them. If somebody is phoning: 'I'm sick.', we send the car to pick them up so the sisters can see what's wrong.'*.

In the government facilities patients are treated differently. First of all, patients have to wait a long time, up to the whole day, or even have to come back the next day when their drugs are not available or when there is no more time to see them.

Respondent 4: '*Well, I won't say much, but like, it depends on the person to whom you speak. Some people would go there and say they are not treated well. They say the nurses don't have time to attend to them. So I won't say much about it because it is only hear-say. I hear patients that come here that take treatment from us, they say that in government sector they are not treated well, they have to wait, like five or ten hours while waiting for their treatment*.'

Second, when patients have been transferred from the private NCARV project to a government clinic, they sometimes get scolded by the nurses at the government, asking them why they come back to them, telling them they should stay at the private clinic since that is what they preferred and things like that.

Respondent 6: '*The attitude was not good. Some said: 'You left the clinics here, you went to that clinic. Now you want to come back. No*.''

Respondent 2: *'… Madadeni is awful, I can say Madadeni is a terrible place sometimes. … And they just say: "You have lots of money, you go to a private sector then at the last moment you come here." We have to tell them they don't pay money*.'

Some respondents have mentioned they and their patients feel that in government, staff is impatient, don't give enough attention to possible side effects and care less. But it also has to be noted, that most respondents have said in general, they think the patients will be treated well. Only they fear the waiting time and the lack of follow up.

Respondent 10: '*I think everything will go well, but they might have difficulties… Because some of the nurses there are not good.'*

(I)*: 'With their attitude?'*

(R)*: 'Yes, and some of the doctors as well.'*

Though the principles of the two organizations match in theory, different attitudes towards patients have been mentioned as one reason to not fully trust the other partner. This means this value is not fully present in the partnership.

- Mutual support

Miller, Perry and Thomson (2007) explained mutuality in collaboration is manifest in partner organizations that (1) combine and use each other's resources so all benefit, (2) share information to strengthen each other's operations and programs, (3) feel respected by each other, (4) achieve their own goals better working with each other than alone, and (5) work through differences to arrive at win–win solutions. So far, there is minimal sharing of skills, and expertise between the partners. There is a start made however, with the intention of using the NCARV project as the initiating site for the Rosary clinic in Blaauwbosch. In this way, the Rosary clinic does not have to be trained to provide treatment initiation and the government can wait till there is time and resources available to take on this task themselves. The information sharing is limited as will be mentioned under 'barriers'. Whether the staff of the NCARV project feels respected is not clear. They say they do, but they also feel government staff is sometimes jealous, because they think in the private sector there is more money and resources. When the NCARV project is not invited to a stakeholder meeting or not informed of changes in government, this is not a sign of respect. The respect towards the government staff from the staff at NCARV project is also not always high, as they feel the staff at government is less committed.

Respondent 2: *'Nurses of NCARV project didn't go on strike like in hospital. There the patients didn't receive their treatment.'*

The staff at the NCARV project in general feels treated well by both staff at Madadeni Hospital and the DDOH. They emphasize there is a good relationship. But the relationship is unequal, the SACBC staff having to be patient, be extra gentle and careful in how they approach the government staff.

Respondent 14: '*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. ... You have to be tactful all the time, come down. ... So the relationship is inferior, it's not equal.'*

Besides being critical of government, the SACBC staff does recognize that government is overloaded and short staffed and has an enormous task to perform.

The 4th aspect, achieving their own goals better together than working alone, is present for the government, they want the help of the NCARV project to do the work. For the NCARV project partnering with the government is more out of necessity than voluntary, they need them for the funds and for the transfer of the patients, but are not too enthusiastic about the work-ethos in government nor the red tape and the slow processes.

The 5th aspect of working through differences will be addressed more in detail in the paragraph about conflicts. The differences are not worked through at the moment.

