Understanding Doctors and Nurses Resistance to Implementing the Universal Test and Treat Policy Pronouncement in South Africa

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DECLARATION

I, Maphotla Emma Mabusela, declare that:

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Name of Supervisor

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It is because of the Lord God Almighty that I am alive and capable to produce this study. I therefore want to acknowledge Elohim before and above all, as I honour him for those, he sent to help me with academic aspects of this study.

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DEDICATION

I dedicate this study to Jehovah, my Father and King, who in His infinite wisdom, prompted me to enrol for this programme in the most perilous of times. This thesis is a demonstration that Elohim is still able to make water flow from a stone. Thank you, Lord, for divine endurance, comprehension, patience and helpers.

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To my home church, City of God Ministries, and my local church Choose Life, thank you, I am a living testimony that “the people who know their God shall be strong and do great exploits” (Daniel 11:32).

GLOSARRY OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
DoH	Department of Health
HIV	Human Immune-deficiency Virus
HRD-SA	Human Resource Development Strategy for South Africa
HRH	Human Resources for Health
NA	National Assembly
NDP	National Development Plan
NDoH	National Department of Health
NGO	Non-Governmental Organisations
PMTCT	Prevention of Mother to Child Transmission (of HIV)
REC	Research Ethics Committee
SA	South Africa
SPSS	Statistical Package for the Social Sciences
TB	Tuberculosis
UTT	Universal Test and Treat
WHO	World Health Organisation
UNAIDS	Joint United Nations Programme of HIV and AIDS
UTT	Universal Test and Treat

ABSTRACT

South Africa is one of the African countries affected by the HIV pandemic. It is a signatory to the UNAIDS initiative to eradicate AIDS by 2030. Consequently, the Universal Test and Treat (UTT) Policy Pronouncement was established to help the country achieve the UNAIDS 2020 targets. However, despite this supportive policy environment, South Africa has not met the UNAIDS 2020 targets.

To achieve the UNAIDS 2030 targets, reasons behind the lack of performance must be understood and mitigated. Studies previously conducted cite health system deficiencies, central policy making and low staff morale as barriers to policy implementation. This study focuses on policies, with the understanding that policy formulation processes should have pre-empted contextual limitations, such as health system failures and low staff morale. This study investigates how the selected policy pathways serve as a barrier to policy implementation. The study's scope is limited to the interface between policy implementers and policy formulation process.

The purpose of the study is to determine whether there was any ambiguity in motivation among HIV clinicians when implementing the UTT Policy.

To achieve the study's objective, mixed research methods were employed in a phased approach. In the first phase, 100 HIV clinicians working in public health facilities across the country were randomly selected to participate in a survey, and 21 clinicians responded. Findings in the quantitative first phase informed the second phase, where qualitative methods were employed to gain a deeper understanding of meanings associated with ambiguity of motivation to implement the UTT policy and how this affected the efficacy of implementing the UTT policy. Six of the survey respondents were selected to participate in the semi-structured, in-depth interviews. The study revealed that most clinicians understood and agreed with the ideals of the policy. However, they felt that the policy did not take their skills, experiences, and concerns into account for its effective implementation. This was attributed to how the policy was introduced, which provided little room for alignment with other policies and institutional practices. The discontent was mostly highlighted by staff members with longer service history.

The policy development process created ambiguity in the motivation to implement the policy, as it was driven by top-level policymakers with inadequate input from the lower levels of the health care system. A bottom-up consultation process would have prevented the delays and challenges experienced, thereby supporting effective policy implementation.

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CHAPTER 1

INTRODUCTION

1.1. Introduction

This is a national study that describes the ambiguity of motive for HIV clinicians to provide patients with Anti-retroviral therapy on diagnoses in line with the Universal Test and Treat Policy of 2016. This is achieved by providing an overview of HIV treatment, followed by a review of literature on HIV policy development context, and exploration of the most suited theoretical framework to understand this phenomenon. This results in the development and implementation of a research process. Findings of the study are discussed through the lens of Weber's theory of bureaucratic management drawing on lessons learnt from literature. This culminates in a determination of the existence of low morale by clinicians to implement the UTT policy and reasons thereof. The dissertation ends on a conclusion, recommendations, and implications of the study.

In this chapter an overview of the problem under investigation is provided. This includes a brief contextual background and the importance of the study. It further provides clarity on the research objectives, key questions, the research approach, and concludes with a brief overview of what will be detailed across the dissertation.

1.2. Background

Over the past four decades, Human Immune-deficiency Virus (HIV) has been a leading Public Health concern. Approximately forty million people are living with HIV globally. Sub-Saharan Africa is home to over two-thirds of the global population living with HIV (UNAIDS, 2020). Over twenty percent of them live in South Africa (HSRC, 2017). Therefore, this makes successful South African HIV response vital for global progress (Venter, 2013).

Myriad interventions were undertaken to prevent and mitigate the impact of HIV through global collaboration. These interventions aimed to reduce new infections and HIV-related deaths. Significant achievements include a 31% decrease in new

infections and a 47% decrease in AIDS-related death between 2010 and 2020 (UNAIDS, 2020).

Several studies have demonstrated that HIV treatment was an effective intervention for both prevention and clinical mitigation of HIV (Brault et al., 2019). This led to the development of UNAIDS 2020 targets, ratified by South Africa and other UN member states (UNAIDS, 2014). Furthermore, the Universal Test and Treat (UTT) policy was announced by Dr Aron Motswaledi, the previous Minister of Health, in his 2016 budget speech (Motswaledi, 2016).

Despite the enabling policy environment, South Africa failed to meet UNAIDS 2020 targets. Therefore, this study seeks to understand and mitigate South Africa's deficient performance. The study will explore barriers to UTT policy implementation at the service level. The study's focus is on exploring ambiguity in motivation prevalent among doctors and nurses working at the forefront of policy implementation.

The process involved conducting a desktop review of the HIV policy development and implementation process, followed by a survey of 21 HIV clinicians providing ART. Furthermore, in-depth interviews were conducted with survey participants who expressed interest in participating.

The findings of the study will strengthen UTT policy implementation and impact. This will contribute to South Africa's and global progress towards ending AIDS in 2030.

1.3. Field of study

This is a Sociological study which borrows from other fields such as social policy, political science, public health, and public administration.

The primary aim of this study is to explore the interface between a social policy, UTT, and doctors and nurses responsible for policy implementation. UTT is identified as a social policy that addresses the HIV, a public health challenge affecting a substantial portion of the population (Ashford, 2006).

The above statement is in context where UTT policy is a product of HIV being framed as a global public health emergency. The public emergency notion is praised for its

high impact at a rapid pace. However, it is critiqued for not considering contextual factors, such as the meaningful participation of policy players, which poses a risk to its sustainability (Seckinelgin, 2012). It further gives rise to policy elites who compound contestation for power inherent in the political process where policy decisions are made (Wedel, 2017).

UTT Policy introduces an additional three million patients to the Public Health Service by changing institutional practices spanning over two decades. This impacts the institutional structure and culture, affecting the effectiveness and efficiency of the Public Health System. The effectiveness and efficiency of public service is the pillar of Public Administration (Bryson et al., 2014).

This study examines the nature of relationships and power dynamics in the UTT policy cycle, and their impact on the institutions providing UTT services and the broader society. The focus is on social relations, institutions, and the society, thus making it a sociological study (Thompson et.al.,2016).

1.4. Objectives of the study

The primary aim of this study is to contribute towards ending AIDS in South Africa, through enhancing successful implementation of the UTT policy in Public Health Facilities. Literature is filled with studies on barriers to accessing health care services. Most of these studies focus on challenges encountered by patients in accessing healthcare systems. These include staff knowledge gaps and attitudes, which are often listed among the most pronounced barriers. However, these studies do not always seek to understand the reasons behind staff attitudes. Fewer studies investigate the relationship between policy changes and shifts in the attitudes of staff responsible for implementing these policies. Similarly, low staff morale is described as a key UTT implementation barrier. In addition, reasons for low staff morale are under explored. Probable reasons for low staff morale, include health system failures and centralised policy-making mechanisms.

This study will focus on the interface between HIV clinicians and UTT policy as a potential implementation barrier. This is significant as health is one of the weakest

public service delivery points of the government despite having world-class policies, and it represents the second largest expenditure item in the country (STATSSA, 2021).

1.4.1. Broad objectives:

To determine whether HIV clinicians readily implemented UTT policy as soon as they received it.

1.4.2. Specific objectives:

- To determine clinicians' willingness to implement UTT policy
- To explore if the policy development process affected clinicians' willingness to implement UTT policy
- To examine how clinicians' willingness or reluctance impacts UTT policy implementation,
- To determine the relationship between years of service and willingness to implement policy,
- To assess if there were opportunities for clinicians to contribute to the policy process, and
- To assess the change in willingness from 2016 to 2024 over time.

1.5. Research questions

- Were HIV clinicians willing to implement the UTT policy as soon as they received it?
- How did the clinicians' perception affect their willingness to implement the policy?
- How did the clinician's willingness to implement UTT Policy affects the policy implementation process?
- How does the length of service affect the intensity of resistance to UTT Policy?
- How did the clinicians communicate their views and experiences on the policy?
- How were clinicians involved in the policy decision-making process?
- What caused changes in clinicians' perceptions of UTT policy from 2016 to date?

1.6. The assumption upon which the study is based

- That UTT policy pronouncement impacted on the institutional knowledge, process, systems, and culture.
- Front line staff experienced and contended with the impact of the policy. This resulted in nurses and doctors' ambiguity of morale for UTT policy implementation.
- The ambiguity of morale was highest in nurses and doctors that had worked the longest and carried institutional memory.

1.7. Hypothesis

If HIV clinicians were not involved in the UTT policy making process, then they will not be willing to implement the policy. The clinicians with the longest time in service will be more reluctant to implement UTT Policy than those with shorter service.

1.7.1 Null Hypothesis

Clinicians' involvement in policy decision making process has no bearing on their willingness to implement UTT policy. The length of service does not affect clinicians' willingness to implement UTT Policy.

1.8. Scope of the study

This is a National Study, primarily targeting HIV Clinicians working in Public Health Service Points. The primary unit of analysis is 21 HIV clinicians working in public health service points. This includes clinics, Community Health Centres and Hospitals. Inputs from clinicians have some bearing on the organisational culture of the National Department of Health.

1.9. Significance of the study

The study findings contribute to strengthening UTT policy implementation and its impact on clinician's morale. This is critical since South Africa failed to meet the UNAIDS 2020 targets, while remaining committed to ending AIDS by 2030. As a country with the highest number people living with HIV in the world, South Africa's success is key for global success (Venter, 2013). Additionally, this study will contribute

to public policy, since South Africa is struggling with policy efficacy. The country has progressive policies that do not impact individuals lived realities.

1.10. Background studies on HIV treatment

South Africa's ratification of the UNAIDS 2020 targets contradicted the HIV/AIDS denialism stance the country had initially taken at the onset of the epidemic (Natrass, 2007). AIDS denialism delayed access to services including treatment for people living with HIV. This resulted in a rapid decline in life expectancy rates compounded by the loss of income, limited access to care, social exclusion, and stigma. Therefore, it resulted in HIV/AIDS being identified as a leading cause of death (National Planning Commission, 2012).

In 2004, treatment programmes were initiated despite political resistance, following public protests by local advocacy groups, such as Treatment Action Campaign and global pressure. A comprehensive programme that received political support, evident in policy development and funding, was implemented and expanded rapidly from 2008 (Venter, 2013). The HIV treatment programme overcame capacity and infrastructure challenges through putting up modular structures and task shifting. Task shifting included capacity building of nurses to provide HIV clinical care, initially offered by doctors (Crowley et al., 2020).

The expansion of treatment programme resulted in reduction of new infections and death rates of over 50% and 60% respectively (UNAIDS, 2014).

Over the years, HIV treatment became more than just a lifesaving intervention. Globally, the provision of HIV treatment proved to be an effective intervention for both prevention and clinical mitigation of HIV (Brault et al., 2019). The World Health Organization (WHO) recommended that HIV Treatment be provided to all patients on diagnoses based on such evidence. This informed the ambitious UNAIDS 2020 targets, a significant milestone in the vison to end AIDS by 2030, which promoted the use of HIV treatment as prevention method. These targets aimed for 90 percent of people living with HIV to know their status, with 90 percent of those diagnosed placed on consistent HIV treatment until 90 percent of them achieve viral suppression (UNAIDS, 2020).

South Africa was amongst the first UN member states to ratify UNAIDS 2020 targets. Ratification of the UNAIDS 2020 targets demonstrated South Africa's commitment to partner with other nations and development agencies to end AIDS (UNAIDS, 2014).

The ratification and adoption of the UTT as a national Policy changed South Africa’s HIV treatment programme drastically. The most significant change was ending an era spanning over two decades, where treatment was reserved for those who qualified following a series of tests. UTT removed a barrier that prolonged time between diagnoses and treatment, leading to delayed or missed treatment opportunities (Etoori et al., 2020). This policy provided more people with access to HIV treatment before the infection advanced. Thus, increasing the quality of life and treatment efficacy, while contributing to a reduction in AIDS-related deaths (Yapa et al., 2022).

Practically, this translates to over three million additional patients requiring chronic care being added to the health system (UNAIDS, 2014). However, the same health system has faced social protest as it is on the verge of complete collapse (Rafapa, 2021). Interestingly, the social advocacy group TAC, which led these protests, advocated for and supports increased access to HIV treatment as provided for in the UTT policy. At the end of 2020, it became evident that the pace and rate of UTT policy implementation did not meet the set policy ideal for rapid HIV treatment programme expansion and targets. Therefore, studies were conducted to determine facilitators and barriers in the policy implementation process. In these studies, facilitators included staff knowledge, effective leadership, and management (Maluleka et al., 2023). Barriers included central policymaking, resource limitations, and management deficiencies (Orange, 2018). Conflicting policies, patient and low staff morale were also cited (Onoya et al., 2021).

This study seeks to deepen our understanding of the central policy making impact on front line staff, policy implementation, and low morale. It examines front-line workers' opinion of the UTT policy, with a view to determine any ambiguity in motivation prevalent in the implementation of the policy.

1.11. Preliminary considerations

The global vision to end AIDS by 2030 is based on agreements that assign responsibilities to countries and provide associated aid. Ratification of the UNAIDS targets also brought on funding and technical skill (Orange, 2018). Local failures in achieving HIV goals have global impacts that extends beyond HIV, public health, and development. Therefore, there are heightened expectations that affect other development aid, leading to economic and diplomatic impacts.

The UTT Policy implementation is in the context of a health system that is strained and challenged by high staff turnover, poor infrastructure, and unavailability of medicines. Such challenges are compounded by historic systemic and structural inequalities (deVilliers, 2021). While this may contribute to poor performance, addressing this challenge is too complex for this study.

The department of health's progress monitoring systems are localised, with data available from a facility to district, to provincial levels (Etoori et al., 2020). This poses a risk of victimisation in cases where there is ambiguity in implementing the policy in facilities, districts, or provinces already burdened with inferior performance.

There are multiple categories of staff in the service front line interacting with patients. These staff members can facilitate or discourage access to treatment. However, choosing to focus on doctors and nurses does not undermine the role played by other staff members. Instead, the focus is placed on doctors and nurses, as treatment cannot be provided without them, even though all other staff members perform well in line with the policy directives for their functions. This study is designed as a national study, drawing from a database outside the department of health to maintain anonymity of individuals, health facilities, District Health Authorities, and Provincial Authorities. It targets those who admit to having ambiguity in morale regarding the implementation of the UTT policy.

1.12. General structure of the thesis

1.12.1. Chapter one: Introduction

This chapter provides an overview of the problem under investigation. This includes a brief contextual background, the importance of the study, and how it will make a difference. It further provides clarity on the research objectives, key questions, and the research approach. A brief overview of what will be detailed across the dissertation is provided.

1.12.2. Chapter two: Literature review

This chapter highlights what is already known about the research problem. This demonstrates that there is no duplication, while highlighting gaps and opportunities to synergize. The chapter provides an overview of various theoretical frameworks to select the best suited approach, to guide and deepening our understanding of the study, and to ensure coherence and congruence.

1.12.3. Chapter three: Theoretical framework

This chapter focuses on the selected theoretical framework. In addition, it will outline the key concepts and their relationships, as well as providing an in-depth analysis. The assumed relationship between the theoretical framework and the study is also outlined.

1.12.4. Chapter four: Methodology

The study's selected approach will be discussed in this chapter. This includes a clear definition of research subjects and sampling methods. Also, the rationale for the selected tools and methods is shared alongside measures to ensure validity and reliability**.**

Details of data capturing, collation, and the analysis process are outlined including challenges experienced in their mitigation, and any other risks.

1.12.5. Chapter five: Presentation of findings

In this chapter, key research findings are presented objectively and neutrally, without interpretation. This is presented by first providing an overview of the sample

characteristics, followed by the participants' experiences in the field of HIV and with the UTT policy. The chapter concludes with the participants' recommendations to strengthen UTT Policy processes and broader Policy Development Space.

1.12.6. Chapter six: Summary of findings, discussion, and conclusion

Key findings, their relationship to the assumption of the study and theoretical framework are discussed in this chapter. This is followed by recommendations based on lessons learned. A judgment on the effectiveness and value of the study will be addressed. The dissertation ends with an account of the study's implications to the broader body of literature and practice.

1.13. Conclusion

In this chapter an overview of UTT policy is presented, and the impact towards the goal of ending AIDS globally by 2030 was provided. This was located within South African HIV treatment Policy context, and associated barriers and facilitators to treatment access. The chapter provided a rationale for the study, its objectives and considerations made in the study design, implementation and report writing.

CHAPTER 2

LITERATURE REVIEW

2.1. Introduction

This chapter highlights what is already known about HIV, AIDS, and public policy to highlight gaps and opportunities. This starts with an overview of the HIV and AIDS landscape, including local and global policy efforts, impressions of the South African policy and concludes with a reflection on the opportunities and gaps in the literature.

These provide insight into the key concepts, and how they have been researched over time. Such knowledge provides clarity on how this study builds on what already exist, without duplication and repetition. Thus, providing clarity on the contribution of the study to the body of literature.

2.2. AIDS: route from pandemic to epidemic towards the end

AIDS is a chronic immune system disease caused by HIV. HIV affects the body's ability to fight infection and disease. The more the HI Virus multiplies in the body the less able the body is to defend itself against diseases. If left without intervention the HI Virus multiplies to a stage where an infected person has multiple diseases and infection at once. This stage is known as AIDS (Sharp & Hahn, 2011). While HIV causes AIDS and AIDS represent a more advanced form of infection both terms are often used interchangeably. At times both terms are stated and used as one and at other times as depicting two different stages of infection.

Piot et al. (2013) assert that, AIDS was first identified in gay men who were living in the United States of America, and later found in injecting drug users (IDU), blood transfusion recipients and children born to mothers that are affected. AIDS was regarded as a medical problem, of people with deviant behaviour, thus limiting the focus to seeking a medical solution for groups that were socially excluded (Harden & Fauci, 2012). This was mitigated through interventions including developing a diagnostic test, condom distribution and needle exchange programmes.

A few years later AIDS was reported in the heterosexual population in Central Africa (Whiteside, 2016)). This was a population that neither used drugs nor received blood

transfusions. The rate of similar incidents was reported to be alarmingly high globally. This defied the notion that AIDS is a disease of a few social deviants but as an indiscriminatory disease that affected everyone in the population (Jackson, 2002).

In the mid-90s, HIV treatment known as Antiretroviral Therapy (ART) was introduced (Gayle & Hill, 2001). ARTs are lauded for saving many lives, outweighed the risks of adverse events that are associated with taking them. In 2000 there were over 36 million recorded HIV infections: 90% were in developing countries. Up to 75% of infected people lived in sub-Saharan Africa, and 20 million AIDS related deaths were recorded globally (Gall et.al, 2017). It was at this stage evident that the impact of HIV and AIDS was a global health emergency.

The higher prevalence of HIV in developing countries was pronounced and could not be ignored. The susceptibility to HIV was rooted in vulnerability associated with poverty, lack of access to health, education, and social exclusion, thus making HIV a human rights issue (Harden & Fauci, 2012)). This led to a shift in the focus in interventions from being purely biomedical to include behavioural, structural, and legislative issues.

2.3. AIDS and development

AIDS has a significant impact on development. It threatens to devastate human development, setting countries back in their efforts to increase child survival, life expectancy and secure livelihoods ((Whiteside, 2016). The 1999 Human Development Report of the United Nations Development Programme states that, "…many African countries had suffered a downward trend in their ranking on the Human Development Index, ascribing this largely to AIDS" (Leclerk-Madlala, 2005:847).

Primarily, HIV infects the age group that is fertile, productive, as well as economically active, resulting in destruction of their lives and livelihoods. AIDS related deaths lead to loss of financial security for families, dissolves the nuclear family, and increases the number of people dependent on one person (Jakson, 2002). At a macro level, AIDS slows down population growth, robs the economy of skilled labour force and increases the number of vulnerable people that depend on state aid.

A lack of public services, poverty and gender inequity increases vulnerability and heighten susceptibility to HIV (Harden & Fauci, 2012). This is compounded by political conflict, war, and displacement, which deepens vulnerability ((Whiteside, 2016)). Thus, the lack of development and state stability increases vulnerability and susceptibility. Therefore, it is not surprising that the underdeveloped nations carry a higher burden of disease.

Development also affects the spread of HIV. HIV spreads the fastest along transport routes and in areas that have migrant labour forces such as mines. This is most evident in South African mining towns which have higher HIV positivity rates (Zuma et al., 2022)

2.4. AIDS: a wicked problem

The rise in HIV infection and AIDS related deaths proved that the causes and effects of AIDS was beyond the scope of Public Health and was similar to a wicked problem. Lönngren, & Van Poeck (2021) regard wicked problems as complex, multi-layered, problems that are difficult to define and resolve. Each problem has multiple roots and causal relationships with others. This makes it difficult to understand and mitigate one problem decisively. The root causes of wicked problems can only be understood by deploying various lenses hence interventions often require multi-disciplinary teams to work on a scourge (Camillus, 2008).

The challenges brought forth by AIDS are complex, multi-layered, and broad. AIDS deaths fragment families, increase the number of orphans, rob industries of skills and families of their means of survival. Therefore, AIDS is a wicked problem that threatens the social and economic health of people, communities, and nations. It further, poses as a risk to the entire global economic systems (UNAIDS, 1996). Thus, the impact of AIDS is at both a macro and micro level. Dealing with AIDS is neither easy nor linear.

Trying to deal with AIDS resulted in a process of seeking policy interventions by muddling through. Lindblom (2018) describes muddling through as a process where many decisions are made amid complexities, such that only alternatives are explored. This leaves little room for rationality and political or social science influence.

Hence AIDS was initially considered a public health problem and later regarded as requiring a global multi-sectoral and multi-dimensional intervention. At the onset of AIDS, interventions focused on what was known. More knowledge was gathered resulting in the exploration of more options or alternatives for broader and better interventions. Interventions became less like muddling through and more rational, evidence based, thus yielding better results.

2.5. Global health emergency

AIDS was brought to the global policy agenda owing to its rapid spread and increased death rates globally. The global policy agenda on AIDS was informed by the condition's uneven spread, where in the, "…poorer and heavily indebted countries were the worst affected. Thus, making AIDS a globalization problem" (Whiteside, 2016). Nations around the world rallied together to seek solutions to the challenge of AIDS, creating a global advocacy for AIDS.

The efforts of nations around the globe culminated in the 2001 declaration of the commitment on HIV/AIDS, which was signed unanimously by 189 United Nations Member states. The declaration redefined international development, and health diplomacy through provision of new funding streams, monitoring and accountability systems (Gall et.al., 2017). While the declaration was hailed a success, it is critiqued by globalization analysts, such as Powers (2012:531), for decreasing the significance of the state due to the rising influence of external political forces. State conformity to external political forces is known as transnational governance.

That said, it is important to highlight that the declaration of the commitment on AIDS recognised that the context and spread of HIV is unique in each member state, thus necessitating country specific responses, that informed global initiatives (Gayle & Hill, 2001).

A series of other global co-operative agreements including political declarations on AIDS have been signed since 2001. The latest of these are; The Political Declaration on HIV and AIDS: Ending Inequalities and getting on track To End AIDS by 2030 that was signed in 2021. In 2020 UNAIDS reported significant success since the signing of the 2001 declaration on AIDS, including 54% reduction in AIDS-related deaths and a

37% reduction in HIV infections globally. While this was a product of myriad interventions, successful HIV treatment roll out was singled out as having, "…averted 16.2 million deaths since 2001" (UN General Assembly, 2021:10). This is marked by a rapid increase in the number of people on HIV treatment from 7.8 million in 2010 to 27 million in 2020 (UN General Assembly, 2021).

The rapid HIV treatment roll out was a product of AIDS being framed as a global public health emergency. The public emergency notion is acclaimed for having high impact at a rapid pace. The global public health emergency approach is critiqued for a lack of consideration for contextual factors such as meaningful participation of policy players, and therefore poses sustainability risk (Seckinelgin, 2012). This is despite the provision made for each state to choose to ratify the declaration and develop local implementation protocols. Thus, allowing for each member state to manage its domestic political and economic systems alongside the global (Troll & Skinner, 2013).

Others argue that the discord between the local context and global imperatives is brought forth by local acceptance of global funding and technical skills (Orange, 2018). While this may appear noble, the current North-South relations cannot be fully appreciated without acknowledging the history of colonialism, which shapes current power relations, global politics, and economies (Troll & Skinner, 2013). Debates have been raging on true beneficiation of aid and technical support. Some argue that big pharmaceuticals greed is the reason for the push in treatment, and some politicians, researchers and clinicians are complicit (Ferner, 2005). Interestingly it is the richer nations that have monopoly over drug production and access whilst poorer nations are consumers (Clearly & McIntyre, 2010).

However, the progress made through the global health emergency approach… cannot be denied, just as much as the magnitude of the challenge that remains. The fact that over 75 million people have become infected with HIV and over 32 million have died from AIDS related diseases shows that more needs to be done (UN General Assembly, 2021). In keeping with treatment success, the latest political declaration was signed in 2021 and sets out to provide HIV treatment to over 34 million people globally. Member states made an undertaking to ensure sustainable access to HIV treatment and people centred prevention services to populations at risk of HIV infection. This is to be

achieved through the introduction of country level supportive legislative frameworks and public policies (UN General Assembly, 2021).

2.6. HIV prevention and treatment as a public policy

Dye (2013:3) defines government's, "…decision to take an action or not," as public policy. This is the same for each governments' position on AIDS interventions. The decision to ratify or not ratify global policy position is a reflection on the member states' policy. The same applies to the choice, mechanism, and pace to either implement the ratified decisions or not. This implies that a policy is not just a once-off decision, but decisions that inform a series of actions that impact the society that the government serves (McConnell, 2010). Thus, policy making is a process.

Public policies are tools used by governments to address challenges, such as HIV and AIDS, that affect a large proportion of society (Wedel, 2017). Government resource allocation priorities are set to ensure policy implementation. In democratic societies, public policy priorities are set out through a political process (Wedel, 2017). Politics is the art of controlling society by exerting, reaching, and implementing collective agreements (Heywood, 2013). This makes the policy formulation process a contest for power. Contestation for power is mitigated by inclusion and meaningful engagement between the state and society, focusing on policy actors. Inclusion and meaningful engagement maintain tension in the power dynamics while legitimising state policy priorities, deepening democracy, and contributing to national peacebuilding (Mkandawire, 2011).

