AN EVALUATION OF PARTNERSHIP EFFECTIVENESS IN THE MANAGEMENT AND CONTROL OF HIV/AIDS IN TAMIL NADU STATE, INDIA

A THESIS PRESENTED BY

A. EDWIN SAM

TO

THE SREE CHITRA TIRUNAL INSTITUTE FOR MEDICAL SCIENCES AND TECHNOLOGY, THIRUVANANTHAPURAM

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF

DOCTOR OF PHILOSOPHY

2009

Achutha Menon Centre for Health Science Studies
Sree Chitra Tirunal Institute for Medical Sciences and Technology
Thiruvananthapuram, India.

CERTIFICATE

I, A. EDWIN SAM., hereby certify that I had personally carried out the work depicted in the thesis entitled **"An Evaluation of Partnership Effectiveness in the Management and Control of HIV/AIDS in Tamil Nadu State, India"**.

No part of the thesis has been submitted for the award of any other degree or diploma prior to the date.

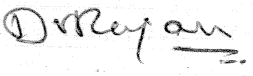
A. EDWIN SAM
(Ph.D. Candidate)

Thiruvananthapuram
30th December 2009

Certificate

Certified that the thesis titled ***"An evaluation of partnership effectiveness in the management and control of HIV/AIDS in Tamilnadu state, India"*** submitted to Sree Chitra Tirunal Institute for Medical Sciences and Technology, Thiruvananthapuram is an original work undertaken by A. EDWIN SAM, under my guidance and supervision.

Thesis Supervisor



[Dr. D. Varatharajan]

An Evaluation of Partnership Effectiveness in the Management and Control of HIV/AIDS in Tamilnadu state, India

A. EDWIN SAM

2009

Thesis submitted to
Sree Chitra Tirunal Institute for Medical Sciences and Technology, Thiruvananthapuram
in partial fulfilment of the Doctor of Philosophy (Ph.D.) degree.

Recommended by

(Thesis Supervisor)

Approved by

(Examiner)

Achutha Menon Centre for Health Science Studies
Sree Chitra Tirunal Institute for Medical Sciences and Technology
Thiruvananthapuram, India.

Acknowledgements

First of all, I express my heartfelt thanks to the Almighty God for his unseen hand yet tangible guidance all through the formation of the thesis.

I would like to take this opportunity to extend my wholehearted and sincere thanks to my thesis supervisor Dr. D. Varatharajan for continuously and constantly providing me the confidence. He taught me a great deal about both scientific research and life in general. As my teacher and mentor, he has taught me more than I could ever give him credit for here and he has indeed shown me, by his example, what a good researcher (and person) should be.

I wish to express my sincere thanks to Dr.K.R. Thankappan, The Head, AMCHSS, and I owe my sincere thanks to the Doctoral Advisory Committee members Dr. Raman Kutty and Dr.Ommen Philip for motivating me and providing me the professional guidance. I am always indebted to Dr. Sankara Sarma for providing me extensive personal and professional guidance during my entire tenure. I also owe my gratitude to the faculties of AMCHSS, Dr. Sundari Ravindran, Dr.Mala Ramanathan, Dr. Manju, Dr. Biju Soman and Dr. Kannan Srinivasan for their academic support.

I would like to acknowledge my sincere thanks to the previous Director, Dr. Mohandas and the present Director Prof (Dr) Radhakrishnan for their encouragement and support. I am very much thankful to Dr.A.V.George, The Registrar, for his continuous motivation and inspiration. I am pleased to acknowledge Mr.Jayasingh, The Deputy Registrar for his constant encouragement and support. I am very much grateful to Dr.Birger Forsberg, Karolinska Institute, Sweden for his technical and financial support for doing my Phd Thesis.

I am very much indebted to (Late) Mr.Ravi, who passed away due to his illness, for his great assistance to complete the data collection at Tirunelveli District. Likewise, I am thankful to

Mr.Vincent, Kanchipuram and Mr Sudhakar, Namakkal for their great help for data collection.

I am very much grateful and thankful to my loving and friendly Father and my Mother for accepting me as a person and encouraging me throughout my life though I didn't do much to them. But they are the ultimate role models for me. I am pleased to record my gratitude to my brother Mr. Alwin and my sister Mrs. Helen for their great support. I am indeed obliged to my Wife Dr. Devahi Sam, for providing me confidence to pursue a research career after marriage and I wish to thank my loving kids Adharsha and Anishka as well. I am also thankful to my late father in-law and mother in law for their constant support. I would also like to document my love and appreciation to my "Athan" Mr. Paramaraj who is very keen about my career and for his love and unending inspiration to complete my PhD work. I would like to also record my thanks to my Aunt Mrs.Rajam Murray for constantly reminding me to complete the work. I am very much indebted to Mr. Samson for his great assistance personally and technically to complete my work in time.

I would like to sincerely thank my friend Dr. Godwin for offering me courage and confidence throughout these years. Dr Arun, CMC Vellore really needs a special mention here. I am obliged to Mr Rajesh Kumar John as well. In addition, I thank my other colleagues, Mr.Arun, Dr.Pradeep, Mr.Anu, Dr.Joe, Mr Rajesh, Mr Suresh, Mr.Unni and others whom I had a pleasure to wok and interact with in SCTIMST.

Above all, I am very much thankful to all the participants who spent their valuable time with me and I would like to thank everybody who gave me permission to carry out the study in their respective jurisdiction.

A. Edwin Sam

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF BOXES

ABBREVIATIONS

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Ante Natal Clinic
APAC	AIDS Prevention and Control Project
ART	Anti retroviral Therapy
BSS	Behavioral surveillance survey
CBO	Community Based Organization
CDC	Center for Disease Control
CSW	Commercial Sex Workers
FGD	Focus Group Discussion
FSW	Female Sex Workers
GIPA	Greater Involvement of People Living with and affected by HIV
HIV	Human Immunodeficiency Virus
IDUs	Intravenous Drug Users or Injection drug users
IEC	Information, Education and Communication
ILO	International Labour Organization
IMF	International Monetary Fund
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
MSM	Men having Sex with Men
NACO	National AIDS Control Organization
NACP	National AIDS Control Programme
NFHS	National Family Health Survey
NGO	Non-Governmental Organization
PEPFAR	President's Emergency Plan for AIDS Relief
PLHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child- transmission of HIV
PPP	Public-private partnerships
PPTCT	Prevention of Parent to Child Transmission of HIV
SACS	State AIDS Control Organization
SAEP	School AIDS Education Programme
STI	Sexually transmitted infection
TANSACS	Tamil Nadu AIDS Control Society
TIs	Targeted Interventions
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
USAID	United States Agency for International Development.
VCTC/ICTC	Voluntary/Integrated Counseling and Testing centers
WHO	World Health Organization

Abstract

An Evaluation of Partnership Effectiveness in the Management and Control of HIV/AIDS in Tamil Nadu State, India

Background

Tamil Nadu reports the highest number of AIDS cases in India with an estimated prevalence of around 0.25 percent in 2008. Evidence from elsewhere in India suggests that the epidemic is gradually spreading from known high-risk populations to certain unknown groups in the general population and urban to rural areas. At the same time, Tamil Nadu registered a significant reduction in the prevalence in the recent past. Yet, only 12.3 percent of women and 37.4 percent of men have comprehensive knowledge about HIV; these proportions are lower than their respective national averages.

Partnerships are vital in HIV/AIDS control programmes. They are likely to enable different people and organizations to support each other by leveraging, combining, and capitalizing on their complementary strengths/capabilities vis-à-vis HIV/AIDS. Evidence on their effectiveness, however, is mixed in practice.

Objectives

The overall objective of the thesis was to evaluate the effectiveness of partnerships in Tamil Nadu in the management and control of HIV/AIDS. Particular emphasis was given to hitherto unknown and untargeted high-risk groups, their first points of contacts, and their potential and willingness to get involved in the management and control of HIV/AIDS.

Concept and methods

The conceptual framework employed by the thesis used theoretical concepts of 'Theories of Change' and 'Realistic Evaluation' besides incorporating *a priori* expectations, local needs and insights provided by the literature. Structure, inputs, processes, outcomes were its key analytical components with the focus on disease and health system management. A variety of methods such as the literature review, Focus Group Discussions, combing, stakeholder interviews, secondary data analysis and partnership evaluation were used. Interview schedules, FGD guidelines, Institutional checklist-Assessment form, and Partnership assessment tool were used to collect the required primary data. For data analysis, effectiveness scoring formula, Cronbach's Alpha, Kolmogrov Smirnov's method, Pearson's correlation, one-way ANOVA and univariate general linear model, and multiple linear regression were used.

Key findings

Results indicated widespread prevalence of high-risk sexual practices among some hitherto unknown population groups. First points of contact for STI and HIV/AIDS included a wide variety of fully and less than fully qualified modern and traditional medicine practitioners. They expressed their willingness to get involved in the formal system of HIV/AIDS management.

Functioning of the HIV/AIDS partnerships was effective from a health system perspective to produce certain desirable health system outcomes viz., equity, accessibility, affordability, coverage and utilization of services, target accomplishments, quality of care, responsiveness, client satisfaction, capacity development, increased health seeking behaviour and overall health improvement. Some areas, particularly concerning the disease management, need further improvement. There are also concerns regarding the sustainability of their efforts and benefits, alignment with the existing health system, duplication of efforts and community/target group involvement. Partnerships' efficiency gains were also inconclusive.

Conclusions

The study contributes to the exiting literature on evaluation of partnership effectiveness which is uncommon in Indian settings. Its findings signalled the possible exclusion of some hitherto unidentified high-risk groups and health care providers from HIV/AIDS related interventions. Partnerships produced some desirable health system outcomes and largely benefited known high-risk groups. There was no evidence to show that they targeted unconventional high-risk groups and their first contact points, as identified by this study.

CHAPTER-I

INTRODUCTION

Since its documented onset in 1981, HIV/AIDS has become one of the most critical and devastating epidemics in human history. This pandemic has turned into a human, social, and economic disaster, with far-reaching implications for individuals, communities and countries (WHO, 2003, 2006). It is reversing decades of development gains, increasing poverty and undermining the very foundation of progress and security (World Bank,2002). HIV/AIDS is not just a medical issue but a social, economical, legal and cultural issue affecting the most vulnerable population which requires multi-dimensional, multi-disciplinary and multi-sectoral efforts (UNAIDS, 2000).

The development of partnerships has been a major factor in all countries and communities that have achieved success in preventing and treating HIV/AIDS (OPRC, 2004). Active involvement through partnerships among the public sector, private sector, NGOs, CBOs and communities have been an important driving force behind the success of comprehensive AIDS prevention and control(WHO,1998; WHO,1999; NACO, 2008). The 58th session of United Nations general assembly(2003) reports that HIV/AIDS related civil society organizations have been persistent and effective in their efforts to get societies and governments to confront difficult issues like sexuality, intravenous drug use, human rights, stigma and discrimination and access to treatment, that are crucial to an effective national response. In addition, the engagement of the private for-profit sector is no less important related to the HIV/AIDS control (UNAIDS, 2003; World Bank, 2007).

1.1 HIV/AIDS Scenario in India

The first HIV infection in India was detected in 1986 in the state of Tamil Nadu (Simoes et al., 1987) and the initial cases were reported among commercial sex workers (CSWs) in Mumbai and Chennai and injecting drug users(IDUs) in the north-eastern state of Manipur (NACO,2001). Thenceforth, there has been a rapid increase in the number of HIV infections in India. In 2007, an estimated 2.31 million (1.8–2.9 million) people lived with

HIV/AIDS (PLHA); women accounted for about 39 percent and children (less than 15 years) constituted 3.5 percent (NACO, 2008). The adult HIV prevalence was 0.34 percent; higher among males (0.44%) than females (0.23%) (NACO, 2009). The prevalence was relatively higher among Men having Sex with Men-MSM (7.4%), Intravenous Drug Users-IDU (7.2%), Female Sex Workers-FSW (5.1%), STI clinic attendees (3.6%) and among truckers (2.4%). Heterosexual transmission accounts for 87.4 percent of the transmission (NACO, 2008). But, the epidemic vary from state to state with heterosexual transmission predominating in southern states, whereas in north-eastern states the infection has not transcended outside of the traditional high-risk groups such as IDUs, FSWs, MSMs and truck drivers(UNAIDS, 2006). The heterogeneous distribution of HIV epidemic is also evident as many isolated pockets of high prevalence are identified in several districts in India (WHO, 2003; NACO, 2008).

However, an overall decline in HIV prevalence is observed in the country, particularly in high prevalence states in the south and the northeast. The adult prevalence has declined from 0.45 percent in 2002 to 0.36 percent in 2006; especially, the declining trend is very evident where interventions were in place for many years (NACO, 2007). Also, there have been more evidences that the epidemic is gradually spreading from the high-risk population to general population, urban to rural areas and it continues to shift towards women and young people making it clear that the epidemic is affecting the entire society and not just the high-risk groups (Arole et al., 2005; UNAIDS, 2004, 2006; NACO, 2008).

1.1.1 Tamil Nadu Scenario

Tamil Nadu reports the highest number of AIDS cases in India with an estimated prevalence of 0.25 percent in 2008; actual number of people living with HIV/AIDS (PLHA) is estimated at 0.184 million accounting for 10 percent of the national HIV burden (NACO, 2008). The prevalence among high-risk population such as IDUs (16.8%), STI clinic attendees (8%), MSMs (6.6%) and FSWs(4.7%) continue to be higher(NACO,2008). Though the overall estimated adult prevalence was relatively low, many districts in Tamil Nadu have recorded a higher prevalence. For instance, out of the 163 'A' category districts

in India (meaning a prevalence of more than 1 percent of antenatal cases during the last 3 years), 22 districts (13.4%) were in Tamil Nadu. Out of 24 districts with seropositivity of more than 10 percent among STI clinic attendees, four (20.8%) were in Tamil Nadu. Ten districts out of the 30 in Tamil Nadu had the seropositivity of one percent or more among antenatal population (either rural or urban site) and 11 districts had more than 5 percent seropositivity among any one of the high-risk population such as STI clinic attendees, FSWs, MSMs and IDUs (NACO, 2006). Out of the 13 districts which had seropositivity of three percent or more among antenatal population, two districts (Namakkal and Salem) were in Tamil Nadu (Table-1.1).

According to the CMIS [1] data (2009), the prevalence among the ICTC (Integrated counselling and testing centres) clients was 1.85 percent. Eleven districts were having more than one percent and Kanchipuram district had the highest prevalence of 2.95 percent among the ICTC clients (Table-1.1). However, the ICTC prevalence may not reflect the general population as the clients visiting the ICTC are those with risk behaviors, and not low-risk men and women. As the levels cannot be ascribed to any specific risk group, they may be used as proxy for high risk groups and bridge population.

The recent mapping data (APAC-IMRB, 2008) indicated that the state had around 77801 Female sex workers, 48209 Men sex with Men and 3361 Injection drug users. Thirteen districts had more than 2000 Female sex workers and 10 districts had more than 2000 MSM population. Chennai and Madurai had more Injection drug users. However, no data were available from many districts of the state regarding the IDUs (Table-1.2). Besides, Salem, Trichy, Coimbatore, Chennai, Namakkal, Erode and Thiruvallur districts had higher number of PLHAs (more than 5000) till 2006 in the state.

[1] *Computerised Management Information system developed by NACO in order to collect and facilitate the analysis of the inputs and outputs of the programme data.*

Table – 1.1

District wise prevalence among different population groups

Sl No	Districts	2004 ANC		2006 ANC		2006 HSS High risk population				2009
		Dist HQ Hospital	First Referral Units	Dist HQ Hospital	First Referral Units	STD	FSW	MSM	IDUs	ICTC Prevalence
1	Chennai	0.50	-	0.25	-	12.40	3.60	4.40	31.60	0.88
2	Coimbatore	0.50	0.75	1	0.75	8	-	-	-	1.05
3	Cuddalore	0	0.75	0	0	-	-	-	-	0.76
4	Dharmapuri	1	0.50	0.50	1	-	14	-	-	0.93
5	Dindigul	0.75	0.75	0.25	0.50	-	-	-	-	1.19
6	Erode	0.75	0.50	0.75	0.75	-	-	-	-	1.22
7	Kanchipuram	0.25	0.75	0	0	4	-	-	-	2.95
8	Kanyakumari	1	0.25	0	0	-	0.40	-	-	0.41
9	Karur	2.5	3.25	1.25	0.50	9.20	-	-	-	0.86
10	Krishnagiri	1.25	1.17	-	-	-	-	-	-	1.46
11	Madurai	0.25	3.70	0.25	0.25	24.80	5.60	-	16.80	1.46
12	Nagappatinam	0.50	0.50	0	0.50	-	-	-	-	0.31
13	Namakkal	2.5	0.75	3	0.50	-	-	-	-	1.40
14	Nilgiris	0.50	0.75	0.5	0.25	-	-	-	-	0.27
15	Perambalur	1.25	1	0.50	1	-	-	-	-	0.84
16	Pudukkottai	0.75	0.50	1	0.50	-	-	-	-	0.54
17	Ramnad	0.75	0.50	0.25	0	2.80	-	-	-	0.27
18	Salem	2	1.25	3	1.50	4.80	12	-	-	1.27
19	Sivagangai	0.5	1.75	0.50	0.50	-	-	-	-	0.67
20	Thanjavur	0.75	0.50	0	0.75	10.80	-	-	-	0.70
21	Theni	1.75	1.24	1.75	0.50	-	2	-	-	1.52
22	Thiruvarur	0.25	0	0	0	-	0.80	-	-	0.28
23	Thiruvallur	0.50	0.75	1.25	0.25	-	1.60	-	-	0.40
24	Thiruvannama	1.75	0.25	0.50	n/a	-	-	-	-	0.49
25	Tirunelveli	0.75	0.25	0.25	0.25	19.60	0.80	-	-	0.55
26	Trichy	1.25	0.50	2.50	1.25	7.60	5.60	-	-	1.27
27	Tuticorin	0.5	1	0.25	0.25	-	-	-	-	0.39
28	Vellore	1	0.50	0	0.25	6	-	-	-	1.21
29	Villupuram	0.5	1.25	0.25	0.25	-	-	6.80	-	0.67
30	Virudhunagar	0.25	0.25	0	0.25	-	4.40	-	-	0.62
	Ariyalur,Tiruppur	-	-	-	-	-	-	-	-	

Source: *The Tamil Nadu HIV sentinel surveillance report-2004, TN AIDS control Society (2005)*
Annual HIV Sentinel Surveillance Country Report - 2006(NACO, 2007)

Table-1.2

Total Number of PLHAs and other High Risk Groups

Sl No	District	No of PLHAs[2]	No of High Risk Population[3]		
			FSW	MSM	IDUs
1	Chennai	5144	14147	3320	1474
2	Coimbatore	12545	1634	2660	-
3	Cuddalore	1801	945	2511	-
4	Dharmapuri	1754	2786	526	-
5	Dindigul	3505	2614	1155	-
6	Erode	7658	1642	544	-
7	Kanchipuram	2599	3119	1046	80
8	Kanyakumari	1519	2996	3306	66
9	Karur	2397	1315	1813	-
10	Krishnagiri	4211	3144	-	-
11	Madurai	4634	7887	1614	1536
12	Nagappatinam	1652	466	1332	-
13	Namakkal	6938	1778	504	-
14	Nilgiris	1455	854	441	50
15	Perambalur	2041	501	537	-
16	Pudukkottai	2873	1550	2239	-
17	Ramanathapuram	1006	533	1788	-
18	Salem	19289	3353	1937	-
19	Sivagangai	1977	1218	929	-
20	Thanjavur	3471	1506	1022	-
21	Theni	4026	1911	458	-
22	Thiruvarur	839	448	1001	-
23	Thiruvallur	8314	3512	2764	-
24	Thiruvannamalai	2850	914	1150	-
25	Tirunelveli	4632	2647	2460	-
26	Trichy	12904	4191	4109	65
27	Tuticorin	2209	4456	2576	90
28	Vellore	3676	2586	1612	-
29	Villupuram	2999	1230	1229	-
30	Virudhunagar	2364	1918	1626	-
31,32	Ariyalur, Tiruppur(New)	-	-	-	-
		133282	**77801**	**48209**	**3361**

According to NACO (2008), Tamil Nadu being the state listed among the high prevalence states, the prevalence has come down to 0.25 percent in the year 2007(Figure-1.1). Considering all the high prevalent states such as Andhra Pradesh, Karnataka, Maharashtra,

[2] *PLHA Estimation from HIV Sentinel Surveillance 2006(NACO, 2007)*

[3] *Mapping of High risk Population by APAC and IMRB Research, Chennai (Unpublished data)*

Manipur, Nagaland and Tamil Nadu, it is the only state where the reduction in the prevalence during the last 5 years was significant (NACO, 2006; NACO, 2008; Pandey et al., 2009). A declining prevalence (Table-1.3) has also been observed among the high-risk population such as FSWs, IDUs, despite MSMs recorded a slightly elevated prevalence. Literature commented that the reduction in the prevalence could be due to the possible impact of the interventions (NACO, 2007). However, it is unclear why and how it worked relatively well in Tamil Nadu when the package of services may be similar in other states as well (Correa, 2008).

Figure-1.1[4]

The trend in HIV Prevalence in Tamil Nadu State (2000 - 2007)

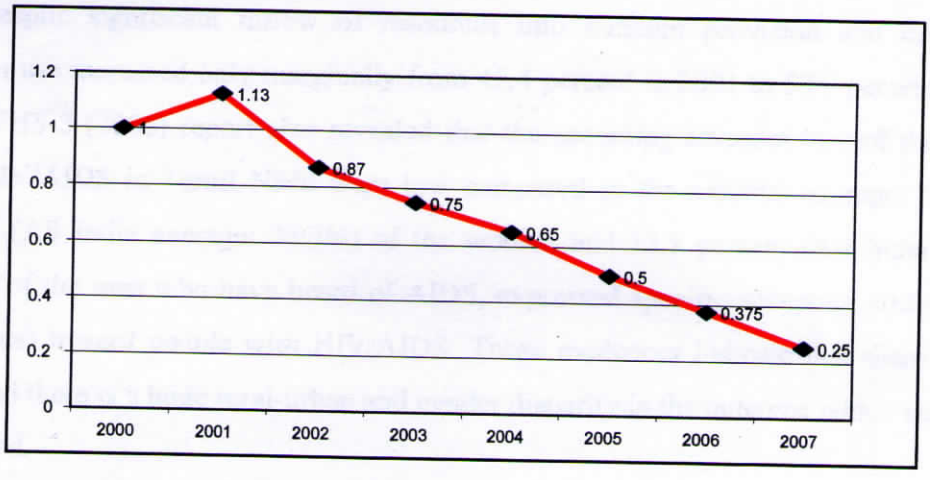


Table-1.3[5]

Trend in prevalence among different population groups (2003-07)

High risk Population	2003	2004	2005	2006	2007
FSWs	8.8	4	3.5	4.6	4.7
MSM	4.4	6.8	6.2	5.6	6.6
IDUs	63.8	39.9	18	24.2	16.8

[4] *India HIV Sentinel Surveillance and HIV Estimation 2006, 2007(NACO, 2007;NACO, 2008),*

[5] *India HIV Sentinel Surveillance and HIV Estimation 2006, 2007(NACO, 2007;NACO, 2008)*

Manipur, Nagaland and Tamil Nadu, it is the only state where the reduction in the prevalence during the last 5 years was significant (NACO, 2006; NACO, 2008; Pandey et al., 2009). A declining prevalence (Table-1.3) has also been observed among the high-risk population such as FSWs, IDUs, despite MSMs recorded a slightly elevated prevalence. Literature commented that the reduction in the prevalence could be due to the possible impact of the interventions (NACO, 2007). However, it is unclear why and how it worked relatively well in Tamil Nadu when the package of services may be similar in other states as well (Correa, 2008).

Figure-1.1[4]

The trend in HIV Prevalence in Tamil Nadu State (2000 - 2007)

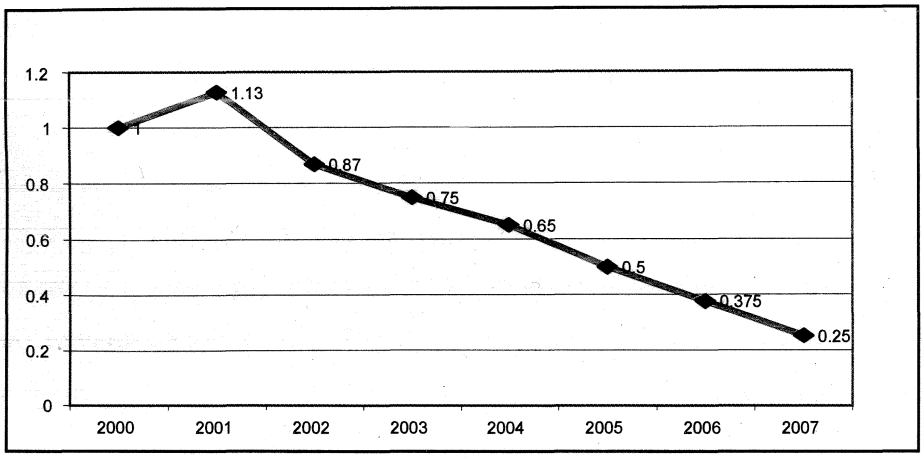


Table-1.3[5]

Trend in prevalence among different population groups (2003-07)

High risk Population	2003	2004	2005	2006	2007
FSWs	8.8	4	3.5	4.6	4.7
MSM	4.4	6.8	6.2	5.6	6.6
IDUs	63.8	39.9	18	24.2	16.8

[4] *India HIV Sentinel Surveillance and HIV Estimation 2006, 2007(NACO, 2007;NACO, 2008),*

[5] *India HIV Sentinel Surveillance and HIV Estimation 2006, 2007(NACO, 2007;NACO, 2008)*

Substantial behaviour change has also occurred in Tamil Nadu among the high-risk behaviour core-transmitter groups, which is a pre-requisite for slowing down of the epidemic (BSS-APAC, 2001, 2006; Ramasundaram et al., 2001). However, the behavioural indicators among the general population indicated a different situation. Despite high awareness (94.5% of women and 98.3% of men have heard of HIV/AIDS), only 12.3 percent of women and 37.4 percent of men had comprehensive knowledge, which was lower than the national average. Over 80 percent men and only 41.9 percent of women knew that HIV/AIDS can be prevented by using condoms (NFHS-3, 2006). National Baseline and End line Behavioural Surveillance Surveys (BSS, 2001; BSS, 2006) among general population reported that the proportion of men reporting non-regular sexual partners in Tamil Nadu has increased from 6.6 percent in 2001 to 15.4 percent in 2006. But, despite significant inflow of resources into condom provision and distribution, condom use increased only marginally from 45.4 percent in 2001 to 50.9 percent in 2006. The NFHS-3 (2006) report also revealed that the accepting attitudes toward those living with HIV/AIDS in Tamil Nadu were low compared to the national average. Only 12.2 percent (All India average: 33.7%) of the women and 13.8 percent (All India average: 36.8%) of the men who have heard of AIDS, expressed specific accepting attitudes (four indicators) toward people with HIV/AIDS. These evidences indicate that there are grey areas and there is a huge rural-urban and gender disparity in the outcome which needs to be addressed.

Ironically, the male-female ratio of HIV infection in the state was 0.7 to 1 whereas the other states recorded a male dominated trend (NACO, 2006; NFHS 3, 2006; Claeson and Alexander, 2008). It is argued that this low male-to-female ratio may represent a mature epidemic where men became infected first and have subsequently died (Claeson and Alexander, 2008). Similarly, the prevalence was higher among the rural women (0.61%) than the urban women (0.40%), whereas most of the high prevalent states recorded higher among the urban (NACO, 2006). This trend in Tamil Nadu indicated very clearly that the disease has already reached the general population especially in the rural areas and among women, and there may be many hidden risk-groups in the general population. There are also evidences to say that HIV epidemic in Tamil Nadu had become generalized and were

not restricted to high-risk populations (Thomas et al, 2002; USAID, 2004). It is also apparent that there is no one epidemic; rather, there are several small and large localized sub-epidemics with their own dynamics and rates of growth, reflecting the diversity in socio-cultural patterns and multiple vulnerabilities.

1.1.2 HIV/AIDS Programmes in Tamil Nadu

HIV/AIDS programme in the state was formally initiated after the State AIDS Cell was formulated in the year 1993 with funding from the World Bank and the National AIDS Control Organization (NACO). In the following year, the state AIDS Cell became the Tamil Nadu State AIDS Control Society (TANSACS) which is the lead agency leading and co-coordinating the fight against the HIV/AIDS epidemic. Initially, besides the government's response, few national and state level NGOs actively participated in the prevention and control efforts (Krishnamurthy and Varma, 2005). Subsequently, many other national and international agencies started their operation in collaboration with the government and private sector both for-profit and not-for-profit sector. Nevertheless, though there are several agencies involved with separate mandates, they are required to plan and implement their programmes in line with the National AIDS Control Programme of the Government of India.

Currently, under the National AIDS Control Programme (NACP-III; 2007-12), which is in progress, the overall goal of Tamil Nadu is to halt and reverse the epidemic. It places the highest priority on preventive efforts while seeking to integrate prevention with care, support and treatment. The programmes can be classified as, programmes to prevent new infection, treatment services, care and support, surveillance, monitoring and training activities. The state is striving to move towards saturation of high-risk groups with comprehensive coverage strategies and empower community based organizations to own the targeted intervention programmes. Emphasis is also on mainstreaming of prevention strategies in the regular government departments. Involvement of private sector in several areas like HIV testing and counseling, Prevention of Parent to Child Transmission (PPTCT), Sexually Transmitted Diseases (STD) etc., is also being taken up in a big way. Strengthening the infrastructure, systems and human resources in prevention, care and

treatment programmes at the district and the state level is also the priority of the state. The overall approach has been to increase the quality of services, to promote better understanding of HIV/AIDS, resulting in attitude and behaviour changes (GOT, 2008).

As a result, there has been a huge scale up in prevention programmes, HIV counseling and testing, ART enrollment and other care and support services in Tamil Nadu (GOT, 2008). One of its key preventive strategies is to target campaigns at both high-risk groups and the general public (Ramasundaram, 2002; Ehouman, 2002). Under the targeted approach, the state has been successful in identifying the vulnerable core transmitter groups and addressed them effectively through the targeted interventions which showed significant success in reducing the prevalence among high-risk population like female sex workers (UNAIDS, 2007). However, the reported success can be partially attributed to the presence of multiple international actors, multilateral, bilateral agencies, extending technical and financial support for implementation of programmes through the government and non-governmental organizations from the earlier stages of the epidemic (Ehouman, 2002). World Bank (2009) reported that the intensity of HIV/AIDS prevention efforts has been high in Tamil Nadu. In addition, around 10 percent of all the targeted interventions in India are in Tamil Nadu which could have increased the coverage among the high risk population. However, the presence of multiple actors might have resulted in duplication of efforts as well. It is also stated that there has been a huge political commitment and support in order to carry out the interventions effectively in Tamil Nadu (Ramasundaram, 2002). The State's success has been also attributed to an early autonomous and comprehensive strategy that built capacity on many levels including programme management, targeted interventions, community awareness and support, and surveillance (Lo et al., 2007).

1.2 Tackling HIV/AIDS through Partnerships

Over recent years, there has been recognition of partnership as a tool by which to address and challenge health, social and economic issues (Austin, 2000; Sagawa and Segal, 2000; Reich, 2002). There is growing realization that the complex and intransigence HIV/AIDS services require multi-dimensional, multi-disciplinary, and multi-sectoral efforts (Schatz and Dzvimbo, 2001; UNAIDS, 2000). Also, the traditional ways of working independently

in such issues have a limited impact (Widdus, 2001). Besides, addressing HIV requires clear understanding of the behavioural, socio-economic and cultural characteristics of the population. So, the private sector especially the not-for-profit sector with their knowledge about the local need, flexibility, expanded autonomy, ability to reach out the poor, and innovation in achieving things could be an effective partner to provide HIV/AIDS services. World Development Report (1993) reported that a significant proportion of the not-for-profit sector in the developing countries has proved that they can provide public goods with higher quality and lower cost. At the same time, private for-profit organizations have also come to recognize the importance of public health goals for their immediate and long-term objectives, and to accept a broader view of social responsibility as part of the corporate mandate (Reich, 2001). So, the magnitude of the HIV/AIDS problem, the private sector's dominance and its immense resources, their wider reach and the community acceptance make it inevitable and potentially overpowering partner to combat public health issues such as HIV/AIDS.

Therefore, major international development agencies like IMF, World Bank and WHO sought to persuade private organizations to engage directly with public agencies through intensive partnerships, particularly for urgent issues like HIV/AIDS (WHO, 1999; World Bank, 2004; Hsiao, 1995). HIV/AIDS related partnerships all over the world are also promoted by the policies such as multi-sectoral approach which is one of the three principles of the "Three Ones" policy developed by the UNAIDS and WHO (UNAIDS, 2003, 2005); decentralization of responsibility; and the community-based and community-driven approach (Delion et al., 2004). Multi-sectoral approaches not only endorse partnerships at the global level between national governments and international organizations, but also at the national levels. Decentralized service delivery implies in many cases that private sector organizations are involved in service provision. The concept of community based and community driven approach is that by grounding development initiatives at the community level, they are anticipated to be more responsive to local level needs because of the increased participation of the community. Within national HIV/AIDS programmes, this involvement is seen in the partnerships between local governments and

community-based organizations, as well as the private partnerships between international donors (funders) and community-based organizations, and between NGOs and CBOs.

The Government in India (2004) presupposes that partnerships could help in ameliorating the problem of poor health services delivery at two levels that are to improve delivery mechanisms and to increase mobilization of resources for healthcare. The need for partnerships in health sector has been emphasized by successive plan documents (from 8th Five Year Plan in 1992), National health policy (2002), National commission on macroeconomics in health (2005) and also by the National Rural Health Mission. In terms of HIV/AIDS, the National AIDS Prevention and Control Policy (2001) advocated that it is essential to continue to encourage the involvement of the private sector especially the voluntary sector in HIV/AIDS. It has encouraged large-scale involvement and participation of NGO, CBOs and private sector in National AIDS Control Programmes in the policy making process, provision of medical facilities including home-based care, opening of community care centres, apart from the conventional areas of awareness, counselling and targeted interventions among risk groups. The first National AIDS Control Programme(NACP I-1992-1999) and the subsequent NACP II(1999-2007) and NACP III(2007-20012) have also emphasized the importance of the private sector especially the NGO and CBOs involvement in providing various services related to HIV/AIDS. The National Policy on the HIV/AIDS and the world of work by the Ministry of Labour and Employment, Government of India (2008), also emphasized the need for partnerships with the private sector to have work place interventions as well as to design other possible HIV/AIDS interventions.

Hence, a significant proportion of the HIV/AIDS interventions in India are being carried out through active participation of the public sector, bilateral organizations, NGOs, CBOs and private health care providers (NACO, 2004, 2006). At the national level, National AIDS Control Organization (NACO) is partnering with the World Bank, DFID, USAID, CIDA, AUSAID, UNAIDS and its nine UN cosponsors; industry coalitions like CII, FICCI and ASSOCHAM; paramedical fraternities like the Indian Red Cross; the Global Fund on AIDS, TB and Malaria and with the Bill and Melinda Gates Foundation to implement the comprehensive national AIDS control programme (NACO, 2008).

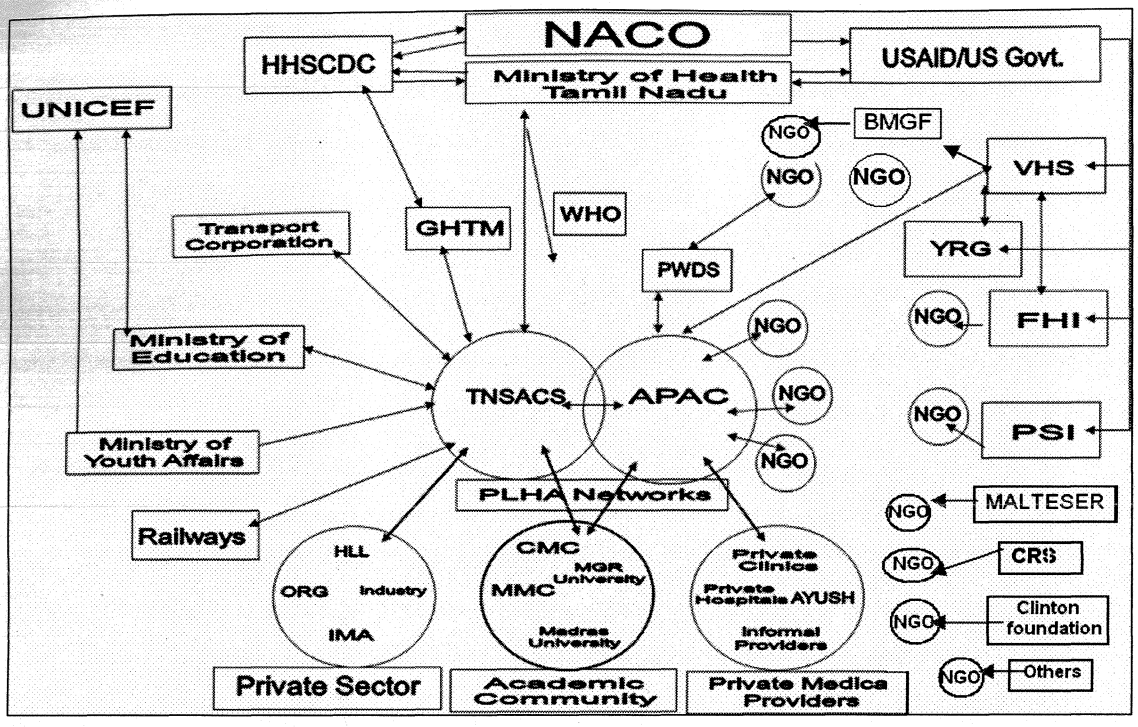
1.2.1 HIV/AIDS Partnerships in Tamil Nadu

In Tamil Nadu, a wide range of public and private institutions; financial and technical support agencies; bilateral and multilateral development agencies have joined hand to orchestrate the state response to the epidemic (Thomas and Kurapati, 2004). Multidisciplinary inputs received from these groups have enabled the state to understand the dynamics of the epidemic, the geographical and community level variations, socio-cultural and political implication of HIV as well as to develop and implement appropriate responses in prevention and care (Thomas and Kurapati, 2004). TNSACS, the state's lead agency, works with a number of partners like the networks of positive people, NGOs, CBOs, FBOs, women's groups, self-help groups, national and international agencies in planning and implementing various initiatives through a multi-pronged approach(GOT,2009). At the program level, prevention, promotion, care and support, treatment, rehabilitation and advocacy activities are being carried out through partnerships (GOT, 2007). The key services consist of targeted interventions that included a myriad of services, such as information campaigns, counselling, condom provision, HIV testing and low-cost HIV/AIDS treatment which was primarily carried out through partnerships. Moreover, community care centres (CCC), drop-in centres, voluntary counselling and testing centres (VCTC), prevention of parent to child transmission centres (PPTCT) and integrated counselling and testing centres (ICTC) are also being managed in collaboration with various private organizations mainly not-for-profit organizations.

In addition to the TANSACS, other major players (Figure 1.2) who collaborate with the not-for-profit and for-profit organizations in the program level are, the USAID funded AIDS Prevention and Control Project (APAC), the Bill and Melinda gates foundation supported Tamil Nadu AIDS Initiative(TAI), UNICEF, Catholic Relief Services (CRS), Family Health International(FHI), Pulmyrrah Welfare Development society (PWDS), Clinton foundation, Centre for Disease Control, Population service International (PSI), Project Concern International (PCI), Malteser International and different PLHA networks. The Clinton foundation, Catholic Relief Services, Pumyrrah Welfare Development Society, Malteser International were mainly involved in care and support programmes.

Figure 1.2

HIVAIDS Network in Tamil Nadu



In 2007-08, there were around 129 targeted interventions funded by public and private funding agencies, implementing different types of targeted interventions. There were 13 interventions for truckers, 11 interventions for migrants, 10 Mobile ICTCs, 100 ICTC centres, 30 drop-in centres, 30 community care centres functioning in partnership with the private for-profit or not-for-profit organizations (TANSACS-AAP, 2008). In addition, red ribbon clubs (RRC), school AIDS education programmes (SAEP), sexually transmitted diseases clinics, mainstreaming activities were also carried out by both the public and private funding agencies in collaboration with for-profit and not-for-profit organizations in Tamil Nadu.

1.3 What is Partnership?

According to the World Bank Institute (1998), a partnership is a clearly articulated arrangement between entities to work towards mutually agreed goals with mutually agreed division of costs, risks, rewards, and mechanisms to assess progress and make adjustment. In the health sector, WHO (1999) describes partnership as a means to bring together a set of actors for the common goal of improving the health of populations based on mutually agreed roles and principles. However, partnership is a complex concept and is synonymously and interchangeably used as collaboration, cooperation, coordination, coalition, network and alliance (Kingsley and O'Neil, 2004; Huxham, 1996). Though partnerships are not a new concept, there remains today no one single agreed-upon definition (Powell and Glendinning, 2002; Sullivan and Skelcherm, 2002; WEF, 2005; Varatharajan and Anandan, 2006).

Several authors have also conceptualized partnerships in many ways. Axelsson, Bustreo and Harding (2003) describe partnership as a variety of co-operative arrangements between the government and private sector in delivering public goods or services which provides a vehicle for coordinating with non-governmental actor to undertake integrated, comprehensive efforts to meet community needs and to take advantage of the expertise of each partner, so that resources, risks and rewards can be allocated in a way that best meets clearly defined public needs. Widdus et al. (2001) argues that the true partnership is really about combining different skills, expertise and other resources, ideally in a framework of defined responsibilities, roles, accountability and transparency to achieve a common goal that is unattainable by independent action. Mitchell Weaver and Manning(1991) states that in order to fulfil the criterion of a "partnership" there must be some ongoing set of interactions, an agreement on objectives and methods as well as a division of labour to achieve the goals.

All these definitions can be loosely grouped into two main categories. One is, derived from the field of economics and the other one is derived from the field of organizational studies. Definitions of partnership derived from the field of economics include references to 'risk sharing', 'relational' contracts and the mathematical modelling of optimal strategies (Field

and Peck, 2004). In an economic view, partnership is a form of collective action in which otherwise independent organizations join forces in pursuit of a common objective. Such collective action will occur when the net benefits of the collaboration exceed those of independent, purely private activity. The most important economic basis of partnerships is improved efficiency and effectiveness under the new Public Management theories (Fourie and Burger, 2000). Partnerships allow considerable leveraging of each partner's resources and unique strengths, and results are often attained in less time, at lower cost, and with greater sustainability than efforts by any single partner (Camille Saadé et al., 2001). In addition, partnerships will increase transparency of prices, quantity and quality as well as competition which will lead to a gain in efficiency (WHO, 1998). The definitions derived from organizational studies include features like mutually agreed goals, interdependency, mutual trust, autonomy, transparency and commitment (Glendinning, 2002).

Besides, the political aspect stresses about good governance, possible through partnerships, is seen as essential for a healthy economy (Marra, 2004). In this regard, Linder (2000) mentions partnerships as collaborative arrangements where the differences between sectors become blurred and policymaking turns out to be a shared responsibility with transparency and accountability which would ensure good governance. In addition, the core ethical principles of partnerships proposed by WHO (1999) are, beneficence (should lead to public health gain); non-maleficence (must not lead to ill-health); autonomy (should not undermine each partner's autonomy); and equity (benefits should be distributed to those most in need).

For the purpose of the study, Partnership is defined as,

> *"A clearly defined arrangement between two or more formal organizations working together for a common and mutually agreed goal of reducing the burden of HIV/AIDS. There will be a funding partner and a program implementing partner. Nevertheless, they will be mutually involved throughout the program planning and implementation process at different levels. The implementing partner could be a NGO, CBO, for-profit or other not-for profit organization".*

1.3.1 What do partnerships try to achieve? : The Objectives

The major policy objectives of partnerships are to increase the coverage especially for essential health care priorities, improve the quality of care, and control excessive health care costs to users especially the poor and increasing the efficiency and effectiveness of services (Widdus, 2001; WHO,2007). The objectives in detail are:

- Increased coverage and penetration of services in vulnerable and hard-to-reach areas and ensuring equity.
- Improving quality of services, increasing the physical, economic and social accessibility, ensuring availability of services and acceptability of services.
- Exchange of skills and expertise between the public and private sector.
- Mobilization of additional resources.
- Improve the efficiency in allocation of resources and additional resource generation
- Strengthening the existing health system by improving the management of health within the government infrastructure.
- Widening the range of services and number of service providers.
- Clearly defined sharing of risks between the public and private providers.
- Increasing the community ownership of activities and services.
- Ensuring optimal return on government and private investments and infrastructure.

1.3.2 Benefits

A number of alliances or partnerships have been formed in response to the changing environment (Bazzoli et al., 1997; Sparer and Brown, 2000). Such affiliations create opportunities to learn from partners, increase resources, reduce organizational risk, strengthen competitive positions, gain political influence, and secure economies of scale (Bazzoli et al., 1997; Zuckerman, Kaluzny and Ricketts, 1995). Partnerships generate shared benefits not only for the partners but also for the community where it operates (Nelson et al., 1999). It maximizes health benefits for the poor and minimizes the potential risks for the partners involved. Moreover, healthy partnerships may produce socially desirable benefits (e.g. for the partner organizations involved), even if they do not result in

better outcomes such as improved health or reduced social exclusion. These benefits constitute what Huxham (1996) terms 'collaborative advantage' positive outcomes not achievable by organizations working independently. However, Mandell (2003) argues that cooperation among organizations within the private sector is supported primarily as a way to benefit the individual organizations involved, whereas partnership in the non-profit sector is championed, not so much as benefiting particular organizations, but as a means of tackling complex social problems. Smith et al. (2006) describe that despite the governance limitations, working in partnership offers two potential benefits. The first is enhanced service delivery and policy achievement through the integration of activities across agencies. The second benefit is the enhanced legitimacy of public policy decisions by engaging a wider group of interested parties. The other specific benefits of partnerships are as follows,

Efficiency: Actors from the private, voluntary and community sector have the opportunity to pool their resource strengths. The resulting synergy offers the opportunity to enhance the efficiency of service delivery.

Cost-effectiveness: Since selection of the service providers depends on competition or some bench-marking, a programme could be generally more cost effective than before.

Higher productivity: By linking payments to performance, productivity gains may be expected within the programme.

Accelerated Delivery: Since the contracts generally have incentive and penalty clauses vis-a-vis implementation of capital programmes, this leads to accelerated delivery of projects.

Clear Customer Focus: The shift in focus from service inputs to outputs create the scope for innovation in service delivery and enhance customer satisfaction. Enhanced involvement of community and voluntary organizations with dedicated volunteers provide the requisite relief.

Recovery of user charges: Wherever possibilities of recovering user charges exist, these can be imposed in harmony with local conditions.

Enhanced quality: Partnering can also be particularly valuable as a method of leveraging technical or management expertise (e.g., performance-based monitoring and incentives), and spurring technology transfer, all of which can lead to quality improvements.

In addition, there can be reduced government spending (e.g., eliminating large up-front investments of scarce public funds) and better healthcare management (e.g., of health services and infrastructure) (Nikolic and Maikisch, 2004).

However, Buse and Waxman (2001) stated that partnerships have potential risks as well. There are financial risk; performance and accountability risks; risk of confrontation between stakeholders; completion risk; termination risk and there is also the reputation risk for the private sector (Thomson and Goodwin, 2005). Partners may have different visions or goals; there may be unequal commitment in terms of time and finances; there may be disagreements in management plans, operational procedures, and future vision. In addition, there may be lack of trust, dominance and over controlling nature of one partner which may result in possible transfer of risks from the dominant partner which may harm the intended outcome of the partnerships.

1.3.3 Donor (Funding Partner) - implementer partnership

Donors or funding organizations have a basis for becoming partners if they are able to agree on a purpose, a task, a project, or a desired outcome which meets the interests of all the partners and can be achieved better, faster, or more efficiently if they unite their efforts (Bassler and Smit, 1997). Partnerships with other actors are pursued precisely because these actors have something unique to offer, whether this concerns resources, skills, services, technical assistance, implementation capacity, legitimacy, and publicity. Though partners do not always bring equal things, they contribute complementary resources to the partnership, depending on their capacity and strengths. Literature suggest the elements that should be present for a successful partnership include, mutual trust, complementary strengths, reciprocal accountability, joint decision making and a two-way exchange of information (Postma, 1994); clearly articulated goals, equitable distribution of costs and benefits, mechanisms to measure and monitor performance and clear definition of roles

and responsibilities (USAID,1997); shared perceptions and a notion of mutuality with give-and-take(Tandon,1990,98); mutual support and constructive advocacy(Murphy,1991).

However, donor-implementer or donor-NGO partnerships have provoked controversy and argument on a number of fronts. Two factors appear to be important in this regard. First, the power imbalance between donor and implementer which may inhibit the mutuality required for partnership work (Lister, 2000). The base of power is examined in terms of the resources involved in the organizational relationships and the relevance of the resource dependence perspective (Pfeffer and Salancik, 1978). These power differences undermined the mutuality needed for effective partnering. Second, donor agency administrative procedures and practices can weaken the full expression of partnership principles (Ashman, 2003). When partnerships occur along the lines of the principal-agent relationship, the principal holds authority and the latter simply receives the support. A common case has been the domination of the donors over recipients and expecting its partners to adapt to their own policies and practices rather than a mutual arrangement and the demands of the former for accountability by the latter (Brinkerhoff, 2004). This affects the core principles of partnerships. So, a symmetric relationship with the opportunity to participate and influence equally means that each actor can more easily protect its organization identity and, hence, the efficiency, effectiveness, and synergistic rewards of the partnership.

Nevertheless, major donors all over the world are implementing HIV/AIDS interventions through partnerships with NGOs, CBOs and other private institutions either directly or through a link organization in the country (IFAD, 2001; Rau, 2006; Pact, Inc, 2005; USAID and Core Initiative, 2006). Similarly, in India and particularly in Tamil Nadu, various donors or funding agencies are partnering with various implementing organizations such as NGOs, CBOs and other for-profit and not-for-profit organizations in the program or operational level. These relationships are not simply purchasing services from the implementing partner. The design of the programme, the objectives and the activities are being jointly determined and mutually agreed by the funding partner as well as the implementing partner. There is a great level of interdependence between the funding partner and the implementing partner as well. If the funding partner is said to have the

financial resources and technical expertise, the implementing partners have the human resources, community knowledge and expertise and implementation capacity which is very important for HIV/AIDS service provision. Besides, both the funding partner and the implementing partner are jointly working and involved in the implementation with clearly defined roles and responsibilities for each partner. For instance, the capacity building activities such as training, monitoring and evaluation, periodic reviews and regular technical support are being provided by the funding partner and the implementing partner is involved in programme implementation. In addition, the partners are equally accountable and responsible for the failure and success of the programmes. In many partnerships, the implementing partnerships are also required to match financial or in-kind resources to the partnerships. Thus, there is a capitalisation of complementary strengths of each partner in these partnerships for achieving the common goal of reducing the burden of HIV/AIDS.

As these relationships between the funding partner and the implementing partner have a number of characteristics of partnership and widely acknowledged as partnerships, the thesis included them in the study.

1.4 Research Issues

As huge amount of financial, human, and material resources are involved under partnerships initiatives, they need to be more efficient, effective and responsive to the need of the community (Hall et al., 2004). However, there has been mixed results related to the effectiveness of partnerships all around the world as well as in India. For instance, in the case of leprosy control in India, an organized strategy of information, education and communication (IEC) involving public and private providers has greatly improved referrals of patients for treatment (Shepard, 2001). Public-private partnership to stem blindness due to cataracts is another success where an IEC strategy has led to more than 30 percent of the cataract surgeries being done in the private sector (NCMEH and Shepard, 2001). The India AIDS Initiative (Avahan) funded by the Bill and Melinda Gates Foundation is also reported to be effective. However, to be able to demonstrate effectiveness empirically in the different settings, it is important to achieve targets in terms of coverage, increased access and achievement of other indicators, which could take a

number of years to accomplish (Williams, Foss and Vickerman, et al., 2006). Other evidences reveal that in partnership arrangements, lack of government capacity to act efficiently, and more specifically to make an appropriate decisions as to whether and when to let out contracts, to design efficient contracts and to monitor effectively have lead to inefficiency through exploitation by contractors and distorted resource allocation (Mills and Broomberg, 1998).

However, it is obvious that evidences related to partnership effectiveness are still scarce. Especially, despite continuous partnership initiatives and the substantial investment of collaborative mechanisms for HIV/AIDS activities in India, there has not been much research on the effectiveness or independent evaluation on the effectiveness of partnerships in achieving the intended results or outcome. Most of the donor – implementer partnership evaluations are either carried out by the donor or an agency appointed by the donor and such evaluations cannot be considered as an objective evaluation of partnership. Independent research using primary data is lacking in this field.

There has not been adequate research evidences to justify partnership as an effective tool in the management and control of HIV/AIDS. Ridley et al. (2001) argued that though there has been much hype and rhetoric about partnerships, it is yet to be demonstrated as superior to other ways of meeting certain health goals. Also not much is known about the conditions required for the successful design and implementation of partnerships (Mills and Broomberg, 1998). Painter and Clarence (2001) argued that theoretical benefits have been well rehearsed, but there is a lack of evidence on how best to proceed in bringing about change. Even existing partnership processes and experiences are not documented adequately (Sundaram and Holm, 2006). As partnerships have potential risks as well as benefits, adequate research aimed at identifying good partnership practice and leveraging private sector contributions to health development is vital. It is also very important to produce evidences by assessing whether or not partnership actually enhances performance, and if it improves the performance, how it is happening and the factors involved in that.

From the health system management perspective, partnerships are expected to increase the access, coverage, effectiveness, efficiency and equity by involving the potential service providers and from the HIV/AIDS disease management perspective it is expected to reach the un-reached (hitherto unidentified and untargeted high populations).

Considering all these, the main research issues concerning partnership evaluation are,

- An assessment of their effectiveness and efficiency. That is, whether or not partnerships are able to achieve what they attempt to do. Also, what types of partnership work - successes or problems concerning their structure, inputs, process and outcome? It needs to understand the process and outcome correlates.
- Whether the partnered HIV/AIDS interventions focus on the ground level issues in the community and address the hitherto untargeted risk groups who may be vulnerable to HIV/AIDS. It is, whether the partnerships address the unaddressed and reach the un-reached?
- Whether the partnerships involve the potential STI/HIV/AIDS care providers?

1.5 Objectives

The overall objective of the thesis was to evaluate the effectiveness of partnerships in Tamil Nadu in the management and control of HIV/AIDS. Particular emphasis was given to hitherto unknown and untargeted high-risk groups, their first points of contacts, and their potential and willingness to get involved in the management and control of HIV/AIDS.

The **specific objectives** were

- To identify the hitherto untargeted high-risk groups and their first points of contact for treatment, care and support.
- To enlist the existing care providers and to analyze their potential and willingness to involve in HIV/AIDS control through partnerships.
- To analyze the structure, inputs, process and dynamics of different partnership types or models.
- To determine if, and to what extent, inputs and process characteristics are associated with outcome of the partnerships.

CHAPTER-II

CONCEPTUAL FRAMEWORK AND METHODOLOGY

The increase in the rhetoric and practice of partnership is based on the assumption that partnership not only enhances outcomes, qualitatively or quantitatively, but also results in synergistic rewards, where outcomes of the partnership as a whole are greater than the sum of what individual partners contribute (Brinkerhoff, 2002). The process of creating these synergetic rewards is not only predicated on efficiency and effectiveness considerations but is expected to bring about organizational and managerial changes (Marra, 2004).

2.1 Partnership evaluation

As partnership is touted as the answer to many public service challenges, it is very important to produce evidences by assessing whether or not partnership actually enhances performance, and if it improves the performance, how it is happening and the factors involved in that (Dickinson, 2006). Therefore, an evaluation should take into account all key factors that may influence outcomes which encompass the institutions and incentives governing the implementation of policies and programs, including informal rules, regulations, controls, and structures in addition to the assessment of the achievement of the stated objectives of the particular partnership initiative (Squire, 1995). As the overall goal of the evaluation should be to assess the effectiveness of the partnerships in changing community and institutional practices, capacity, policies and action that address and prevent public health problems and promote community health, it needs to principally be measured through the eyes of service users, citizens and other stakeholders involved in the partnership initiatives (Provan and Milward, 2001).