Mutuality is also closely related to reciprocity, which is very much present. Especially in government at the DDOH level, they exuded the 'I-will-if-you-will' attitude. They asked the SACBC AIDS Office for things in return for taking over their patients. To the staff of the NCARV project, this does not seem right, as it is the government's responsibility to take care of the health of its citizens in the first place. The issues that are related to reciprocity and trust mentioned in paragraph 2.4.2 and the results for them follow now. The 'experienced trustworthiness of other organization' has been mentioned under trust and is still an issue. The 'organizations taking advantage of the others' is being felt by the NCARV project, not a good foundation for a successful partnership. 'Being able to count on the partner to meet its obligations' has not been so up until now, another negative element in the reciprocity/mutual support value. 'Meeting your own obligation, even if the other organizations do not' is seen to a certain degree. The NCARV project has done their part, is giving the government the requested computer and some more materials, but on the other hand, they have not gone out of their way to make the transition for themselves and for their patients as smooth as possible.

The next aspect 'Does the partner try to get the upper hand?' points towards unequal power relationships. Though this is addressed in the thesis of my co-researcher Tim Sweegers

(2011), it should be mentioned the relationship feels unequal with the government demanding and the NCARV project being patient and flexible. The final aspect 'developing long term personal relationships' is made difficult by changing staff in both organizations. This undermines this value aspect of mutual support, though the personal relationships that are present, are valued as good.

Respondent 8: *'The District Manager is good to us. She understands where we come from and what we want. We are on good terms with the three of them (ARV coordinator, District Manager, HAST coordinator).'*

In conclusion it can be said the value of mutual support is not strong. More use of each other's resources can be made as well as sharing information. The respect between the partners is moderate. For the government, they do understand they need the NCARV project, but the NCARV project would rather keep on doing the work themselves, though they understand the need to down refer the patients. The differences in the partnership are not worked through. Finally, reciprocity is present, but this is not always an aid to the partnership, as the NCARV project experiences the requests from government as unjust, the developing of personal relationships is difficult and obligations are not met.

4.5.3- Causes of conflict

The second aspect of focus in this research is the causes of conflict in Public Private Partnerships (PPP). From the work of Tonder, Havenga and Visagie (2008), the potential causes of conflict relating to personal behavioural oriented aspects in a PPP are: *-differences in knowledge, beliefs or basic values, - competition for position, power or recognition, -a drive for autonomy, -personal dislikes and -differing perceptions or attributes brought about by the organizational structure (different role structures, heterogeneity of the workforce, environmental changes, differences in goals, diverse economic interests, loyalties of groups, and value discrepancies).*

In order to analyse the causes of conflict, in the research it first had to be established if there were conflicts. According to the staff of the SACBC AIDS Office, there are no conflicts. Even when asked more and different questions about it, the respondents would still say there

are no conflicts. The 'bumps' in the partnership are not considered as conflicts but most of all, the main reason for not experiencing conflicts is the humble and flexible attitude of the SACBC AIDS Office and staff at the NCARV project. When the government changes its plans or does not live up to an agreement, they wait until they commit to another agreement. The SACBC AIDS Office doesn't feel they are in a position to 'have' a conflict. However, from the observations and interviews, some possible causes of (latent) conflicts have been deduced. The organizations have a different reason for their existence therefore there can be different basic values, though the focus on the patients and on good care for HIV/AIDS infected persons stands out for both of them. Not all the staff at government clinics is trained in the same way as the staff at the NCARV project (nurses not having followed the NIMART training yet), possibly creating a feeling of inequality between the nurses in both organizations. The staff at the NCARV project have mentioned they hope the patients will be treated well and side effects and opportunistic diseases will be noticed, but they are sceptical of that. A quote that shows this coming from one of the nurses:

Respondent 1: '*In government, when they have a CD4 over 200 they won't get treatment. They say their CD4 must be less than 200. But they said long time ago that they are going to commence patients on treatment when their CD4 is less than 350. But they don't do that. Because there are patients who are coming here, maybe their CD4 count was taken three months ago, they are not on treatment. When she comes here, she will get help. I think what they are doing there, they don't check the symptoms. Our doctor checks, when the patient has a lot of symptoms, they will commence treatment. But at the government they don't do that. They work with the CD4 count only*.'