Therefore, a democratic government would only ratify global policy positions that advance and support local public values. The government would further ensure that their application of global policy position considers contextual issues. This is critical as governments and their public administration primarily exist to meet public needs (Twizeyimana & Andersson, 2019). This notion assumes that the state manages transnational politics well, placing the interest of its citizens above diplomatic pressures, while maintaining all the benefits of being a respected global player.

2.6.1. Policy changes

Policy changes can be small, progressive, aligned to the existing policy trajectory, or urgent and on a large scale. Progressive policies are path-dependent, while those urgent, large-scale policies are mostly brought on by focused events. Douglass North asserts that path-dependent policies build on the historical, and emerge out of what is tried, tested and is familiar (Friedman, 2021:38). Therefore, they strengthen or advance existing institutional frameworks. Resultantly, path dependent policies are accepted with minimal resistance (Kay, 2005). They are also critiqued for stifling innovation and lacking urgency.

Conversely a focusing event demands urgent action, which emphasises the potential harm on a large scale ((Birkland & DeYoung, 2012). An agreement by close to 200 nations that AIDS is a global health emergency, calls for development plans, monitoring systems to track and report on progress as a global focused event. This is echoed by country activities and progress reports that command public attention. This was most evident during the recent COVID-19 pandemic.

AIDS became and remained a health emergency for over four decades. HIV and AIDS aroused concern, research, and media coverage than any other health condition (Whiteside, 2016). This concern is maintained by set calendar events locally and globally, thus keeping AIDS high on the policy agenda. The onset of the COVID-19 global health emergency placed HIV and AIDS on the side track, resulting in sharp concerns raised by AIDS policy players. Interestingly despite similarities, AIDS and COVID-19 were not effectively managed together (Chenneville et al., 2020).

2.6.2. HIV/AIDS policy players in the globe and in South Africa

Policy was earlier defined as government decision to act or not (Dye, 2013). This decision can only be understood in the context of who and what informed it or who had the power to make it. Guzini (2012:97) argues that "…power is understood through the study of the outcome of (government) decisions, that is, by analysing which (public) actors prevailed in different policy domains". The public actors are also known as policy players or stakeholders. These are people that have vested interest in the policy and are able to contribute to policy success. Therefore, the identification and analysis

policy player network are critical in the policy formulation process. Determining players, power dynamics, and ensuring representation is the first step in the policy development cycle (Beyers, 2014). Each network must be represented by a legitimate representative.

This far, it has been established that AIDS is a global health emergency, and global policy decisions, inform the national ones. Therefore, in policy responses to HIV and AIDS there was transnational governance. Powers (2012:532) caution against," …collapsing conceptions of the 'global', 'national' and the 'local' into a single, uniform socio-cultural process, to understand political response to the AIDS epidemic".

The first declaration on AIDS and all other subsequent global tools have always placed partnerships across UN agencies, nations, civil society, research, private sector, and aid agencies as central to winning the battle against AIDS (Gall et.al., 2017). Each member was charged with replicating this model at a national level, based on their context. This was to avoid possible conflation of the global and national that was alluded to by Powers (2012).

The effect of unique context was most evident when looking at some neighbouring countries in SADC. Leclerc-Madlala (2005) noted differences in implementation between Botswana and South Africa and that these differences are brought forth by institutional structures, power relations and policies. In the early years Botswana's policy and networks were lauded as progressive and inclusive, while South Africa was a direct opposite.

Two key distinctions can be drawn between Botswana and South Africa. Firstly, South Africa was slow in implementing the global policy positions on access to HIV treatment, while Botswana adopted this rapidly. The second is the devolution of power to players outside government, which was done rapidly in Botswana while South Africa set up structures that had limited powers (Leclerc-Madlala,2005).

In South Africa, the recognition of HIV as a cross sectoral challenge did not filter into decision and policy making structures. AIDS policy making powers were concentrated in the department of health. Funding to civil society by government and global partners was funnelled through government led agencies such as the National Development

Agency. While civil society was consulted, government held all the power. This demonstrates that government regarded citizens as beneficiaries as opposed to partners that can contribute to finding solutions to the problems they face (Leclerc-Madlala, 2005). However, a close examination of AIDS politics in South Africa reveals that the ANC-led government developed institutional arrangements and alliances with non-governmental organisations (NGOs) to limit the effect of transnational political influence during the administration of the former President Mbeki (Powers, 2005).

Mbali & Mbali (2013) argues that the ANC government understood that the availability of resources and incentives facilitates or inhibit the expansion of groups. Therefore, they exerted control on access, power, and resources. The structure and manner of civil society representation in South Africa was only resolved in 2007, seven years after the first National Strategic Plan (NSP) for AIDS was published. This was caused by the ruling party's desire to," …create limitations on the autonomy of NGOs that are critical of the ruling party" (Powers, 2012:535). The value of the partnerships between civil society and government is best demonstrated by successful litigation against global pharmaceutical companies to lower ART prices (Butler, 2005).

2.6.3. South African National AIDS Council (SANAC)

Today South Africa has a similar pattern to what was recommended in the UN General Assembly, where in, collaboration across policy players is coordinated through the South African National AIDS Council (SANAC). This is in direct contrast to the first years of the South African AIDS response.

Powers (2012:535) argues that:

> *" …the South African National AIDS Council was founded in January 2000, taking the place of the Inter-Ministerial Committee on AIDS as the national institution coordinating the public health response to the epidemic. Initially, managerial structures that were implemented retained the power of the ANC to control the National AIDS Council. In particular, the Resource Management Committee was established to manage South Africa's relationship with the Global Fund and to secure additional funds to support the implementation of the National Strategic Plan (NSP)'. This was done to retain 'the*

conceptualisation of the state as 'higher' or 'above' society' is produced in order to secure its legitimacy, to naturalise its authority, and to represent itself as superior to, and encompassing of, other institutions and centres of power"

SANAC includes various government departments, 18 civil society, and private sector role players, supported by development partners, and funded by multi-national agencies (SANAC, 2017). While this is a step in the right direction some believe that this is a product of a corrupt process. An analysis of contention of power in the field of AIDS in South Africa demonstrate that, "…the ANC-led government developed institutional arrangements and alliances with non-governmental organisations to limit the effect of transnational political influence during the administration of the former president" (Powers, 2005:531). SANAC representatives are diversly elected to ensure that diverse policy playing networks are represented. This assumes that each representative is duly delegated by the network that they represent and that each network is homogenous.

The selected representative in each network has access to other stakeholders and real access to power while other members have access by proxy or association. This gives rise to policy elites. Policy elites are a group of a few individuals who have the political power to impose their decision on the majority (Matti & Sandström, 2011)). It may be argued that power is diffused, negotiated, and managed in civil society networks that have a horizontal structure. This reality is different in public service entities or government departments.

Relationships in government are hierarchical in structure, with clearly defined employer-employee roles. The lines between political and administrative leadership are also defined and so are the set forums for consultation and collaboration. Max Weber (1966 as quoted in Albrow,1994) argues that clearly defined roles and hierarchies of power and authority are essential elements of a rational and efficient government. This suggests that all who are employed based on their qualifications should do their job at their allocated level of power and authority.

One of the government departments represented in SANAC, is the Department of Health (DoH) which alludes that interest amongst stakeholders are anything but

homogeneous. However, in the DoH, there is dissatisfaction and conflict amongst staff and administrators, demonstrated by high staff turnover (Tosanloo et al., 2019). While trade unions have a set programme of engagement with the employer, they primarily advocate for general working conditions. Technical policy matters are far too many and too complex so that they have no room for expression in Trade Unions who represent staff across various categories. The lack of an advocacy plan by clinicians dilutes their bargaining power (Matti &Sandström, 2011). Therefore, clinicians are not seen or heard. They are considered a resource to implement the policy as instructed, not a critical stakeholder responsible for policy success. They are not considered stakeholders whose opinion, experience, and technical expertise should inform the policy.

The above is compounded by DoH's collaboration with its development partners. While development partners place HIV clinicians to augment staff and capacity deficits in DoH facilities, there are tensions between development partner staff and DoH employed clinicians who perceive development partner staff to have access to decision makers (Orange, 2018). Most development partners document and conduct research on HIV and AIDS interventions (Onoya et al., 2021). They also inform and have access to global good practice that is tested in facilities. Therefore, they sit in most National Policy working groups and inform policy directives. Hence, they are seen as policy elites that influence state functions.

The function of academic policy elites undermines public participation leading to policies made without public input (Hirsch & Shotts, 2018). This suggests that policies are based on conclusions made by academics who interacted with those affected by the policy, not policy players themselves. In this instance clinical staff do not directly inform the policies that they implement but depend on development partners to do so.

Development partners' access to health facilities legitimises their ability to speak with authority on implementation. Notwithstanding, development partners' experience is drawn out of vertical programme lens while the experience of the staff that is employed directly by the departments is, broader, more holistic, and uses a health systems lens.

The contestation and competition across SANAC members are expected in the hope that consistent communication and negotiation results in synergy. This is best

demonstrated by the nature of the relationship between the DoH and civil society which is both antagonistic and mutually beneficial.

Tension between the DoH and civil society dates from the onset of AIDS and intensified when HIV treatment was delayed. This period was characterised by civil society protests that were directed to the DoH (Venter, 2013). Synergies are most evident in the care, support, and HIV treatment programme expansion, whereat government and civil society work in partnership. At the same time civil society has organised a series of protests against the health system failure (Rafapa, 2021). These tensions, contradictions, and resistance are expected (Mekonnen, 2019), hence all policy processes are characterised by negotiations, and compromises.

2.7. Resistance to change

Resistance is synonymous with change. It occurs even if there is consensus that change is necessary. Change management practitioners suggest that resistance to change is an unavoidable consequence of change that can be used to strengthen the change process (Metz, 2021). Poor management of resistance hinders policy implementation and could result in policy failure.

There are myriad factors that cause and contribute to resistance to change. These include the decision-making process that led to the change, the scale of the change, and the pace of change. The scale of change is a key contributing factor of resistance. The more significant the change, the more intense is the resistance (Metz, 2021). This is because change can be disruptive to institutional practices, culture, and systems. The bigger the change the bigger the perception of disruption.

Top-down decisions also generate significant resistance (Cummings et al., 2015). This is associated with the fear of losing power by those in lower levels of management, who would not have had an opportunity to contribute to the change and ensure that their concerns and hopes are considered. Resultantly, they feel undervalued (Mekonnen, 2019).

Rapid change disrupts institutional culture and practices and results in increased, chances of political conflict (Lindblom, 2018). Controversy is often manifest in

resistance to change. That said, resistance can be mitigated through inclusion, meaningful consultation, and transformational leadership (Metz, 2021). To better understand this phenomenon, we examine the relationship between, politics, policy, and public administration in the South African context.

Incremental policy changes are preferred and have the least amount of resistance because they are borne out of trial-and-error. They are also path dependent, steady and provide space for reflection, consultation as well as adaptation which result in synergy. However, incremental changes do not work well in times of emergencies, where time is of essence.

2.7.1. Politics, policy, and public administration

Butler (2005:600) asserts that public institutions are created in respect of socio-economic rights, to promote open and democratic politics as well as to facilitate appropriate contestation of policy. This suggests that the primary purpose of public institutions is to ensure that public services are determined by the public through policy processes. In this instance the public's rights are more than that of a beneficiary but a legitimate custodian of the policy. Public administration institutions are a platform for public policy contestation, to determine policy priorities and processes.

The nature of the relationship between politics, policy, and public administration has been a subject of debate amongst scholars. There are those who believe that there is a distinct difference while others believe that the relationship is symbiotic. The former see administration as responsible for turning policy ideals into tangible results, while the function of politics is to develop policies based on public valued choices (Demir & Nyhan, 2008). This is best described by Weber who predicates successful institutions as rational, authoritative, well structured, with skilled staff, and operating within clearly defined powerlines that are respected by all (Wendt, 2016).

In principle, the South African government system is structured, as defined above. In South Africa political party campaigns are based on party politics called manifestos and linked to the political election term. This allows the electorate to vote in a party that best represents their public value. There is a set division between the political executives and the administration, on paper. According to Butler (2005), the reality of

this separation of power is undermined by the ANC's popularity and hierarchical structure.

The term of office of senior leadership is aligned with the political office term. While it is argued that this is to ensure alignment between the political, and administrative heads and to secure the best suited skills to further the policy agenda, the ANC's cadre deployment system, blurs the lines between political and administrative roles (Selepe, 2003). This is compounded by staff positioned at service delivery levels in the coalface. Therefore, public servants face some type of changes in which they cannot contribute or have control over, at least in every five years. Those higher up in the hierarchy, have no institutional memory but have access to political power of determining the policy.

The contradictions in the ideal and reality in the South African government echoes that, politics, policy, and management in the public sector are interwoven (Stewart, 2004). This means that the nature of policies and ability to implement such policies successfully depends on politics. This is echoed by Leclerc-Madlala (2005:845) who offers a people centred approach by saying,

> *" …an ideal response to HIV/AIDS would be one that seeks to meet the needs of people, both those infected and those affected by the disease, while promoting a culture of openness in treatment and of democratic values in policy responses."*

2.8. Universal access to HIV treatment

Over the years HIV treatment became more than a lifesaving intervention. Several studies demonstrate that HIV treatment was an effective intervention for both prevention and clinical mitigation of the impact of the pandemic (Brault et al., 2019). The World Health Organization (WHO) recommended that HIV treatment should be provided to all patients on evidence-based diagnoses. This informed the ambitious UNAIDS 2020 targets, an important milestone in the vison to end AIDS by 2030, which promoted the use of HIV treatment as a prevention mechanism.

In the UNAIDS 2020 targets: 90% of the people living with HIV were to know their status, 90% were to be placed on consistent HIV treatment until 90% are virally

suppressed. South Africa was amongst the first UN member state to ratify UNAIDS 2020 targets (UNAIDS, 2014). A key policy position to reach this goal was to make HIV treatment easily and consistently accessible on diagnoses. This was a policy that was called the Universal Test and Treat (UTT).

Ratification of the UNAIDS 2020 targets demonstrated South Africa's commitment to working in partnership with other nations and development agencies to end AIDS in 2030 (UNAIDS, 2014).

2.9. HIV treatment policy in South Africa

The ratification of UNAIDS 2020 targets by South Africa contradicted HIV/AIDS denialism stance that the country had adopted at the onset of HIV/AIDS epidemic (Natrass, 2007). AIDS denialism delayed access to services including treatment for people living with HIV. This resulted in a rapid decline in life expectancy rates, loss of income, limited access to care, social exclusion, and stigma. Resultantly, HIV/AIDS was a leading cause of death in South Africa for a few years (National Planning Commission, 2012).

2.9.1. President Thabo Mbeki and AIDS dissidence

There have been debates on either HIV causes AIDS. There were also views that HIV does not exist or does exist but only leads to AIDS if the infected person lives in poverty, is malnourished, has other infection, or uses drugs. Those who did not believe that HIV causes AIDS were known as AIDS dissidents.

While there were some consensuses that poverty can increase susceptibility and vulnerability to HIV infection, no causal link was established between HIV and poverty. There were many people living in poverty who were HIV negative just as the affluent who were not injecting drugs but were HIV positive (Harden & Fauci, 2012).

In South Africa AIDS seemed to affect those in the fault line of apartheid and have struggled with socio-economic exclusion the most. In a new democracy that emerged from years of segregation, oppression, and conspiracy theories including biological warfare, trust was a rare commodity (Powers, 2012).

The dissident view was supported and placed on the policy agenda by President Thabo Mbeki, the second democratic president of South Africa. Mbeki wrote to world leaders indicating," …doubt that HIV was the exclusive cause of AIDS and arguing for a consideration of socio-economic causes" (Fassin & Schneider, 2003:495). He even established a presidential advisory board, led by dissident scientists and activists.

President Mbeki's position later changed, but the cost was insurmountable and included loss of lives for children who could have benefited from the Nevirapine roll out to, prevent HIV transmission to children born to HIV positive mothers.

Some scholars attribute the change from the AIDS dissident state to the pressure applied by Treatment Action Campaign (TAC) and its global allies (Powers, 2012) While other scholars believed it was due to public opinion surveys that suggested that voters placed AIDS high on the agenda (Fourie, 2013). This was because the relationship between transition in administration is important in democratic societies as the electorates political identity is formulated based on the performance of current administration.

The notion of foreign interest being furthered by local interest groups was used to undermine and discredit groups that contoured the AIDS dissidence stance such as the TAC (Powers, 2012).

2.9.2. Responses to government AIDS dissident policy

The South African government's dissident position contradicted global policy positions and placed citizens at risk. This was changed when, "…forces in society that accumulate power to determine the direction of the policy agenda" (Cloete et al., 2011:112). This is a product of active citizenry were societal groups harness and channel their agency to compel the state to prioritise and effect change in areas of public value. Engagements with the South African government were led by TAC. a social movement and advocacy group that was most visible in the fight to ensure access to HIV treatment at public health services (Leclerc-Madlala, 2005).

TAC employed a multi-pronged advocacy campaign inclusive of public protests, litigation, and non-violent civil disobedience. They further provided scientific evidence to counter government misinformation and worked with global allies to mount

international pressure (Butler, 2005). The global diplomatic pressure was due to South Africa's position, and it contradicted some of the WHO recommendations as well as the Declaration on AIDS, borne out of global diplomacy for health process (Gall et.al, 2017).

The litigation culminated in a constitutional court order for government to make Nevirapine available to all HIV positive pregnant women. This ushered in a National Assembly resolution to make Antiretroviral Therapy (ART) available (Fassin & Schneider, 2003:495). There were myriad efforts to undermine TAC. This included being branded, "…an extension of multinational pharmaceutical corporations," by the ANC government (Powers, 2012:540). On a local level they faced political resistance from ANC affiliated groups such as SANCO (Powers, 2012). TAC's ability to resist and prevail over the South African government was primarily sponsored by neo-liberal globalisation. Ferguson, as quoted in Powers (2012:535), contends that neo-liberal globalisation has enabled NGOs to access international donor funding, thus levelling out the traditional hierarchy between state and civil society as well as fundamentally changing the basis of politics in the global south.

2.9.3. The impact of changes in leadership on the evolution of HIV treatment

The National Assembly resolution to make ART available ushered a new era in HIV treatment. ART availability was broadened after the Mbeki administration and with every subsequent appointment of the Minister of Health. Minister Motsoaledi's term is renowned for aligning National Department of Health Policies with global treatment policies and norms. The internal shift in politics of HIV/AIDS within South Africa has been strongly supported by international institutions and global AIDS activists alike (Powers, 2012). However, the shift can be critiqued as a form of conformation to transnational politics, which may lead to divergence from contextual realities if it is not appropriately managed.

What is clear is that all the changes in administration, leadership, and AIDS policies serve to, manage issues related to President Mbeki's dissident era. South Africa's political leaders in the Mbeki's dissident era started on a backfoot, as they needed to rebuild trust nationally and globally, while catching up progress made by other

countries. This is whilst changing and correcting public perceptions and beliefs that were maintained by the same government.

2.9.4. HIV treatment programme expansion

In 2004, treatment programmes were eventually initiated despite political resistance. A fully-fledged programme that enjoyed political support evident in policy development and funding, was implemented and expanded rapidly from 2008 (Venter, 2013). The initial criterion to access HIV treatment was well considered and stringent. This included set staffing norms and required psycho-social readiness as well as clinical eligibility. Key distinctive features of the expansion were an increase in the number of sites that provided treatment, as well as the expansion of clinical criteria for accessing treatment.

HIV and AIDS treatment initiatives started as vertical programmes led by a multidisciplinary team of experts, led by doctors and included: nurses, lay counsellors, social workers, psychologists, pharmacists, as well as dieticians (Crowley et al., 2021).

This multidisciplinary team serviced a set number of patients. When the set number was exceeded, a new team would be added.

A series of educational talks and counselling sessions on patients' rights and responsibilities, were undertaken prior to patient initiation on treatment. This rights-based approach resulted in patients that were well informed, motivated, supported, and involved in their care. However, this meant that HIV and AIDS treatment programmes were confined to central hospitals (Venter, 2013). The limitation was that HIV treatment could only be provided at a few initially selected sites. But this was gradually changed until treatment was accessible at public health service centres.

Clinical eligibility included that the patient's immunity must be compromised, but they must not have tuberculosis (TB) or should have been on TB treatment for a set period. The patient immunity was tested by measuring the availability of cells that help fight off infections known as a CD4 cell. A lower CD4 cell count demonstrated that the immunity was more compromised. A CD4 cell count of 200 cells per cubic millimetre of blood (ul) and below was the initial requirement. This was increased to 350 cells/ul

in 2012, and 500 cells/ul in 2015 and was removed as a criterion when UTT was introduced in 2016 (Yapa et al., 2022). The psycho-social assessment and preparation component was also removed as a treatment pre-requisite (Onoya et al., 2021). A series of challenges had to be overcome to ensure that HIV treatment is universally accessible.

2.9.4.1. **Financial constraints**

Funding HIV and AIDS treatment programmes was complex and expensive. This was compounded by treatment being lifelong, making the costs recurrent. The scale of infection also pointed to the case load being ever expanding. Cost consideration included supply of human resources capacity, equipment, laboratory costs, operational costs, and treatment (Cleary et al., 2006). The human capacity and drugs were amongst the highest anticipated costs. This was due to South Africa having clinical staff who were amongst the highest paid in the continent (Venter, 2013).

Drugs were expensive, manufactured in the Global North and with unit cost being priced at currencies stronger than the local currency. While interventions by groups such as TAC and Clinton Health Access Initiatives have assisted in lowering prices, the costs remain high and will continue to escalate to commensurate the addition of new patients. Funding for ART is primarily covered through the national fiscus (Clearly & McIntyre, 2010).

2.9.4.2. Human capacity constraints

Human capacity limitations were and remain the most difficult challenge to overcome. The AIDS treatment plan promised an additional 15 000 vacancies while there were over 30 000 unfilled posts. This was compounded by South Africa's public health system loosing over 80 000 health workers owing to migration (Labonte et. al., 2003).

The loss of health workers was countered by the appointment of clinicians from other African countries as well as government's undertaking, to rapidly recruit and train new health professionals (Buttler, 2005). Nurses that were already employed were capacitated to provide clinical HIV treatment services for patients, a role initially reserved for expert doctors. Thus, effectively shifting the task from doctors to nurses.

Task shifting was implemented in 2010, after being shown to be effective when coupled with training and consistent mentoring (Venter, 2013). Services were effectively moved to a more broadly available staff cadre, that was paid less. Training and mentoring of clinical staff were a key enabler for task shifting. Development partners provided technical support services for training, mentoring, as well as direct placement of staff (Maluleke et al., 2023). The impact of the change from a doctor centred to a nurse centred approach meant that ARTs could be offered outside of hospital and in all health facilities, making HIV treatment more accessible (Venter, 2013).

Universal treatment accessibility was made possible by integrating HIV treatment services to other public health services. This effectively cancelled the staffing norms, expert model, as well as the dedicated space, staff, and service that patients living with HIV had been accustomed to. That said, the expansion of treatment programmes resulted in progress including a reduction in new infections and death rates (UNAIDS, 2014).

All changes to HIV treatment policies started as small pilot projects, which expanded gradually with strong emphasis on consultation and capacity building (Venter, 2013).

Policies that change slowly along the same trajectory are defined as incremental and path dependent. Therefore, HIV treatment policies were path dependent until 2016, when the UTT Policy pronouncement was made in parliament.

2.10. Universal test and treat policy

Dr Aron Motswaledi, the then Minister of Health, announced that South Africa would implement the UTT policy in his budget speech in 2016 (Motswaledi, 2016). This policy pronouncement was borne out of South Africa being amongst the first among UN member states to ratify the UNAIDS 90-90-90 targets (UNAIDS, 2014). This demonstrated further progress away from the AIDS denialist position of the past and commitment to end AIDS in partnership with other nations.

A policy pronouncement is a call to immediate action. It is not a call to consider implementation options. Therefore, in South Africa, the pronouncement was a sign of the government making it happen (Cloete et al., 2011). The pronouncement follows

the conclusion of policy cycle process such as problem definition and milestone setting as led by government. This is a classic case that is led by political monopoly, with limited public consultation (Hirsch & Shotts, 2018).

Nonetheless, the urgency and positive impact of UTT policy must be highlighted. The UTT policy allowed all people living with HIV to access treatment upon diagnosis. This effectively removed the HIV treatment eligibility criteria that required a series of clinical assessments and tests leading to prolonged time between diagnoses and treatment, which resulted in some patients not being placed on treatment (Onoya et al., 2021).

To advance the UTT policy, the Same Day Initiation (SDI) programme was introduced through formal written communication to all health facilities in 2017. This communication provided an instruction to initiate treatment for all patients that tested positive for HIV on the day of diagnoses. SDI removed any ambiguity in the UTT policy language, completely eradicated treatment waiting times, set a much clearer initiation target for newly diagnosed patients, and an increase in the pace of implementation (Onoya et al., 2021).

Therefore, the UTT policy pronouncement, ended an era spanning over two decades, where treatment was reserved for those who qualified following a series of tests. This meant that more people could access HIV treatment on diagnoses and before their HIV infection advanced. Thus, increasing the quality of life, and treatment efficacy, while contributing to a reduction in AIDS-related deaths (Brault, 2019).

Practically, the UTT policy meant over 3 million additional patients being added to the health system for chronic care (UNAIDS, 2014). This is despite the health care sector being constrained with challenges of high staff turnover, poor infrastructure, and unavailability of medicines. Such difficulties are compounded by historic systemic and structural inequalities (deVilliers, 2021). Interestingly the same social advocacy group TAC, that supported UTT policy with 3 million patients being added to the health care system, has been protesting against the health system which was on the verge of collapse (Rafapa, 2021).

The effectiveness and efficiency of public service is the pillar of public administration (Bryson et al., 2014). Therefore, the public health care system exists to provide value

to the citizens in an effective and efficient manner. This is the ideal behind the UTT policy. However, at the end of 2020 it became evident that, the pace and rate of UTT policy implementation did not meet the set policy ideal of rapid HIV treatment programme expansion and targets.

Studies were conducted to determine facilitators and barriers in the policy implementation process. Facilitators were found to include staff knowledge, effective leadership, and management (Maluleka et al., 2023). While barriers included central policymaking, resource limitations, and management deficiencies (Maluleke et al., 2023; Orange, 2018). Conflicting policies, and low staff morale were also cited as barriers (Onoya et al., 2021).

2.11. Impression of the South African AIDS policy

When AIDS was declared as a health emergency, devastated individuals, families, and nations around the globe, rallied around a shared vision. South Africa's contribution to the global vision has not always been sterling but progressed significantly over the years. The latest in the global agreements that were to be implemented by member states in their respective counties, included ensuring early and consistent access to HIV treatment. This initiative is known as the UTT and was a strategic enabler for the UNAIDS90-90-90 targets, which were to be reached in 2020(UNAIDS, 2012). South Africa ratified this target, and the Minister of Health made a policy pronouncement on how this target would be reached.

The announcement of the UTT policy from the highest executive office of health in the country, indicated that the policy was an urgent directive that was not negotiable. The route undertaken by the minister to implement the UNAIDS 90-90-90 was a top-down approach for implementation. This in keeping with Weber's theory of bureaucracy, is the imperative of the minister and all others should focus on operationalising the policy.