2.1.1 Defining the success

The literature conceptualized the success of partnerships in two main ways that are process, such as how well the partners work together in addressing joint aims and the long-term sustainability of the partnership; and outcome success, including the changes in

service delivery, and subsequent effects on the health or well-being of service users (Dowling et al., 2004). More often, ineffectiveness can also be attributed to the poor inputs and design of the collaboration process. This calls for identifying the underlying causal mechanisms that link inputs, implementation processes, and outcomes (World Bank, 2006), that is, taking into consideration the dimensions of cost (monetary and non-monetary), risk sharing, accountability, power, prestige, commitment, trust and so on. Kingsley and O'Neil (2004) have also defined the performance measurement of public-private partnerships as involving the measurement of program capacities, processes, and outcomes. At the same time there are also arguments that achieving these process indicators is likely to make partnership working 'healthy', in terms of encouraging harmonious relationships and reducing the risks of time-consuming disagreement, but without necessarily affecting service outputs or user outcomes (Dowling et al., 2004). In addition, the assessment should also consider other external environment causal factors that have an effect on the progress of activities, outputs, and outcomes, such as changes in the location, the legal structure, or the governance processes of the program as well as the political, social, legal and economic context within a country during the time period of the evaluation(World Bank, 2006).

2.1.2 Input-process-outcome

2.1.2.1 Inputs

Input explains what has gone into the partnered activity, such as financial resources, human resources, technology added and money spent. A number of less tangible factors also act as key inputs to the process. Recognition of a need for partnership and willingness to collaborate are some of the less tangible resources. Besides, the literature suggest that the environmental context in which partnerships operate, the structure and configuration of participating organizations, and the nature of the potential activities will also affect collaboration (Bazzoli et al., 1997).

2.1.2.2 Process

The process measures explain the details of implementation. The process measures focus on partnership working, the relationships between partners, and the health of the

partnership (Dowling et al., 2000). The goal of process evaluation is to use data to provide a description of how the partnership is operating, compared with the manner in which the partnership is intended to operate. The power to combine perspectives, resources, and skills of a group of people and organizations has been called synergy (Lasker et al., 1997; Richardson and Allegrante, 2000). Synergy is the proximal outcome of partnership functioning that captures the mechanism that makes collaboration effective. The level of synergy is the extent to which perspectives, resources, skills of a group or an organization contribute to and strengthen the work (Lasker et al., 1997). It is one of the evaluation means of partnership, central to all partnerships. Synergy can be evaluated through the process measures.

In addition, factors such as appropriate leadership, management structures, accountability arrangements, plus audit and assessment processes are applicable to all organizational forms including partnerships. However, levels of engagement, the commitment of partners, the existence of a common purpose and vision, high levels of trust, reciprocity and respect, plus an environment susceptible to sharing, joint working and interagency activities are more distinctive features of partnership or collaborative ways of working (Dowling et al., 2004). Waddock and Bannister (1991) defined mutual trust, adequate power to make decisions(autonomy), mutual benefit, right partners, interdependency, need of partnerships, mutuality(power balance), well defined objectives, strategic review, robust monitoring mechanism, leadership as important process factors facilitating the outcome of the partnerships. Hudson and Hardy (2000) identify six principles of partnership that can be used to guide a process evaluation. Charles and McNulty (1999) suggest that the partners' attitudes and behaviours in terms of the way people deal with or react to given situations, groups, or individuals; mechanisms to deal with governance, conflict resolution, performance monitoring; and the equitable distribution of costs and benefits are important process measures.

2.1.2.3 Outcome

Outcome evaluation is the systematic identification of the effects, positive or negative, intended or not, on individual households, institutions, and the environment caused by a

given development activity such as a program or project (World Bank, 2007). An outcome can be defined as a measure of an intervention's desirable (benefits, less burden and savings) or undesirable effects (including harms, greater burdens and cost). The outcome focuses on whether partnerships lead to benefits such as better services or improved health for users (Dowling et al., 2004). Moreover, unintended outcomes that effect through partnership activities or the behaviour of agents external to the planned program results may also need to be assessed.

Currie et al. (2005) recommend that the partnership evaluation need to assess impacts on individual, organizational, and community levels. Impact has been conceptualized in terms of stages or processes such as awareness, use, and consequences of information; levels of outcome such as outputs, applications, and final outcomes (Buxton and Hanney, 1996). Asthana et al. (2002) concluded that a key outcome of partnership was the progress made in terms of shared principles, knowledge and understanding. Other literature discusses these outcomes in terms of behavioural change in individuals, service level changes, and community, social, or system level changes, such as enhanced community capacities, stronger community networks, better service integration, or greater accessibility of services in a region (Gillies, 1998; Glasgow, Vogt, and Boles, 1999; Laverack and Labonte, 2000). Different types of outcomes related to the effectiveness of health partnerships are also mentioned such as, satisfaction of stakeholders; quality of partnership plans; sustainability of the partnership; changes in community programs, policies, and practices; improvements in the utilization, responsiveness, and costs of health services; and improvements in population health indicators (Wandersman, Goodman, and Butterfoss, 1997). But, the most commonly considered success criteria are within the domains of: effectiveness, efficiency, equity, acceptability, accessibility, appropriateness and responsiveness (Thomas and Palfrey, 1996; Glendinning, 2002).

2.1.3 Existing Frameworks for assessing partnerships

Various investigators and institutions have used a variety of approaches to conceptualize partnerships success and developed their frame works for the partnership evaluation. But, most of the frameworks focused on the inputs, process and outcomes. But, a review on

partnership assessment revealed that research on successful partnership working has largely used qualitative methods (67% of the partnerships) and focused overwhelmingly on process rather than outcome issues (Dowling et al., 2004). The review by Dowling et al. (2004) also concluded that only 11 percent of the partnership evaluations included outcome measures and all the remaining included only the processes of the partnerships.

The Nuffield Institute of Health Partnership Assessment Tool (PAT) developed by Hardy et al.(2000) suggested six dimensions in the assessment of partnerships that are, recognize and accept the need for partnership; develop clarity and realism of purpose; ensure commitment and ownership; develop and maintain trust; create clear and robust partnership arrangements; monitor, measure and learn. The Verona Benchmark (Watson et al., 2000) supplemented this frame work with three additional dimensions, that are, nurture a partnership culture in individual partner organizations and groups; involve all relevant stakeholders in a meaningful way; develop effective communication. A specific framework developed for assessing partnerships comes from the US Agency for International Development's (USAID) work on inter-sectoral partnerships and the New Partnership Initiative (Charles and McNulty, 1999). Drawing upon the work of other assessment and evaluation tools, the proposed framework identifies three dimensions for assessment: values and capacity, process, and impact.

The DETR (1999) states the '7Cs of partnership working' which are clarity of leadership, understanding, purpose, role, commitment, management, and measurement. CIVICUS (the World Alliance for Citizen Participation) looks specifically at civil society and social capital, examining four facets: structure, values, space, and impact (CIVICUS, 2001). The Partnership self assessment tool of the centre for the advancement of collaborative strategies in health proposed to assess the partnership synergy, the process and outcome of partnerships which includes, the effectiveness of the partnership's leadership; the efficiency of the partnership; the effectiveness of the partnership's administration and management; and the sufficiency of the partnership's resources(CACSH, 2002).

The ADBI (2000) identifies the enabling conditions for the success of a partnership as:

- a clear understanding between the partners about mutual benefits;
- a clear understanding of the responsibilities and obligations between the partners;
- strong community support;
- the need for some catalyst to start the process of partnership (maybe an individual, a donor, a clear vision or even a political or economic crisis);
- stability of the political (government) and legal climate (laws);
- regulatory framework that is followed and enforced;
- capacity and expertise of the government at different levels in designing and managing contracts (partnership);
- appropriate organizational and management systems for partnerships;
- strong management information system; clarity on incentives and penalties

Wandersman, Goodman, and Butterfoss (1997) have focused on inputs and throughputs to understand how partnerships process resources into outcome. Those efforts have shed considerable light on various aspects of partnership functioning, such as partner participation, partner relationships, staff support, sufficiency and flows of resources, leadership, management, communication, governance, partnership structure, and the external environment. The approaches of Fawcett and colleagues (1997) and Taylor-Powell, Rossing, and Geran (1998) have emphasized the importance of process and outcome measures to guide coalition development and empowerment evaluation. Mitchell and Shortell (2000) have examined how governance and management align partnership strategy and capabilities with environmental forces. Provan and Milward (2001) have used network analysis techniques to understand how collaborating agencies integrate and coordinate their activities.

Barr (2007) suggested eight principle aspects of protocol for the evaluation of partnerships which includes the relationship; the nature; the financial arrangements; the structure, scope and functions; Government Policy, Legislation, or Regulation; issues of equity etc. Wolff (2001) presented nine dimensions that are critical to coalition success. These include

coalition readiness, intentionality, structure and organizational capacity, taking action, membership, leadership, dollars and resources, relationships, and technical assistance. In the health field, Leonard (1998) suggested assessment criteria which include: willingness to share ideas and resolve conflict, improved access to resources, shared responsibility for decisions and implementation, achievement of mutual and individual goals, shared accountability of outcomes, satisfaction with relationships between organizations, and cost effectiveness. Further, literatures explain that, in conducting formative evaluation the actions carried out in various phases of a partnership formation, implementation, and maintenance need to be looked (Butterfoss, Goodman, and Wandersman, 1996).

Each of the frameworks offers lessons as well as examples in terms of the partnership assessment or evaluation. It is also argued that these tools do not provide a comprehensive framework, and do not make explicit distinctions between inputs, processes and outcomes of successful collaboration (Asthana et al., 2002). Therefore, as recommended by Charles and McNulty (1999), there is a need for specifically designed framework with precise indicators for each of the assessment categories which can be applied to the specific partnerships, considering the entire factors specific to the situation where the partnerships operate, with the primary objective of maximizing the effectiveness of partnerships.

2.1.4 Approaches to partnership evaluation

According to existing literature, a number of the key approaches, both method- and theory-led have been used to evaluate health and social care partnerships and there are strengths and weaknesses in practice using these approaches (Dickinson, 2006).

2.1.4.1 Method led approaches

It is by using formal research methods. Method-led approaches tend to suggest that many of the problems in evaluation result from methodological shortcomings, thus refinement of research methods alone will lead to the solution of difficulties (Chen, 1990). The major method-led approaches (Dickinson, 2006) which have been employed within partnership evaluations are,

2.1.4.1.1 Randomized controlled trials

They seek to control as many variants as possible in order to isolate relationships between the variables which are the subject of the study. It is the 'gold standard' within healthcare evaluation (Davies et al., 2000) and can cover large service user groups, ability to generalize results. The disadvantages are, failure to assess the processes within the partnership leading to attribution, difficulties associated with the randomization process and the problems in identifying unintended consequences.

2.1.4.1.2 Non-randomized comparative design

It seeks to control a number of variants in order to isolate relationships between the variables which are the subject of the study. The strength of it is that it seeks to eradicate as much bias as possible through experimental approaches, can cover large service user and groups and ability to generalize results. The weaknesses are same as RCTs as well as the difficulties associated with identifying homogenous groups.

2.1.4.1.3 Qualitative methods

They tend to take more grounded approaches to research. It can accommodate multiple user perspectives and it can provide in depth account of process and context issues. But it is quite labour intensive and has difficulties in generalizing results, attribution difficulties and the difficulty to identify actions and policies and their direct effects.

2.1.4.1.4 Multi-method approach

This approach combines both quantitative and qualitative approaches to gain the advantages of both types of approaches. This approach to research on partnerships is optimal, thus drawing on differing frameworks and seeking to embrace the perspective of all stakeholders and the complexity of the phenomena under study (El Ansari and Weiss, 2006). But it does not necessarily overcome issues of attribution and has difficulties of consolidating data from different frameworks, and the possibility of confusion of which stakeholder perspectives to be accepted.

2.1.4.2 Theory-led approaches

One method of doing evaluation that is based on developing a clear understanding of the intervention process is called theory-based evaluation (Chen and Rossi, 1983). Theory in this usage simply refers to a program logic model, or "theory of change" that represents a "plausible and sensible model of how the program is supposed to work" (Bickman, 1987). It is an approach to evaluation that requires surfacing the assumptions on which the program is based in considerable detail: what activities are being conducted, what effect each particular activity will have, what the program does next, what the expected response is, what happens next, and so on, to the expected outcomes (Chen, 1990; Chen and Rossi, 1983). The evaluation then follows each step in the sequence to see whether the expected steps actually materialize. It seeks to find out whether the theories on which the program is based are realized in action (Goodman and Wandersman, 1994). So, theory based evaluation involves identifying the key service components and expected program outcomes, and working with programs to make explicit the underlying assumptions about how these service components will lead to the desired outcomes. These services, outcomes, and the hypothesized links between them are the basis for developing a program model or theory. This program theory becomes the framework to guide the development, implementation, and interpretation of the evaluation. Complexity Theory (CT) also suggests that the behaviour of partnerships will result from a dynamic interaction between the component parts over time and emerge as the 'holistic sum' of these interactions (Sanderson, 2000).

Rather than inferring causation from the input and outputs of a project, theory-led evaluation aims to map out the entire process and the expected outcome (Pawson and Tilley, 1997). This allows to declare with confidence, which parts of the programme worked and why, whether they would be applicable to different situations, and if there are any positive or negative effects which would otherwise not be anticipated (Birckmayer and Weiss, 2000). Gambone (1998) suggested that data collected without 'theory' has the status of 'information' and is limited to describing phenomena, while data collection guided by theory produces what can be called 'knowledge'. There are two major theory-led

approaches which are generally employed in the evaluation of health and social care partnerships that are,

2.1.4.2.1 Theories of change (ToC)

It is the 'systematic and cumulative study of the links between activities, outcomes and contexts of the initiative'. This approach involves stakeholders surfacing the theories underpinning how and why a programme will work in as fine detail as possible, and identifying all the assumptions and sub assumptions built into this process. ToC is concerned with theorizing prospectively, rather than retrospectively (Connell and Kubisch, 1998), with the majority of surfacing exercises taking place during the planning stage of an initiative where there is an opportunity to explore a number of competing theories between stakeholders. By specifying what will happen in terms of short, medium- and long-term outcomes of the interventions, ToC seeks to overcome issues of attribution, assists in the planning and implementation of an initiative, in-depth analysis of internal process issues and multiple stakeholder involvement.

2.1.4.2.2 Realistic Evaluation (RE)

The characteristic of this approach is to stress what the components of a good programme theory should be: context (C) and mechanism (M), which account for outcome (O). Evaluation is based on the CMO configuration. Pawson and Tilly (1997) argue that no individual-level intervention works for everyone, and no institution-level intervention works everywhere. Likewise, this realistic evaluation seeks to identify which mechanisms work for whom, and within which contexts. But the problems are, identifying the outcomes of partnership working, problems in identifying mechanisms; difficulties in conceptualizing context (Calnan and Ferlie,2003) and difficulties in differentiating mechanisms from context (Byng et al., 2005).

Dickinson (2006) argues that method-led approaches to evaluations have proved to be insufficiently complex, and have largely failed to be able to overcome the ability to attribute changes specifically to partnership arrangements. Theory-led approaches seem

better able to accommodate these complexities, and particularly, the combined use of a ToC and RE may prove the most fruitful to evaluate health and social care partnerships

2.1.5 The challenges of partnership evaluation

One of the fundamental difficulties encountered with partnerships and their associated evaluation lies in a definitional problem (Dickinson, 2006). There are various definitions as well as variety of terminologies such as partnership working, collaborative working, integration and joint-working, used to refer to this phenomenon, often interchangeably.

Evaluating partnerships is difficult for various other reasons such as, the long timescales for achieving impact (National Audit Office, 2001), different perspectives on what success means, the complexity and variability of partnership interventions, and the different contexts within which partnerships work. In addition, partnerships have very different purposes, and accordingly, there are a number of different models of partnership (Hastings, 1996). Within these models, it is likely that different stakeholders will have different goals and aspirations and having a common methodology for evaluation would be a difficult task.

Other literatures mention that there are at least two kinds of problems that can arise during evaluation. First, process and outcome variables in partnering experiences cannot be neatly distinguished in the short run. From the outset, partnership has been defined both as a process and a policy goal, thus, implementation, organization, and management are key facets of partnering, which evolve over time. Second, as the literature on implementation suggests, both a top-down and a bottom-up approach should be adopted to grasp the organizational change resulting from partners' interaction (Marra, 2004) which is also a challenging task. Regarding the outcome evaluation, demonstrating the successful outcomes of partnerships is both methodologically more complex and may be a lengthy endeavour, particularly if the successes of partnership working are iterative or cumulative (Hardy et al., 2000). There are arguments that the outcome may not be visible for some time, perhaps even longer than the lifetime of the partnership (Berkowitz, 2001; Fawcett,

Lewis and Paine-Andrews, 1997) and indicators of impact have been difficult to capture (Gillies, 1998) which in turn makes, assessing the impact of partnership a challenging task.

It is also recognized that evaluations of the impact of partnerships, with all the attendant problems of attribution and causality, are problematic (Perkins et al., 1998). The most critical aspects of partnership evaluation are attribution and establishing counterfactuals (Sullivan and Skelcher, 2002). It means that attributing the positive and negative outcomes or results to partnership initiatives and establishing counterfactual that is defining what would have happened without the partnership initiatives. Barr (2007) also elaborates that the critical and crucial aspect of public-private partnership research is the ability to identify and quantify outcomes and to establish that changes in these measures that coincide with public-private partnership efforts were actually the result of partnership activities.

2.2 Conceptual framework of the study

The key objective of this thesis was to evaluate partnerships in reducing the HIV/AIDS burden and enhancing access to HIV/AIDS care services especially to all vulnerable high-risk groups. As mentioned elsewhere, interventions in India at different levels are being carried through partnerships between the public, private for-profit, and private not-for profit sectors; partnering institutions also include the bilateral, multi lateral organizations, business organizations, private foundations, universities, voluntary Non-Governmental Organizations (NGOs), Community Based Organizations (CBOs), Faith Based Organizations (FBOs) and municipal organizations.

With numerous partnerships aiming to achieving varied goals, an evaluation of their value addition is of utmost importance. The partnership approach is expected to increase the efficiency and effectiveness as well as it is expected to bring about organizational and managerial change. The effectiveness and efficacy of partnerships are central to equitable and optimal provision of HIV/AIDS care. Ineffective partnerships could even widen the real gap in HIV/AIDS care if they duplicate efforts, double-count clients and exclude key stakeholders. On the other hand, partnered interventions need to address key issues of local relevance, target hitherto un-reached local high-risk population and include first contact points (service providers) who have the potential to carry out HIV/AIDS interventions, so as to increase the overall effectiveness of HIV/AIDS care.

The partnership evaluation framework, as described in this chapter, was developed based on the key effectiveness, efficiency and equity principles vis-à-vis HIV/AIDS care. The framework uses the theoretical concepts such as 'Theories of Change (TOC)' and 'Realistic Evaluation (RE)' besides incorporating *a priori* expectations, local needs and insights provided by the literature.

Therefore, this thesis explicitly included the inputs, processes, outcomes/impacts as key analytical components of the conceptual framework. Figure-2.1 explains the partnership evaluation framework; all the factors are inextricably linked and some even overlap.

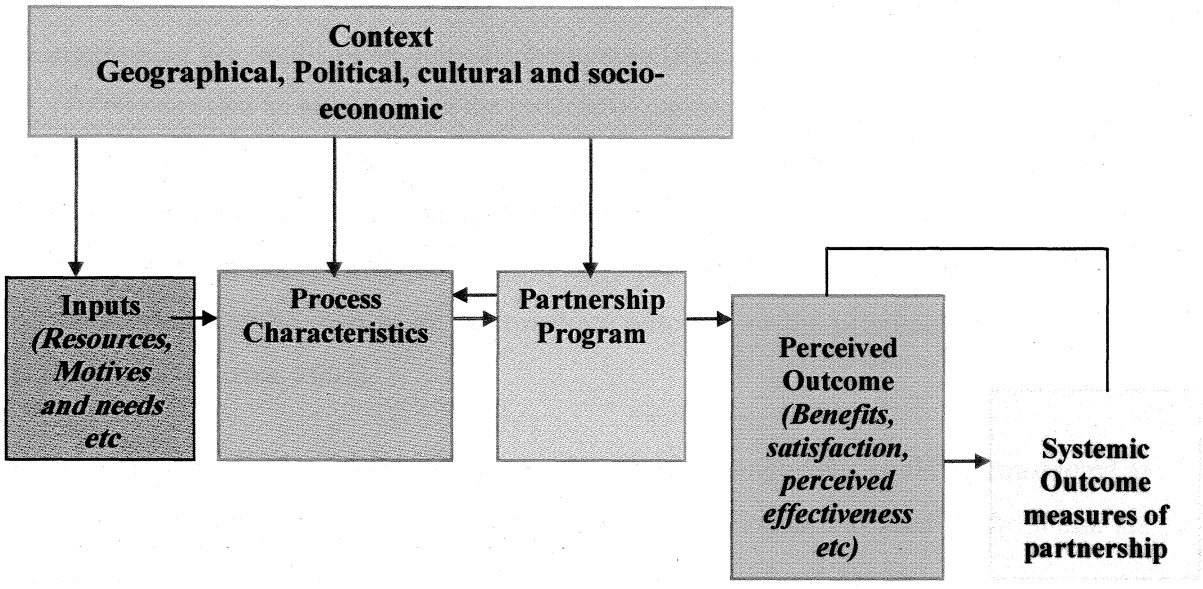
2.2.1 Inputs

Past researches have shown that the development of meaningful partnerships rests on the availability of key inputs (Asthana et al., 2002). Strategic management literature emphasizes the differential ability of organizations to collaborate and the capabilities of organizations to respond to changes in their environment and to engage in collaborative relations which will affect the effectiveness (Shortell and Zajac, 1990; Nielson, 1986). Input explains what has gone into the partnered activity such as financial and human resources, technology added and money spent. Inputs are predominantly characterized in terms of money, for example workers' salaries and, on occasion, funds for rent, administration and equipment.

In addition, to the quantitatively measurable inputs, such as budgets and staffing, the assessment also considered other less tangible causal factors that have an effect on the progress of activities and outcomes, such as the location, the legal structure, the perceived need, the motive, and the environmental context of the program.

Figure-2.1

Partnership Evaluation Framework



Key input and structural variables included in the partnership evaluation framework are:

- Financial, human and material resources
- Facilities
- Perceived need for partnerships
- Pre-partnership processes
- Partnership motives
- Partnership objectives
- Nature and type of partnerships
- Legal structure

2.2.2 Conceptualizing the success: process

In this section, various components related to the partnership process (process evaluation), assessing the extent to which the partnerships adhered to principles or characteristics associated with effective partnership, are described. This evaluation is used as mechanisms for partners to discuss, analyse, and take action to address concerns related to the partnership process and strengthen their ability to achieve the goals and objectives of the partnerships. Literature says that outcome and process evaluations are closely related and interconnected because understanding how well a program has been implemented is vital to interpreting the results of an outcome evaluation (Rossi and Freeman, 1993). Dowling et al. (2004) state that an emphasis on the process of partnerships may be seen as a pragmatic, albeit second-best, solution and argue that the health of partnerships can be assessed in the short term, and this avoids the challenge of identifying outcomes that may take a long time to materialize and also be difficult to attribute to the partnership. So, the effective process of partnership may be seen as an intermediate outcome or the proximal outcome of the partnerships (Curriea, 2005).

In the present study also, in few occasions, the process components could be considered as outcome components too. The process components developed and used in the thesis are described here after.

2.2.2.1 *Developing clarity and realism of purpose*

Successful partnerships are considered to require agreement about the purpose of and need for the partnership (Evans and Killoran, 2000; Asthana et al., 2002). A key factor for effective partnership working is a strong and shared vision for the partnership itself (Wildridge et al., 2004). From a process perspective it is also important that the mission, vision, and goals be mutually determined and agreed; this enhances the likelihood of goal attainment and the partners' commitment (Leonard, 1998). Besides, the aims and objectives which are not realistic of attainment will soon diminish enthusiasm for partnership. So, it is vital to the success of partnership working that, amongst the partners, there is an understanding and acceptance of why each partner is engaged in the partnership. This may be a blunt self-interest or narrow organizational pressure. It may, on the other hand, be an acknowledgement of a shared interest and collective purpose. Whatever the reason, partnership working can flounder if based on partner motivations and purposes that are misunderstood.

2.2.2.2 *Clear and robust partnership working arrangements*

The successful partnership would have clear and robust partnership working arrangements and create written agreement and plans that include a partnership organization form or structure, definition of geographic service area, targets to be achieved, specific standards and benchmarks for quality, identification of key health indicators, resource manual etc. The agreement is usually in the form of written contract or memoranda of understanding or statement of work. The McKinsey (2002) study identifies two fundamental prerequisites for partnership success: a simple and compelling goal, together with a clearly defined and focused scope (disease, geography, population, activities). This principle refers to the need to ensure that partnership working is not hindered by cumbersome, elaborate and time-consuming working arrangements as well. The evidence is that complex structures and processes reflect partners' defensiveness about their own interests and uncertainty about degrees of mutual trust (Slater et al., 2007). The result of such excess bureaucracy is frustration amongst the partners and a sapping of their enthusiasm for, and commitment to, the partnership (Hardy et al., 2000). Moreover, partnership agreement needs to make it clear and transparent about what financial

resources (capital and revenue) and other tangible resources (human resources and facilities) the other partners brings to the partnership activities which would facilitate its smooth functioning.

2.2.2.3 Internal Governance

Successful partnerships establish clear governance structures which define the various roles that partners will play and ensure that all partners understand and accept these roles (Smith et al., 2006). The main governance functions examined in the Mectizan Donation Programme(MDP) partnership include the factors such as creating a vision; securing resources; defining clear roles and responsibilities; establishing and monitoring benchmarks for performance; accounting to key stakeholders for the organization's direction and performance(Peters and Philips, 2004). McKinsey report (2005) describes that explicitly defined roles are required to optimize partnership performance. Poor specificity can lead to failure to deliver critical inputs as well as to misunderstandings both of which undermine collective working arrangements and impede performance monitoring and accountability. Poor governance habits including: failure to clearly specify partners' roles and responsibilities; inadequate performance monitoring; insufficient oversight of corporate partner selection and management of conflict of interest; and a lack of transparency in decision making (Buse and Harmer, 2007). In order to have successful partnerships, it is recommended that strategic, value-added, and operational-cum-business plans with measurable outputs and outcomes, and clearly defined roles for all partners, need to be developed ex-ante and regularly reviewed.

2.2.2.4 Accountability

Satisfactory accountability arrangements, plus appropriate audit, assessment and monitoring of the partnership are regarded as essential for successful partnerships (Charlesworth, 2001). Those involved in partnerships need to know how they and each other are accountable for partnership work, both to their own organization and to the partnership as a whole. Formal structures and processes need to be in place that facilitate and guarantee the horizontal and downward accountability. Firstly, the partners of a partnership are horizontally accountable to each other. Secondly, the partnership itself is

downwardly accountable to its stakeholders. And thirdly, each partner is downwardly accountable to their individual set of stakeholders and to the service-users and the public. Balancing these different relationships is complicated. An accountability deficiency in one of these relationships can impact upon the others. Lack of accountability in a partnership between the partners may result in a partner being forced to make compromises and concessions that reduce its accountability to the ultimate beneficiaries (Hale and Mauzerall, 2004)

2.2.2.5 Transparency

Partnerships need to be adequately transparent to be successful. Successful partnerships are truly authentic, promoting transparency and accountability (Rasmussen and Agarwal, 2000). There should be transparency right from the beginning of selection, decision making and implementation of the partnered activities (Buse and Harmer, 2007). During the partnership process, transparency is vital in the bidding and contracting process, as well as the contract arrangements themselves and it should help eliminate incentives for any potential asset-stripping and rent-seeking behaviour by the private partner (Nikolic and Maikisch, 2006). Transparency is most commonly operationalized as formal information exchange requirements and response to specific information requests. Transparency can also be less formal and/or structured, such as impromptu telephone calls, e-mails, and conversations.

2.2.2.6 Resources Flow

Partnership involves a commitment of resources, time and effort by individuals from all partner organizations. Adequate and necessary resources to carry out planned activities or to finance the true costs required for partnership is essential for the success of partnerships (Wildridge et al., 2004). Research draws attention to the funding crisis plaguing many partnerships around the world and as a result, there is a danger that some partnerships will simply collapse because of lack of financial support (Buse and Harmer, 2007). Moreover, constant resource mobilization is needed to sustain the partnership activities. In addition to this, one of the critical issues in partnership, all over the world, is the timely release of grants or reimbursements to the partners (Venkatraman, 2000). The entire issue of timely

release of payment appears to be a sensitive one, and the private partners underplayed their difficulties. It is not only financial resources but also human resources, other equipments and materials, non monetary resources like training and expertise are also important for the success of partnerships.

2.2.2.7 Partnership Interdependency

This refers to the extent that partners depend upon each other to accomplish the partnership objectives. Dowling et al. (2004) defined that basic element of successful partnerships are the degree to which aims and vision are shared, and the existence of interdependency between partners. Three types of interdependence have been identified: pooled, sequential and reciprocal. Pooled refers to relationships that are not highly interdependent where each partner works fairly independently. Sequential refers to relationships where the work of one partner feeds into the work of another partner and this second partner is not able to proceed until the work of the first partner is accomplished (Kinglsley and O Neil, 2004). Under reciprocal interdependence each partner must share work back and forth until it is completed. Reciprocal relationships are the most interdependent and successful form of partnership.

2.2.2.8 Co-ordination with the existing health system

The Partnerships especially the health related partnerships need to work in coordination with the existing health system to achieve maximum reach and effectiveness. Nishtar (2004) narrated that global principles must specify that partnerships should be in harmony with national health priorities; they should complement and not duplicate state initiatives and should be optimally co-ordinated and integrated with national health systems without any conflict of interest. The co-ordination with the existing health system would ensure sustainability of the programmes as well.

2.2.2.9 Inclusivity or participatory

This is the extent of the partnership's involvement of all the key players- public, private, community and voluntary sectors and service users including businesses, business organizations employees, unemployed etc (Mouawad et al., 2004). A good partnership will

involve both parties in the strategic planning process, i.e. determining population needs, deciding on appropriate patterns of service provision and their inter-relationships, designing systems and identifying resources to meet need (Field and Peck, 2004). Successful partnerships will make decisions and strategies in consultation with all the partners and stake holders. But usually, the decision-making process in a partnership may be biased because of the stronger partners' influence. At a county level and in the case of governments interfacing with NGOs, the stronger partner, which is usually the government generally tends to make the rules (Nishtar, 2004). Also, inclusive approach ensures that that all partners have the capacity to be fully engaged in the partnership and works democratically with accountability to stakeholders and decisions open to scrutiny which would enhance the success of partnership.

2.2.2.10 Risk Management

There is a growing belief that public and private sectors in health can potentially gain from one another (Bloom et al., 2000; Agha, 2003). At the same time, the sharing of risks is also a key driver for a quality private partner to enter into a collaboration or partnership. The success of partnership depends on the successful identification, allocation, mitigation, and management of risks (Sachs et al., 2007). So, each partner should ensure that contracts are based on realistic evaluations of the situation and do not transfer unmanageable risks to the other partner. Buse and Waxman (2001) mention that partnerships have potential risks as well as benefits and the more critical factors are the ability to reduce the potential risks to the partner organizations. Successful partnerships aim to maximize health benefits for the poor and minimize potential risks for the partners involved (WEF, 2005). Marra (2004) argues that the efficiency needs to be assessed in relation to the risk sharing arrangements. At the operational level, the risks for both the partners are on many dimensions. There are financial risk; performance and accountability risks; risk of confrontation between stakeholders; completion risk; termination risk and there is also the reputation risk for the private sector. While the for-profit private sector may well be capable of withstanding any financial risks during the implementation, any error on the part of not-for-profit agency could close down the organization. In allocating risk in a partnership, it is a general

principle that risk should be carried by the party which is best able to control, manage, or mitigate that risk. .

2.2.2.11 Developing and maintaining trust

Trust is emphasized as a key element of an effective partnership (Parkhe et al., 1998; Adams and Goldsmith, 1999). The phrase 'trust but verify' is reiterated in various studies to indicate the importance of both trust and transparency between partners (Druce and Harmar, 2004). Partnerships evaluated as less effective in generating consensus and delivering results also tended to have partners who were less trustful and more critical of each other, and less clear about their roles. The consensus is that, although it is possible to work jointly with little trust between partners, the most successful partnerships have (and, through hard work, maintain) a strong level of mutual trust (Wildridge et al., 2004). Truly working in partnership requires more than just occasional multi agency meetings: it calls for a substantial degree of commitment and trust amongst organizations, otherwise partnership may fail (Huxham and Vangen, 2000).

2.2.2.12 Flexibility

Without trust you just do not have a partnership to start with and without flexibility, the relationships on which your partnership rests can become very shaky (Diarra, 2001). Trust, flexibility, persistence, endurance are important keys to a strong, dynamic partnership. A striking finding across several reviews is that, where one important partner's role is perceived as over-controlling, dominant, exclusive, non-consultative, these partnerships were also perceived as less effective in terms of their outputs. Also, partnerships need to be sufficiently flexible to accommodate changes in the physical, economic, social, political and technological(PEST framework) aspects of the environment (Druce and Harmer,2004).

2.2.2.13 Leadership

It is often observed that partnerships are formed between organizations but succeed because of individuals who are strong leaders and who champion the partnership projects with vision, energy and enthusiasm(Venkataman and Björkman,2002). Evidence suggests that active leadership is a critical input in determining the extent and pace of partnership

development at all levels in the partnership (Ashthana et al., 2003). There is also evidence that key personalities can act as barriers to effective partnership working (Maddock and Morgan, 1999). Besides, a successful partnership can result only if there is commitment from "the top leaders" of both the government and private sector organization to work together (NASCIO, 2006). Senior management support contributes to partnership performance both directly and indirectly. Directly, such support translates into resource commitments (e.g. financial, personnel, etc.) and often entails flexibility and consequent time savings in terms of making adaptations to standard procedures to accommodate partner preferences and constraints, or to maximize partnership performance. Indirectly, the participation and support of senior management symbolize the organization's commitment to the partnership and its success, contributing to trust building among partner organizations.

2.2.2.14 Ensure Commitment and Ownership

Successful partnerships are believed to depend on the level of engagement and commitment of the partners (Dowling et al., 2004). Partnership working cannot be guaranteed to be characterized by either spontaneous growth or self-perpetuation, therefore the understandings and agreements need to be supported and reinforced. It should be ensured that across the partners there is a widespread commitment to, and ownership of, partnership working; and, especially, a sufficiently senior level commitment (Smith, 2006). Organizational commitment to partnership working is more likely to be sustained and commitment, at whatever level in the organization, needs to be consistent (Hardy et al., 2000). It is identified regular team interaction; human factors such as loyalty, commitment and the enjoyment of working together and the clear objectives as important factors for success (Reich, 2000). Stern and Green (2005) provide pragmatic definition and argued that partnership is a programme that has a high level of commitment, mutual trust, equal ownership and the achievement of a common goal.

2.2.2.15 Communication

Communication refers to the frequency with which partners interact and the direction of these interactions. The role of clear, consistent communication is implicit and sometimes

explicit in much of the partnership literature. Open, clear, frequent and accessible communication between the partners and the relevant stakeholders are very important for the success of partnerships (Elkins, 2002; Wildridge et al., 2004). It is critical to create trust in dispersed organizational forms, such as partnership, and trust is critical to partnership functioning. Communication with the partners (horizontal), the community (downward) and other stakeholder (upward) are very important for an effective partnership approach. It involves timely sharing of information, accurate and consistent messages conveyed to key audiences, realistic messages from trusted sources that set realistic expectations. Providing accurate and timely information is both a professional duty and an expression of respect (Peterson, 1997) and effective communications are the key to the public' understanding of public-private partnerships. So, communications are required to be planned and carried out as an integral part of the management process for any partnership initiatives.

2.2.2.16 Mutuality

Mutuality is the degree of equality in the interactions among organizations (El Ansari and Weiss, 2005). Mutuality encompasses the spirit of partnership principles and it can be distinguished as horizontal, as opposed to hierarchical, coordination and accountability, and equality in decision-making, as opposed to domination of one or more partners (Brinkerhoff, 2002). The opportunity to participate and influence equally means that each actor can more easily protect its organization identity, and hence the efficiency, effectiveness, and synergistic rewards of the partnership. With mutuality, partners can more easily raise new ideas and propose new, more effective approaches. Mutuality enables partners to contribute to the partnership with fewer constraints (e.g. approvals, scrutiny, regulation and other forms of interference) and greater legitimacy. Mutuality can help to ensure acceptance of the partnership's policy and procedures, and ease their implementation, when each actor has agreed to them and feels a sense of ownership. Besides, success deriving from alliances is based on a 'relatively even, but not equal exchange of benefits and resources' (Whipple and Frankel, 2000,). The important element is that partners need to determine for themselves if they are satisfied with the relative evenness of the benefits and costs of the partnership work.

2.2.2.17 Autonomy

One of the cornerstones of true partnership is the relative autonomy enjoyed by both the partners on day-to-day operations as well as in the overall management of the partnership. According to WHO (1999), one of the core elements of viable partnership is autonomy. Autonomy is seen as non-intrusiveness, from the public sector and the freedom of the private agency to take operational decisions without having to resort to cumbersome bureaucratic approvals or being constantly told about "do's and don'ts". It is also essential for the public sector to respect the organizational autonomy and priorities of the non-profit sector (Nishtar, 2004)

2.2.2.18 Complaint or conflict management

Conflict management is that, how well the partnership manages conflict that arises among members (El Ansari and Weiss, 2005). In any collaborative effort, conflicts will arise and a key to the success of any collaboration has to be the minimization of conflicts and the effective management of them. Conflict resolution of partnership is one of the functioning measures to capture group characteristics and process variables (Roussos and Fawcett, 2000; El Ansari, 2003). Conflicts over resources may also lead to 'cost shunting' between or within partner agencies and this can build distrust (Wildridge et al., 2004). Political science emphasizes the importance of coalitions in negotiating potential conflicts among members so that collaboration can occur and provide desired benefits to participants (Kimberly, Leatt and Shortell, 1983). Differences in personalities and their respective styles could jeopardize the functioning of the partnership. So, conflict resolution and consensus-building is an important process for the success of any partnership (Asthana et al., 2002). But, the absence of conflict may also imply that mutual influence is compromised or non-existent (Brown and Ashman, 1996).

2.2.2.19 Monitor, measure, review and learning process

Partnerships need to monitor and respond to changes, by undertaking regular strategic reviews and redefining objectives. Performance monitoring refers to the ongoing process of collecting and analyzing data to measure the performance of a program,

process, or activity against expected results(Charles and McNulty, 1999). On-going monitoring of the performance of the partnership is important in assuring its success. Monitoring and evaluation are important in order to share successes with the partners, learn from mistakes, modify program activities as necessary, demonstrate accountability to funders and others who are in a position to make decisions about the future of a program, and to help stakeholders learn (THCU, 2005). Satisfactory accountability arrangements, plus appropriate audit, assessment and monitoring of the partnership are also regarded as essential for successful partnerships (Campbell, 2001; Charles worth, 2001).

2.2.2.20 Organizational identity

Organization identity generally refers to that which is distinctive and enduring in a particular organization. Each partner has individual identity and competitive advantage as separate organization enhanced through partnership (Brinkerhoff, 2002). It is the extent to which an organization remains consistent, committed, accountable, and responsive to its mission, core values, and constituencies. The key is not necessarily to maintain organization systems, processes, and strategies over time, but to maintain the organization's core values and constituencies. The partners need not compromise their original vision and mission of the organization in order to partner with another organization. Instead the resources of each organization can be efficiently utilized to have a synergy and competitive advantage to achieve the combined goal through the partnerships (Ensign et al., 1998). Partnerships with other actors are pursued precisely because these actors have something unique to offer (Brinkerhoff, 2002). If organization identity is lost, by definition comparative advantages are lost, the organization loses legitimacy in the eyes of its defined constituencies, and its effectiveness wanes.

2.2.3 Conceptualizing the outcome

It is often claimed that partnerships should be measured in terms of their outcomes rather than their processes (Klein, 1988; Hardy et al., 1992). Dowling et al. (2004) explained that evaluating health and social care partnerships in terms of their outcomes has two potential dimensions that are, the changes that result in the levels, organization or delivery of services; and the improvements (or absence of deterioration), if any, that may subsequently arise in the health status, quality of life, well-being or social inclusion of patients or users. This positivistic model of evaluation assumes that outcomes can be measured against pre-specified criteria and subsequently inform judgments of economy, efficiency and effectiveness (Ross and Kemshall, 2002). It is also proposed difference elements such as coverage and take-up of a service; effects on other parts of the (health) system; adoption of norms and standards advocated by the partnership; and improvements in the life-conditions of people for whom the partnership was established (Druce and Harmer, 2004).

In this study, outcome measures were divided into two categories - perceived outcome and systemic outcome.

2.2.3.1 Perceived outcome

The partnership outcome is described, as perceived by the partners. Evaluating value-added due to the partnerships can be done primarily, though not exclusively, by assessing the perception of the beneficiaries (partners) and it is often closely related to partner satisfaction as well (Brinkerhoff, 2002). The perceived outcome components included in the study are the following,

2.2.3.1.1 Satisfaction with partnerships

Satisfaction with the partnerships is based on the notion that success is determined, in part by how well the partnerships achieve the performance expectations set by the partners (Anderson and Narus, 1990). Also partnership which generates satisfaction exists when performance expectations have been achieved (Mohr and Spekman, 1994). So, partnerships is expected to increase the satisfaction of the partners in terms of their role, involvement, influence and functioning of partnerships.

2.2.3.1.2 Reduction in the duplication of efforts

It is one of the important expected results to increase the overall efficiency of partnerships (Dowling et al., 2004). It is also envisaged that the synergy between the partners will reduce the duplication of efforts and wastage of funds (MOHFW, 2004).

2.2.3.1.3 Capacity enhancement

Partnership initiatives are expected to enhance the technical, managerial and organizational capacity of the organizations and individuals involved in the partnerships (Walker, 2007; Vian et al., 2007).

2.2.3.1.4 Target accomplishments

The real effectiveness of any partnership initiatives is the delivery of the Partnership's own targets (Barr, 2007; Mouawad et al., 2004). This included the intended targets as planned by the partnerships initiatives.

2.2.3.1.5 Increased coverage

There are plenty of literatures mentioning, increase in the coverage of services as one of the important objective as well the expected results of partnerships (Druce and Harmer, 2004). This component included both geographical coverage as well as population coverage of partnered interventions.

2.2.3.1.6 Increased resource mobilization and pooling of resources

Resource mobilization is the process by which resources are solicited by the program and provided by donors and partners. This is particularly important for partnerships as they are typically externally financed programs with little or no capacity to earn income from their own resources. Mobilizing and pooling resource includes financial, commodity and human resources.

2.2.3.1.7 General community and target community involvement

Smith, Mathur and Skelcher (2006) said that community consultation and involvement would shape and influence the goals, operation and decision-making of the partnership according to the community need. Participation of community members ensures that the project is representative of the community. Though it is also a process, as community involvement and target group involvement is widely advocated in HIV/AIDS programmes, it has been considered as an expected results and hence included as an outcome component.

2.2.3.1.8 Benefits of partnerships

Healthy partnerships may produce socially desirable benefits (e.g. for the partner organizations involved), even if they do not result in better outcomes such as improved health (Gulliver et al., 2000; Dowling et al., 2004). According to Barr (2007) the expected benefits of the partnership relationship will be an important part of the analysis of the effectiveness of public-private partnerships. The major expected benefits of partnerships are, better ability to address HIV/AIDS, enhancement of public reputation, increased utilization of the expertise from other partners, better understanding of community needs and increased involvement in policy making.

2.2.3.2 Systemic outcome

Major criteria for successful systemic partnership outcome as seen by this thesis are described in the sections that follow,

2.2.3.2.1 Equitable services

Equity is concerned with creating equal opportunities for health, and bringing health differentials down to the lowest level possible. It is cross-cutting and involves issues of access, quality, and financing especially for the most vulnerable groups of the population. Whitehead (1992) defined health inequities as differences in health that are unnecessary, avoidable, unfair and unjust. Nishtar (2004) stated that the driving principles for partnership initiatives be rooted in 'benefit to the society' rather than 'mutual benefit to the

partners' and should centre on the concept of equity in health. The inequities in accessing the services related to HIV/AIDS are significant as this disease affects the most poor and vulnerable population. Especially, access to effective HIV/AIDS treatment, for example, remains largely inequitable worldwide (Zwi et al., 2007). Partnerships have been explored as a mechanism through which to mobilize additional resources and support for health activities, particularly in under-resourced developing countries in order to reduce the inequity (Venkatraman, 2002). Barr (2007) stressed that research on the effectiveness of partnership efforts should include specific details regarding the effect of the partnership efforts on equity for vulnerable groups as an outcome distinct from the assessment of overall effectiveness. This includes issues of gender, racial or ethnic, geographic and economic equities. Dowling et al. (2004) says that it could include both horizontal and vertical equity. This has been assessed through examining the distribution of services in relation to need and the utilization.

2.2.3.2.2 Increased Efficiency and Effectiveness

The most important benefit and expected outcome of the partnerships initiatives are improved efficiency and effectiveness. Working together seeks to meet the objectives of each by performing better than either one acting alone. Thus, effectiveness and efficiency are key evaluative criteria to assess partnerships (Rosenau, 2000)

Effectiveness, as against efficiency, is the achievement of stated objectives and the extent to which each objective has been achieved which depends on clear objectives being set by the partnership (Thomas and Palfrey, 1996). Effectiveness is concerned with the success of those stated intentions, and with the desired results, for example the reduction of problematic behaviours (Ross and Kemshall, 2002). The effectiveness can be measured by assessing the changes in the community and institutional practices, capacity, policies and action that address and prevent public health problems and promote community health. The assessment of effectiveness should not be limited to the achievement of expected outputs and outcomes, but should also cover unintended outcomes, whether negative or positive also.

Efficiency is the extent to which the program has converted or is expected to convert its resources and inputs (such as funds, expertise, time, etc.) economically into results in order to achieve the maximum possible outputs, outcomes, and impacts with the minimum possible inputs. According to Smith et al. (2006), partnerships create an opportunity to pool their resource strengths and the resulting synergy offers an opportunity to enhance delivery efficiency. It also involves rationalizing health inputs to ensure maximum output. In addition, a partnership to improve efficiency considers complementarities and minimizes duplication of services where possible (Dowling et al., 2004). Efficiency in its widest sense also implies that consumer preferences are served optimally.

2.2.3.2.3 Improved Accessibility of services

One of the important expected outcomes of partnership initiatives is improvement in the accessibility of services (Brown et al., 2003). This includes the geographical, economical, social and cultural accessibility and the partnerships are expected to address the barriers affecting the accessibility. Greater accessibility of services is considered as one of the long term impact of partnership initiatives (Gillies, 1998; Glasgow, Vogt and Boles, 1999; Laverack and Labonte, 2000).Accessibility is an eclectic criterion, which may refer to access to information about services, distance to services, and processes of assessment and waiting for services (Glendinning, 2002). Users of services are likely to value this issue highly, as it impacts significantly on their ability to use services appropriately. Measures that have been used to assess this outcome are whether clients experience earlier interventions through a quicker response from service providers, and the convenience of the service location without any barriers.

2.2.3.2.4 Improvement in the quality of services and client satisfaction

The partnership initiatives are expected to provide quality of services to the targeted beneficiaries with increased responsiveness and choice. Quality of services delivered through partnerships is one of the outcome success criteria (Burch and Borland, 2001; Linder, 2000; Rosenau, 2000). The perception of the service users regarding quality of services and the satisfaction could be measured, that are key expected outcome of the partnership initiatives.

2.2.3.2.5 Responsiveness

The World Health Report (2000) describes responsiveness as "meeting the expectations of individuals' non-health enhancing aspects of care". This also refers to the speed and accuracy with which a service provider reacts to a request for action or information (Thomas and Palfrey, 1996). Service users are likely to value responsiveness very highly as it is of direct relevance to their experience of the service. It can be achieved by providing, the population with a choice of health provider, providing services with respectful treatment, involving the individual in deciding the treatment or services option, maintaining confidentiality of personal information, prompt attention without much waiting time and by maintaining quality of basic amenities.

2.2.3.2.6 Community and target group involvement

Successful partnerships involve the community and include them when developing programs and services. Community involvement can also ensure that programs and services developed by a partnership are culturally and linguistically appropriate for the populations being served. The greater the level of local community involvement in setting agendas, the larger the impact and the more sustainable the gains (Gillies, 1998). Community participation is described as essential to ensure that real needs are being met and that the decisions reached are acceptable to local communities (Jones, 2000). By involving the community in different levels, the partnership arrangements can give communities a vehicle to express their views, gain access to decision-makers, and develop more knowledge of how the anchor institutions are structured and behave. Partnerships are expected to maximize the level of community involvement in planning, decision making, implementation and evaluation of partnership initiatives to ensure maximum benefits from the investment. Therefore, partnership evaluation focussed to examine the nature and extent of community and target group involvement.

2.2.3.2.7 Health system strengthening

Druce and Harmer (2004) describe that strengthening the existing health system by improving the management of health within the government infrastructure is one of the

expected outcome of the partnerships related to public health. There is also a growing international interest in a better integration of HIV programmes and health system strengthening. UNAIDS (2009) advocates that there is a need for promoting health system thinking in all HIV-related partnerships and the private sector should be guided to apply a health system perspective to all HIV and health-related projects. It also argued that continuous multisectoral interventions with a renewed focus on public health systems strengthening with full and active participation of the private sector are needed. According to UNAIDS (2009), the AIDS related partnerships are expected to contribute to the building blocks of a health system as defined by the World Health Organization(2007) that are service delivery; human resources; information; medicines and technologies; financing; leadership and governance.

2.2.3.2.8 Sustainability

Sustainability is a key requirement for partnership success and a major challenge for such organizations (Alexander et al., 2003). Successful partnerships work to maintain the momentum and to sustain their work over time which is one of the outcomes related to the effectiveness of health partnerships. Sustainability is the continuation of benefits from a development intervention after major development assistance has been completed. The mixed system (Public-Private Health system) created would be stronger and can compensate for weaknesses in either provider. Another aspect of sustainability is the sustainability of the network, the relationship among the partners after the immediate issue which brought them together has disappeared and the partnership has disbanded (Charles and McNulty, 1999). It is important to assess the measures taken by the partnerships to ensure the sustainability of the program with regard to financial, institutional, and other resources. It is also important to know the proportion of partnerships sustaining after the funding period is over.

2.2.3.2.9 Improvement in the health seeking behaviours and Health improvement

The overall objective of the health related partnerships is to increase the health seeking behaviour of the targeted populations and to improve their health status. There are several studies which mentioned that improvements in the health status, quality of life or well-

being experienced by people using services, or reductions in otherwise likely deteriorations in their health as important outcomes of the health related partnerships(Gulliver et al., 2002;Brown et al., 2003; Dowling et al., 2004). This outcome could be measured by examining the improvements in the health, as perceived by the services users. In addition, other important expected outcome is to increase the health seeking behaviour of the infected as well as the other vulnerable populations.

2.2.3.2.10 Issues of local relevance

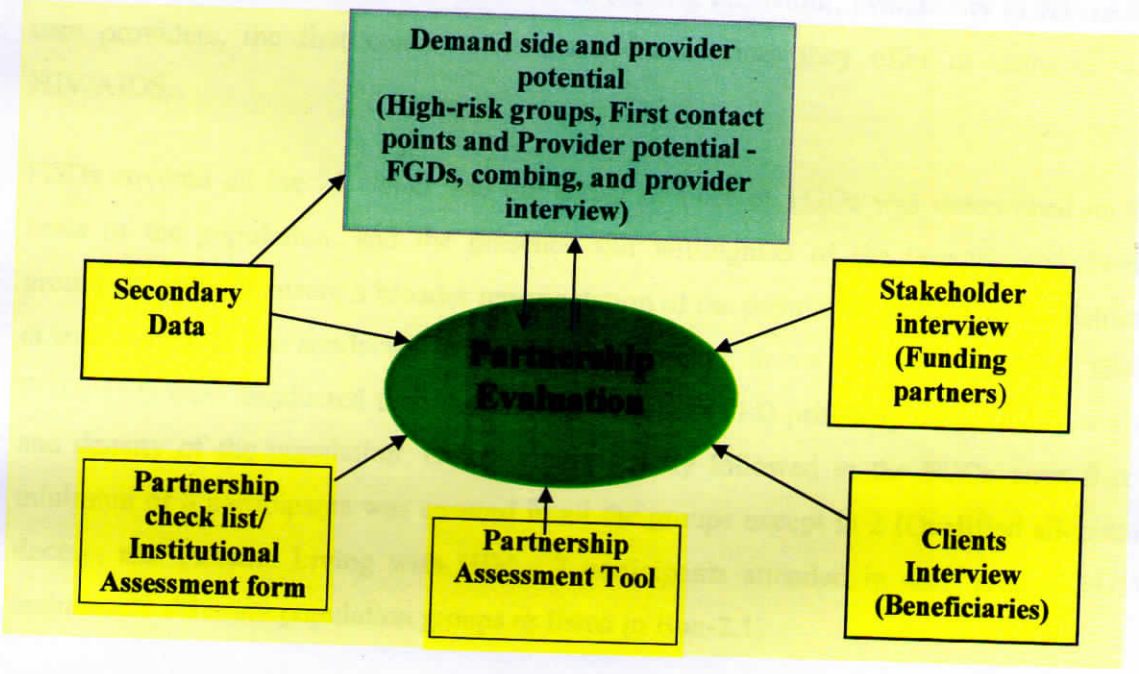
In the end, partnered interventions in HIV/AIDS are required to address issues of local relevance, target locally relevant high-risk population and include the potential first contact points or the local providers of HIV/AIDS and STI care. The HIV/AIDS partnerships can be effective in increasing the access of HIV/AIDS services if the potential local service providers or the first point of contacts are involved in the partnered interventions. There are evidences to pronounce that there are different kinds of providers providing HIV/AIDS related services and these providers, irrespective of the system of medicine they practice, are sought for HIV/AIDS related services (Mignone et al., 2007; De Costa and Diwan, 2007; Solomon et al., 2002). It is well documented that the infections have already moved from the conventional high risk groups to the general population and from urban to rural populations. So there may be many high risk groups who are equally at risk for infection but are currently "invisible" to program designers, especially heterosexual married women who have monogamous sexual relationships with their husbands other than the conventional risk groups like FSWs, MSM, IDUs and truckers. In order to reduce the transmission and the burden, the partnered interventions need to involve the locally relevant high risk populations as well.

So, the thesis tried to understand whether locally relevant issues, all the high-risk groups and potential providers were part of local partnerships so that their effectiveness can be maximized.

A bottom-up or demand-led approach was employed in the thesis. Accordingly, the evaluation methodology started with the assessment of community needs, locally relevant issues, opportunities, and approaches vis-à-vis HIV/AIDS. It then moved on to first contact points, established HIV/AIDS care providers; and subsequently to institutions or organizations followed by partnerships. Hence, there were four distinct data collection phases. While the secondary data and the literature (published academic journals, articles, books, annual reports and other documents of partner organizations, reports of the public and private funding agencies, communications from agencies and people working on HIV/AIDS and other records) provided the basic background and the state level data on this topic, separate tools were used during different phases of the study (Figure-2.2).

Figure-2.2

Framework of Methodology



2.3.1 Study setting

The phased data collection was executed in three districts in the state of Tamil Nadu. In order to capture the variation in the clients, providers and partnerships in its entirety,

districts (one each) were chosen from the southern, middle and northern Tamil Nadu regions; their Geographic locations are indicated in Figure-2.3 while their basic profile is given in Table-2.1. As it can be seen from Table-2.1, total population covered by different phases of the study was 7.1 million with the chosen districts together having 23 *taluks*[6] (sub-districts), each having a population of about 0.3 million on the average.