The second cause, competition for power, is not found in the leadership of the partnership itself, as no one is really in charge. It is not found in the motivation for the partnership at either side. But amongst the NGOs in the area, there is a sense of competition for their role in assisting the government, one reason is they are in a way competitors for PEPFAR grants and other funding. This is an issue that needs to be addressed between the stakeholders.

Personal dislikes are present to a certain degree. Overall, the working relations are good, but a sceptical attitude towards some representatives of the Hospital and the clinics has

been observed and not without grounds for it, because some staff did not demonstrate involvement in the stakeholder meetings. Adding to this the changes in staff, the personnel dimension, is a possible cause of conflict, it is if anything not helping the partnership.

Then there are the differences because of the organizational structure. The staff at the NCARV project has more decision making authority with shorter lines to the management, creating unequal timelines when decisions need to be made. The main difference pertaining to the organizational structure are the differences in goals or motives of the partners. From the data, a few main motivational reasons have been found for the SACBC AIDS Office to want to partner with the government. The first things stressed is that to be able to work in the health care sector in general and the HIV/AIDS care specific in South Africa, there always needs to be a relationship with the government. Then, they also believe the government is ultimately responsible for the health care of its citizens. Since the government is providing ARVs now, they should take over the care for the patients that were first taken care for in the non-profit sector. The SACBC AIDS Office has assisted the government in its task, but wants to hand over the care where possible. A practical motive is the end of the PEPFAR grant in 2013, with which the SACBC AIDS Office has been able to procure the ARVs up until now. This means there will probably not be enough money to procure ARVs for the patients in the future. Whether or not there will be sufficient funds from other donors to pay staff and other costs is not yet certain. From the start, the staff at the SACBC AIDS Office knew that the project would end and their goal was to show the government and the outside world that it is possible to get people to test and to go on treatment and help them adhere to the ARV regime in a resource poor area. There is proof now that adherence is possible, now the government can take over. This conflicts in certain respects with the motive of the government. Overall, the respondents have said they think the main motive for the government to work with the NCARV project is to get their statistics. They can add the number of people tested and the number of patients on ARVs to theirs, so they will have reached more people and are closer in reaching the target set for each year. To work with the NCARV project is convenient for the government, as they get '*a helping pair of hands'* (Respondent 14) for free. They don't have to pay the salaries and do the work, but can report the statistics to the PDOH and NDOH. This leads to the second motivation, saving money. According to one respondent a motive for the government to allow SACBC to provide ARVs is a recognition that the PEPFAR funded

programme has saved South Africa money since the country did not pay for the services rendered by PEPFAR funded projects. The government hasn't had treatment for their own patients all the time. The SACBC AIDS Office has saved them money, because they put all these patients on ARVs and provided for them for up to the first seven years of their treatment. Even though they are now in the process of accepting NCARV project patients in the government clinics and may start providing ARVs to the NCARV project, up until now, all the work done has been without costs for government. Additionally, the DDOH has asked the SACBC AIDS Office for materials; a car, computers, gazebo's (tents) and they asked for counsellors. So the partnership for the government would be a way to gain more help and not a way of taking full responsibility for the HIV/AIDS care. That said, one should not lose sight of the fact that South Africa's treatment programme is the biggest in the world, and also the most costly.

Back to the theory from Tonder, Havenga and Visagie (2008), who mentioned three *main* causes of conflict, number one originating in managerial practices that are perceived as racially informed abuses of power. The SACBC AIDS Office has a mixed racial staff just like the DOH, so no racially conflict is to be expected here. The second major source of conflict identified are inadequate and ineffective resources, being physical resources and ineffective staff. This could be a cause of conflict, resources (money and materials) are low at both organizations. Deciding who is responsible for which resources can be an issue. Also ineffective staff is an issue, the people that represented the government clinics and Hospital were not aware of the ins and outs of the partnership and were not actively playing their part, so this is a point that needs attention. The third main cause of conflict is changes in work demands associated with changes in technology, e.g. innovation, and management practices. Also this cause is relevant. There are changes in work demands flowing forth out of the partnership, the staff at government facilities need to do more, need to incorporate more patients in their facilities. When the partnerships develops, it may require a new system to join the both existing data systems and ways of organization, which will put a strain on the organizations.