The top-down approach is known to attract great resistance even if there is a broad agreement that change is necessary. This is because top-down decisions leave no space for the exploration of alternatives, commonly known as policy appraisal (Howlett, 2014). All policy players must simply toe the line. This negates the power of stakeholder consultations that can anticipate contextual barriers and strategic

enablers. This includes HIV clinicians at the coalface of service delivery, who have a nuanced understanding of contextual risks and should, therefore, be considered an important stakeholder.

The history of HIV treatment in South Africa demonstrates that the notion of a government that knows what is best for its citizens and runs quickly to announce and implement is quite common (Powers, 2012). While the UTT was backed by global evidence and diplomacy, pronouncement that precedes broad consultation as legislated, negates citizens agency and exploration of alternatives. The advantage of South Africa's public announcement, through parliament, created a pathway for rapid response with financial and technical expert support from UNAIDS agencies and partners. This ensured resource availability, making implementation rapid and well supported. Howlett (2014) describes such a process as lump-free.

Notwithstanding, dependency theory regard expert-led processes as problematic because they tend to undervalue indigenous knowledge and contextual issues (Curler, 2021). A key contextual issue is the state of the health system. That is, a health system that is strained and regarded as on the verge of collapse.

At the end of 2020 it became evident that, the pace and rate of UTT policy implementation did not meet the set policy ideal of rapid HIV treatment programme expansion and targets. Studies were conducted to determine facilitators and barriers in the policy implementation process and their recommendations include strengthening the health system, policy making process, leadership, as well as improving staff morale.

2.12. Conclusion

This literature review has established that AIDS interventions are largely influenced by global agreements which are drawn from tried and tested good practice. The duties of each member state are to implement agreements locally, as part of their contribution to the global imperatives. This is done through the development or refinement of local public policies such as UTT Policy as an intervention to reach UNAIDS 2020 targets.

The changes in South African AIDS policy landscape have been filled with contestation for access to treatment and developing inclusive governance structures. SANAC has emerged as a legitimate governance structure that bring civil society, business and government in a fight against AIDS but may have had an unintended consequence of producing policy elites.

Despite the enabling policy environment, South Africa failed to meet UNAIDS 2020 targets. A wealth of research has been conducted to determine facilitators and barriers in the policy implementation process. These studies identified barriers including limitations in central policymaking, health systems limitations and low motivation to implement policies by front-line workers. While all this are important, these findings are not new or unique to UTT policy. They should have therefore been identified as risks in the policy development process. In future research it would be important to determine the impact of efforts to mitigate systemic health problems including health system collapse and low staff morale.

The focus of this study is on selected policy pathways and its impact on staff working in the service delivery front line, particularly the ambiguity of morale to implement the policy. This in turn impacts on local policy success and South Africa's set contribution to the global goals as outlined in the Political declaration on ending AIDS that was signed in 2012.

CHAPTER THREE

THEORETICAL FRAMEWORK

3.1. Introduction

In this chapter Max Weber's theory of Bureaucratic Management is outlined as the theoretical framework for this study. The theoretical paradigm where Weber's theory ascribes to is highlighted at the onset, followed by Details on key concepts of Weber's theory, their relationship and critique. This is followed by an outline of how Max Weber's theory of Bureaucratic Management is applied in this study. This provides a rich framework to guide the research process and deepen analysis, thus contributing to scholastic rigor while ensuring that focus is retained.

3.2. Functionalism

According to Smith (2010), functionalists view the society as an organism, in which each of its parts serve a particular function. Each of the parts depends and is dependent on others, making all parts work well together in the interest of the whole organism. Changes in the organisms are like evolution; they serve to gradually improve the organism over time, without disruption. Functionalists see the society as composed of a series of social systems, that are maintained through rules and regulations that the society imposes upon its members. According to functionalists, the society also internalises socially approved values, expected behaviour patterns, and codes of social existence. The process of internalisation occurs in the social specialist institutions such as hospitals and schools that work together for the good of the whole society (Esmaeili et.al, 2020).

Emile Durkheim is considered a father of functionalism. His ideas were furthered by Talcott Parson a third-generation functionalist that is lauded for his expansion of the functionalist views, in his effort to understand social action and social systems. According to Parsons as cited in Schwandt (2010), society is maintained by stable social patterns, with all parts of society working together harmoniously, and change occurs gradually to meet new demands or as a part of improvement just like in

evolution. Parsons viewed most of what happens in society as inevitable and saw society as good.

Parsons was primarily interested in maintaining social order and critiqued for ignoring conflict as well as change (Schwandt 2010). This influenced the work of Merton, a student and successor of Talcott Parson. According to Adler & Laufer (2020) Merton postulates that societies' tensions and conflicts may contribute to dysfunction. This was because while all institutions and societal patterns served in functions that they were designed for, they also had unintended negative consequences, this presents as both chaos and order. An example of this, which I will return to later in this chapter, is that regulations in a bureaucracy are intended to instil order but they tend to confine staff by taking away their room for creativity. This is best demonstrated in Merton's anomie theory.

Anomie is based on Merton's belief that each society has set pathways for reaching certain goals, but individuals in society have several choices including, conforming to both the proposed societal pathway and goal or rebelling against both. This is when others choose what he called anomie. Anomie is when an individual either embraces the societal goal and finds a new pathway there or take the pathway but choose a different end goal. The perception that there is only one set way to get to a goal limits creativity and innovation (Merton, 2017).

The focus on institutional specialisation on the greater good of society results in the, legitimation of authority, as it strengthens nation-states and corporations" (Adler & Laufer, 2020).

The South African state, like most nation state, is based on the bureaucratic authority model. The focus of this study is on the impact of the bureaucratic authority's hierarchical policy decision-making on policy implementation in the South Africa state. Therefore, I employ Max Weber's theory of bureaucratic management to inform and guide ventures in this study. Weber (1966) predicates successful institutions as rational, authoritative, well structured, have skilled staff, and operates within clearly defined powerlines that are respected by all. The theory of bureaucratic management helps in understanding the epistemological roots of most organisational and public management approaches (Wendt, 2016).

Weber is regarded as the most influential scholar in the field of bureaucracy, and has been linked to various organisational theories, public administration, governance theories as well as change management theory (Byrkjeflot, 2018). He is lauded as well as he is critiqued. In this chapter I will draw on Weber's theory of bureaucratic management, and his critique to deepen our understanding of the operation of bureaucratic institutions and locate my research problem within a sound theoretical framework.

3.3. Max Weber's theory of bureaucratic management

Weber's theory of bureaucracy was borne out of his observation and historical review of the transition to industrialisation from an agrarian society, dominated by institutions that were founded and operated by families. In Weber's view the change from families as a productive unit to mass employment came with inevitable change in how organisations were operated and managed (Baskurt & Demirci, 2022). The argument that changes in society effect changes in institutions and vice versa is echoed by Parson's theory of functionalism. Schwandt (2010) sees society as system that is made up of many interrelated components such that a change in one component creates a change in others.

That is, the patriarchal leadership system that is based on kinship and personal relationships in agrarian society was replaced by rational, impersonal institutions where all are treated as equitably, based on laws in industrial society. Just as business moved from being operated in personal homes to dedicated business sites.

Byrkjeflot (2018) postulates that Weber was primarily concerned with how people organise and sought to relate organised action to the given historical and political cultural context. He employed a historical lens to review and synthesise how action was organised in capitalist industries in his home country of Germany as well as the USA. In so doing Weber sought to reveal cultural and historical variations, and on that basis, developed multidimensional explanations for specific trajectories of historical development. He understood that organisational practices are rooted in political cultural dynamics and that, "…social values, institutionalized structures and elites," have a marked influence in certain geographical areas, at different points in time, and specific fields of work (Byrkjeflot, 2018:29).

Weber concluded that modern organisations are better than traditional organisations and what sets them apart is that they are, 'rational organisations.' Rational organisations are bureaucratic. Serpa and Ferreira (2019:13) understand bureaucracy to be a process of formalisation, wherein elements of operations are redefined and reclassifies to ensure increased, "…control and direction, enabling the extension of the modern institutions". Therefore, Weber proposes the concept of bureaucracy in a context in which he considers rationalisation of society as inevitable (Pollitt, 2008) and offers this theory as an ideal-typical concept.

3.3.1. Bureaucracy

Wren and Bedeian (2020:462) define bureaucracy as an ideal management system that provides the highest degree of efficiency. Thus, demonstrating the most rational form of institutionalised authority over people. While some may argue that Weber's original text did not contain the word efficiency or any meaning associated with efficiency, efficiency was the core driver of industrialisation and most modern-day institutions. The rationale for the introduction of industrial machines was to increase production pace and quality.

Weber's bureaucracy is an ideal type which has specific features and criteria that sets it apart from historical family-based institutions (Florian, 2018). Baskurt and Demirci (2022:668) list the following features of an ideal type: "…certainty, speed, sustainability, obedience, and impersonality." Fukuyama (2013:52) sets out the criteria for bureaucracy as, "…a separation between private and official property, impartiality, a strict division of labour also known as meritocracy, institutionalized memory, and routines for maintaining organisational integrity or autonomy and hierarchy."

In a bureaucracy the place of business is separated from a home and so are the resources and property. This sets boundaries that ownership is not private, making it impersonal and setting a tone for all to interact in a 'neutral setting' where none has more power and access than the other (Feeney & DeHart-Davis, 2009).

In historic institutions, kinship and role in the family are keys to decision making power and access, while all are treated equally in a bureaucratic institution and rules, qualifications and competence are what drives decisions and maintains integrity in

bureaucratic institutions. All members respect authority, and those in authority give instructions in a lawful manner while allocating tasks fairly to each member to enable the institution to meet its goals. There are written rules to support and reinforce authority (Baskurt & Demirci, 2022).

A hierarchical structure, that has a strictly defined ordering pack, and role definition is also a key feature of bureaucracy. Yilmaz and Telsac (2021:47) highlight that power is centralised for," …coordination, and within the framework of the chain of orders, the upper unit is given the authority to give orders to and to control the lower unit."

Weberian scholars agree that Weber provides for more than one type of bureaucracy. Meier (2019) suggests that Weber implicitly referred to two types of bureaucracy. The first type being representative form of bureaucracy, based on the rules laid down by agreement and technically justified as well as administered by specialists. The second type is called punitive bureaucracy, based on the imposition of norms and on pure and simple obedience. This is echoed by Baskurt and Demirci (2022) who named the former rational bureaucracy and the latter patrimonial bureaucracy. The divisions of bureaucracy by type highlight how bureaucratic rules and structures are developed, which determines how they are perceived and experienced wherein bureaucratic agreement is presented as better than imposition.

A further yet slightly different distinction of bureaucracy is offered by Silberman. Silberman identified two distinct types of bureaucracy namely, professional, and administrative (Byrkjeflot, 2018). Professional bureaucracy is built on technical knowledge of the field of focus, while administrative bureaucracy is concerned with acceptable norms, standards and rules that make organisations effective

While the value of bureaucracy is clear, it is also important to highlight how it reinforces and recreates power amongst a few elites. Weber (1966:24-26) highlights that, "…bureaucratic organisations, or those in power tend to become even more powerful by the knowledge that comes from the practice that they attain in the function." This suggests that bureaucratic organisations have potential to produce and sustain bureaucratic elites. Baskurt and Demirci (2022:667) assert that, "…formal rationality is bureaucracy and that the organizational apparatus in the form of legal-rational

authority is bureaucracy." Therefore, we cannot fully comprehend bureaucracy without examining rationality and authority.

3.3.2. Rationality

Rationality involves the increased, "…use of information to have more control over the people and factors around them within the framework of the impersonal relationships that exist between social actors" (Baskurt & Demirci, 2022:676). The use of information ensures that decisions are made objectively, with all options considered and not based on personal preference, opinions, and benefits. This explanation creates a perception that rationality neutralises contention for power (Raphael, 2014).

If we consider the possibility of contention for power, the meanings associated with the definition of rationality, then the above, becomes complex. An alternative meaning of the definition becomes the search and use of information can serve to attain and retain power as well as control. This suggests that while information legitimises decisions and actions it can also be used negatively. Therefore, it is of importance to ensure that sources of information are credible, reliable, and do not use misinformation to favour the elite.

The pursuit of knowledge to inform policies, decisions and institutional arrangement is known as evidence-based decision making. Evidence based decision making is common in modern day institutions and has brought forth fields for monitoring and evaluation as well as knowledge management. It consists, of technical knowledge, which provides extraordinary power for bureaucracy (Serpa & Ferreira, 2019).

Godoi et al. (2017) postulate that Weber was primarily concerned with the personal preference over taking cooperate interests. Bureaucratic rationalisation ensures that decision-making is impersonal and based on formal rules and regulations that are known, thus delineating cooperate interests from the personal (Serpa & Ferreira, 2019).

The primary aim of rational action is to limit uncertainty, thus providing a better sense of control. This creates a level of stability and predictability. The certainty that what you do will give you the desired result is important in ensuring good use of financial

resources and time. It also provides ease in replication at a broader range. The notion of evidence-based decision-making is borne out of rationality.

A practical view of rationality presents when exploring relationships between patients and doctors, wherein patients trust and depend on doctors' knowledge for their health, without doubt, question, and further investigation. This suggests that the institution is tried, tested, and proven to be reliable, consistent, and is trusted. Therefore, rationality also builds trust.

3.3.3. Authority

Baskurt and Demirci (2022:676) believe that "Weber's concept of bureaucracy is based on how people and institutions generate and maintain authority." If one looks at the definition of authority without looking at power, authority seems all encompassing, peaceful, and homogenous. To build an in-depth understanding of the concept of authority, Weber was greatly influenced by political science concepts of power, and he asked a question, "Why people obey?" This resulted in Weber defining power as, "…the ability to force people to obey and do things they do not desire" (Heiskala, 2011: 242). The definition of power suggests that there is some trade off as well as winners and losers. This is because, one is forced into doing what they do not desire. This suggests that there is a level of resistance that is suppressed. The exploration of why people obey, introduces the concept of power which demonstrates that the centre is held together by gentle tension.

Authority is defined as, "…legitimate, that is, consensual power" (Baskurt & Demirci, 2022:676). This suggests that there is consent from all parties to the set rules that govern the use of authority. Those in power use their delegated authority well and their subjects willingly submit to their authority.

Three types of authority are identified and broadly agreed upon by several Weberian scholars: traditional, charismatic, and legal-rational authority (Haugaard, 2018). Leaders in traditional authority are born into their roles and are obeyed if their ways conform to tradition. Charismatic authority leaders rise to authority by their ability to inspire people. This describes most leaders of revolutions. Yilmaz and Telsac's (2021:44) understanding of legal-rational authority, is that "…since people's obedience

is based on laws, legitimacy comes from laws, and it is said that this type is the most effective type of authority." They believe that leaders are seen as servants of the people who are bound by and obey the law. Legal rational authority is lauded as the ideal type of authority because it," …stems from the rule of law" (Beetham, 1991:39) and is also known as bureaucratic authority.

3.4. Interpretations of Max Weber's bureaucratic management

Most modern day organisational and public administration theories are based on Weber's theory of bureaucracy and its criticism. This has earned Weber recognition as the father of organisation theory and public administration (Byrkjeflot, 2018). These includes the widely accepted and applied new public management (NPM) theory, institutional theory, and organisational theory. Weber's theory also informed Parson's theory of social change.

NPM theory is concerned with organisational efficiency, effectiveness, and economy (Kuipers, 2014). NPM advocates for inclusion of stakeholders as a key to efficiency and sustainability. It is the latest in a series of theories that are drawn from the public management theory.

While organisational theories seek to understand how different units or organisations relate and connect with each other, institutional theories are concerned with how organisational structures, values, and norms connect to the broader as well as external social and cultural environment. All the above share Weber's need to understand how organisations work, emphasising different elements of his theory while opposing and critiquing some.

The rationale and approach behind other theorists brought contrasts that deepened Weber's theory while raising sharp criticism. Key amongst these is Parsons, who significantly expanded Weber's work in his theory of social change. Parsons wanted to develop a theory that could be generalised and applied across cultures, while Weber sought to understand organisations applying a historical lens, looking at individual cases, with an understanding that socio-cultural factors would have an impact.

Parsons views organisations as part of a social system and sought to understand their contribution to the society, as well as how society affects them (Schwandt, 2010). He

believes that the society was in a continuous struggle to maintain equilibrium and a primary catalyst for social change is a struggle to maintain equilibrium.

A key distinction between Parsons and Weber is that Weber's focus is primarily on hard rules while Parsons explores how such rules sustained the social system. In his theory of functionalism, Parson postulates that the society functions best when members conform to societal rules, values, and behaviour patterns. Parson's theory also explores why and how social change occurs and the role that institutions play in this regard (Sciortino, 2021). The good governance model that promotes spontaneity, flexibility, and authenticity in public administration is also informed by Weber (Fukuyama, 2013).

3.5. Criticism of Max Weber's bureaucratic management

Having considered how Weber was affirmed and has positively contributed to the body of knowledge, I now turn my attention to his critiques as this deepens my ability to meaningfully apply the theory. The most difficult criticism of Weber's theory to dispel is that times, the nature of societies, administrations, and governments have changed significantly since his theory was coined (Byrkjeflot, 2018). This critique is based on the context of modern time interpretations of Weber's theory by his proponents and detractors who offer a more contextually relevant interpretation.

3.5.1. The ideal type

The notion of Weber's theory being regarded as the ideal type gives the impression that it is a panacea for all organisations which can be generalised and duplicated, which was not Weber's intent and in the theory's capacity. Parsons saw that the theory needed to be adapted to different socio-economic situations, as each organisation affects and is affected by society. Therefore, he set off to develop a more adaptable theory. The ideal type was also critiqued by many organisational theory scholars such as Merton. Merton argues that Weber implied that his theory improves efficiency (Swedberg, 2018).

3.5.2. Hierarchy

Weber's emphasis on the hierarchical structure has been widely critiqued for reasons including its focus on the higher echelons and its impact on organisational culture. Weber placed less emphasis on organisational members. Members' opinions, and actions were not tested or considered. There was a general perception from Weber that all leaders and followers are rationale exemplary beings, who can manage and stand above personal opinions and needs that are not contrary to organisational rules (Wendt, 2016).

The impact of the top-down approach was broadly critiqued by management scholars in the 90s. The critique was mainly focused on that it creates a dichotomy between management and staff, to meaningfully contribute to binding decision-making including policies and laws (Boltanski & Chiapello, 2005). Therefore, there was no space for expression of experiences and contributions of staff outside of management, in improving the work process and organisation. Their contextual knowledge at the coalface of service could only be expressed through managers who lacked first-hand experience. According to Meier (2019) basing bureaucracy on democratic processes, is a better alternative that encourages cooperation.

3.5.3. Formal rules

Formal rules and procedures are created to ensure clarity and consistency in the workplace. This guide and control all operation including day to day functions. Pimentel (2012) highlights that, challenges with formal rules stem from inconsistent interpretations of the law and acting outside of the law, which can also be called informal laws. According to Paul et.al. (2015), acting outside the law includes adaptation or replacement of formal rules with informal rules that are created by staff to ease operations. Merton describes working outside the rules as a sign that members of institutions must adapt to survive. Adaptation of laws by some members affects and changes the institution. This is because institutions are like, "…living organisms that evolve and adapt to survive" (Byrkjeflot, 2018:17).

The above indicates that the existence of formal rules does not equate to utilisation and implementation. Laws are only used where they contribute positively to the staff

working experience and are therefore valued. Adaptation and replacement of the formal with the informal is a consequence of the "…lack of flexibility that can be gained by unofficial adjustments to formal rules" (Giddens, 1997:355).

Merton contends that unintended consequences of laws and routines is over conformity (Krisp, 2012). In these instances of over conformity, staff cannot take initiative and use their discretion when necessary. Over-conformity is also called trained incapacity. Paul et.al (2015) believe that the ignorance of the human dimension including a sense of agency, and creativity is said to trap staff in a red tape also known as an iron cage. A classic case of these occurs when dealing with most call centres wherein call centre agents fail to answer simple queries that require minimal diversion from the official scripted responses (Byrkjeflot, 2018).

According to Weber (1966 as cited in Godoi et al., 2017:436) the solution to over conformity, adjustment, and replacement of formal rules with the informal is, "…for an employee to object to an erroneous rule or directive." In a bureaucratic hierarchical structure this may be difficult to achieve unless it is set in rules and the organisational culture promotes bottom-up communication.

Werbel & Lopes (2009) recommends that a healthy cooperative relationship between superiors and subordinates facilitates the establishment of legitimate orders that have better prospects of holding. An understanding of how rules are contested and legitimised is critical to understanding the organisational structure (Paul, et.al., 2015). Without this understanding, rules function as an end in themselves (Giddens, 1997).

3.5.4. Democracy and bureaucracy

Albrow (2014) postulates that Weber's theory of bureaucracy fails to capture the nuances behind a well-functioning government and the power dynamics which are significantly complex. This is because bureaucracies in democratic countries are borne out of inherently conflictual political contestations. Such contestations and power struggle shape what the public considers a social problem (Wedel, 2017).

Public policy making process is believed to be a rational ideas-driven process. Rationality undermines political process that policies are developed from, which is characterised by contestation and power struggles (Raphael, 2014).

Mill (1956 as cited in Albrow,2014) contrasts democracy from bureaucracy by exploring the representative power and the political economy. In a democracy, legitimacy of authority is from the bottom up and is sustained by appeasing those at the bottom. This challenges Weber's (1966) notion of bureaucracy who views hierarchical authority as from top-down.

Dahlström and Lapuente (2017) postulate that a separation of politics and administration in the state depoliticises service delivery while acting as a buffer to corruption. While administrations in most countries are structured in line with the recommendation of separation, this appears to be mainly in principle. The political leadership sets out government priorities and develops policies, while administrative leadership manages technical staff that implements such policies. Since political leaders are appointed to account to, they have influence, power, control, and legal authority over the administrative leadership.

The hierarchy in democratic governments have political heads at the top, administrators in the middle, and staff that are employed in the coalface of service delivery are at the bottom. Those working in service delivery public services, which often require a high level of technical skills that benefit the entire community. They are held in high esteem by the public as well can influence public opinion and are gate keepers for services. They are the only window through which the public experience government and are ipso facto the face of the government to the electorate.

The cadre of public servants have power and agency through representative associations and cannot be simply held hostage by the iron cage of stringent bureaucratic rules and hierarchies. When they feel trapped, they then promote incompetence (Paul et.al, 2015), creating a whole new set of challenges in the system. This challenge is best expressed as bureaucracy, causing a growing impersonality in the social relationship, and consequently disenchantment of the world. The dynamic flow of power across interest and representative groups within a bureaucracy are as important as understanding the political economy (Matti & Sandström, 2011).

3.6. Application of Max Weber's theory of bureaucratic management to the UTT policy of the South African government

Rationality is at the core of bureaucracy. A rational decision is one that is based on information without personal considerations (Baskurt & Demirci, 2022). The global policy position to provide universal access to UTT services was based on empirical research. South Africa's adoption of the global UTT policy was therefore rational. The local law (UTT policy) to further the country's commitment was made by the minister who had legal authority, to do so. The UTT policy pronouncement, did not follow a regular law-making process. There was no consultation and consideration of political cultural dynamics at the coalface of service delivery. According to Friedberg (2011) this is a punitive type of bureaucracy as rules are imposed and not collectively agreed upon as would be the case in representative bureaucracy.

Weber (1966) postulates that clearly defined roles and hierarchies of power and authority are essential elements of a rational and efficient government. This suggests that all who are employed based on their qualifications should do their job at their allocated level of power and authority**,** as prescribed by those in higher power and authority. This effectively states that the Minister of Health was within his right and delegation within the bureaucratic hierarchy to bring forward the UTT policy pronouncement. He is the duly appointed executive head. All others including HIV clinicians should do the jobs that they were appointed to do in line with the limits of their mandate. Any deviation from the mandate of employment muddles the hierarchies of power and authority, making the organisation less efficient.

Weber contends that the understanding of bureaucracy cannot be outside of an exploration of the political-cultural dynamics. In this case the application of the political cultural lens reveals that the decision was made by the minister who is a political elite as swayed by AIDS elites, transnational politics, and global AIDS diplomatic pressure, which demands constant reassurance that South Africa has moved from the AIDS dissident history.

In a democratic country where laws are made through inclusive consultative processes, from the bottom up, the UTT policy was an anomaly. The expectation for those in the front line of service delivery to follow the laws that impact on their work, traps the staff

in an iron cage. This places the policy at risk of being adapted to fit the service delivery context, be completely replaced by informal laws, or render those in the coalface of service delivery incompetent. This is a classic case of a conflict between professional and administrative bureaucracy which were distinguished by Silberman as quoted in Byrkjeflot (2018). The conflict creates a division between professional staff that have technical knowledge and administrators who create and enforce organisational standards. This division is the reason why the top-down approach has been extensively critiqued (Boltanski & Chiapello, 2005).

Weber's theory of Bureaucratic Management together with its critics offers a sound framework for understanding the impact of the interface between the policy development process and policy implementers. This is as the theory provides rationale and intent for a rule and how they are developed. It also sets forth the meanings associated with rules by those who are charged with implementing the rules and how these impacts on their choice to act within the rules or create informal rules.

3.7. Conclusion

In this chapter that the study interfaces between people and policy change can best be understood from a functionalist perspective was highlighted. Key elements of Weber's theory of management including bureaucracy, rationality, and authority were discussed at great length. This included incorporating views from other functionalists, such as Merton, and Weberian scholars and detractors.

The chapter was concluded with a discussion on considerations for application of Weber's theory of bureaucratic management while exploring political-cultural dynamics including transnational politics and the democratic South Africa that has a history of AIDS dissension.

CHAPTER FOUR

RESEARCH METHODOLOGY

4.1. Introduction

This chapter discusses the research methods that were used for this study. This entails a detailed plan that was developed to conduct this study including, the elected research approach, associated planned activities, research instruments, reasons why these were selected and measures to preserve validity. Research methods determine how the research is conducted. and with that the knowledge that is produced (Patten, 2016). The presentation of the research design, in this chapter, is followed by an account of the implementation process, detailing what worked or did not work as planned, how this was mitigated, and the impact thereof on the study's outcomes. A description of advantages and limitation of each decision are also highlighted.

4.2. Research setting and target population

There is a national study that is located in the DoH, South Africa. The study explores the impact of policy making process on policy implementation from the perspective of implementers working in the coalface of service delivery. The focus area in health, is on HIV and AIDS, a national and global AIDS emergency, that impacts on global socio-economic stability. Within HIV and AIDS, the primary interest of the current study is on the UTT policy, which was formulated in 2016 out of South Africa's ratification of the UNAIDS 2020 targets, a key milestone in ending AIDS by 2030. UNAIDS is charged with monitoring UN member states' progress in meeting its targets. Therefore, successful policy implementation has implications for the DoH and how it is globally perceived.

DoH employs several healthcare practitioners and workers to support policy implementation. This includes policy practitioners, managers, and a whole range of front-line workers. The study does not focus on all implementing staff, thus making it important to define the research population. Bless et al. (2006) describe the research population as, "…the entire set of objects and events or groups of people which is the object of research and about which the researcher wants to determine some

characteristics about." The definition of a population is an important component of the research as it influences research design choices.

Furthermore, a research population further sets forth who the focus of the research is and why. This safeguards against asking questions to groups who would not have direct information about the study. An example would be asking a security guard about the impact of changes in policy in his work, while he may not even be aware of the policy and there is no link. Within the identified population it is also necessary to appropriately identify the target population by defining the essential elements of the target population (Patten, 2016).