2.3.2 Phase-1: Understanding the demand side

The first phase stage of the study concentrated on identifying and understanding various ground level HIV/AIDS issues including the hitherto unidentified and untargeted high-risk general population who are vulnerable to the spread of HIV infection. It also tried to understand their care seeking and their first points of contact for HIV/AIDS related care. The main methodology for the first phase of the data collection was Focus Group Discussions (FGDs) using the guidelines. The major themes or issues discussed in the FGDs were high-risk sexual behaviour, particularly among the unconventional and untargeted risk groups, STI, HIV/AIDS care seeking behaviour, availability of HIV/AIDS care providers, the first contact points and the services they offer in terms of STI, HIV/AIDS.

FGDs covered all the 23 *taluks* and the actual number of FGDs was determined on the basis of the population, and the presence and willingness of the targeted stakeholder groups. In order to ensure a broader representation of the population in the chosen districts, at least one FGD was conducted in each block. However, in one district (*Namakkal*), fewer FGDs (12) were conducted than the number of blocks (14) primarily due to the low size and density of the population. Other criteria strictly followed in the FGDs were that a minimum of 8 participants was ensured in all the groups except in 2 (Qualified allopathic doctors and Patients Living with HIV - 7 participants attended in each group). FGDs included 21 different population groups as listed in Box-2.1.

---

[6] *A Taluk is an administrative division in the federal set-up in India.*

Figure-2.3

Location map of the chosen districts[7]

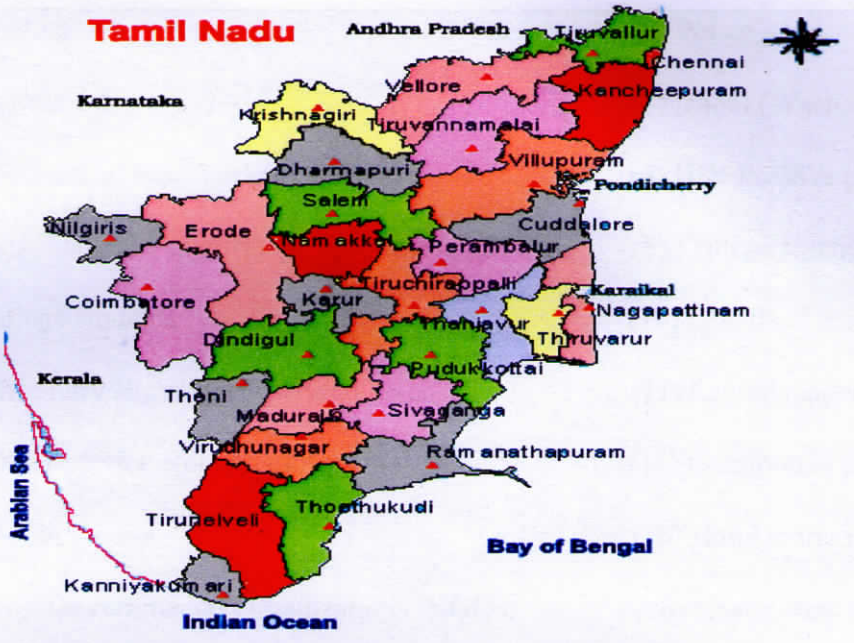


Table-2.1

Basic profile of the chosen districts

Name of the District	Population Size	No. of *Taluks*	No. of Blocks	No. of health sub centres[8]
Tirunelveli	2,723,988	11	19	383
Namakkal	1,493,462	4	14	240
Kanchipuram	2,877,468	8	13	352
Total	7,094,918	23	46	975

[7] *The chosen districts are indicated using the red colour.*

[8] *Health sub-centres are the first rural points of contact for formal health care under the public sector. Each sub-centre covers about 5,000 people in plain areas and 3,000 in hilly or difficult terrains.*

Box-2.1

Population groups covered under the FGDs

(1) Doctors	(2) Police
(3) Pharmacists	(4) Dhobi (Washer men)
(5) Commercial Sex Workers (CSWs)	(6) HIV Positive people
(7) Less-than-fully qualified practitioners (LTFQs)	(8) College teachers
(9) College students	(10) Qualified nurses
(11) Auxiliary Nursing Midwives (ANMs)	(11) School teachers
(13) Other service employees	(14) Community members
(15) Youth groups	(16) Hotel workers
(17) Non-Governmental Organizations (NGOs)	(18) Health care workers
(19) Self help groups	(20) Truck drivers
(21) Men having sex with men (MSM)	

In order to effectively conduct the FGDs, assistance was sought from local NGOs/CBOs, different associations, self-help groups, principals of colleges, Head masters of schools and local community leaders or representatives. Before conducting the FGDs, the investigator explained in detail about the study and made sure that utmost confidentiality would be maintained. After getting the verbal consent of each participant from the group, FGDs were conducted. The entire proceedings were audio recorded. It was also written down by a research staff besides the notes taken by the researcher. Using the notes and the audio recordings, all the FGDs were transcribed. The FGDs were conducted in the local language (Tamil). Participation was voluntary and participants were not given any monetary remuneration. They had the option and freedom to deny or withdraw from participating in the FGDs.

2.3.3 Phase-2: Understanding the first contact points

The second phase was conducted to understand the first contact points of those who are in need for STI, HIV/AIDS related services. The aim was to enumerate, classify and understand the various care providers at the local level and their potential, involvement vis-à-vis HIV/AIDS. Their views on their possible future involvement in the management and control of HIV/AIDS were also elicited. Combing of the first contact points using the snowballing technique and subsequently a semi-structured interview schedule was used to collect the required data from the providers.

2.3.3.1 Choice of areas for combing and interview

In 23 *taluks* in the chosen districts, as on March 2007, there were a total of 149 Primary Health Centres (PHCs)[9] and 975 health sub-centres (Government of Tamil Nadu, 2007). After obtaining the list of sub-centres from the Department of Public Health, Government of Tamil Nadu, one sub-centre was randomly chosen from each *taluk* yielding a total of 23 sub-centres covering a total population of about 115,000. In order to facilitate a thorough combing of an area, the combing unit was exactly the same as the serving area of a sub-centre (about 5,000 people).

2.3.3.2 Combing operation

In order to assess the full potential of all health care providers in the chosen areas, every health care provider, irrespective of their qualification and the system of medicine practiced, serving as first point of contact was identified and mapped through a combing operation using the snowballing technique. The snowball was first rolled among the FGD participants followed by enquiries and discussion with various social groups and key informants like community leaders, religious leaders, pharmacists and already located health care providers in each sub centre area. Triangulation is a critical component of any mapping exercise. So, information gathered from one source was verified against information from other sources. Till a saturation level was achieved in that area, when the

[9] *A PHC, covering a population of about 30,000 in plain areas and 20,000 in hilly areas, is the first contact point with a qualified physician for the rural people.*

already known names were just repeated, this process was continued and after that a comprehensive list of health care providers was prepared.

2.3.3.3 Interview of first contact points

After the mapping process, all the providers were interviewed using a semi-structured interview schedule in order to assess the nature of the providers (types), qualification, system of medicine practiced, type and amount of clients, experience in HIV/AIDS service provision, capability and potential in the prevention and treatment of STD and HIV/AIDS and willingness to participate in partnerships aiming at the equitable and efficient management and control of HIV/AIDS. Providers were explained in detail about the research study and informed consent was obtained from each health care provider. Out of the total 249 providers, in 3 districts, identified through the combing process, 223 (89.5%) participated and completed the interviews. They were given the complete freedom to withdraw from interview or skip certain questions.

For the purpose of analysis, providers were classified into 3 major groups. Those who hold a recognized medical degree in any system of medicine from a recognized institution was categorized as qualified practitioners; those who hold a formal qualification or training in nursing, pharmacy, paramedical courses, etc were categorized as Less-than-fully-qualified-practitioners with training *(LTFQ-T)*. On the other hand, those who practiced medicine with no formal qualification or training whatsoever in medicine were classified as less-than-fully qualified practitioners *(LTFQ-UT)*.

2.3.4 Phase-3: Understanding the formal organizations

This phase was designed to describe various organizations and their role in the management and control of HIV/AIDS. Reviews of documents, institutional checklist cum institutional assessment form were used to compile the required information and data in this phase.

As the first step, all the organizations involved in HIV/AIDS services through partnerships with different organizations in the chosen districts were enlisted. The list was prepared

using the existing data, reports, the profile of the various funding agencies such as Tamil Nadu AIDS Control Society (TANSACS), AIDS Prevention and Control Project (APAC), Family Health International (FHI), Tamil Nadu AIDS initiative, Palmyra Welfare Development Society (PWDS), Malteser International Catholic Relief Services (CRS) and other funding agencies. Details regarding the organizations were also obtained from the community and the other sources while undergoing the previous two stages of the study. Efforts were made to involve maximum number of organizations in the study. It was found that there were few organizations having their head offices in the adjacent districts but having operation and branch office in the selected districts. These organizations were also included under the selected district. Selection and inclusion of organizations was mainly based on the availability of the organizations, their interest and willingness to participate.

Institutional assessment was carried out using an institutional checklist cum institutional assessment form. This tool was administered to the heads of the organizations, mainly to assess the profile of the organizations. Box-2.2 lists the profile indicators covered by the study. This tool was administered after explaining in detail about the study to the heads of the organizations who were the respondents. Written informed consent was obtained from all the respondents.

2.3.5 Phase-4: Understanding partnerships

The fourth or final phase was the key component of the thesis. It aimed at the evaluation of partnership effectiveness in terms of the stricture/inputs, process and the outcome (perceived and systemic) through the eyes of the implementing partners, funding partners and the community. The important aim was to understand how far the partnerships have added value in reducing the burden of HIV/AIDS.

In this phase, a partnership assessment tool (PAT) based on the evaluation framework and stakeholder interviews (Funding Partners) were used to elicit detailed information on various types of partnerships and their functioning in enhancing the HIV/AIDS services. Besides recording the implementing partner's and the funding partner's views, the

community's (clients) views were also recorded using the following instruments in order to evaluate the effectiveness of partnerships.

Box-2.2

Variables used to describe the institutional profile

1. Age of the organization
2. Ownership type and type of registration
3. Location of the Organization
4. Area of operation
5. Size of the partnership(No of partners involved in each partnerships)
6. Experience in health care and HIV/AIDS
7. Areas of work and services provided in general
8. Services provided in terms of HIV/AIDS
9. Resource availability (manpower, finance and material resources) in general.
10. Resources for HIV/AIDS activities
11. Source of funds
12. Proportion of expenditure like salary proportion
13. Number of partnerships
14. Reason or motivation for partnerships
15. Perceived need for partnerships
16. Experience in partnered activities in general and for HIV/AIDS
17. Different types of partnered activities,
18. Annual value of partnerships,
19. Share of the partners in terms of financing,
20. Perception about the partnership working and the overall effects of partnerships in general.

2.3.5.1 Partnership Assessment Tool

As a first step of developing the evaluation frame work for the study, theoretical and empirical literature on partnerships or collaboration, partnership working and partnership evaluation etc was reviewed. Based on the theoretical review and *a priori* expectations of partnerships and local needs, the inputs, processes, outcomes/ impacts, were identified as key analytical concepts of the evaluation framework. Emphasis was placed on creating a framework that was sufficiently comprehensive to accommodate the complexity of issues in terms of the inputs/structure, the process and outcomes which is based on a mix of practical and theoretical evidences. Common themes were identified under the three analytical concepts such as inputs, the process and outcome and later synthesized into a set of analytical components. On top of all, the main objective was to produce a realistic framework based on theoretical concepts as well as considering the practical issues related to partnership working.

The Partnership Assessment Tool (PAT) was administered to the partnership managers who were managing the respective partnerships. Seeking to assess the process effectiveness and outcomes of individual partnerships, the tool included 70 process indicators and 26 outcome indicators. Key variables used in the partnership evaluation are given in Box-2.3. This tool was administered to the Head/in-charge/manager of the respective partnerships after getting the written informed consent from the respondent.

2.3.5.2 Stakeholder interviews

In order to seek the views of the funding partners about the functioning of partnerships, 18 guided in-depth interviews were conducted among them. All the major funding partners in Tamil Nadu were contacted. At least one responsible person in the rank of Project Director/Project Manager from the major funding agencies was interviewed using interview guidelines.

Major areas covered in the interviews were procedures in the partner selection, need for partnership approach, funding partner's role, processes and outcomes of the partnerships including the effectiveness, efficiency, equity, quality of services, sustainability of

services, attribution of success to the partnerships, counterfactuals, future plans and lessons learned. Prior to the interview, respondents were clearly informed about the study. All the interviews were audio recorded with the consent of the respondents. Later it was transcribed by the researcher.

Box-2.3

Key Partnership Assessment variables

i.	Age of the partnership
ii.	Specific target group
iii.	Target population
iv.	Area of operation
v.	Services provided
vi.	Purpose of partnerships(broadly)
vii.	Motives of the partnership
viii.	Mode of partnership initiation
ix.	Pre partnership processes
x.	Perceived need
xi.	Annual value and the share of each partner
xii.	Resource availability in terms of men, money, materials
xiii.	Nature and type of partners
xiv.	Nature and type of partnerships
xv.	The inputs and structure
xvi.	The process components of partnership working(20 components and 70 indicators)
xvii.	The outcome components of partnership working(12 components and 30 indicators)
xviii.	The satisfaction level of the beneficiaries or clients

2.3.5.3 Client interviews

A structured interview schedule was used to interview the beneficiaries or the clients of the partnered activities. The respondents were selected randomly and interviewed either while exiting one of the partnering institutions after receiving the service. In order to record the views of the most vulnerable population for HIV/AIDS, widows, Patient Living with HIV/AIDS, high-risk population like commercial sex workers, men sex with men, injection drug users were also included in the study. At least three clients from each partnered intervention were selected for the study.

Client interviews were conducted to understand, the beneficiaries of the partnered interventions, the increase in the physical, economical and social access, the responsiveness, the improved health status and the satisfaction level of the beneficiaries of the partnered interventions. Responsiveness included quality of basic amenities, choice of providers, dignity, prompt attention, confidentiality, communication, and autonomy. The client interviews also had variables to identify the duplication of efforts, reason for choosing the service, economical status of the beneficiaries and the involvement of the community/clients in the partnered interventions.

The beneficiaries or clients were approached while undergoing the second stage itself. When each partnership was assessed, the clients of the partnerships were also interviewed using the client interview schedule. The respondents were explained in detail about the study and after getting the consent of the respondents, the interviews were conducted .

2.3.6 Inclusion criteria

2.3.6.1 Inclusion criteria for provider assessment

- The providers should be operating within the range of the sub-centre

2.3.6.2 Inclusion criteria of organizations or Institutions

- The main criteria for the inclusions were that an organization should have a minimum of one year experience in HIV/AIDS activities in the specific district.

- The organizations should have programmes and projects through partnerships or collaboration which mean that they get funding from other organizations.
- They should have an office or branch office in the district.

2.3.6.3 Inclusion criteria for partnerships

- There should be at least two different organizations involved.
- The partnerships should have completed a minimum of one year experience in implementing HIV/AIDS interventions.
- Both, legally binding (contractual) and non-legal binding (Collaborative) partnerships have been included.

2.3.6.4 Inclusion criteria of funding partners (stakeholder Interviews)

- The funding agency or the funding partner should have a minimum experience of one year in the state and they should have already implemented HIV/AIDS interventions through partnerships with various organizations in the specific districts.
- The respondent need to be attached with a funding or donor organization, in a rank of not less than a Project Director or Project Manager.

2.3.6.5 Inclusion criteria for clients (client interviews)

- The clients should have registered with the implementing partner organization and availed services from the partnered organization.

2.3.7 Exclusion criteria

- Organizations which had less than one year experience in HIV/AIDS were excluded from the study.
- The individual partnerships which did not complete one year were not considered.
- The clients registered with the organizations but not availed any services were excluded from the study.

2.3.8 Pilot testing

The instruments for the provider interview schedule, partnership organization assessment (checklist cum institutional assessment form), the partnership assessment tool, and the client interview schedule were pilot-tested in order to fine-tune the tools in terms of missing vital information and understand the amount of time and other resources required to complete a tool in a setting. The instruments were standardized and validated by means of a small-scaled pilot test on providers (provider interview), partnership organizations (partnership checklist), partnerships (partnerships assessment tool) and the community (client interview). Important additional information and corrections were incorporated in the respective instrument later.

2.3.9. Data Collection experience

The study yielded few important lessons for the benefit of those who may want to carry out similar health system management research.

2.3.9.1 Experience from FGDs

Focus group discussion, as a tool, was indeed effective to understand the demand side, particularly to reach out to vulnerable sections of the society. However, its organization and conduct were proved to be challenging and this is one area where lessons can be learned from this study. One of the main challenges was to identify the potential groups, particularly when the target was to identify unknown risk groups. Some groups were identified as the FGDs progressed in rural areas. A related challenge was to fix an optimal number of FGDs in all. In this study, FGDs were conducted till they produced new information. While some amount of repetition was welcome to strengthen the results, we stopped FGDs once the repetitions were too many.

Among various groups, the most difficult group to handle was the qualified allopathic doctors. Repeated attempts were made to have an optimal gathering among them. In one district, the top official of the big public hospital was approached and the objective of the study was explained in detail. After initial reluctance, the official consented for a 30 minutes' meeting in the afternoon after proper written request. However, it happened after

a second attempt. However, this group was vital as they provided certain key information relevant to the study. So, conducting FGDs among the qualified doctors need to be carefully planned and it is very important to approach the right person to get any optimal size of gathering of physicians.

Other difficult group was the *Kothis* (transgender). Though their size of presence was good in one of three districts, mobilising an optimal number of them for the FGD was very difficult. A local NGO was contacted for this purpose and through it, the head (a kind of) of the *kothis* was approached. He consented to arrange for a discussion. But, the difficulty to gather everybody in one place was a challenging task. Finally, it was decided to conduct the FGD in a park which was the meeting point for them. So, before they started accessing their clients by around 7 PM, the discussion was conducted in the park itself.

FGD among the CSWs was also a challenging task. The place of gathering and the time need to be very appropriate for them. The best time for having discussions with them was late morning and early afternoon. Also, bringing their focus to the subject was difficult as they tended to deviate a bit and were disturbed by repeated phone calls. We could not do much to avoid the distractions. But, they were one of the best groups where one could get plenty of information related to emerging high-risk groups, condom usage and other sexual behavioural pattern.

The easiest way to conduct FGDs among the general community was to contact the local village head, youth club leader, leader of the self help group or *panchayat* member. If one could explain clearly the importance, advantages and possible implications of the study, it would be very easy to conduct among these people. Evening time was the most preferred time for conducting FGDs among them.

FGDs among the lorry drivers could be also conducted relatively easily. The best way was to go to the lorry stands and if there is adequate number, gathering them in one place was easy. The truckers were willing to talk freely because they have been given adequate interventions related HIV/AIDS. It needed lot of waiting to get the enough number of truckers.

As getting adequate number of pharmacists was found very difficult after repeated failures, it was decided to conduct in a small town where the numbers of pharmacies were higher. The owners of the pharmacies were contacted and after brief discussions, many of them consented to send the representatives. But, they do have an association and contacting the leader of association yielded easy results.

Less than fully qualified practitioners (LTFQs) could be approached through their association. In each district, there were associations and there would be head for them. Meeting them after their regular meeting would be the feasible option. They would be very interested to voice their opinions if their services were recognized and due respect was given to their work. One can always expect lot of emotions from them because of the less recognition to their services from the government.

2.3.9.2 The combing operation

As sub-centre area was taken for the combing operation, area demarcation was a problematic process. The target area of the sub centre was really difficult to comprehend. The number of villages and area covered by sub-centre was finalized after discussion with the staff of the primary health centres. But, it was really very difficult to get the time of the health care providers. Though they consent to talk, there will be many disturbances and so, the numbers of questions need to be very less and precise. Especially, in spite of the assurance to maintain confidentiality, the less than fully qualified practitioners would be very defensive in their answers. So, developing trust and confidence among them would be the top priority during the provider's interview. Many LTFQs tend to answer that they have qualification and training in paramedical and nursing courses which need to be cautiously interpreted.

2.3.9.3 Interviewing clients

Conducting interviews among the clients in the premises of the organizations might give a skewed response as they tend to be in favour of the organizations. But, this would be the most feasible way to conduct interviews among the beneficiaries of the partnerships. The

numbers of questions need to be very less and precise as there would be always a tendency of urgency among the clients to finish the interviews at the earliest.

2.3.9.4 Interviews with funding partners

In spite of the prior information and appointments, meeting the representatives of the funding agency was really a very difficult process. Too much of waiting, cancellation of appointment and postponement was very frequent during the study. So, the second level leaders in the funding agencies would be the best alternative who can really spare their time and provide adequate information.

2.3.9.5 Partnership evaluation

During partnership evaluation, the partners did not feel comfortable with the questions as they always had a doubt that the investigator was an external evaluator. They felt uncomfortable with revealing the quantitative details of the partnership initiatives as well as addressing the relationship dynamics. The researcher had to explain in details of the study and ensure confidentiality in addition to stressing the objective of the study

It was found that the number of indicators was very high and too qualitative, which took much time to explain, though it was reflecting different views. Some of the indicators gave similar answers of the other indicators, which could have been avoided. Grouping all the indicators into component also led to difficulty as many indicators/variables were eligible to fit into more than one component. So, the partnership evaluation tool could have been more precise and short.

2.4 Data analysis and statistical methods

While analysing the Partnership assessment tool, scoring was done for all individual variables (indicators) using the scoring pattern of '1' for disagreement, '2' for neutral or agreed to some extent, and '3' for agreement. For analysis, the process variables were grouped into 20 different analytical components and the perceived outcome variables were

grouped into 11 analytical components depending on their functional processes. For each variable, the total score was calculated using the formula,

$$\frac{\textit{Actual score - Minimum possible score}}{\textit{Maximum possible score - Minimum possible score}}$$

Score for each component and the overall score concerning a process and outcome was obtained using the same formula. Scoring was done wherever appropriate in all the tools. Based on the score obtained, each variable and component was placed in one of the three zones viz., ***"target zone", "work zone" and "danger zone"***. Partnerships placed in the danger zone (score below 0.33) required a lot of improvement while those in the work zone (0.33-0.66) needed more efforts in order to be effective; partnerships in the target zone (Above 0.66) were assessed as doing well. The systemic outcomes of the partnerships were analysed, collating the information's from all the tools, as well as using the secondary data.

The internal consistency of the process variables was verified using Cronbach's Alpha. The statistic was calculated for all the 70 process variables and also separately for the 20 components made out of it. The overall (70 items) Cronbach's Alpha was 0.891. The same calculated for each component was > 80% (or > 0.80).

In addition to the descriptive and other basic statistical methods, Normality of the variables was tested using Kolmogrov Smirnov's method. Pearson's correlation coefficient was applied to find correlation between different process components and outcome scores. One-way ANOVA and Univariate general linear model were used to compare mean scores between different types of partnership. In order to clearly identify the process components that significantly contribute to the outcome in presence of other components, a multiple linear regression analysis was performed with the overall outcome score as the dependent variable and the process components as the explanatory variables. Enter method was used to include process components into model. R^2 was calculated to examine the fitness of the multivariate regression.

2.5 Ethical considerations

The Ethics Committee of Sree Chitra Tirunal Institute for Medical Sciences and Technology examined the probable ethical issues which might be coming up at the different stages of the study including study design and methodology, before granting approval to the study.

FGDs were conducted using a schedule. They were allowed to give their opinion freely within the subject area. Before conducting the FGDs, the investigator explained in detail about the study and made sure that utmost confidentiality would be maintained and verbal consent of every member of the group was obtained before the FGDs.. Participation was voluntary and participants were not given any monetary remuneration. They also had the option and freedom to deny or withdraw from participating in the FGDs.

During the provider interviews, providers were explained in detail about the research study and informed consent was obtained from each health care provider. They had complete freedom to withdraw from interview or skip certain questions if they felt uncomfortable. While administering the institutional assessment form and Partnerships Assessment Tool, written consent from participants were obtained. They also had the freedom to deny or withdraw from the study.

During the stakeholder interviews, respondents were clearly informed about the study. All the interviews were audio recorded after getting the consent of the respondent. Later it was transcribed by the researcher. When interviewing a responsible person other than the Head of the funding agency, written and oral permission was sought from the Head as well. Clients were explained in detail about the study and after getting the consent of the respondents, interviews were conducted among them. As the client interviews had some confidential information's, the names of the respondents were not recorded and instead a code number was given to each client. Respondents were given the freedom to deny their participation and withdraw from the interview even in the middle of the process. In addition, all the required and appropriate measures and ethical guidelines were followed during the entire process of the study.

2.6 Strengths and limitations

The study adds to the existing literature by bringing out in detail the high-risk sexual behaviour among the general population, health seeking behaviour and different unconventional risk groups in the community. It also improves the understanding of the existence of various health care providers practicing different systems of medicine particularly related to STI and HIV/AIDS.

The study also contributes to the exiting literature on evaluation of partnership effectiveness which is uncommon in Indian settings. This thesis evaluated the partnerships from both health system and disease management perspective. It also provided a multi-dimensional framework and statistical testing for evaluating partnerships. It also used a variety of techniques including the FGDs, combing of sub-centre areas, interviews, checklist, and an evaluation form besides the literature review and analysis of secondary data. This variety added real strength to the findings since health system is a complex phenomenon.

2.5.1 Limitations

Although the study used a variety of techniques to collect the required data, some findings are still indicative, but not definitive. They need to be explored further before making any definitive statements about them. More specifically, high-risk sexual behaviour and the prevalence of pre and extra-marital relationships need to be interpreted with caution and the exact proportion could be corroborated through the existing surveys and literature.

Provider interviews to understand the provider potential were restricted to rural areas only. In the partnership evaluation, main emphasis was placed on the process, functioning, perceived outcome and systemic outcome. But, it did not involve cost-effectiveness and cost-efficiency results in terms of DALY gained etc, which needs to be really studied. Moreover, the evaluation was a cross sectional study and did not have baseline data or comparison data.

CHAPTER-III

DESCRIPTION OF THE PRIMARY DATA

The thesis attempted to connect the supply side approaches with the demand side. It adopted a bottom-up approach by evaluating the community needs first followed by health care opportunities and supply side approaches vis-à-vis HIV/AIDS. This chapter describes the data arising out of the focus group discussions, combing survey, provider interviews, institutional checklist and assessment form, and Partnership evaluation Tool.

3.1 Profile of FGD participants

In total, 59 FGDs were conducted in three districts (Table-3.1), a maximum of 24 (40.6%) FGDs were conducted in Tirunelveli district. On the average, about nine persons participated in each FGD making a total of 540 persons; it included 322 (59.6%) males, 209 (38.7%) females and 9 (1.7%) trans-genders while 53 percent were from urban areas (Table-3.2). Moreover, participants were from 21 diverse groups (Table-3.3); lay public (16.7%), college or school teachers (11.5%), qualified nurses or auxiliary nursing midwives (11.3%), youth (8.3%), police (6.9%), self help group members (6.1%), NGO workers (5.6%), commercial sex workers (4.8%), pharmacists (4.3%), HIV positive people (4.3%), college students (3.7%), men having sex with men(3.3%), truckers (2.9%), physicians (2.8%), barbers and washer men (1.6%), service employees(1.5%), health care delivery staff (1.5%), hotel workers (1.5%), and less-than-fully qualified practitioners (LTFQs, 1.5%). Each FGD took a minimum of about 50 minutes (95 minutes maximum).

Table-3.1

Focus Group Discussion details in the chosen districts

District	Population	Taluks Sub-dist	No. of FGDs	particip ants	Persons /FGD	Population /FGD
Tirunelveli	27,23,988	11	24	220	9.16	113,499
Namakkal	14,93,462	4	12	119	9.91	124,455
Kanchi	28,77,468	8	23	201	8.73	125,107
Total	**70,94,918**	**23**	**59**	**540**	**9.15**	**120,252**

Table-3.2

Demographic profile of FGD participants *(% within brackets)*

	Male	Female	Transgender	Total
Rural	102	130	0	**241 (44.6)**
Urban	220	79	9	**299 (53.4)**
Total	322 (59.6)	209 (38.7)	9 (1.6)	**540 (100)**

Table-3.3

Typology of the FGD participant groups

Groups	District			No. of FGDs	Total participants	Participants/ FGD
	Tirunelveli	Namakkal	Kanchi			
Doctors	1	0	1	2	15	7.5
Police	2	1	1	4	37	9.25
Pharmacy	2	0	1	3	23	7.6
Dhobi	1	0	0	1	9	9
CSWs,	1	1	1	3	26	8.6
LTFQs	1	0	0	1	8	8
Positive people	1	1	1	3	23	7.6
College teachers	1	0	1	2	17	8.5
College students	1	0	1	2	20	10
Qualified Nurses	1	0	1	2	17	8.5
ANM	2	1	2	5	44	8.8
School teachers	2	1	2	5	45	9
Service employees	1	0	0	1	8	8
Community	4	2	3	9	90	10
Youth groups	1	1	2	4	45	11.25
NGOs	1	1	1	3	30	10
Health care staff	1	0	0	1	8	8
Self help groups	0	1	2	3	33	11
MSM	0	1	1	2	18	9
Hotel Workers	0	0	1	1	8	8
Lorry Drivers	0	1	1	2	16	8
Total	**24**	**12**	**23**	**59**	**540**	**9.15**

3.2 Provider profile

Out of 249 health care providers or first contact points listed during the combing/mapping process, 223 (89.5%) were approached and interviewed using a structured interview schedule; the highest proportion (44%) of them came from Tirunelveli district (Table-3.4). Each sub-centre, covering around 5,000 populations, had an average of 9.7 providers (i.e., 1.9 providers per 1,000 populations). It included all type of providers such as qualified practitioners, Less-than-fully qualified practitioners with some formal training (LTFQs-T)[10] and less-than-fully qualified practitioners without any training (LTFQs-UT). Majority (82.5%) of the providers were from the private sector and the remaining from the public sector.

Table-3.4

Providers interviewed in each district *(% within brackets)*

Districts	Selected sub centres	No. of providers interviewed	Private	Public	Mean interviewed
Tirunelveli	11	98 (43.9)	79(80.6)	19(19.4)	8.9
Namakkal	4	42 (18.8)	34(80.9)	8(19.1)	10.5
Kanchipuram	8	83 (37.2)	71(85.5)	12(14.5)	10.4
Total	**23**	**223 (100)**	**184(82.5)**	**39(17.5)**	**9.7**

Over 70 percent (71.4%) of the providers were male; it was 76.6 percent in Tirunelveli district and 67.4 in Kanchipuram. The mean age was 40.0 years (SD 7.0 years, range: 23-68 years) and the length of their experience was 14.2 years (SD 6.6, range: 1-41 years) (Table-3.5). About 29 percent (64 interviewees) were qualified practitioners 32 percent were LTFQs with some formal training with the rest being LTFQs without any training;

[10] *Those who hold a recognised medical degree in any system of medicine from a recognised institution was categorised as qualified practitioners; those who hold a formal qualification/training in nursing, pharmacy, paramedical courses, etc were categorised as Less than Fully Qualified Practitioners with training(LTFQ-T) and the remaining were categorised as Less than Fully Qualified Practitioners(UT).*

Tirunelveli district had more qualified practitioners (32%). Namakkal district had slightly higher (33% and 43%) proportion of LTFQs (trained and untrained).

Table-3.5

Age and experience of the different types of providers*

Type of Provider	Age	Experience
Qualified	**38.4** (26-65)	**12.7** (2-37)
LTFQ-Trained	**39.96** (23-68)	**13.90** (2-41)
LTFQ-Un-trained	**41.79** (32-65)	**16.64** (1-30)
Total	**40.00** (23-68)	**14.2** (1-41)

* *Range given in parenthesis*

Mean age of the qualified practitioners was 38.4 years with the mean experience of 12.7 years. Mean age and experience of the LTFQs-untrained were higher than the other two. Data concerning this are given in Table-3.6 and Figure-3.1. All these districts had 0.55 qualified practitioners per 1,000 populations - 0.66 LTFQs with some formal training and 0.76 LTFQs without training.

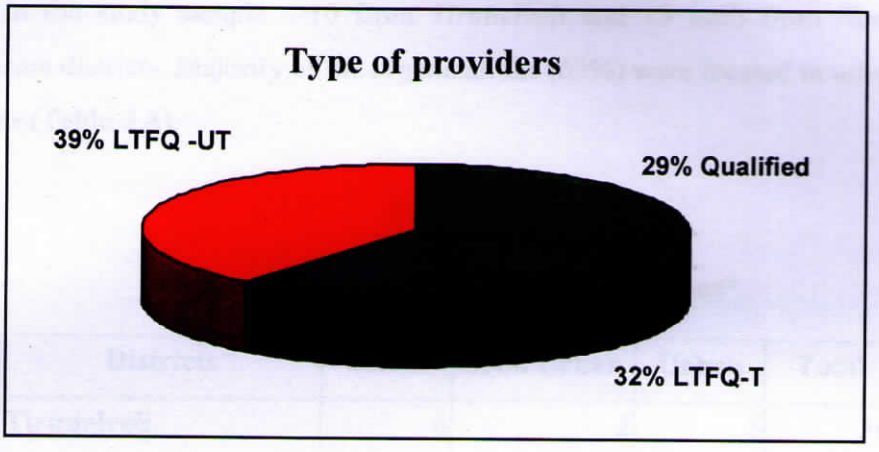
Table-3.6

Provider types *(% within brackets)*

Type	Tirunelveli	Namakkal	Kanchipuram	Total
Qualified	**31 (31.7)**	10 (23.8)	23 (27.7)	64 (28.6)
Trained LTFQs	30 (30.6)	**14 (33.3)**	27 (32.5)	71 (31.8)
Untrained LTFQs	37 (37.7)	**18 (42.8)**	33 (39.7)	88 (39.4)
Total	**98**	**42**	**83**	**223**

Figure-3.1

Type of Providers



3.2.1 Income

Reported average monthly income of the providers, who have disclosed, was INR 5799.26 (SD 4731.95, Range: Rs.1, 000 - 25,000) or USD 121 (Range: $ 21 - 521); refer Table-3.7 for details. The qualified practitioners were having the highest mean income but the mean income of the trained LTFQs was higher than the untrained LTFQs.

Table-3.7

Average monthly Income of the providers

Qualification	Mean	N	Standard Deviation	Range	
				Minimum	Maximum
Qualified	1.23E4	32	3938.540	6,000	25,000
LTFQ-Trained	4406.15	45	2789.594	1,000	12,000
LTFQ-Untrained	2625.00	36	2090.711	1,000	9,000
Total	**5799.26**	**113**	**4731.957**	**1,000**	**25,000**

3.3 Profile of the Organizations

In total, 65 organizations were enlisted from three selected districts. Out of this, 46 were included in the study sample - 16 from *Tirunelveli* and 15 each from *Namakkal* and *Kanchipuram* districts. Majority of the organizations (63%) were located in urban and semi urban areas (Table-3.8).

Table-3.8

Geographical location of the organizations*

Districts	Rural	Semi Urban	Urban	Total
Tirunelveli	6	2	8	**16**
Namakkal	4	1	10	**15**
Kanchipuram	7	3	5	**15**
Total	**17(36.9)**	**6(13)**	**23(50)**	**46(100)**

**Percentages within parenthesis*

3.3.1 Experience in health and HIV/AIDS

Average experience of the organizations was 15.2 (SD 8.6, range: 1–37) years (Table-3.9). Experience in health related services in general was 13.2(SD 7.8) years and they had an average experience of 7.3 (SD 3.4) years in HIV/AIDS work. As mentioned in Table-3.10, 74 percent of them existed for over 10 years; only two had less than 2 years of experience. Almost all organizations (96%) involving in HIV/AIDS had over 2 years of experience. Over 80 percent took up HIV/AIDS issue at a later point of time which means that they have started the organization well before they took up HIV/AIDS as one of their objective.

Table-3.9

Experience of the Organizations (Health and HIV/AIDS)

District ID		Total Experience of the organization	Experience in health	Experience in HIV/AIDS
Tirunelveli	Mean	16.44	14.12	8.19
	Std. Deviation	6.870	5.965	4.020
	Minimum	4	4	1
	Maximum	36	28	17
Namakkal	Mean	14.87	13.20	6.73
	Std. Deviation	9.471	8.562	2.987
	Minimum	2	2	2
	Maximum	33	27	12
Kanchi	Mean	14.07	12.13	6.93
	Std. Deviation	9.588	9.094	3.218
	Minimum	1	1	1
	Maximum	37	37	11
Total	Mean	15.15	13.17	7.30
	Std. Deviation	8.558	7.815	3.438
	Minimum	1	1	1
	Maximum	37	37	17

Table-3.10

Experience of the organizations *(% within brackets)*

	District ID			Total
	Tirunelveli	**Namakkal**	**Kanchipuram**	
< 2 years	0	1	1	2 (4.3)
3 to 5 years	1	3	1	5 (10.8)
6 to 10 years	1	1	3	5 (10.8)
= 11 years	14	10	10	34 (73.9)
Total	**16**	**15**	**15**	**46**

3.3.2 Ownership and registration

Ownership and type of the included organizations are given in Table-3.11; as it can be seen, 95.6 percent were private not-for-profit organizations. Almost all the not-for-profit organizations were registered either as society or trust - 56.8 percent as society under Societies Registration Act, 1860 and 38.6 percent registered as trust under Indian Trust act 1882 or Public Trusts Acts applicable to different states in India (e.g., The Bombay Public Trusts Act, 1950, MP trust act.); four were not registered. About 85 percent of them were Non-governmental and community based organizations and 15.2 percent were allopathic clinical institutions (Table.3.12); Out of all these, 5 were HIV/AIDS specific organizations.

Table-3.11

Ownership and type of registration *(Percentages within parenthesis)*

	Private Not-for-profit	**Private for-profit**	**Total**
Trust	17 (38.6)	0 (0.0)	17 (36.9)
Society	25 (56.8)	0 (0.0)	25 (54.3)
Not registered	2 (4.5)	2 (100.0)	4 (8.6)
	44 (100)	**2 (100)**	**46 (100)**

Table-3.12

Type of organizations

	Number	**Per cent**
Clinical Allopath	7	15.2
Clinical Non Allopath	0	0.0
Non Clinical	0	0.
NGOs	36	78.2
CBOs	3	6.5
Total	**46**	**100**

3.3.3 Areas of operation

All of them operated in rural areas. While 2 operated exclusively in rural areas, 9 (19%) had rural and semi-urban coverage; 37 (80.4%) targeted all (rural, semi-urban and urban areas). There was no urban specific institution.

3.3.4 Services provided

The not-for-profit organizations were involved in various social, economic and other developmental issues in addition to the health care services and HIV/AIDS interventions. For instance, 63 percent of the organizations involved in social development and welfare activities and 52 percent in women empowerment (Table-3.13).

Table-3.13

Services provided

Services	Number of organizations	Percentage of Organization
Health care	46	100.0
HIV/AIDS	46	100.0
Social development and welfare	29	63.0
Education	24	45.6
Rural development	16	34.7
Environment	3	6.5

3.3.4.1 HIV/AIDS services provided

As described in Table-3.14, 97.8 percent were involved in prevention and promotion activities accounting for 42.5 percent of all the services provided by these organizations. Seventeen provided exclusive prevention and promotion services while 2 had exclusive care and support.

Table-3.14

Details of services provided

Services	% out of all the services	% of organizations
Prevention and promotion	42.5	97.8
Treatment	7.5	17.4
Care and support	24.5	56.5
Rehabilitation	16	37
Advocacy	5.7	13
Training	2.8	6.5
Research	0.9	2.2
Total	100.0	

3.3.5 Human resources

There were totally 1,639 fulltime employees working in all these organizations in the year 2007 and out of this 46.7 percent (766 employees) of them were involved in HIV/AIDS interventions. As indicated by Table-3.15, average number of total full time employees was 36 (SD 24, Range: 2 - 80) and the mean number of full-time staff involved in HIV/AIDS was 17 (SD 12, Range: 2 - 48). Out of the total 404 Part-time staff in these organizations, 133 (33%) were involved in HIV/AIDS services.

3.3.6 Financial resources

The status of the financial resources in the chosen organizations is given in Table-3.16. In total, Rs. 368.12 million (US$ 7.6 million) was the budget of all the organizations in the year 2007. In which, 30.9 percent (Rs. 113.8 million – US$ 2.37 million) was the budget for HIV/AIDS activities. The mean annual budget of the organizations was Rs 8 million (US$ 166,725) and the mean annual budget for HIV/AIDS was Rs 2.4 million (SD 2.71) (US$ 51,570). The reported proportion of budget spent on manpower alone was 53.3 percent (SD 15, Range: 25–90) and 47.8 percent of the organizations' manpower allocation

exceeded 50 percent of the total budget and a significant 50 percent fell in the 26-50 percent range of the annual budget.

Table-3.15

Human resources for the organizations

District		Total full time staff	HIV/AIDS full time staff
Tirunelveli	Mean	42	19
	Std. Deviation	24.13	11.78
	Minimum	10	3
	Maximum	80	44
Namakkal	Mean	31	15
	Std. Deviation	25.22	14.13
	Minimum	2	2
	Maximum	80	48
Kanchipuram	Mean	34	16
	Std. Deviation	22.94	10.29
	Minimum	3	3
	Maximum	77	38
Total	**Mean**	**36**	**17**
	Std. Deviation	**24.02**	**12.04**
	Minimum	**2**	**2**
	Maximum	**80**	**48**

Table-3.16

Financial Resources

	Over all Annual Budget	HIV/AIDS Annual Budget
Mean	80,02,804.35	24,75,369.57
SD	94,30,316.08	2711393.486
Minimum	90,000	90,000
Maximum	400,00,000	150,00,000
Sum	36,81,29,000	11,38,67,000

3.3.7 Material resources

The size of material resources is given in Table-3.17. Over 60 percent had own office spaces while others were in rented spaces. Around 70 percent of the institutions had more than 3 computers for their work and almost all of them had internet facility as well. About 97 percent had land line telephone facility while 61 percent owned four wheelers. Very importantly, 48 percent (22 institutions) had branch offices mainly in adjacent districts or in the state.

Table-3.17

Material resources available

		Tirunelveli	Namakkal	Kanchi	Total
Office premise for HIV/AIDS	**Own**	10	9	10	29 (63)
	Rented	6	5	5	17 (47)
Computer for partnership	**0**	0	2	0	2 (4.3)
	1-2	2	3	6	11 (24.0)
	=3	14	10	9	33 (71.7)
Presence of the Internet		16	13	14	44 (95.6)
Faxes used for HIV related work		7	8	6	21 (45.6)
Telephone facility (landline)		16	14	14	44 (95.6)
Four wheel vehicles		10	9	9	28 (60.8)
Two wheel vehicles		7	5	7	19 (41.3)
No. of Branches		7	8	7	**22 (47.8)**

3.4 Understanding the partners and partnerships

The details of the partnerships existing in 46 organizations are given in Table-3.18. There were totally 105 HIV/AIDS related partnerships in 46 organizations at an average of 2.3 (SD 1.1, Range: 1 - 6) partnerships per organization; 43.5 percent of the organizations had single partnerships while 36.9 percent had multiple (3 or more) partnerships.

Table-3.18

Partnership details

No. of partnerships	No. of organizations	Total no. of partnerships	%
1	20	20	43.5
2	9	18	19.6
3	6	18	13.0
4	7	28	15.2
5	3	15	6.5
6	1	6	2.2
	46	**105**	**100**

3.4.1 Types and nature of existing partnerships

Many forms of interaction exist between public sector and private for-profit sector and private non-profit sectors in the area of policy formulation and implementation of HIV/AIDS related policies, programmes and interventions.

Different types of partnerships are classified as follows (Figure: 3-2, 3-3)

3.4.1.1 Bi or multi lateral

Bilateral means that there will be two parties and multilateral denotes that there will be more than two parties in the partnerships. Out of the 105 partnerships, around 84 percent

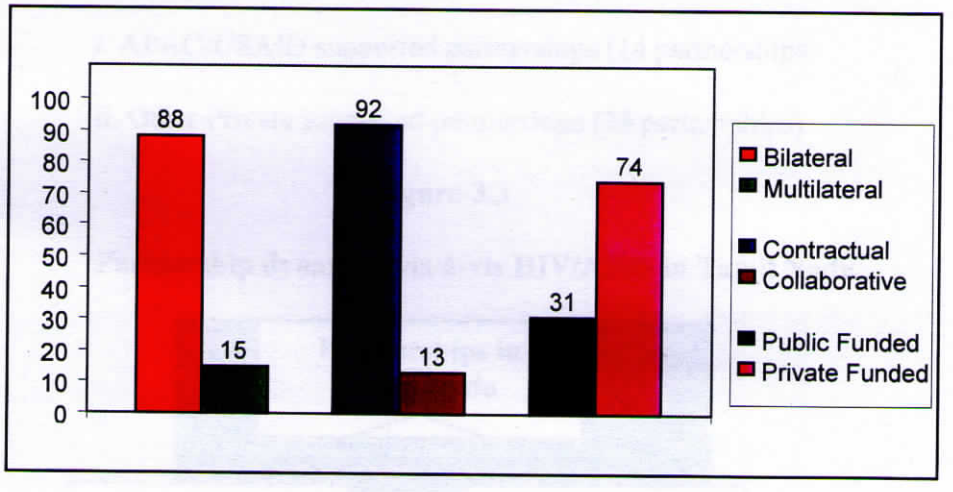
(88 partnerships) of the partnerships were bilateral partnerships and around 14 percent (15 partnerships) were multipartite partnerships.

3.4.1.2 Contractual (legally binding) and collaborative (Non-legal)

In contractual partnerships there will be a formal and legally bound written contract document signed by the parties. In collaborative partnerships such kind of legally bound contracts will not be there. A vast majority (87.6%, 92 partnerships) of the partnerships were contractual partnerships which are legally bound and around 12 percent (13 partnerships) were collaborative partnerships without legally bound contracts.

Figure-3.2

Types and Nature of Partnerships



3.4.1.3 Domestic and International (Based on funding)

Domestic Funding partner is a registered body in India. Most of the partnerships were classified as domestic partnerships as the funds were routed through a registered organization in India though their source of fund is from overseas. International denotes that they received funds directly from the international partner. Except one, all the organizations were having partnerships supported by domestic funding. Seven organizations had direct international funding for partnerships.

3.4.1.4 Public funding-Private implementation (Public-Private)

Partnerships between Public sector (Funding partner) and Non-governmental organizations, Community based organizations and other private organizations. 31 (29.5%) partnerships were funded by the public sector.

3.4.1.5 Private Funding and Private Implementation (Private-Private)

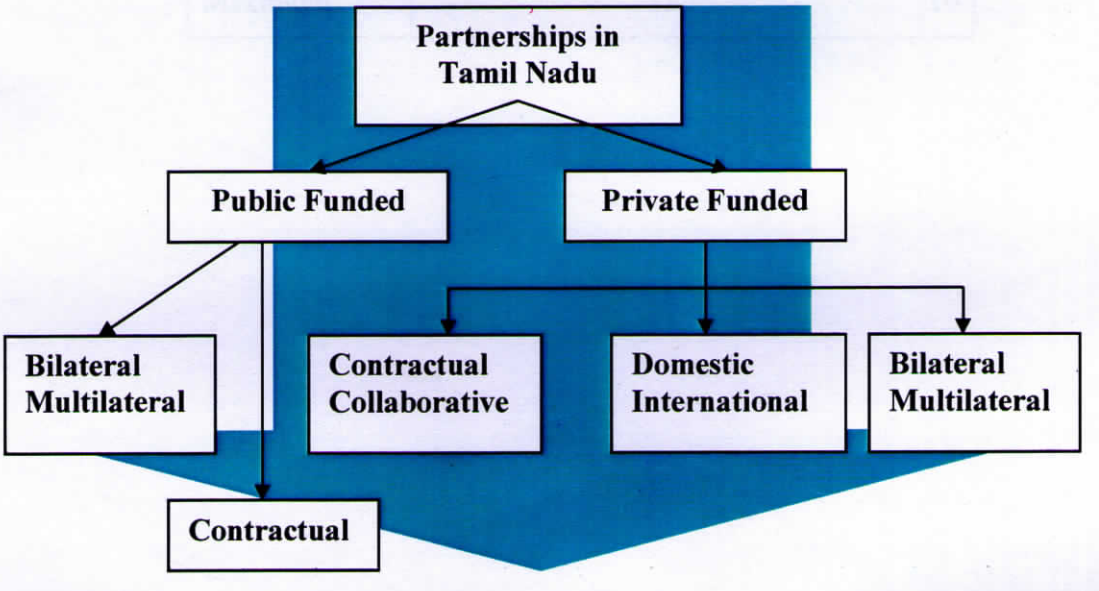
The funding partners are private such as private foundations, funding agencies, donors and private organizations. 73 (69.5%) were funded by private not-for-profit sector one partnership was funded by private for profit sector. Though several private funding partners were involved, significant proportion of them were from the AIDS Prevention and Control (APAC) Project administered by Voluntary Health Services (VHS) with financial assistance from USAID. So, private funded partnerships are classified as,

i. APAC-USAID supported partnerships (14 partnerships)

ii. Other Private supported partnerships (36 partnerships)

Figure-3.3

Partnership dynamics vis-à-vis HIV/AIDS in Tamil Nadu



3.4.2 Experience of the organizations in managing partnerships

In Tamil Nadu, the organizations had an average experience of 9.6 (SD 6.17) years in conducting health related partnerships and an average experience of 6.97 (SD 3.54, Range: 1-15) years in conducting HIV/AIDS interventions through partnerships. As shown in Table-3.19, they had an average of 5 health related partnerships and an average of 3.26(SD 2.38, Range: 1-10) HIV/AIDS related partnerships during 2001 - 2007. In total, these organizations had 226 partnerships related to health care from 2001 to 2007 and majority (66.6%) of them were for HIV/AIDS related interventions.

Table-3.19

Mean number of partnerships in health and HIV/AIDS (2001 to 2007)

	No of partnerships in Health	No of partnerships in HIV/AIDS
Mean	4.91	3.26
Std. Deviation	3.794	2.380
Sum	226	150
Minimum	1	1
Maximum	15	10

3.5 Partnerships under study

Out of the 105 partnerships existed in 46 organizations included in the study, 70 (Mean: 1.52; SD 0.69; Range 1-3) were studied. *Tirunelveli* had 27 partnerships from 16 organizations included while 22 and 21 from 15 organizations each were included from *Kanchipuram* and *Namakkal* districts respectively.

3.5.1 Partnership age

The mean age (Table-3.20) of the partnerships was 3.21 (SD: 2.4, Range: 1-11) years. Namakkal district (3.62 years) had higher mean partnership duration than the other districts. The mean partnership duration was lowest in Kanchipuram District (2.82 years).

Table-3.20

Average partnership duration (Age)

District ID	Mean age	SD	Maximum	Minimum
Tirunelveli	3.22	2.792	11	1
Namakkal	3.62	2.156	9	1
Kancheepuram	2.82	2.130	9	1
Total	**3.21**	**2.401**	**11**	**1**

3.5.2 Types of partnerships under study

As mentioned in the (Table-3.21), nearly three-fourth (71.4%-50-partnerships) of the partnerships was with private sector funding (Private-Private) and the remaining 28.6 percent (20) was with the public sector (Public-Private).

3.5.2.1 Types among the private

A prominent group emerging from the private sector (50 partnerships) funding was the USAID supported AIDS Prevention and control Project (APAC), Voluntary Health Services (28%). The other major private funding partners were, Alliance supported Pulmyrrah Welfare Development Society –PWDS (10%), Catholic Relief Services-CRS

(8%), Malteser International supported Provision (10%), Tamilnadu AIDS Initiative (TAI) supported by Bill Melinda gates foundation (8%), Clinton foundation (4%), INP Plus (4 %) and other (28%) funding agencies.

Table-3.21

Types of partnerships *

Funding Partner	Tirunelveli		Namakkal		Kanchipuram		Total
	Bilateral	Multi lateral	Bilateral	Multi lateral	Bilateral	Multi lateral	
Public	7	2	5	1	3	2	**20 (28.6)**
Private	10	8	13	2	12	5	**50(71.4)**
APAC	4	0	5	0	5	0	**14**
Others	6	8	8	2	7	5	**36**
Total	**17**	**10**	**18**	**3**	**15**	**7**	**70(100)**

**Percentages within parenthesis*

3.5.2.2 Bilateral or Multilateral

A vast majority of the partnerships (71.4 %) were bilateral Partnerships (Table-3.21) where two institutions were involved in the partnership activities and there were 20 (28.6%) multipartite partnerships where more than two institutions were involved in the partnership activities. In the study, multilateral partnerships had an average of 3.2 (SD 0.52 partners, Range: 3-5) per partnership.

3.5.2.3 Contractual or collaborative

84.2 percent (59) of the partnerships were contractual partnerships with formal legally bound contractual agreements between the partners and the remaining 15.8 percent (11) were collaborative partnerships without legally bound agreements between the partners.

3.5.2.4 Domestic or International

Majority of the partnerships were (92.9%) funded domestically. But, five (7.1%) organizations received direct international funds.

3.5.3 Classification of partnerships based on target groups and activities

As indicated in the (Table-3.22), a significant 40 percent (28) of the partnership were for Targeted interventions (TIs) targeting CSWs, IDUs, MSM, industrial workers and tourists. 35.7 percent (25 partnerships) were for care and support and the remaining 24.2 percent were for various other programmes such as training, advocacy, VCTC etc.

Table-3.22

Details of the partnered Interventions

Name of the partnered Interventions	Total	Percentage
Targeted Interventions - TI	**28**	40
Care and support	**25**	35.7
VCTC, ICTC, PPTCT	**5**	7.1
General community	**4**	5.7
Training	**3**	4.3
Advocacy	**2**	2.9
Children ART Initiative	**2**	2.9
Women	**1**	1.4
Total	**70**	**100**

3.5.4 Geographical focus of partnerships

More than half (54.2%) of the partnerships focused all the areas such as rural, urban and semi-urban areas. 10(14.2%) partnerships were exclusively focusing their services in urban and semi-urban areas only; 8.5 percent (6) of them were exclusively rural and semi urban focused; 8.5 percent focused exclusively the urban areas and 2 partnerships were focusing exclusively the rural areas.

3.6 Client profile

In total, 225 clients (75 from each district) were included in understanding the clients' perspectives of the partnerships initiatives. A greater number of respondents (58%) were from rural areas - 64 percent in Namakkal, 59 percent in Tirunelveli and 51 percent in Kanchipuram.

3.6.1 Socioeconomic characteristics

A little above half of the respondents (53%) were female beneficiaries (Table-3.23). Around 46 percent of them were married; 13 percent were never married; a significant 21 percent were widow and widowers, 20 percent of them were either married but separated and living away from their spouses. Majority of the respondents (62%) was in the 30-44 age groups and 32 percent were from 15-29 years and the rest (13%) were from above 45 years. The mean age of the population was 31.8 (SD 6.1) years and among male population, it was 32.7(SD 6.3) years and among the female 29.9(SD 6.0) years.

Average schooling was 7.9 (SD 3.3) years - male 9.3 (SD 3.6) years and female 6.6(SD 2.3) years. Around 57 per cent of the population had high school education; around 27 percent have completed primary school education and 3 percent of the population did not go to school at all.

Average Monthly Family Income (Table-3.24) was INR 3,567 (US$ 74) (Range: INR 200-13000; US$ 4-271). The rural average family income was lower than the urban; and male family income was higher than the female family income. As shown in Table-3.24, average individual income of the population was INR 2,222 (Range 0-10,000) or US$ 46 (0-208). The rural individual income (INR 1,845; USD 38) was lower than the urban individual income (INR 2,739; USD 57). Around 40 percent earned less than INR 1,250 (US$ 26) and only 6 percent earned over INR 5,000 (Above US$ 104). Males had higher income than females (male-female income ratio 2.4:1). Table-3.25 shows that among various known high-risk groups, truckers had a maximum monthly income of INR 4,139 (US$ 85), 2.5 times compared to average income in the general population.