Concluding; there are a number of possible underlying causes that are likely to produce conflicts when the partnership continues. These are differences in knowledge, beliefs and basic values; competition not between the NCARV project and the DOH, but between the

NGOs in the area; personal dislikes as to the attitude and involvement of the staff at the government facilities; and differences in hierarchy and in the motives for the partnership. Though no actual conflicts have appeared yet, when the partnerships continues, both at a local and national level, attention to these causes of conflicts is needed to ensure a healthy development of the partnership in the future.

4.5.4- Barriers

Now, the results regarding the four barriers in collaborations (El Ansari, Phillips and Zwi, 2004) are given.

(A) Barriers of organization: structures, systems, personnel and communication. The organizations are different in scale, the NCARV project being one clinic with 15 staff members and the DDOH and Madadeni Hospital being larger, having more staff and 17 clinics under them. The organizational structure differs as well. The government is very hierarchical. There are many layers of government and a lot of respondents have mentioned the abundance of 'red tape', including the District Manager of the DDOH, which makes the government very slow. It takes months to receive an answer on a request for supplies. The SACBC AIDS Office has a hierarchical structure as well, with a Director on top, a Project Manager that oversees various projects, a board at the local level and a Project Coordinator at the local level. But locally, the various sites have quite a lot of decision making power. They have to account for the money they receive, but can decide for themselves what is needed. Answers can be acquired quickly, as the lines are short and the organization is small. The atmosphere is also more informal, staff being on a first name basis with their Project Coordinator, whereas in government facilities, there is a very strict hierarchy and a large distance between the nurses and the doctors.

Respondent 14: '*There is less hierarchy here. If I want to do something, I just go to ... (Project Manager). In the hospital you have to go to your supervisor, who will go to the matron, matron will go to the big matron, big matron will go to someone else, you know, and it takes days.'*

Several of the respondents have said that in general, the government facilities are short staffed. They think this is one of the reasons everything with the transfers is going slowly. The government facilities are always very crowded with patients, so these transfers are just more work for them.

The systems they use regarding the care for the patients are different and are not compatible yet. At the NCARV project they work with both written files of patients and a Patient Data System (PDS). In the Hospital and clinics from government there is not PDS yet, most clinics don't even have a computer yet. This makes sharing information difficult. The forms used for the actual down referral or transfer have been designed by the NCARV project themselves, though based on information given by the Hospital. It would be easier if the Hospital had standard down referral or transfer forms to give to the NCARV project and ultimately it would be beneficial if nation wide the same files were used, with the same PDS and the same down refer forms etc. It is not clear if both organizations write down the same information about patients because there has not been any contact about that yet.

Personnel at government clinics are not all trained in initiating ARVs yet. This process has started, but it will take time before all nurses can initiate. At SACBC, many of the nurses have followed the NIMART training qualifying them to initiate treatment. Also the nurses are very experienced with ARV care, when government staff often is not. The attitude from government staff towards doctors is also different, more subordinate, which may be a cause for conflict, as nurses of the SACBC AIDS Office are used to approach doctors more directly and to have greater responsibility.

According to El Ansari (2004) communication should be efficient, ongoing between all the collaborating partners and stakeholders. This is not the case. The NCARV project has hardly any contact with other stakeholders, including the Madadeni Hospital, outside the stakeholder meetings and communication is not ongoing, but irregular. The communication between the two organizations is mostly at the local level. This means the Project Coordinator and the District DOH. For important decisions however, the Head office of the SACBC AIDS Office is involved, usually in the form of the Project Manager, because he/she knows the most recent information around PEPFAR and other developments. Communication usually takes place whenever there is a need.