In this study, while I recognise that there are many health workers that are affected by HIV and AIDS policies in their studies or practice while working in private or public practice, academia, or policy development, I am not interested in all of them. Instead, doctors and nurses that are employed in public health facilities across South Africa are the objects of the study. Therefore, are my target population. Hence, the elements of my research population are defined as doctors and nurses that work in the public health sector. I am also interested in deciding on whether gender has an impact on responses, thus the ability to determine and ensure equal participation of participants across gender groups is the second element of my research population.

All the participants that I targeted have formal education as either professional nurses or doctors that are registered with a professional council and are employed in the public service. They also had additional training or experience managing people living with HIV. The focus of the study is on the middle class, but its findings will have implications on the quality of health services received by those in the lower economic class in both urban and rural setting. It will also have a bearing on the participants and employers who are charged with policy implementation, the DoH who is the policy custodian, and South Africa's global diplomatic agency where country UTT policy implementation is monitored.

4.3. Research design

Asenahabi (2019:77) postulates that research design is an, 'overall plan for connecting the conceptual research problems to the pertinent and achievable empirical research'.

Research design effectively details activities that are undertaken to answer the research question using information that is collected in a scientifically sound manner, based on the research aim, contextual factors, and resource availability. Therefore, this segment lists details of practical decisions made to conduct this study.

4.3.1. Descriptive research

While the study objectives were outlined in the previous chapters, it is important to restate the research aim because it determines the employed type of research design. The aim of this study is obtaining information on HIV clinicians' perceptions of the UTT policy and their impact on clinicians' willingness to implement the policy. Therefore, the study describes the impact of HIV clinician's policy perceptions on their willingness to implement the policy. Therefore, this is descriptive research. Descriptive research places emphasis and details an event or repetitive characteristics (Siedlecki, 2020). Descriptive research can include a narrative account sourced from analysing interviews and or a structured statistical analysis that can be drawn from a survey.

4.3.2. Research paradigms

4.3.2.1. Interpretivist paradigm – qualitative research

A narrative account is also known as qualitative research. According to Roulston & Choi (2018), qualitative research methodology provides space for explanations. The explanations draw out cultural meanings and social realities from the participants' perspective. Explanations can bring out a deepened understanding of phenomenon under investigation based on the lived experiences of the participants. Qualitative research allows participants to shape the narrative and gives the researcher some room to adjust their initial line of enquiry based on new information. This must be done with caution as there is an inherent risk that the researcher may completely veer off the objectives of the study (Patten, 2016). However, they can be mitigated by thorough planning and preparation for interaction with participants, that keep the researcher in check.

Qualitative research is drawn from the interpretivist tradition which believes that social science research must be based on an understanding that people change regularly

which causes their interpretation of the world to also change, (Chowdhury, 2014). Therefore, an attempt to understand any phenomenon in the world starts with an enquiry on how people see and interpret their world. This is echoed and best explained by Fossey et al. (2002), who regard interpretivist approach as based on subjective meanings that are attached to practices, in a defined context.

The above suggests that meanings are complex and similar practices can have different meanings, based on the person giving the meaning as well as the context within which the practice occurs. Therefore, meanings are not definite. Since the researcher also makes meaning and interpretations of the interviews, this poses a risk for researcher bias that must be managed. The researcher who conducts the interviews also has personal, interpersonal, and political values that shape their interpretations (Roulston & Choi, 2018). The roots of the interpretive social science can be traced to Max Weber, whose theoretical framework of bureaucracy is the anchor in this study (Chowdhury, 2014).

This study is aligned to the interpretivist paradigm through the employment of semi-structured interviews for respondents that volunteered following participation in the survey. The semi-structured interviews prevented the researcher from veering of course, while allowing the participant freedom to answer. Questions were developed based on lessons learnt from literature and gaps identified in the survey phase.

4.3.2.2. Positivist paradigm – quantitative research

In a structured statistical analysis, the researcher is detached from the process and the focus is on objectively measuring the variables. This is also known as quantitative research. Quantitative researchers believe in using numbers to understand things (Bloomfield & Fisher 2019).

The use of numbers to interpret behaviour is closely associated with statistical analysis, a natural science phenomenon, that is seen as definite, controlled and objective. The focus on control lends quantitative methods to closer association with the positivist paradigm. Alharahsheh & Pius (2020:41) see positivists ‘working with observable reality within society leading to production of generalizations. Positivism focusses on the importance of what is given in general, with more strict focus to consider pure data

as well as facts without being influenced by interpretation of bias of human'. This means that research statistics with a hypothesis or assumption in mind and all activities that the researchers engage in are aimed at confirming or disproving the hypothesis.

Positivists believe that social scientists must follow similar principles to natural sciences wherein researchers are objective in their pursuit to seek universal laws. In this regard, objectivity is based on the maintenance of distance between the researcher and subjects. This includes having a standard way to measure responses which has an added advantage of making statistical manipulations easy (Bloomfield & Fisher, 2019). Responses are measured in logical groupings known as variables, which can be easily statistically analysed.

Variables can be used to describe behaviour using statistical controls. Variables are defined as concepts that differ based on features such as measure, and strength (Patten, 2016). Each variable has attributes, which are values or categories associated with it. If gender is an example of a variable, male and female are its attributes. Variables make it possible for social attributes and perception to be quantified and statistically analysed. The application of statistical analysis to social sciences brings forth many statistical hypothesis tests, including chi-squared tests and standard deviations (Bloomfield & Fisher, 2019).

In this study the Pearson correlation coefficient is used to test whether there is a significant relationship between years in service and the motive to implement UTT policy as prescribed. Data used for this test was derived from survey responses. This is a questionnaire containing various scales that are used to ease the strength of response, data capturing and analysis. The Likert scale which measures perceptions based on intervals was amongst the scale used. The use of tools including a questionnaire, inferential statistics demonstrated that a positivist paradigm is employed in this study.

The search for control in participants' responses, as emphasised by the quantitative research paradigm, is one of the key limitations. Control limits and contradicts a key feature in social sciences, that is the ability to understand the world from participants' perspectives, and this places participant into predetermined categories. Thus,

participants' lived experiences that are explored through qualitative paradigm can be affected by the researchers own lived experiences. Yet, bias based on researchers lived experience is minimal in quantitative research. For the current study, to obtain maximum advantages enshrined in both quantitative and qualitative methods, while mitigating associated disadvantages, a mixed methods approach was employed.

4.3.2.3. Combination of methods

This study has a dual function of firstly, confirming the existence of resistance to UTT policy, and secondly, exploring how resistance manifests, is managed, as well as resolved. To effectively accomplish this dual function, it was necessary to adopt a mixed methods approach, which were implemented in two phases.

In the first phase, quantitative methods were employed to determine the existence of resistance, and causes thereof, using variables that are pre-selected based on the literature review. In this phase, I used the methods that were based on its strength of testing assumptions as recommended by Patten (2016). The variables include the policy process, and a causal link between clinicians' length of service and resistance.

Information received in the first phase was analysed and used to inform the second phase. This includes areas that need further probing, as well as the correct language or terminology. Furthermore, an opportunity for those who were willing and available to participate in the next phase of the study was provided in the first phase. Thus, providing a natural link between the phases. The freedom to choose to participate or not in the next phase was a basic right of each participant, and a critical ethical consideration (Ginghina, 2024)).

In the second phase, a more qualitative approach was employed to deepen knowledge in areas highlighted in the first phase. Particularly, what caused resistance to policy, as well as how resistance was manifested, managed, and resolved. This was an opportunity for participants to share their experiences, opinions and meanings associated with the study (Roulston & Choi, 2018).

The phased approach ensures that we draw strengths from both methods, while using each method to mitigate the risk of the other. This enabled the study to be both broad

and deep as quantitative research reaches many people with standard information that is easily analysed, while the labour-intensive qualitative method gathers detailed accounts which may not have been anticipated in the questionnaire design (Patten, 2016). The added advantage of mixed methods is that it improves validity as highlighted later (Patten, 2016).

4.3.3. Research tools

The selection of research tools followed a decision to employ a combination of quantitative and qualitative research methods, considering the context in which the study was conducted, which included the risks related to COVID-19. This resulted in online surveys selection as the best suited quantitative research tool, while semi-structured interviews that were conducted online are a complementary to the qualitative research tool of the survey.

4.3.3.1. Survey

Surveys are the most frequently used research tools in the social sciences and in descriptive studies. Bloomfield & Fisher (2019) highlights key advantages of using surveys to include the ability to reach many people, located in multiple locations, with the same information, in a short time, and with minimum effort. Surveys also allow efficient data collection and analysis (Paradis et al., 2016), this is amplified when an electronic self-administered survey is used.

Self-administered questionnaires are completed by respondents without assistance and are best suited to adequately literate respondents (Bloomfield & Fisher 2019). The cost of conducting a survey is also low and self-administered surveys make populations that are generally too busy to meet, easily accessible. Surveys were a good fit for this study which targeted professionals, has national reach, and is carried out using limited resources. The low response risk that is associated with using self-administered questionnaire is mitigated by a series of follow up emails, that contain the survey link.

The additional benefit of using electronic surveys is that it eliminates the tedious use of paper in clinicians' daily routines, while enhancing privacy. Responses are captured and collated on completion, thus eliminating human error, while facilitating for

immediate data availability to enable live response rate tracking. The questionnaires were self-administered using a smart phone or laptop. The electronic survey included many statistical features which ensure that responses were collated on survey completion and inbuilt validity rules prevented human errors while entering data (Engard, 2009). The efficacy of this measures was tested in questionnaire piloting. Questionnaires were electronically distributed to a hundred clinicians as sampled.

4.3.3.2. Interview

Roulston & Choi (2018) describe a qualitative interview as, a semi structured discussion between the interviewer and a respondent where in the interview has prepared questions. Therefore, interviews provide space for questions that may be difficult to answer, in a manner that allows participants' views to form the next series of questions. A key advantage of interviews is that it provides a more detailed account, using the participants, which gives deeper meaning and understanding of the contextual factors.

Interviews also provide the researcher with an opportunity to probe and ask questions that were initially unanticipated. The opportunity to probe, provides for misunderstanding to be cleared and additional information to be sought. (Bless et.al, 2006). To affect this advantage the interview guide was revised based on formative survey results.

The disadvantage of qualitative research is its dependence on the researcher's ability to remain objective when in the face of participants that are contrary to their values (Roulston & Choi, 2018). This is as according to Fish (1990, in Gasa, 1999) the researcher's interpretation is also influenced by their social context, and political values. Bias can be mitigated through the researcher's awareness of their possible bias, declaration of interests, and commitment to ethical research values. This was mitigated by piloting the interview guide with skilled researchers that have knowledge of the HIV and AIDS field.

I chose semi-structured electronic interviews as the best suited tool to complement and deepen knowledge on trends identified in the survey. Semi-structured interviews list issues for investigation before the interview, thus ensuring that all critical elements

are addressed (Bless et al, 2006). The list is not followed logically, but is used to provide a guide. Semi-structured interviews ensure that the researcher remains focused while giving the participant an opportunity to answer in their own words (Paradis et al., 2016). They also mitigate common errors that may be made by an inexperienced interviewer to stray from the topic.

Direct contact with the interviewee removes a layer of privacy. Interviews also take longer to conduct, transcribe, and interpret (Roulston, & Choi, 2018). It is recommended that full transcription be done to facilitate an easy way to note key points from the interview, although this undermines the contextual meaning. That said, some interviews may take up to six hours to transcribe using classical methods (Paradis et al., 2016). The long transcription time in this study is mitigated using Express Scribe an Artificial Intelligence tool used by editors.

4.3.4. Sampling

Sampling is the act, process, or technique of selecting a suitable sample, or a representative part of a population for the purpose of determining parameters or characteristics of the whole population (Verma et.al, 2017). Sampling allows the researcher to select a smaller and more manageable group from the overall population, to participate in the study. Earlier, I established that, people who had the characteristics that I wanted to study were professional nurses and medical doctors that provide Antiretroviral Therapy (ARV) in public health facilities, whose gender was known (Venter, 2013). There is over 100 000 doctors and nurses that are currently employed in over 4000 public health facilities across South Africa (Statistics South Africa, 2022). This number was far too big to reach with my study's limited capacity and resources.

Therefore, I sampled a subset of the population that I focused on studying, without compromising the ability for the study to be generalisable. Notwithstanding, generalisability is dependent on fair selection (Emanuel et al., 2004). Therefore, in this study I used simple random sampling to provide all members of the population with an equal chance of being selected for participation.

Participants that had participated in the survey and willing to continue participation volunteered to be interviewed. Voluntary participation presents a risk of low response rates as 'the decision to participate strongly relies on respondents due to the non-individualized nature of invitations' (Vehovar et al., 2016:330). The utilisation of voluntary participation is convenient, efficient, and ensures that the participants have detailed information on the nature of the interview prior to committing.

A limit of 100 participants is imposed and regarded as reasonable, considering the resource limitations. However, this figure can be regarded as too small to be representative of over 100 000 clinicians (Werma et.al, 2017). To address this, I included interpretive approach.

A sample was drawn from the South African HIV Clinicians Society (SAHIVCS) members database. The total number of members registered on the SAHIVCS database at the time of this study was 10993, which served as a sampling frame. Those who were not working in public health facilities and had not disclosed their gender were excluded. Participants were further separated into professional nurses and doctors, to facilitate equal opportunity for selection of 50 doctors and 50 nurses, of which each staff category had an equal number of 25 males and 25 females.

A member was selected to participate in the study based on the number they appeared on the database. There was a total of 3874 doctors, of which 2004 were male and 1870 female. Every 80^{th} male and 74^{th} female was selected. A total of 1970 nurses were on the sampling frame of which 1647 were female and 323 were male. Every 65^{th} female nurse was selected as with every 12^{th} male nurse. Therefore, the selection of each member was based on the number on which they were placed at in the database, thus giving each person an equal opportunity for selection, in line with the simple random sampling method.

4.3.5. Analysis

This section outlines how I analysed this study's data. Data analysis involves making data manageable and easy to interpret by using calculations and visualisation (Wickham & Wickham, 2016). These provide the researcher with a better view and

ability to frame and draw insights from information received in a structured manner, thus increasing understanding, insights, and interpretation.

The choice of the process and method of analysis is dependent on the research type and methodology. The decision to employ mixed methods for data collection, complicates the method of data analyses because the type of data gathered in surveys differ from that which is gathered through interviews, thus requiring a different process of analysis. Data that was gathered in the survey is mainly statistical and was directly entered into Limesurvey which automatically coded, collated, and provided some statistical analysis. The data that was gathered through interviews first had to be transcribed, manually cleaned, classified, coded and analysed.

Data from the interviews were analysed using discourse analysis. Discourse analysis is a study of language in context (Gee, 2011). This is a complex method of seeking meaning beyond the obvious, it seeks deeper meaning from the analysed data. Discourse analyses is important as according to Paltridge (2012:34) it highlights the use of language as communicating beyond what is said to include different meanings based on where or how things are said. Discourse analysis draws meaning in context and is set out with a purpose in mind. Therefore, the purpose of discourse is more than just to communicate but influence and set a course for action (Parker, 1992 as cited in Willig, 2008). This suggests that the focus is not on what is and how it is said but to what end it was said. In discourse analysis the focus is less on the truth and more on the effect of the truth. This is known as a social constructivist approach. Constructionism's greatest advantage is that it can bring forth lived experiences of political choices, and their consequences. The disadvantage of constructionism is that the lived experiences of the researcher also emerge creating possible bias. This is mitigated by the researcher drawing a distance between themselves and the text (Paltridge, 2012).

A social constructivist approach to discourse analysis was therefore undertaken. The selected approach was rooted in Parker's interpretation of Foucauldian Discourse Analysis (FDA) which sets out steps to comprehensive data interpretation (Willig, 2008). This approach is best suited as our primary interest is on how power is interpreted and expressed which is in line with FDA.

Descriptive analysis was used to get the initial impression of the data collected while inferential analysis determines whether relationships exist and help the researcher draw conclusions about the population from the sample (Bless et al., 2016). Together, descriptive and inferential analysis provide population estimates, summary of responses and determine relationships between variables that are displayed in this study as descriptive statistics.

Descriptive statistics are tools used to present data in a user-friendly way. way. Descriptive statistics effectively reduces the volume of raw data that is received through a study, into a format that is easily understandable and usable. In the current study, the use of descriptive statistics was enhanced through the employment of Statistical Package for Social Sciences (SPSS) Version 27.

SPSS is designed with a view to 'ease statistical analysis for ordinary researchers' through the use of features including data management and data documentation (Rahman & Muktadir, 2021). Employing SPSS makes data visualisation easy, which enhances accuracy because outliers are easier to spot. SPSS also improves the ability to understand relationships and patterns including correlations (Knaflic, 2016). Bloomfield & Fisher (2019) see correlations measure the strength of relationships between two or more variables. elements. This is important as this study's aim is testing correlations between policy development process and resistance as well as years in service and resistance levels. Pearson correlation analysis (r) test was employed to determine the direction and strength of the relationship (Schober et al., 2018). Pearson correlation analysis is also included in SPSS capabilities.

4.3.6. Ethical considerations

Ethics are concerned with what is legitimate, moral, and acceptable or not. The focus and inclusion of ethics in research is aimed at making researchers aware of their responsibility to ensure that research is beneficial to all and does not contribute to abuse or harm. Research ethics according to Ginghina (2024:93) serve to 'establish norms, and principles of conduct applicable to public and professional environment'.

Primary consideration are the rights of a participant. The rights have to be respected, and they include privacy, anonymity, and confidentiality. Privacy relates to a person's

right not to disclose aspects of their life and to do so with full comprehension of the risks or benefits associated with disclosure. Expectations for privacy are different for adults and children. Consent can be sought directly when adults are concerned but parental consent is required for children. (Bless et al., 2006). The greatest burden that lies with the right to privacy is the ability to fully comprehend what consent means, which requires extra caution when dealing with vulnerable groups as undue pressure may be applied. Anonymity relates to that information that may identify the participant must not be shared in the research process and report (Ginghina & Silvia, 2024).

In this study all research participants were professionals, who had knowledge of the implications of participation in research. Therefore, they attracted lower risks of undue pressure. All participants were invited to participate at will using an electronically designed mail. The use of an email made it easy for some potential participants to choose not to participate. Prospective participants were provided with an information sheet and consent form to ensure that they understood the goals, process, and risk of the study prior to participation. Informed consent was sought from participants to affirm their understanding of their rights and risks in each of the two phases of the study (Gajjar, 2013). Participants could undertake the survey and elect to participate in the in-depth interview once after giving informed consent. Incentives and renumerations were not offered, thus eliminating the risks of coercion and undue inducement (Trimmer, 2016).

The nature of this study deals with compliance to standard procedures which all clinicians are measured against. The greatest risk in this study is that it may highlight that, clinicians were intentionally not implementing a national policy. This could subject them, their districts, and their provinces to prejudice, thus placing their employment at risk. Therefore, maintenance of absolute anonymity and confidentiality was critical. This was more so in the interview phase where participants disclosed personal information to facilitate direct interactions with the researcher (Bless et al, 2006).
Inviting participation from outside government, mitigates risks of prejudice for participants who wish to be vocal about not implementing the policies, that they are employed to implement. Therefore, a sample would be drawn from a database of outside government.

Anonymity and confidentiality were maintained by managing all inputs and responses as confidential and in the strictest possible virtual and physical security which included password protection. Access to the research material is restricted to the researcher and supervisor only.

Independent ethical review was conducted by the University of Kwa-Zulu Natal's Human and Social Sciences Research Ethics Committee (HSSREC). HSSREC approved the HSSREC/00005616-2023 application for ethical clearance in line with the university research ethics guidelines. Through the ethics application process the university keeps all researchers accountable and ensures that the ethical standards are met including, safeguarding research participants rights (Ginghina, 2024).

4.3.7. Design validity

The primary reason for a research design is to ensure that all processes undertaken to contribute to the production of a scientifically rigorous research. Lakshmi and Mohideen (2013:2753) assert that 'validity is the process of ensuring that an indicator actually measures what it is supposed to measure'. Validity is therefore concerned with measuring what we set out to measure accurately, without changing the meaning of that particular element or issue. A research design is the first step to ensuring that findings can be trusted, making design validity critical to the entire study. Design validity is concerned with the exclusion of other hypothesis that can result in the change seen as well as whether the findings are applicable beyond the sample and to the population and can therefore be generalized. The former is known as external validity while the latter is internal validity (Bless et al., 2006).

The selection of mixed methods is intended to enhance internal validity. The study has a hypothesis and assumptions that are developed based on literature review. The interviews provided space for alternative assumptions and hypothesis to be highlighted.

Research tool reliability and validity according to Tsang et al. (2017) refers to the tools ability to test what it sets out to test and produce the same results if retested under the same condition. This is achieved by developing survey and interviews tools based on lessons learnt from the literature and piloting them prior to distribution. Piloting or

pretesting the questionnaire, mitigates the common error of censoring a questionnaire that is ambiguous, lacks logical flow, and has leading questions (Tsang et al., 2017).

External validity is enhanced by employing random sampling and sourcing participants outside of government enhances external validity (Taherdoost, 2016). This mitigates undue pressure from clinicians to respond in a manner that is expected by their employer, which in this case is the government.

4.4. Field work report

This section details activities undertaken to conduct the study and how they were implemented or changed from the research design stage in response to factors encountered during implementation. These include how contextual, resource and capacity hinderances were overcome and what impact this had on the validity of the study.

4.4.1. Community entry

Negotiating access to participants is a critical component of any study (Patten, 2016). This is because the process of gaining access determines the community response to the project based on how information is first received. The knowledge of community dynamics including culture, problems, attitudes towards past research experiences, and gatekeepers is critical.

Gate keepers according to Uwamusi et al. (2023:1401), are middlemen that manage access to communities or groups that academics are interested in investigating." Gate keepers have responsibility, formal or informal power, or some sort of authority over people or places. Knowing and managing gatekeepers can facilitate or frustrate the research process. The DoH is the custodian of all health policies and employs HIV clinicians to implement the policy under review. While it may seem like, the most natural gatekeeper, previous studies have alluded to tensions between the departments management and staff. Furthermore, the current study has an impact on the department's policy making process and employer-employee relationships with clinicians, which makes DoH a stakeholder with vested interest in the outcome of this study. Stakeholders that participate in capacity building on the implementation of the

policy were identified in this study as best suited gate keepers to facilitate access to the research population that could be utilised to improve training.

I approached three institutions that had a track record for training HIV clinicians on policy changes, which maintains a database of HIV clinicians across South Africa. The institutions were: Foundation for Professional Development (FPD), Clinical Care Platform (CCP) and the South African HIV Clinicians Society (SAHIVCS). The terms of the request were the recruitment, sampling, and employment of the survey using their database, with a commitment to share the full dissertation and present the findings. FPD declined the request stating changes in organisational focus while CCP and SAHIVCS agreed.

Access to CCP database was unsuccessful as an agreement could not be reached on practical ways to provide access while safeguarding members personal information in line with Protection of Personal Information Act (POPIA). The POPI Act governs the protection of privacy for personal data, "…laws of data protection and privacy in South Africa". Proposed actions to continue with the research while upholding POPI were seen as sufficient leading to failure in continuing with the research with CCP. Measure to ensures that POPIA was adhered to while continuing with the research in SAHIVSA included, sending a sampling frame that only has membership, with features that can identify the members their names, professional registration number, and contact details removed. Contact with all participants was through SAHIVSA until the interview phase was concluded and respondents volunteered for one-on-one interviews.

4.4.2. Questionnaire administration

The questionnaire was sent to five people that had experience in HIV and AIDS, two of which had engaged in research. Feedback from the pilot was integrated into the survey before opening it up to the participants.

4.4.2.1Survey Administration Platform

Considerations in the questionnaire development stage included finding the correct platform to administer the questionnaire that would ease response through enhancing the look and feel. The challenges in relation to the platform selection process was the

cost attached to well-known, cutting-edge platforms. Lime survey was selected as a tool that UKZN subscribed to. Learning how to use Lime survey correctly was the most difficult and time-consuming challenge that I faced.

Lime survey has inbuilt capabilities including clustering questions into groups as well as assigning labels or codes to each group, question, and responses. It includes many statistical features which ensure that responses were collated on survey completion and inbuilt validity rules prevented human errors while capturing questionnaire data (Engard, 2009). A key validity rule was that, a respondent could not continue with the survey without completing the informed consent form and that provision of additional responses to those listed can only be provided if another button is selected. The use of an on-line survey eliminated tedious traditional survey process including, physically sorting, reviewing, and storing questionnaires as this was done automatically (Bloomfield & Fisher, 2019).

An electronic self-administered survey was developed and sent to the 100 research participants by email. The emails were developed by the researcher and distributed by SAHIVCS, copying the researcher. The purpose of the study, contact details of the researcher, and her supervisor, the length of time it would take to complete the survey, and the link to the survey were included in the invitation email. Four emails were sent, including the invitation to participate, notice of the survey closing dates, and two reminders.

4.4.2.2 Survey Response Rate

Of the 100 surveys sent, 21 completed responses were received of which 6 indicated interest in participating in the next phase of the survey. This indicates a 21% response rate and 28% interest rate in continuing with interviews.

4.4.3. Interviews

Six survey participants volunteered to participate in interviews and were all interviewed. Participants made contact through a mobile phone or email, and appointments were set using the same mans of contact. All interviews were conducted telephonically and recorded using a third-party software to ensure safe keeping of the data.

Roulston & Choi (2018) assert that preparing and conducting interviews happens in stages. This starts with ensuring that the language and categories used in the interview schedule are known and clearly defined. In this study this was achieved by using a formative report generated from data received through the survey to strengthen the interview guide.

Information received was used for the second stage of the study in which an interview guide was developed. An interview guide is a critical tool in semi-structured interviews that keeps the interview focused and ensuring that all critical questions were asked (Roulston & Choi 2018). The draft guide was also tested on five people that had experience in HIV and AIDS, two of which had engaged in the study. No changes were recommended.

In the third phase, interviews flowed like a natural conversation. They began with an overview of the process, including purpose, duration, expectations, and the rights of the participant as highlighted in the informed consent, such as consent to being recorded. The interview guide was used to mark questions that were sufficiently answered, keeping the interview focused and on track, without stifling the flow of the conversation or the participant's area of passion (Bless et al., 2006). All questions asked were open ended, and responses were explored with some requests to rephrase. The greatest challenge faced was managing the delicate balance between asking clarity on noted contradictions without appearing sceptical of the answer already provided. Therefore, why questions were used instead (Roulston & Choi, 2018). Much caution was taken to avoid interrupting the participant, leading to more time taken in some interviews than anticipated. The shortest interview was 32 minutes and the longest 50 minutes.

To ease the fourth and fifth stages, which is transcribing and analysing, salient points were noted during the interviews and transcribed immediately or within 24hours of being conducted. Everything said during the interviews was transcribed as meaning is garnered in the context of other statements made (Roulston & Choi, 2018). To mitigate the transcription period and promote accuracy, Express scribe a popular electronic transcription tool was employed. Further details on the fifth to the seventh stages: analysis, verifying, and reporting are provided in the following sections.

4.4.4. Data analysis

4.4.4.1Quantitative Data analysis

Data analysis was conducted using SPSS statistical software Version 27 (SPSS). SPSS has inbuilt validation rules which enhance the accuracy of data capturing. It does not withstand the initial utilisation of inbuilt Lime survey analytical capacities linked to SPSS.