Table-3.23

Socioeconomic characteristics of the interviewees*

Place of residence	Sex		
	Number of persons		
	Male	Female	Total
Rural	55 (24.4)	75 (33.3	130 (57.8)
Urban	50 (22.2)	45(20.0)	95 (42.2)
Total	**105 (46.7)**	**120 (53.3)**	**225 (100.0)**
Marital Status			
Married	59 (26.2)	44 (19.6)	103 (45.8)
Widow/widower	4 (1.8)	44 (19.6)	48 (21.3)
Never Married	28 (12.4)	1 (.4)	29 (12.9)
Married but separated	6 (2.7)	21 (9.3)	27 (12.0)
Living away from the spouse	8 (3.6)	10 (4.4)	18 (8.0)
Age of the respondents			
15 to 29 years	35 (15.6)	37 (16.4)	72 (32.0)
30 to 44 years	63 (28.0)	77 (34.2)	140 (62.2)
45 to 59 years	7 (3.1)	6 (2.7)	13 (5.8)
Mean	**32.66**	**29.92**	**31.80**
Std deviation	**6.297**	**5.965**	**6.110**
Educational status			
Nil	2 (.9)	5 (2.2)	7 (3.1)
1 to 5 years	16 (7.1)	44 (19.6)	60 (26.7)
6-10 years	60 (26.7)	67 (29.8)	127 (56.4)
11 to 15 years	24 (10.7)	4 (1.8)	28 (12.4)
16 and above	3 (1.3)	0 (.0)	3 (1.3
Mean	**9.28**	**6.61**	**7.85**
Std deviation	**3.553**	**2.345**	**3.250**

* *Percentages within parentheses*

Table-3.24

Monthly household and personal Income

Sex	Place of residence	Personal income			Household income		
		Mean	N	SD	Mean	N	SD
Male	Rural	2710.91	55	1932.536	4629.09	55	3725.124
	Urban	3850.00	50	2046.027	5110.00	50	2621.127
	Total	3253.33	105	2058.709	4858.10	105	3240.423
Female	Rural	1209.33	75	910.364	1976.00	75	1520.032
	Urban	1504.44	45	1566.547	3206.67	45	2148.509
	Total	1320.00	120	1201.389	2437.50	120	1871.236
Total	Rural	1844.62	130	1610.398	3098.46	130	2977.512
	Urban	2738.95	95	2171.885	4208.42	95	2579.694
	Total	2222.22	225	1915.461	3567.11	225	2863.593

3.6.2 Classification of respondents based on vulnerability

Around 28.5 percent of the respondents were high risk population such as commercial sex workers (CSWs), Injection Drug Users (IDUs) and Men Sex with Men (MSM); 24 percent of them were bridge population such as truckers and migrants; around 28 per cent were HIV/AIDS infected or affected (Table-3.26).

Table-3.25

Monthly income of the high-risk populations

High Risk Category	Mean	N	Std. Deviation
CSW	2434.09	44	1453.455
Trucker	**4138.89**	**18**	**1713.318**
IVDUs	3625.00	8	1246.423
Migrant	2930.56	36	2328.558
MSM	2791.67	12	1827.297
HIV Positive	1290.91	44	1064.669
Spouse positive	780.95	21	411.848
Gen Population	1838.10	42	2196.555
Total	**2222.22**	**225**	**1915.461**

Table-3.26

High risk category and place of residence*

Vulnerable population	Rural	Urban	Total
Commercial sex workers	20(8.9)	24(10.7)	**44(19.6)**
MSM	8(3.6)	4(1.8)	**12(5.3)**
IVDUs	0	8(3.6)	**8(3.6)**
Migrant	16(7.1)	20(8.9)	**36(16.0)**
Trucker	8(3.6)	10(4.4)	**18 (8.0)**
PLWHA	33(14.7)	11(4.9)	**44(19.6)**
Spouses of PLWHA	17(7.6)	4(1.8)	**21 (9.3)**
General Population	28(12.4)	14(6.2)	**42(18.7)**

** Percentages within parenthesis*

CHAPTER IV

RESULTS-1

UNDERSTANDING THE DEMAND SIDE AND FIRST CONTACT POINTS

This chapter, in essence, presents the results of the FGDs, mapping/combing of first contact points and interviews with them. It touches five issues viz,

- High-risk sexual behaviour
- Emerging high-risk groups, particularly among the unconventional and untargeted risk groups in the general population
- HIV/STI care seeking
- First contact points - who are they? And what they do?
- Their potential and willingness to partner in the HIV/AIDS management and control.

4.1 High-risk sexual behaviour

In terms of sexually transmitted infections (STIs) and HIV/AIDS, any sex outside of marriage or a one-to-one relationship, especially without the use of condoms, is risky. Also, sex within marriage becomes risky when one or both partners have extra-marital sexual relationships. In this study, the FGDs revealed that high-risk sexual practices were somewhat widely prevalent among the general population across a wide range of specific population groups, as well as among the conventional high-risk populations irrespective of the geographic and socio-economic variations. In specific, the FGDs recognized that, men having sex with men (MSM) was a significant problem. Even after marriage, many of them continue to have sex with other men without the knowledge of their wives. Many of these contacts were with strangers and condom usage was not regular because of the hurried and casual nature of sex. In addition, many men did not consider anal penetration as sex and therefore did not recognize the risk involved and tend to avoid condoms with their partners and later with their wives. Though there is higher level of awareness among

the commercial MSMs, their clients were not having much knowledge and awareness which lead to unprotected high risk sexual practices.

> *"Our clients are mainly married men and youngsters. We get clients from both towns and villages"*
>
> ***- Commercial sex workers***

> *"Sexual practices, both paid and unpaid, among unmarried people are somewhat widespread in villages."*
>
> ***– Youth community members***

> *"We get all kind of Panthis[11] (clients), from school students to police to business men, but majority of them are married family men. We would always tell them to use condoms. But only half of them use it."*
>
> ***- Kothis[12] (Transgender)***

4.1.1 High-risk pre and extra marital sex

In many discussions, it was expressed that the concept of being faithful to one partner hardly existed in practice. It was also revealed that premarital and extramarital sexual practices were not very uncommon and it was not considered as a taboo or crime as perceived generally in the past. The focus group discussions revealed that casual pre-marital sex among the adolescents and adults particularly among students and young employees were increasing both in the urban and rural areas due to curiosity, high flow of money during young age, increased opportunities to mix with the other gender etc. The risk for transmission of STIs, HIV/AIDS in such clandestine encounters is also high because people often do not take adequate precautions. In some communities, the casual

---

[11] *Panthis are often the clients of kothis. It is a kothi name, given to "real men" usually the clients of the Kothis.*

[12] *Kothi is a self-identified label used by feminized males who have sex with men, and use their feminized behaviours in public spaces to attract "real men" for sex. They are usually sexually penetrated. However, many kothis will also be married with children in a culture of "compulsory heterosexuality*

multi-partner sexual practices were literally allowed and it was not seen as immoral or erroneous.

> *"Only about 30 - 40% among the married probably keeps alive the concept of 'faithfulness' to one partner."*
>
> ***– Community members***

> *"At least 50% of the unmarried people indulge in sex. In villages too, it is quite common, but hidden. About 50% of college students would have had some (sexual) experience"*
>
> ***– College students***

> ***"****Seventy five percent of the unmarried people are indulging in sex. Mainly, young and small boys are affected. At the same time we get lot of married clients****"***
>
> ***– Commercial sex workers***

> *"Sex experience during the adolescent age is a status symbol and a proud experience to be discussed with the peers. Many are having married sexual partners"*
>
> ***– Youth members***

> *"There is a specific community called ------- (cannot be named due to ethical reasons) whose members have (sexual) relationship with close family members and multi-partner sex is very common among them. In another community, they change the spouses very often and they also have multi-partner relationships. It is their culture and it is not seen as wrong"*
>
> ***– NGO workers***

> *"The awareness level has increased, but the increasing numbers of young girls coming for abortion and for birth control after sexual encounters are really worrying"*
>
> ***- Nurses***

It was also briefed that urbanization, mobility, and communication technology have made easy access for sex. Other than the commercial sex workers, many indulged in sex work when in need of money for luxury life and in case married women, to supplement the

money given to them by their husbands for running the household expenses. In addition, men and women sought sex for pleasure with different partners, especially when their spouse has lost interest, an alcoholic or very abusive or violent. Sex in exchange for favours was also very common in rural areas where it is driven by poverty and desperation, in addition to a variety of other social and individual reasons.

4.1.2 Condom usage

Though there have been huge efforts to promote condoms among the sex workers, vulnerable populations and among the general population, condom usage was not really in practice especially during high risk sexual encounters in spite of the overall improvement in the levels of knowledge and awareness. This dismal situation of condom usage was due to various reasons such as lack of availability, difficulty in the accessibility, storage and disposal of condoms especially in the rural areas. The higher rate of unplanned sex, lack of adequate knowledge, perception that condom reduces the pleasure and other misconception related to condoms was also contributing to unsafe sexual practices. Even the highly targeted groups like commercial sex workers and MSMs were not able to maintain continuous and consistent use of condoms. In spite of the elevated awareness level among the commercial sex workers, many have too little ability to negotiate with all their clients to use condoms for want of more money and also due to the fear of losing the clients. They, thus, continue to be highly vulnerable to all STIs and HIV/AIDS.

> *"More number of youngsters coming for free condoms telling other reasons and now-a-days people are not very reluctant"*
>
> ***- PHC Nurses***

> *"Customers are reluctant to use condoms. Because they feel that there will not be real pleasure. We too don't insist since we will get more money for not using the condom or lose the customer otherwise. Among the unmarried, condom usage will be difficult 90 percent of the times. Majority of them don't like to use it. But married people will be little careful"*
>
> ***- Commercial sex workers***

"Sex for us will not be a planned one. 'That time' condoms will not be available"

- College students and youth members

Sexual practices among college students are really increasing for various reasons such wanting for luxury life, fun, and compulsion of the partner to strengthen the relationship and even for physical desire, but they are knowledgeable and they can safeguard themselves

- College Teachers

"Condom usage is not at all possible in villages. Where is it available? Even if it is available, it is very difficult to buy and use it"

- Community members

"Many people are coming to us for medicines before and after going for sex, but very rarely people ask for condoms"

– Pharmacists

"After 15 years (of age), both male and female are going for this (sex). They know about condoms, but do not use it. Because, it will not be good"

– Dhobis (Washer men)

Especially the unmarried are reluctant to use condoms. They tell us "If I should use condoms I can go to prostitutes, why should I come to you" we also develop a close bond between our regular friends, we don't use condom among our regular clients

- Kothis (Transgender)

Moreover condom usage was very much influenced by the appearance, education and socio-economic status of the partners. These characteristics encourage both the partners to perceive negligible risk of infection through them. For most people whether it was a commercial sex worker or a person from the general population, the perception of risk was associated more with socio-economic status rather than the behaviour.

"Lot of college boys and youngsters are coming to us. They want to experience the real pleasure. We also do not insist for college students and for decent people. Otherwise we don't go without condoms.

– Commercial sex workers

Ironically, many who suffer are not aware of the consequences of risky sex for mental, emotional and physical health and many others are making wrong choices in spite of knowing the risks.

Lot of unmarried youngsters, labourers, and even elderly are going to prostitutes (CSWs). Even if we tell them that a particular person is HIV positive, some of them do not mind and proceed to have sex with them. We don't know whether they are using condoms.

– HIV positives (A peer worker in a NGO)

So, it is evident that increased knowledge and awareness and high-risk sexual behaviour co-existed together. The real problem was absence of continuous and consistence condom usage among those who indulge in high risk behaviours both in rural and urban areas.

4.2 Emerging High-risk groups

It has been once again established from the FGD results that CSWs, MSM, IDUs, long distance truck drivers, slum people, migrants and returnee migrants are the high-risk population for STIs and HIV/AIDS. However, there were enough clues from the FGDs that high-risk sexual behaviour was not restricted to these groups only; it was also prevalent among various other hidden and hitherto un-targeted groups in the general population. The illiterate, the poor and the underprivileged rural people faced more STI and HIV/AIDS risk than the literate urban populations. It was also realized from the FGD findings that it was indeed very hard to segregate high-risk groups from the general community.

"Other than the high-risk groups like CSWs, there are varieties of people who may be in high-risk of getting/transmitting these diseases due to their behaviours. We can't exclude anybody from the risk, as sex with non-regular partners is rather increasing."

– Qualified medical practitioners

4.2.1 Industrial workers

The discussants mentioned many population groups, based on their occupation, as vulnerable for the infections in all the three districts. For instant, in Tirunelveli district, it was mentioned about the small-scale industries such as match box business, cracker business, tobacco (*Beedi*) related business. Urban industrial workers, textile mills and other small factories workers were mentioned in the other districts. In addition, the discussion revealed that poor and illiterate, mainly, adolescent girls and boys who were working in these industries were very vulnerable because exploitation of female workers for favour and other benefits was common. These workers were either exploited or they voluntarily involved in high-risk sexual activities for various reasons.

> *"Lot of adolescents and unmarried young girls are working in small scale business. Sexual practices are very common within the campus. For getting the material and even for selling the beedis(tobacco product) made by them, the poor women need to make compromises with the agents and owners"*
>
> ***– Youth community members***

> *"In industries like textile mills, sexual abuse and practices are very common. From our experience we can very well say that many are having sexually transmitted infections and even HIV"*
>
> ***- NGO workers***

4.2.2 Drivers other than the long distance truckers

It was quoted in almost all the FGDs that not only the highly targeted long distance lorry drivers but also the rickshaw pullers and auto drivers were at risk of getting STIs and HIV/AIDS because of their high-risk sexual behaviours. They get more opportunities due to their interactions with the public and indulge in high-risk sexual practices as they perceived that sex would reduce the body heat. Many a times it would end up in high risk sexual practices.

4.2.3 Moving populations

It was mentioned by many discussants that those who travel a lot for various reasons (e.g. marketing employees and mobile vendors) are vulnerable for STI/ HIV/AIDS related infections as they tend to involve in high risk sexual practices. In specific, vendors in trains were identified as one of the high-risk groups. It was quoted that there were agents as well as sex workers in the short route trains. Other vendors like daily paper workers, milk man etc were pointed out as bridge populations[13] as they get connected with the local population easily and indulged in unsafe sexual practices. The spouses of these people, with monogamous relationship, usually get affected through their partners. .

4.2.4 Construction workers

As seen in Table-4.1, construction workers (male and female) were mentioned as an important high-risk group in various group discussions. They used to go to different places for construction work which paved the way for high-risk sexual behaviours. This is one major group with high chance of transmitting the disease to the general community through their respective spouses.

> *"The construction workers both men and women go to distant places for work and they usually stay there for their work. Both, consensual sex and exploitative sex are very common among these groups. There are even agents for these people for commercial sex"*
>
> ***- Community members***

4.2.5 Casual Labourers

It was also mentioned that other casual labourers, coolies, hotel and lodge based workers, load men and women as vulnerable to sexually transmitted diseases. Another occupation related group was fishermen and sea related workers Alcohol was closely related to their life and a considerable proportion of these hard labourers were very regularly using alcohol and after consumption a significant proportion would seek for commercial sex as well. They justify that alcohol coupled with sex mostly commercial sex would reduce the body

[13] *Population who transmit the infection from high risk population to the low risk general population*

pain and the heat. During most of these encounters, condom usage would not be possible due to non-availability and inability to use condoms. High risk sexual practices among forest based work was also common in one of the districts. Both men women go in-group to forest areas for regular work and high risk sexual practices were considered as common.

> *"Sex is considered as a physical and mental pain reliever among the labourers who work hard during the day. Alcohol and after that women are part of their life in order to relive the pain. The unmarried and those who stay away from their spouses go for paid sex"*
>
> ***- Community members***

> *"Those who go for work in the forests are very vulnerable for infections as both men and women go in groups to work. STIs are very prevalent among them"*
>
> ***– NGO workers***

4.2.6 College, School students and young employees

They were also cited as high-risk population by many focus group discussions. The FDGs among the students also disclosed that a significant proportion involved in casual high-risk sexual practices. But, it was also found that, in spite of the high knowledge and awareness level, safer sexual practices among them was not usually possible both in non-commercial and commercial sex encounters. In addition, there are an increased number of young people in their early years, become economically self-sufficient. They tend to involve in high risk sexual practices for fun as well as because of curiosity

> *"Half of the male college students have experience of sex from either a regular partner or from the commercial sex partner. Among female also it is there. We can't ensure condoms in all the encounters. Many have started even in their school levels. They even share their experiences with their close friends"*
>
> ***-College students***

> *"Now-a-days many start earning in their early 20s, when they become economically sound. The next choice for them is to enjoy their life and have sexual experiments either with regular partners or commercial partners"* ***-other service employees and college teachers***

Table-4.1

High-risk groups other than the conventional ones

Risk groups	No. of FGDs mentioning it	% (N=59)
Construction workers	46	77.9
Industrial workers	38	64.4
Daily wages/casual labourers	28	47.4
Moving populations	24	40.6
Village small scale industry workers, workers in small shops	22	37.2
College Students/youngsters	17	28.8
Riksha pullers, Auto and taxi drivers	16	27.1
Health care delivery staff	11	18.6
Village dancers	10	16.9
Forest Workers	8	13.5
Staying/working in lodges(lodge boys)	8	13.5
Police	8	13.5
Tribals	7	11.8
Blood transfusion in villages	4	6.7
Refugees/street children/school drop outs	4	6.7

4.2.7 Village (folk) dancers

During festival times in villages, group dancers and drama people come to villages in great number and one of their main agenda was to have as much possible sex business and earn money during festival seasons. The discussions revealed that the local villagers go to them for sex with them in great number without knowing the risk.

> *"Many villages invite group dancers to perform in their villages. They would have sex with the local population for more money. They will have as many numbers of partners as possible during their stay"*
>
> ***- Community members***

4.2.8 Some tribal groups and others

Narikkuravars,[14] street children, drop out school children, and refugees were some of the other populations who were at higher risk for STIs and HIV/AIDS.

4.2.9 Healthcare workers

Most of the focus groups with some medical background explained their worries that they were at a higher risk of getting the infections, due to inadequate facilities, supplies, inability to adopt precautions because of the high quantity of patients especially in government hospitals. Lack of knowledge to prevent acquired infections in the health care settings was also one of the reasons cited by the FGDs. In addition, the unsafe practices in the health care settings were mentioned as risk for STI and HIV/AIDS infection. Few FGDs even mentioned that un-safe injections and even unsafe blood transfusion in emergency was common in rural nursing homes.

> *"There are no adequate facilities in government hospitals. Gloves, kits and disposable syringes and needles are not freely available. So, even health care workers are at high risk though there is a very remote chance for the transmission of STIs and HIV."*
>
> ***– Primary health care centre nurses***

> *"In many clinics, they same syringes are used for all the patients without proper cleaning and sterilization"*
>
> ***– Youth members***

> *"In villages, our barbers are still using the same knife and blades. So all are at risk"*
>
> ***– College student***

> *"Poor village people are exposed to quacks (less than fully qualified practitioners) needles."* ***– Doctors***

[14] *A tribal community in India whose members usually move around freely without having stable places of residence.*

"Blood transfusion is happening in local private hospitals though they do not have blood banks. They do it without proper screening"

–Rural school teachers

From the FGDs, it was also found that high-risk population groups who are the drivers of the epidemics vary from place to place and from district to district. It mainly depends upon the business opportunities, industries, income and specific cultures of the particular location and district. It is also evident from the focus group discussions that no occupation and no population group is free from the risk of STIs and HIV/AIDS as high risk sexual practices cannot be secluded from any occupation groups, community, age groups and based on their residence.

4.3 STI, HIV/AIDS care seeking behaviour

The results specified that the stigma and discrimination, the myths and misconceptions prevailing in the community greatly influenced the health seeking behaviour of those who were in need of STI and HIV/AIDS care and treatment. The other factors influencing the health seeking behaviour were the availability of the providers and services, distance, geographical location, affordability, experience with the providers as well as social and cultural barriers.

4.3.1 Myths and Misconceptions

There were varieties of myths and misconceptions persisted in the community such as, sexually transmitted infections are caused by body heat, food habits and even evil spirit. So, whenever the symptoms occurred, these people took self medication such as consuming curd to reduce the heat; washing the genital area using permanganate solution, hot water, lime, dettol, local herbs and soda in the affected areas; drinking donkey milk and herb juices; and even they go to local priests (*samiars*) to send out the devils from their body. In few places, there was still a belief that that having sex with a virgin or donkey would protect and cure the STIs. These kinds of myths and misconceptions not only

prevented them to seek treatment and care in time but also increased the severity of the problems.

> *"In our target area, many people have a mis-conception that using soda, lime and donkey milk cures STIs. They also believe that sex with virgin or donkey will protect and cure the infections"*
>
> ***– NGO workers***

> *"Most of these kinds of diseases are because of excess heat so we will take cool foods like curd. If it is not cured, we will then take herbal juices (Veppilai Kashayam or other kashayam) which will immediately cure the problems. If we go to the elders they will advise very clearly"*
>
> ***– Village women community members***

> *"Applying lime juices, hot water or dettol immediately after the sex will protect from this kind of diseases. Otherwise we can take medicines or have injection from the local pharmacist or village doctor to protect from the diseases"*
>
> ***- Male Community members***

4.3.2 Fear, stigma and discrimination

The discussion disclosed that there has been a huge reduction in the stigma and discrimination faced by the affected community, in the family, community and in the health care settings thanks to the continuous efforts by various players. However, it was also revealed that stigma and discrimination still persisted in many communities and even in health care settings. There were discriminating attitude of the health care workers existed in both private and public health care settings. These included denial of and delayed treatment, not treating the patient with respect, lack of confidentiality, segregation from other patients, and early discharge. In general, stigma and discrimination in the community and in the health care settings prevented the general community to voluntarily coming for testing and to seek health care. Especially in the public health care settings, denial of adequate time to discuss, lack of respectful treatment, lack of space to maintain confidentiality were the important factors, prevented the community to access treatment for even sexually transmitted infections.

"Many private providers in their clinics and hospitals used to treat us differently. Once they know our HIV status, we can sense a different kind of treatment. They will be very careful in sending us out as early as possible. Many times, we will be referred immediately to government hospitals. In government hospital, we can't expect any respect and the treatment will be entirely different. So we are forced to seek health care from other providers. But fortunately, the situation is improving"

- PLWHAs

We can never tell openly in a hospital about our HIV status. It will always affect the experience in a clinic or in a hospital. So unless and until it is necessary, we don't disclose out status

– HIV positives

These fear, stigma and discrimination not only prevented the affected from seeking care but also forced them to seek care from far off places from their homes and to seek treatment from un- qualified medical practitioners in order to maintain secrecy. But discussions also recorded that there was an increase in seeking testing, treatment and care both in urban and rural areas.

"Only 5-10 percent goes to health care providers if they know about the problem. Initially they will discuss with the friends. They will go to doctors if it become serious and unavoidable"

- College students

"People will try all the possible ways to cure it without revealing to anybody. Because, if it comes out, there will be lot of problems in the society. Final choice is to meet the doctor"

– Police

"Though there are lot advantages of huge awareness programmes, it is also true that it has increased the fear among the community. So, though we want to get tested and get treatment, we would go to other places only due to various reasons. If something bad comes, we cannot live in our place if we access any services in our place"

– Male community members and other service employees

"Many may go to doctors without knowing that this is an STD. If we already know about it, we will not go to anybody"

- Youth and Community members

"Now-a-days the number of people coming for treatment is not like earlier days. There is a definite increase"

- Qualified Doctors

"People, if young, are scared and don't go to doctors at all. Fear makes them to go to other providers and quacks"

- NGO workers

So, though there is an overall improvement in the knowledge and awareness level, stigma and discrimination, myths and misconception persisted in the community especially in the rural areas which affected the health seeking behaviours of the community in addition to the Geographic, economic, social, cultural and organizational factors.

4.4 First points of contact

The desired health care seeking behaviour for an individual to respond to an illness episode related to STI and HIV/AIDS is by seeking first and foremost help from a trained doctor, in a formal health care setting. There have been huge efforts to increase the availability of services and to raise the community awareness regarding the importance of seeking care from trained personnel.

But the focus groups discussions among various population groups disclosed that there were variety of health care providers who were the primary health care providers or the first point of contacts in terms STIs and HIV/AIDS related services (Table-4.2).

4.4.1 Traditional Healers and Self-medication

The group discussions unveiled that the initial reaction of a significant proportion of the community was to attempt different kinds of self-medications especially in the form of "*Kai Marunthu*" in villages. They prepared the medicines using the available materials in the home mainly herbals, based on the practice by elders. When it failed, they preferred to

go to the local herbal practitioners and traditional healers (55.9%), like *"country Vaidyar or Naatu Vaidyar"* for treatment. Few discussions mentioned that the community even go to priests (*samiars*) and even fortune-tellers for advises due to the misconceptions that sexually transmitted infections are caused by evil spirit. Simultaneously, when self medication failed, they did go to even the grocery stores where drugs would be available.

Table-4.2

First points of contact for suspected STI, HIV as mentioned by the FGDs

First point of contact for treatment and care	No. of FGDs mentioning this (N = 59)	%
Private Doctors and Hospitals	43	72.8
RIMP and RMPs (LTFQs)	40	67.7
Pharmacy or medical store	39	66.1
Traditional healers/ *Naattu Marunthu Vaidhyam*	33	55.9
Advertisement/Lodge based practitioners	26	44.0
Self Medication/*Kaimarunthu*	19	32.2
Health care staff in the villages	22	37.2
Village health nurses	20	33.8
Siddha and Ayurveda	19	32.2
Grocery Stores	11	18.6
PHC/government hospitals	21	35.5
Postal Medicine	5	8.4
Temple priests/*Samiars*/Fortune tellers	7	11.8
NGOs	6	10.1

"It is very difficult to go to hospitals as it is time consuming, expensive and far away. So we prepare Kai marunthu[15] *or go for Naatu marunthu*[16]*"*

- A women community member

[15] *A form of self medication*
[16] *Country Medicine*

Village country vaidyars are the people who are approached initially. Even Fortune-tellers and priests are approached. If they tell not to seek any health care they will not go to any health care practitioner

- Auxiliary Nursing Midwives

They try their "Kai vaithyam and Patti vaidyam". They use lemon and milk for curing STD

- A positive network person

"In our villages, we go to grocery stores where we can get medicines for small problems. There will be tablets and even ointments. The first thing we do is getting something from there for any kind of problems"

-Women community members

4.4.2 Pharmacies

Pharmacists or Medical stores (66%) were the much sought after providers which was mentioned in many group discussions. Especially in rural areas, as medical care are relatively costly and unavailable they tend to buy medicines from the pharmacy or medical stores. The discussion revealed that it would reduce the cost of consulting a doctor and also people could buy medicines according to the availability of money.

"Many people don't go to doctors or seek any treatment for STIs though they know that they might be affected. But they come to us"

- Pharmacists

"In many villages in our area, pharmacists run even clinics with a doctor's name who never come to the village"

– A community member

"If they know that they are having a STI, 60 percent immediately come to Medical stores only. We treat them and if it is severe, we refer them to doctor. If they have to go to doctors they have to spend minimum 20 rupees other than the medicine cost, so they will consult us and get the medicines directly"

- A Pharmacist

"Initially, we go to medical stores only. We go there 4 or 5 times. If no cure, poor people go to government hospitals. Others go to private doctors or private hospital"

- A Community member

4.4.3 Less-than-fully qualified practitioners (LTFQs)

Majority of the discussions (67.7%) disclosed that the registered medical practitioners (RMP) and registered Indian medical practitioners (RIMP) who are often less than fully qualified practitioners (LTFQs) were one of the strong favourites for both the urban and rural care seekers. They were approached because of their convenient time, proximity, cheaper medicines and also because of the un-availability of other qualified medical practitioners. The different discussion groups also felt that the duration of the treatment by them was shorter and effective, and the cost was less as compared to the full course prescribed by a government doctor or private qualified practitioner. In addition, they were having sympathetic attitude towards the patients, willing to listen to the patients, deferring of the payment to a later date were all important reasons for seeking these providers.

The discussions recorded the role of the village health nurses (VHN) also, as they were the first one who usually knows about the STIs among women during their home visits. Moreover, many people approached those who are working with doctors or worked with doctors in the past with or without qualifications.

"Qualified doctors may not understand the body language of the STI patients. Because, patients usually tell non-specific things. We need to understand. A busy practitioner may not be able to build a relationship with the patients. The OP time and the OP set up are also not conducive for STI or HIV treatments. So they may go to LTFQs.

– Doctors

"In villages they consult village health nurses or Local unqualified doctors. Most of the people do not go to any qualified people. But 95 percent of the time, they don't get cured. Many a times, the affected people would make up their mind that it will be there for life long. "

- A Fully Qualified Doctor

"There are many unqualified Tamil vaidyars, claiming as STI specialist, having medicines for STDs and HIV/AIDS. Most of the people would not go to allopath Doctors out of fear of people"

– A police

"The affected are coming to us only. You can't see a village without a rural medical practitioner. Each one covers 4-5 villages. The patients will tell everything to us as the people have high confidence on us".

– LTFQs

"In villages, RMP RIMP are contacted a lot, as the fee for qualified doctors are very high and also they write lot of investigations"

- School Teachers

"If we go to the local RMP, we can tell everything to him. He will also spend time with us and he can understand the feelings of the people as he is with us. Moreover, he will come to us whereas we have to go behind to meet the other doctors"

– Community members

4.4.4 Qualified practitioners of other system of medicine

The group discussants also mentioned that they would seek care and treatment from the qualified practitioners in other systems of medicines like *siddha, ayurveda, unani* and *homeopathy*. These practitioners were contacted for STI and HIV/AIDS treatment mainly because of the notion that there is no cure in allopathic medicines. In addition, it is over emphasized and it has not been properly denied that there are medicines in these systems of medicines for STI and HIV/AIDS.

"Many newspaper items tell that there are HIV/AIDS medicines in siddha and ayurveda. So, many of the affected approach them"

- CSWs

"Medicines are available in Siddha and Ayurveda and importantly there will not be any side effects and it will improve our health also"

- Teachers

"People go to alternative system because even in advertisements it is mentioned that there is no medicine for this in modern medicine"

– A Pharmacist

4.4.5 Fully qualified private medical practitioners

Among those who seek care and treatment from qualified medical practitioners, private practitioners were much preferred than the public practitioners due to factors like respectful treatment, less waiting time, accessible, responsive to the needs and confidentiality. However, very often, if a patient is diagnosed as HIV positive or if he had developed AIDS, he or she will be immediately referred to government hospitals. There were even higher level of awareness to seek treatment and care from the specialists (STI specialist), both from the public and private sector particularly by the educated and youth. Very poor people preferred government hospitals and primary health centres (PHCs) also. The main reasons for not accessing the government services are that they were not sympathetic towards the patient, un-availability of medicines, unavailability of doctors and nurses, lack of willing to listen, no confidentiality and long waiting time. .

"There are so many VD specialists. If we get any symptoms we would go to the specialists only. But we can't go to the doctors who are near to our place. We have to go to other towns only. Otherwise, it will become a big issue in the community"

- Youth community members

"If we know that we are affected it would be very difficult to go to any doctor. They go to a doctor whom they can depend as well as confidential. In government hospitals they do not give respect and proper treatment. So we are reluctant to go to GH".

- Community members

"People are very open to talk about all these issues. There is no hesitation to go to a doctor for treatment even if it is a doubtful sexually transmitted disease. Now a days government hospitals are providing good services"

– Other service employees

"As we do not have any option, we go to PHCs. They treat us very badly and they do not give proper treatment. If with some STD, it is really difficult to get proper treatment from government sector"

- Youth community members

"In private set up when they know the status, they immediately refer the patients to government hospitals".

– Doctors

We go to private doctor who is very simple and not costly. We do not go to Government hospital, as they will be sending here and there for 3, 4 days. We have to go for work, so we have to save time also.

–Dhobis

"They usually do not go to government facilities as the treatment will not be good and there will not be any respect for people. Other wise, there will not be medicines available"

– Pharmacist

"When we go to government hospital, there will not be doctors and even medicines. We have to come back after travelling a lot. But we are depending on the government hospitals only. But, it is better to take some treatment from private clinic"

- Women self help group members

4.4.6 Other health care workers

Other health care workers (37.2%) like nurses, lab technician, pharmacists, field level health care workers who reside in the nearby areas were also contacted for medical advises and treatment.

4.4.7 Lodge and advertisement based practitioners

Qualified and unqualified practitioners of different systems who advertise in TV, paper and other media were also playing an important role in STI, HIV/AIDS treatment. These practitioners often claimed that they have medicines for curing STI and HIV/AIDS. The focus group discussions revealed that the affected even approached the providers who

offered medicines by post. The affected also accessed the services of the providers who were lodge based doctors. They visited regularly to different places in specific dates. The affected consulted them because they would be new to them and there will be privacy and confidentiality.

> *"People go for treatment based on advertisements mainly outside their places or the doctors who are coming to different lodges. This is common among both educated and uneducated people"*
>
> ***- Community members/Teachers/Police***

> *"Many even get medicines through post from those who claim that the have medicines for STIs and HIV/AIDS"*
>
> ***– NGO workers***

SO, from the FGDs, it could be understood that a variety of providers were accessed as first points of contact for STI and HIV/AIDS services in addition to the qualified practitioners.

4.5 Provider potential and willingness

The attempt to understand the availability of different care providers and their potential, elicited information regarding the availability of different types of providers as well as their involvement in STIs and HIV/AIDS prevention, treatment and care. Out of the 223 health care providers enumerated and interviewed, 28.6 percent (64) of them were qualified practitioners, 31.8 percent (71) were LTFQs with some formal training and 39.5 percent (88) were LTFQs without training.

A greater number of (82.5%) of the providers were from the private sector. The study population (3 districts) had only 0.55 qualified practitioners per 1000 population, but they had 0.66 LTFQs with some formal training and 0.76 LTFQs without any training. In total, there were 1.9 providers per thousand populations.

4.5.1 Reason for the choice of the Providers, as perceived by the Providers

Proximity and cost were mentioned by most of the LTFQs both trained(64.7%) and untrained(61.2%), as the important reason for the community to seek health care from them (Table-4.3). Fully qualified practitioners mentioned their qualification (37.5%), proximity (20.3%) and quality (15.6%) of services as the driving factors for the people to access them.

Table-4.3

Reason for the choice of providers*

	Qualified	LTFQ-Trained	LTFQ-Untrained	Total
Nearer	13 (20.3)	21 (29.5)	27 (30.6)	61 (27.1)
Cheaper	7 (10.9)	25 (35.2)	27 (30.6)	59 (26.4)
Well Qualified	24 (37.5)	5 (7)	5 (5.6)	34 (15.2)
Experienced provider	7 (10.9)	10 (14)	11 (12.5)	28 (12.5)
Good quality	10 (15.6)	7 (9.8)	9 (10.2)	26 (11.6)
No other way	3 (4.6)	3 (4.2)	9 (10.2)	15(6.7)

** Figures in parentheses are percentages*

4.5.2 Perception about STI and HIV/AIDS prevalence

Majority (81.6%) of the providers felt that that the prevalence of sexually transmitted infections (STIs) and HIV/AIDS was significant (Table-4.4) in their surroundings. In specific, 38.6 percent of the providers mentioned that the prevalence was high and 43 percent of them mentioned that it was medium.

But, 13.6 percent of the providers felt that they were getting STIs including HIV often (Table-4.5), of which almost half of them (53.3%) were qualified providers. 47.5 percent of the providers reported that they were coming across occasional STI and HIV cases.

Table-4.4

Perceived STI and HIV/AIDS prevalence in their area

Prevalence	Qualified	LTFQ-Trained	LTFQ-Untrained	Total
High	27 (42.1)*	32 (45)	27 (30.6)	86 (38.6)
Medium	22 (34.3	29 (40.8)	45 (51.1)	96 (43)
Low	15 (23.4)	9 (12.6)	13 (14.8)	37 (16.5)
Don't Know	0 (0.0)	1 (1.4)	3 (3.5)	4 (1.7)
	64	**71**	**88**	**223**

** Figures in parentheses are percentages*

Table-4.5

Frequency of coming across STIs including HIV/AIDS*

	Qualified	LTFQ-Trained	LTFQ-Untrained	Total
Often	16 (25.0)	8 (11.2)	6(6.8)	30 (13.4)
Occasionally	36(56.3)	32(45)	38(43.1)	106 (47.5)
Rarely	12(18.7)	28(39.4)	33(37.5)	73 (32.7)
Never	0 (0.0)	3(4.2)	11(12.5)	14 (6.2)

** Figures in parentheses are percentages*

4.5.3 Perceived ability and experience in managing HIV/AIDS

When it is specific to managing HIV/AIDS cases, 81 percent of the qualified providers mentioned that they could manage HIV cases whereas 59.1 percent and 53.4 percent of the LTFQs-Trained and LTFQs-Untrained reported so (Table-4.6). But irrespective of the perceived ability, a significant proportion of all the three types of providers had the experience of managing HIV/AIDS cases within the duration of last 6 months. 62.5 percent of the qualified practitioners, 63.3 percent of the LTFQs-Trained and slightly lesser

proportion (54.5%) of the untrained LTFQs had the experience of managing HIV patients in the past.

Table-4.6

Ability to manage and experience in managing HIV Cases

	Qualified	Trained LTFQs	Untraiend LTFQs	Total
Ability to manage HIV/AIDS cases	52 (81)*	42 (59.1)	47 (53.4)	141 (63.2)
Prior Experience in Managing HIV/AIDS	40 (62.5)	45 (63.3)	48 (54.5)	133 (59.6)

** Figures in parentheses are percentages*

4.5.4 Willingness to involve in HIV/AIDS control

Invariably all the providers irrespective of the types, showed their willingness in prevention and counselling activities in collaboration with the public, private or not-for profit sector (Table-4.7). Relatively a lesser amount of providers confirmed their willingness to involve in treatment and care to the HIV/AIDS clients. However, a higher number of the qualified providers (84.3%) and 66 percent of the LTFQs-Trained and 59 percent of the LTFQs-Untrained showed their willingness to involve in treatment and care of HIV/AIDS clients.

Table-4.7

Willingness to involve in HIV/AIDS control*

	Qualified	LTFQ-trained	LTFQ-untrained
Prevention promotion and counselling	61 (95.3)*	71 (100.0)	82 (93.1)
Treatment	54 (84.3)	47 (66.1)	52 (59.0)

** Figures in parentheses are percentages*

4.5.5 Factors preventing the providers from involving in HIV/AIDS management

Out of the 134 providers (Table-4.8) who gave their opinions about the factors preventing them from involving in the management of HIV/AIDS, 32.8 percent mentioned that they were not having the adequate knowledge and training to manage HIV/AIDS (13.6% of the qualified, 39.7% of the LTFQs-Trained and 35.4% of the LTFQs-Untrained); 35.8 percent mentioned, lack of facilities of which 39.5 percent were qualified providers. Fear of losing clients (13.4%), and fear of contracting the disease (13.4%) were the other major reasons quoted by the providers. The fear of losing clients and contracting the disease was relatively higher among the LTFQs.

Table-4.8

Factors preventing the providers from the involvement in HIV/AIDS management*

Type of practitioners	Lack of training/ knowledge	Lack of facilities	Stigma	Fear of losing clients	Fear of contracting the disease	Total
Qualified	6	19	2	3	3	33
Trained LTFQ	21	14	3	6	9	53
Untrained LTFQ	17	15	1	9	6	48
	44 (32.8)	**48 (35.8)**	**6 (4.4)**	**18 (13.4)**	**18 (13.4)**	**134 (100)**

** Figures in parentheses are percentages*

CHAPTER-V

RESULTS-2

PARTNERSHIPS EVALUATION FROM HEALTH SYSTEM PERSPECTIVE

This chapter brings out partnership evaluation results from a health system perspective. The evaluation explicitly included inputs, processes, perceived and systemic outcomes as key analytical components. Inputs such as financial and human resources explain what has gone into the partnered activity. A number of less tangible factors were also considered as key inputs to the process; age of the partnership, objective, motive, recognised need and pre-partnership processes are some of them. Process evaluation focused on partnership working, relationships among partners, and the partnership health. Outcome evaluation provided a picture of the results or effectiveness of a programme in achieving its intended goals; the intervention's desirable or undesirable effects, intended or unintended effects. Results are presented here using the input-process-outcome framework

5.1 Key characteristics

On the average, partnerships under evaluation existed for 3.2 years (SD 2.4, Range 1-11 years) - Namakkal 3.6 years (21 partnerships, SD 2.2, Range 1-9 years), Tirunelveli 3.2 years (27 partnerships, SD: 2.8, Range 1-11 years), and Kanchipuram 2.8 years (22 partnerships, SD 2.1, Range 1-9 years). Public funded partnerships had higher mean age (3.9 years, SD 2.3) than the private funded ones (3.0 years, SD 2.4); similarly, among the private funded partnerships, APAC-USAID supported partnerships had higher mean age (4.1 years, SD 3.0) than others private funded partnerships (2.4 years, SD 2.0).

5.1.1 Partnership objectives

Over 54 percent of the partnerships had prevention and promotion as their primary objective while it was care and support for 35.7 percent; training for 4.3 percent; treatment and advocacy for 2.9 percent each. Rehabilitation was not the primary objective for any of them. For 21.4 percent of partnerships, prevention and promotion was the secondary

objective; treatment was the secondary objective for 8.5 percent and rehabilitation was the secondary objective for 2.9 percent. Overall, majority of them (75.6%) included prevention and promotion as either primary or secondary objective.

5.1.2 Partnership motives

The study indicated that the underlying motive (explicit or implicit) for each partner entering into partnerships varied (Table-5.1). Attracting financial resources was the primary motive for 49 percent to seek partnerships; 26 percent mentioned that there was a need in the community felt by them which could be addressed only through partnerships; 11.4 percent wanted to expand the existing services through partnership; 7.1 percent wanted to strengthen their institutions and the organization's programme requirements forced them to seek partnerships in the case of another 7.1 percent. In addition, 55.4 percent and 30.4 percent stated expansion of services and institutional strengthening respectively as their secondary motives. Three fourth of the public funded partnerships mentioned, attracting financial resources was their primary motive whereas only 38 percent of the private funded mentioned it. A significant proportion (32%) of the private funded mentioned that they have perceived the need in the community which could be addressed through partnerships.

5.1.3 Pre-partnership process

Pre-partnership processes before getting into the partnership agreement such as formal and informal discussions, negotiations are likely to increase the understanding between partners and enhance the effectiveness. In this study, 80 percent of partnerships held formal invited discussions among the partners (Table-5.2). All the public and APAC-USAID funded partnerships held formal discussions. Almost all the partnerships (96%), irrespective of the type of partners, fully agreed that there were gaps that could be filled by partnership interventions.

Table-5.1

Motive of Partnerships*

Motive of partnerships	Public	Private	Private		Contract tual	Collob orative	Total
			APAC USAID	Other Private			
To attract financial resources	15 (75)	19 (38)	10(71.4)	9 (25)	31(52.5)	3 (27.2)	**34(48.5)**
To expand the existing services	2 (10)	6 (12)	0	6 (16.6)	7(11.8)	1 (9)	**89(11.4)**
Institutional strengthening	0	5 (10)	1(7.1)	4 (11.1)	4(6.7)	1 (9)	**5(7.1)**
Forced by program requirements	1 (5)	4 (8)	0	4 (11.1)	3(5)	2 (18.1)	**5(7.1)**
Felt Need	2 (10)	16 (32)	3(27.4)	13 (36.1)	14(23.7)	4 (36.3)	**18(25.7)**
Total	**20**	**50**	**14**	**36**	**59**	**11**	**70**

**Percentages within parentheses*

Table-5.2

Pre-partnerships process

Pre-partnership process	Public	Private		Contractual	Collaborative	Total
		APAC USAID	Other			
Formal	20 (100)*	14 (100)	22 (61.1)	53 (89.8)	3 (27.2)	**56 (80.0)**
Informal	0	0	14 (38.9)	6 (10.2)	8 (72.8)	**14 (20.0)**

* *Column percentages are within parentheses*

5.2 Partnership inputs

Three types of inputs were involved in the partnerships - human, financial and material.

5.2.1 Human resources

In total, 570 (85.7% full time) staff members (Mean 8.1/partnership, SD 4.3, Range 2 - 20) were involved in these partnered interventions (Table-5.3). Private funded partnerships had

more staff (Mean 8.4, SD 4.7) involved in the partnerships than public ones (Mean 7.6, SD 2.8). APAC-USAID supported partnerships had the highest number of staff involved (Mean 11.1, SD 4.8). Similarly, contractual partnerships had higher staff involvement (Mean 8.5, SD 4.2) compared to collaborative ones (Mean 6.4, SD 4.5).

5.2.2 Financial resources

Annually, Rs. 68.02 million (US$ [17] 1.4 million) was spent on various HIV/AIDS interventions through partnerships (Table-5.4); average budget per partnerships was Rs. 0.971 million (SD 0.614, Range Rs.0.09–2.64 million) or US$ 20,244. Private funded partnerships had relatively higher annual budget (Rs.1.01 million, SD 0.68, Range Rs 0.09 – 2.64 million) compared to public funded ones (Rs. 0.85 million, SD 0.39, Range Rs. 0.16 – 1.6 million). Similarly, APAC-USAID supported partnerships had higher annual value (Rs. 1.4 million, SD 0.69, Range Rs. 0.84 – 2.64) compared to other private funded ones (Rs. 0.83 million, SD 0.59, Range Rs. 0.09 – 2.28 million) partnerships. Contractual partnerships too had higher annual value (Rs. 1.04 million, SD 0.62, Range Rs. 0.1 – 2.64 million) than collaborative partnerships (Rs. 0.58 million, SD 0.43, Range Rs. 0.09 –1.4 million).

Table-5.3

Human resources involved in partnerships

	Public Funded			Private Funded			Total		
	Total	Full-Time	Part-Time	Total	Full-Time	Part-Time	Total	Full-Time	Part-Time
Mean	7.60	7.45	0.15	8.36	6.76	1.52	**8.14**	**6.96**	**1.13**
SD	2.81	2.68	0.366	4.76	3.65	2.80	**4.29**	**3.40**	**2.44**
Sum	152	149	3	418	338	76	**570**	**487**	**79**

[17] *1 US$ = Rs. 48*

Table-5.4

Annual value of partnerships – Different types - In million (Rs)

	Public	Private	Private Funded		Contractual	Collaborative	Total
			APAC USAID	Other private			
Mean	0.85	1.01	1.48	0.8	1.04	0.58	**0.97**
SD	0.38	0.68	0.69	0.59	0.62	0.42	**0.61**
Minimum	0.16	0.08	0.80	0.08	0.10	0.08	**0.08**
Maximum	1.60	2.64	2.64	2.20	2.6	1.40	**2.64**
Total Value	17.04	50.97	20.84	30.13	61.55	6.46	**68.02**

5.2.3 Material resources

As seen in Table-5.5, 44.2 percent of partnerships had their own office space for the partnered interventions while others operated in rented premises. Computer, internet and telephone played a major role in partnership functions. Vehicles and fax, however, had very little role to play.

Table-5.5

Material resources involved in partnerships

Material resource		Public	Private Funded		Total
			APAC	Others	
Office space	Own	7	2	21	31 (44.2)
	Rented	13	12	15	39 (55.8)
Computers		20	14	28	62 (88.6)
Internet for HIV		19	14	27	60 (85.7)
Fax for HIV		1	0	8	9(12.8)
Four wheeler vehicles		0	1	3	4 (5.7)
Two wheeler vehicles		0	2	0	2 (2.8)
Telephone connection		19	14	31	64 (91.4)

Table-5.4

Annual value of partnerships – Different types - In million (Rs)

	Public	Private	Private Funded		Contractual	Collaborative	Total
			APAC USAID	Other private			
Mean	0.85	1.01	1.48	0.8	1.04	0.58	**0.97**
SD	0.38	0.68	0.69	0.59	0.62	0.42	**0.61**
Minimum	0.16	0.08	0.80	0.08	0.10	0.08	**0.08**
Maximum	1.60	2.64	2.64	2.20	2.6	1.40	**2.64**
Total Value	17.04	50.97	20.84	30.13	61.55	6.46	**68.02**

5.2.3 Material resources

As seen in Table-5.5, 44.2 percent of partnerships had their own office space for the partnered interventions while others operated in rented premises. Computer, internet and telephone played a major role in partnership functions. Vehicles and fax, however, had very little role to play.

Table-5.5

Material resources involved in partnerships

Material resource		Public	Private Funded		Total
			APAC	Others	
Office space	Own	7	2	21	31 (44.2)
	Rented	13	12	15	39 (55.8)
Computers		20	14	28	62 (88.6)
Internet for HIV		19	14	27	60 (85.7)
Fax for HIV		1	0	8	9(12.8)
Four wheeler vehicles		0	1	3	4 (5.7)
Two wheeler vehicles		0	2	0	2 (2.8)
Telephone connection		19	14	31	64 (91.4)

5.3 Partnership process evaluation

The evaluation of the process focused on the assessment of the partnership implementation - partnership functioning, relationships between partners, and health of the partnership. Seventy process indicators were used and were classified into 20 process components for analysis.

5.3.1 Clarity and realism of purpose

Over 80 percent of the partnerships had consensus, understanding and mutual agreement about partnership goals and objectives. About 70 percent felt that aims and objectives were realistic; 85.7 percent saw services, targets and target population as attainable; and 67.1 percent felt that partnerships were designed according to local needs.

The overall score for clarity and realism of purpose was 0.84 (SD 0.19). The score was higher for private funded partnerships and the difference in scores between public and private funded partnerships was statistically significant ($p<0.0001$). However, differences between APAC funded and other private partnerships ($P=0.378$) and between contractual and collaborative partnerships ($P=0.21$) were not significant.

5.3.2 Clear and Robust Partnership working Arrangements

Over 30 percent of partnerships had clearly defined organizational structures and 20 percent had standards and benchmarks to ensure quality in the functioning of partnerships. About half of them had mutual agreement and clarity about budget and human resources required for the partnerships and had easy and unambiguous procedures. The overall score for this component was 0.64 (SD 0.21). There were more clear and robust working arrangements in private funded partnerships (0.68, SD: 0.19) than the public funded (0.52, SD 0.21) and the difference was statistically significant ($p= 0.04$). No statistically significant difference was observed between other types.

5.3.3 Internal Governance

Only 15 percent of the partnerships had written vision and mission statement and 30 percent had written standing orders, guidelines and norms while 50 percent had documents

clearly defining the roles and responsibilities. Although 80 percent had periodic planning review meetings, only 27 percent had combined board or coordination committees to ensure good governance. The overall governance score was 0.52 (SD 0.21). Though private funded partnerships (0.55, SD 0.21) were better than the public funded, it was not statistically significant ($p < 0.061$). Same was true for other types too.

5.3.4 Accountability

A three level accountability relationship is required in partnerships; successful partnerships need to be accountable horizontally, vertically (upward-any actor that have formal authority over the organization) and downward to service users, lay public and other groups that the partnerships might affect directly and indirectly. Horizontal accountability (95.7%) and vertical accountability (97%) between the study partners was quite high (95.7%); however, they had less (20%) public accountability.

The overall accountability score was 0.76 (SD 0.15). Once again, private funded partnerships were more accountable (0.79, SD 0.12, P=0.008). Similarly, contractual partnerships were more accountable (0.79, SD 0.10, P=0.004) and the difference was not significant (P=0.59) among the private funded ones.

5.3.5 Transparency

There was transparency in the selection process of partners among 40 percent of partnerships while the decision making process was transparent in 46 percent. Information sharing was restricted to partners and the public had access in only around 17.1 percent. The score for this component was 0.56 (SD 0.20) with a significant difference between public and private funded partnerships (P=0.002). However, there was no significant difference between other types.

5.3.6 Resource Flow

One-third of the partnerships did not have adequate and timely financial resources to carry out the intended partnership activities. Similarly, human resources were adequate in 56 percent and material resources were adequate in 50 percent of partnerships. The overall

score was 0.58 (SD 0.24) with private funded having higher score (0.66, SD 0.22, P<0.001). There was no statistically significant difference between other types.

5.3.7 Partnership interdependency

It refers to the extent that partners depend upon each other for resources or materials to accomplish the partnership objectives. Majority of the partners (63%) totally agreed that the present activities could not be carried out without partnerships. Although about 54 percent agreed that there was reciprocal relationship, only 34 percent said that there was interdependency. The overall score of interdependency was 0.68 (SD 0.23). Private funded partnerships were more inter-dependable (0.74, SD 0.22, P<0.001). There was no statistically significant difference between contractual and collaborative partnerships (p= 0.12) and among private funded partnerships (p = 0.75).

5.3.8 Coordination with the state and the existing health system

The partnerships especially the health related partnerships need to work in coordination with the government and existing health system to achieve maximum reach and effectiveness. The results indicated that though there was adequate support from the government (50%) and public health system (56%) for the interventions, less proportion of the partners reported that there were mutual seeking of support; 33 percent fully agreed that they sought the support of the public health system and only 31 percent mentioned that that the public health system sought the support of them for HIV/AIDS related activities. Average total score for this component was 0.61 (SD 0.20). Public funded partnerships had better (0.66, SD 0.19, P=0.26) coordination with the state and existing health system though statistically insignificant. Contractual partnerships had better coordination (0.63, SD 0.2, P=0.03) and among private funded partnerships, APAC-USAID funded partnerships (0.66, SD 0.15, P=0.05) had better coordination.

5.3.9 Inclusivity or participatory

This is the extent of the partnership's involvement of all partners. Successful partnerships will be having participatory decision making process and the decisions and the strategies will be in consultation with all the partners and stake holders. About 46 percent of the

partners were not involved in the strategic planning process although 70 percent mentioned that their opinions were valued and adequate chances to express their ideas. The overall score was 0.64 (SD 0.31). Once again, private funded partnerships were more inclusive and participatory (0.73, SD 0.26, P<0.001). Though collaborative partnerships (0.75, SD 0.3) were more participatory and inclusive than contractual partnerships (0.61, SD 0.3), the difference was not statistically significant. However, other private funded partnerships (0.77, SD 0.26, P=0.03) were more inclusive and participatory than APAC-USAID funded partnerships (0.60, SD 0.21).

5.3.10 Risk Management

Successful partnerships aim to maximize health benefits for the poor and minimize potential risks for the partners involved. The success of partnerships depends on the successful identification, allocation, mitigation, and management of risks. Only 29 percent mentioned that there were adequate mechanisms to reduce risk. At the same time, majority of them (89%) reported that the funding partner was not thrusting the unmanageable risk to the implementing partner and around 47 percent fully agreed that their partners were ready to share the various risk arising out of the partnerships. The overall score was 0.70 (SD 0.22). Though contractual partnerships (0.73, SD 0.2) managed the risk arising out the partnerships better, it was not statistically significant. There was no statistically significant difference between the public and private funded partnerships as well as among the private funded partnerships.

5.3.11 Developing and maintain mutual Trust

Trust is emphasized as a key element of an effective partnership. The consensus is that, although it is possible to work jointly with little trust between partners, the most successful partnerships have (and, through hard work, maintain) a strong level of mutual trust. Majority (83%) of the partnerships reported that there was sufficient mutual trust between them; 69 percent emphasized that the monitoring processes were not out of mistrust and a vast majority (87%) had confidence on their partners as well. The total score of the component, developing and maintaining trust was 0.87 (SD 0.20). Private funded partnerships had more mutual trust and understanding (0.92, SD 0.12, P=0.008). But there

was no statistically significant difference between contractual and collaborative partnerships (p = 0.36) and among the private funded partnerships (p = 0.54).

5.3.12 Flexibility

About 70 percent of the partners perceived that they had the flexibility to function according the situation and local need but only 36 percent fully agreed that they had the flexibility to take decisions on their own. Around 26 percent reported that the partnership functioning had rigid administrative procedures and practices imposed by the funding partner. The overall score of this component was 0.63 (SD 0.30). Collaborative partnerships were more flexible (0.82, SD 0.2, P=0.007). There was no statistically significant difference between the public and private funded partnerships (P=0.13) and among the private funded partnerships (P=0.47).