(I): '*How often do you have contact?'*

(Respondent 8): *'When the need arises. Sometimes they tell us things that are happening, and sometimes they don't.'*

There is no contact systematically, though at the Amajuba district there are quarterly stakeholders meetings in which the SACBC clinic also participates. Unfortunately, these meetings do not always take place or not everyone is informed about them. The notes made of each stakeholder meeting are sometimes hard to understand and very minimal. Communication is mainly verbal, with few formal written agreements. Another element that makes communication difficult is the language barrier. In South Africa there are eleven official languages. The one used in the stakeholder meetings is English, because there are people present from different ethnic backgrounds. For most people English is not their first language, resulting in stakeholders asking each other for clarification in their native language. This disrupts the meetings and it is very possible that important stakeholders or staff at e.g. the Madadeni Hospital do not completely understand what is agreed upon. Because most agreements are not in writing, it is hard to keep anyone to their promise. During the transfer process, which started in April, there was little to no communication between the different organizations about the 'how to' of the process. It was not clear who was responsible, who was the right contact person at Madadeni Hospital, what forms were needed and what the time frame was. A positive aspect of the communication is that it is mostly between the NCARV Project Coordinator and the District Manager themselves, and as mentioned in chapter two, personal contact strengthens the partnership and can make it more sustainable. The communication is a barrier that needs to be overcome when the partnership continues. The communication process needs to be more defined, putting one person in each of the involved organizations in charge of communication between the organizations and internally and putting one person in charge of the total communication between the partners. Also the contents of the notes from DDOH off the stakeholder meetings can be improved, more professionalized and informative. Communication between DDOH, Madadeni Hospital and the local clinics needs to be improved as well.

The above made evident there is indeed a barrier present between organizations, the organizations are very different from each other. The differing systems and the poor communication being the main barriers.

(B) Barriers of attitude: political considerations and conflicts, and turf guarding. Because it was not possible to interview government staff directly, it is hard to determine their attitude towards the partnership and their political considerations. The District Department of Health is in a way forced to be in the partnership, because the Provincial Department of Health agreed on it. Out of political considerations, being involved in a partnership and having stakeholder meetings would be smart as it provides a picture to the outside world of the willingness to cooperate with the private sector and the acknowledgment that the government needs help.

Turf guarding means that often an organization wants to protect its own turf and not give away territory to other organizations so it won't lose its influence or work (Nishtar, 2004). This could be a problem for the NCARV project, as they would like to keep their position. But the motive to work with HIV/AIDS patients seems genuine and the staff is not in it for their own interest. Though the staff at the NCARV project would like to '*stay as we are'* (respondent 7) and keep their patients, they understand the need to down refer and have not shown they purposely slow down the transfer process. So far, turf guarding does not appear to be a real barrier.

(C) Barriers of vision: history, tradition, and absence of clear directives or adequate models. This barrier relates to the vision of the organizations for themselves and for the partnership in the short and in the long terms, on the question of what the partnership is trying to achieve. The two organizations have a different development in history. One is a religious organization, the other a public organization with lots of changes in the last few decades. Only over the last few years has the government been actively involved in HIV/AIDS care, while the Church has been involved for longer and has been pioneering ARV treatment in resource poor areas. This means their history and traditions are different and could be a barrier. However, in the observations this did not come across as being a barrier, with mutual understanding where the other organization is coming from and of the big task at hand.

There is however the barrier of clear directives. There is no real vision for the future, as it is not decided yet what the future situation in Blaauwbosch will be. For now, the partnership works out two of the three scenario's, the government procuring ARVs for the NCARV project in the near future and the NCARV project transferring out all patients that do not live in Blaauwbosch to the government. But it is unclear if these scenario's will work out, if they will decide on the NCARV project to remain the only initiating site in Blaauwbosch and what the plans and possibilities are for the SACBC AIDS Office after the end of PEPFAR in 2013. These factors combined show the partnership is not working toward a common goal right now. With no specific situation to work towards, there are no clear directives to follow. Especially the SACBC AIDS Office and their local clinic, the NCARV project, should decide on their desired road for the future and then see if that is attainable.