Analysis was eased by pre-coding all research tools before employment and the utilisation of tools designed to work together. Lime survey was selected as a survey tool wherein features eased merging, transferring, and interface between Lime survey and STATSSA. In addition, all assigned codes were reviewed consistently during the capturing and analysis process to avoid duplication and ensure inclusion of emerging themes.

Data analysis followed the same phased approach as the research design. The first phase, a survey, informed the second phase which consisted of interviews. The initial analysis resulted in the formative report generated through Lime survey, which informed the interview process.

The employment of Lime survey eased analysis in the first phase since transcription, compilation, coding, and classification of data had to be done prior to capturing on SPSS. Through SPSS capabilities, it was possible to run statistical tests and retrieve both descriptive and inferential statistics.

Descriptive statistics were employed to provide a summary of sample data and estimates on population. Pearson correlation analysis (r) test was employed as planned, reaching more variables than years in service and resistance. This assisted in determining the strength of the relationship (Schober et al, 2018). Furthermore, the Pearson correlation analysis is included in SPSS capacities.

4.4.4.2 Qualitative data analysis

Interview data was analysed using Parker's interpretation of FDA. This commenced with distinguishing discourse according to sections outlined by Parker, with analysis

being a coherent set of meaning. Other sections explored were discourse as text, objects, subjects, discourse as located within other discourse, and discourse as a form of self-reflection (Parker, 1992 as quoted in Willig, 2008). This study did not venture into historically located discourse as highlighted by Parker. This approach ensured that all discourse was viewed holistically and within context.

Therefore, the study ventured into seeking meanings in what was said by spelling out what was said, how it was said and why they said it in that manner as well as the choices made. The six categories were listed, coded, collated, and analysed with a view to distil these into binary oppositions, and effects, before locating them into patterns identified into literature and the theoretical framework (Patten, 2016).

4.6. Data trustworthiness and Reliability

4.6.1. Trustworthiness

Cameron (2011) sets out four criteria for measuring research quality which is also known as trust worthiness. These criteria informed the research process as follows. Credibility, meaning that the respondents views were reflected honestly was ensured by checking with members and peer briefing. A traceable paper trail of processes, and triangulation with survey enhanced dependability and confirmability. Transferability was ensured by the provision of direct quotation of respondents' statements.

4.6.2 Reliability

Reliability refers to research stability and consistency when time, and researchers change. Higher degrees of stability and consistency are an indicator of enhanced reliability (Kumar, 2014). Research process was documented timeously to enhance reliability. This included documentation of reflection on interviews and transcription as soon as they were concluded. Piloting the interview guide with more skilled researchers also strengthen reliability as it enhanced researcher skills. Furthermore, all interviews were conducted by the same researcher. That said, a key limitation of reliability is that people change over time and with new experience this is hard to accomplish, hence absolute reliability may not be attainable.

4.7 Conclusion

This chapter presented the study's framework and its implementation process. These included the various choices made, reasons, and how they were implemented or adjusted to ensure success in execution. The reasons for all choices made are justified, together with the disadvantages and implications for ethical considerations. This includes the maintenance of tension between employing traditional manual tools and modern digital efficient research tools.

The above is preceded by clarification of the nature of research and the context in which the study is conducted, including the target population. These are key considerations in developing a research plan with scientific vigour and is not harmful.

The purpose of this study is to describe the impact of the UTT policy making process on HIV clinicians' policy implementation. This was achieved through employing combined research methodology with both quantitative and qualitative methods. In employing the survey, a qualitative research tool, statistical summary of the population, and their views were obtained rapidly, providing guidance on areas that needed to be deepened. In-depth interviews, and a qualitative research tool provided thicker contextually rich description of participants' views. Therefore, employing a combination of research methodologies added complexity to the analysis and strained limited resources. However, it also provided the advantage of enhancing scientific rigour, reliability, and validity.

Ethical protocols followed are also outlined. The process began with application for ethical clearance prior to the commencement of the study. Considerations for gatekeepers and participants' rights were maintained, including the right to withdraw participation even in the advanced stages of the study. Factors that were not anticipated or fully catered for in the design, which presented as challenges in implementation were also highlighted together with mitigation activities undertaken and their impact.

In conclusion, the research design and process in this study considered time, resources, and capacity constraint, resulting in a descriptive study with a small sample

size. While this limits the generalisability of the findings, it provides valuable insights into the lived experiences of clinicians on the coal face of service delivery.

CHAPTER FIVE

PRESENTATION OF FINDINGS

5.1. Introduction

This study seeks to explore HIV clinicians' perception of the UTT Policy and the impact it has on policy implementation. Therefore, this study is based on workplace experiences of HIV clinicians, collected through qualitative and quantitative data. In this chapter, key research findings are presented objectively and with neutrality, without interpretation.

This is presented by first providing an overview of the sample characteristics, including demographic details, professional level, experience, and location. These characteristics are crucial since individual perceptions are based on knowledge, history, and experience. The demographic details are followed by the participants' experiences with HIV and the UTT policy.

Findings are presented in a way that integrates both qualitative and quantitative data under a single heading, where applicable. This approach ensures a logical flow and simplifies the presentation of similarities, emphasis and contradictions. This is followed by direct extracts drawn from qualitative data gathered in open ended questions and interviews. Further analysis on qualitative data is provided in comparison to participants views and recommendations. Survey data which is mainly quantitative precedes qualitative data from the interviews and is shared in figures and tables. This chapter concludes with a summary of key findings, which are the key focus of the chapter that follows.

5.2. Demographic data

Participants responded to all questions in this section. Therefore, there are no missing elements or omissions.

5.2.1. Age distribution of respondents

The age component was categorised to ease survey completion, as well as minimising errors.

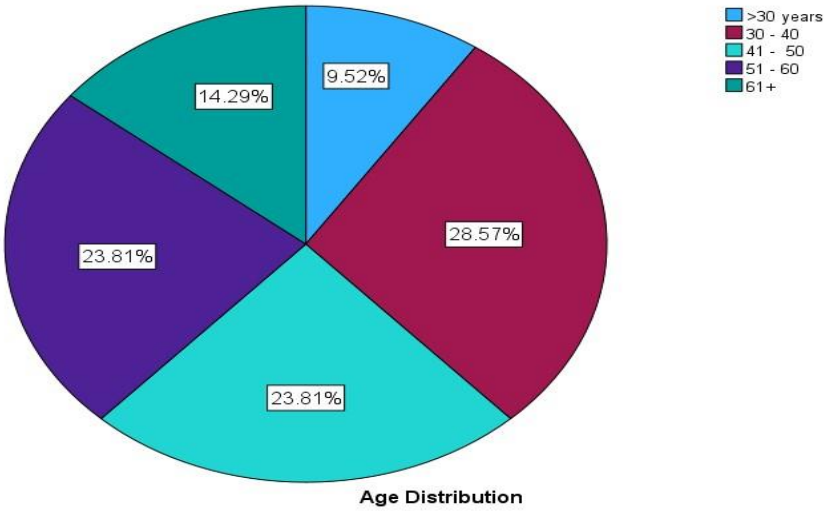

Figure 1: Respondents' age distribution

More than half of the respondents were in the 30–50-year age group category as presented in Figure 1. Of these, over 28% were aged 30 and 40 years, while 23.8% were aged between 41 and 50 years. Respondents aged below 30 were the smallest category, representing less than 10% of the population. From this age distribution it can be concluded that the study participants are relatively young.

Age was highlighted as an important consideration in the work environment. This sentiment was shared by respondents in their statements, such as ‘these young ones like hotels, so we send them (to meetings and workshops)’ and ‘as a younger clinician you are more likely to listen to your mentors because at the end of the day, we are at work so you do not want to get into trouble and lose your livelihood’. This view suggests that older clinicians have the authority to assign roles due to their higher occupational rank and the respect from younger clinicians, who feel obliged to comply with their requests.

5.2.2. Gender

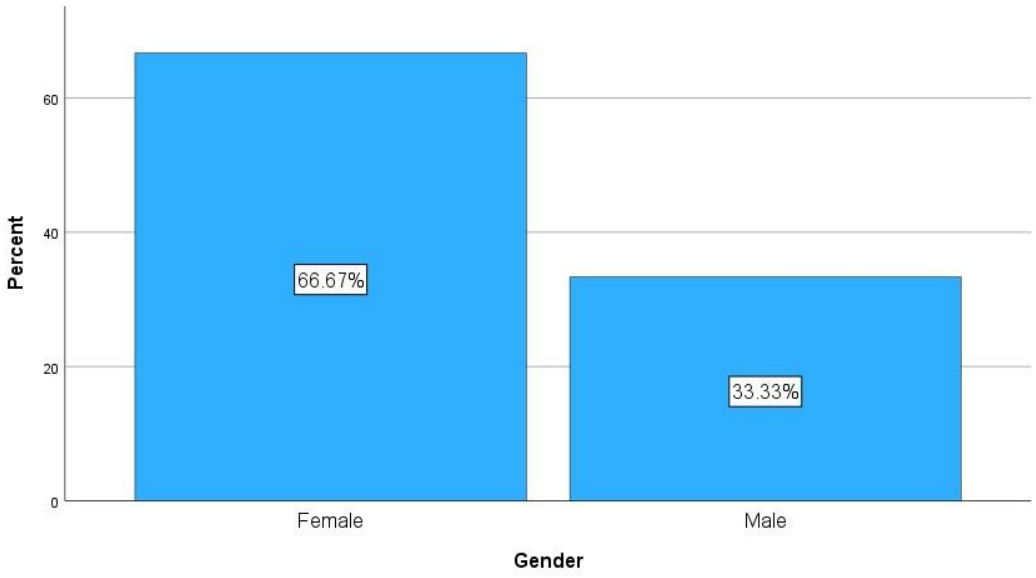

Figure 2: Respondents' gender distribution

Figure 2 shows that the number of female respondents was twice that of males. This trend is typical since in health care settings there are more female nurses compared to males. In addition, majority (66.7%) of participants are female nurses as reflected in Figure 4.

5.2.3. Race

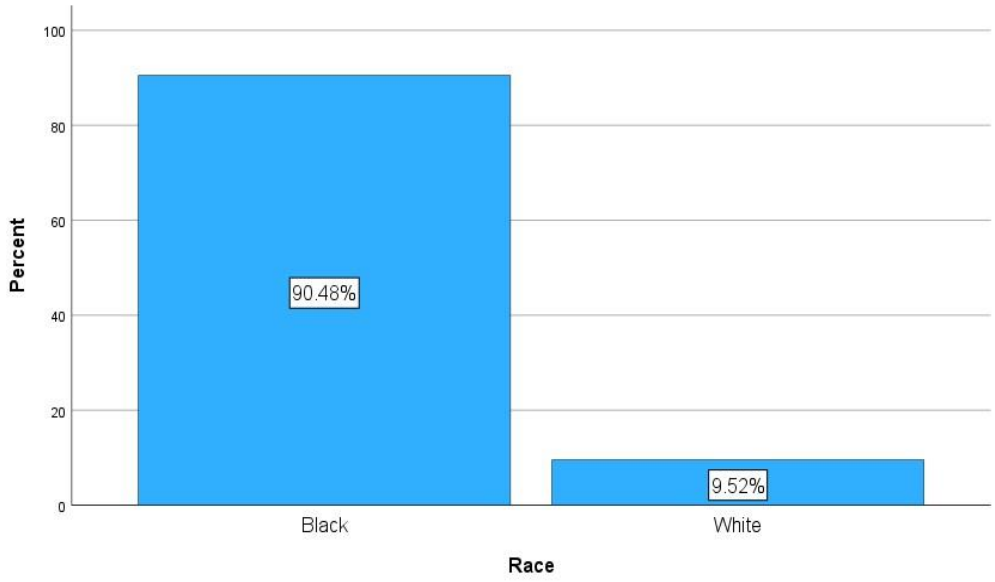

Figure 3: Respondents' racial distribution

Most of the respondents depicted in Figure 3 were black, while less than 10 percent were white. Given the demographics of the country, where majority of the population is black, this trend is not surprising.

5.3. Professional details

5.3.1. Type of clinician

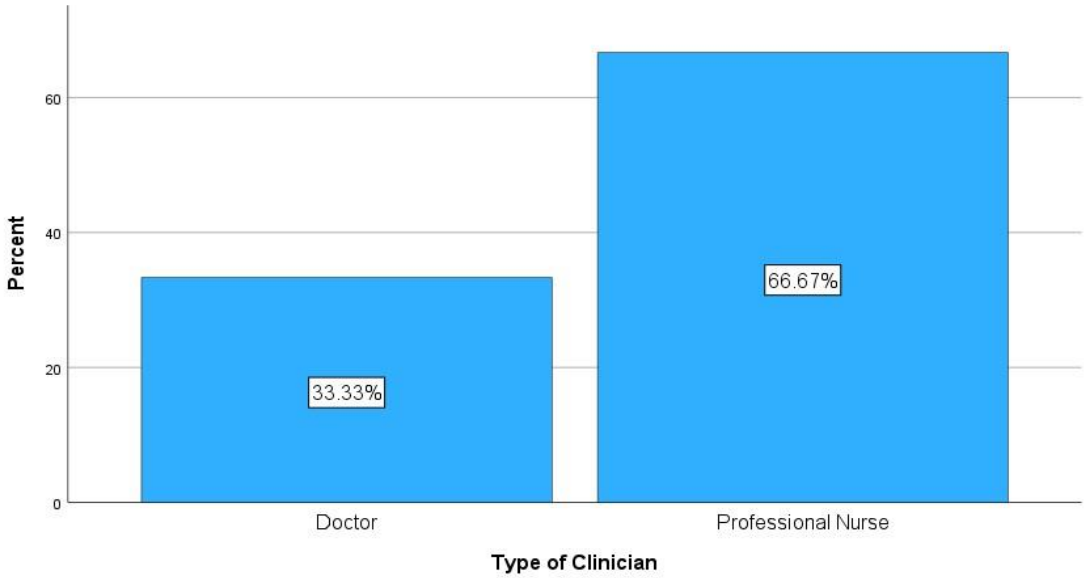

Figure 4: Respondents' clinician type

Twice as many nurses as doctors responded to the survey as shown in Figure 4. This trend is not surprising as nurses supersedes the number if doctors in health care facilities.

5.3.2. Number of professional service in years

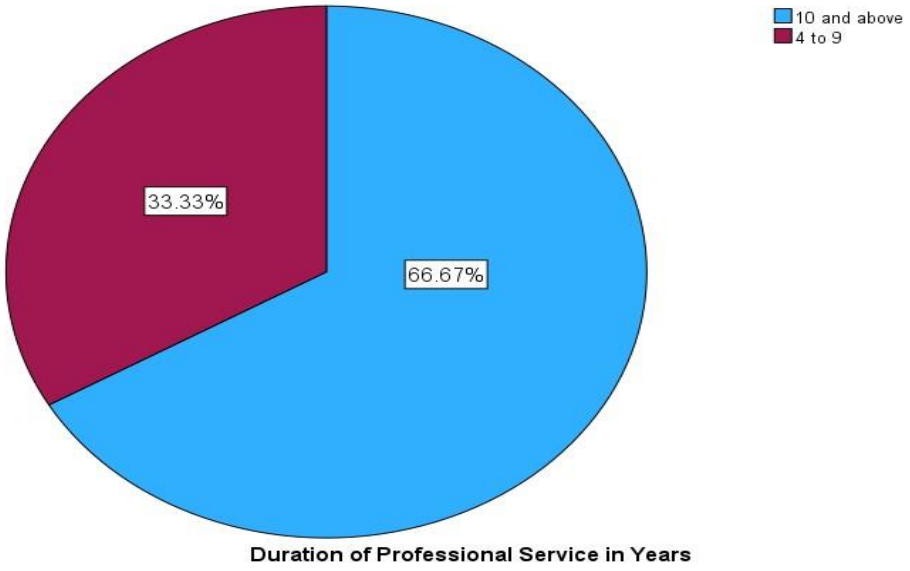

Figure 5: Professional distribution of respondents

Figure 5 depicts that over 65% of the respondents had professional experience exceeding 10 years. This finding suggests that respondents bring to the medical service a wealth of knowledge.

Moreover, clinicians depend on more experienced ones to establish themselves in practice. One of the respondents highlighted that ‘I always get stressed and excited when we get new staff … at times we get very blank staff who can be a danger to themselves and others but can be the best clinicians with a bit of guidance.’ Another respondent indicated that ‘when you are new, most of the senior clinicians would be the ones saying if anything goes wrong you will be alone.” Therefore, years in service are a key determinant of credibility, influence and trust in practice.

5.3.3. Type of health care institutions that participants work in

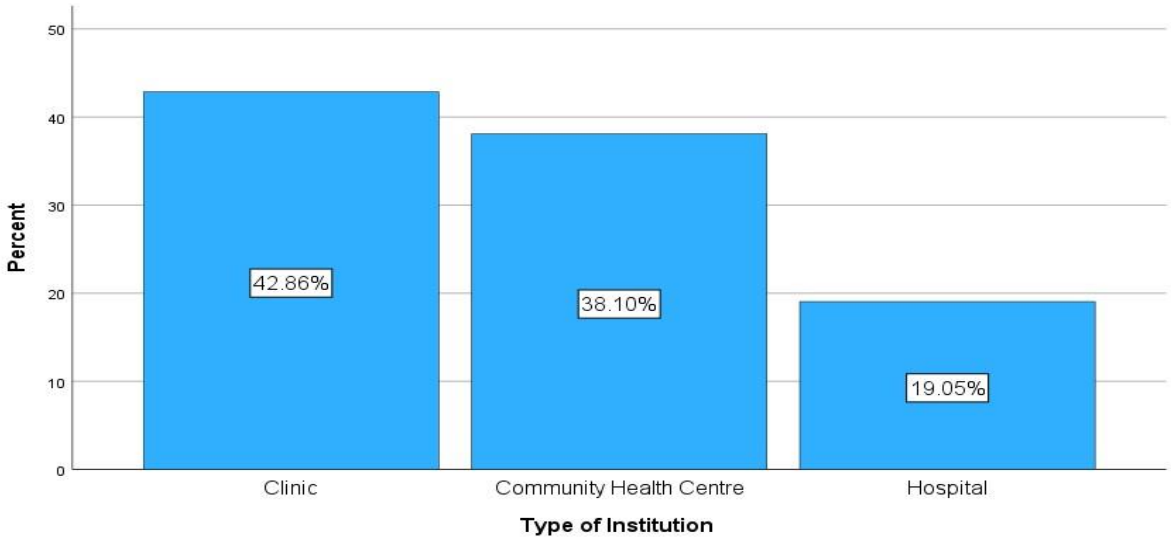

Figure 6: Health care institutions served by clinicians

Most respondents work in clinics (43%), followed by community health centres (38%) with the least being hospitals (19%). Since South African health care services place emphasis on primary health care, this finding highlight that most of the respondents work in clinics and community health care centres.

5.3.4. Type of community where health institution is based

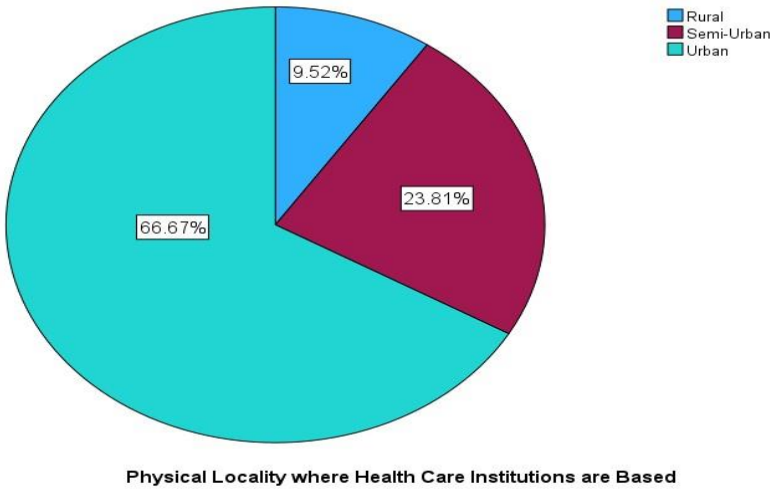

Figure 7: Distribution of physical localities where health institutions are based

The illustration in Figure 7 depicts that majority (65%) of respondents work in urban based institutions, followed by 23% in semi-urban and with the least representation of

9% in rural areas. This finding is not unusual given the physical locality of health care services in South Africa. Health care facilities in rural areas are underdeveloped and lacking in resources. In some rural areas, due to lack of health care facilities, patients travel long distances to peri-urban and urban areas to access health care services.

5.4. Experience in HIV and AIDS

5.4.1. Number of years in HIV service provision

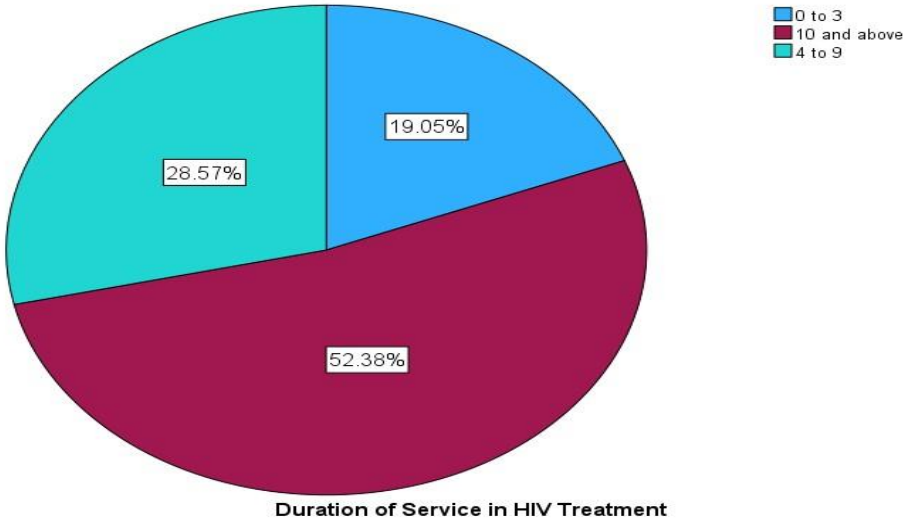

Figure 8: Distribution of service in HIV treatment

52.36% of the respondents have been providing HIV services for a decade as depicted in Figure 8. 30 % of the respondents had between four- and nine-years' experience, while 19% had less than three years' experience.

Respondents who have been providing HIV treatment services for a long time perceived their work as fast paced and increasingly complex over the years. 'It started small and now it is becoming large, there are also more partners that are involved'. 'We are moving from crisis to crisis, from emergency to emergency, there is quite a bit of stress especially if you are in the leadership role… there are too many changes to cope with and everyone is tired and just hates it'. The intensity of the work pace is echoed by HIV clinicians with less years of experience. It is a 'difficult environment to work in…, it is like a roller coaster, (there are) new things every month'. However, they also perceive their work as important and with implications beyond patients' health. They assert that working towards mitigating HIV is 'more than a health problem'. This suggests that HIV clinicians recognise that while their role in HIV mitigation focuses

on health, the success or failure of the health system impacts families and communities. This recognition requires multi-stakeholder involvement, which unintentionally leads to fatigue due to multiple changes.

Feelings of happiness, hope and overworking were also expressed by participants with high experience in HIV treatment service. 'I am enjoying the programme I am working under'. 'I was worried we are fighting a losing battle but every year I am becoming hopeful that this is a battle we can win'. The experience of working in HIV is best summed by this comment from a newer HIV clinician 'it is very difficult but rewarding.'

5.4.2. Training in HIV

All respondents had received training in HIV and AIDS. However, the duration of the training and training service providers differed.

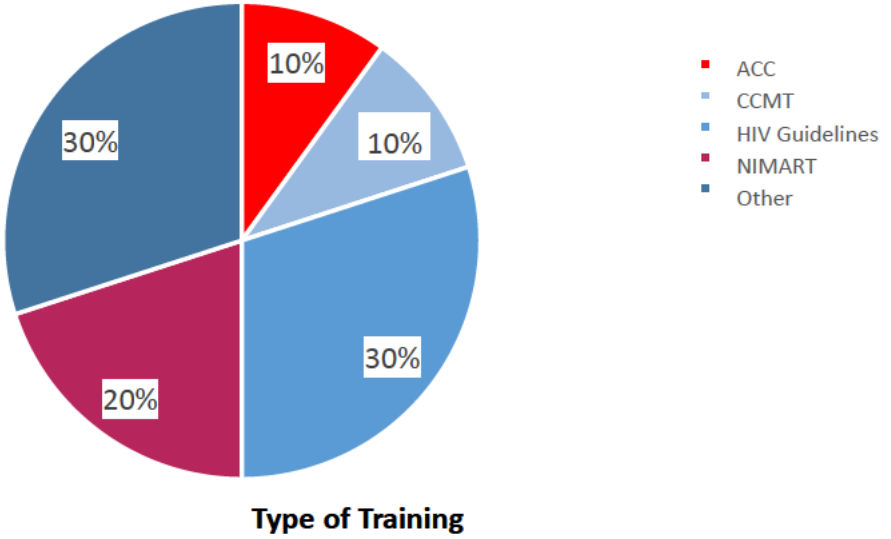

Figure 9: Types of HIV training distribution of respondents

Only 10% of respondents attended Nurse Initiated Management of Antiretroviral Treatment (NIMART) training. Earlier Figure 4 shows that majority of respondents (66.9%) were nurses. NIMART, the flagship programme that shifted the competence of HIV treatment provision to nurses, is considered a basic entry requirement for nurses to provide HIV treatment services. However, training on Comprehensive Care Management and Treatment of HIV (CCMT) and HIV Treatment guidelines, were attended by most participants, with each constituting 30%.

Eight comments were made in the section provided to indicate courses not listed on the survey. This included the provision of more details than requested as follows:

- Names of training service providers in four of the courses. Two of those were conducted by the Department of Health (DoH), with one being conducted by DoH and the Foundation for Professional Development (FPD) jointly and the fourth by Right to Care.
- Two respondents indicated the length of training as three days and two weeks respectively.
- One respondent indicated that they attended an online training programme
- Additional courses that were not listed were ART Guideline course, Newly Updated ART Guidelines, and Paediatric HIV Training course.