5.3.13 Leadership

Evidence suggests that active leadership is a critical input in determining the extent and pace of partnership development at all levels. Though, partnerships are formed between organizations but succeed because of individuals who are strong and unbiased leaders and who champion the partnership projects with vision, energy and enthusiasm. Majority (71%) of the implementing partners opined that there were strong and unbiased leaders; clarity in the leadership (89%) and leaders were taking initiative and responsibility (81%). The total score for the leadership component was 0.88 (SD 0.21). Private funded partnerships had better leadership (0.96, SD 0.11, P<0.001). Likewise, collaborative partnership was better (0.95, SD 0.1, P=0.047). Among the private funded, there was no statistically significant (P =0.47) difference between the APAC and other private funded partnerships.

5.3.14 Commitment and Ownership

Successful partnerships are believed to depend on the level of engagement and commitment of the partners. It should be ensured that across the partners there is a widespread commitment to, and ownership of, partnership working; and, especially, a sufficiently senior level commitment. The results very clearly defined that there was

collective sense of ownership (94%) and strong commitment (87%) from the partners. The overall score for commitment as a process component was 0.94 (SD 0.20) and the commitment level was higher among the private funded partnerships (1.00, SD 0, P=0.011). Likewise, collaborative partnerships were better (1.00, SD 0, P=0.014).

5.3.15 Communication

The results revealed that 64 percent of the partners' experienced frequent communication between the partners whereas only 34 percent reported that there were regular communication between the relevant stakeholders and just half of the partnerships completely agreed that necessary reports were prepared and disseminated to the partners. The component, communication scored 0.71 (SD 0.24). There was effective communication between private funded partnerships (0.77, SD 0.24, P<0.001). Likewise, contractual partnerships (0.75, SD 02, P=0.009) and APAC-USAID funded partnerships (088, SD 0.17, P=0.01) were more effective in communication.

5.3.16 Mutuality

Mutuality is the degree of equality in the interactions among organizations. Successful partnerships are believed to involve high levels of trust, reciprocity, respect between partners and sharing of benefits equally. Mutuality enables partners to contribute to the partnership with fewer constraints. According to the results, 70 percent of the partners perceived that there was equal respect and involvement of partners, but only 50 percent fully agreed that there was equitable spreading of benefits to all the partners; 44 percent fully agreed that that there was a high degree of equality to participate and influence the partnership activities.

The overall score of mutuality as a process component was 0.71 (SD 0.23). The degree of equality was higher among private funded partnerships (0.78, SD 0.18, P=0.01), but it was not significantly different among other types.

5.3.17 Autonomy

One of the cornerstones of true partnership is the relative autonomy enjoyed by both the partners on day-to-day operations as well as in the overall management of the partnership. Autonomy is seen as non-intrusiveness, from the funding partner and the freedom of the implementing partner to take operational decisions without having to resort to cumbersome bureaucratic approvals or being constantly told about "do's and don'ts". It is clear from the results that a significant proportion (59%) had individual freedom in the functioning and 53 percent felt that the funding partner was not dominant or over controlling. But, only 16 percent fully agreed that they had the freedom to take decisions on their own. Average score for autonomy as process component was 0.63 (SD 0.26). The autonomy entertained by private funded partners was higher (0.69, SD 0.24, P=0.02). Though collaborative and other private funded partners enjoyed more autonomy than contractual, and APAC-USAID funded partnerships, they were not statistically significant (P=0.2, P= 0.39).

5.3.18 Complaint or conflict management

Conflict management is that, how well the partnership manages conflict that arises among members which is important to ensure effectiveness. The study revealed that only 30 percent agreed that there was a proper mechanism to reduce conflicts arising out of the partnerships but relatively higher proportion fully agreed (56%) that addressing conflicts and complaints was smooth and quick. Complaint management as a component scored 0.59 (SD 0.32). Private funded partnerships were effectively (0.66, SD 0.28, P=0.005) managing the complaints. Difference between contractual and collaborative partnerships was not statistically significant (P=0.44).APAC-USAID funded partnership were relatively less effective in managing the conflicts though statistically not significant (P = 0.19).

5.3.19 Monitor, Measure, Review and Learning process

Partnerships need to monitor and respond to changes, by undertaking regular strategic reviews and redefining objectives. Monitoring and evaluating is very vital important in order to share successes with the partners, learn from mistakes, modify program activities as necessary, demonstrate accountability to donors and others who are in a position to

make decisions about the future of a program, and to help stakeholders learn. The results indicated that there were clear success criteria in terms of service goals among 56 percent of the partnerships; 66 percent agreed that there were regular and systematic monitoring and supervision; 86 percent of the partners revealed that the partners shared the monitoring and review findings but only 50 percent were in agreement that there were strategic review processes where the aims, objectives and working arrangements were reviewed and revised.

This component scored 0.72 (SD 0.24). Monitoring and review processes were carried out effectively among private funded partnerships (0.80, SD 0.20, P<0.001). But there was no statistically significant difference between contractual and collaborative partnerships (P=0.33). Among the private funded partnerships, APAC-USAID funded partnerships were more effective (0.88, SD 0.09, P=0.008).

5.3.20 Organizations Identity

A greater proportion of (86%) of the partners perceived that their institution's over all goals and objectives did not get distorted because of partnerships but only about 26 percent totally agreed that they did not make changes in the structure and functions to suit the partnerships needs. Organizational identity as a process component scored 0.73 (SD 0.20). Though private funded and collaborative partners were able to maintain their organization's identity better than public funded and contractual partnerships, the differences were not statistically significant (P = 0.23 and P = 0.10).

5.4 Overall process effectiveness

The mean total score of the overall process effectiveness was 0.68 (SD 0.13) which is just above the "target zone"[18] (Table-5.6). As indicated by Table-5.7, nine(45%) process components comprising 22 (31.4%) process indicators are in the ***"work zone"*** scoring between 0.33 and 0.66; Eleven (55%) of the components which include 48 (68.5%)

[18] ***Danger Zone***: *<0.33 percent - Requires a lot of improvement;* ***Work Zone***: *0.33-0.66 percent - Needs more efforts in order to be more effective*; *and* ***Target Zone***: *>0. 66 – Doing well*

process indicators are in the ***"target zone"*** that scored 0.66 and above. According to the results, none of the process indicators or components scored below 0.33 to be considered as "***Danger Zone***".

Table-5.6

The overall scores of the partnership process effectiveness

Component	Mean score	SD	Min
Developing clarity and Realism of purpose	0.84	0.20	0.25
Clear and Robust Partnership working Arrangements	0.64	0.21	0.17
Internal Governance	0.52	0.21	0.10
Accountability	0.76	0.15	0.50
Transparency	0.56	0.20	0.13
Resources Flow	0.58	0.24	0.00
Partnership Interdependency	0.68	0.23	0.17
Co-ordination with the state existing health system	0.61	0.20	0.25
Inclusivity and participatory	0.64	0.31	0.00
Risk Management	0.70	0.22	0.33
Developing and maintain Trust	0.87	0.20	0.17
Flexibility	0.63	0.30	0.00
Leadership	0.88	0.21	0.17
Commitment and Ownership	0.94	0.20	0.00
Communication	0.71	0.24	0.00
Mutuality	0.71	0.23	0.00
Autonomy	0.63	0.26	0.00
Complaint management	0.59	0.32	0.00
Monitor, Measure, learning and Review	0.72	0.24	0.00
Organizations Identity	0.73	0.20	0.25
Overall Process Score	**0.68**	**0.13**	**0.36**

Table-5.7

Categorization of Process components based on the performance

Work Zone	Target Zone
1. Internal Governance	1. Developing clarity and Realism of purpose.
2. Clear and robust Working arrangements	2. Horizontal and vertical accountability
3. Transparency	3. Partnership Interdependency
4. Resources availability	4. Risk Management
5. Co-ordination with the existing health system	5. Developing and maintain Trust
6. Inclusivity and participatory	6. Leadership
7. Flexibility	7. Commitment and Ownership
8. Autonomy	8. Communication
9. Complaint Management	9. Mutuality
	10. Monitor, Measure and Learning
	11. Organizations Identity

5.4.1 Process effectiveness of public and private funded partnerships

Public funded partnerships scored an average process score of 0.56 (SD 0.13) which lies in the *"work zone"* while private funded partnerships scored 0.73 (SD 0.09) which lies in the *"target zone"*. There was a significant difference between the process scores of public and private funded partnerships ($p < 0.001$). Fifteen process components of public and private funded partnerships were having statistically significant difference (Table-5.8). Among public funded partnerships, 13 components were in the "work zone" and others in the *"target zone"*. Among private funded partnerships, 5 were in the *"work zone"* and the rest in the *"target zone"*.

5.4.2 Process effectiveness among private funded partnerships

Among the private funded partnerships, the process score of the APAC-USAID funded partnerships was 0.74 (SD: 6.9) and the other private funded partnerships was 0.73 (SD:

9.3) and there is no statistically significant (P = 0.81) difference in the mean score of all the components. As indicated in the Table-5.9, six components of the APAC-USAID funded partnerships were in the *"work zone"* and the remaining 14 were in *"target zone"* whereas 4 components of the other private funded partnerships were in *"work zone"* and the remaining were in *"target zone"*.

5.4.3 Process effectiveness of contractual and collaborative partnerships

The mean score of contractual partnerships was 0.69 (SD 0.13) and collaborative partnerships was 0.67 (SD 0.10). Though there was no statically significant difference between the overall means of contractual and collaborative partnerships (P = 0.740), 6 process components had statistically significant differences. As seen in Table 5.10, Nine (45%) components of contractual and collaborative partnerships each were in *"work zone"* and the remaining 11 (55%) were in *"target zone"*. Components recording significant difference in means were accountability (P=0.004), coordination with the state and existing health system (P=0.037), flexibility (P=0.007), leadership (P=0.047), commitment (P=0.014), and communication (P = 0.009).

Table-5.8

Public and Private Funded Partnerships

Process Components[19]	Sector	Mean	SD	t value	p value
Clarity and Realism of purpose	Public	0.63	0.21	-5.7	<0.0001¶
	Private	0.92	0.12		
Working Arrangement	Public	0.52	0.21	-3.0	0.005¶
	Private	0.68	0.19		
Internal Governance	Public	0.45	0.19	-1.9	0.061
	Private	0.55	0.21		
Accountability	Public	0.70	0.12	-2.8	0.008¶
	Private	0.79	0.15		
Transparency	Public	0.44	0.20	-3.4	0.002¶
	Private	0.61	0.18		
Resource Flow	Public	0.38	0.17	-5.7	<0.0001¶

[19] *Components, having statistically significant difference are mentioned in grey shades.*

	Private	0.66	0.22		
Interdependency	Public	0.53	0.20	-3.7	0.001¶
	Private	0.74	0.22		
Coordination with state and existing health system	Public	0.67	0.19	1.3	0.206
	Private	0.59	0.20		
Inclusivity or participatory	Public	0.41	0.31	-4.0	<0.0001¶
	Private	0.73	0.26		
Risk Management	Public	0.68	0.22	-0.5	0.604
	Private	0.71	0.22		
Mutual Trust	Public	0.73	0.29	-2.9	0.008¶
	Private	0.92	0.12		
Flexibility	Public	0.54	0.32	-1.5	0.137
	Private	0.67	0.29		
Leadership	Public	0.67	0.25	-5.1	<0.0001¶
	Private	0.96	0.11		
Commitment	Public	0.79	0.34	-2.8	0.011¶
	Private	1.00	0.00		
Communication	Public	0.56	0.18	-3.9	<0.0001¶
	Private	0.77	0.24		
Mutuality	Public	0.53	0.27	-3.7	0.001¶
	Private	0.78	0.18		
Autonomy	Public	0.48	0.23	-3.4	0.002¶
	Private	0.69	0.24		
Complaint Management	Public	0.40	0.34	-3.0	0.005¶
	Private	0.66	0.28		
Monitoring and Review	Public	0.54	0.25	-4.1	<0.0001¶
	Private	0.80	0.20		
Organization Identity	Public	0.69	0.20	-1.2	0.237
	Private	0.75	0.20		
Overall Process Score	**Public**	**0.56**	**0.13**	**-5.7**	**<0.0001¶**
	Private	**0.73**	**0.09**		

¶*Statistically significant ($p<0.05$)*

Table-5.9

Process components in the work zone (among the private funded partnerships)

APAC Funded	Other private funded
1. Internal Governance 2. Clear and robust Working arrangements 3. Transparency 4. Inclusivity and participatory 5. Autonomy 6. Complaint Management	1. Internal governance 2. Transparency 3. Resource Flow 4. Co-ordination with the state and existing health system

Table- 5.10

Process components in the work zone (contractual and collaborative)

Contractual	Collaborative
1. Clear and robust Working Arrangement 2. Internal governance 3. Transparency 4. Resource Flow 5. Interdependency 6. Co-ordination -state and health system 7. Flexibility 8. Autonomy 9. Complaint/conflict management	1. Clear and robust Working Arrangement 2. Internal Governance 3. Accountability 4. Transparency 5. Resource Flow 6. Co-ordination - state and health system 7. Risk Management 8. Communication 9. Compliant/conflict management

5.4.4 Process effectiveness by programmes

Process scores were categorized into three types of programmes such as, Targeted Interventions, Care and Support and Other Programmes. When compared, care and support programmes(0.77, SD0.11) scored higher score than targeted interventions(0.69, SD 0.11).

But, the difference between the types of interventions was not statistically significant (P=0.204).

5.5 Process effectiveness by individual partnerships

When the individual partnerships were categorized based on the score attained by each of them, it was found that 69 percent partnerships were in the *"Target Zone"* and around 31 percent of the partnerships were in the *"work zone"*. As mentioned in the Table-5.11, among the private funded partnerships, 86 percent were in the *"Target zone"* and among the public funded 25 percent were in the *"Target zone"*. Around 69 percent of contractual partnerships and 64 percent of collaborative partnerships were in the *"target zone"*.

Table-5.11

Process effectiveness – Individual Partnerships

Zone[20]	Public	Private	Private				Total Score
			APAC USAID	Others	Contractual	Collaborative	
Danger Zone	0	0	0	0	0	0	0
Work Zone	15 (75)	7 (14)	2 (14.2)	5 (13.8)	18 (30.5)	4(36.3)	22 (31.4)
Target Zone	5 (25)	43 (86)	12(85.7)	31(86.)	41 (69.4)	7(63.7)	48 (68.5)
	20	**50**	**14**	**36**	**59**	**11**	**70 (100)**

** Percentages within parentheses*

5.5.1 Association between the partnership duration and process effectiveness

No correlation between age and process effectiveness existed meaning increase in the years of working was not related to process effectiveness; r value was-0.08(P=0.509).In addition, no process component had statistically significant correlation with partnership age.

[20] *Danger Zone: Below 0.33%; Work Zone: 0.33 - 0.66%; Target zone 0. 66 and above*

But, the difference between the types of interventions was not statistically significant (P=0.204).

5.5 Process effectiveness by individual partnerships

When the individual partnerships were categorized based on the score attained by each of them, it was found that 69 percent partnerships were in the *"Target Zone"* and around 31 percent of the partnerships were in the *"work zone"*. As mentioned in the Table-5.11, among the private funded partnerships, 86 percent were in the *"Target zone"* and among the public funded 25 percent were in the *"Target zone"*. Around 69 percent of contractual partnerships and 64 percent of collaborative partnerships were in the *"target zone"*.

Table-5.11

Process effectiveness – Individual Partnerships

Zone[20]	Public	Private	Private				Total Score
			APAC USAID	Others	Contractual	Collaborative	
Danger Zone	0	0	0	0	0	0	0
Work Zone	15 (75)	7 (14)	2 (14.2)	5 (13.8)	18 (30.5)	4(36.3)	22 (31.4)
Target Zone	5 (25)	43 (86)	12(85.7)	31(86.)	41 (69.4)	7(63.7)	48 (68.5)
	20	**50**	**14**	**36**	**59**	**11**	**70 (100)**

** Percentages within parentheses*

5.5.1 Association between the partnership duration and process effectiveness

No correlation between age and process effectiveness existed meaning increase in the years of working was not related to process effectiveness; r value was-0.08(P=0.509).In addition, no process component had statistically significant correlation with partnership age.

---

[20]*Danger Zone: Below 0.33%; Work Zone: 0.33 - 0.66%; Target zone 0. 66 and above*

5.5.2 Association between human resources and process effectiveness

There was no statistically significant correlation found between human resource availability and process effectiveness. The r value was 0.12 (P = 0.32) indicating that the relationship was not significant. None of the components also had significant association.

5.5.3 Association between financial resources and process effectiveness

The process effectiveness was fairly correlated with financial resources of the partnerships. The r value was 0.25 (P=0.037) indicating positive correlation which was statistically significant. Few components also had positive correlation. Refer Table-5.12 for results concerning financial resources.

Table-5.12

Financial Resources Vs Process effectiveness

Outcome Components	Pearson's Correlation coefficient with Annual Value	P value
Realism of Purpose	0.26	0.028
Working Arrangement	0.17	0.161
Internal Governance	0.20	0.092
Accountability	0.29	0.016
Transparency	0.03	0.788
Resource Flow	0.29	0.014
Interdependency	-0.04	0.737
Coordination	0.25	0.040
Inclusivity or participatory	0.09	0.478
Risk Management	0.13	0.298
Trust	0.16	0.173
Flexibility	0.08	0.492
Leadership	0.19	0.122
Commitment	0.11	0.352
Communication	0.17	0.164
Mutuality	-0.04	0.752
Autonomy	0.07	0.565
Complaints	-0.03	0.808
Monitoring and Review	0.29	0.017
Organization Identity	-0.22	0.067
Overall Process Score	**0.25**	**0.037**

5.5.4 Association between partnership motive and process effectiveness

The partnerships, whose motive was to fulfil the community need, performed relatively better in the processes of partnerships (Score: 0.75, SD 0.11) whereas whose motive was to attract financial resources (0.66, SD 014) and other reasons have scored slightly lower. But, the differences were not statistically significant (P = 0.172).

5.6 Partnership outcome

Outcome measures focussed on whether partnerships lead to benefits such as better services or improved health for users, coverage of services, strengthening of the health system, equity, access, efficiency, quality, increased ability, satisfaction of the partners and sustainability of partnership services. This outcome could be perceived as well as systemic outcome.

5.6.1 Services Provided

Though the primary and secondary objectives of partnerships were very specific, many partnerships have provided multiple services related to HIV/AIDS (Table-5.13). Over 80 percent of the partnerships provided health education, promotion and IEC activities while 60 percent provided counselling services, 50 percent condom promotion activities, 67 percent referral services, 37 percent provided home based care, 30 percent provided some rehabilitation services and 37 percent socio-economic support to their clients.

5.6.2 Perceived Outcome

Outcomes perceived by the partners were benefits of partnerships, community involvement, satisfaction with the partnerships, reduction of duplication, pooling of resources, capacity enhancement, target accomplishments, coverage increase, untargeted high risk group coverage and involvement of potential players and perceived efficiency.

Table-5.13

Services Provided

Services	Count	Percent
Health education and Promotion and IEC	57	81.4
Counselling services	60	85.7
Condom Promotion	35	50.0
Home visits	19	27.1
Case identification	33	47.1
VCTC/ICTC	3	4.3
PPTCT	3	4.3
Referrals	47	67.1
Training/capacity building	12	17.1
Treatment for STIs and OIs	12	17.1
Home based care	19	27.1
Care for the children	13	18.6
Social and economic support	27	37.1
Rehabilitation services	21	30.0

5.6.2.1 Benefits of partnerships

Majority (96%) of the partners reported that there was increased ability to address HIV/AIDS and increased skills and knowledge. Around, 41 percent mentioned that there was an increased utilization of expertise; 67 percent reported increased ability to meet community needs, 91 percent mentioned that there were additional financial support for the partnerships, only 37 percent mentioned that there was an increase in the public reputation but a very smaller proportion (14.2%) revealed that there was an increased involvement in the policy making process. The score for the overall benefits perceived by the implementing partners was 0.73 (SD 0.13) which is in the *"target zone"* (Table-5.14).

Table-5.14

Perceived Benefits

Indicators	Pub	Pvt	Private		Contr actual	Collab orative	Total Score
			APAC USAID	Others			
Better ability	0.97	0.98	1	0.97	0.98	0.95	***0.97***
Enhancement of public reputation	0.58	0.66	1	0.97	0.98	0.95	***0.64***
Increased utilization of expertise	0.55	0.65	0.71	0.62	0.67	0.31	***0.62***
Increased participation in policy making	0.15	0.46	0.29	0.52	0.34	0.50	***0.37***
Better ability to meet community needs	0.80	0.78	0.89	0.73	0.80	0.68	***0.79***
Additional Financial Support	0.93	0.97	1	0.96	0.95	1	***0.96***
Total score	***0.66***	***0.75***	***0.65***	***0.77***	***0.64***	***0.72***	***0.73***

The score for the perceived benefits of public funded partnerships was 0.66 (SD 0.12) and the private funded partnerships scored better (0.75, SD 0.13) and the difference was statistically significant (P=0.011). But, there was no statistically significant difference between APAC-USAID and other private funded partnerships (P=0.201); contractual and collaborative partnerships (P = 0.313).

5.6.2.2 General community and Target Community involvement

Literature suggested that successful partnerships would involve the general community and the target community like PLHAs, when developing and implementing programs and services.

According to 61 percent of the implementing partners, there was increased general community involvement and 93 percent mentioned, increase in the target communities involvement such as PLHA and other vulnerable population. Total score was 0.88 (SD 0.13) with public funded partnerships doing well though statistically insignificant (score 0.92, SD 0.16, P = 0.18). There was no difference (P = 0.5) between contractual and collaborative partnerships as well.

Client's perception about their involvement

Ironically, the perception of the clients about their involvement in the partnership activities was different. As indicated in the Table-5.15, only 35.8 percent of the general community and 49.8 percent of the target communities were involved in the programme activities; around 40 percent of the general community and 66 percent of the target communities felt that their opinions related to the programmes were sought. Moreover, 31 percent of the general community and 45 percent of the target communities perceived that their suggestions were given importance and implemented. There was a statistically significant ($P< 0.001$) difference between the perceptions of public funded (Score: 0.12, SD 0.22) and private funded partnerships' clients (Score: 0.35, SD 0.35).

Funding partners' view

Funding partners also voiced their opinion during stakeholder interviews that community involvement was a concern and few even agreed that general community and target community were neither consulted nor considered adequately. But they also admitted that there is an increase in the community (especially target community like PLHA) involvement as it has been made mandatory by the funding agencies.

Table-5.15

Community involvement - client's perspective

	Indicator 1 **Involvement in activities**		*Indicator 2* **Seek opinions for programmes**		*Indicator 3* **Suggestion given importance and implemented**	
	Gen Community	**Target community**	**Gen Community**	**Target community**	**Gen Community**	**Target community**
Always	7(16.6)	16(8.7)	5(11.9)	17(9.2)	3(7.3)	19(10.5)
Some Times	8(19)	75(40.9)	12(28.5)	85(46.4)	12(28.5)	55(30)
Never	27(64.2)	92(50.2)	25(59.5)	81(44.2)	27(64.2)	109(59.5)
Total	**42**	**183**	**42**	**183**	**42**	**183**

* *Percentages within parentheses*

5.6.2.3 Satisfaction with partnerships

The satisfaction of the partners with the way people and organizations work together in the partnerships, their role, their influence and the overall functioning of the partnerships was significantly high. Around 53 percent of the partners were fully satisfied about the functioning of the partnerships; More than half of them (58%) were fully satisfied with the way people and organizations in the partnerships work together; but only around 39 percent of them were fully satisfied with their role in the partnerships and 26 percent of them were satisfied with their influence in the partnership.

The overall score of satisfaction was 0.66 (SD 0.25). The satisfaction level of the public funded partnerships was lower 0.45 (SD 0.27) than the private funded partnerships 0.74(SD: 0.20) and the difference was statistically significant (P <0.001). No statistically significant difference between contractual and collaborative partnerships (p=0.313). Among the private partnerships, APAC-USAID funded partnerships were less satisfied (0.65, SD 0.15) than the other private funded (0.77, SD 0.21) partnerships which was statistically significant (p=0.03).

5.6.2.4 Reduction in the duplication of efforts

Around 57 percent of the partners perceived that there was a reduction in the duplication efforts by different players but a significant 39 percent mentioned that duplication of efforts still existed and 4 percent even mentioned that it has increased.

The overall score for this component was 0.76 (SD: 0.29). The difference between the perception of the public (0.65, SD: 0.29) and private funded (0.81, SD: 0.28) partnerships was statistically significant (p=0.041). The difference was not statistically significant between the contractual and collaborative partnerships (p=0.465). This indicates that higher reduction in the duplication of efforts was perceived by the private funded partners than the public funded partnerships. Among the private funded partnerships, APAC-USAID funded partnerships (0.71, SD: 0.37) perceived relatively less reduction in the duplication of efforts than the other private funded partnerships (0.84, SD: 0.23) but not statistically significant (p=0.2).

However, the other details of the partnership assessment revealed that there were on the average 6.5 (SD 3.9. range: 0–20) HIV/AIDS organizations in one target area with multiple organizations carrying out similar intervention. In 10 places 2 organizations were carrying out the same types of interventions in the same target area; in 7 places 3 organizations were carrying out the same types of interventions; and in 3 places 4 organizations were carrying out the same types of HIV/AIDS interventions. This indicates that there was duplication of efforts.

The client interview also revealed that 74 (32.9%) of the respondents went to other institution for the same services and 73 (32.4%) of them have registered themselves in other institutions. However, the duplication of efforts, according to key stakeholders, was being addressed through a common consortium of major players through the "three ones" principle (One Action Framework, one National Coordinating Authority and one Monitoring and Evaluation System). Many funding partners also mentioned that there was a reduction in the duplication of efforts after the consortium.

5.6.2.5 Resource mobilization, Pooling, and matching of resources

One of the expected results of the partnerships was pooling and matching of resources by both the partners and about 47 percent of partners mentioned that there was an increased pooling of resources. However, almost all HIV/AIDS interventions and partnerships were having higher dependence on funding partners for financial resources; 58.6 percent of the implementing organizations did not make any matching contribution to the annual value of partnership activities. Of those who contributed, the average proportion is 10.4 percent (SD: 3.17, range 5-10 %) to the annual value.

The average contribution of the funding partner, as indicated in Table-5.16, was 95.7 percent. But the public funding partner's contribution was 96.6 percent and the contribution of private funding partner was 95.4 percent of the total value. APAC-USAID had contributed relatively lower contribution (88.6%) for the partnerships than the other private partnerships (98.1%). So, the APAC-USAID implementing partners have

contributed a higher proportion (11.4%) in the total value of the partnerships whereas all the other types have contributed less than 5 percent in the total value of partnerships.

Other than the regular funding from the funding partner, there was no significant contribution form any other sources. The other sources of financial contributions were, from user fee (score: 0.014), commercial activities (score: 0.12); community contributions (score 0.19) and donations (0.20) which was very minimal. The overall score was 0.08 (SD 0.08) and there was no statistically significant difference between the public and private funded (p=0.863); contractual and collaborative partnerships (p=0.388).

5.6.2.6 Capacity enhancement

Majority of the partners (93%) reported that there was improvement in their knowledge and skills due to the partnerships and around 84 percent said that the overall capacity has increased. The overall score was 0.94 (SD 0.14). The private funded partnerships perceived of a higher capacity enhancement (0.98, SD 0.10) and the difference was significant (P=0.02) and there was no significant difference between contractual and collaborative partnerships (P = 0.78) as well as among the private funded partnerships (P = 0.7).

Table-5.16

Matching of resources -Funding Partner's contribution

Public Private	**Mean %**	**SD**	**Minimum**	**Maximum**
Public(TANSACS)	96.6	4.9	87.50	100.00
Private	95.4	5.9	80.00	100.00
Total	**95.7**	**5.6**	**80.00**	**100.00**
Private Funded Partnerships				
APAC	88.6	3.6	80.00	90.00
Other Private funded	98.1	4.2	85.00	100.00
Contractual and collaborative				
Contractual	95.4	5.8	80.00	100.00
Collaborative	97.7	4.1	90.00	100.00

5.6.2.7 Target Accomplishments

Majority of the partners (97.1%) reported that there was increase in the client base, and achievement of planned targets (91.4%). In addition, there was improvement and increase in the client targeting (90%) as well as the range of services (91.4%) provided by the organization thanks to the partnership initiatives.

The overall score of this component was 0.96 (SD 0.07). The private funded partnerships (0.97, SD 0.07) were slightly having better target accomplishments than the public funded partnerships but the difference was not statistically significant (P = 0.137). No significant difference was found between the contractual and collaborative partnerships (P = 0.345) as well as among the private funded partnerships.

5.6.2.8 Coverage

Regarding the coverage of services, around 59 percent of the partners reported that there was increase in the geographic coverage and 86 percent reported that they had increase in the coverage of targeted population. The overall score was 0.86 (SD 0.18). The public funded partnerships had more coverage 0.88 (SD 0.17) than the private funded partnerships but the difference is not statistically significant (P = 0.427). No significant difference was found between them contractual and collaborative partnerships (P = 0.725) and among the private funded partnerships (P = 0.56).

5.6.2.9 Coverage of untargeted high-risk groups and involvement of potential providers

It has been well documented that there were many hitherto unidentified and untargeted high risk groups and also there were many providers related to HIV/AIDS care. The study revealed that only 38.6 percent of the partnerships fully agreed that they were involved in identification of the hitherto unknown high risk population and only 21.4 percent of the partnerships fully involved various health care providers who are the first point of contacts for STI, HIV/AIDS services.

Overall score of hitherto untargeted high risk group coverage was 0.63 (SD 0.25) (Table-5.17). The public funded partnerships covered more risk groups than the private funded partnerships and the difference is statistically significant (p=0.030). No significant difference was found between the contractual and collaborative partnerships (p=0.401). But the APAC funded partnerships covered more risk groups which was statistically significant (p=0.02).

Score of the involvement of potential providers was 0.61 (SD 0.24). Public funded partners (0.53, SD 0.31) involved less proportion of the potential providers than the private funded (0.65, SD: 0.20) and no significant difference was found between them (p=0.111) but a statistically significant difference was found between contractual (0.58, SD 0.2) and collaborative (0.77, SD 0.2) partnerships (p=0.007). Among the private funded, APAC funded ones involved less proportion (0.53, SD 0.16) of them comparing to other private funded partnerships (0.69, SD 0.19) and the difference was statistically significant (p=0.008)

Table-5.17

Involvement of unknown high risk groups and involvement of potential players

Attribute	Agreed %	Neutral	Disagree
Identification of hitherto untargeted high-risk groups	28.6	62.8	8.6
Involvement of potential players	21.4	72.9	5.7
Overall score : 0.63 and 0.61			

5.6.3 Perceived Effectiveness

Increased cost effectiveness and efficiency in providing services is one of the important expected outcomes of partnership initiatives. According to the study, 60 percent of the partners felt they were able to achieve increased desirable cost effectiveness in delivering the services due to partnership and 57.1 percent felt that there was an increase in the efficiency in delivering the services thanks to the partnership.

Overall score of this component was 0.78 (SD: 0.22) which is in *"Target Zone"*. The public funded partnerships scored 0.76 (SD: 0.22); the private funded partnerships scored 0.79 (SD: 0.22). There was no statistically significant difference (p=0.111) between them as well as among the contractual and collaborative partnerships (p=0.874) and among the private funded partnerships (p=0.32)

5.6.4 Overall perceived outcomes

As indicated in Table-5.18, overall score of the perceived outcome component is 0.74 (0.08); all but three components were in the *"Target Zone"*. Satisfaction with the partnerships (0.65, SD 0.25), additional untargeted high risk coverage (0.63, SD 0.24) and the involvement of the potential providers (0.61, SD 0.24) were in the *"work zone"*.

Table-5.18

Perceived Outcome

Output components	**Mean**	**SD**	**Minimum**
Reduction of Duplication of efforts	0.76	0.29	.00
Pooling of Resources	0.72	0.27	.00
Capacity Enhancement	0.94	0.14	.50
Target Accomplishments	0.96	0.07	.75
Coverage Increase	0.86	0.18	.50
Community Involvement	0.88	0.13	.50
Additional un targeted high risk group coverage	0.63	0.24	.00
Involvement of potential Service Providers	0.61	0.24	.00
Increased Effectiveness	0.78	0.22	.25
Perceived benefits of partnerships	0.72	0.13	.42
Satisfaction with the partnerships	0.65	0.25	.00
Overall Score	**0.74**	**0.08**	**0.54**

5.6.4.1 Perceived outcomes of public and private funded partnerships

Perceived outcomes (Table-5.19) of the private funded partnerships was relatively higher (0.77, SD: 0.07 $p<0.001$) which indicates that they were more effective in producing outcomes compared to public funded ones. Among public funded partnerships, 5 components were in ***"work zone"*** and only two components of private funded partnership were in ***"work zone"***. Components with significant difference between public and private funded are reduction in duplication of efforts, capacity enhancement, additional high risk groups, perceived benefits and satisfaction with the partnerships.

Table-5.19 (¶*Statistically significant (p<0.05)***)**

Perceived outcome of Private and Public Funded partnerships

Outcome Components	Sector	Mean	SD	t value	p value
Reduction of Duplication of Efforts	Public	0.65	0.29	-2.1	0.041¶
	Private	0.81	0.28		
Pooling of Resources	Public	0.68	0.24	-1.0	0.347
	Private	0.74	0.29		
Capacity Enhancement	Public	0.86	0.19	-2.5	0.020¶
	Private	0.98	0.10		
Target Accomplishments	Public	0.94	0.10	-1.5	0.137
	Private	0.97	0.06		
Coverage	Public	0.89	0.17	0.8	0.427
	Private	0.85	0.19		
Community and target Group Involvement	Public	0.93	0.16	1.3	0.189
	Private	0.87	0.13		
Additional High risk groups	Public	0.65	0.21	2.2	0.030¶
	Private	0.56	0.25		
Involvement of potential Service Providers	Public	0.53	0.31	-1.7	0.111
	Private	0.65	0.20		
Effectiveness	Public	0.76	0.22	-0.5	0.642
	Private	0.79	0.22		
Perceived Benefits	Public	0.66	0.12	-2.7	0.011¶
	Private	0.75	0.13		
Satisfaction with the partnerships	Public	0.45	0.27	-4.4	<0.0001¶
	Private	0.74	0.20		
Overall Outcome	Public	0.69	0.08	-4.1	<0.0001¶
	Private	0.77	0.07		

5.6.4.2 Perceived outcome among the private funded partnerships

No significant difference was found between the APAC-USAID funded (0.75, SD 0.06) and other private funded partnerships (0.76, SD 0.07, p=0.575). But the satisfaction level and the involvement of potential providers were significantly low (***"work zone"***) in the APAC funded partnerships. But the APAC-USAID funded partnerships targeted more additional high risk groups than the other private funded partnerships. None of the components of the other private funded partnerships were in the ***"work zone".***

5.6.4.3 Perceived outcomes of contractual and collaborative partnerships

The total score of the contractual partnerships was (0.74, SD: 0.1) almost similar to the collaborative partnerships (0.75, SD: 0.1) and there was no statistically significant difference between them (p<0.727). But, the collaborative partnerships (0.77, SD: 0.2) tend to involve more potential service providers which was statistically significant (p= 0.007).

5.6.4.4 Perceived outcomes by type of interventions

The outcome score based on the type of interventions was also similar. No statistically significant difference between the different types of interventions was found (p=0.427). The care and support programmes were effective in involving the community and the target groups in their programmes which is statistically significant (p=0.02).

5.7 Perceived outcomes by Individual Partnerships

As per the scoring of the perceived outcome of the individual partnerships, majority of the partnerships have performed well in producing the outcomes (Table-5.20). 83 percent of the partnerships were in the *"target zone"* and only 17 percent were in the *"work zone"*

Out of all the partnerships, the proportion of partnerships in the "target zone" was higher among private funded partnerships (92%) than public funded partnerships (60%). Among the private funded partnerships, higher numbers of other private funded partnerships (94.5%) were in the "target zone" than the APAC-USAID funded partnerships (85.8%). More collaborative partnerships (91.8%) were in the "target zone" than the contractual partnerships (81.4%).

Table-5.20

Perceived outcome – Individual Partnerships

Zone	Public	Private	Private		Contractual	Collaborative	Total Score
			APAC-USAID	Others			
Danger Zone	0	0	0	0	0	0	0
Work Zone	8(40)	4(8)	2 (14.2)	2 (5.5)	11(18.6)	1(9.2)	**12(17.1)**
Target Zone	12(60)	46(92)	12 (85.8)	34 (94.5)	48(81.4)	10(91.8)	**58(82.9)**
	20	**50**	**14**	**36**	**59**	**11**	**70(100)**

- *Percentages within parentheses*

5.7.1 Association between the partnership age and Perceived outcomes

The Perceived outcomes of the partnerships were not correlated with the partnership age. The r value was -0.05 (P = 0.706) which clearly indicates that there was no positive and negative correlation coefficient. None of the components were having statistically significant association.

5.7.2 Correlation between the human resources and Perceived outcomes

The Perceived outcome of the partnerships and the human resources was not having statistically significant correlation (Figure-5.1). The r value is 0.12 (p=0.331) which indicates that there was a very poor positive correlation coefficient which was not statistically significant. None of the components were also statistically significant.

5.7.3 Association between the financial resources and Perceived outcomes

As indicated in figure-5.2, perceived partnership outcome was not significantly correlated with financial resources available for partnerships. The r value is 0.16 (p=0.180) which indicates that there was very weak positive correlation coefficient. None of the components were also having statistically significant correlation.

Table-5.20

Perceived outcome – Individual Partnerships

Zone	Public	Private	Private		Contractual	Collaborative	Total Score
			APAC-USAID	Others			
Danger Zone	0	0	0	0	0	0	0
Work Zone	8(40)	4(8)	2 (14.2)	2 (5.5)	11(18.6)	1(9.2)	**12(17.1)**
Target Zone	12(60)	46(92)	12 (85.8)	34 (94.5)	48(81.4)	10(91.8)	**58(82.9)**
	20	**50**	**14**	**36**	**59**	**11**	**70(100)**

- *Percentages within parentheses*

5.7.1 Association between the partnership age and Perceived outcomes

The Perceived outcomes of the partnerships were not correlated with the partnership age. The r value was -0.05 (P = 0.706) which clearly indicates that there was no positive and negative correlation coefficient. None of the components were having statistically significant association.

5.7.2 Correlation between the human resources and Perceived outcomes

The Perceived outcome of the partnerships and the human resources was not having statistically significant correlation (Figure-5.1). The r value is 0.12 (p=0.331) which indicates that there was a very poor positive correlation coefficient which was not statistically significant. None of the components were also statistically significant.

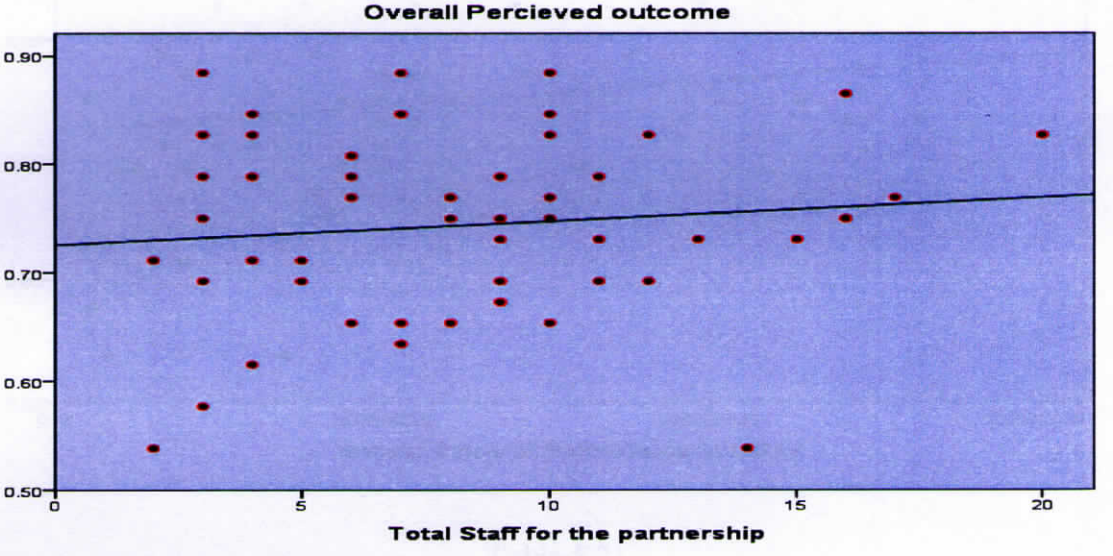
5.7.3 Association between the financial resources and Perceived outcomes

As indicated in figure-5.2, perceived partnership outcome was not significantly correlated with financial resources available for partnerships. The r value is 0.16 (p=0.180) which indicates that there was very weak positive correlation coefficient. None of the components were also having statistically significant correlation.

However, the outcome components such as perceived benefits (r-0.21) and satisfaction (r-0.21) were very weakly associated with the financial resources.

Figure-5.1

Correlation between the human resources and perceived outcomes



5.7.4 Association between partnership motive and perceived outcome

As indicated in Table-5.21 the partnerships whose motive was to fulfil the need in the community, performed relatively better in the perceived outcomes of the partnerships (0.78, SD 0.08) whereas whose motive was to attract financial resources (0.74, SD 0.08) and other motives have scored slightly lower but the difference was not statistically significant (p-0.121). But motives and satisfaction with partnerships had statistically significant relationship. The partners whose motive was to fulfil the need in the community (0.83, SD 0.21), were more satisfied with the partnerships than the other motives like attracting the financial resources (0.59, SD 026) which was statistically significant (p=0.017).

Figure -5.2

Association between the financial resources and perceived outcomes

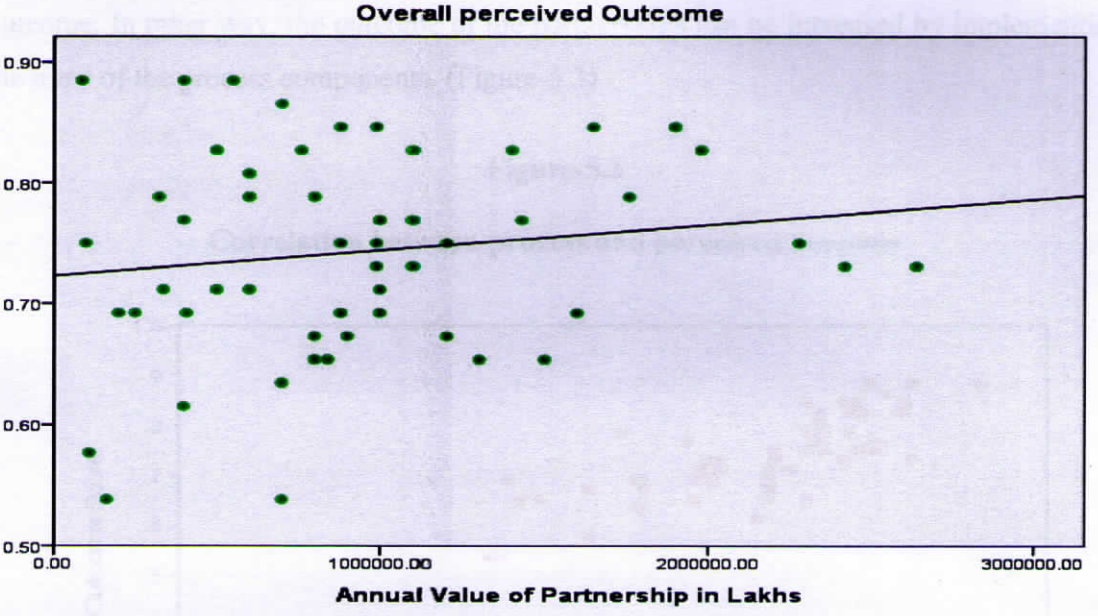


Table-5.21

Primary motive and perceived outcome

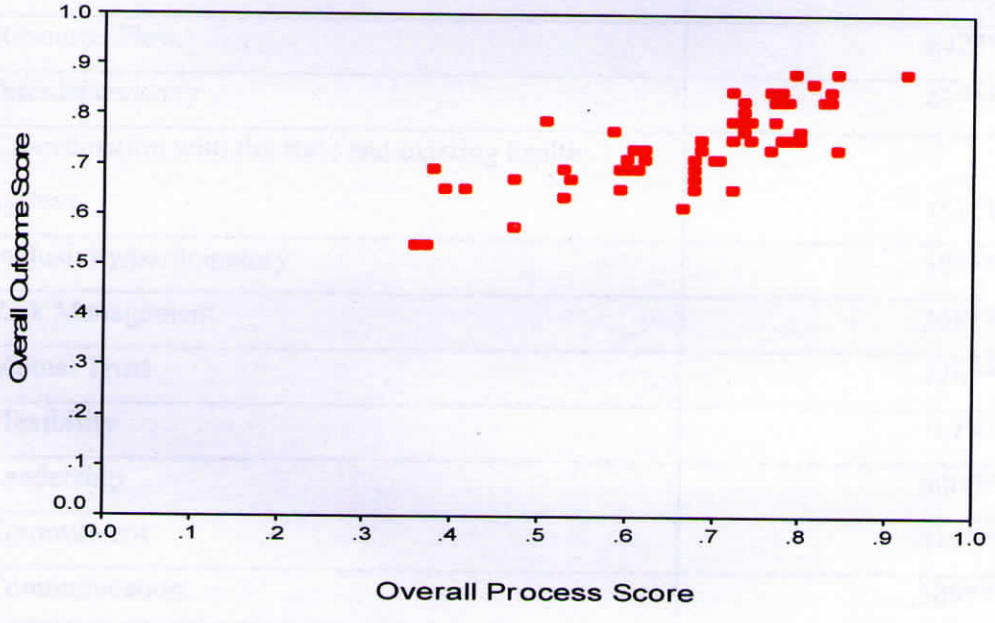
Motive	Outcome score	SD	F Value	P Value
To attract Financial resources	0.74	0.08		
To expand the existing services	0.75	0.07		
Institutional strengthening	0.70	0.06	1.90	0.121
Forced by programme requirement	0.70	0.10		
Felt Need	0.78	0.08		

5.7.5 Association between process effectiveness and perceived outcome

The process effectiveness had high positive ($r=0.778$, $p<0.001$) correlation with the perceived outcome implying that 'better' process implementations resulted in 'better' outcome. In other way, the outcome of the partnerships can be increased by implementing the most of the process components. (Figure-5.3)

Figure-5.3

Correlation between process and perceived outcome



Majority of the process components (85%) had a strong or moderate degree of association that was between the score 0.25 and 0.75, with the perceived outcome as mentioned in the Table-5.22. Only three components have low degree of association which was below 0.25. Three components were not having significant association with the perceived outcome.

Figure -5.2

Association between the financial resources and perceived outcomes

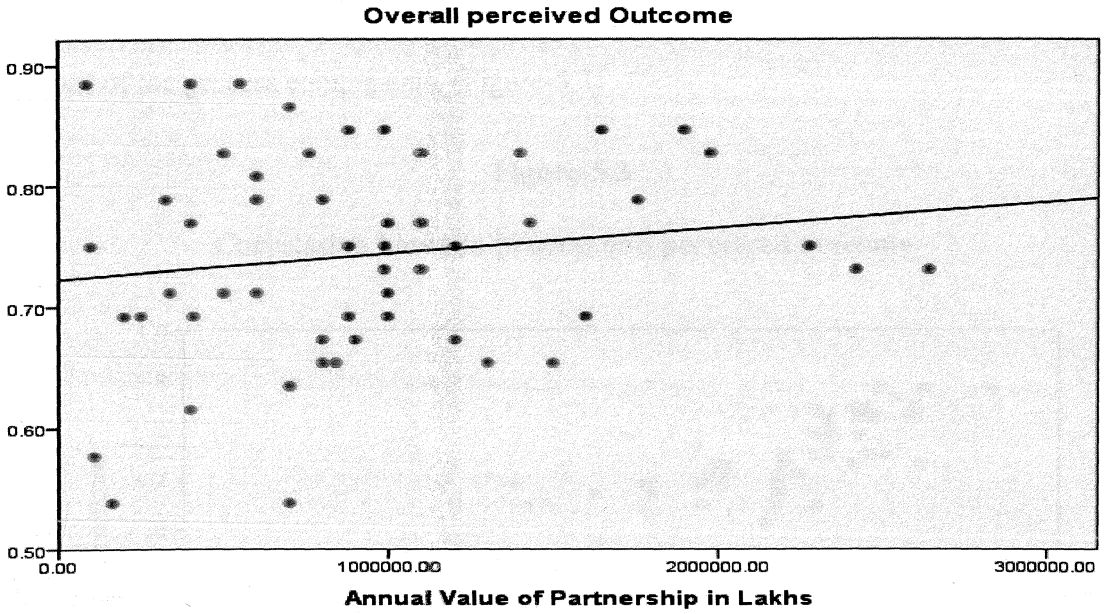


Table-5.21

Primary motive and perceived outcome

Motive	Outcome score	SD	F Value	P Value
To attract Financial resources	0.74	0.08	1.90	0.121
To expand the existing services	0.75	0.07		
Institutional strengthening	0.70	0.06		
Forced by programme requirement	0.70	0.10		
Felt Need	0.78	0.08		

Table-5.22

Process effectiveness Vs Perceived outcome

Process components	Perceived Outcome(r)
Clarity and realism of purpose	.545**
Working Arrangement	.496**
Internal Governance	.460**
Accountability	.426**
Transparency	.409**
Resource Flow	.642**
Interdependency	.437**
Co-ordination with the state and existing health system	0.111
Inclusivity/participatory	.588**
Risk Management	.368**
Mutual Trust	.526**
Flexibility	0.192
Leadership	.600**
Commitment	.419**
Communication	.509**
Mutuality	.449**
Autonomy	.372**
Complaints Management	.498**
Monitoring and Review	.591**
Organizational identity	-0.08

5.8 Multiple linear regression of perceived outcome

The multiple linear regression analysis(Table-5.23) carried out in order to clearly identify the process components that significantly contribute to the outcome in presence of other components, showed two process components significantly affected the outcome that were, resource flow and inclusivity or participatory (p=0.030). Enter method was used and R^2 was 0.72 for the model implying good predictability by the process components entered in the model. The rest of the variable which showed significant correlation in bivariate analysis did not turn out to be significant in the multiple linear regression. However, their contribution cannot be ignored, but it is revealed that these three play the most important role in the perceived outcome of the partnerships.

Secondly, in order to understand the importance of the process components in predicting the outcome and also to eliminate the co-linearity problem, a multiple linear regression with stepwise method of inclusion of variables was performed. The probability of F criteria for inclusion of a process component into the model was 0.05 and removal was 0.01. The model included four variables until the change in F value was significant – i.e. variables included in the model made significant impact in improving R^2 (0.79). Four process components were included in the order - resource availability (p<0.001), leadership (p=0.003), risk management (p=0.004) and inclusivity (p=0.026).

The relationship between process components and the perceived outcome can be influenced by partnership types based on funding, nature (contractual or collaborative) and experience. Hence the relationship between outcome and process components was checked using multiple linear regression after adjusting for these extraneous variables and results indicated significant contribution to the process component was resource availability (p=0.003) and inclusivity or participatory (p=0.048). When looked at the relationship in a conceptual manner ignoring types, age and nature, all four components such as resource management, inclusivity or participatory, leadership and risk management influenced the outcome significantly. Intensive implementation of these components would enhance outcome of the partnerships. However, resource flow stands out and cuts across different partnership profiles and proves to be a significant.

Table-5.23

Multiple linear regression of the partnership outcome against process components

Process Components	Non-standardized ß	Standardized ß	t	p value
Mutual Agreement	-0.12	-0.29	-1.75	0.086
Working Arrangement	0.01	0.02	0.14	0.891
Internal Governance	0.02	0.06	0.45	0.655
Accountability	0.08	0.15	1.32	0.194
Transparency	0.04	0.11	0.97	0.336
Resource Flow	0.14	0.43	3.05	0.004*
Interdependency	0.07	0.20	1.84	0.072
Coordination	0.02	0.05	0.50	0.618
Inclusivity/participatory	0.07	0.28	2.23	0.030*
Risk Management	0.05	0.14	1.33	0.190
Trust	0.03	0.07	0.60	0.548
Flexibility	0.01	0.04	0.40	0.694
Leadership	0.09	0.23	1.29	0.204
Commitment	0.04	0.09	0.71	0.481
Communication	-0.03	-0.10	-0.71	0.478
Mutuality	-0.06	-0.16	-1.41	0.166
Autonomy	0.02	0.08	0.68	0.501
Complaints	0.01	0.05	0.36	0.724
Monitoring and Review	0.00	0.00	0.00	0.999
Identity	-0.05	-0.12	-1.24	0.219
(Constant)	0.45		7.65	<0.0001

5.9 Systemic outcomes

The systemic outcome mainly deals with the equity enhancement, responsiveness, quality increase, client satisfaction, increased health seeking, increased health improvement, increased access and sustainability.

5.9.1 Equity

Partnership presupposes that equity, accessibility and quality of care would be ensured to the targeted beneficiaries, i.e. the rural, poor and deprived sections of the population. The results indicated that the partnerships served lower socio-economic population, female, rural and vulnerable population.

The (Table-5.24) provides details related to those who have accessed the services of partnership initiatives in Tamil Nadu. Majority (71%) of them were from the lower socio-economic class, 22 percent were in the medium level and only 7 percent of them were from the higher socio-economic class. As indicated in Table-5.24, the private funded partnerships served more lower socioeconomic population (73%) than the public funded (67%) partnerships but it was not statistically significant (p=0.178). The collaborative partnerships (83.09%) served more poor populations than the contractual partnerships (68.8%) which was statistically significant (p=0.004). Among the private funded partnerships, the APAC-USAID funded partnerships served relatively less socioeconomic population than the other private funded partnerships.

In addition, the partnered interventions served more rural populations (61.2%) than the urban (Table-5.25). In specific, the private funded partners (62.2%) served slightly higher rural population than the public funded (58.4%) partners but the difference was not statistically significant (p=0.537). The collaborative partnerships(79.09%) extended more services to the rural population than the contractual partnerships (57.8%) which was statically significant(p-0.002); the APC-USAID funded partnerships (47%) served less rural population than the other private funded partnerships(68.19%) which was also statistically significant($p<0.001$)

Besides, as indicated in Table-5.26, the partnership initiatives served around 48 percent of the female population, and 8.6 percent of the children. The public funded partnerships served more female population than the private funded partnerships but it was not statistically significant (p=0.554). The private funded partnerships served more children and transgender. Among the private funded, APAC-USAID funded partnerships(40%) served less female population than the other private funded partnerships(50%) but it was not statistically significant(p=0.355). Though collaborative partnerships served more proportion of female and children than the contractual partnerships that was also not statistically significant (p=0.09)

Table-5.24

Socio-economic status of the Beneficiaries of partnerships (%)

Socio-economic status	Public Funded	Private Funded	Private		Contractual	Collaborative	Total
			APAC	Others			
Low	66.75	72.80	68.93	74.31	68.83	83.09	**71.1**
Medium	25	20.84	9.29	5.36	23.46	14.36	**21.9**
High	8.25	6.46	22.14	20.33	7.88	2.55	**7**
Total	100	100	100	100	100	100	**100**

Table-5.25

Geographic area of the Beneficiaries of partnerships

	Public Funded	Private Funded	Private		Contractual	Collaborative	Total
			APAC	Others			
Rural	58.4	62.2	47	68.19	57.81	79.09	61.2
Urban	41.6	37.7	53	31.81	42.19	20.91	38.8
Total	100	100	100	100	100	100	100

The client interviews result indicated (Table-5.27) that, 40 percent of the clients of the partnered interventions was from the lowest income quartile and only 6.7 percent from the highest income quartile. In addition, more than half (53.3%) of the clients were women.

57.8 percent from the rural areas, and 21.3 percent widows. In addition, 22.4 percent (64) of the clients were high risk populations like female sex workers, Men sex with Men and Intravenous drug users, 24 percent (54) were bridge population, 19.6 percent(44) were PLHAs and 9.3 percent (21) were spouses of the PLHAs.