(D) Barriers of ignorance: lack of awareness of problems and potential solutions. This barrier is definitely present. All organizations involved, the DDOH, Madadeni Hospital and the NCARV project show a lack of future orientation and are not looking for potential problems and solutions. They take things as they go and only respond to a problem when it arises, this brings inconvenience for everyone involved, not in the least for the patients. It would help if there would be a feeling of equality between the partners and everyone would take their responsibility in making the transition process work, that would create an openness to address potential problems and discuss solutions. As El Ansari, Phillips and Zwi (2004) mentioned, potential problems are competing priorities and interests, operational understanding and role clarity. The priorities of both organizations are different at the moment, each focused on their own work at hand and the short term. Additionally, there is no role clarity about the diverse roles of each organization in the partnership and what exactly is being asked of each of the organizations. To top it off, there is little operational understanding of the other organizations, leading to uncertainty and frustration.

The barriers of (A), (C) and (D) are present in the partnership between the NCARV project and the DDOH and other government facilities. Each of these address certain issues that are not functioning well and that need to be worked at in the future to make this partnership more

effective. A conclusion about all the aspects of PPPs and recommendations to the SACBC AIDS Office follows now in the next chapter.

5. Conclusions and recommendations

The previous chapter has shown the results for the research about the personal behavioural factors in the Public Private Partnership (PPP) between the SACBC AIDS Office and the government of South Africa in KwaZulu-Natal. On basis of these results, conclusions about the partnership can be made that answer the research questions, which are:

Which of the values, causes of conflicts and barriers related to Public Private Partnerships are present in the partnership between the Newcastle Catholic ARV project and the Provincial and Amajuba District Department of Health in KwaZulu-Natal, South Africa, and which should be addressed to improve the partnership?

Subquestions:

1. What values that are needed for a fruitful partnership to occur (Bojovic, 2006) are present in the partnership and which could be strengthened?

2. What are the conflicts between the partners and which causes of conflicts based on the work of Tonder, Havenga and Visagie (2008) can be identified?

3. Which of the barriers as mentioned by El Ansari, Phillips and Zwi (2004) are present in the formation of the partnership and need to be addressed?

The results have shown the development of the partnership so far and overall, it can be said the partnership is still a work in progress. The local scenario needs to be worked in more detail and agreements made have to be acted on. Regarding the advantages of PPPs, two of the three advantages are present. The government and private actor can and are both willing to have an active role in the care for HIV/AIDS patients. Attention must be given to a transfer of skills, to be able to make use of the third advantage as well.

None of the values needed for successful partnerships are fully present yet. Trust between the partners needs to develop and more openness is needed. Integrity and fairness are not completely present, as staff of the NCARV project is sceptical of the attitudes towards patients in government facilities and the government has not lived up to its agreements. The value of mutual support is not strong, more use of each other resources can be made as well as

an improvement in sharing information, increasing respect between the partners, working through differences in the partnership and creating more equality in reciprocity.

Though there have been no conflicts between both partners, a number of possible causes of conflicts have been identified: differences in knowledge, beliefs and basic values; competition between the NGOs in the area; personal dislikes; and differences in hierarchy and in the motives for the partnership. Though as mentioned no actual conflicts have appeared yet, attention to these causes of conflicts is needed to ensure a healthy development of the partnership in the future.

Barriers of organization, vision and ignorance have been found in the partnership, though not all in the same manner. The poor communication is one of the main barriers, followed by a lack of future orientation for the partnership and ignorance concerning potential problems.

Although not all values are present in the partnership between both organizations, some possible causes of conflict have been identified and some of the barriers are indeed present, this does not stop the SACBC AIDS Office from going on with their work or with the partnerships. This is mainly their attribute, since they are the flexible partner and will do whatever is possible to make this partnership work. The reason they are in this work, is to help people. Since this is their main motive, not to make money or gain anything, they can continue with their work even when there are many challenges. For them, the outcome, the wellbeing of the patients, is worth working for. This attitude is also visible in the staff at the NCARV project. Their aim is to help people and support the community. If SACBC can no longer fund them, they will try and find another way to do that. To help them in their work in further developing the partnership with the government, a few recommendations can be made.