5.5. Universal test and treat policy

5.5.1. Initial policy experience

5.5.1.1. Channels and mechanisms where initial information on policy change was received

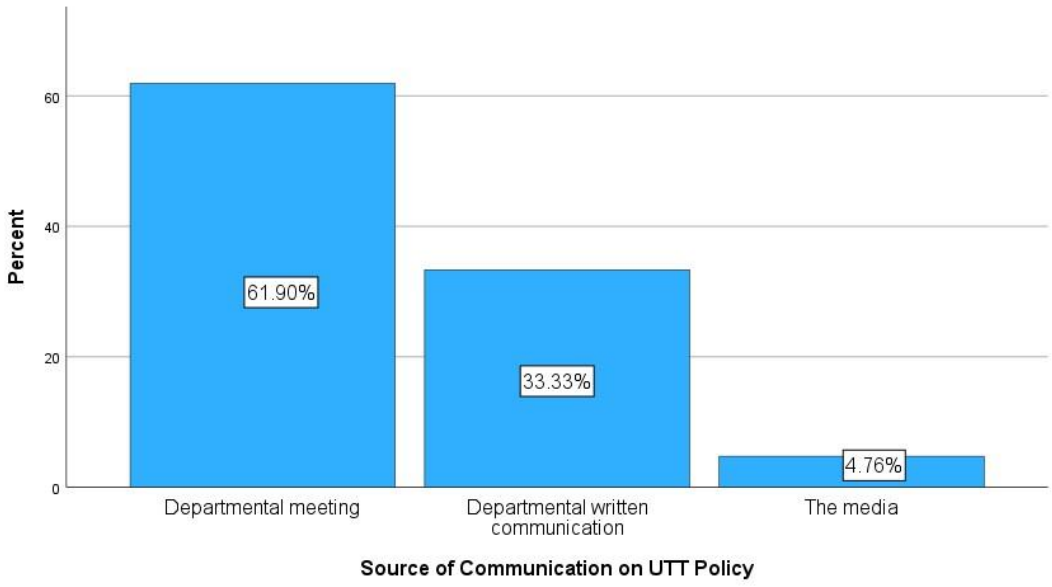

Figure 10: Distribution of responses where clinicians first heard about UTT policy

Figure 10 depicts cumulatively that over 95% of respondents first heard of UTT Policy through official departmental channels. Of these respondents, over 60% were informed in a meeting while 33% received written communication. An ignorable percentage (4.76%) first heard of the policy in the media, while none heard through patients.

Information on the UTT Policy was received through official departmental channels, leaving no room for questions or detailed discussions. 'You find there is a new policy on World AIDS Day…we start implementing today'. 'When there is new changes and new policies, two or three senior clinicians will be invited for a training…. who will share the information's and provide us feedback on the policy'. 'We just get told things are changed … they just tell you things have changed'. Instructions on policy changes were made at departmental events, including World AIDS Day and capacity building workshops.

5.5.1.2. Feelings associated with receiving initial policy information

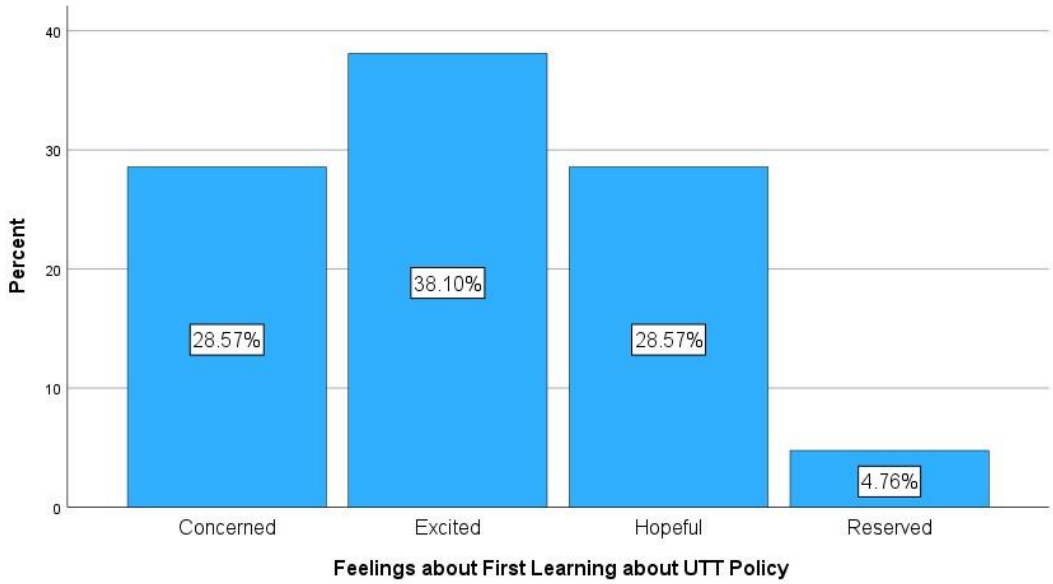

Figure 11: Distribution of respondents' initial feelings on UTT policy

Initial feelings on the policy were mixed, with many being excited (38%), 28% were concerned, 28% hopeful, with less than 5% being reserved as outlined in Figure 11.

Respondents' feelings included concerns over the language, scale, pace and implications of the change for practice. 'The intention of the policy was good but the

way the policy was written, and the implementation could have been better'. 'The language was just wrong and instructive and non-negotiable'. 'The policy had 'huge change for us and the patients' we 'were concerned about the toxicity'. "That is another chaotic one. An unnecessarily urgent policy emergency that had no consideration for what we have been teaching our patients for years and what we have been practicing. It can cause confusion (as) there are different interpretations.' Therefore, the introduction of the policy was concerning for participants, for operational and clinical reasons.

5.5.1.3. Actions taken by clinicians when the opportunity to implement the UTT policy presented, at a service delivery level

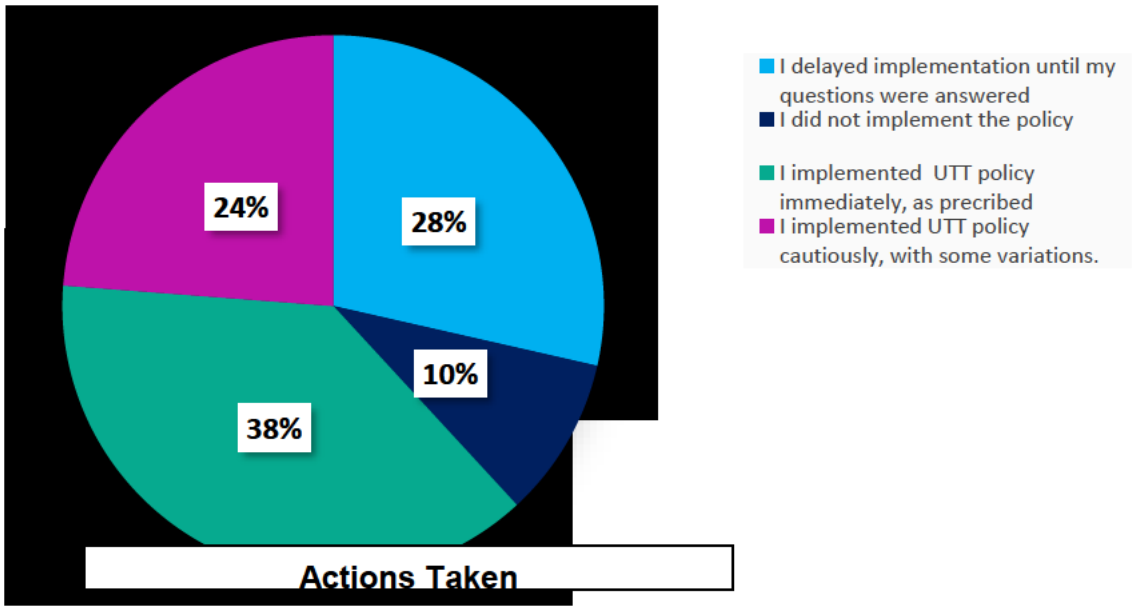

Figure 12: Distribution of respondents' initial action after receiving UTT policy

The actions taken by clinicians on receiving the policy varied widely as illustrated in Figure 12. Less than 40% of the respondents implemented the policy immediately as prescribed, 23% implemented with variation, 28% delayed implementation until all questions were answered, while the remaining respondents did not implement.

Actions taken by clinicians include seeking more clarity and implementing the policy with some adjustments. Respondents highlighted that 'anything new that is coming in, everyone is cautious, they are just waiting for someone to implement first, we see how it goes and then from there we follow suit'. There was 'a lot of push back from

clinicians.' 'We had our own coping strategies, that satisfied some of the policy without putting us at risk'. 'They are guidelines and not set in stone, I do what is best for my patients. I implemented what made sense to me and advised my team to do the same.' 'I encouraged everyone to do the best that they could and was available for anyone who needed support.'

5.5.2. *Involvement and knowledge of others' involvement in UTT policy development*

Table 1: Involvement in UTT policy development

	I Participated	My colleagues participated	District Managers Participated	Provincial Managers Participated	National Managers Participated	Development Partners Participated	I do not know who participated
Valid	21	21	20	20	19	20	21
N Missing	0	0	1	1	2	1	0
Mean	1.7619	1.6667	2	2.85	3.2632	3.4	3.0476
Mode	1	1	1.00[a]	3	3	3.00[a]	5
Std. Deviation	1.13599	0.85635	0.91766	1.08942	1.19453	1.14248	1.56449

Keys: 5 Strongly Disagree; 4 Disagree; 3 Neither Agree or Disagree; 2 Agree; 1 Strongly Agree
Multiple modes exist. The smallest value is shown.

5.5.2.1. Mean

A five-point Likert scale was employed, wherein, values below 1.8 reflect strong disagreement, values between 1.81 to 2.60 reflect disagreement, values from 2.61 to 3.40 bear a neutral stand, while values between 3.41 to 4.20 and 4.21 to 5 reflect agree and strongly disagree respectively.

Most survey respondents strongly disagreed that they or their colleagues participated in the policy making process. Similarly, some respondents disagreed that their institution participated in the process. A neutral stance was taken by other respondents on Provincial, National Managers and Development Partners participation. A neutral stand was also maintained by some respondents on lack of knowledge on the policy making process.

5.5.2.2. Mode

The central tendency of the data reflects the Mode of 1, which indicates that most participants strongly disagreed that they, their colleagues and district managers participated in the policy development process. A mode of 3 was registered on the participation of provincial and national managers, as well as development partners in the policy development process. It reflects that most participants neither agree or disagree on being involved. This is affirmed by the mode of 5, which indicates that most respondents did not know how the policy was developed.

5.5.2.3. Standard deviation

There was broad deviation in elements except for personal participation in policy development, which recorded the least deviation of 0.62591. This was followed by participation of colleagues at 0.81035, and District Managers at 1.08234. The data was most spread out on partners' participation with a deviation of 2.25752, followed by National and Provincial managers at 2.06867 and 1.76058 respectively.

All respondents highlighted not contributing in the policy making process. However, 'others' were involved. 'Funders and politicians make decisions (policy) when we are not reaching targets …and send to NDoH'. 'They want quick solutions.' 'They are written by someone who does not care about patients, does not know the environment we work in and just want to get quick results and recognition'. 'I am convinced these are written by people sitting in a hotel somewhere'. 'There is space between how the policy is being done and how you can participate in it'. This indicates that the policy making process is separate from the implementers experience.

5.5.3. Training

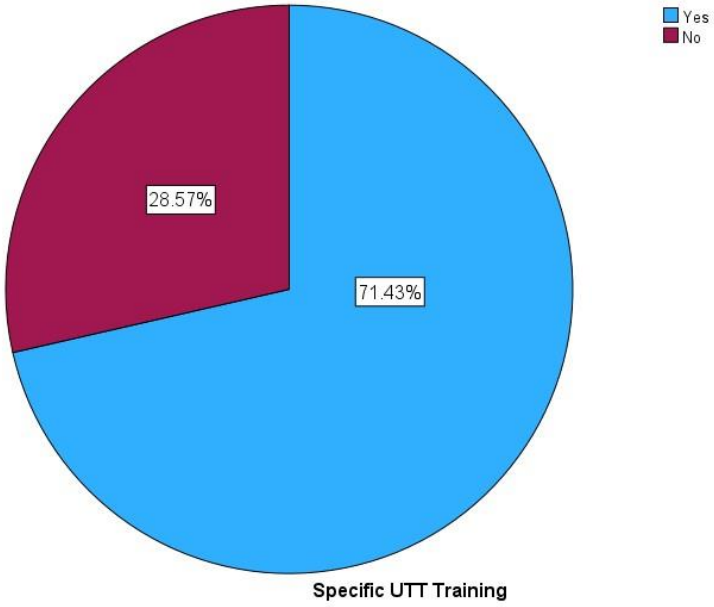

Figure 13: Distribution of UTT training attendance

Figure 13 illustrates that majority of respondents (71.43%) had received training on UTT.

Participants indicated that training was conducted and used as an opportunity to inform implementers on the policy. ‘There was one- or two-day training. It was information actually that things have changed’. This statement confirms that there was training, but it also presents a contradiction by suggesting that it was merely an information sharing session. Training is supported by mentoring; ‘the nominated champion for UTT in the facility would be the one that is responsible to make sure that it (training) is done and to monitor that it is done and if there is a gap like if the clinician is not confident and needs more training, they get the training’. This indicates that training is valued and closely monitored, with on-site mentoring capacity.

5.5.4. Implementation planning

Table 2: Distribution of respondents' operational team implementation planning

		Our team developed a UTT Policy Implementation Plan	The team met regularly to review and strengthen implementation	We did not plan together but everybody did their best to accommodate the policy	We continued to work independently as we did before the policy
N	Valid	21	21	21	21
	Missing	1	1	1	1
Mean		2.5238	2.4762	3.3333	2.9524
Mode		2.00[a]	4.00	4.00	4.00
Std. Deviation		1.20909	1.32737	1.35401	1.20317
a. Multiple modes exist. The smallest value is shown					

5.5.4.1. Mean

The middle number of all values registered across all statements measured is between 2.61 to 3.40, which reflects a neutral stand.

5.5.4.2. Mode

Most respondents agreed that the team met regularly for meetings, did not plan but everybody did their best to accommodate the policy, and that they continued to work independently. However, most respondents disagreed that Policy Implementation Plans were developed.

5.5.4.3. Standard deviation

The greatest deviation of 1.97932693 was registered in response to the statement that the teams did not plan together. However, everybody did their best to accommodate the policy. While the smallest was on regular team meeting to review the plan together, which was set at 1.14882287. This was followed by the team developing the implementation plan together (1.3147). Continuing to work independently recorded the second highest deviation of 1.74921054.

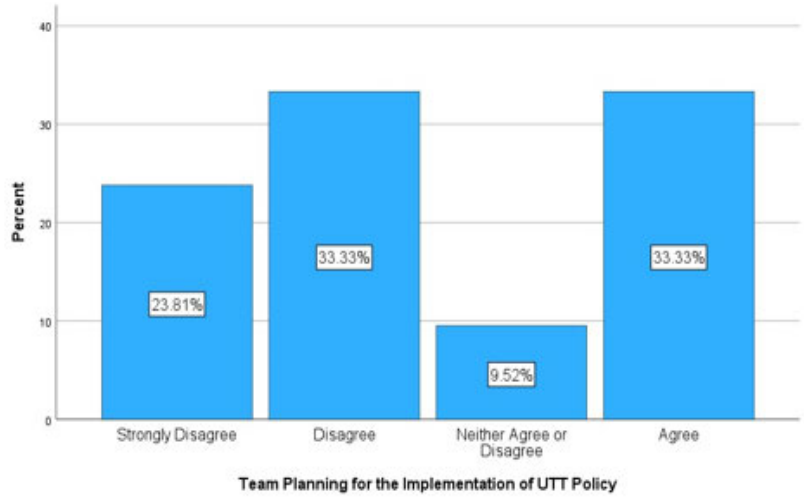

Figure 14: Implementation planning conducted by respondents' operational team members

An equal number of respondents (33%) disagreed and agreed that implementation plans were developed. While 24% strongly disagreed and 10% took a neutral stand, as illustrated in Figure14.

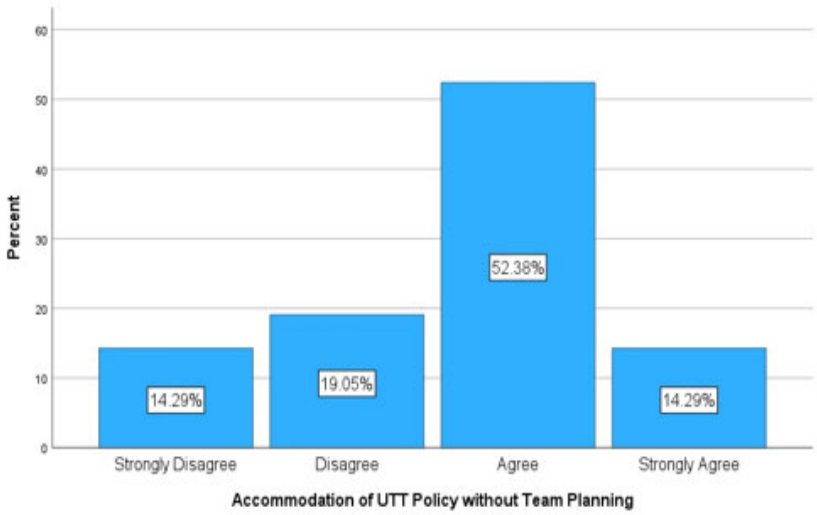

Figure 15: Distribution of best effort with no implementation planning within operational team

In Figure 15, more than half of the respondents indicated that they did their best individually in the absence of a team plan. An equal number of respondents (14%) strongly agreed and strongly disagreed, while 19% disagreed.

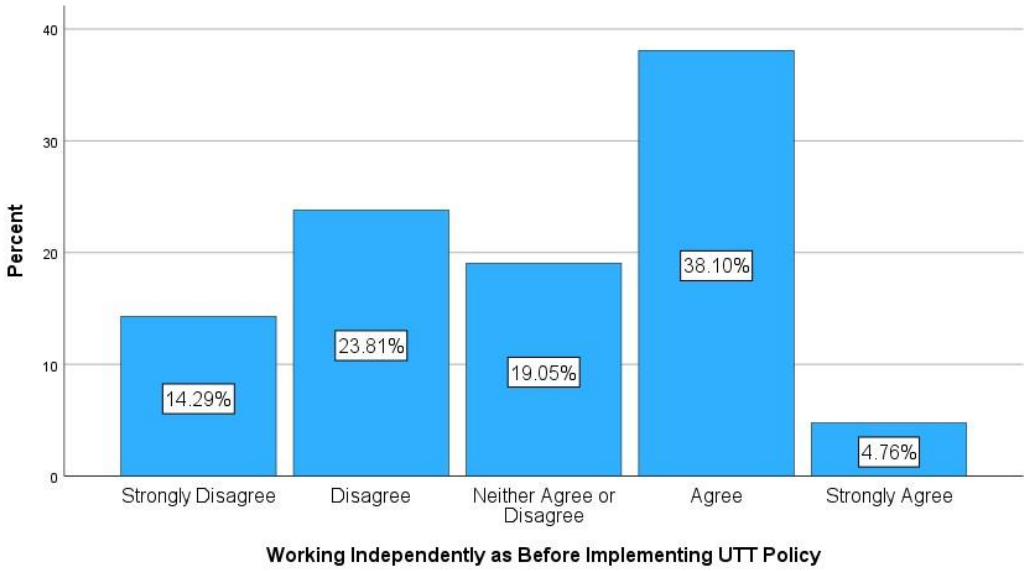

Figure 16: Distribution of independent work without operational team planning

Figure 16 illustrates that most participants (38%) agreed that they worked independently as they did before the policy, while 5% strongly agreed. 19% of participants took a neutral stand, whereas 24% and 19% disagreed and strongly disagreed respectively.

The nature and pace of work limits formal planning opportunities, normalising informal arrangements, and power dynamics. This was expressed in statements such as; 'I try but there is not enough time as we have many programmes and the changes are too many'. 'We hardly get time to discuss in the meeting, most of the discussion is going to be done outside while we are consulting with patients because during the meetings, we try to keep everything short so that we don't keep patients waiting'. 'There are too many people coming in and out of our facilities starry eyed with some new project to test, while our ques have become longer and our staff have not increased. So, we do our best'. Long ques, multiple changes and programmes made planning difficult.

5.6. Changes in views on UTT policy from 2016 to date

5.6.1. Respondents changes in views on UTT policy

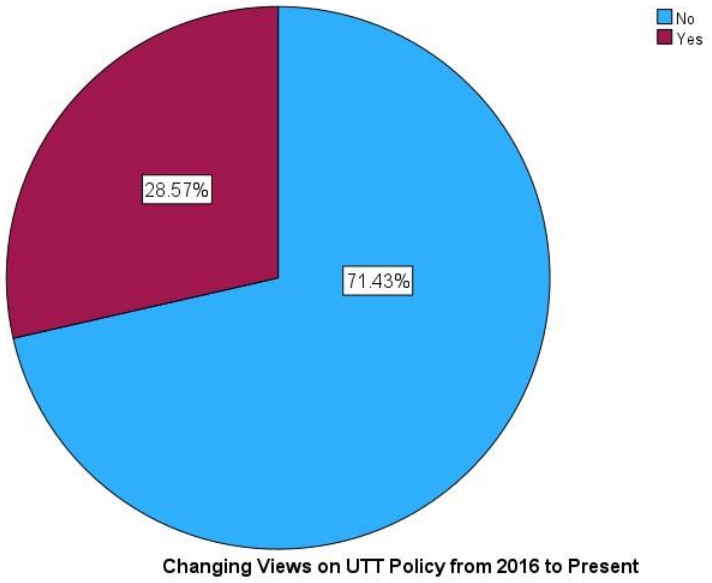

Figure 17: Distribution of changes on respondents' view on UTT policy

5.6.2. Causes for change of views on UTT policy

Six respondents responded to this question. These participants represented all that reported a change in views on UTT policy. Another respondent explained that their initial response to the policy was informed by concerns about patients' ability to consent to starting treatment and the overall health of the patients. In addition, they highlighted that 'the policy felt forced and target driven rather than being about the patient's welfare'.

One of the respondents indicated that they changed their views on the policy 'when all their questions on the policy were answered' Three respondents indicated that their attitudes changed when patients did not have complications. Two respondents started to agree with the policy when patient's awareness and knowledge of the benefits of the UTT Policy improved.

Participants highlighted reasons for changes in practice such as, increased information and pressure from higher ranks of power. They changed because 'some of the questions have been answered through the years' and 'some of our issues were addressed as the policy changed.' Those that were started on treatment were coping well'. 'Now everybody sees the benefits.' 'Pressure from above' and that 'we did what

we could so that our numbers were not the worst but we only got better with time'. Therefore, interventions including policy revisions, practice and increased communication across ranks led to a broader acceptance of the policy.

5.7. Correlation of implementation duration of UTT policy

Table 3: Correlation between number of years in service and actions taken to implement policy

		Number of years providing HIV treatment services	What actions did you take, when you first received the policy-
Number of years providing HIV treatment services	Pearson Correlation	1	.289
	Sig. (2-tailed)		.203
	Sum of Squares and Cross-products	9.810	6.524
	Covariance	.490	.326
	N	21	21
What actions did you take, when you first received the policy-	Pearson Correlation	.289	1
	Sig. (2-tailed)	.203	
	Sum of Squares and Cross-products	6.524	51.810
	Covariance	.326	2.590
	N	21	21

A positive correlation (*r*1) has been established between years in service and actions taken when the policy was received. The more time spent in HIV service, the less likely were respondents to implement the policy when they first received it.

The number of years in service is a defining factor in adaptability in policy making; 'Senior clinicians, they are the most reluctant in terms of implementing policies, rather the newer younger clinicians, we are the ones who are most likely to implement'. 'I wanted to initiate patients for treatment, other senior clinicians would come to me and tell me to be cautious in terms of UTT, because we are not hundred percent sure that

it will work, and things like that.' 'I do what is best for my patients. So, I implemented what made sense to me and advised my team to do the same.

Years in service were also important in the assignment of roles for policy implementation, although some contradictions were highlighted. One respondent indicated that when there is new changes and policies, two or three senior clinicians will be invited for a training. While the other respondent said that 'the young ones like visits to hotels…when they come back, we only implement what makes sense'. There is contradiction in who is sent to learn about changes to policy, one respondent indicated that they send 'senior clinicians' and the other said 'younger ones.' However, it is the senior clinicians who decides on the course of policy implementation. The reason provided for sending younger clinicians appears to be based on preference or convenience, such as 'liking hotels,' rather than professional confidence in them, as illustrated 'when they come back, we only implement what makes sense'. More experienced and senior clinicians were resistant to implement the policy and discouraged others to do the same.

5.8. Comparisons of participants views on UTT policy process

5.8.1. Corroborated statements

5.8.1.1. Policy making as a function of higher spheres of government

That policy making was a function of a higher sphere of government. 'I know that with different levels of management' and "we don't make decisions". "Funders and politicians make decisions (policy) when we are not reaching targets …and send to NDoH".

5.8.1.2. Fragmentation due to hierarchical decision making

The policy was communicated using a top-down approach, leaving little to no room for negotiation or revision. 'Up there they are working vertically'. **'**I do not make the policy decision but as a HIV, AIDS, Sexual Transmitted Diseases and TB (HAST) champion I know about them first and am tasked with telling others about them and making sure that they are implemented. I am therefore often stuck in between the decision makers and implementers. 'We just get told things are changed'.

5.8.1.3. Poor policy development and implementation process

The UTT Policy was necessary, but was developed too quickly, without contextual information and consultation with implementers. ‘The intention of the policy was good but the way the policy was written and the implementation, could have been better.’ ‘Everything with HIV is always in a rush maybe it is because it is politically motivated’. If they had asked us ‘we can add that this will not be possible. We can even ensure synergy between policies.’ ‘They are written by someone who does not care about patients, does not know the environment we work in and just wants to get quick results and recognition.’ ‘The intention of the policy was good but the way the policy was written and the implementation could have been better’.

The nature and pace of the change led to slow policy implementation and amendments. What ‘I implemented was made sense to me and advised my team to do the same’. ‘We had our own coping strategies, that satisfied some of the policy without putting us at risk.’ ‘They are guidelines and not set in stone, I do what is best for my patients’.

5.8.1.4. Open communication and responsiveness to improved implementation

UTT Policy implementation improved when more information was received, with intervention and the policy amendment. ‘Some of the confusion has been clarified even though some elements are left behind, but there is hope.’ ‘The more the policy changed and we felt heard the more implementation improved.’ There was also ‘pressure from above and the observation that those that were started on treatment were coping well’.

It was recommended that future policy development should include perspectives from implementers to ensure that policies are responsive to contextual factors. The policy development process should start with ‘consulting the people that are going to implement the policy.’ Therefore, there must be a feasibility study.

5.8.2. Contradictions

5.8.2.1. Policy development process

Those who develop policies have limited understanding; ‘Government has an idea of how to develop policies … they do not have an idea of how we work’.

5.8.2.2. Communicating the policy

There were limitations with communicating the policy change. ‘We (are) just told there was a new policy…Clinicians don’t know what is going on’.

5.8.2.3. Training

While training occurs, it is perceived not as capacity building but merely as an information sharing session. ‘There was one or two-day training. It was information actually that things have changed’.

5.8.2.4. Operational context

Working in HIV was described as complex, fast paced and exhausting yet rewarding, characterised by regular growth and improvements. ‘It is a ‘difficult environment to work in’, there are too many changes to cope with and everyone is tired and just hates it’. ‘I am enjoying the programme I am working under’. ‘I was worried we are fighting a losing battle but every year I am becoming hopeful that this is a battle we can win’. These precepts indicate that as many changes are and as complex as the environment is, they bring advancement and hope.

5.9. Ways in which UTT policy can be improved

All respondents responded to this question and offered a varying level detail to their responses. One participant expressed being content and had no recommendation ‘So far so good with the UTT policy’. However, other respondents made various recommendations which are consolidated into categories below for ease of reading.

5.9.1. Stake-holder Inclusion

Four respondents indicated the need for greater inclusion in policy process. This includes a need to involve ‘doctors and nurses and people on the ground’, ‘engagement of all stakeholders and alleviate all doubts and concerns’, ‘by involving implementers on all changes as they are the ones with patients every day’. Another participant stated that ‘policy makers need to get involved with the ground people, to see the real effects of their policies and their impact on the people's lives including clinicians’ themselves’. A similar sentiment was expressed as ‘more context need(s) to be elaborated to help health care providers get the real insight behind this limitation’. In addition, three respondents expressed the same with the following two worded comments ‘community involvement’, ‘client involvement’, ‘stakeholder involvement,’ and ‘discuss with doctors first’.