Table-5.26

Gender of the Beneficiaries of partnerships

	Public Funded	Private Funded	Private		Contractual	collo borative	Total
			APAC	APAC			
Female	52.35	47.30	39.86	50.19	46.14	62.73	48.74
Male	41.00	41.04	57.57	34.61	43.42	28.18	41.03
Children	6.00	9.82	1.57	13.03	8.36	10.73	8.73
Transgender	0.65	2.84	1.00	3.56	2.59	0.18	2.20
Total	100	100	100	100	100	100	100

Table-5.27

Income of the Partnership beneficiaries

Monthly Income	Rural	Urban	Total
Lowest - < Rs.1250	64	25	**89 (39.6)**
Rs.1251 to 2500	34	30	**64 (28.4)**
2501 to 5000	25	32	**57 (25.3)**
Highest - 5000 and above	7	8	**15 (6.7)**
Total	**130**	**95**	**225**

5.9.2 Responsiveness

It is now seen as a key feature of effective health systems and it denotes how well the health system meets the legitimate expectations of the population for the non-health enhancing, non financial aspects of health care. It is also important that the clients

experience earlier interventions through a quicker response from service providers with dignity, confidentiality and provide care without much waiting time.

Majority of the clients (63%) responded that they were treated with respect; 73.8 percent were satisfied with the confidentiality; around 66 percent and 57 percent felt that the quality of basic amenities were good and the services were near and accessible to them. But, only 49 percent mentioned that the waiting time was not high and around 47 percent mentioned that they were involved in deciding the treatment or services for them.

The total score, as indicated in the Table-5.28, for responsiveness was 0.78 (SD: 0.19) which was in the *"target zone"*. According to the clients, the private funded partnerships were more responsive (0.83, SD: 0.17) than the public funded partnerships (0.68, SD: 19) and the difference was statistically significant ($p<0.001$). There was not much difference among the private funded partnerships ($p=0.543$).

Table-5.28

Responsiveness

Attribute	Public	Private	Private		Total
			APAC USAID	Other Private	
Treated with respect and dignity	61.80	83.98	83.72	84.09	**76.88**
Clients involvement in deciding	54.16	71.89	69.76	72.72	**66.22**
Adequate time to discuss	70.83	83.66	83.72	83.63	**79.55**
Information's in an understandable way	84.02	90.19	89.53	90.45	**88.22**
Informed consent	76.38	86.27	90.69	84.54	**83.11**
Confidentiality	77.77	87.90	86.04	88.63	**84.66**
Less waiting time	35.41	73.52	68.60	75.45	**61.33**
Basic amenities	72.22	84.31	81.39	85.45	**80.44**
Convenient, Near and accessible	64.58	79.41	81.81	81.81	**74.66**
Overall score	**68.10**	**83.23**	**81.5**	**83.9**	**78.4**

5.9.3 Quality of services and client satisfaction

Majority (81.3%) of the beneficiaries responded that the quality of services was good. The overall score was 0.74. The clients of the private funded (0.79, SD: 0.28) partnerships perceived high about quality than the public funded partnerships (0.64, SD: 0.36) which was statistically significant as well (p=0.003). Among the private, the service quality of the APAC-USAID funded partnerships (0.73, SD: 0.36) were lower than the other private funded partnerships (0.81, SD: 0.24) but it was not statistically significant (p=0.163).

Regarding the satisfaction, most (70.7%) of the clients were satisfied with the services, 26.7 percent were satisfied to some extend and only 2.7 percent were dissatisfied with the services (Table-5.29). The overall client satisfaction score was 0.84(SD: 0.26) which was in the *"target zone"*. The satisfaction level was slightly higher among the private funded partnership beneficiaries (0.85, SD: 0.25) than the public funded (0.79 SD: 0.27) but not statistically significant (p=0.114). 65.3 percent of the clients mentioned that they would always recommend the services to others.

Table-5.29

Satisfaction*

	Public	**APAC**	**Other Private**	**Total**
Satisfied	45(62.5)	34(79)	80(72.7)	**159(70.6)**
To some extend	25(34.7)	8(18.6)	27(24.5)	**60(26.6)**
Not satisfied	2(2.7)	1(2.3)	3(2.7)	**6(2.6)**
Total	72	43	110	**225**
Would they recommend to others				
Always	40(55.5)	32(74.4)	75(68.1)	**147(65.3)**
If no other option	11(15.2)	8(18.6)	14(12.7)	**33(14.6)**
Never	21(29.1)	3(6.9)	21(19)	**45(19.9)**
Total	**72**	**43**	**110**	**225**

** percentages within parenthesis*

5.9.4 Increased health seeking and perceived health improvement

When asked, whether the availability of the present facilities increased the frequency of seeking STI, HIV/AIDS and other related services, around 69 percent mentioned that there was an increase in the frequency of seeking the services (Table-5.30). The mean total score for increased health seeking was 0.83 (SD 0.26). Though health seeking frequency was slightly higher among the private funded partnerships (0.84, SD 0.24) the difference was not statistically significant (p=0.239). The other private funded (0.85, SD 0.21) beneficiaries reported of more frequency of health seeking than the APAC-USAID funded (0.81, SD 0.21) partnerships (p=0.132).

Regarding the health status improvement, as indicated in Table-5.31, majority of the clients (76.4 %) perceived that there was an improvement in the health status after seeking services from the partnered interventions. The overall score for the improvement in the health status was 0.85 (SD 0.28). More private funded partnership beneficiaries (0.89, SD 0.21) than the public funded beneficiaries (0.81, SD 0.28) reported health improvement which was statistically significant (p=0.024). Among the private funded partnerships, the APAC-USAID beneficiaries (0.93, SD: 0.20) reported higher health improvement than the other private funded (0.88, SD: 0.22) partnerships but the difference is statistically insignificant (p=0.250).

Table-5.30

Increased health seeking behaviour*

	Public	APAC	Other Private	Total
High	66.6	88.3	78.2	**155 (68.9)**
To some extend	29.2	9.4	20.9	**64 (28.4)**
No	4.2	2.3	0.9	**6 (2.7)**
Total	100	100	100	**225**

**Percentages within parentheses*

Table-5.31

Improvement in the health status*

	Public	APAC	Other Private	Total
Increased	65.2	88.3	78.2	**172(76.4)**
To some extend	29.1	9.3	20.9	**48(21.3)**
No	4.1	2.3	1.8	**5(2.2)**
Total	**100**	**100**	**100**	**225**

** Percentages within parentheses*

5.9.5 Accessibility of services

Improvements in the physical and economic access of services to users, convenience of the service location and time are some of the important expected outcomes. Although clients travelled an average of 20.1 km (range 1-80 km) to access HIV/AIDS services, around 57 percent of the beneficiaries opined that the services were near and easily accessible (score:0.74, SD 0.32).

The private funded (0.79, SD: 0.28) partnership services were more accessible than the public funded (0.69, SD: 0.36) partnerships (p=0.003). Among the private funded, APAC-USAID partnership services (0.73, SD 0.36) were perceived less accessible than the other private funded partnerships (0.81, SD 0.24) (p=0.241).

Also, more than half of the present clients (53.8%) of partnered interventions stated that they could not get or access the services prior to accessing the present services, though they required the services. Unavailability of services (13%), unaware of the facility (31.8%), unaffordability, lack of transport, adverse prior experience, and inconvenient timing were the important reasons cited by them. But, 46.2 percent were not in need of services.

Around 98 percent of the clients mentioned that they did not pay any money in the form of fee for accessing the services. But, importantly 41.8 percent felt that they would not have

availed this facility if it was not given free. However, 22.1 percent of the clients felt that other expenses such as travel cost; inconvenient timing of services were barriers to access the services.

5.9.6 Sustainability

Only 20 percent of the partners mentioned that they would continue all the existing activities, 64.3 percent mentioned that they would continue some activities and around 13 percent said that they would not be able to continue any activity after the funding period is over. But, only 10 percent of the public and 24 percent of the private funded partnerships; 18.6 percent of the contractual and 27.2 percent of the collaborative; 28.5 percent of the APAC funded and 22.2 percent of the other private funded mentioned that they would continue all the services. It clearly shows the difficulty in continuing the services after the funding period.

The funding partners also indicated that partnership activities might not survive after the funding period unless they receive funding from other sources for similar activities. As, partnership activities were carried out mainly through external funding and so, sustainability was a real concern. They also argued that most of the partnerships sustain in terms of the capacity development, institutional development etc. However, there was consensus that none of the funding partners had a mechanism to follow up the partners after the formal funding period was over. Also, few argued that the approach to transfer the activities from NGOs to Community based organizations is one of the steps for building sustainability.

CHAPTER-VI

DISCUSSION AND CONCLUSIONS

HOW EFFECTIVE ARE THE PARTNERSHIPS IN REACHING THE UNREACHED?

This thesis is all about two targets – high-risk groups and their first points of contact and one key instrument – partnership with the overall aim of enhancing access to STI/HIV/AIDS services. Good partnerships tend to increase the STI/HIV/AIDS care coverage, improve the quality of care, control excessive user costs to users especially the poor, and increase the efficiency and effectiveness of services. Healthy partnerships may produce socially desirable benefits, even if they do not result in better outcomes such as improved health or reduced social exclusion. Such affiliations also create opportunities to learn from partners, increase resources, reduce organizational risk, strengthen competitive positions, gain political influence, and secure economies of scale (Bazzoli et al., 1997).

6.1 Target-1: High-risk groups

Safer sex practices using condoms, abstinence before marriage and being faithful to a single partner were the main approaches emphasized by various HIV/AIDS interventions in India, particularly in Tamil Nadu, as the other mode of transmissions is not very prevalent (NACO/UNGASS, 2008). More importantly, safe sex practices among sex workers are considered perhaps the most effective method of preventing the spread of the epidemic (World Bank, 1997)

6.1.1 High-risk sexual practices among the unconventional groups

The study results, while once again indicating the prevalence of high-risk sexual practices among the conventional high-risk populations, also showed that such practices were prevalent among the so called general population, irrespective of the geographic and socio-economic variations. This trend makes not only the high-risk population but also the general population vulnerable for STIs and HIV/AIDS. This is in agreement with the

UNGASS report (2008) which explained that the HIV/AIDS epidemic in India is characterized by heterogeneity; it seems to be following the Type 4 pattern, where the epidemic shifts from the most vulnerable populations such as FSW, IDU, MSM to bridge populations such as clients of sex workers, STI patients, partners of drug users and then to the general population. The UNAIDS (2004, 2006) also reported that epidemic is affecting all the sectors of Indian society not just the high-risk groups such as sex workers, intravenous drug users, gays, migrant workers, and lorry (truck) drivers originally associated with this infection.

The results also revealed that unprotected pre-marital, post marital and extra-marital sex was significantly prevalent; pre-marital sex was particularly reported among the adolescents, students and young employees both in the urban and rural areas. This is consistent with the BSS (2006), among 15 and 24 years of age, which found that 8.4 percent (15 million youngsters) in India, are snuggling up for pre-and post-marital sex which is higher than the rate found by similar survey in 2001. Surveys among the general population have also reported premarital sexual activity among 7 to 48 percent of male respondents and 3 to 10 percent of female respondents (Prasad et al., 2000; Savara, 1992,) The BSS (2006) revealed that a significant 15.7 percent of young men and 5.9 percent of the young women (15 to 24 years) had sex with non-regular partners in Tamil Nadu which was higher than the national average; the situation was similar among the urban and rural areas. Significant pre-marital sex, predominantly sexual activity, among unmarried school and college students (mostly in urban areas) has been reported among 8 to 39 percent of male students and 1 to 20 percent of female students (Rakesh, 1992; Singh et al., 1998); importantly, these pre-marital sexes were by and large unsafe. Of those who experienced sex before marriage, over one-fifth of young women and one-quarter of young men had sex with two or more partners. Ever use and consistent use of condoms were also limited; only 7 percent of young women and 27 of young men reported that they had ever used a condom in their pre-marital sexual relationships, and 3 percent of young women and 13 percent of young men reported that they had always used a condom (Population Council, 2009). The BSS (2006) also reported a low level of condom usage among non regular partners in Tamil Nadu (31%) which makes them vulnerable.

This study also recorded the prevalence of extra marital sex both in rural and urban areas. Other studies also mentioned about the prevalence of extramarital sex in India. A study done in rural north India revealed that extra-marital sex was common among young men in the age-group of 18-25 in all the states (Longkumer et al., 2005). Small scale studies among groups such as STI clinic patients and truck drivers have reported higher levels (81–98%) of premarital and extramarital sexual experience and this high risk sexual behaviour among the population might increase the HIV/AIDS numbers in India (Rao et al., 1994). The problem of extramarital sex can be felt by the fact that 22 percent of new HIV cases in India were housewives in relationships with one partner (UNAIDS, 2006). More studies have noted that an increasing proportion of HIV infected women are married and monogamous (Newmann et al., 2000; Panda et al., 2000; Steinbrook, 2007). A report from South India found that 95 percent of HIV infected women were currently or previously married, and 88 percent reported a history of monogamy, implying that most were infected by their husbands (Newmann et al., 2000).The spouses of these women who frequented sex workers, is one of the major driving forces behind the spread of HIV into the non-high-risk population.

6.1.2 Condom use

This thesis found that, in spite of huge efforts and the resultant elevated knowledge and awareness level in the community, safer sex using condoms was still not practiced continuously and consistently by both targeted and untargeted groups engaging in high-risk sexual practices. BSS and NACO reported an increased condom usage among sex workers, MSM, truckers and among the general population (BSS, 2006; NACO, 2008). However, the major problem is the discontinuous and inconsistent usage in Tamil Nadu (APAC-BSS, 2004, 2006). The population-based National Family Health Survey (NFHS-3, 2006) revealed that only 24 percent of the rural women and 60 percent of the rural men knew that HIV/AIDS could be prevented using condoms and limiting sexual intercourse to one uninfected partner whereas 50.5 percent of the urban women and 79 percent of the urban men were aware of it. Only, 29.7 percent of the rural men reported using a condom during the last high-risk intercourse while 53 percent of the urban men reported so. The National Baseline Behavioural Surveillance Survey (BSS, 2001) and End line BSS (2006) among

the general population also reported that the proportion of men reporting non-regular sexual partners in Tamil Nadu has increased from 6.6 percent in 2001 to 15.4 percent in 2006, but condom use increased only marginally from 45.4 percent in 2001 to 50.9 percent in 2006. In addition, though majority (84%) of sexually active youngsters were aware of the importance of condoms, but only 40 percent consistently used it (BSS, 2006). All these clearly indicate that there are a lot of grey areas which need to be addressed by the interventions in Tamil Nadu.

The thesis also disclosed that the reasons for the low level of condom usage were due to the lack of availability, difficulty in the accessibility, difficulty in storage and disposal of condoms especially in the rural areas. The higher rate of unplanned sex, lack of adequate knowledge, perception that condom reduces the pleasure and other misconception related to condoms was also contributing to unsafe sexual practices. Many studies reported the same as well. Roth et al. (2001) reported that the lack of privacy in stores and the social stigma associated with condom use were indicated as the most significant barriers of condom usage. Even the highly targeted groups like FSWs, MSMs and Truckers were not able to maintain continuous and consistent use of condoms. A study among the truckers revealed that various myths and misconception and lack of availability when required, prevented them to use condoms (Saini and Singh, 2004). A study among the MSM population revealed that around 47 percent did not use condom during the last encounter and the reasons were non-availability of condom, dissatisfaction with condoms, not needed with regular partner and partner's objection to condom use (Dandona et al., 2004). Many sex workers have too little ability to negotiate with all their clients to use condoms for want of more money and also due to the fear of losing the clients. UNAIDS (2002) stated that condom use varies among sex workers and the decision to use condoms is often controlled by the customer or brothel owner. Descriptive and analytical studies show that sex workers commonly use condoms less often with regular partners, spouses, and non-paying customers (Ngugi et al., 1999). The BSS (2006) indicated that, among the female sex workers, though there was a high level condom usage during their last encounter, consistent condom usage among the female sex workers with their paying client was 54.1 percent and with the regular client it was 9.2 percent in Tamil Nadu. Condom use for

penetrative sex with the regular sex partner was negligible, and 41.8 percent FSWs had neither used condom consistently with clients and nor had used with their regular sex partner in the last sexual act (Dandona et al., 2005). Moreover the study revealed condom usage was very much influenced by the appearance, education and socio-economic status of the partners as the perception of risk was associated more with socio-economic status rather than with behaviour. This lower condom usage among the high risk population denotes low usage of condom among the general population who are often their clients. Also, Indian women are especially vulnerable due to their low levels of awareness and education. Because of their low status and limited access to resources, women in poverty are not able to negotiate for safe sex including condom use, which makes them vulnerable to diseases including HIV infections (Kodandapani and Alpert, 2007).

6.1.3 Emerging new high-risk groups

The study results clearly indicates that there are many newly emerging hitherto untargeted high-risk populations that are vulnerable to STI/HIV/AIDS other than the highly targeted groups such as CSWs, MSMs, IVDUs, Truckers and migrants. Other studies and reports too documented that the HIV/AIDS epidemic has already moved from the high-risk to the general population and to rural areas (NACO, 1999, 2004; Mitra, 2004; NACO, 2008). As mentioned earlier, it was mainly through the bridge population as well as due to the high risk sexual behaviours among the general community. Unlike other states, in Tamil Nadu, the prevalence was higher among the female populations (Male:Female 0.7:1) and among the rural (NFHS 3, 2006; NACO, 2006) which is a clear indication that the epidemic has matured and penetrated the general population (Claeson and Alexander, 2008).

According to the thesis results, many new groups could be perceived and categorized as high-risk based on their high-risk sexual activities. Construction workers (78%), casual labourers (47%), industry workers in the urban areas (64%) as well as village small scale industry workers (37%), college students and youngsters (29%), different types of vendors (41%), tribal population and few other population groups were identified as new high-risk groups. Very importantly, sexual partners of these new high-risk groups were not only commercial sex workers but also from the general community. This might propel the

overall incidence and prevalence of the epidemic. It was also revealed that these high-risk population groups, who are the drivers of the epidemics, vary from place to place and from district to district. The National AIDS control organization (2008) reported that the epidemic in India is really a collection of a number of small and large localized epidemics with their own dynamics and rates of growth, in different groups and parts of the country, reflecting the diversity in socio-cultural patterns and multiple vulnerabilities present in the country (NACO, 2008). Several studies also reported that there were many emerging high risk population, vulnerable for HIV/AIDS. For example, BPO and call centres employees are considered vulnerable for HIV/AIDS as incidents of alcohol, drug abuse and HIV/AIDS were on the rise where an estimated 1.3 million youth are working (UNODC, 2007). It was also reported that street children who are estimated to be 18 million in India, were vulnerable for host of reasons (International Herald Tribune, 2006). Many of them were injecting drug users, they were exposed to sexual abuse and they have very little access to safe healthcare. In addition, several tribal were mentioned as high-risk groups for STI, HIV/AIDS due to the lack of structured marriages and tribal permissiveness for pre and extra-marital sexual relationships (Naik et al., 2002)

Given the situation, the strategies need to focus not only the conventional high risk population but also the emerging high-risk populations. It is also true that many high-risk groups revealed in the study have been recognized by few partnerships and they have included them in their interventions. However, Out of the 129 targeted interventions which were being carried out by different agencies in partnerships with the NGOs in 2007-08, 84(65%) intervention were for the conventional high risk groups and 30 (23.2%) interventions were for the bridge population like truckers and migrants and only 15 for the other groups.

The trend of high-risk sexual activities mainly depends upon the opportunity and the facilitating environment for sexual activities. Many new high-risk groups emerged due to their work environment and the opportunity they might get to indulge in sexual practices within the premises. Besides, lack of knowledge and misconception among the community was mentioned as a factor for few specific groups entering into high-risk sexual practices.

As the concentration of high-risk population varied across different social and geographic contexts, interventions need to be placed according to the local need because the localized epidemic would have different type of high risk populations as well as specific pattern of risk behaviours which need to be addressed. In addition to addressing high prevalence groups, more attention is needed for people perceived to be at low risk, such as married women and the rural population, as HIV spreads amongst the general population and to the rural areas in Tamil Nadu. Much analysis is also needed to determine whether the present strategies are appropriate regionally in order to redesign and reprioritize according to local need.

6.2 Target-2: STI/HIV/AIDS care seeking: first points of contact

The results indicated that fear, stigma and discrimination in the community, work places and health settings; the myths and misconceptions played a major role in the health seeking behaviour of the vulnerable and the infected. These factors not only prevented them to seek care and treatment but to seek HIV/AIDS services from far off places and from unqualified health care providers.

Centre for Disease Control (2008) reported that shame, stigmatization or both lead many affected individuals to seek treatment outside established health care systems, whether with traditional healers, self-treatment using alternative medicines or over-the-counter remedies, or through other avenues or to not seek treatment at all. The delay in the treatment seeking as well as the self-medication many a times increased the severity of the problem. According to the thesis study, other common factors influencing the health seeking behaviour were, distance, geographical location, affordability, and experience with the providers, the perceived quality as well as social, cultural barriers and beliefs. The result of the study is consistent with several other studies and reports. Roy et al. (1998) mentioned that inhibition, time and distance were important considerations for seeking care for sexually transmitted diseases. A study reported that treatment-seeking in India is determined by a number of variables, among which are: perceived seriousness and causality of symptoms; availability and accessibility of health care; costs (including

opportunity costs) of treatment; perceived and actual quality of care; and beliefs about the appropriate provider to consult (Hawkes and Santhya, 2002).

In consistence with the finding of this study, Prasad et al. (2000) reported that there was huge delay in seeking the treatment and it was also reported that women in rural Tamil Nadu waited, on average, for a month before seeking any treatment. There are variable proportions of symptomatic men who seek care (Joseph et al., 1998). WHO (2004) cited lack of confidentiality, financial limitation, lack of friendly services, ignorance as the reasons for the adolescents not to seek care when they get STIs. Poverty is directly related to nutritional status and health seeking behaviour especially relevant with respect to STIs (UNESCO, 2002).

The study indicated that myths and misconceptions prevented seeking of health care which is in line with UNESCO (2002) which reported that beliefs and perceptions of the community influenced the seeking of treatment for STIs. It was also determined that denial, stigma and discrimination as one of the issues affecting the health seeking behaviours. Though men seek care and treatment for STIs, but do not necessarily inform their wives or partners and later when wives get infected most of them do not have the courage to disclose it to their husbands. Due to the culture of silence, seeking treatment for women is often the last recourse (UNESCO, 2002). It also reports that young people, especially girls and women do not seek treatment for STI due to embarrassment. In the event of falling sick, the options available to them are no treatment but rest. Findings from the recent study done among the MSM stated that as result of discrimination many turned to the local unqualified providers or even used a friend's prescription for treatment (Sankalp, 2008). Other studies also reported that stigma and discrimination against people living with HIV/AIDS in hospitals, clinics and other health care settings discourage many from seeking care which include denial of and delayed treatment, segregation and isolation from other patients, and early discharge (Mahendra et al., 2002; UNAIDS, 2006). Negative attitudes from health care staff have generated anxiety and fear among many people living with HIV/AIDS. As a result, many keep their status secret (Kodandapani and Alpert, 2007; Deshmukh, Kavi and Anand, 2004). Stigma also affects prevention efforts with the harassment of AIDS outreach workers and peer educators (Human Rights News, 2002).

The social consequences of both felt and enacted stigma are experienced by the individuals in terms of their rights, freedom, self-identity and social interactions that often influence the decisions to seek HIV testing and to access prevention services (Green, 1995). In addition, discrimination within the families and communities, health care settings, and employment is documented in many studies in India which influenced the health care seeking as well as open admission of their status (UNAIDS, 2001; Bharat and Aggleton, 1999). The NFHS (3) also reported that only 42 percent of the urban and 33 percent of the rural population; 34 percent of the women and 37 percent of the men had the accepting attitude towards the PLWHAs. But in Tamil Nadu state, only 12 percent of the women and 14 percent of the men had the accepting attitude which is an indication that stigma is still highly prevalent in Tamil Nadu. Considering the situation, the partnered interventions need to address the factors affecting the health care seeking behaviour of the affected. It is not only the behavioural interventions but structural interventions which address the prevailing issues affecting the health care seeking is very important to make a dent on the disease.

Though the desired health care seeking behaviour for an individual to respond to an illness episode related to STI and HIV/AIDS is by seeking first and foremost help from a trained doctor in a formal health care setting, the study results clearly brought out the facts that the first points of contact for the affected and vulnerable community were a variety of providers including fully and less than fully qualified providers of different systems of medicine. The combing process revealed that majority of them (82.5%) was from the private sector.

6.2.1 Formal government health care setting

Around 36 percent of the discussions mentioned government health care setting as their first points of contact. The BSS (2006) also reported that 22 percent of the urban and 26 percent of the rural population sought STI treatment from government hospitals in Tamil Nadu. The low preference was because of the lack of confidentiality, high waiting time and perceived quality (BSS, 2001).

6.2.2 Formal private sector

Majority of the focus group discussions(72.8%) mentioned private qualified allopath practitioners either in a solo clinic or in a health care setting, as the first points of contact when they get an STI or doubtful about STI. Surveys of health seeking behaviour in India are also in consistent with the study which indicated that the poor increasingly prefer and use private providers of healthcare, as opposed to public providers (Bennett, 1997). The poor, as well as the rich, often seek health care from private providers, including for conditions of public health importance such as malaria, tuberculosis, and sexually transmitted infections in spite of the fact that the services of public providers are free (Zwi et al, 2001; Uplekar, 1998). WHO (2002) reports that in the South-East Asia region, 60-70 percent of all patients with tuberculosis and an equal number of patients with STIs preferred to use the private sector. Bhat (1999) stated that these private providers are a major source of care in rural India and especially over 71 percent of all non-hospitalized rural illness in Tamil Nadu was treated at private facilities. As reflected in the study, the private practitioners were often the first points of contact especially for the rural poor in the health system, largely due to their extensive reach and coverage of the population (Yadav et al., 2009). The BSS (2006) also reported of a higher proportion of STI infected seeking treatment from the private sector. The recent study indicated that uptake of HIV/AIDS testing services in the private sector was around 50 percent and in Tamil Nadu 57 percent of the men and 49 percent of the women sought testing services from the private sector (Selvaraju, 2009). A study in Chennai also documented a significant number of high volume private laboratories conducting HIV testing, with a large number of both men and women seeking testing (Solomon et al., 2002).

6.2.3 Less than fully qualified practitioners (LTFQs)

The next major group was (67.7%) the registered medical practitioners (RMP) and registered Indian medical practitioners (RIMP) who are often less than fully qualified practitioners (LTFQs) and they were one of the strong favourites for both the urban and rural STI care seekers. A survey indicates that approximately 1.25 million unqualified rural medical practitioners were in India (Rohde and Viswanathan, 1995). Martens et al. (1998) states that private medical practitioners especially the unqualified private health providers

are the primary sources of initial ambulatory care for the rural poor in India. Prakasamma (1993) stated that the unqualified private providers found a niche market and began to provide the services demanded by the rural population. Rhode and Viswanathan (1995) stated that rural private providers were found to be the mainstay of rural medical care, consulted first (and exclusively in most cases) for 60-80 percent of illness, especially for women and children. They also stated that the existing network of rural practitioners is the *defacto* primary health care system of rural India. Another report says that the rural medical practitioners (RMPs), who provide 80 percent of outpatient care, have no formal qualifications for it (Kumar et al., 2007). As found from the study, the high demand for unqualified private providers in rural India is also attributable to a complex interaction of factors such as lower cost, accessibility, and the ability of these providers to combine traditional and allopathic medical systems to meet client demand and perceptions of quality care (Khare, 1996).

Traditional healers (55.9%) were also one of the first points of contact stated by the discussion. It was stated by Mackian et al. (2004) that, for some illnesses, people will chose traditional healers, village homeopaths, or untrained allopathic doctors above formally trained practitioners or government health facilities. A report by the CDC and World Bank (2008) pointed that many men do not utilize public sector primary care systems for STI care, although they may seek treatment from private sector or with alternative providers (e.g., traditional healers, pharmacists). A survey of 1,667 HIV infected persons in 4 regions of India found that 41 percent reported using some form of traditional Indian medicine and homeopathy although only 5 percent believed that this was more effective than allopathic ART (Ramachandan et al., 2007). As revealed by the study, many of these medicines are locally prepared and it is available in the market with the claim that complete cure is possible (Klein, 2007). Therefore, it is also important for the government and policy makers to really assess the claim by the alternative system of medicine so that the affected community will know the potential benefits and harms of using that, in addition to the encouragement of further research to understand the effectiveness and mechanism of action in the treatment of HIV/AIDS.

6.2.4 Qualified other system of practitioners

A significant proportion of the discussions mentioned about the qualified practitioners of other system of medicines like Siddha, Ayurved and Homeopathy in addition to the traditional healers and local herbal practitioners. This is because of the widespread availability of this type of providers and in many villages they were the only providers available to the community. Studies indicate many qualified non-allopathic healthcare providers, including homeopathic and ayurvedic practitioners, who are a readily accessible form of healthcare especially in rural areas (Singh et al., 2005; Lambert, 1997). Presently it is estimated, India has over 600,000 registered AYUSH practitioners including ayurvedic doctors (60%), homeopaths (30%), and yunani providers (6%); and probably much more non-registered AYUSH healers, including most of the gurus and other purist traditional healers. There are nationwide about 70 registered AYUSH providers and 50 allopaths per 100,000 populations (MOHFW, 2004; WHO, 2004). The WHO (2003) says that over 65 percent of the population in rural India use Traditional Indian Medicine, Homeopathy and medicinal plants to help meet their primary health care needs. This is used to treat a wide variety of conditions, including cancer, diabetes and HIV/AIDS (Banerji, 1981; Deivanayagam et al., 2001).

6.2.5 Pharmacists

Pharmacists or medical stores were mentioned as the first points of contact by a significant proportion of the community (66.1%) during a STI infection especially in the rural areas. According to the results, these pharmacists even run clinics with some doctors' name. These pharmacists or medical stores were accessed because of easy and quick process; cheap without many investigations, availability, and possibility to get medicines according to the need of the clients were some reasons. As a result, they reflect a growing tendency to avoid medication and prefer self-medication (by consulting with chemists and medical stores) rather than seek formal services (Singh et al., 2005). Though the quality of the services provided by the pharmacists is questioned and unclear, considering the number and the amount of services provided, these pharmacies are considered a valuable resource for health advice and medicines in many communities (Smith, 2009).

Other first points of contact were village health nurses (VHN, 33.8%). Many women in rural areas disclose their health conditions only to VHNs as they were interacting with them closely and also they were the only health care provider accessible to them. In many occasions, the affected get medicines even from the grocery stores where medicines are available for basic ailments. The other health care workers (37.2%) like nurses, lab technician, pharmacists, field level health care workers who reside in the nearby areas were also mentioned as the first points of contact for STIs. A recent study is in consistent with the present study which disclosed that a significant proportion especially women get treatment from private nurses, dais, pharmacist and other healthcare workers for STI and RTI related symptoms (Bhawsar, Singh and Khanna, 2005).

Results indicated that all these private qualified and unqualified providers were accessed because of the close proximity, respectful treatment, less waiting time, cheaper, easy accessibility, better and more flexible access, responsive to the needs and confidentiality which is consistent with many studies related to other diseases as well (Khare, 1996; Bhat, 1999; Nandraj and Duggal, 1996; Phadke and others 1995; WHO, 2002). The provider interviews among both the qualified and less than fully qualified practitioners also revealed that cost, proximity, low cost were the main reasons for the clients to access them for STI and HIV/AIDS related services.

6.2.6 Provider potential and willingness to get involved in HIV/AIDS control

It has been proved once again that the private sector is the first points of contact for a vast majority of people which is in consistent with many studies. The mapping and the provider interviews also revealed that there was a high proportion (82.5%) of private qualified and unqualified practitioners available as well as offering STI, HIV/AIDS related services. Majority (81.6 %) of the providers felt that that the prevalence of STIs and HIV/AIDS was significant and around 61 percent of the providers were getting STIs including HIV/AIDS cases also. In addition, a significant proportion (63.2%) of the providers had the ability to manage HIV/AIDS cases (81% qualified 59% LTFQ-Trained and 53% LTFQ-Untrained) and around 60 percent had prior experience of managing HIV/AIDS (63% Qualified, 63% LTFQ-Trained and 55% LTFQ-Untrained) in the recent past as well.

Invariably all the providers irrespective of the types, showed their willingness in prevention and counselling activities in collaboration with the public, private or not-for profit sector. More qualified providers (84.3%) and 66 percent of the LTFQs-Trained and 59 percent of the LTFQs-Untrained showed their willingness to involve in treatment and care of HIV/AIDS as well. The major factors preventing them to involve in the management of HIV/AIDS were lack of knowledge (32.8%) and lack of facilities (35.8%). Fear of losing clients (13.4 %), fear of contracting the disease (13.4 percent) were the other major reason quoted by the providers.

Therefore, it is very important that partnership initiatives need to have new strategies to effectively reach out the locally relevant untargeted risk groups and HIV/AIDS care providers by redefining the programme scope. In addition, the hitherto unutilized local health care providers or the first-contact points could be involved in the management of HIV/AIDS care. They prove to be additional cost-effective resources for HIV/AIDS care and could be part of a specific aspect of identification of suspects, HIV testing, treatment, or care. With appropriate training, provision of facilities, and incentives, majority (81%) of the fully trained physicians could be involved in HIV/AIDS care including the administration of ART. LTFQs, on the other hand, could be involved in identification of HIV suspects, HIV prevention and counselling and referrals. In addition, considering the cost effectiveness of syndrome management of STIs using algorithms(Vuylsteke, 2004), especially in resource-constrained settings, the LTFQs could be trained in STIs management in order to ensure the quality as well as wider reach of STI services especially in the rural areas. Otherwise, numerous high-risk people may be missed or may continue to receive inappropriate treatment. Increasingly health care seeking behaviour studies are coming to the conclusion that traditional and unqualified practitioners need to be recognized as 'the main providers of care in relation to some health problems in developing countries (Parkrust and Rahman, 2000; Mackian, 2004). There is also a realization that public and private sectors in health can potentially gain from one another in the form of resources, technology, knowledge and skills and cost efficiency (ADBI, 2000). Therefore, it is vital to bring all the potential private health service providers such as medical colleges, hospitals, industrial or corporate hospitals, nursing homes, NGOs,

practicing doctors and even the LTFQs and jointly plan and implement the programmes with the public sector for the success of public health programmes like HIV/AIDS interventions, so that the spread and the effect of the disease could be controlled effectively.

This study also clearly indicated the availability and capacity of various private providers to provide HIV/AIDS-related services, and their willingness to partner with governments and donors. So, it is suggested that donors and governments could explore ways to partner with the potential for-profit sector not only to deliver HIV/AIDS related services to all the people but also to ensure that private providers' services meet quality standards and follow accepted protocols for HIV/AIDS related services.

6.3 Evaluation of the Partnerships

This study provided evidence on the effectiveness of partnerships in the management and control of HIV/AIDS in Tamil Nadu state. It mainly elicited critical information related partnerships such as their primary objective, recognized need, motive, pre-partnerships processes, the inputs mustered, the process effectiveness and the perceived as well as the systemic outcome of the partnerships. It evaluated the effectiveness of partnerships and the predictors of effectiveness through the eyes of the implementing partners, funding partners and the beneficiaries of partnerships. It also identified the variation in the inputs, process measures and outcome of the different types of partnerships.

6.3.1 Objectives of partnered interventions: need for widening scope

The results indicate that the primary objective of more than half (54%) of the partnerships was prevention and promotion. Excluding the care and support partnerships, majority of the (73%) of the partnerships was for targeted interventions targeting conventional high risk groups like CSWs, MSMs, Truckers and Migrants. Also, it can be found that in the light of declining prevalence among high-risk groups there were many high risk groups emerging among the general population. It is also important to note that high risk sexual

practices and high risk groups vary across communities, districts, regions and social groups. In order to ensure the prevention strategies to reach out needy, it is vital to reorient the partnered interventions especially targeted interventions, widen the scope of targets and to include locally relevant high risk groups in addition to the conventional high risk groups. The literature also indicates that combination prevention, that is a combination of behavioural, structural, and biomedical prevention paradigms and approaches (Rao et al, 2008; Padian et al., 2008; Coates et al., 2008) adapted and prioritized to specific contexts and based on scientifically derived evidence and bottom-up wisdom and ownership of local communities offers the best hope for success in prevention (UNAIDS, 2004).

6.3.2 Partnership motives

The study indicated that the underlying motive (explicit or implicit) of a higher number of partnerships was either to attract financial resources or to strengthen their organizations and only 26 percent felt of a need in the community for HIV/IDS issues.. This is in corroboration with many reports that there is mushrooming of new private NGOs after the origin of HIV/AIDS in India (John, 2008; Pace and Bagasra, 2008) mainly because of the increased funding. The World Bank's (2007) detailed implementation review of the Indian health sector also reported that the real motive of many NGOs in India is financial resources. The present study also revealed that around 31 percent of the total budget of the organizations was for HIV/AIDS which reveals that HIV/AIDS funding was one of the important component for these organizations. However, our study results revealed that most of the (83%) organizations took up HIV/AIDS issue at a later point of time which means that they have started the organization well before they took up HIV/AIDS as one of their objective, which is not in agreement with the notion that many organizations were started exclusively to receive HIV/AIDS funding. However, in spite of the pivotal role of NGOs in the HIV/AIDS control (Barnett and others, 2001; NACO, 2007) these motives obviously raise the suspicion of the credentials of few organizations and it reinforces the need for a strong regulatory mechanism as well as a robust and transparent partner selection procedures and monitoring mechanism which would increase the effectiveness. (Dowling et al, 2004). It can be noted that, partnerships whose motive was to fulfil the community need, performed relatively better in the partnership processes (score: 0.75, SD

0.11) and outcome (0.78, SD 0.08) whereas those whose motive was to attract financial resources and other reasons have scored relatively low. Also, the satisfaction level of those whose motive was to fulfil the community need was higher than others which were statistically significant. Literature also suggests that there is a positive relationship between satisfaction and performance (Anderson and Narus, 1990). Mohr and Spekman(1994) says that partnerships generating satisfaction exist when performance expectations are achieved

6.3.3 The process and outcome effectiveness

Results indicated that partnership appears to be functioning well in terms of process effectiveness as well as perceived outcome. The overall process effectiveness score was 0.68, falling in *"target zone"*. At the same time, nine process components were in the "*work zone*" which means that there is much scope for improvement in the process measures of partnerships as well. The over all perceived outcome score was 0.74 which was in the *"target zone"* which means that the perceived outcome was indeed good. The individual scores of the partnerships also revealed that 69.6 percent were in the "work zone" in terms of the process scores and 17 percent in *"work zone"* in terms of the perceived outcome. However, despite the satisfactory performances of the partnerships, a significant proportion of partnerships were in the *"work zone"* which means that there is a need for improvement and also there is a scope for them to maximize the effectiveness to optimum level.

6.3.3.1 Partnership longevity and effectiveness

The results indicated no association between the longevity of the partnerships and the process (r=0.08, P=0.509) and perceived outcome (r=0.05, P=0.706). This is in agreement with few studies which mentioned that the value of a partnership is not necessarily measured in the longevity of the partnership and partnership longevity may not be an indicator of success (Kingsley and O'neil, 2004). But, there is a common thinking that mutual understanding and the relationship between partners could be strengthened and the partners could learn the way of working if partnerships are longer enough. Others argue that although success in strategic partnerships might be viewed as a function of

continuation, relationship longevity may not absolutely capture the partnerships success as some partnership purposely dissolved after a period of time (Pace et al., 2000).

6.3.3.2 Human and financial resources and effectiveness

The partnership evaluation did not indicate any association between the size of the human resources and the process (r=0.12, P = 0.32), perceived outcome (r= 0.12, p=0.331) of the partnerships. However, the financial resources available for the partnerships had a weak association with the process (r=0.25, p=0.03) but no association with the outcome(r=0.16, p=0.180). The exiting literature also defines that it is not the size of the resources but adequate financial and well tailored human resources to implement the planned activities (Buse and Harmer, 2007), transparency in the financial resources each partner brings to the partnership(Walt and Buse,2006) combing and leveraging the human and material resources (Lasker et al., 1997; Wandersman, Goodman, and Butterfoss, 1997), effective and efficient use of the available resources (Nikolic and Maikisch, 2007; World Bank, 2007) as important factors associated with the effectiveness of partnerships. In addition, one of the critical issues in partnerships, all over the world, is the timely release of grants or reimbursements to the private partner which affects the effectiveness of partnerships (Venkatraman, 2008). The present study also found that the adequacy, timely availability of funds and effective utilization had a positive association with the perceived outcome of partnerships(r=0.642, p<0.001)

6.3.3.3 Process effectiveness and perceived outcome

As established by many descriptive and empirical studies on partnership which mentioned process factors generally influences the outcome (Dowling et al, 2004; Wandersman, Goodman and Butterfoss, 1997; Kumpfer et al, 1993), the present study also revealed that the process effectiveness was very much associated with the (r=0.778, p<0.001) perceived outcome, implying that 'better' process implementations resulted in 'better' outcome. Except three, 17 percent of the process components had positive correlation with perceived outcome. In other way, the outcome of the partnerships can be increased by implementing the most of the process components effectively. Druce and Harmer (2004) also defined that

there is a causal link between the various determinants or processes and results at various levels.

According to the bivariate analysis, perceived outcome was highly correlated (r=0.51 and above) with the process components such as, resource flow(r=0.642), leadership(r=0.600), monitoring and review (r=0.591), inclusive and participatory(r=0.588), clarity and realism of purpose(r=0.545), mutual Trust(r=0.526), communication(r=0.509). These results of the study corroborated with previous research on partnership effectiveness. The strong correlation with the resource flow is in agreement with many studies which mentioned those adequate, necessary resources and regular flow funds to carry out planned activities or to finance the true costs required for partnership is essential for the success of partnerships (Venkatraman, 2000; Buse and Harmer, 2007; Wildridge et al, 2004). The importance of individual leadership in predicting partnership effectiveness substantiated previous earlier studies (Waddock and Bannister, 1991). Many literatures have mentioned that successful partnerships require agreement about the purpose and a clear need for partnerships (Harrison, 1999; Evans and Killoran, 2000; Jones, 2000; Asthana *et al.*, 2002). As found in the study, communication and mutual trust were also mentioned as an influencing factor of effectiveness in many studies. The study adds credence to the notion that communication problems are associated with the lack of success in partnerships (Sullivan and Peterson, 1982). Buse and Harmer (2007) and Mouawad (2004) emphasized the participatory nature of functioning and decision making in the partnerships. Moreover, Waddock and Bannister (1991) defined, mutual trust, adequate power to make decisions(autonomy), mutual benefit, right partners, interdependency, need of partnerships, mutuality(power balance), well defined objectives, strategic review, robust monitoring mechanism, leadership as important process factors facilitating the outcome of the partnerships. Few others also emphasized improved communication, strong leadership, trust and personal investment (Gunn, 1990; Reid, 1988).

The moderate correlates (r=0.25 to 0.49) included complaints management(r=0.498), mutuality(r=0.449), Interdependency(r=0.437), internal governance (r=0.460), clear working arrangements(r=0.496), accountability(r=0426), transparency (r=0.409), risk management (r=0.368) and autonomy (r=0.372). These factors are also in agreement with

existing studies. Hardy et al, 2003 emphasised the need for clear working arrangements. Buse and Harmer (2007) mentioned about the need for good governance and transparency in the partnerships functioning. Satisfactory accountability arrangements, plus appropriate audit, assessment and monitoring of the partnership are regarded as essential for successful partnerships by few others (Evans and Killoran 2000, Campbell 2001, Charlesworth 2001). Others mentioned that successful partnerships are truly authentic, promoting transparency and accountability (Rasmussen and Agarwal, 2000). Mutuality, which is the degree of equality in the interactions among organizations, was also mentioned by few authors (Brinkerhoff, 2002; Kellner and Thackray, 1999). Autonomy was considered as one of the core elements of viable partnerships (WHO, 1999). But it is also important to note that flexibility in the partnership functioning, organization identity and co-ordination with the state and the existing health system as process component were not associated with the perceived outcome though there were cited by the existing literature.

Other important finding is that high correlates of outcome was behavioural characteristics such as leadership, inclusive and participatory, mutual trust, communication etc. The literature also demonstrates that successful partnerships generally demonstrate more intense behavioural characteristics (Borys and Jemison, 1989). So, by improving the process measures which has a strong association, the outcome could be increased.

6.3.4 Partnership types and effectiveness

Though the overall score of the process and outcome scores were in the *"target zone"*, the results indicated that there was a statistically significant variation ($p<0.001$) between the private funded and the public funded partnerships. Especially the process effectiveness score of the public funded partnerships (0.56, SD 0.13) was in the *"work zone"* whereas the outcome score was 0.69(SD 0.08), the lower part of the *"target zone"*. When analyzed based on the individual scores of the partnerships, 25 percent of the public funded and 75 percent of the private funded partnerships were in the *"target zone"* in terms of process and 96 percent of the private funded and 60 percent of them were in the *"Target zone"* in terms of the perceived outcome.

While analyzing the components it was found that majority (13 components) of the process components of the public funded partnerships were in the *"work zone"* while 5 components of the private funded were in the *"work zone"* and in terms of perceived outcome, 5 components of public funded were in the *"work zone"* whereas only two component of the private funded were in the *"work zone"*. But, it is also important to recognize that none of the components of public and private funded partnerships were in the *"Danger zone"*.

The systemic outcome results also indicated a significant variation between the public and private funded partnerships in terms of the equity enhancement, responsiveness, quality of services, client satisfaction, and increased health seeking, and perceived health improvement, access of services and sustainability of services which were mainly the perspectives of the beneficiaries of the partnerships.

There are lots of reasons for the relatively lower performance of the public funded partnerships. Firstly, when comparing with the private funded partnerships, the inputs for the public funded partnerships were low. For example, the human resources available for the public funded was 7.6 staff /partnerships whereas the private funded had 8.4 and the APAC funded partnerships had 11.4 staff; the public funded had a annual budget of Rs 0.85 million whereas the private funded had Rs 1.01 million and the APAC funded had Rs 1.41 million. But, the expected results out of the similar interventions are almost equal for both of the partnerships. Though the inputs of the partnerships did not show significant association with the perceived outcome, even a weak association might have affected the performance. Second reason is the lower salary and benefits for the employees in the public funded partnerships comparing with the private funded partnerships. Because of these, it was observed that there was a higher level of attrition among the employees of the public funded partnerships which might have affected the effectiveness. Leadership in the public funded partnerships was another factor. The leaders of the public funded partnerships were mainly bureaucrats and frequent transfer for them was prevalent. In addition, though both the public and private funding partners were partnering with mainly the non-governmental organizations, the working style of the implementing partner was very much influenced by the funding partner. Though state AIDS control

societies(Funding partner) are registered as societies in order to have more flexibility and autonomy, it cannot be denied that the bureaucratic approach still exists and in fact they have relatively less flexibility to respond effectively to local realities reallocate financial, capital and human resources to achieve better outcomes. Few literature also argued that the voluntary sector ceases to function properly when organizations within it partner with the state, given the latter's coercive powers (Boettke and Prychitko, 2003). Huxham and Vangen(1996) argued that democracy and equality are problems and concerns when partnering with the state. In addition, the public sector was involved in all the areas of HIV/AIDS whereas the private funded partnerships were involved in specific activities with relatively less number of interventions. So managing the high number of partnerships would be a difficult process for the public partners which might have resulted in relatively poor performance.

Moreover, among the public funded partnerships which scored low(less than 0.50) in the process components were, resource flow (0.38), internal governance (0.45), transparency (0.44), inclusivity or participatory(0.41),complaints management(0.40) and autonomy(0.48). As established, resource flow was one of the important correlates of effectiveness. Many public funded partnerships mentioned negatively about the timely release of funds and sufficient funds for the activities. The key informants of the implementing partners also agreed that it was a problem due to various reasons. Besides, lack of clearly defined roles and responsibilities, lack of transparency in the selection process which affected the selection of right partner, lack of participatory decision making and functioning, dominance of the funding partner and poor conflict management process might have really influenced the effectiveness of the public funded partnerships. In addition to this, as found in the process evaluation, lack of adequate communication, robust monitoring mechanisms and clear working arrangements might be other reasons for the relatively low effectiveness of the public funded partnerships.

At the same time, the private funded partnerships were performing better and there might be lots of reasons for that. The relatively higher availability of resources and the higher salary and benefits for the employees might have added to the performance. The major reason was that the private funded partnerships were forced to perform and show results to

their donor. The robust selection procedures, performance targets, the performed based reviews, stable leaderships, effective monitoring mechanism, and participatory decision making and functioning, less bureaucratic procedures might have influenced the effectiveness. Prompt and effective communication between the partners also made them more effective. Especially, the relative higher autonomy and flexibility enjoyed by the funding partners allowed them to take decisions immediately and act according to the local needs which in turn might have resulted in operational efficiency. It is also in agreement with existing literature that operational efficiency of the private sector is better (Radwan, 2005, WHO, 2001) especially the non-profit sector (World Bank, 2004)

6.3.4.1 Private funded partnerships

Comparisons were made between the APAC-USAID funded partnerships and the other private funded partnerships. The results indicated that the APAC-USAID funded partnerships were propelling more resources than the other private funded partnerships as well as the public funded partnerships. In spite of that, there was no statistically significant difference between them in the effectiveness in terms of the process ($p=0.814$) and outcome ($p=0.575$) effectiveness. But, 6 process components of the APAC funded and 4 of the other private funded partnerships were in the "work zone" and in terms of the outcome two components of the APAC funded partnerships were in the *"work zone"* whereas none of the outcome components of the other private funded partnerships were in the *"work zone"*. The systemic outcome results also indicated that the other private funded partnerships scored relatively higher in accessibility, health seeking behaviour, client satisfaction, quality of services but the health improvement was slightly higher among the APAC-USAID funded partnerships. In addition, other private funded partnerships targeted high proportion of low socio-economic population, rural and female population.

This result indicates very clearly that the size of the resources was not a predicting factor for the success of partnership initiatives. It also indicates that the other private funded partnerships were relatively more effective and efficient than the APAC-USAID funded partnerships who are the pioneers of HIV/AIDS control in Tamil Nadu.

6.3.4.2 Contractual and collaborative partnerships

The comparison between the contractual and collaborative partnerships did not indicate any significant difference in term of the overall process as well as the outcome. The collaborative partnerships had less resource in terms of the human and financial resources. But, as expected, the collaborative partnerships were more effective in the process components of behavioural characteristics such as interdependency, flexibility, inclusive and participatory, commitment, leadership and Trust. This is in agreement with the extant literatures which indicates that the key to collaborative partnership is trust in the relationship, commitment and confidence that builds both parties to explore emerging trends, new ideas and a better understanding of the challenges and issues (Humphreys, Shiu and Lo, 2003; Foskett, 2005; Saltiel, 1998). But at the same time it is also argued that the most stable partnerships in the form of contractual binding on both the parties.

Besides, when the partnerships were compared based on the interventions they did, no significant difference was found among the targeted interventions, care and support and other programmes in terms of both process and outcome.

6.3.5 Effectiveness of partnership in terms of the systemic outcome

The literature suggests that, in redeveloping measures of partnership effectiveness, the perceived outcome need to be compared with the objective measures of partnership effectiveness using traditional outcome indicators (Waddock and Bannister, 1991). The evaluation need to address whether the objectives of partnerships have been addressed (Druce and Harmer, 2004; Kemshall and Ross, 2002). The major objectives of the partnerships is to increase the coverage, availability, accessibility, improve the quality of care, and enhance equity and increasing the efficiency and effectiveness of services (Widdus, 2001). The planning commission in India (2004) suggested strengthening the existing health system as one of the objective. Importantly, Barr (2007) suggests that the partnership objectives need to be met and the services should be responding to the identified need of the community. The study results have been viewed keeping the objective of partnerships in mind.

6.3.5.1 Equity enhancement

Though there was variation between different types of partnerships, especially between the public and private funded partnerships, the partnered interventions ensured equitable distribution of services. It provided more services to the poor, rural; women, vulnerable, deprived section, as well as the HIV/AIDS infected and affected population. The partnership assessment indicated that majority (71%) of their clients were from the lower socio economic population and the clients interviews also revealed that 68 percent of them were from poor population who earned less than Rs 2500 (USD 52) per month. In addition, the partnered interventions served more rural (57.8%), female (53.3%) and a significant proportion of widows, high risk populations and patient living with HIV/AIDS. Existing reports mentioned that HIV/AIDS disproportionately affect the poor, vulnerable and especially in Tamil Nadu, unlike other states in India, more rural and women were affected(NACO, 2006, NFHS-3, 2006) and the study partnerships addressed them well.

6.3.5.2 Effectiveness

The overall effectiveness has been discussed in terms of the increased coverage, target accomplishments, increased access, and quality of services, client satisfaction, and health seeking behaviour, responsiveness and perceived health improvement

6.3.5.2.1 Target accomplishments

The results of the study clearly indicated that the partnerships were able to achieve the targets as per the plan. Majority of the partners (97.1%) reported that there was increase in the client base and achievement of planned targets (91.4%). The funding partners also mentioned that they were able to achieve their intended targets in time though there were some flaws. Literatures also reported that partnerships have found to have increased the efficiency and effectiveness of Targeted Interventions; built local capacities including that of vulnerable groups, and secured the sustainability of the prevention activities in India. (Sadhana and Sebastian, 2004). The significant reduction in the prevalence in the state might also be considered as an overall target accomplishment of the state, which has come down from 0.75 percent in 2003 to 0.25 in 2007(Chandrasekaran et al.,2006;NACO,2008).

However, though the Annual BSS conducted by APAC in Tamil Nadu has shown a steadily increasing rate of condom use (APAC, 2004, 2006), The NFHS-3(2006) data shows that Tamil Nadu lags, in terms of comprehensive knowledge, condom usage, HIV testing, especially rural areas and women consistently lag behind urban areas and men.

6.3.5.2.2 Coverage increase

The results indicated that there was increase in the geographic (59%) and population coverage (86%) which reveals that that there was a major expansion of services through partnership initiatives. In addition, there was improvement and increase in the client targeting (90%) as well as the range of services (91.4%) after the inception of partnerships. Because of this increased coverage, there are more reporting of STI, HIV/AIDS cases as well. It can be also understood from the fact Tamil Nadu is having the highest number of reported AIDS cases in India (NACO, 2008, Sankaran, 2006). A significant proportion of (around 10%) of the targeted interventions in India, in collaboration with the non-governmental organizations are from Tamil Nadu and the intensity of interventions has been high (World Bank, 2007). It is also important to note that almost all the major players, funding agencies and donors are implementing programmes in Tamil Nadu unlike other states, which might have definitely played a role in the increased coverage. Nevertheless, when the saturation of coverage among the high risk groups was analysed, Tamil Nadu, was able to achieve 74 percent each among the FSWs and among MSM whereas the other high prevalent states had relatively higher achievement (UNAIDS, 2009)

The increased coverage and range of services offered by the different partners in Tamil Nadu have produced few unintended outcome as well. Informal discussion with the PLHAs in Tamil Nadu revealed that they have been involved in many programmes by different organizations as the organizations were forced to show targets. A PLHA quoted,

> *"We have become decent beggars. We know, in which organization, regular meeting will be conducted and what will be given (money and food) to us. We are regular in going everywhere. They (organizations) want us and we also want them".*

This was true for other target groups as well. This indicates very clearly that that there was too much dependence created for the infected and affected rather than empowering these communities. The study results also indicated duplication efforts, which might be due to the increased geographical and population coverage of services.

6.3.5.2.3 Increased access

It could be interpreted from the results that the partnered interventions have increased the accessibility of services. It might be due the involvement of increased number of organizations with funding from various organizations as well as the provision of free services. The results indicates that, though clients travelled 20.1 km (range 1-80 km) to access HIV/AIDS services, over 55 percent of them felt that the facility was easily accessible and convenient. Significant proportion of the beneficiaries (54%) accessed the partnered interventions which they did not get in the past due to various reasons. Also, 98 percent of the clients mentioned that they did not pay any money in the form of fee for accessing the services which might have definitely increased the access of services. However, a significant proportion mentioned that the other expenses did not prevent them to access services except around 22 percent mentioned of travel and contingency expenses.