Recommendations

As demonstrated from the theory, investing in personal relationships is important. This can be done at the national, provincial and local levels. When the SACBC AIDS Office has a stable workforce of their own and gives attention to a transfer process with personal introductions to staff of the other organization when there are staff changes, personal relationships can grow and will not be lost.

As developing trust takes time, the SACBC AIDS Office can take only responsibility for their own role in the partnership; they can show themselves to be trustworthy, to meet obligations etc. so they create a basis for the government to trust them which will hopefully cause the government to work on their trustworthiness and integrity as well.

Understandably the SACBC AIDS Office focuses on several options for local partnerships and is happy with whatever will work. But for the government it is not clear what they really want. If the SACBC AIDS Office would make a clear vision statement for their role in the HIV/AIDS care, the government would know their plans, which creates openness, and it will become easier to negotiate how to work together to achieve this plan.

Openly discuss differences, conflicts, expectations and plans of your own organization with the partner organizations. When a partner is open about its own plans, the other partners will consider them as trustworthy and this will create an incentive to cooperate and be open themselves.

Address the possible causes of conflicts. The SACBC AIDS Office is a partner that has shown they are valuable in the HIV/AIDS work in South Africa, they are not just an organization that is 'allowed' to assist the government. As a partner, they can address issues themselves which will create clarity and shows the involvement and dedication to the partnership.

At the local level, more effort can be put into developing a good relationship with other stakeholders. The practical sides of the work, values in the care for HIV/AIDS patients and plans for the future can be discussed which might result in other possible. The main motive for the current partnership is not to partner with the government as such, but to assist HIV/AIDS patients, and other partnerships might contribute to that goal.

Reflection on the research

It was not possible to fully include both partners of the collaboration in the research. This is unfortunate, as interviews with government staff of the DDOH and the hospital and clinics in the Amajuba District would have given insight information into their organization and would have given a fuller understanding of the partnership. To be able to have interviews with government staff, official permission is needed from the PDOH and as this process takes up to six months it could not be completed during the time frame of this research. Where possible

observations have been made when the researcher accompanied staff of SACBC on visits to the DDOH and government hospitals in the area. For the clinic in Pomeroy, it has been possible to have an interview with one of the doctors in the Tugela Ferry hospital who was able to provide a lot of information about the collaboration in the past and the present. Informative were also the interviews held with staff at the NCARV project of whom some have worked in government facilities before, mainly the nurses. Because the information about the government staff's attitude and values are from hear-say, this information has not been verified. Though the results still give valuable information of the perceived attitude and treatment of HIV/AIDS patients by government staff and the like, because the informants have used their own experiences to base their opinions on, the results should be treated with care and no definite conclusions can be based on them.

It took a long time to understand how the SACBC AIDS Office and its sites are in relationship to each other and even more how the government layers are related and how these in turn are related to the NCARV project. If this had been clear from the beginning, more time would have been available for the research itself. The information on internet is not always up to date and in South Africa digital information is not the primary source, which makes preparations for research from Holland difficult. For future research that involves the government of South Africa as an information source, a longer timeframe should be planned to be able to prepare and await the approval of the research.

It would be of great value if this research could be further expanded in the future. Once the scenario for the NCARV project has been worked out, seeing how it actually functions and if conflicts do indeed arise will give further insight into PPPs in the developing world. Alongside, research at other sites of the SACBC AIDS Office and other NGOs in the field can be performed that will further increase the knowledge about the informal aspects of PPPs creating more universal applicable knowledge.

As a concluding remark, the interviewed staff at the NCARV project has repeatedly asked to stress that they are thankful for the opportunity they have had so far to help HIV/AIDS patients in their local community as they see the big differences this project has made.

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Appendix I

Topic list used for the interviews.

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 have been 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 whom 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 ARV's?
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!