One participant indicated that ‘each work place to develop an implementation plan’ while another participant stated that a ‘regular review of number of patients tested’ was necessary. Ongoing consultation and regular review are recommended.

5.9.2. Increased information education and communication

Three respondents indicated that dissemination of information on the policy should be increased. One participant said it is important to continue emphasising the importance of UTT. With others specifying the groups that should be targeted; ‘patients, family members and community at large’ and ‘marketing it (UTT) to the community through civil society and different sectors.

5.9.3. Training

One participant indicated that ‘Nurse Initiated Management of Antiretroviral Therapy (NIMART) training (was needed) for all new clinicians joining the work force’. The second participant highlighted the need for ‘continuous training for both old and new clinicians. Moreover, the third participant stated that clinicians need to be trained the same way that partners were trained, for policy implementation to be the same. Furthermore, another participant specified that hospitals should be mentored and monitored.

5.9.4. Client readiness

Respondents highlighted the need to ensure that clients start treatment whenever they are ready and choose to: ‘focus on the social and emotional readiness of the patients. Because it becomes so sudden to the patient who just found out about their status, that they have to start treatment immediately’. ‘Allow…clients to take a decision whether they want to start treatment immediately…the policy it's like, it's forcing clients to start on treatment in which results increase numbers of disengagement’

5.9.5. Policy omissions

The policy needs to ‘extend implementation to private sectors. The patient’s choice to start treatment must also be included; ‘do Cd4 count and viral load to all patients initially and give them a choice to start medication or not, since medication also has side effects.’

The policy needs to include ‘TB work-up (as) we need time to investigate due to severe complications being encountered that lead to morbidity and mortality’. This was contradicted by another participant who indicated that ‘TB testing as a baseline for all clients was (already) highlighted (in policy revisions)’.

5.10. Recommendation for future policy planning

5.10.1. Stakeholder consultation

Four respondents recommended that there should be an increased involvement of stakeholders in the policy process. Including ‘people that work directly with patients (be included) in this decision making’ and ‘implementors should be consulted so they can come with a better way of implementation’. Other respondents emphasised; ‘community involvement, client involvement (and) stakeholder involvement’ as well as those delivering services.

5.10.2. Monitoring policy compliance

Three respondents recommended that policy monitoring process be strengthened. ‘There must be a way of ensuring that Implementers fully comply to avoid missed opportunities in both Private and Public sectors. It is also recommended that ‘there

has to be a record of both good prognosis and poor prognoses and a clear description of how data will be collected (be provided).'

5.10.3. Contextual relevance

Participants recommended that 'there must not be too many changes at once.' This requires for other policies that will be impacted to be 'integrated …closely with programs that are directly related like TB to forge synergy'. That policy makers 'must align themselves with the ever-changing spheres of technology and science'.

5.11. Conclusion

In this chapter, data was gathered from doctors and nurses of all genders, with varying levels of professional experience working as HIV clinicians in urban, rural, and semi-urban health facilities. This data was presented both statistically and narratives derived from respondents' interviews**.**

Most of the respondents indicated that they had learnt of the UTT Policy through official government channels. The communication was experienced as authoritative, with no room for inputs and discussions. Some respondents indicated that the policy was developed by others and did not consider the respondents lived experiences.

Almost all participant attended training, and experienced as an information sharing sessions. The heavy workload made implementation planning difficult, and most respondents implemented the policy with variations, until their concerns were addressed. Therefore, UTT policy was known and mainly implemented with variations when it was first introduced. The rate of policy implementation increased with interventions, including policy amendments.

CHAPTER 6

DATA ANALYSIS, DISCUSSION AND CONCLUSION

6.1. Introduction

This study is aimed at exploring how the UTT policy development process influenced HIV clinicians' willingness to implement the policy. In previous chapters, such as literature review on HIV & AIDS and policy development, leading to the selection of Max Webers theory of bureaucratic management as the most suited theoretical framework to understand this phenomenon. The research process undertaken, as well as results were also presented in the previous chapters.

In this chapter, an analysis of all the information gathered from literature and this study will be conducted to synthesize an opinion. This analysis will begin with a summary of findings and an examination of Max Weber's theory of bureaucracy. These are followed by a detailed comparison of the two, with findings from this study to establish areas of conformity and contrast, supported by other literature. This will lead to a determination of whether there was any ambiguity in motivation among HIV clinicians in implementing the UTT policy. This chapter concludes with a discussion on implications, limits, recommendations and conclusions on the study.

6.2. Summary of findings

6.2.1. Research findings

Over 90% of the participants indicated that they heard of the UTT policy through official government channels. This official communication was authoritative, with no room for inputs and discussions. Feelings about the policy were mixed, ranging from concerned to hopeful, with less than 5% of the participants feeling reserved. Less than 40% of the participants reported implementing the policy as prescribed from the onset, while the remaining implemented it with some variation or not at all. There was broad consensus among participants regarding not participating in the policy development process. They were also unsure of who was involved. Some suggested that funders and politicians made policy decisions and then sent them to the National Department

of Health for implementation. There was a broad consensus that the policy did not consider contextual factors.

Only 33% of participants reported planning UTT policy implementation as a team, despite over 70% having received training on UTT and the presence of a facility based UTT policy champion.

The lack of implementation planning was attributed to training being perceived as information sharing sessions, as well as heavy workloads and competing priorities. As a result, most discussions about the policy were informal.

Longer serving clinicians determined who attended training, and how this training was implemented. They were also expected to provide leadership and consent on implementation. However, a direct correlation was established between longer length of service and not implementing the UTT policy as prescribed.

6.2.2. Literature review

Policies are defined as government choices to act or not to act. Policy decisions in a democracy emerge from a political process (Wedel, 2017). In addition, politics are characterised by contestation for power (Heywood, 2013). If we define power as making people do what they do not want, then it is likely that they are losers and winners. Therefore, the UTT policy was a decision by the South African government to act, and it may have some losers and winners.

Max Webbers theory of bureaucratic management is concerned with what makes organisations such as government work, as guided by policies born out of contention for power. He identifies the following as key composites of bureaucratic management; rationality, authority, skilled staff, working in a well demarcated structure with defined powerlines, held together by mutual respect for rules (Paul et al., 2015).

This theory is particularly suitable for understanding the dynamics at the interface between policy and practice within the Department of Health, a bureaucratic institution characterised by clearly defined structures and hierarchical authority levels. This understanding is crucial for implementing UTT policy, which is grounded on evidence-based research and designed to be rational in its approach.

6.3. Interpretation of findings

6.3.1. Demographic and professional data

The study was designed to offer equal opportunity to doctors and nurses across both genders. Hence, all other demographic data collected was incidental. Representation of both doctors and nurses, as well as both genders was achieved. Incidentally, various age ranges, locations, as well as a broad range of professional distribution of participants' years was also achieved.

Clarity on the type of clinician is crucial, as initially, HIV treatment services were reserved for doctors and provided in hospitals before shifting to nurses and clinics through task-shifting (Venter, 2013). Having twice as many nurses (67%) as doctors (33%) responding was expected, since there are many nurses than doctors working in the field (Figure 4). The same can be said for Figure 2, were 67% of the respondents were females and 33% male, as there are more female nurses than males.
Interestingly, participants did not mention differences in clinician and institution types in interviews, suggesting that task shifting and expanding HIV services to all facilities has been successful. The inequitable distribution of doctors and nurses in the survey has limited significance, as their roles in providing clinical services to patients under the UTT policy are similar.

The number of years in service was identified as significant in clinical practice. This was expressed by over 65% of respondents with more than 10 years of experience, with none of the respondents having less than four years of professional service (Figure 5). While the respondents' distribution of service in HIV treatment depicted in figure 8, includes those who worked for 0 -3 years. Thus, suggesting that working in HIV and AIDS is a specialised field of work. However, the differences can also be attributed to South African HIV Clinician Society (SAHIVCS), from which the sample frame was drawn. SAHIVCS is an advocacy organisation that seeks to advance quality of care. Newer clinicians who are still getting accustomed to clinical practice may not be aware of this organisation.

Distributions in race, age, type of health institution and community were examined to determine if any perspectives were excluded. The impact of age, gender, race,

location and other demographic details were not tested. Therefore, we can conclude that the responses received where broad, ranging across clinical service staff members, experiences, communities, and health service points.

6.3.2. Experience in HIV and AIDS

The participants' account of their years in HIV service included close to 20% who have worked three or less years in the HIV & AIDS field (Figure 8). This contrasts with the overall account of years in professional service, where all participants had over five years of experience (Figure 5). This suggests that HIV & AIDS is considered a specialised field reserved for clinicians with some experience.

Over 50% of participants had more than 10 years of experience working in the HIV & AIDS department (Figure 8). These participants witnessed and participated in various changes in the HIV & AIDS policy landscape, including the HIV treatment programme expansion over a decade. Participants expressed feeling fatigued and hopeful due to these changes; 'it's like a roller coaster, (there are) new things every month', 'it is very difficult but rewarding'. Changes in the HIV programme are erratic, they contradict literature in that current interventions are rational and evidence-based approach. There is still a certain level of muddling through, characterised by a frantic search for alternatives, which leaves little room for rationality (Lindblom, 2018). This poses a significant challenge to HIV and AIDS programming and policy making, highlighting the tension between established knowledge, and the uncertainties in the journey towards 2030.

Changes in HIV treatment policies and guidelines prior to UTT were incremental and path dependent. Path dependent policies are based on historical familiarity (Friedman, 2021), built on existing institutional frameworks, and are easily accepted. In the HIV treatment program, changes focused on increasing access to HIV services by raising the CD4 cell count eligibility threshold from under 200 cells/ul to 350 cells/ul and 350 cells/ul (Yapa et al., 2022). All other eligibility criteria, such as psycho-social readiness and being TB free or on TB treatment for a set amount of time remained in place. Emphasis on multidisciplinary team approach remained in place, albeit in decentralised formations (Crowley et al., 2021). The multidisciplinary team ensured that the complex and multifaceted nature of HIV and AIDS, with its multiple layers,

roots and causal relationships, was well understood and effectively managed for each patient (Camillus, 2008).

The UTT policy requires the clinician to counsel, test and treat patients. Thus, shifting from a multi-stakeholder intervention to a clinician centralised approach (Onoya et al., 2021). This is while the considerations for TB patients infected with HIV and TB were excluded, as well as other eligibility criteria, including psycho-social readiness to accept treatment. Therefore, UTT policy presented a significant change in scale, practice, and institutional arrangements for the provision of HIV treatment.

6.3.3. UTT policy formulation process

Majority of participants highlighted being unaware of how to and who participated in the policy formulation process. Some participants have the impression that the policy decision was made by people who have not interacted with implementers. ‘I am convinced these are written by people sitting in a hotel somewhere’. Some respondents believe that UTT policy makers have no understanding of its implementation. ‘They are written by someone who does not care about patients, does not know the environment we work in and just want to get quick results and recognition.’ This sentiment reflects a dichotomy in knowledge, space, and interests between policy makers and implementers.

Most participants strongly disagree with the statement that they, their colleagues, and district managers, were involved in the policy making process. This is reflected in the measure of central tendency, which shows a mode of 1 (one). The mode of 3 (three) indicates that participants neither agreed nor disagreed about the participation of provincial managers and development partners in the policy-making process (Table 1). Furthermore, this indicates that most participants who are policy implementers were certain that those they interact with regularly at a health institution and at district level were not involved in the policy process. However, they were unsure of the involvement of higher provincial level officials within the department and development partners. This also suggests a dichotomy between development partners, provincial health representatives, and those who work at the service delivery points. Onoya et al. (2021) assert that DoH employed clinicians perceive development partners as having access to decision makers (Onoya et al., 2021).

Some participants suggested that the policy decision was made by ‘others’ outside the department. ‘Funders and politicians make decisions (policy) when we are not reaching targets …and send to NDoH’. These ‘others’ are there to further their own interests. ‘They want quick solutions.’ Therefore, the respondence expressed that they were excluded, and lack of trust in the policy making process.

The decision made by politicians could be attributed to the former Minister of Health to be the one who made the policy pronouncement (Motswaledi, 2016). According to Weber’s theory of Bureaucratic Management, the minister’s pronouncement can be regarded as having legal rationality. Therefore, the policy decision was made evidence based and objective (Baskurt & Demirci, 2022:676). Furthermore, the minister is a high-ranking member of the South African bureaucratic system and has authority over those he leads in the government.

UNAIDS coordinates, monitors, and provide technical advice to member nations working with other development partners to support countries in meeting their targets as stipulated in agreements (UNAIDS, 1996). Therefore, it is fitting that participants perceive the role of partners as extending to the policy decision making.

Participants' knowledge and experiences of UTT policy Development process is best summed up by a statement that asserts: ‘There is space between how the policy is being done and how you can participate in it’.

6.3.4. UTT implementation process

6.3.4.1. UTT policy communication

Almost all participants (95%) first engaged with UTT policy in governments official spaces and communication channels (Figure 10). Yet, this does not seem to be enough as captured in a participant’s comment ‘We just get told things are changed … they just tell you things have changed’. This statement reflects that while clinicians were informed of changes in policy, they felt disempowerment. Weber posits that having written rules that are known and respected by all is essential in bureaucratic institutions, as they support and reinforce authority (Baskurt & Demirci, 2022). In this

instance, rules were written, communicated, but questioned, which does not reinforce authority.

A third of the participants first received UTT Policy in writing, while close to 70% got it in a meeting (Figure 10). One would assume that those in a meeting had better understanding of the policy's purpose and process. However, this does not seem to be the case as previously discussed and reflected in Table 1. Given that the policy pronouncement was made in the highest office in the country, HIV clinicians were given orders that were non-negotiable in the meeting.

6.3.4.2. Initial policy impressions

Most participants (38%) had anticipated policy change, perceived it as progressive, and excited to learn about it as illustrated in Figure 11. This anticipation was due to access to HIV treatment being expanding since its inception in 2008 (Venter, 2013). Hence, this shift from a CD4 cell count of 500 to removing the CD4 cell count as a measure for eligibility, as along with the lack of clarity on managing patients co-infected with Tuberculosis (TB), made the changes in this this policy more drastic. This can be attributed to the uncertainty demonstrated by the 28% of participants who expressed concern (Figure 11). One participant highlighted that we 'were concerned about the toxicity'.

In his theory for social change, Parsons, a functionalist like Weber, posits that change is necessary for society to meet new demands and occurs gradually to maintain stability and harmony within society (Schwandt, 2010). The UTT policy was a necessary change in operational rules for clinicians to meet new demands. However, it created uncertainties in the macro environment, as it deviated from the past policy trajectory and practice. Some of the participants believed that the policy was 'an unnecessarily urgent policy emergency that had no consideration for what we have been teaching our patients for years and what we have been practicing'.

This demonstrates that the rapid pace of change brought forth by the policy challenged institutionalised beliefs and practices. The uncertainty brought on by the policy challenges Parsons view of change, contributing to harmony has reference. In addition, it leans more towards the critiques that Parson's theory of social change ignored

conflict. It further brings to question the value of this policy in reinforcing authority, as a key contribution of rules to bureaucracy by Weber (Baskurt & Demirci, 2022). This is due to this rule being received with concern by those who are to implement it.

6.3.4.3. Training on UTT

A key element of the HIV expansion programme is capacity building. The value of training seems to be institutionalised as, Figure 9 depicts that all participants received training on HIV treatment. Over 70% had received specifically UTT training (Figure 13). Furthermore, respondents provided more details on training than requested as compared to other sections in the survey.

The importance of training was also evident in the selection of seasoned clinicians to attend the training and then mentor others. This creates a formal packing order that gives more seasoned clinicians authority. One participant highlighted that ‘as a younger clinician you are more likely to listen to your mentors because at the end of the day, we are at work so you do not want to get into trouble and lose your livelihood’.

Mentoring is amongst the effective key strategies used in HIV Programme expansion. Mentoring enables experiential learning on-site, thus making the training practical and efficient (Maluleke et al., 2023). However, it has unintended consequence of limiting the freedom and capacity to innovate younger clinicians as indicated in the statement ‘likely to listen to your mentors…we do not want to get in trouble’. This suggests that what the mentor says is held in high esteem, and any deviation from their guidance is considered risky.

Interestingly, a direct correlation has been established between a longer tenure in service and acting outside the stipulations of the UTT policy, indicating increased resistance to implementing UTT policy among more experienced clinicians (Table 3). This suggests that there was greater resistance to the implementation of UTT policy among more experienced clinicians, and a higher use of informal rules. Therefore, those who did not implement the UTT as prescribed and relied on informal rules were given formal power to mentor others to do the same. More experienced clinicians can be regarded as asserted by Byrkjeflot (2018:29) that, having a marked influence rooted in political-cultural dynamics, as well as ‘social values, institutionalised structures and

elites' within health facilities. This is quite concerning as one participant indicated that 'as a younger clinician you are more likely to listen to your mentors'.

Training was also mentioned as a platform where information on UTT policy was first received by some respondents. 'There was one- or two-day training. It was information actually that things have changed'. This contradictory statement alludes to the respondents' reality that receiving training included new information that was unexpected, which they struggled to imbibe. Hence, they did not feel capacitated. This is best expressed by participant's statement 'the intention of the policy was good but the way the policy was written and the implementation could have been better'.

That said, the participants acknowledgment that they have been provided with multiple capacity building opportunities, with 70% having attended training, demonstrates their capability to implement the policy.

6.3.4.4. Actions taken to implement UTT policy

Over 60% of participants did not implement the policy as prescribed at its inception, as outlined in Figure 12. This deviates from Weber's theory, which asserts that staff within a bureaucracy operate according to the rules that govern the institution (Wendt, 2016). Considering the inability of Weber's theory to help us understand this phenomenon, we turn to his critics and those who furthered his work. Critics of Weber attributed this gap to his lack of focus on conflict and change.

Modern-day organisational change theorist view conflict as an inherent feature of change, manifesting through resistance. They propose that resistance should be expected in any change process, even when the change is necessary. Also, this resistance can be used to enhance the change process if properly managed (Metz, 2021). Therefore, it should have been anticipated that some HIV clinicians would demonstrate resistance, resulting in not implementing the policy when they first received it. This enables the development of a mitigation strategy, thus improving initial policy uptake.

Resistance is said to be highest when the pace of change is intense, the scale of change is significant, and change is implemented through a top-down approach. Therefore, the UTT policy encompassed all three of these elements.

It was previously indicated, that the scale of change disrupted the HIV treatment eligibility criteria, which had been lauded as measures to prevent HIV treatment toxicity and had been institutionalised for over a decade. The significance of this change required a shift in practice, creating some disruption and increasing resistance (Metz, 2021).

With HIV being proclaimed a global emergency, the UTT policy was urgent since it was a major determinant for South Africa in meeting the UNAIDS 2020 goals. While the global emergency concept allows for optimal financial and technical support for UTT policy, Seckinelgin (2012) critiques it for lacking consideration of contextual factors, such as the meaningful participation of policy players. The lack of consultation in the UTT policy development process and the frustration it brought is reflected in a participant's statement that 'we are just told'. This means that the lived realities of patients and HIV clinicians were not considered. Participants expressed that 'they are written by someone who does not care about patients, does not know the environment we work in and just want to get quick results and recognition'. The participants' expression suggests that the policy is developed by outsiders with different interests from the HIV Clinicians.

The importance of consultation and meaningful engagement is further strengthened in the third and last element that increases resistance, the top-down approach. As previously stated, the UTT policy was introduced as a pronouncement from the highest office of health in the country, indicating a top-down approach. Friedberg (2011) perceives the top-down approach as a punitive type of bureaucracy. This occurs because the rules are imposed rather than collectively agreed upon, as would be the case in representative bureaucracy. This results in conflict and, in this case, fragmentation of views. One of the participants highlighted that: 'I do not make the policy decision but as a HIV, AIDS, Sexual Transmitted Diseases and TB (HAST) champion I know about them first and am tasked with telling others about them and making sure that they are implemented.' The assertion by the same respondent that

‘I am therefore often stuck in between the decision makers and implementers’, best describes this dichotomy, and the impact thereof.

While the above explanation addresses conflict as resistance, expressed by 60% of respondents who did not adhere to the set rules, we also need to understand how this resistance impacts the overall change process (Figure 12). In his theory of social change, Parsons expounded on Weber’s theory of bureaucratic management. Parsons posits that societal change is similar to ecology, wherein change is a necessary part of improvement, that ensures the ongoing stability. The introduction of UTT Policy is a change that sought to improve patients’ access to treatment (Maluleke et al., 2023). Interestingly, while Parsons’ theory of social change built upon Weber’s work, Parsons was also criticised for being too focused on societal stability to fully comprehend and acknowledge conflict (Hamilton, 1993). It was Merton, Parson’s student who integrated conflict into theories of change.

Merton’s Anomie Theory provides deeper insight into why clinicians do not simply adapt and perform their prescribed duties, based on rules aimed at improvement set by legal authorities. Anomie suggests that while society, and in this case the health department, has a goal of ending AIDS by 2030. The department has defined pathways like ensuring all diagnosed HIV patients receive treatment on the same day, as articulated in the UTT policy. However, clinicians’ response to these goals and pathways is not guaranteed (Adler & Laufer, 2020). According to Merton, individuals within a society, and in this case HIV clinicians, embraced the goal to end AIDS but rejected the set pathway. This is reflected by 60% of the participants that did not implement the policy as prescribed. They only implemented it upon receiving more clarity. In addition, the policy was revised to include some of the clinicians’ concerns (Figure 12). To this effect, one participant stated that: ‘I implemented what was made sense to me and advised my team to do the same’. Another participant indicated that their first loyalty lies with the patients and perceives the UTT policy as recommendation and not a rule: ‘They are guidelines and not set in stone, I do what is best for my patients’. These responses are reflected in the 24% of respondents that implemented the policy with amendments and the 10% who chose not to implement the policy at all (Figure 12). Merton suggests that creativity and innovation are limited when a singular path to a goal is rigidly defined (Merton, 2017). The policy formulation

process creates space for creativity and innovations to be garnered from all stakeholders during the policy appraisal process. Howlett (2014) postulates that the policy appraisal process provides an important platform for exploring different pathways to achieve the set goal, thereby encouraging stakeholder buy-inn. Participants' responses indicate that they did not get the opportunity to explore other alternatives, and they 'were just told'. Without trust in the set pathways, 60% of clinicians acted outside of the law.

Acting outside the law involves the creation of informal laws and adaptation of formal laws to ease operations (Pimentel, 2012). In this case, 24% of respondents implemented the policy with amendments. Some respondents perceived the policy as a burden that put their careers at risk: 'We had our own coping strategies, that satisfied some of the policy without putting us at risk.'

However, the importance of rules as outlined by Weber cannot be ignored. Formal rules, guide, and control operations include day to day functions to ensure clarity and consistency in the workplace. Paul et al. (2015) asserts that when rules make operations difficult, they ignore the human dimension, including a sense of agency, and creativity becomes trapped within an iron cage for staff.

Meaningful consultation during the policy making process enables exploration of other alternatives, also known as policy appraisal (Howlett, 2014). This means a goal is agreed upon and different options of achieving it are fully explored, thus, mitigating anomie, conflict, and pre-empting resistance. It also breaks staff out of the iron cage and ensures that the formal rules are valued. Most respondents highlighted not knowing those responsible for the policy process as indicated in Table1, thus, indicating lack of consultation.

6.3.4.5. Implementation planning

According to Weber, the primary benefit of bureaucracy is the assurance that the same standard of expected outcomes is achieved by multiple individuals performing the same type of work across the organisation, as prescribed by rules (Baskurt & Demirci, 2022). Therefore, the expectation is for UTT Policy implementation to be standardised

across all public health service facilities. However, it has also been established that successful policy implementation depends on accommodating contextual differences.

The development of an implementation plan allows for contextual factors to be considered in policy implementation. According to Troll and Skinner (2013), this enables team members to manage institutional, bureaucratic, and local socio-economic factors while meeting national and global expectations from each facility.

70% of respondents had knowledge and understanding of UTT policy, and its implications for practice since they had been trained (Figure 13). Therefore, they had the capacity to plan for policy implementation. Interestingly, only 33% (Figure 14) of respondents highlighted having developed an implementation plan, while 52% accommodated the policy in their work without team engagement (Figure 15).

These findings suggests that while the training for UTT policy implementation was available, approach to UTT implementation differed across facilities, and clinicians. Without joint facility planning, HIV clinicians within the same institutions were likely to approach UTT policy differently. One respondent indicated that ‘I implemented what made sense to me.’ Therefore, it is not surprising that over 42% of respondents approach to HIV clinical practice did not affect UTT policy directives. They continued to work as before the UTT policy implementation (Figure 16).

However, the primary purpose of setting rules to ensure consistency and standardisation across the NDoH facilities was not met in UTT policy.

6.3.5. Changes in view on UTT policy from 2016 to date

Approximately 30% of respondents indicated that their perception of the UTT policy changed over time (Figure 17). Their reasons for changing their views, include meaningful engagement and experiential learning. Participants highlighted that the change was a result of ‘questions …answered’ and ‘some issues were addressed as policy changed.’

Matters addressed included contradictions between the UTT policy and other existing policies and institutionalised practices. This included the historical institutionalisation of TB infection status, patient education, and readiness as key indicators for initiating

HIV treatment, which were not excluded in the UTT Policy (Yapa et al., 2022). Interestingly, considerations for TB patients that aligned UTT policy to TB treatment guidelines were included in the revised UTT policy of 2020. Thus, indicating an admission of omissions in the initial policy development process.

It should be a norm for policies to start with a pilot process and implemented incrementally prior to the adoption and broad implementation. Another participant indicated that their perception changed upon realising that 'those on treatment were coping well'. This perception indicates that trust was built after witnessing the positive impacts of the policy, in line with past practice. While testing and validation are standard practices, accompanied by consultation, the introduction of practices established through global research seemed insufficient, even when accompanied by training (Venter, 2013). There is need for cooperation and trust as expressed by participants 'now everybody sees the benefits', as a reason for change in views.

An interesting contradiction in reasons for change was a participant who indicated that the 'the policy felt forced, and target driven rather than being about patient welfare'. They lauded the 'pressure from above' as the reason for the change across their health facility as, 'we did what we could so that our numbers are not the worst'. This indicates that close monitoring and supervision from the authorities gave the facility the necessary impetus for change and provided space for reflective learning. Additionally, it suggests that team implementation planning began after the commencement of the policy implementation.

6.4. Discussion

The decision-making process for the UTT policy adhered to objective information and impersonal consideration, aligning with Weber's principles of rationality (Baskurt & Demirci, 2022). While the value of evidence-based decision making cannot be undermined, it is equally important to highlight that the information can be used as a tool to retain power. Furthermore, the information guiding the UTT policy was influenced by global AIDS emergency partners' priorities. This can be seen as an alignment with transnational priorities, where external entities influence in-country objectives (Powers, 2012). Transnational priorities limit considerations for in-country political and cultural dynamics which are critical in Weber's opinion. Most participants

strongly agreed that they did not know who participated in the policy development process (Table 1). The revision of the UTT policy to include TB considerations that were initially excluded demonstrates that the UTT policy contradicted existing local policies and practices. Thus, demonstrating the gap between the policy decision making process and policy implementers experiences. This supports the view expressed by one of the respondents that the policy makers priorities and motives may not be patients but reaching targets: 'they are written by someone who does not care about patients, does not know the environment we work in and just want to get quick results and recognition'.