6.3.5.2.4 Responsiveness, quality of services and client satisfaction

The results indicated that the responsiveness, perceived quality of the services and clients satisfaction was in the" target zone". Majority (70.7%) of the clients were satisfied with the services and the perceived quality of service was also good (81.3%) though there was variation between the different types of partnerships. The increase in the quality is in agreement with other studies (Shantha et al., 2004; Brown et al., 2002). This may be due to the healthy competition among the different players as well as the constant and continuous efforts and advocacy by the major players. Promoting quality of services was one of the important objectives of almost all the major players and they also developed adequate mechanism to ensure quality. The client satisfaction level also increased though waiting time was cited as a major barrier which is also in agreement with other studies (Karunamoorthi et al., 2009). But, the lower level of achievement in the public funded partnerships needs to be adequately addressed.

6.3.5.3 Community and target group involvement

Though there was an increase in the community and target group involvement, there was a clear mismatch of perception between the partners and the clients. According to 61 percent of the implementing partners, there was an increased general community involvement and 93 percent mentioned of increase in the target communities involvement. But, according to the beneficiaries, only 35.8 percent of the general community and 49.8 percent of the target communities were involved in the programme activities; around 40 percent of the general community and 66 percent of the target communities felt that their opinions related to the programmes were sought. It also indicates that the expectation of the beneficiaries regarding their involvement was not matching with the provider's perception. But, the higher involvement of the target groups was mainly because of the mandatory requirement of target group's such as PLHAs, FSWs and MSMs, involvement in programme activities. The less involvement of the community was voiced by the funding partners as well. However, they mentioned an increase in the involvement of community especially the targeted community as it has been made mandatory by the funding agencies.

6.3.5.4 Health seeking behaviour and perceived health improvement

There was an increase in the frequency of seeking HIV/AIDS related services (Score: 0.83) in Tamil Nadu which might be due to the increased availability, accessibility and affordability, quality and responsiveness of services. Many reports and studies have also mentioned increased seeking of HIV/AIDS services including increased usage of VCTC services, ART and condoms (BSS, 2001; BSS, 2006; APAC-BSS, 2004, 2006; NACO, 2008,). But, it cannot be totally ignored that there are still many barriers which affect the service seeking behaviours of the infected and affected particularly the unmarried youth (CDC, 2008; Sankalp, 2008; UNAIDS, 2001; NFHS-3, 2006). In agreement with many studies (World Bank, 2004; Solomon et al. 2009; WHO, 2008) the study results indicated that there were improvements in the health status, after seeking services from the partnered interventions.

6.3.5.5 Efficiency

There are enough literatures to justify partnerships in terms of the efficiency. At the same time there are several arguments that partnerships are inefficient due to various reasons. According to Mills and Bloomberg(1998), partnership arrangement in countries like India were found as inefficient due to various reasons such as lack of government capacity to act as an efficient purchaser, inappropriate decision, lack of monitoring mechanism and inefficient design of contracts. It has already been stated that partnerships are expensive and have many hidden costs. Also, it is reported that development of partnership initiatives take longer time to perform than those developed by a single institute operating alone and time is an obvious example of an underestimated cost.

The study also provided mixed results regarding the efficiency. For example, reduction of duplication of efforts is one of the important components to increase the efficiency (Dowling et al.., 2004). According to the study, a significant 39 percent of the partners mentioned that duplication of efforts still existed and 4 percent even mentioned that it has increased though a significant proportion mentioned a decrease. But the other evidences disclosed that that there were on the average 6.5 HIV/AIDS organizations in one target area with multiple organizations carrying out similar intervention. In 10 places 2 organizations, in 7 places 3 organizations, in 3 places 4 organizations were carrying out the same types of HIV/AIDS interventions. 33 percent clients revealed that they went to other institution for the same services and 32 percent of them even registered themselves in other institutions. Though, the duplication of efforts, according to key stakeholders, had been addressed through a common consortium of major players, it was evident that there was still duplication of efforts, which might reduce the efficiency of partnership initiatives. However, a joint supervision and monitoring of efforts by the different players might reduce the duplication efforts otherwise it might be difficult to totally avoid duplication of efforts in HIV/AIDS service provision.

Besides, half of the total budget was spent in salary alone which was even higher among the public funded (64.3 percent) partnerships which resulted in fewer resources for the programme expenses. This might not only affect the efficiency of the partnerships but also

the effectiveness. In addition, partnerships are expected to match and pool their resource strengths of each partner, resulting synergy which offers the opportunity to enhance efficiency of delivery (Smith et al., 2006). But the study results indicate that the partnerships were highly dependent on the funding partner for financial resources (just 10% contribution from the implementing partner) and it also indicates that there was no significant contribution from any other sources. This leads to power disparity, and Lister (2000) even questioned whether project-based development partnerships between non-profit and powerful donors can actually be considered partnerships, given wide power disparities. In this situation, the pooling and mutual sharing of comparative advantages of each partner, as theorized, might not be possible which might reduce the expected efficiency from partnerships.

Also, from the study results, it could be identified that there is no association between the size of resources and the outcome. A significant proportion of the partnerships which propelled higher resources were not relatively effective in producing the outcomes when comparing with the other partnerships. So, it was indeed very hard to explain whether the partnered interventions were efficient in providing the outputs and outcome.

However, a significant proportion of the partners perceived that there were, increase and improvement in the cost effectiveness (60%) and efficiency (57%) of implementing the services. The funding partners also mentioned that the partnered interventions were cost effective and efficient. Also, majority (72%) of the funding partners were very positive that the partnership initiatives were producing the expected outputs and outcomes in a timely manner as planned. But, they were also suggesting for further research to exactly understand the cost-effectiveness and efficiency of implementing HIV/AIDS interventions through partnerships.

However, although it was not possible to establish cost effectiveness and efficiency of the partnered interventions using health outcome measures like DALY gained and by other outputs but it can be very well understood from the fact that relatively lower staff salary under partnered interventions, long working hours, an increased target achievement and better coverage of services may be considered to indicate the effectiveness and efficiency.

6.3.5.6 Strengthening the existing health system

Druce and Harmer (2004) describe that strengthening the existing health system by improving the management of health within the government infrastructure is one of the expected outcome of the partnerships related to public health. UNAIDS(2009) advocates that there is a need for promoting health system thinking in all HIV related partnerships and the private sector should be guided to apply a health system perspective to all HIV and health-related projects. Therefore, any programme related to public health need to be sufficiently a part of the overall health system and have local health departments been strengthened as a result of this initiative which would sustain the activities. Though, according to the results that there was adequate co-ordination and co-operation from the health department for carrying out the programmes, it was doubtful whether the partnered interventions really strengthened the health system. However, there are enough evidences that HIV/AIDS programmes all over the world have strengthened the health system by providing funds for construction of buildings, renovation of existing facilities at health centres like blood banks and hospitals, and training of health personnel (Murzalieva, 2007; NACO, 2008). However, as these programmes in Tamil Nadu through partnerships were vertical in nature and time bound, they did not really have any concrete strategies to improve the existing health system. But, the study indicated that 95.6 percent of the cases were referred to public-run health care centres like ICTC, ART and PPTCT centres by the partnering organizations. This may be due to the fact these services are mainly available in the public healthcare system. But, the capacity building and training programmes related to HIV/AIDS have been given to both public and private healthcare providers by the partnered interventions. Funding partners also admitted that there had not been steps to strengthen the existing health system due to the programme's vertical nature.

6.3.5.7 Sustainability of the activities

One of the important concerns of the partnership initiatives is sustainability. In poor countries, even if improvements can be achieved with targeted external support, the activities and the improvements cannot easily be sustained after the period of funding (Caines, 2004; Skolnik, 2003; Caines and Abeykoon, 2004). So, funding sustainability is always an underlying issue for projects that rely so heavily on external support. In

agreement with the existing literatures, very less number of partners (20%) mentioned that they would continue all the existing activities after the funding period is over. Access and eligibility to continuous funding were the prime obstacles of the sustainability of partnerships. The key informants also indicated that partnership activities might not survive after the funding period unless they receive finding from other sources. None of the funding partners had a mechanism to do follow up activities with the partners after the formal funding period was over. Moreover, partnership activities were carried out mainly through single funding and no significant funding from other sources was found. So, sustainability of activities and programmes is a real concern. Though there have not been many steps for ensuring sustainability, the proposed approach in NACP III to transfer the activities from NGOs to community based organizations is one of the steps for building sustainability which is yet to be implemented and evaluated.

6.3.5.8 Reaching the un-reached

The study found that high-risk sexual practices were found among several hitherto untargeted population groups who are vulnerable for STI, HIV/AIDS. Yet, 65 percent of the interventions in Tamil Nadu targeted conventional high-risk groups, 23.2 percent the bridge population (truckers and migrants) and only 11.8 percent other groups (TANSACS, 2007-08). In addition, about 75 percent of resources meant for targeted preventive interventions are spent on these conventional high risk and bridge population (NACO, 2006). According to the partnership evaluation of this study, out of the 28 partnerships which were carrying out targeted interventions, only one exclusively targeted the industrial workers and all the other were targeting the conventional high risk groups and bridge population. However, around 39 percent of the partnerships reported that they took measures to reach out the hitherto untargeted high risk groups in some ways though they were meant for specific targeted interventions. But the intensity of reach and importance given to them are not known very clearly. Practically, reaching these unidentified and untargeted high risk groups would be a least preference for the partnered interventions as the targets given to them would be related to the targeted community for whom they were supposed to do the interventions. Therefore, considering the situation, there is a high

probability that these vulnerable populations may be missed or unnoticed by the present interventions through partnerships.

6.3.5.9 Involvement of potential providers

The study also indicated that there were different types of providers, existed as the first points of contact to the STI, HIV/AIDS vulnerable which included qualified and less than fully qualified practitioners. It is also evident that these providers have the potential as well as willingness to involve in HIV/AIDS control in collaboration with the government and not-for-profit organizations. The partnership assessment revealed that 21.4 percent of the partnerships involved different types of providers in the partnered activities though they did not have any formal collaboration with them. The reported involvement was mainly related to providing one time training in STI, HIV/AIDS. But, considering their potential and willingness, it was observed that these providers were not actively and formally involved in the HIV/AIDS interventions. Encaging the local health care providers has been advocated for TB control programmes (WHO, 2006) which has been successful approach as well. Smith (2009) reported that the roles of pharmacies are considered a valuable resource for health advice and medicines in many communities (Smith, 2009). Rahman(2008) stressed the need to traditional and unqualified practitioners care' who are the first points of contact for many illnesses especially in the rural areas. So, in order to increase the access and improve the quality of services related to STI, HIV/AIDS, all the potential care providers need to be involved formally and appropriately through suitable collaborative mechanism.

6.3.6 Attribution and counterfactuals

The most critical aspects and the major hurdles of partnership evaluation are attribution of the outcome to partnerships (partnership causing the improvement in outcome) and establishing the counterfactual that is, what would have happened without the partnerships. From the study, it can be very well understood that partnership was the main reason that many organizations had planned HIV/AIDS services. Only, 15.7 percent of the partnerships mentioned that they would have planned the same services even without partnerships and 37.5 percent mentioned that they would not have planned any activities at

all. So it is very evident from the results that most of the HIV/AIDS services in the state would not have happened without the partnership initiatives. On the other hand, a significant proportion (47.1%) mentioned that they would have planned few activities even if the partnerships were not there. This argument could be acceptable that, they would have carried out few activities as they might want to establish themselves as good not-for-profit organizations so that they would be eligible for future funding opportunities. In addition, 77.7 percent of the key informants mainly the representatives of the funding partners attributed the positive outcome of the HIV/AIDS interventions to the partnership initiatives. Majority of them (88.8%) could not find any other alternative to partnerships to carry out the activities. It was also emphasised that partnerships with the not-for-organizations were the only option to penetrate the community especially the high risk population as these organizations have a close link with the community, the ability to reach poor and have a wider reach especially with the high risk populations

In the absence of partnerships, many of them mentioned, that the rate of decline and the impact would not have been very high like the present situation and there might be an increased prevalence of HIV/AIDS in the community especially among the high risk groups. It was also mentioned widely that the impact would not have been this much, had the government alone taken up the responsibility.

Most of the key informants cautioned about the risk of resurgence of the epidemic if all the partnerships were dissolved immediately and suggested that the partnership initiatives need to continue for some more time to prevent new infection and to maintain stability in the efforts. It was also observed by few funding partners that they might need to restart the interventions from scratch if the partnerships initiatives were withdrawn during the very crucial time of stability. Majority (72%) of the funding partners were very positive that the partnership initiatives were producing the expected outputs and outcomes in a timely manner as planned. Besides, 77.7 percent of the key informants attributed the good outcome of the HIV/AIDS management and control in Tamil Nadu to the partnership initiatives. Though, in fact, the entire success cannot be fully attributed to partnerships, it can be very well understood from the study results that the partnerships have been playing a very important role in the management and control of HIV/AIDS in Tamil Nadu.

6.4 Conclusions

The study results indicated widespread prevalence of high-risk sexual practices among some unknown groups of people in the general population. This is not an unusual finding given some already known national data on this. This finding signals the possible exclusion of some hitherto unidentified high-risk groups from the HIV/AIDS related interventions. Perhaps due to this reason and the relatively low levels of knowledge and awareness among rural people, especially women, the prevalence of safe sex remained at the sub-optimal level even after massive efforts and resources towards behavioural interventions for over two decades. High-risk sexual practices, however, seem to vary across communities, districts, regions and social groups.

6.4.1 First points of contacts

First points of contact for STI and HIV/AIDS include a variety of fully and less than fully qualified modern and traditional medicine practitioners. Less-than-fully-qualified practitioners included lab technicians, nurses, paramedical personnel, pharmacists, village health (primary care) nurses, other 'registered' medical practitioners, and traditional healers. People sought care from them due to their proximity, affordability, availability, dependability, confidence, and experience. Some people avoided public health care services mainly due to non-availability of staff, lack of confidentiality, and high waiting time.

6.4.2 Provider potential

Since some providers were already offering some kind of STI and HIV/AIDS related services for some time, they carried some potential to offer to the management and control of HIV/AIDS and STIs. They also expressed their willingness to get involved in prevention, early detection, treatment, and counselling activities. At the same time, some constraints do exist preventing them from openly getting involved in HIV/AIDS related activities. The study findings concerning the untargeted groups and the potential of their first contact points vis-à-vis HIV/AIDS, however, are indicative, not definitive. More information is required in this area to make them conclusive.

6.4.3 Partnership effectiveness

Functioning and perceived outcomes of the HIV/AIDS partnerships were evaluated as effective from a health system perspective. They seem to have produced desirable health system outcomes viz., equity, accessibility, affordability, coverage and utilization of services, target accomplishments, quality of care, responsiveness, client satisfaction, capacity development, increased health seeking behaviour and overall health improvement. Type of funding, however, does not seem to determine their effectiveness although private funded partnerships scored well over public funded ones.

Some areas, however, need further improvement, particularly concerning the disease management. There are concerns regarding the sustainability of their efforts and benefits, alignment with the existing health system, duplication of efforts and community and target group involvement. Efficiency gains of these partnerships are also inconclusive. There is also no evidence to show that these partnerships targeted unconventional high-risk groups and their first contact points, as identified by this study. In other words, all the gains achieved by these partnerships were concerning the already known high-risk groups. That is, their targeting needs to be refocused.

6.5 Policy relevance of the findings

The thesis contributes to better understanding of the *'reality-know-do'* gap. It is essential to bridge these gaps in order to arrest the disease trend any further. The need for targeting the untargeted populations is a relevant policy issue in the present day context. Any HIVA/IDS efforts could be now evaluated from their effectiveness in reaching the un-reached.

Human resource management in the context of human resource shortage vis-à-vis HIV/AIDS is also of policy relevance. The thesis has thrown new groups of STI/HIV/AIDS care providers. On the one hand, there are not enough STI/HIV/AIDS care providers in rural settings while there are groups of providers who are hidden in the health system. If they are not appropriately mainstreamed, then their potential may be wasted besides allowing them to exist in their present form potentially harming the HIV/AIDS

management and control in the long run. The technique of *'task shifting'* could be applied to these groups so as to maximize the access and to minimize any potential damage they may do to the disease management otherwise. However, given the limited study scope, their credentials were not adequately verified by this study.

Partnership is seen as an appropriate way of managing HIV/AIDS. It is particularly relevant from an efficiency perspective. Partnership is also potentially helpful in reaching out to all sections of HIV/AIDS care providers and risk groups. Whether or not it achieved its key objective is a key policy question. Answering this question positions partnership in correct perspective so that it adds value to HIV/AIDS management. Otherwise, there needs to be a rethinking on this. This thesis provides a good evidence base for this.

BIBLIOGRAPHY

Adams, C.L. and **Goldsmith, P.** (1999) Conditions for Successful Strategic Alliances in the Food Industry, International Food and Agribusiness Management Review 2:2.

ADB (2006) Facilitating PPP for Accelerated Infrastructure Development in India, Regional Workshops of Chief Secretaries on PPP, Department of Economic Affairs (DEA) Ministry of Finance, Government of India and Asian Development Bank (ADB).

ADBI (2000) Public Private Partnerships in Health, Executive Summary Series No. S34/01, Asian Development Bank Institute.

Agha, S. (2003) A Quasi experimental study to assess the performance of a reproductive health franchise in Nepal. Commercial Market Strategies (CMS). Country Research Series Paper No.14. Washington DC.

Ahmed SM, Adams AM, Chowdhury M, Bhuiya, A (2000). Gender, socio-economic development and health seeking behavior in Bangladesh. Social Science and Medicine 2000:51:361-71.

Ahmed, M. (2000) Promoting Public-Private Partnership in Health and Education: The Case of Bangladesh. In Wang: 219-291

Ahn, M., Herman, A. and Damonti, **J.** (2000) Public-private partnerships in health care for developing countries: a new paradigm for change. Manag Care Q.8 (65–72).

Alter, C., and **Hage,J.**(1993) Organizations Working Together. Newbury,Park, Calif.: Sage.

Anderson,E and **Narus,J.A.**(1990)A Model of Distributor Firm and Manufacturer Firm Working Relationships. Journal of Marketing, 54: 42-58.

APAC-AIDS Prevention and Control Project (2004) HIV Risk Behavior Surveillance Survey in Tamil Nadu Wave IX-2004." APAC, Chennai, India.

APAC-AIDS Prevention and Control Project (2006) HIV Risk Behavior Surveillance Survey in Tamil Nadu Wave XI-2006." APAC, Chennai, India.

Arole, S., Premkumar, R., Arole, R., Mehendale, S., Risbud, A., and Paranjape, **R.** (2005). Prevalence of HIV infection in pregnant women in remote rural areas of Maharashtra State, India. Tropical Doctor, 35(2), 111–112.

Arora, P. (2008) Trends in HIV incidence in India from 2000 to 2007, The Lancet, 372,290.

Asthana, S., Richardson, S. and **Halliday, J.** (2002) Partnership working in public policy provision: a framework for evaluation. Social Policy and Administration 36, 780–795.

Ashman, D (2003) 'Seeing Eye to Eye? InterAction Member Agencies and World Bank Staff Assess their Operational Collaboration and Policy Engagement for Poverty

Reduction and Sustainable Development'. Washington, D.C.: Just Associates, for InterAction and the World Bank.

Austin, J. (2000) The Collaboration Challenge: How Nonprofits and Businesses Succeed Through Strategic Alliances. San Francisco: Jossey-Bass Publishers.

Axelsson, H., Bustreo, F. and Harding, A. (2003) Private Sector Participation in Child Health: A Review of World Bank Projects, 1993-2002. Washington, DC: The World Bank

Banerji, D. (1981) The place of indigenous and Western systems of medicine in the health services of India. Soc Sci Med Med Psychol Med Sociol, 15A (2):109-114.

Barnett, C., Connor C. and **Putney,P.**(2001) Contracting Non-governmental organizations to combat AIDS. Special Initiative Report No. 33. Partnerships for Health Reform, Maryland.

Barr, D.A. (2007) Public-Private Partnerships as a means to improve health and welfare systems globally: A Research protocol to evaluate their effectiveness and their potential problems. The American Journal of Public Health, 97(1), 19-25.

Bassler, T and Smit, M. (1997) Building donor partnerships. Newyork:OSI.

Bazzoli, G. J. et al (1997) Public–Private Collaboration in Health and Human Service Delivery: Evidence from Community Partnerships, The Milbank Quarterly, 75(4).

Bell-Elkins, J. (2002) Assessing the CCPH Principles of Partnership in a Community-Campus Partnership. Authored by Julie Bell-Elkins, Director, Office of Social Issues and Wellness,

Bennett, S. (1991) 'The Mystique of Markets: Public and Private Health Care in Developing Countries', PHP Publication No.4 , London School of Hygiene and Tropical Medicine, London.

Bennett, S., McPake, B. and Mills, **A.** (1997) Private health providers in Developing Countries: Serving the Public Interest? Zed Books London (United Kingdom).

Berkowitz, B. (2001) Studying the outcomes of community-based coalitions. American Journal of Community Psychology, 29, 213–227.

Berman, P. (1995) 'Health Sector Reform: Making Health Development Sustainable'. Boston: Harvard University Press.

Berman, P (1995) Health Sector Reform: Making Health Development Sustainable.
In Peter Berman, ed. Health Sector Reform in Developing Countries: Making Health Development Sustainable. Boston: Harvard University Press (13-33).

Bharat, S. and **Aggleton, P.** (1999) Facing the challenge: household responses to AIDS in Mumbai, India. AIDS Care, 11:31–44.

Bhat,R.(1999) Private medical practitioners in rural India: implications for health policy, Indian Institute of Management, Ahmedabad

Bhattacharya, G. (2004) Socio-cultural and behavioral contexts of condom use in heterosexual married couples in India: Challenges to the HIV Prevention program, Health Education and Behavior, Vol. 31, No. 1, 101-117

Bhawsar, R.D., Singh, J.P., and **Khanna, A.** (2005) Determinants of RTIs and STIs among the women in Punjab and their health seeking behaviours, Retrieved from http://medind.nic.*in*medind.nic.in/jah/t05/i1/jaht05i1p24.pdf

Bickman, L. (1989) Barriers to the use of program theory, Evaluation Practice, 12, 387- 390.

Birckmayer, J.D. and **Weiss, C.H.** (2000) Theory-based evaluation in practice. What do we learn? Evaluation Review 24, 407–431.

Bloom, D. E., Craig, P. and **Mitchell, M.** (2000) 'Public and Private Roles in Providing and Financing Social Services: Health and Education', in Wang Y. (Ed.) Public Private Partnership in the Social Sector: Issues and Country Experiences in Asia and the Pacific,

BMGF (2004) Developing Successful Global Health Alliances (Bill and Melinda Gates Foundation) Retrieved from http://gatesfoundation.org/nr/downloads/globalhealth/Global Health Alliances.pdf

Boettke, P. J., and Prychitko, D (2003) An independent non-profit sector prone to failure? An Austrian school perspective of the Salamon Paradigm and Lomann Challenge, Global prosperity initiative, WP no:23, George Mason University. http://www.mercatus.org/pdf/materials/447.pdf

Borys, B. and Jemison, D.B. (1989). Hybrid arrangements as strategic alliances: Theoretical issues in organizational combinations. Academy of Management Review, 14(2): 234-249.

Brinkerhoff, J.M. (2002) "Assessing and Improving Partnership Relationships and Outcomes: A Proposed Framework," Evaluation and Program Planning, 25,215-231.

Brown, D. L., and **Ashman, D.**(1996) Participation, social capital, and inter-sectoral problem-solving: African and Asian cases. World Development, 24(9), 1467–1479.

Brown, L., Tucker, C. and **Domokos, T.** (2003) Evaluating the impact of integrated health and social care teams on older people living in the community. Health and Social Care in the Community 11, 85–94.

Burch, S. and Borland, **C.** (2001) Collaboration, facilities and communities in day care services. Health and Social Care in the Community, 9, 19–30.

Buse K, Waxman, A.(2001) Public-private health partnerships: a strategy for WHO. Bull World Health Organization; 79: 748–754.

Buse, K. and **Harmer, A. M.** (2007) seven habits of highly effective global public–private health partnerships: Practice and potential, Social Science and Medicine 64, 259–271

Butterfoss, F. D., Goodman, R. M. and Wandersman, A. (1996) Community coalitions for prevention and health promotion: factors predicting satisfaction, participation, and planning. Health Education Quarterly, 23(1), 65–79.

Buxton, M., and Hanney, S. (1996). How can payback from health services research be assessed? Journal of Health Services Research, 1, 35–43.

Byng, R., Norman, I.J. and **Redfern, S.** (2005) Using realistic evaluation to evaluate a practice-level intervention to improve primary healthcare for patients with long-term mental illness. Evaluation 11, 69–93.

CACSH (2002) Partnership Self Assessment tool, The Center for the Advancement of Collaborative Strategies in Health at The New York Academy of Medicine, Retrieved from http://cacsh.org/pdf/psatreport.pdf

Caines, K (2005). Key evidence from major studies of selected Global Health Partnerships. High-Level Forum on the Health MDGs, Paris, 14–15 November 2005. Available at: http://www.hlfhealthmdgs.org/Documents/ GHP Background Paper Final.pdf.

Caines, K. (2004) Global Health Partnerships and neglected Diseases, DFID Health Resource Centre, London

Caines, K. and **Abeykoon, P.** (2004) Impact of Public-Private Partnerships Addressing Access to Pharmaceuticals in Low and Middle Income Countries: Sri Lanka, Initiative on Public-Private Partnerships for Health, Switzerland. ISBN : 2-940286-24-X.

Calnan, M. and **Ferlie, E.** (2003) Analyzing process in healthcare: the methodological and theoretical challenges. Policy and Politics **31,** 185–193.

Camille Saadé and Massee (2001) Public-private partnerships: Mobilizing resources to achieve public health Goals, The Story of a Successful Public-Private Partnership in Central America: Hand washing for Diarrheal Disease Prevention, Retrieved from: www.EHProject.org,

Campbell, F. (2001) The public health agenda: strengthening the democratic voice.Managing Community Care, 9, 23–31.

Governemnt of India-Census *(2001)* Government of India. From http://censusindia.gov.in

Centre for Health Research and Development–CHRD (2003) Involvement of private practitioners in the RNTCP - the rationale, problems encountered and likely operational models. Health Administrator 15, 61—71.

Chandrasekaran, P. and **Dallpetta, V.** et al (2006) Containing HIV/AIDS in India: the unfinished agenda. Lancet Infectious Diseases, 6,508–21.

Charles, C. and **McNulty, S.** (1999) Partnering for results: Assessing the impact of inter-sectoral partnering. Washington, DC: Agency for International Development.

Charlesworth, J. (2001) Negotiating and managing partnership in primary care. Health and Social Care in the Community, 9, 279–285.

Chen, H. and **Rossi, P.**(1983). Evaluating with sense: The theory-driven approach, Evaluation Review, 7(3), 283-302.

Chen, H. T. (1990) Theory-Driven Evaluation. London: SAGE.

Chisholm, D. (1989) Coordination without Hierarchy: Informal Structures in Multi-organizational Systems. University of California Press: Berkeley, CA.

Christenson, M., Eldredge, F., Ibom, K., Johnston, M. and Thomas, **M.** (1996). Collaboration in support of change. Theory into Practice, 35, 188-195.

CIVICUS (2001) CIVICUS (the World Alliance for Citizen Participation) index on civil society project, http://www.civicus.org/index/diamondhome.html

Claeson, M. and **Alexander, A.** (2008) Tackling HIV in India: Evidence-Based priority setting and programming, Health Affairs, 2 7(4).

Coates, T.J., Richter, L. and **Caceres, C.**(2008). Behavioral strategies to reduce HIV transmission: how to make them work better. Lancet, 23; 372(9639):669-84.

Cohen, J. (2004) 'Asia and Africa: on different trajectories?', Science,304(5679) .

Connell, J. and A. **Kubisch** (1998) `Applying a Theory of Change Approach to the Evaluation of Comprehensive Community Initiatives: Progress, Prospects and Problems', in K. Fulbright-Anderson,

CSIS (2006) The Private Sector and HIV/AIDS:Finding Models for India, South Asia Monitor.

Currie, M et al. (2005) A model of impacts of research partnerships in health and social services. Evaluation and Program Planning, 28(4), 400-412.

Correa, M (2008) Prevention of HIV transmission: Do we know what works and what doesn't?, Info Change Agenda, http://infochangeindia.org/200801076829/Agenda/ HIV/AIDS-Big-Questions/Prevention-of-HIV-transmission-Do-we-know-what-works-and-what-doesn-t.html

Dandona, R., Dandona, L., Mishra, A., Dhingra, S., Venkatagopalakrishna, K. and **Chauhan, L.S.**(2004). Utilization of and barriers to public sector tuberculosis services in India. Natl Med J India17:292-99.

Davies, H., Nutley, S. and **Tilley, N.** (2000) Debates on the role of experimentation What Works? Evidenced-Based Policy and Practice in Public Services, The Policy Press, Bristol.

De Costa, A. and Diwan, **V.** (2007) Where is the public health sector? ' Public and private sector healthcare provision in Madhya Pradesh, India. Health Policy, 84,269–76.

Dean, K. and **Hunter, D.** (1996) New directions for health: towards a knowledge base for public health action. Social Science and Medicine, 42, 745–750.

Deivanayagam, C.N., Krishnarajasekhar, O.R., and Ravichandran, **N.** (2001) Evaluation of Siddha medicare in HIV disease. J Assoc Physicians India 49:390-391.

Delion, J, Peeters P and **Bloome, A.K** (2004): Experience in scaling up local response in multi-country AIDS programs (MAP) in Africa. Downloadable from: http://siteresources.worldbank.org

Deshmukh, V., Row Kavi, A. and **Anand, V.,** (2004) Stigmatization of Transgender individuals: A barrier to access of health services. [Abstract no. WePeD6258]. 15th International Conference on AIDS: Thailand.

Dewan et al (2006) Improving tuberculosis control through public-private collaboration in India: literature review, BMJ. 2006 March 11; 332(7541): 574–578.

Diarra. (2001) Making a public–private partnership work-an insider's view, Bulletin of the World Health Organization, 79 (8).

Dickinson, H. (2006) The evaluation of health and social care partnerships: an analysis of approaches and synthesis for the future, Health and Soc Care in the Community14(5)375–383

Dowling et al., (2004) Conceptualizing successful partnerships, Health and Social Care in the Community 12 (4), 309–317

Dowling, B. (2000) GPs and Purchasing in the NHS: the Internal Market and Beyond. Ashgate, Aldershot.

Dowling, B. and **Glendinning, C.** (2003) The New Primary Care: Modern, Dependable, Successful? , 54–69. Open University Press, Maidenhead.

Druce, N. and **Harmer, A.** (2004) The Determinants of Effectiveness: Partnerships That Deliver: Review Of The GHP And 'Business' Literature, DFID Health Resource Centre,London.

Ehouman, L. (2002) Tamil Nadu: The Path to Becoming India's Leading State: A Strategic Analysis of Health, Education Biotechnology and Tourism, Center for International Development, Kennedy School of Government, Harvard University

El Ansari, W (2003) Educational partnerships for health: do stakeholders perceive similar outcomes? Journal of Public Health Management Practice, 9, 136–56.

El Ansari, W. and **Phillips, C.J.** (1997) Altogether better health personnel education? Findings from three community partnerships in health in South Africa.The Australian Problem Based Learning Network:New Castle, Australia, 4, 127 – 138.

El Ansari, W. and **Weiss, E.S.** (2006) Quality of research on community partnerships: Developing the evidence base. Health Education Research **21** , 175–180.

El Ansari, W. and **Weiss, E.S.** (2005) Quality of research on community partnerships: developing the evidence base, HEALTH EDUCATION RESEARCH Theory and Practice

El Ansari, W., Phillips, C.J. and **Hammick ,M.** (2001) Collaboration and partnerships: developing the evidence base. Health and Social Care in the Community, 9, 215–227.

European Commission (2008), Final Conclusions and Recommendations of the High Level Pharmaceutical Forum, 2005 – 2008, http://ec.europa.eu

Evans, D. and **Killoran, A.** (2000) Tackling health inequalities through partnership working: learning from a realistic evaluation. Critical Public Health, **10**, 125–140.

Farmer, P. E., Connors, M. and **Simmons, J.** (1996) Women, poverty, and AIDS: Sex, drugs, and structural violence. Monroe, ME: Common Courage Press

Fawcett, S.B., Lewis, R.K. and **Paine-Andrews, A.** (1997) Evaluating Community Coalitions for Prevention of Substance Abuse: The Case of Project Freedom. Health Education and Behavior, 24,812–28.

Field, J.E. and **Peck, E.** (2004) CONCORDAT OR CONTRACT: Factors facilitating or impeding the development of public/private partnerships in healthcare in England. Public Management Review, 6(2), 253-272.

Foskett, R (2005) Adult Education and Lifelong Learning, University of Southampton, UK Research in Post-Compulsory Education, 10(3), 351- 372

Fourie, F.C.V.N. and Burger, P.(2000) An economic and fiscal analysis and assessment of PPP. The South African Journal of Economics, 68, 4

Francisco, V., Paine, A. and Fawcett, **S.** (1993) A methodology for monitoring and evaluating community health coalitions. Health Education Research, 20(4), 403–416.

Fransen, L. and **Whiteside, A.** (2006) Study of the impact of HIV epidemic on the social and economic development of developing countries. The Commission of the European Communities.

Fried, B.J. and **Rundall, T.J.** (1994) Managing Groups and Teams In Health Care Management: Organization, Design, and Behavior, eds. S.M. Shortell and A.D. Kaluzny, 137–63. Albany, N.Y.

Gambone ,M.A. (1998) Challenges of Measurement in Community Change Initiatives', in K. Fulbright-Anderson, A. Kubisch and J. Connell (eds) New Approaches to Evaluating Community Initiatives, vol. 2, Theory, Measurement, and Analysis. Aspen Institute.

Ganatra, B. and **Hirve, S.** (2002) "Induced abortions among adolescent women in rural Maharashtra, "Reproductive Health Matters 10(19): 76–85.

Gillies, P. (1998) Effectiveness of alliances and partnerships for health promotion. Health Promotion International, 13, 99–120.

Glasgow, R., Vogt, T. and **Boles, S.** (1999) Evaluating the public health promotion interventions: The RE-AIM framework. American Journal of Public Health, 89, 1322–1327.

Glendinning, C. (2001) Progress in partnerships. British Medical Journal 323, 28–31.

Glendinning C., Coleman A., Shipman C. and **Malbon G.** (2001) Progress in partnerships. British Medical Journal 323, 28– 31.

Glendinning, C. (2002) Partnerships between health and social services: developing a framework for evaluation. Policy and Politics, 30, 115–127.

Glendinning, C., Powell, M. and **Rummery, K.** (2002) Partnerships, New Labor and the Governance of Welfare, 229–245. Policy Press, Bristol.

Global Forum for Health Research (1999) helping to correct the 10/90 gap: an overview, Geneva. Global Fund: Fighting HIV/AIDS in India. Retrieved from www.the globalfund.org.

Go, V. F., and **Sethulakshmi, C. J.** (2003) when HIV-prevention messages and gender norms clash: The impact of domestic violence on women's HIV risk in slums of Chennai, India. AIDS and Behavior, 7, 263-272.

Goodman, R.M. and **Wandersman, A.** (1994) FORECAST: A Formative Approach to Evaluating Community Coalitions and Community-Based Initiatives. Journal of Community Psychology (CSAP Special Issue), 6–25.

Government of India (2003) Integrated Disease Surveillance-District Surveillance Office Operations Manual, Ministry of Health and Family Welfare, Government of India and INDIACLEN and WHO.2003

Government of India(2004) Concept note on, Ministry of health and Family welfare, Government f India. Retrieved from http://mohfw.nic.in/PPP%20concept%20note-final.htm.

Government of India (2006) NSSO 60th Round – 2004, No.507, NSSO, New Delhi, 2006

Government of Tamil Nadu (2007), Tamil Nadu State AIDS Control Society (TNSACS) – an overview: www.tn.gov.in/policynotes/archives/...09/.../aids_control_society.pdf.

Government of Tamil Nadu (2008) Tamil Nadu State AIDS Control Society (TNSACS) – an overview:http://www.tn.gov.in/policynotes/archives/policy2008-09/pdf/health.

Government of Tamil Nadu (2009) Tamil Nadu State AIDS Control Society (TNSACS) – an overview:http://www.tn.gov.in/policynotes/archives/policy2008-09/pdf/health/

Ganatra, B. and **Hirve, S.** (2002) "Induced abortions among adolescent women in rural Maharashtra, "Reproductive Health Matters 10(19): 76–85.

Gillies, P. (1998) Effectiveness of alliances and partnerships for health promotion. Health Promotion International, 13, 99–120.

Glasgow, R., Vogt, T. and **Boles, S.** (1999) Evaluating the public health promotion interventions: The RE-AIM framework. American Journal of Public Health, 89, 1322–1327.

Glendinning, C. (2001) Progress in partnerships. British Medical Journal 323, 28–31.

Glendinning C., Coleman A., Shipman C. and **Malbon G.** (2001) Progress in partnerships. British Medical Journal 323, 28– 31.

Glendinning, C. (2002) Partnerships between health and social services: developing a framework for evaluation. Policy and Politics, 30, 115–127.

Glendinning, C., Powell, M. and **Rummery, K.** (2002) Partnerships, New Labor and the Governance of Welfare, 229–245. Policy Press, Bristol.

Global Forum for Health Research (1999) helping to correct the 10/90 gap: an overview, Geneva. Global Fund: Fighting HIV/AIDS in India. Retrieved from www.the globalfund.org.

Go, V. F., and **Sethulakshmi, C. J.** (2003) when HIV-prevention messages and gender norms clash: The impact of domestic violence on women's HIV risk in slums of Chennai, India. AIDS and Behavior, 7, 263-272.

Goodman, R.M. and **Wandersman, A.** (1994) FORECAST: A Formative Approach to Evaluating Community Coalitions and Community-Based Initiatives. Journal of Community Psychology (CSAP Special Issue), 6–25.

Government of India (2003) Integrated Disease Surveillance-District Surveillance Office Operations Manual, Ministry of Health and Family Welfare, Government of India and INDIACLEN and WHO.2003

Government of India(2004) Concept note on, Ministry of health and Family welfare, Government f India. Retrieved from http://mohfw.nic.in/PPP%20concept%20note-final.htm.

Government of India (2006) NSSO 60th Round – 2004, No.507, NSSO, New Delhi, 2006

Government of Tamil Nadu (2007), Tamil Nadu State AIDS Control Society (TNSACS) – an overview: www.tn.gov.in/policynotes/archives/...09/.../aids_control_society.pdf.

Government of Tamil Nadu (2008) Tamil Nadu State AIDS Control Society (TNSACS) – an overview:http://www.tn.gov.in/policynotes/archives/policy2008-09/pdf/health.

Government of Tamil Nadu (2009) Tamil Nadu State AIDS Control Society (TNSACS) – an overview:http://www.tn.gov.in/policynotes/archives/policy2008-09/pdf/health/

Gray, B. (1989) Collaborating: Finding Common Ground for Multiparty Problems, 1st ed. San Francisco: Jossey-Bass.

Green, G. (1995) Attitudes towards people with HIV: Are they as stigmatizing as people with HIV perceive them to be? Soc Sci Med; 41: 557-68.

Greig ,R. and **Poxton, R.** (2001) Nice process – but did joint commissioning change anyone's life? Managing Community Care, 9, 16–21.

Gulliver, P., Peck, E. and **Towell, D.** (2000) Evaluation of the implementation of the mental health review in Somerset: methodology. Managing Community Care, 8, 13–19.

Gupta, A., and **Bollinger, R.C.** (2006) Combating HIV/AIDS in India: Public-Private Partnerships Are Necessary for Success. Stanford Center for International Development, Working Paper No. 309, December 2006. Stanford, CA.

Hale, T.N and **Mauzerall, D.L** (2004) Thinking Globally and Acting Locally: Can the Johannesburg Partnerships Coordinate Action on Sustainable Development? Journal of Environment and Development, 13(3).

Hall,D., Lethbridge,J. and Lobina,E.(2005) Public–public partnerships in health and essential services, Regional Network for Equity in Health in Southern Africa (EQUINET), Public Services International Research Unit, University of Greenwich, Discussion Paper 23

Ham,C.,Hunter,D.J.,and **Robinson, R.**(1995)Evidence based policy making. BMJ310, 71-72

Hardy, B., Hudson, B. and **Waddington, E.** (2000) What Makes a Good Partnership? Nuffield Institute for Health, Leeds.

Hardy, B., Turrell, A. and **Wistow ,G.** (1992) Innovations in Community Care Management. Avebury, Aldershot.

Harrison, L. (1999) Integrating mental health services. Managing Community Care **7**, 15–25.

Hastings, A. (1996) Unraveling the process of 'partnership' in urban regeneration policy. Urban Studie, 33 , 253–268.

Hawkes, S and Santhya, K.G (2002) Diverse realities: sexually transmitted infections and HIV in India, Sex Transm Infect, 78: 31-39.

Health Action International (2000) Public-Private 'Partnerships' Addressing Public Health Needs or Corporate Agendas, seminar Report, Retrieved from http://www.haiweb.org/campaign/PPI/seminar200011.html

Hess, Michael, and **Adams, D.** (2001) ''Community in Public Policy: Fad or Foundation?'' Australian Journal of Public Administration. 60(2), 13–23.

Hsiao,W.C.(1994) 'Marketization'- the illusory magic pill. Health Economics 3:351–357.

Hulme, D. (1996) Too close for comfort? The impact of Official Aid on non-governmental Organizations. World Development, 24(6).

Humphreys, P., Shiu, W. K. and **Lov. H. Y. (2003)** Buyer–supplier relationship: perspectives between Hong Kong and the UK,Journal of Materials Processing Technology,138,(1-3)236-42.

Hunter, D. J. (2000) Disease management:Has it a future?BMJ, 320 (7234), 530.

Huxham, C. (1996) Collaboration and Collaborative Advantage. In Creating Collaborative Advantage, ed. C. Huxham, 1–18. London: Sage

Huxham, C. and **Vangen, S.** (2000) Leadership in shaping and implementation of collaboration agendas: How things happen in a joined-up world, Academy of Management Journal, 43 (6),1159-75

Huxham, C., and Vangen, S (1996) Working together: Key themes in the management of relationships between public and non-profit organizations. International Journal of Public Sector Management, 9(7): 5-17.

Huxham,C. and **Vangen ,S.** (2000) What makes partnerships work? In: S. Osborne (Ed.) Managing Public Private Partnerships for Public Services. Routledge, London.

IBBA (2007) Indian Council of Medical Research and Family Health International, National Interim Summary Report–India, Integrated Behavioral and Biological Ass'sment (IBBA), Rd-1

IMRB and APAC (2008) Mapping of high risk population in Tamil Nadu(Un published)

India Planning Commission (2002) Tenth Five-Year Plan, 2002–2007. Vol. 2. Chapter 2.8; Retrieved from http:// www.planningcommission.nic.in/plans/planrel/fiveyr/10th/ default.htm

International Fund for Agricultural development (2001) Strategy paper on HIV/AIDS for east and southern Africa. http://www.ifad.org/operations/regional/pf/aids.pdf

International Herald Tribune (2006) 'A child of India's streets', International Herald Tribune, **Jan26, 2006**

National Family Health Survey, India (NFHS-3), 2005–2006, vol. 1, Retrieved from http://www.nfhsindia.org /nfhs3_national_report.html.

Jones, N.(2000) Joint investment plans: a positive move forward. Manag Commy Care, 8,3–5.

Joseph, A., Srikanth, R.A., Abraham, S., et al. (1998) Sexual behavior: older husband's younger wives. Paper presented at the workshop on men as supportive partners in reproductive and sexual health. Kathmandu: 23–26 June

Jütting, J. (1999) Public-private-partnership and social protection in developing countries: the case of the health sector, Center for Development Research (ZEF) University of Bonn Paper presented at the ILO workshop on "The extension of social protection", Geneva, 13./14.12.1999

Karunamoorthi, K., Rajalakshmi, M., Makesh Babu, S. and **Yohannes, A.** (2009) HIV/AIDS patient's satisfactory and their expectations with pharmacy service at specialist antiretroviral therapy (ART) Eur Rev Med Pharmacol Sci , 13 (5):331-339.

Kellner, P. and Thackray, **R.** (1999) A philosophy for a fallible world. The New Statesman, 12(547), 22–25.

Kelly, K. and **Collin,s.**(2003) Monitoring and Evaluation of the European Union (EU) 'Partnerships for Health' programme, South Africa: Outline and framework for baseline studies and monitoring and evaluation.

Khare, R.S (1996) Dava, Daktar and Dua: Anthropology of Practiced Medicine in India."Social Science and Medicine, Sep; 43 (5): 837-48.

Kimberley, J., Leatt,P. and **Shortell.S.**(1983) Organization Design. In Health Care Management, 291–332. New York: Wiley.

Kingsley, G. and **O'Neil, D.V.** (2004). Performance Measurement in Public-Private Partnerships: Learning from Praxis, Constructing a Conceptual Model, Paper presented at the American Society for Public Administration 65th Nat -Conference, Oregon, March 27-30.

Klein, A. (2007): India: Supreme Court suspends manufacture of ayurvedic medicine being sold as a "cure" for AIDS. HIV AIDS Policy Law Rev 2007, 12(1):54.

Klein, R. (1988) Joint Approaches to Social Policy: Rationality and Practice. Cambridge University Press, Cambridge

Knight, T., Smith, J. and Cropper, **S.** (2001) Developing sustainable collaboration: learning from theory and practice. Primary Health Care Research and Development, 2, 139–148.

Kodandapani, K. and **Alpert, P.T.** (2007) AIDS in India: When Denial Kills, Home Health Care Management and Practice, 20(1), 21-26.

Krishnamurthy,P and Varma,P.(2005) Organizational Development in repnse to HIV/AIDs Epidemic. Tamil Nadu response to HIV/AIDS 1986 to 2005: Conquering a Silent epidemic, University of Madras.

Kulkarni, S. (2003) 'India Sector Paper: Health -Overview and Prospects', Centre for Media Studies (CMS), New Delhi (submitted to Asian Development Bank)

Kumar et al. (2007) Inequity in Health Care Delivery in India: The Problem of Rural Medical Practitioners, Health Care Analysis, Volume 15, Number 3

Kumpfer, K.L., Turner, C., Hopkins, R. and **Librett, J.** (1993) Leadership and team effectiveness in community coalitions for the prevention of alcohol and other drug abuse. Health Education Research, 8, 359–374.

Lambert, H. (1997) popular therapeutics and medical preferences in rural north India. Lancet. 348, 1706–9.

Lamptey, P.R.(2002)Reducing heterosexual transmission of HIV in poor countries.BMJ,324,207-11

Lasker, R.D et al (1997).Medicine and Public Health: The Power of Collaboration. Chicago: Health Administration Press.

Laverack, G. and **Labonte, R.** (2000) A planning framework for community empowerment goals within health promotion. Health Policy and Planning, 15, 255–262.

Leonard, L. G. (1998) Primary health care and partnerships: Collaboration of a community agency, health department and university nursing program. Journal of Nu'ing Education, 37(3),

Linder, S. H. (2000) Coming to terms with the public—private partnership, a grammar of multiple meanings.

Lister, S. (2000) Power in partnership? An analysis of an NGO's relationships with its partners. Journal of International Development, 12: 227-239.

Lo, Y J, et al. (2007) Controlling the HIV/AIDS epidemic in India. NCMH Background Papers·Burden of Disease in India.

Longkumer, M., Singh, S.K. and **Lhungdim,H.**(2005) Sexual Behavior in Rural Northern India: An Insight,http://iussp2005.princeton.edu/download.aspx?

Lopez (2006) Global and regional burden of disease and risk factors, 2001: systematic analysis of population health data, Lancet; 367, 1747–57.

Lorenz, N (2007) Effectiveness of global health partnerships: will the past repeat itself?, Bull World Health Organ, 85(7): 567–568.

MacKian, S. et al (2004) up the garden path and over the edge: where might health-seeking behavior take us? Health Policy and Planning; 19(3): 137–146

Maddock, S. and **Morgan, G.** (1999) Conditions for Partnership (Executive Summary), North West Change Centre, Manchester Business School, Manchester.

Mahal, A et al. (2002) Who Benefits from Public Sector Health Spending in India. New Delhi: National Council for Applied Economic Research.

Mahal, A., Srivastava, V. and **Sanan, D.** (2000) Decentralization and its impact on public service provision in the health and education sectors: The case of India. In: Dethier J (ed). Governance, decentralization and reform in China, India and Russia. Academic Publishers.

Mahal, A., Yazbeck, A. S., Peters, D. H., and **Ramana, G. N. V.** (2001). The Poor and Health Service Use in India. August. World Bank Report. Washington DC.

Mahendra, V.S., Panda, A.K., Bajaj, S., Mudoi, R.J., George, B., Gilborn, L. and **Bharat** (2002) International Conference on AIDS. Int Conf AIDS Jul 7-12; 14:

Mandell and **steelman, T.A.** (2003) 'Understanding what can be accomplished through inter-organizatioanl innovations: The importance of typologies, context and management strategies'. Public Management Review, 5(2), 197–224.

MAP (2004), AIDS in Asia: Face the facts, Bangkok: Monitoring the AIDS Pandemic Network, available at http://www.mapnetwork.org/docs/ MAP_AIDSinAsia2004.pdf.

Marra, M. (2004) Knowledge partnerships for development: what challenges for evaluation, Evaluation and Program Planning, 27, 151–160.

McCombie, S.C. (1996) Treatment seeking for malaria: a review of recent research. Soc Sci Med.43 (933-45)

McGann,J. and **Johnston.**(2006) The Power Shift and the NGO Credibility Crisis. The International Journal of Not-for-Profit Law, 8(2).

McKinsey (2005) Global health partnerships: Assessing country consequences. Seattle: Bill and Melinda Gates Foundation

McKinsey (2002) Developing successful Global Health Alliances,BillMelinda Gates Foundation.

Mercer et al. (1991) The role of non-governmental organizations in the global response to AIDS. AIDS Care, 3-3, 265 – 270

Merson, M et all (2008) The history and challenge of HIV prevention. Lancet, 372, 475–88

Merson, M. H., Black, R.E. and **Mills, A.J.** (2004) International Public Health: Diseases, Programs, Systems and Policies. Jones and Bartlett Publishers.

Merson, M.(2008) The history and challenge of HIV prevention. Lancet, 372,475–88.

Mertens, T.E. and **Smith, G.D.** (1998) Observations of sexually transmitted disease consultations in India. Public Health, 112,123-28.

Mehra, N (2005) Flawed, Failed and abandoned 100 P3s Canadian and International Experience, Ontario Health Coalition

Mignone, J. and Washington, **R.G.**(2007) Formal and informal sector health providers in southern India: role in the prevention and care of sexually transmitted infections, including HIV/AIDS. AIDS Care, 19,152–8.

Mills and **Broomberg** (1998). Experiences of Contracting: An Overview of the Literature. Geneva, Switzerland, World Health Organization.

Mills, A. (1998) To contract or not to contract? Issues for low and middle income countries. Health Policy and Planning, 13 (1), 32–40.

Milward, Brinton, H. and **Provan K.G.** (1993). "The Hollow State: Private Provision of Public Services." In Helen Ingram and S. R. Smith, eds., Public Policy for Democracy. Washington, DC: Brookings Institution, 222-237.

Mitchell, S.M. and Shortell, S.M. (2000) The Governance and Management of Effective Community Health Partnerships: A Typology for Research, Policy and Practice. Milbank Quarterly 78(2), 241–89.

Mitchell-Weaver, C. and Manning, B.(1992) "Public-Private Partnerships in Third development: A Conceptual Overview", in Studies in Comparative International Development Winter, 26 (4), 45-67

Mitra, P. (2004) India's HIV/AIDS Crisis: A Moment of Truth SAIS Review, 24(2)55-67.

Mohr, J. and **Spekman, R.** (1994) Characteristics of Partnership Success: Partnership Attributes, Communication Behavior, and Conflict Resolution Techniques, Strategic Management Journal, 15(2) 135-152.

Mohiddin, A. and Johnston, D. (2006) HIV/AIDS mitigation strategies and the State in sub-Saharan Africa – the missing link? Globalization and Health *2006, 2:1*

Montagu,D.(2002) Franchising of Health Services in Developing Countries. Health Policy and Planning; **17**(2): 121–130

Moorman, J. (2002) Public–Private partnerships. South African health review 200183–100).

Mouawad, D.D. and **Walker, D.**(2004) Tool for Evaluating Economic Development and Regeneration Partnerships, Improvement and Development Agency, Chief Economic development Officers society

Murzalieva, G. (2007) Tracking Global HIV/AIDS Initiatives and their Impact on the Health System: the Experience of the Kyrgyz Republic. Global HIV/AIDS Initiatives Network, Retrieved from http://www.ghinet.org/downloads/kyrgyz.pdf.

Murphy, B. (1991) 'Canadian NGOs and the politics of participation' in Swift, J and Tomlinson, B. (eds) Conflicts of interest Toronto: Between the Lines

NACPII/NACO (1999) National AIDS Control Organization, The scheme for prevention and control of AIDS (Phase II), Ministry of Health and Family Welfare, New Delhi.

NACO (2001) National AIDS Prevention and Control Policy, Ministry of Health and Family welfare Government of India, New Delhi

NACO (2001), National Baseline Behavioral Surveillance Survey (BSS) among General Population" Ministry of Health and Family Welfare, Government of India.

NACO (2006) Annual HIV Sentinel Surveillance Country Report, National AIDS Control Organization (NACO) Ministry of Health and Family Welfare

NACO (2006), End line Behavioral Surveillance Survey (BSS) , General Population Final Report, MOHFW, Government of India

NACO (2007) AIDS Case Reporting, Jan-Dec 2008 National AIDS Control Organization, Ministry of Health and Family Welfare, Government of India, New Delhi.

NACO (2007) HIV Fact Sheets Based on HIV Sentinel Surveillance, MOHFW, New Delhi

NACP-III/NACO (2007) National AIDS Control Organization, Ministry of Health and Family Welfare, Government of India.

NACO (2008) National Behavioral Surveillance Survey (BSS), 2006; Youth (15-24 Years). Ministry of Health and Family Welfare, Government of India.

NACO (2008) UNGASS Country Report 2008, India, National AIDS Control Organization, Ministry of Health and Family Welfare, Government of India, New Delhi,.

NACO (2008) HIV Sentinel Surveillance and HIV Estimation in India 2007: A Technical Brief, Ministry of Health and Family welfare New Delhi: NACO. Retrieved from http://www.nacoonline.org/upload/Publication/MandESurveillance,Research/HIVSentinelSurveillanceandHIVEstimation2007_ATechnicalBrief.pdf>

NACO (2002 to 2009) National AIDS Control Organization, Ministry of Health and Family Welfare, Government of India. Annual Reports 2002–2003, 03–04, 04-05, 05-06, 06-07, 07-08, 2008-2009

Naik, E.G., Karpur, A., Balasubramaniam, R., Seetharam, R., Munnireddy, S., Taylor, R.and Galwankar, **S.**(2002) Indian tribal: an emerging high-risk group for HIV/AIDS.; International Conference on AIDS. Int Conf AIDS. Jul 7-12; 14: abstract no. WePeE6491.

Nandraj, S., and **Duggal, R.,** (1996) Physical Standards in the Private Health Sector. A Case Study of Rural Maharashtra. Mumbai: Centre for Enquiry into Health and Allied Themes.

NASCIO (2006) Keys to Collaboration: Building Effective Public-Private Partnerships, The National Association of Chief Information Officers (NASCIO)Corpor.Leadership Council

National Audit Office (2001) Joining Up to Improve Public Services.The Stationery Office, London.

National commission on macroeconomics in health (2005) Ministry of health and family welfare, New Delhi. Government of India.

National Health Policy (1983, 2002) New Delhi: Ministry of Health and Family Welfare, Government of India.

National AIDS Prevention and Control Policy, ***www.nacoonline.org/prog_policy.htm***

Nelson, J. and **Rashid, H.** (1999) "Public/Private Partners: Key Factors in Creating a Strategic Alliance for Community Health." American Journal of Preventive Medicine, 16 (3).