However, it is important to highlight that UNAIDS primarily exists to strengthen member state capabilities, to tailor in-country policies in a manner that is responsive to local needs (UNAIDS, 1996). South Africa's policy may have not been as responsive to contextual factors as expected. This might be attributed to the need for compensating the history of AIDS denialism which delayed the provision for HIV treatment (Natrass, 2007). Therefore, it can be argued that the South African state conformed to external political forces in its implementation of the UTT policy. Transnational governance resulted in divergence from contextual factors (Powers, 2012).

The UTT policy pronouncement was made from the highest health office. The policy aligned with Weber's assertion that those in authority must establish rules to reinforce their authority and ensure consistency in operations (Baskurt & Demirci, 2022). It was also symbolic as it was made in the National Assembly, marking a departure from the previous approach where the first resolution to provide Antiretroviral Therapy (ART) was made following successful litigation by civil society (Natrass, 2007). While this ensured the rapid flow of funds and technical expertise, it was evident that more than 70% confirm their capability to implement UTT (Figure 13). Respondents' capabilities did not result in immediate implementation as indicated by over 60% of respondents (Figure 12). This is because the expert-based model constricts indigenous knowledge (Curley, 2021). It can be argued that all decisions are made in South African National AIDS Council, which includes People Living with HIV (PLHIV), labour unions, as well as the National Department of Health. Thus, all stakeholders were represented. However, the conflict between staff and administrators with the NdoH is well documented (Tosanloo et al., 2019). For clinicians to lack a coherent advocacy

coalition undermines their common cause Matti & Sandström, 2011). The voices of clinicians will only be heard if they unite and compel the state to prioritise their concerns on the policy agenda (Cloete et al., 2011:112).

This is complicated by that NdoH and Development partners access and work with clinicians legitimises their ability to position to speak on behalf of the clinicians' This leads to the clinicians' experiences not being directly accessed in the decision-making process, thus being excluded from the policy development process. This form of exclusion in the policy development space is known as policy without publics a reality. Nonetheless, exposure to HIV clinicians does not translate to comprehension of their lived realities and should not be seen as an authority on their lives. This creates a perception that technical experts are policy elites creating tumultuous power dynamics and mistrust in HIV clinicians (Onoya et al., 2021). While the value of technical support is closely monitored by UNAIDS as programme improvement, it often neglects the broader institutional and social impacts, such as the balance of power dynamics and morale among healthcare providers. Addressing these factors is crucial for sustainable program success and maintaining trust within healthcare system.

The true benefits of aid and technical support are debated, further complicating the issue. Some argue that the push for treatment is driven by big pharmaceutical greed, with some politicians, researchers, and clinicians being complicit (Ferner, 2005). For a country among the ones with the highest number of patients who require ART, and does not manufacture these locally, this debate must be considered.

The UTT Policy Pronouncement was the government's way of making it happen (Cloete et al., 2011). In addition, with the unintended consequences of presenting the minister as one of 'members of political monopoly' was the governments way of taking a lead (Hirsch & Shotts, 2018)). However, there was no space for meaningful consultation and exploration of alternatives, with staff at the coal face of service delivery. This move left clinicians feeling helpless and excluded as indicated by one participant 'we are just told'. This type of decision-making is known as punitive bureaucracy, as rules are imposed and not collectively agreed upon (Friedberg, 2011). Therefore, punitive bureaucracy results in anomie. Anomie is indicated by 60% of respondents creating informal rules by not implementing the policy or implementing

the UTT policy with amendments. Informal rules are created when formal rules are perceived as stifling operations, trapping staff in an iron cage.

The iron cage not only promoted the informal rules but undermined the skills, competence, values, and institutional practices of clinicians. Hence, clinical practice is rooted in guidelines developed following rigorous clinical research and commitment of doing client no harm. The UTT policy rules contradicted other regulations that have proven to be lifesaving for patients, including the management of those co-infected with TB & HIV. Consequently, the UTT policy was later amended to close this gap.

However, amending the policy does not only show that it was flawed, but also normalises deviation from regulations.

The normalisation of informal rules is most concerning. A correlation has been established between clinicians with longer service term and the use of informal rules instead of UTT policy of 2016. This is due to being charged with mentoring and training newer clinicians, thus passing on both clinical skills and values, including the use of informal rules. This undermines, effectiveness and efficiency of the services they offer, a pillar of public services (Bryson et al., 2014).

The fact that over 60% of participants did not take the opportunity to ensure a standardised approach to mitigate contextual limitations to policy implementation at a facility level is most concerning. The lack of team implementation planning suggests that patient care differed within the same institution. This contradicts the very objective of a bureaucratic system, where people from different walks of life are expected to provide the same standard of services, guided by the same objective rules. The reasons given for lack of implementation planning included a heavy workload and change fatigue due to managing multiple fast paced changes.

The rapid pace of policy change was intended to provide sufficient implementation time to meet the 2020 deadline. However, the scope of change was broad and sweeping, extending beyond the incremental nature of previous changes. Additionally, the top-down approach decreased the motivation to implement UTT policy. Interestingly, it was only when monitoring and supervision were strengthened that the programme improved and the UTT policy was revised.

Included in policy decision making process and meaningful engagement were primary recommendations for future policy development. Had this been done as advised in policy development process, challenges such as conflict with other policies, resistance leading to informal rules would have been pre-empted and mitigated. Mekonnen (2019) asserts that contradictions and resistance are expected in policy process and managed through negotiations, and compromises. While this may have extended the policy development, timeline, and delayed implementation, it would have also improved implementation and the policy outcomes. A more significant, though less immediately visible, loss is the missed opportunity to legitimise state policy priorities, build trust, and deepen democracy (Mkandiwire, 2005). According to McConnell (2010) a policy is a sum of all decisions and actions before, during, and after the policy development, with an impact on all stakeholders in the society. These stakeholders include those who placed the policy on the agenda, who participated in the policy development process, why the policy was passed, and who benefited or suffered as the result of the policy.

In the UTT policy implementation process, there is a dichotomy between politics, policies, and public administration. The implementers are instructed without any formal engagement with the policy and politics that inform policy decision. This response is completely different from one advocated for by Leclerc Madlala, (2005:845) who asserts that: ‘an ideal response to HIV/AIDS would be one that seeks to meet the needs of people, both those infected and those affected by the disease, while promoting a culture of openness in treatment and of democratic values in policy responses’ (Leclerc-Madlala, 2005:845).

6.5. Limitations of the study

This study corroborated earlier studies that identified multiple reasons for UTT policy failure, focusing specifically on the lack of morale to implement the policy. While other factors are acknowledged and recognised as impacting morale, they were not investigated in this study. The study is limited to examining the interface between policy and practice and its impact on staff morale.

The views of HIV clinicians working at the coal face of service delivery were sought. However, counsellors, admin staff, managers, and development partners working with

clinicians at the coal face were not invited to participate. This is because HIV treatment cannot be administered without HIV clinicians.

A key limitation of the study is that participants were limited to 100 due to lack of resources. This yielded 21 participants, which may be regarded as a small sample to represent thousands of clinicians (Patten, 2016). Therefore, this study cannot be generalised.

While data on participants' distributions on race, age, type of health care institution, and community were gathered, they were not analysed, as they extended beyond the scope of this study. The impact of these demographic details on ambiguity of motive to implement the policy has not been tested and can be subject for further research.

Official NdoH documents which would have provided insights into policy making process, and communication to clinicians were not reviewed, making it a limitation of the study (Bowen, 2009)

The study established that UTT policy implementation was not standardised across facilities and possibly within facilities. The spread and its impact were not tested as it was beyond the scope of the study. Similarly, the power dynamics of senior clinicians in determining policy implementation were noted but not fully explored. Therefore, both these concepts need to be studied further.

6.6. Implications of the study

This study corroborated findings on studies to determine barriers to UTT policy made by Onoya et al. (2021) who asserted that low staff morale to implement UTT Policy and the contribution of central policy making as articulated by Orange (2018) is similar to the findings in this study. It further confirmed the assertion made by Maluleka et.al (2023) that knowledge was important in the implementation of policy, which is also highlighted in this study that without willingness to implement the policy, knowledge is ineffective.

This study demonstrates that factors such as resource availability, capacity, rational rules set by legal authorities are important in successful policy implementation. Such

factors are important because without a high staff morale at service delivery level policy failure is inevitable.

Morale is built when staff buy into the policy and institutionalise it, which heavily depends on their interaction with the policy. According to participants, HIV clinicians' first official interaction with the UTT policy was when they were instructed to implement it. At this stage, all policy decisions were made by policy elites and political monopoly, with limited room for expression, resulting in use of informal rules. Therefore, this study confirmed the findings of previous studies that the failure of the UTT policy to achieve its goals was due to low staff morale. It further identified the reason for low staff morale as lack of meaningful consultation at the service delivery level during the UTT policy development process. This was compounded by delays in acknowledging and addressing resistance, and by not using resistance to improve the UTT policy during the implementation phase.

This study highlighted that a key reason clinician's voices are not heard beyond their facility level is the lack of a dedicated space for them to communicate their views. Clinicians require an advocacy network that represents their views across all decision-making structures.

The effect and impact of multiple changes in HIV and AIDS policy and programming on staff in the policy implementation level, was highlighted as a threat to overall program and policy success. This is mainly due to change fatigue and contradictions.

This study deepens understanding of a well-documented phenomenon: patients' barriers to services due to staff knowledge barriers and attitudes, staff perspective, attributing it to staff alienation from the decision-making process.

Therefore, this study contributes to enhancing UTT policy success, a key contributor to ending AIDS in 2030. Additionally, this study will contribute to the field of public policy as South Africa is struggling with policy efficacy. The country has progressive policies that do not impact individuals' lived realities. In particular, it provides clarity on reasons for persistent poor performance in Health care, despite the presence of worldclass policies and resources.

6.7. Recommendations

6.7.1. Improved UTT policy implementation

It is recommended that compliance monitoring be enhanced to 'avoid missed opportunities' and ensure the policy is continuously improved as 'poor and good prognosis are recorded' and studied. It was further recommended that UTT policy implementation be expanded to the private sector.

6.7.2. Broader HIV and AIDS policy development

Although being part of the global AIDS emergency response, strengthens South Africa's ability to respond rapidly, it should not undermine indigenous knowledge, contextual factors, and the capacity for the country to solve its own problems. Information received and good practice through global networks must first be tested locally and adopted to local realities. This can be achieved through feasibility studies rooted in effective practice and built on real life experiences. Knowledge on local level realities will ensure 'synergy' and that 'there must not be too many changes at once'.

The impact of changes in the HIV program landscape on clinical practice and health institutions must be explored to ensure these changes positively contribute to service quality over the past twenty years. Exploring the option of establishing dedicated times and priorities for implementing changes is crucial.

6.7.3. Broader policy development

The policy development process should be inclusive of those working in the coal face of service delivery. This will ensure that the policy is aligned to other policies and is contextually relevant. Additionally, it will ensure the department takes a lead of all policy decision making. Thus, building trust and eliminating the notion of policies without publics.

Multiple meaningful engagement opportunities must be established throughout the policy engagement process, paired with robust monitoring and supervision. This approach will facilitate continuous policy improvement and ensure that comprehensive information is collected to inform future policy development process. Thus, ensuring

the voice and experiences of all stakeholders are reflected in the policy review and development process.

6.7.4. Future research

The study should test the impact of location and type of institution on the ambiguity of motives to implement the UTT policy, similar to exploring the role and impact of informal rules and power on the implementation of formal rules and power.

Reasons for multiple concurrent policy changes should be investigated and its impact on clinician's workload. In addition, institution capabilities to effectively implement policies should be investigated.

Moreover, the policy development process in the department of health should be reviewed to determine institutionalised practices and the impact on policy implementation. This is important, considering that the department of health receives one of the highest budget allocations in the country**.**

Furthermore, it is critical to conduct an analysis of the actors who are successful in having their preferred policies passed. This will provide a deeper understanding of who holds the power to influence polices in the country.

6.8. Conclusion

The study aimed to investigate HIV clinicians' ambiguity of motive to implement the UTT policy, based on existing literature that informed our research process. The study analysed and discussed findings using Weber's theory of bureaucratic management as a framework.

In addition, the study found that while it cannot be argued that the UTT policy implementation was rational, most participants did not implement the policy as prescribed, they rather implemented the policy with amendments. Thus, acting outside the policy and creating informal rules. Creating informal rules indicated that clinicians did not have the motive to implement the policy.

Clinicians created their own informal rules because the introduction of the UTT policy brought sweeping changes rapidly with little consideration for institutional frameworks

and culture. This resulted in clinicians with longer terms of service, recognised as clinical leaders having less morale to implement. The policy implementation process, including the initial communication on the policy, did not allow for hearing, understanding, and transforming resistance into positive inputs that could strengthen implementation.

While the UTT policy decision was made based on credible global evidence, it was still insufficient. The following three essential steps should have been taken. Firstly, meaningful consultation across all levels. Secondly, a review of contextual factors, including past practices, other policy implications, and service level experiences. Thirdly, a process to explore alternative approaches. Although these steps may have delayed implementation initially, they would have identified areas of disagreement and strengthened the policy accordingly. This approach would help mitigate resistance to the policy, prevent the need for rapid revisions, and ensure effective implementation in the long term.

As a result, a well-intentioned policy ideal conflicted with existing policies, undermined local knowledge, and institutionalised practices, leading to implementation with amendments. Consequently, the UTT policy failed to enhance the staff working experience, leading to ambiguity in their motivation to implement it.

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APPENDIX A: ETHICAL CLEARANCE CERTIFICATE

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

22 May 2023

Maphotla Emma Mabusela (951055867)
School Of Social Sciences
Pietermaritzburg Campus

Dear ME Mabusela,

Protocol reference number: HSSREC/00005616/2023
Project title: Understanding doctors and nurses resistance to implementing the universal test and treat policy pronouncement in South Africa
Degree: Masters

Approval Notification – Expedited Application

This letter serves to notify you that your application received on 11 May 2023 in connection with the above, was reviewed by the Humanities and Social Sciences Research Ethics Committee (HSSREC) and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

This approval is valid until 22 May 2024.
To ensure uninterrupted approval of this study beyond the approval expiry date, a progress report must be submitted to the Research Office on the appropriate form 2 - 3 months before the expiry date. A close-out report to be submitted when study is finished.

HSSREC is registered with the South African National Health Research Ethics Council (REC-040414-040).

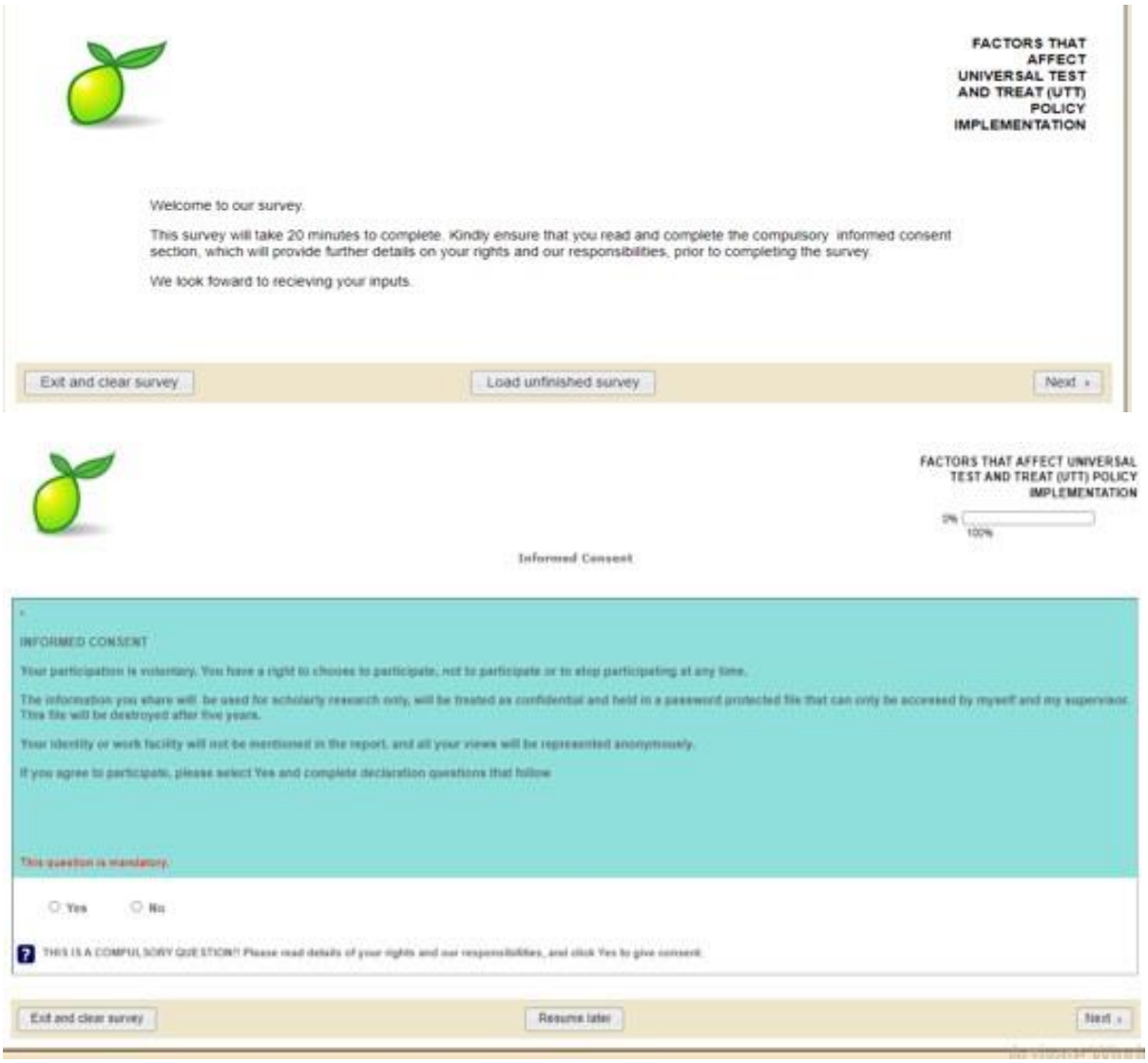
Yours sincerely,

[redacted]

Professor Dipane Hlalele (Chair)

/dd

APPENDIX B: CONSENT FORM AND QUESTIONAIRE



If you agree to participate, please select Yes and complete declaration questions that follow

This question is mandatory

- (•) Yes
- ( ) No

? THIS IS A COMPULSORY QUESTION! Please read details of your rights and our responsibilities, and click Yes to give consent.

DECLARATION

1. I consent to participating in the study.
2. I have received, read, and understand the nature and process of this study.
3. I was afforded an opportunity to ask any questions and raise any concerns and am satisfied to continue.
4. I understand that my participation will not result in any immediate benefit to me, and I will not be paid.
5. I have been given assurance that all the information I give will be treated confidentially and I will not be identified in the study.
6. I know and understand that I can withdraw from this study at anytime and would not have to give a reason.If I withdraw all the data, I provided will be destroyed.

- ( ) Yes
- ( ) No

? By clicking yes, you agree to the declaration.

Exit and clear survey | Resume later | Next

FACTORS THAT AFFECT UNIVERSAL TEST AND TREAT (UTT) POLICY IMPLEMENTATION

0% 100%

Demographic Details

Type of Clinician
Choose one of the following answers

- (•) Doctor
- ( ) Professional Nurse

? Please select your best suited answer

* Gender

- ( ) Female
- ( ) Male

AGE
Choose one of the following answers

- ( ) BELOW 30 years
- ( ) 30 to 40
- ( ) 41 to 50
- ( ) 51 to 60
- ( ) 61 and above

RACE
Choose one of the following answers

- ( ) Black
- ( ) Coloured
- ( ) Indian
- ( ) White
- ( ) Other


Number of Years in Proffessional Service
Choose one of the following answers
0 to 3
4 to 9
10 and above
Number of years providing providing HIV treatment services
Choose one of the following answers
0 to 3
4 to 9
10 and above
Type of Institution
Choose one of the following answers
Please choose
Community setting where institution is based
Choose one of the following answers
Rural
Semi-Urban
Urban
FACTORS THAT AFFECT UNIVERSAL TEST AND TREAT (UTT) POLICY IMPLEMENTATION
0%
100%
HIV Specific Training
Have you recieved HIV Treatment training
Yes
No
Have you recieved any training that is specifict to Universal Test and Treat or Same Day Initiation
Yes
No
Exit and clear survey
Resume later
Next

FACTORS THAT AFFECT UNIVERSAL TEST AND TREAT (UTT) POLICY IMPLEMENTATION

0%
100%

Participation in Policy Development Process

How were you or your institutions representatives involved in UTT Policy development?

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
I participated in the UTT Policy Development Process					
My colleagues participated in the UTT Policy Development Process					
District Managers participated in the UTT Policy Development Process					
Provincial Manager participated in the UTT Policy Development Process					
National Manager participated in the UTT Policy Development Process					
Development Partners participated in the UTT Policy Development Process					
I do not know who or how the policy was developed					

? Please mark you best suited answer with an X

Exit and clear survey | Resume later | Next »

FACTORS THAT AFFECT UNIVERSAL TEST AND TREAT (UTT) POLICY IMPLEMENTATION

0%
100%

Initial Impressions on the Policy

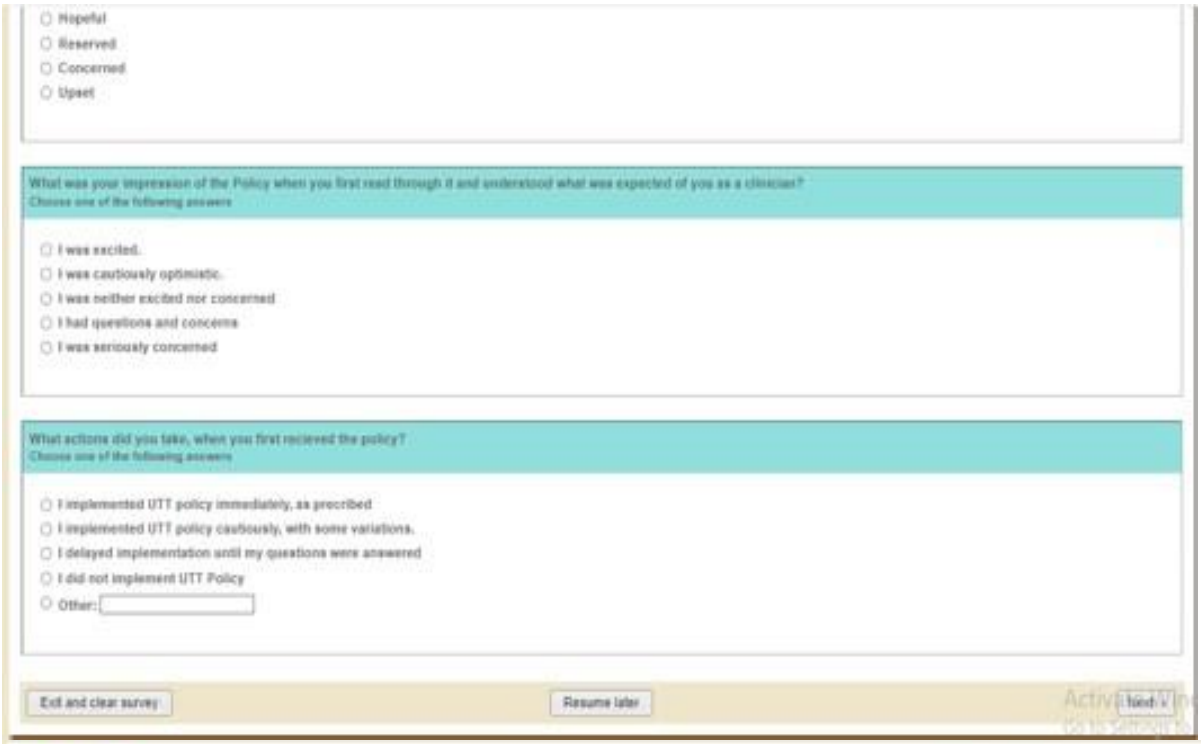
Where did you hear about UTT Policy for the first time?
Choose one of the following answers

- The media
- Social Networks
- A patient
- Departmental written communication
- Departmental meeting

How did you feel when you first learnt about UTT Policy?
Choose one of the following answers

- Excited
- Hopeful
- Reserved
- Concerned
- Upset

What was your impression of the Policy when you first read through it and understood what was expected of you as a clinician?
Choose one of the following answers


Hopeful
Reserved
Concerned
Upset

What was your impression of the Policy when you first read through it and understood what was expected of you as a clinician?
Choose one of the following answers

I was excited.
I was cautiously optimistic.
I was neither excited nor concerned
I had questions and concerns
I was seriously concerned

What actions did you take, when you first recieved the policy?
Choose one of the following answers

I implemented UTT policy immediately, as precribed
I implemented UTT policy cautiously, with some variations.
I delayed implementation until my questions were answered
I did not implement UTT Policy
Other:

Exit and clear survey | Resume later | Next


FACTORS THAT AFFECT UNIVERSAL TEST AND TREAT (UTT) POLICY IMPLEMENTATION

0%
100%

Policy Implementation Planning and Monitoring

How did you plan and monitor UTT Policy implementation in your unit.

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Our team developed a UTT Policy Implementation Plan					
The team met regularly to review and strengthen implementation					
We did not plan together but everybody did their best to accommodate the policy					
We continued to work independently as we did before the policy					

Please mark you best suited answer with an X.

Exit and clear survey | Resume later | Next


FACTORS THAT AFFECT UNIVERSAL TEST AND TREAT (UTT) POLICY IMPLEMENTATION

0%
100%

Current perceptions and Experiences of UTT Policy Implementation

Have your views on UTT policy changed from 2016 to date?

Yes
No

Exit and clear survey | Resume later | Next

Thank you for having participated in this survey

Your time and inputs are highly appreciated. Kindly contact me as detailed below, if you are able to participate in a 30 minutes indepth interview on the same topic

Name: Emma Mabusela

Email: 951055067@stu.ukzn.ac.za

Mobile [redacted]

APPENDIX C: INTERVIEW GUIDE

WORK EXPERIENCE

- Tell me about your experience in working in the health sector
- What made you start working in the field of HIV
- How does working in HIV treatment different from other health care work

POLICY MAKING

- What role have you played in policy making since you have started working
- What role do you think you should be playing?
- What do you know about the policy making process?

EXPERIENCE IN HIV

- How has your journey in HIV been thus far?
- What where some of the major changes?
- How have these changes affected your work?
    - How you do work
    - ○ The people you work with ○ Your patients

UIVERSAL TEST AND TREAT (UTT) POLICY

- What has been your experience with UTT Policy?
- What impact has the UTT Policy have on your work?
- How is it different from other policies?
- What would you need to be comfortable implementing?
- What are your opinions on the UTT policy making process?
- How can the UTT Policy be improved?

UIVERSAL TEST AND TREAT (UTT) POLICY IMPLEMENTATION

- How did you prepare to implement the policy?
    - Who was involved in the process and why were they involved
- Have you always been comfortable with implementing it? ○ Why ○ What changed
- What impacted on your level of comfort in implementing?

Provisional dissertation 951055867 less references and anexures.pdf

ORIGINALITY REPORT

4%	4%	1%	%
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