Newmann, S., et al (2000) 'Marriage, monogamy and HIV: a profile of HIV-infected women in south India', International Journal of STD and AIDS 2000; 11:250-253

Ngugi, E.N., Branigan, E. and Jackson, **D.J.** Interventions for commercial sex workers and their clients. In: Gibney L, DiClemente RJ, Vermund SH, eds. Preventing HIV in developing countries. New York: Kluwer Academic/Plenum, 1999: 205–29.

Nielsen, R.P. (1986) Cooperative Strategies. Planning Review, 14,16–20.

Nikolic, I.A. and Maikisch, **H.** (2006) Public-private partnerships and collaboration in the health sector: an overview with case studies from recent European experience. Discussion Paper. World Bank Health, Nutrition and Population (HNP): Washington

Nishtar,S. (2004) Public – private 'partnerships' in health – a global call to action, Health Research Policy and Systems 4(2), 5.

NPHP(2002) National Public Health Partnership Final Evaluation Report, A Consortium between the Australian Institute for Primary Care, La Trobe University and the School of Public Health, Queensland University of Technology

Oakley, D. (1989) Collaborative research: Process and measurement. Nurse Edu,14, 11–15.

OPRC (2004) Russia's HIV/AIDS response/Public-Private Partnerships, Retrieved from http://hivpolicy.net/topics/?id=106

Pace, D.G. and **Bagasra, O.** (2008) NACO must clean up phony NGOs in India. Indian J Med Res 128: 87-8.

Pace, S., Frelinger, D., Lachman, B., Brooks, A. and **Gabriele M.** (2000). The Earth below: Purchasing science data and the role of public-private partnerships. Report to NASA. Arlington, VA: RAND Corporation.

Pact, Inc. (2005) Engaging local non-governmental organizations (NGOs) In the response to HIV/AIDS. Washington, DC, http://www.pactworld.org /galleries/ resource-center/ engagingweb.pdf

Padian, N.S., Buvé, A., Balkus, J., Serwadda, D. and **Cates, W.** (2008) Biomedical interventions to prevent HIV infection: evidence, challenges, and the way forward. The Lancet,372

Painter, C. and Clarence, E. (2001), UK local action zones and changing urban governance, Urban Studies, 38: 1215–32.

Pallikadavath, S., Garda, L., Apte, H., Freedman, J., and Stones, R. W. (2005). HIV/AIDS in rural India: Context and health care needs. Journal of Biosocial Science, 37(5), 641–655.

Panda, S., Chatterjee, A., Bhattacharya, S. K., Manna, B., Singh, P. N., Sarkar, S., et al. (2000). Transmission of HIV from injecting drug users to their wives in India. International Journal of STD and AIDS, 11(7), 468–473.

Pandey et al.(2009) Improved estimates of India's HIV burden in 2006. Indian J Med Res 129.

Parkhe and Arvind(1998)Building Trust in Intern'l Relations. Journal of World Business, 3(4).

Pawson, R. and **Tilley, N.** (1997) Realistic Evaluation. Sage, Thousand Oaks, CA.

Pfeffer, J. and Salancik, G. (1978) The external control of organizations: a resource dependence perspective New York: Harper and Row

Perkins E., Allen I., Dowling B.S. and **Leat D.** (1998) Creating Partnerships in Social Care: An Evaluation of the Caring for People Who Live at Home Initiative. Policy Studies Institute, London.Perspective." Health Policy Plan 14(1): 26–37.

Peters et al. (2002) Better Health Systems for India's Poor: findings, analysis and options. Hindustan Publishing Corporation for the World Bank.

Peters, D.H . and **Philips, T.**(2004) Mectizan Donation Program: evaluation of a public–private Partnership. Tropical Medicine and International Health, 9 (4) a4–a15.

Peters, D., Mirchandani, G. and Hansen, P.(2004) Strategies for engaging the private sector in sexual and reproductive health: How effective are they?' Health Policy and Planning, 19 (Supp.1): i5–i21

Peters, D.H. (2002) The role of oversight in the health sector: the example of sexual and reproductive health services in India. Reprod Health Matters, 10,82-94.

Phadke, Anant, Fernandes, A., Sharda, L., Mane, P. and **Jesani, A.** (1995) A Study of Supply and Use of Pharmaceuticals in the Satara District. Mumbai: Foundation of Research in community Health

Population Council (2009) Romance and sex before marriage among young women and men in Jharkhand, Youth in India: Situation and Needs, Policy Brief Number 10, 2009.

Population service International (2007) PSI/Avahan Male clinic Intervention. www.psi.org.in

PRAI(2002) Society for Participatory Research in Asia (PRIA) downloaded from http://pcserver.nic.in/ngo/data/ngo-pria.pdf,

Prakasamma(1993) in S. Chakraborty PhD Dissertation

Prasad, J.H. and George, V.(2000) Prevalence of reproductive tract infection among adolescents in a rural community in Tamil Nadu. Paper presented at the Workshop on Reproductive Health in India: New Evidence and Issues. Pune, 28 February–1 March 2000.

Price, N. (2001) The performance of social marketing in reaching the poor and vulnerable in AIDS control programmes. Health Policy and planning 16(3), 231-239.

Provan, K. G. and **Milward, J. B.**(2001) Do networks really work? A framework for evaluating public-sector organizational networks. Public Adm'tration Review, 61(4),414–423.

Postma, W. (1994) 'NGO partnership and institutional development: making it real, making it intentional' Canadian Journal of African Studies vol 28, no 3

Radwan,I.(2005) India - Private Health Services for the Poor, Health, Nutrition and Population (HNP) Discussion Paper, World Bank, Washington, DC 20433

Rakesh, A. (1992) premarital sexual attitudes and behavior among adolescent girls. Jaipur: Printwell.

Ramasundaram et al. (2001) HIV/AIDS control in India – Lessons learned from Tamil Nadu, Commission on Macro economic and Health, CMH Working Paper Series Paper No. WG5: 23.

Ramasundaram(2002) Can India avoid being devastated by HIV? Yes, by scaling up local prevention efforts targeted at the most vulnerable groups. British Medical Journal, 324

Rao Gupta, G., Parkhurst, J.O., Ogden, J.A., Aggleton, P. and **Mahal, A.** (2008) Structural approaches to HIV prevention. Lancet; 30; 372(9640):764-75

Rao,A.,Nag, M. and **Mishra, K.**(1994) Sexual behaviour patterns of truck drivers and their helpers in relation to female sex workers. Indian J Social Work, 55,603.

Rau,B.(2006)The politics of civil society in confronting HIV/AIDS. International Affairs, **82**-2, 285 – 295

Reich, M. (2002) Public Private Partnerships for Health, Harvard Series on Population and International Health.

Reich, M.R. (2000) Public-private partnerships for public health. Nat Med.6 (617–620)

Ridley RG, Lob-Levyt J and **Sachs J**, et al. (2001) The role for public-private partnerships in controlling neglected diseases? Bulletin of the World Health Organization 79, 771–777.

Richardson, W.C. and **Allegrante, J.P.** (2000) Shaping the Future of Health through Global Partnerships. In Critical Issues in Global Health, eds. C.E. Koop, C.E. Pearson, and M.R. Schwarz, 375–83.San Francisco: Jossey-Bass.

Rohde, J.E. and **Vishwanathan, H.** (1996) 'The Rural Private Practitioner', New Delhi:Oxford University Press

Rosenau, V. (Ed.), (2000) Public–private policy partnerships. Cambridge,: MIT Press.

Ross, L. and Kemshall, **H.**(2002) Partners in Evaluation: Modelling Quality in Partnership Projects. Social Policy and Administration, 34(5), 551 – 566.

Rossi, P. H. and **Freeman, H. E.** (1993) Evaluation: A Systematic Approach, Thousand Oaks, Calif.: Sage Publications, 1993.

Roth, J., Krishnan, S.P. and **Bunchm, E.**(2001) Barriers to condom use: results from a study in Mumbai (Bombay), India. AIDS Education and Prevention, 13(1) 65-77.

Roussos, S.T. and **Fawcett, S.B.** (2000) A review of collaborative partnerships as a strategy for improving community health, Annual Review Public Health, 21, 369–402.

Roy, V., Bhargava, P., Bapna, J. S., and **Reddy, B. S. N.** (1998) Treatment seeking behavior in sexually transmitted diseases Indian Journal of Public Health 42(4)133-135.

Rummery, K. (2002) Towards a Theory of Welfare Partnerships' in C Glendinning, M Powell, and K Rummery (2002*)* New Labour and the Governance of Welfare, Policy Press,

Ruxrungtham,k., Brown,T. and **Phanuphak,P.**(2004)HIV/AIDS in Asia,Lancet ,364, 69–82.

Sachs, T. (2007). A matter of perception - The impact of political risks in public-private partnerships (PPP) in Asia".

Sadhana, R and **Sebastian, K.S.** (2004) Civil society-Government Partnership in HIV/AIDS Programs - India's Experience. International Conference on AIDS (15th : Bangkok, Thailand). I*nt Conf AIDS.* 2004 Jul 11-16; 15:

Sagawa, S. and **Segal, E.** (2000). Common interest, common good: Creating value through business and social sector partnerships. Boston, MA: Harvard Business School Press.

Saini, R. and **Sinhg, J.**(2004) Perceptual barriers to condom use amongst truckers in northern India. International Conference on AIDS (Bangkok, Thailand). Int Conf AIDS. 2004 Jul 11-16; 15: abstract no. MoPeD3968.

Sanderson I. (2000) Evaluation in complex policy systems. Evaluation 6, 433–454.

Sankalp (2008) MSM and transgender communities: Understanding vulnerability and risk to HIV, SANKALP, 7 (4)

Sankaran, J.A. (2006) Current Situation of HIV/AIDS in India and Our Response. Journal, Indian Academy of Clinical Medicine, 7(1)

SASHD (2004) Private Health Services for the Poor, Policy Note http://www.sasnet.lu.se/EASASpapers/11IsmailRadwan.pdf

Savara, M. and **Sridhar, C.R.** (1992) Sexual behavior of urban educated Indian men: results of a survey Vermund SH, eds. Preventing HIV in developing countries. New York: Kluwer Academic/Plenum, 1999, 205–29.

Schatz, P and Dzvimbo,K.P (2001) The adolescent sexual world and AIDS prevention: a democratic approach to programme design in Zimbabwe. Health Promotion International, 16- 2, 127-136.

Selvaraju (2009) Private Sector Utilization of HIV/AIDS-Related Services and Health Expenditures by People Living With HIV/AIDS. Bethesda, MD: Private Sector Partnerships-One Project, Abt Associates, Inc.

Sengupta, A. and Nundy, **S.** (2005)The private health sector in India. *BMJ* 331:1157-58.

Shantha, S., Ramachandan, M., Nataraj, S. and **Mahanty B.** (2004) Evaluation of Hospital VCT Services, India.; International Conference on AIDS (15th : Bangkok, Thailand). *Int Conf AIDS.* Jul 11-16; 15: abstract no. C12764.

Shepard, D.S (2001). Public-private collaborations in health care: lessons from India. International Journal of Quality Health Care, 13:277-78.

Shortell, S.M. and **Zajac,E.J.**(1990) Health Care Organizations and the Development of the Strategic Management Perspective. In Innovations in Health Care Delivery, eds. S.S. Mick and Associates, 144–80.San Francisco: Jossey-Bass.

Simoes, E.A. et al (1987) 'Evidence for HTLV-III infection in prostitutes in Tamil Nadu (India)', Indian Journal of Medical Research, 85,335-8.

Singh, K.K., Bloom, S.S. and Tsui, **A.O.** (1998) Husbands' reproductive health knowledge, attitudes, and behaviour in Uttar Pradesh, India. Stud Family Plann29:388–99.

Singh, P., Yadav ,R.J. and **Pandey ,A.**(2005) Utilization of indigenous systems of medicine and homoeopathy in India. Indian J Med Res, 122,137–42.

Singh, S.K., Lhungdim, H., Chattopadhyay, A. and **Roy,T. K. (2005)** Women's Vulnerability to STI/HIV in India, Findings of the CHARCA Baseline Survey ,International Institute for Population Sciences,Mumbai 400 088.

Skolnik, R, Agueh, F., Justice, J. and Lechat, **M.** (2003) Independent Evaluation of the Global Alliance For the Elimination of Leprosy, World Health Organization, Geneva.

Slater, R., Frederickson, J., Thomas, C., Wield, D. and **Potter, S.** (2007) A critical evaluation of partnerships in municipal waste management in England Resources, Conservation and Recycling 51(3)643-664.

Smith, F (2009) The quality of private pharmacy services in low and middle-income countries: A systematic review, Pharmacy World and Science, 31(3).

Smith, M.M., Mathur, N. and **Skelcher, C.K.** (2006). Corporate Governance in a Collaborative Environment: what happens when government, business and civil society work together? Corporate Governance: An International Review, **14,** 3, 159-171.

Smith, R. (1995) The scientific basis of health services. BMJ 311, 961–962.

Solomon, S. and Krishnan, **A.K.** (2002) HIV VCT services in Chennai, India: Expeditor or hurdle. XIV International AIDS Conference; Barcelona, Spain.2.

Solomon, S., Batavia, A., Kartik et al. (2009) A Longitudinal Quality-of-Life Study of HIV-Infected Persons in South India: The Case for Comprehensive Clinical Care and Support Services

Solomon, S., Kumarasamy, N., Ganesh, A. K., and **Amalraj, R. E.** (1998). Prevalence and risk factors of HIV-1 and HIV-2 infection in urban and rural areas in Tamil Nadu, India. International Journal of STD and AIDS, 9, 98–103.

Sparer, M., and **Brown,L.**(2000) "Uneasy Alliances: Managed Care Plans Formed by Safety-Net Providers." Health Affairs, 19 (4). 23-35.

Squire, L. (1995) Evaluating the effectiveness of poverty alleviation programs. New Directions for Evaluation, 67, 27–37.

Steinbrook, R (2007) HIV in India — A Complex Epidemic Volume 356(11)1089-1093.

Sullivan, H. and **Skelcher ,C.** (2002) Working Across Boundaries. Palgrave, Basingstoke

Sullivan, J. and **Petersen, R.B.** (1982) "Factors associated with trust in Japanese- Summer 1988, 17-23.

Sundaram, L. and **Holm, K.**(2006) Public-Private Partnerships for health Global Forum for Health Research, Switzerland, Geneva

TANSACS-AAP (2007-2008) Tamilnadu AIDS Control Society, Chennai

Tandon, R. (1990) 'Partnership in social development evaluation: a thematic paper' pp96-113 in Marsden, D, and Oakley, P. (ed.) Evaluating social development Projects, Oxford:Oxfam

Taylor-Powell, E., Rossing, B. and **Geran,J.**(1998) Evaluating collaborative : Reaching the Potential. Madison: University of Wisconsin-Cooperative Extension.

Teisman,G.R and **Klijn, E**(2002) Partnership Arrangements: Governmental Rhetoric or Governance Scheme?, Public Administration Review 62(2)197 -205.

THCU (2005) Evaluating Comprehensive Workplace Health Promotion, The Health Communication Unit (THCU), Canada, Retrieved from www.thcu.ca

The Global Fund (2008), Strengthening Human and Institutional Capacities of the National Health System to Enable Accelerated Implementation of the National AIDS Control Program, India, Retrieved http://www.theglobalfund.org/programs/grant/

Thomas, P. and **Palfrey, C.** (1996) Evaluation: stakeholder-focused criteria. Social Policy and Administration, 30, 125–142.

Thomas, K. and Thyagarajan, **S.P.** (2002) Community prevalence of sexually transmitted diseases and human immunodeficiency virus infection in Tamil Nadu, India: a probability proportional to size cluster survey. Natl Med J India, 15, 135-40.

Thomas, K and Kurapati, S.(2004) Tamil Nadu response to HIV/AIDS, 1986-2005:conquering a silent epidemic, University of Madras, Chennai.

UN (2003) 58th General Assembly Report, Retrieved from http://data.unaids.org/publications / External-Documents/ga58_hivaids_infonote_en.doc

UNAIDS (2004- 2008). UNAIDS report on the global AIDS epidemic (2004, 2005, 2006, 2007, and 2008), Geneva: Joint United Nations Programme on HIV/AIDS

UNAIDS (2001) India: HIV and AIDS-related Discrimination, Stigmatization and Denial, Joint United Nations Programme on HIV/AIDS (UNAIDS) 2001

UNAIDS (2002) Sex work and HIV/AIDS. Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS (2005). The Joint United Nations Programme on HIV/AIDS. Global Facts and Figures. Fact sheet, 22/07/2005

UNAIDS (2007) Practical guidelines for intensifying HIV prevention: towards universal access.http://data.unaids.org/pub/Manual/2007/20070306_Prevention_Guidelines_Towards_Universal_Access_en.pdf

UNAIDS (2009) Retrieved from data.unaids.org/pub/EPISlides/ /.../ 2009_epiupdate_ report_figure10_en.ppt

UNAIDS and **UNICEF** (2004) The Framework For the Protection, Care and Support Of Orphans And Vulnerable Children Living in a World with HIV AND AIDS, Retrieved from http://www.unicef.org/aids/files/Framework_English.pdf

UNAIDS and **WHO** (2007). AIDS epidemic update: December 2007. Geneva: Joint UN Programme on HIV/AIDS, World Health Organization,

UNAIDS (2005) The "Three Ones" in action: where we are and where we go from here, Geneva

UNAIDS(2009) HIV-related Public-Private Partnerships and Health Systems Strengthening, Geneva.

UNDESA (2004) United Nations Department of Economic and Social Affairs, Pop'n Division

UNDP (2006) The Socio-Economic Impact of HIV and AIDS in India, 2006

UNDP (2007) HUMAN TRAFFICKING ANDHIV, Exploring vulnerabilities and responses in South Asia

UNESCO, (2002) A Cultural Approach to HIV/AIDS Prevention and Care, A Hand Book for India Overall Assessment Case Studies Strategies/Conclusions/ Recommendations, Studies and Reports, Special Series, n°16, Division of Cultural Policies

UNICEF (2003) http://unicef.org/infobycountry/india.html

Uplekar, M. and **Juvekar ,S.** (1998) After health sector reform, whither lung health? Int J Tuberculosis Lung Diseases; 2,3249.

USAID (1997) 'New partnership initiative (NPI) resource guide: a strategic guide to Development partnering'. Report of the NPI Learning Team. Washington DC: United States Agency for International Development.

USAID (2004) USAID Health: HIV/AIDS, Countries, India,, http://www.usaid.gov/ our_work/global_health/aids/Countries/ane/india.html

USAID and Core Initiative (2006) Supporting Community Solutions to HIV/AIDS: Lessons Learned from Implementing Small Grants Programs. http://www.coreinitiative.org /Resources/ Publications/CORE_ Lessons Learned.pdf

Varatharajan, D. and **Arul Anandan, D.** (2006) Re-activating Primary Health Centres through Industrial Partnership in Tamilnadu is it a sustainable model of partnership? Working paper no. 10, Achutha Menon centre for health science studies SCTIMST

Venkat Raman, R. (2000) The promise of entrepreneurship as a field of research", Academy of Management Review 25(1), 217-226.

Venkat Raman, A. and **Bjorkman, J. W.**(2008) Public/ Private Partnerships in Health Care Services in India, Retrived from medind.nic. in/haa/t08/i1/haat08i1p62.pdf.

Venkataramana, C. B. S. and **Sarada, P.V.** (2001) Spread of HIV through commercial sex in India. Tropical Medicine and International Health, 6(12), 1040-1061.

VHAI (1997) Voluntary Health Association of India (VHAI), Report of the Independent Commission on Health in India. New Delhi

Vuylsteke, B. (2004), Current status of syndromic management of sexually transmitted infections in developing countries, Sex Transm Infect 2004; 80:333-334

Waddock, S. A.(1988). Building Successful Partnerships. Sloan Management Review,

Waddock,S.A. and **Bannister, B.D.**(1991)Correlates of Effectiveness and Partner Satisfaction in Social Partnerships. Journal of Organizational Change Management 4:64–79.

Walker, P(2007) Innovations in Social Welfare:Trust, risk and control within an indigenous–non-indigenous social service partnership, International Journal of Social Welfare,16:281–290

Wandersman, A., Goodman,R.M. and **Butterfoss,F.D.** (1997) Understanding Coalitions and How They Operate. In Community Organizing and Community Building for Health, ed. M. Minkler, 261–77. New Brunswick, N.J.: Rutgers University Press.

Watson, J., Speller,V., Markwell,S. and **Platt ,S.**(2000) 'The Verona Benchmark – Applying Evidence to Improve the Quality of Partnership', Promotion and Education,7(2), 16–23.

WBI (1998) World Bank Institute, The partnership program, program brief.

WEF (2003) Annual Meeting Public-private partnerships: Meeting in the Middle. United Nations Foundation and the World economic Forum, Washington, DC 20036

Whitehead, M. (1992) The concepts and principles of equity in health.Int J Health Serv, 22,429–445.

WHO (1993) Health development in a changing world—a call for action. 46th World Health Assembly. Geneva, 3–14 May 1993 (Resolution WHA46.17). World Health Organization, Geneva,.

WHO (1998) Health Insurance Schemes for People outside Formal Sector Employment. Bulletin of the World Health Organization 13 79, 748–754.

WHO (1998) Planning and Implementation HIV/AIDS Care Programmes: A step-by-step approach. Regional Office for South East Asia, New Delhi

WHO (1999) NGOs and TB Control, Principles and examples of organization joining the fight against TB, World Health Organization, Geneva

WHO (1999) WHO Guidelines on Collaborations and Partnership with Commercial Enterprise. World Health Organization, (Draft discussion document), Geneva

WHO (1999) Public private partnerships for health. Report by the Director-General. Geneva: World Health Organization

WHO (2000) World Health Report 2000: Health systems: Improving performance. Retrieved from http://www.who.int/ whr/2000/en/.

WHO (2001) Making a Public-Private Partnership Work: An Insider's View. Bulletin of the World Health Organization 79(8):795-796

WHO (2002) Traditional Medicine Strategy: 2002–2005. Retrieved from http://whqlibdoc.who.int/ hq/2002/ WHO_EDM_TRM_2002.1.pdf

WHO (2002) Involving Private Medical Practitioners in TB and STI, SEARO Publications on HIV/ AIDS

WHO (2003) Traditional Medicine: Report by the Secretariat. Geneva: World Health Organization.

WHO (2003) Global health-sector strategy for HIV/AIDS 2003-2007: Providing a framework for partnership and action. World Health Organization, Geneva

WHO (2003) Independent Evaluation of the Global Alliance For the Elimination of Leprosy. World Health Organization, Geneva

WHO (2004) Sexually Transmitted Infections: Issues in Adolescent Health and Development. WHO Discussion papers on Adolescence, Department of Child and Adolescent Health and Development, World Health Organization, Geneva

WHO (2005) 'India: Summary country profile for HIV/AIDS treatment scale-up'.

WHO (2006) Global Strategy for the Prevention and Control of Sexually Transmitted Infections, 2006-2015. World Health Organization,Geneva.

WHO (2006) Encaging all health care providers in TB control, Guidance on implementing public private mix approaches, World Health Organization

WHO (2007) Everybody's business. Strengthening health systems to improve health outcomes, WHO, Geneva.

WHO (2007) Public–Private Partnerships: Managing contracting arrangements to strengthen the Reproductive and Child Health Programme in India: Lessons and implications from three case studies, World Health Organization, Geneva.

WHO (2007), HIV/AIDS in the South-East Asia Region, March, Retrieved from http://www.searo.who.int/ LinkFiles/AIDS_SEARO-Report07.pdf

WHO (2008) PUBLIC HEALTH APPROACH TO COMBATING HIV/AIDS, Retrieved from http://www.searo.who.int/LinkFiles/RC61_12-pa_Item-14.pdf

WHO, UNAIDS and UNICEF (2008) Epidemiological Fact Sheet on HIV and AIDS: India.

Widdus ,R. (2001) Public–private partnerships for health: their main targets, their diversity, and their future directions. Bulletin of the World Health Organization, 79 (8).

Widdus, R et al. (2001) Towards better defining public-private partnerships for health. Geneva, Global Forum for Health Research.

Wildridge et al. (2004) How to create successful partnerships—a review of the literature. Health Information and Libraries Journal, 21, 3–19.

Wildridge, V. (2004) How to create successful partnerships—a review of the literature Health Information and Libraries Journal,21, 3–19.

Williams et al.(2006) What is the achievable effectiveness of the India AIDS Initiative intervention among female sex workers under target coverage? Model projections from southern India, Sex Transm Infect 2006; 82:372-380

Wolff, T. (2001) A practitioner's guide to successful coalitions. American Journal of Community Psychology, 29(2), 173-191.

World Bank (1986) Divestiture in developing countries. Washington D.C., World Bank.

World Bank (1993) The World Development Report, Washington DC: The World Bank

World Bank (1997), Confronting AIDS: Public Priorities in a Global Epidemic," Oxford University Press.

World Bank (2001) India: Raising the Sights: Better Health Systems for India s Poor.

World Bank (2001) India: Raising the Sights: Better Health Systems for India s Poor. Washington, DC: HNP Unit-India, Report # 22304.

World Bank (2002) Vouchers for Health: Using Voucher Schemes for Output-Based Aid, Public policy for the private sector, No 243. Retrieved from www.worldbank.org / viewpoint /

World Bank (2003) Franchising in Health: Emerging Models, Experiences, and Challenges in Primary Care, No 263.Retrieved from jttp://rru.worldbank.org/ Viewpoint/index.asp

World Bank (2004) India-Private Health Services for the Poor, Policy Note

World Bank (2004) Increasing public-private partnerships for health. Retrieved from http://web.worldbank.

World Bank India (2004) Private Health Services for the Poor. Draft Policy Note, Retrieved from http://www.sasnet.lu.se/EASASpapers/11IsmailRadwan.pdf

World Bank (2004) India: Private Health Services for the Poor. Policy Note. Washington, DC: The World Bank.

World Bank (2006) Sourcebook for Evaluating Global and Regional Partnership Programs, World Bank, Washington DC

World Bank (2007) HIV/AIDS in India. Retrieved from http://siteresources. worldbank.org/ INTSAREGTOPHIVAIDS/Resources/HIV-AIDS-brief-Aug07-IN.pdf

World Bank (2007) Corporate Responses to HIV/AIDS: Case Studies from India. The International Bank for Reconstruction and Development/The World Bank 1818 H Street NW Washington DC 2043

World Bank (2009) HIV/AIDS in India, Retrieved from www.worldbank.org/saraids

World Bank (2009) HIV/AIDS in India, http://siteresources.worldbank.org /SOUTHASIA/ Resources/223546-1192413140459/4281804-1231540815570/5730961-1235157256443/ HIVAIDSbriefIN.pdf

World Economic Forum (2005) Building on the Monterrey Consensus: The Growing Role of Public-Private Partnerships in Mobilizing Resources for Development. Geneva: United Nations high-level plenary meeting on financing for development (September).

World Economic Forum (2005) Development-Driven Public-Private Partnerships in Health-Emerging Priorities from Roundtable Discussions, www.weforum.org

World Economic Forum (2006) Business and HIV: A Healthier Partnership? A Global Review of the Business Response to HIV/AIDS2005-2006, WEF,Geneva.

Yadav, K.(2009), Revitalizing Rural Health Care Delivery: Can Rural Health Practitioners be the Answer?, Centre for Community Medicine, Old OT Block, All India Institute of Medical Sciences, New Delhi, India

Zuckerman, H.S., Kaluzny, A.D., and **Ricketts, T.C.** (1995) Alliances in Health Care: What We Know, What We Think We Know, and What We Should Know. Health Care Management Review 20:54–64.

Zwi et al. (2007) Private health care in developing countries, BMJ 2001; 323:463-464

APPENDIX

Institution No: _____

I. Institutional checklist and Assessment Form

An Evaluation of partnership effectiveness in the management and control of HIV/AIDS in Tamil Nadu state, India

A. Edwin Sam, PhD Scholar

Achutha Menon Centre for Health Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences & Technology, Thiruvananthapuram, Kerala 695 011

I assure that the information collected shall be used only for study purpose and necessary confidentiality of the study subjects will be maintained. Your participation in the study is purely voluntary and you are given a choice to withdraw from the interview or to deny answer to any questions during the course of the interview.

Investigator

The purpose and objective of the study have been explained to me and I voluntarily agree to participate in the study and retain the right to withdraw from the study at any stage.

Signature of the participant **Date:** _____

Name: _____ **Designation:** _____

Organizational Details

Name and address of the organization: _____

Established in: _____ **Years in health:** _____ **Years in HIV/AIDS:** _____

Ownership: (1) Government (2) Private not-for-profit (3) Private for-profit

Type of registration: (1) Trust (2) Society (3) Company-25

(4) Cooperative (5) Not registered (6) others (specify) _____

Location: (1) Rural (2) Semi Urban (3) Urban

Area of operation: (1) Rural (2) Semi Urban (3) Urban

Type of organization:

Type of practice	Solo clinic	Poly clinic	Hospital/nursing home/
Clinical - Allopathic			
Clinical – Non allopathic			
	Small	**Medium**	**Big**
Non-Clinical			
NGOs/CBOs			
Non health			

Areas of work

Area of work	Approx. staff time spent per year (person months)		Approximate resources spent per year (Rs. '000)
	Full Time staff	Part-time staff	
Overall health			
HIV/AIDS			
Social Development/welfare			
Women empowerment			
Human rights			
Education			
Rural Development			
Environment			
Others			

Details of work in HIV/AIDS

Area of work	Approx. staff time spent per year (person months)		Approximate resources spent per year (Rs. '000)
	Full time staff	Part-time staff	
Prevention/Promotion			
Treatment			
Care and support			
Rehabilitation			
Advocacy			
Training			
Research			
Specific intervention(Any)			
Others			

Facilities

Type of facility	Fulltime		Part-time	
	Total	For HIV/AIDS	Total	For HIV/AIDS
Total number of staff				
Doctors (no. of persons)				
Other health staff (no. of persons)				
Non-health (no. of persons)				

	Own		Rented	
	Total	**For HIV/AIDS**	**Total**	**For HIV/AIDS**
Office space (sq. km.)				
Computers (no.)				
Fax (no.)				
Internet connections (no.)				
4-wheelers				
2-wheelers				
Telephone connections (no.)				

Branches if any: _____

Details of current partnerships in HIV/AIDS

Initiation of partnership of any form (year of first partnership)

(1) Health _____ (2) HIV/AIDS _____ (3) Other areas _____

No. of partnerships in which the organization was a part from 2001 to 2006

(1) Health _____ (2) HIV/AIDS _____ (3) Other areas _____

No. of partnerships in which the organization is currently involved in 2007

(1) Health _____ (2) HIV/AIDS _____ (3) Other areas _____

No. of partnerships on HIV/AIDS initiated by your institution (please provide the list separately):

Up to 2006 _____ During 2007 _____ In future _____

No. of organizations involved in HIV/AIDS in your target area:

Total _____ No. carrying out same interventions _____

Details of Current partnership in HIV/AIDS

Area of work	**No. of p'ships**		**Estd duration (yrs)**		**Total no. involved Institutions**	
	Bi-lateral	**Multi-lateral**	**Bi-lateral**	**Multi-lateral**	**Bi-lateral**	**Multi-lateral**
Prevention/Promotion						
Treatment						
Care and support						
Rehabilitation						
Advocacy						
Training						
Research						
Specific intervention if any						

Nature of org'ns with whom the institution is partnering and has partnered so far

Nature of organization	No. of present partnerships				No. of partnerships so far			
	Domestic		International		Domestic		International	
	Bi-lateral	Multi-lateral	Bi-lateral	Multi-lateral	Bi-lateral	Multi-lateral	Bi-lateral	Multi-lateral
Public sector								
Pvt. for-profit sector								
Pvt. not-for-profit								
Donor/funding agency								
Non-health institution								

Nature and form of existing partnerships

Nature of partnership	Contractual (legal)		Collaborative (non-legal)			
	Bi-lateral	Multi-lateral	Formal		Informal	
			Bilateral	Multilateral	Bilateral	Multilateral
Prevention/Promotion						
Treatment						
Care and support						
Rehabilitation						
Advocacy						
Training						
Research						
Specific intervention if any						

Financing of partnership:

Overall Annual Budget: _____

Annual HIV/AIDS Budget: _____

Annual value of partnerships: _____

Annual value of partnerships for HIV/AIDS: _____

Share of financing (own): _____

Other share (mention) :

Partnership process and motive

What is the general mode of partnership process in your area?

(1) Open tender (2) Closed tender (3) Invitation
(4) Advertisement and selection (5) Own initiative

What motivates institutions to go for partnerships?

(1) To attract financial resources
(2) To expand the existing services
(3) Institutional strengthening
(4) Forced by programme requirements
(5) Felt need
(6) To fulfil organization's vision/mission

Do you think that the institution's over all goals gets distorted through partnerships?

(1) Yes, always (2) Yes, to some extent (3) No, not at all

Do you make changes in your organizational structure and functions to suit partnership needs?

(1) Yes, always (2) Yes, to some extent (3) No, not at all

How do you rate your representation in the partnerships in general?

(1) High (2) Moderate (3) Low

Benefits of partnerships

Benefit	Agree	Agree to some extend/Neutral	Disagree
Better ability to address HIV/AIDS			
Development of knowledge and skills			
Enhancement of public reputation			
Increased utilization of expertise			
Increased participation in policy making			
Better ability to meet community needs			
Additional financial support			
Efficient use of financial resources			

II. Partnership Assessment Tool

Institution No: _____

Partnership No: _____

An Evaluation of partnership effectiveness in the management and control of HIV/AIDS in Tamil Nadu state, India

Partnership name			
Start date		**End date**	
Instrument(s) used for intervention			
Specific target group(s)			
Target population (in '000)			
Area of operation	**Urban**	**Rural**	**Semi urban**
Output measures described in the partnership			
Services provided under the partnership			

Purpose of the partnership

(1) Prevention/Promotion (2) Treatment (3) Advocacy
(4) Care & support (5) Rehabilitation (6) Training (7) Research
(8) Specific intervention if any

Overall motive of the partnership

(1) To attract financial resources (2) To expand the existing services
(3) Institutional strengthening (4) Forced by programme requirements
(5) Felt need (6) Other (specify)

What is the mode of partnership initiation in this partnership?

(1) Open tender (2) Closed tender (3) Invitation
(4) Advertisement and selection (5) Own initiative

Did you have any formal and informal discussion or negotiation before the partnership agreement? If Yes what kind of

(1) Formal invited discussion (2) Informal discussion
(3) Formal invited negotiations (4) Informal negotiations

Do you think that there are identified gaps in the service provision of HIV/AIDS that need to be addressed by partnership and join efforts?

(1) Agree (2) Agree to some extend (3) Disagree

Type of organisation with whom the institution is partnering (Funding partner)

	Domestic		International	
Nature of organization	**Bi-lat**	**Multi-lat**	**Bi-lateral**	**Multi-lateral**
Public sector				
Pvt. for-profit sector				
Pvt. not-for-profit				
Donor/funding agency				
Non-health institution				

Nature and form of existing partnerships

partnership focus *(Mention the intervention and focus*	**Contractual (legal)**		**Collaborative (non-legal)**			
	Bi-lateral	**Multi-lateral**	**Formal**		**Informal**	
			Bilateral	**Multilateral**	**Bilateral**	**Multilateral**

Financing of partnership

Annual Value of partnership:_____ Proportion of own share: _____

Size of the partnership *(Financial Involvement of other partners)*

Name of institution *(Mention all the partners involved in the partnership)*		**Major area of involvement /Role in the partnership**	**Commitment from this institution to the partnership**	
			Value of resources (Rs.)	**Share of partnership budget (%)**
1				
2				
3				

Financing

Feature	Good	Average	Bad/NO
Community contribution			
Contribution from non-partnering institutions			
Other Donor contribution			
Fund from commercial activities			
Government contribution			
User fee			
Others			

Facilities available for the partnership:

Type of facility	Fulltime	Part-time
Total number of staff		
Doctors (no. of persons)		
Other health staff (no. of persons)		
Non-health (no. of persons)		
	Own	**Rented**
Office space (sq. km.)		
Computers (no.)		
Fax (no.)		
Internet connections (no.)		
4-wheelers		
2-wheelers		
Telephone connections (no.)		

Partnership Process Effectiveness

Content	Agree	Neutral	Dis agree
Clarity and Realism of Purpose			
1. Shared vision, goals & objectives			
2. Realistic aims and objectives			
3. clearly defined and attainable targets			
4. Local need based			
Clear and Robust Partnership working Arrangements			
5. Clarity and Mutual agreement about the financial resources			
6. Clarity and mutual agreement about the human resources.			
7. Agreement consists services and targets to be delivered			
8. Specific standards and benchmarks			
9. Defined organizational form/structure for the partnership			
10. Easy and unambiguous administrative procedures			
Internal Governance			
11. Written vision and mission statement for the partnership			
12. Document– Roles and responsibilities of each partners clearly defined			

13. Written constitution or set of standing orders, rules, guidelines and norms defining how it will conduct its activities – Work Plan			
14. Combined Coordination committee or board			
15. Periodic planning and review process			
Accountability			
16 Under a jurisdiction/commission/ regulatory authority or inspectorate			
17. Downward Accountability(public/service users)			
18. Horizontal accountability (Between partners).			
19. Financial accountability			
20. Subject to external assessment, evaluation and audit.			
Transparency			
21. Transparency in the selection process			
22. Transparency decision making			
23. Regular sharing of information among partners about the reviews and activities			
24.Public access to information- review and evaluation reports etc			
Resource Flow			
25. Adequate fund availability			
26. Timely release of committed resources			
27. Adequate Equipment, medicines and materials			
28. Adequate manpower by the partnership			
29. Adequate Non-monetary resources provision(E.g. Training, orientation/expertise)			
30. Sustained funding for the partnership activities			
Interdependency			
31. Inter-dependency between partners.			
32. Sharing of work back and forth until the work is completed.			
33. Without partnerships activities cant be carried out			
Co-ordination with the state/ existing health system			
34. Adequate Government support			
35. Adequate Public Health system support			
36. Seeking support from public health system			
37. Public health dept seek support from partnerships			
Inclusivity and Participatory			
38. Involvement in strategic planning and policy decisions			
39. Opinions are valued and adequate chances to express the ideas and views.			
Risk Management			
40. Unmanageable risk is not bestowed			
41. Ready to share the potential risk			
42. Adequate Mechanism to reduce the risk			
Developing and maintaining Mutual Trust			
43. Sufficient mutual trust			
44. Check measures and monitoring are not out of mistrust			
45. Confidence on each other			
Flexibility			

46. No Rigid administrative procedures and practices			
47. Flexibility in functioning according to the community and local need			
48. Flexibility in decision making.			
Leadership			
49. Strong and unbiased leadership)			
50. Clarity about the leadership			
51. Leaders are taking initiative and responsibility			
Commitment and Ownership			
52. Enthusiasm and Strong commitment from partners.			
53. Collective sense of ownership.			
Communication with the stakeholders			
54. Frequent communication between partners			
55. Regular consultation and communication with other relevant stakeholders			
56. Continuous dissemination of materials and reports.			
Mutuality			
57. Matching of own resources			
58. Equal responsibility and involvement			
59. Equitable spreading of benefits to *partners*			
Autonomy			
60. Individual freedom – Autonomy			
61. Freedom to make decision on their own			
62. donor partner is not dominant or over controlling			
Compliant/conflict Management			
63. a proper mechanism for complaint and conflicts management			
64. Quick disposal of complaints			
Monitor Measure, Review and Learning process			
65. Clear success criteria			
66. Regular, systematic monitoring and supervision i			
67. Sharing of monitoring and review findings			
68. Strategic reviews			
Organizations Identity			
69. No distortion of institution's over all goals and objectives			
70. No changes the organizational core structure and functions to suit partnership needs			

Perceived outcome

Feature	Improved	Remained same/Neutral	Reduced
Reduction of Duplication of efforts			
Pooling of resources			
Skill enhancement			
Capacity enhancement			
Precise client Targeting			

Delivery(achievement) of targets			
Client Base			
Range of services			
Geographic coverage			
Population coverage			
General community involvement			
Target community involvement			
Identification of hitherto unknown high-risk			
Involvement of potential players			
Cost effectiveness			
Cost efficiency			
Satisfaction	**Satisfied**	**Neutral**	**Dissatisfied**
The way the people and organizations in the partnership work together			
Role in the partnership			
Influence in the partnership			
Overall functioning of the partnership			
Benefits	**Agree**	**Neutral**	**Disagree**
Increased ability to address HIV			
Enhancement of public reputation			
Increased utilization of expertise			
Increased participation in policy making			
Better ability to meet community needs			
Additional Financial Support			

In what way the general community/Target community is involved in partnership activity?

	General community		Target community	
	Yes	**No**	**Yes**	**No**
Planning of the programme activities				
Decision making				
Implementation				
Evaluation				
Others - Mention				

Clients served by the partnership in 2006-07

Target group	**No. of clients served**					
	Male		**Female**		**Transgender**	
	Urban	**Rural**	**Urban**	**Rural**	**Urban**	**Rural**
CSW						
Truckers						
IVDU						
MSM						
Migrants						
General population						

Services provided under the partnership in 2006-07

Service	No. of clients served					
	Male		Female		Transgender	
	Urban	Rural	Urban	Rural	Urban	Rural
Advocacy						
counselling						
Testing						
ART						
Condom promotion						
Health education/promotion						
ICTC/ VCTC/ PMTCT						
Rehabilitation						
STD services						
Treatment for OIs						
Training						
Socio-economic support						
Others						

Age profile of the partnership clients

Age group	No. of clients served					
	Male		Female		Transgender	
	Urban	Rural	Urban	Rural	Urban	Rural
< 14						
15-29						
30-44						
45-59						
= 60						

Socio economic profile of clients

Target group	No. of clients served								
	Male			Female			Transgender		
	High	Medium	Low	High	Medium	Low	High	Medium	Low
CSW									
Truckers									
IVDU									
MSM									
Migrants									
PLHAs									
G. population									

It is possible to do the activities and achieve the goals even without partnership?

(1) Agree (2) Agree (3) Disagree

Would you have planned for the same activities without the partnership?

(1) Would have done the same services (2) some services (3) wouldn't have done (4) Don't Know

Will you be able to continue the activities of the partnership even after the funding period is over?

(1) All the activities (2) some activities (3) No activities (4) Don't know

How do you rate your representation in the partnership?

(1) High (2) Moderate (3) Low

Client No: _____

III. Client Interview schedule

An Evaluation of partnership effectiveness in the management and control of HIV/AIDS in Tamil Nadu state, India

A. Edwin Sam, PhD Scholar

Achutha Menon Centre for Health Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences & Technology, Thiruvananthapuram, Kerala 695 011

I assure that the information collected shall be used only for study purpose and necessary confidentiality of the study subjects will be maintained. Your participation in the study is purely voluntary and you are given a choice to withdraw from the interview or to deny answer to any questions during the course of the interview.

Investigator

The purpose and objective of the study have been explained to me and I voluntarily agree to participate in the study and retain the right to withdraw from the study at any stage.

Signature of the participant / Thumb impression **Date: _____**

Name: _____

Age: _____ **Sex _____**

Address: _____

Rural/Urban _____

Marital status: (1) Married 2) Widowed
(3) Never married (4) Married but separated
(5) Living away from the spouse

High Risk Category :

Years of schooling: _____ **Occupation:** _____

Community: (1) FC (2) BC (3) MBC (4) SC/ST

Household size: Adult _____ Children _____

Reading of newspaper/magazine:
(1) Daily (2) Occasionally (3) Rarely (4) Don't/can't read

Access to TV:

(1) Own TV (2) Neighbour's TV
(3) Public TV (4) No access or don't watch TV

Type of house:

(1) Concrete wall & roof (2) Concrete wall & tiled roof
(3) Mud wall & tiled roof (4) Mud wall & thatched roof (5) Houseless

No. of rooms: _____ **Electrification** (1) Yes (2) No

Ownership: (1) Own (2) Leased (3) Rental

Separate cooking area (1) Yes (2) No

Toilet facility

(1) Flush toilet within house (2) Public/Shared flush toilet
(3) Pit toilet within house (4) Public/Shared pit toilet (5) Use open field

Source of drinking water:

(1) Own piped water (2) Piped water from outside
(3) Hand pump (4) Own well
(5) Public well (6) River/canal/pond

Cooking fuel

1) Cooking gas (2) Electricity (3) Biogas
(4) Fire wood (5) Others (specify)

Water purification method:

(1) Electric purifier (2) Boiling
(3) Water filter (4) Filter using cloth (5) No purification

How often do you consume:

Milk/curd _____ Pulses/beans _____
Green leafy vegetable _____ other vegetable _____ Fruits _____
Egg _____ Meat/chicken/fish _____

Land holding: Agriculture (acres) _____ Housing plots (no.) _____

Livestock: Cattle (no.) _____ Birds (no.) _____

Approximate monthly income (Rs.) Self _____ Family _____

Status of poverty (1) APL (2) BPL

1. Institution from where intervention is sought _____

2. Distance from residence (km) _____

3. Mode of transport

(1) Own motor vehicle (2) Hired motor vehicle (3) Institution provided vehicle
(4) Cycle (5) Bus (6) Walk (7) Received support from others (7) Others_____

4. Intervention sought:

(1) Advocacy (2) ART (3) Blood safety (4) Care & support (5) Counseling/testing (6) Condoms (7) Health education/awareness (8) PMTCT (9) Home-based care (10) Rehabilitation (12) STD care (13) Training (14) ICTC/VCTC (15) Treatment for OIs

5. Are you coming to the facility first time? (1) Yes (2) No

6. Reason for choosing this facility?

(1) Referral (2) Near to my Place (3) Far from my place (4) Outreach
(5) Brought by Peer (6) Media Advertisement (7) Others

7. Are the same services you require available in other facilities in your area?
(1) Yes (2) No (3) Don't Know

8. Are you here for availing the same services which you availed else where in the past? If yes, why?

(1) Yes (2) No
(1) Referral (2) Near to my Place (3) Far from my place (4) Outreach
(5) Brought by Peer (6) Through NGO/Community health workers (7) Media ad
(7) Need Good care (8) need Cheaper (9) need Quality of services
(10) need to be treated with respect (11) others mention_____

9. What was the reason, in case if you did not get services in the past?

(1) No need (2) Couldn't afford (3) No transport (4) Denied care
(5) Adverse prior experience (6) Non availability of required facility/service
(7) No service at all (8) Not aware of facility (8) Inconvenient timing 9) others _____

10. Are you getting all the services you want, from this facility? (1) Yes (2) No

If no, what else do you expect? _____

11. Do you visit any other institution for the same services?
(1) Always (2) Sometimes (3) Never

12. Are you registered with more than one institution? (1) Yes (2) No

13. Are you paying any fee for services availed here? (1) Yes (2) No

14. If yes, do you think that the cost of availing the services is affordable?

(1)Very much affordable (2) Affordable (3) to some extent (4) Not affordable

15. Does the cost of services would prevent you further from availing these services?

(1)Always (2) Many times (3) sometimes (4) Never

16. If it is not given free of cost what you would have done?

(1) Wouldn't have availed (2) Would have availed by paying
(3) Would have gone to public (4) NGOs (5) others

17. Are you or the clients of this facility involved in any activity of this institution?
1) Always (2) Sometimes (3) Never

18. Does the organization ask your opinion related to programmes?
(1) Always (2) Sometimes (3) Never

19. Do you think that your opinions or suggestions are given importance and implemented?
(1) Always (2) Sometimes (3) Never

20. What way can you help this institution to serve the clients better?

21. How do you feel about the organization with respect to the following?

Feature	Agree	Some what agree/Neutral	Dis agree
Responsiveness			
Treated with respect and dignity			
Clients involvement in deciding the treatment or services option			
Adequate time to discuss			
Adequate Information's are given in an understandable way			
Informed consent			
Confidentiality			
Less waiting time			
Quality of basic amenities			
Convenient, Near and accessible			
Others			

Ability to address required HIV/AIDS services			
Quality of services are good			

22. Improvement in the health status and overall satisfaction

Do you think that there is an improvement in your health status after seeking the services from here?

1) Improved 2) Neutral 3) No 4) Don't know

23. Does the availability of the present facility increase the motivation and frequency of seeking STD, HIV/AIDS related services?

(1) High (2) To some extend (3) No (4) Don't know

24. Overall, are you satisfied with the services provided by this facility?

(1) Satisfied (2) Not so satisfied (3) Not satisfied

25. Would you recommend this programme/activity/service to others?

(1) Always (2) recommend if no other way (3) Never (4) Don't Know

26. What suggestion do you have for improving the programme /service/activity in the future?

Provider no:_____

IV. Provider's Interview schedule

An Evaluation of partnership effectiveness in the management and control of HIV/AIDS in Tamil Nadu state, India

A. Edwin Sam, PhD Scholar

Achutha Menon Centre for Health Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences & Technology, Thiruvananthapuram, Kerala 695 011

I assure that the information collected shall be used only for study purpose and necessary confidentiality of the study subjects will be maintained. Your participation in the study is purely voluntary and you are given a choice to withdraw from the interview or to deny answer to any questions during the course of the interview.

Investigator

The purpose and objective of the study have been explained to me and I voluntarily agree to participate in the study and retain the right to withdraw from the study at any stage.

Signature of the participant **Date:** _____

Name of the provider:	**Village/Town:**	
Taluk:	**Age:**	**Sex:**
Qualification:	**Total years of service in providing health care:**	
Are you formally employed?	**If employed, whether it is govt. or private:**	
If not employed, do you have an office?	**Approx. no. of patients seen in a day:**	
Patient charge per visit (Rs.):	**Approximate monthly income (Rs.):**	

1. Reason for being in health care profession

   (a) Qualified doctor (b) Qualified in other health profession (c) Family tradition
   (d) working in a health care institution (e) Prior experience with a doctor
   (f) Own interest in medicine (g) Other (Specify)

2. How many clients do you see in a day in the following categories?

Category	No. of clients	Predominantly rich/poor
Antenatal care		
Digestive disorders		
Respiratory illnesses		
Skin ailments		
Sexual and related disorders		
Diabetes		
Hypertension		
Bone and joint disorders		
Others (Specify)		

3. What proportion of your clients are women/men/children/elderly?

Sex	Children	Adult	Elderly
Men			
Women			

4. Type of treatment provided (there can be more than one option)

   (a) Ayurvedic (b) Allopathic/western (c)Local herbal
   (d) Siddha (e) Others (Specify) _____

5. Why, do you think, are patients coming to you for treatment?

(a) Nearer (b) Cheaper (c) Well qualified
d) Experienced provider (e) Other (Specify) _____

6. Do you think that STIs, HIV/AIDS are prevalent in this area?

(a) High (b) Medium (c) Low (d) I don't know

7. Who in this area are generally suffering from STIs/HIV/AIDS?

Category of people	Whether they seek treatment? Yes/No

8. How often do you come across HIV/AIDS cases in your area?

(a) Often (b) Occasionally (c) Rarely (d) Never

9. Do you think that you can treat HIV/AIDS? (a) Yes (b) No

10 If yes, have you ever treated HIV Case during last 3 months? (a) Yes (b) No

11. If No, Reasons for not being able to treat?

(a) Lack of training and knowledge (b) Lack of facilities (c)Stigma
(d) Fear of losing other clients (e) Fear of contracting HIV/AIDS (f) Other (Specify)

12. Which medicine do you use to treat them?

(a) Allopathic (b) Ayurvedic (c) Sidha
(d) Other Indian system of medicine (e) Local herbs (f) Other (Specify)

13. If you are not treating, what do you do?

(a) Refer him/her to a qualified Pvt. doctor/institution (b) Refer him/her to a qualified govt. doctor/institution (c) Refer him/her to specialty institutions (d) Other (Specify)

14. Are you aware of ART? (a) Yes (b) No

15. Do you provide ART? (a) Yes (b) No

16. If yes, from where are you receiving ART?

17. Who in the community do you think will be in a position to identify HIV/AIDS cases?

19. If you are asked to help in HIV/AIDS control, in what way can you help?

20. Are you willing to work in collaboration with government of not-for-profit organization for HIV/AIDS control?

21 in what way, you can involve your self?

(1) Prevention, promotion and counseling (2) Treatment

(3) Provision of ART (4) Others (Mention)

22. Remarks

V. Stakeholders Interview Guide

An Evaluation of partnership effectiveness in the management and control of HIV/AIDS in Tamil Nadu state, India

Name of the participant: **Position:**

Organization: **Type of Organ:**

Address:

1) Number and the types of organizations involved in partnerships in the implementation Level in Tamil Nadu?

2) What are specific areas of work/ specific interventions/Specific target groups?

3) How the partnership process is done or initiated? The procedures governing partner selection, Management etc?

4) Do you think that the problem is very relevant to be addressed through partnerships in the current situation? Can it be addressed by some other way? How?

5) How collaborative have different partners been in the process of decision making?

6) In what way the existing health care system (Both public and private) is related to the

partnership? Are programs of the partnerships sufficiently a part of the overall health system, and have local health departments been strengthened as a result of this initiative?

7) In what ways and in what level the general community and the affected community is involved in the partnerships?

8) What proportions of partnership sustain after the funding period is over? What measures have been taken (or mechanism you follow) to sustain the partnership activities after the term of partnership is over?

9) Do you get enough political support and commitment to the Partnership activities? What do you do for this?

10) What steps have been taken to harmonize the interventions or services with one another in the implementation level, and with other donors to avoid duplication and waste?

11) Has the program cost more or less than planned? How do actual costs compare with benchmarks from similar programs or activities? Do you feel that the outputs and outcomes achieved in the most cost-effective way?

12) Do you get the outputs/outcomes as predicted or expected by the partnership? How?

13) To what extent have the various partnerships contributed to the aim of HIV/AIDS management and control in Tamilnadu?

14) Whether the community/affected community is better off today because of the collaborations? Is the success due to the effectiveness of partnership?

15) If so, how can you attribute the outcome or success/failure to the partnership effectiveness?

16) What would the current HIV/AIDS situation have been like without these kinds of partnerships?

17) Is there any best way for implementing these programmes without partnerships?

18) What would happen if the partnerships are dissolved immediately?

19) From your perspective, what challenges or concerns have you encountered with these partnerships?

20) What is your view on the future partnership?

National and International Conference

Presentations out of the PhD Thesis work

- Edwin Sam A & Varatharajan D "Efficient HIV/AIDS management through fuller useof local non-government resources: Capacity and strength of first-contact providers vis-à-vis HIV/AIDS care in rural Tamil Nadu, India" presented at the pre-congress symposium on the role of the private sector in health, held on 11th July 2009 in Beijing.

- Edwin Sam A & Varatharajan D "Revisiting the resource allocation strategy vis-à-vis HIV/AIDS care: Newly emerging new risk groups and potential care providers in the Indian state of Tamil Nadu" presented at the 7th World Congress of the iHEA, Beijing, China from 12-15 July 2007.

- Edwin Sam A & Varatharajan D "Reorienting the HIV/AIDS resource use: Emerging new risk groups and the need to reallocate resources in Tamilnadu, India" selected for presentation at the XVII International AIDS Conference Mexico City, Mexico held from 3-8 August 2008.

- Edwin Sam A " Missing targets in HIV/AIDs control" A qualitative study in a district of Tamilnadu, presented at the National conference on "Emerging issues in public health" held in AMCHSS, Trivandrum from 11-13th Janury 2008

- Edwin Sam A "How effective are partnerships in the management and control of HIV/AIDS? Evaluation of existing partnerships in Tamil Nadu state of India" presented at the 6th World Congress of the iHEA, Copenhagen, Denmark from 8-11th July 2007.

- Edwin Sam. A & Varatharajan D "Potential non-governmental partners for P3(PPP) in the management and control of HIV/AIDS in Tamilnadu" presented at International conference on "Private sector in health at Jinan, China from 26th to 28th September 2006 organized by PSP Programme, Karolinska Institute, Sweden.

- Edwin Sam. A. "Working towards public-private partnership in HIV/AIDS care: What strength does private sector hold in India?" presented in National Seminar on Health Sector Reforms organized by Annamalai University, Chidambaram, India during 30-31st Jan 2006.

- Edwin Sam. A & Varatharajan D "Looking beyond the state: Partnering with not-for-profit private sector to tackle HIV/AIDS in India. At International conference on HIV/AIDS at Toranto, Canada, 2006.
