UNIVERSITY OF THE WESTERN CAPE

Faculty of Community and Health Science

School of Nursing

HIV MANAGERS' PERCEPTIONS AND EXPERIENCES REGARDING IMPLEMENTING HIV POLICIES AT PRIMARY HEALTH CARE FACILITIES IN THE WESTERN CAPE

A thesis submitted in fulfilment of the requirements for the degree of Master of Nursing in the School of Nursing, Faculty of Community and Health Sciences, University of the Western Cape

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KEYWORDS

Challenges

Experiences

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Perceptions

Primary health care facilities

Policy and HIV policy

Policy implementation

LIST OF ABBREVIATIONS

ART	Anti-retroviral Therapy
BANC	Basic Antenatal Care
CCT	City of Cape Town
CDC	Community Day Centres
CHC	Community Health Centres
HAST	HIV/ AIDS/ STI and TB
HIV	Human Immunodeficiency Virus
FDC	Fixed Dose Combination
NDoH	National Department of Health
NIMART	Nurse Initiated Management of Anti-retroviral
PEP	Post-Exposure Prevention
PrEP	Pre-Exposure Prevention
PHC	Primary Health Care
PTMCT	Prevention of Mother-to-Child Transmission
SA	South Africa
SOP	Standard Operations Practices
UTT	Universal Test and Treat
WCDoH	Western Cape Department of Health
WHO	World Health Organization

DECLARATION

I declare that HIV managers' perceptions and experiences regarding implementing HIV policies at primary health care facilities in the Western Cape is my own authentic work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

Signature: 

Date: November 2022

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DEDICATION

Isaiah 46:10

"Declaring the end from the beginning and from ancient times things not yet done saying,

'my counsel shall stand, and I will accomplish all my purpose."

This study is dedicated to loved ones whom I love dearly but are no longer with me, their memories are forever engraved in my heart:

To my late Mother, Medelene Elzete Hendricks,

my late Grandfather, George Leslie De Beer

and the late Richard Nicolas De Beer

ABSTRACT

Background: The implementation of policy involves translating the goals and objectives of a policy into action. One major problem involved with implementing HIV policy within the Western Cape, South Africa is that there is a lack of proper direction or guidelines on how to put it into practice. Within the context of HIV, the term 'policy implementation' refers to the legal framework in which various organisations and stakeholders work together, applying procedures and techniques, to put policies into effect to attain goals. Policy models have been developed to accelerate policy implementation, while quality assurance is utilised to determine whether the policies are successfully implemented or not. This study was guided by the constructivism paradigm which allows researchers to view the world through the perceptions and experiences of the participants. In seeking answers for a research study, the researcher uses the participants' experiences to construct and interpret their understanding of the HIV manager's perceptions and experiences regarding implementing HIV policies at Primary Health Care (PHC) facilities.

Purpose: To explore and describe the HIV managers' perceptions and experiences regarding the implementation of HIV policies at PHC facilities within the Northern Tygerberg sub-district of the Cape Metropole in the Western Cape.

Objectives: The following research objectives have been identified:

1. To explore the process followed by HIV managers in implementing HIV policies at PHC facilities.
2. To describe the challenges experienced by HIV managers during the implementation of HIV policies at PHC facilities.

Research methods: This study utilised an exploratory-descriptive qualitative research design in which the researcher explored and described the perceptions and experiences of HIV managers in PHC facilities regarding the challenges in implementing HIV policies. Purposive sampling was used to identify the HIV managers within the Northern Tygerberg sub-district, Cape Metropolitan area. A total of ten participants were interviewed for this study during the timeframe of May to August 2022. Data were collected using individual semi-structured interviews, using an interview guide with probing questions to obtain detailed information. Interviews were audio recorded, and field notes were made; the researcher could review these when necessary. Using Braun and Clark's thematic data analysis, various sub-themes were identified that would lead to the development of new knowledge.

Findings: The study found that there is a collaborative approach amongst stakeholders to strengthen policy implementation process and to ensure they adhere to their responsibilities of policy implementation. This study found that there is a lack of adequate human resources, staff attitudes and clinical competency all have implications for effective policy implementation. Additional challenges included a lack of proper and adequate infrastructure, faulty equipment, inadequate information technology equipment and resistance to embracing technology by clinicians. Training poses challenges, however. Thus, there is a lack of innovative training such as self-paced online studies, and webinars, as service pressures and requirements do not always allow staff to attend formal training. Administrative challenges such as the training registration process and a need for self-registration for courses need to be investigated.

Ethics: Scientific rigour was achieved through trustworthiness, while ethical approval was issued by Research and Ethics Committee of the University of the Western Cape. All ethical principles such as autonomy were adhered to, for example, informed consent and

confidentiality, beneficence, non-maleficence, and justice. All participants were involved in the study on a voluntarily basis. Informed consent forms were completed by all participants.

Conclusion: Effective implementation of policy is an essential component of the national response to HIV, and it contributes to ending the endemic as indicated in the Sustainable Development Goals (SDG)3 by 2030. It can be a very challenging process at times and although major targets have been met in relation to the National Strategic plans, there is still opportunity for much improvement. To ensure the effective implementation of policy, comprehensively trained staff are required who can deliver integrated care with adequate equipment and resources.

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CHAPTER 1: OVERVIEW OF THE STUDY

1.1 Introduction

Chapter one provided an introduction and background to the problem statement, research question, study purpose, study objectives, the significance of the study, operational definitions of key concepts, theoretical framework, and outline of the study was also presented.

The implementation of policy involves translating the goals and objectives of a policy into action and ensuring that all policies are followed correctly and for the proposed purpose (Hofmann & Türk, 2018). The implementation of the Human Immunodeficiency Virus (HIV) policy ensures standardised care for all patients while meeting national and global indications of treatment goals. However, the successful implementation of policy depends on the active involvement of all stakeholders, and on the way that policy formulation at the national level is filtered down to the district, sub-district, and facility levels.

The function of the National Health Council (NHC) in South Africa, in relation to the policy implementation process, is as follows: The National Health Council is composed of the Minister of Health, the Directors-General of national departments, and relevant members of the Executive Council, including the heads of the provincial departments. Nine provincial Departments of Health are responsible for ensuring the implementation of policies filtered from national to the relevant provincial health policies. On a provincial level, policies are implemented through the district and sub-district health system, with each district being responsible for the development of a district health plan that supports the implementation of national and provincial health policies (National Department of Health [NDoH], 2004).

At the district and sub-district levels, the HIV/sexually transmitted infections (STI) and tuberculosis (TB) (HAST) coordinators receive the new or updated policy from the NDoH and

ensure the implementation of new policies as well as the integration of HIV policies across programmes. HAST coordinators are responsible for providing HIV managers with the necessary information and documents, and for monitoring and evaluating the policy implementation process; this entails assessing monthly performance and monthly internal audits for quality assurance. In addition, they assist with in-service HIV training, clinical guidance at facilities and the development of standardised processes to improve access to HIV care.

The HIV managers on the sub-district level are responsible for monitoring policy implementation by the primary health care (PHC) workers (Orange, 2018). Their administrative duties include compiling monthly data reports such as the number of patients initiated, lost to follow-up and complicated referrals to the HAST coordinator of the sub-district (Western Cape Government, 2018). In addition, some HIV managers render clinical HIV treatment and care services in PHC facilities.

HIV policies are often translated into guidelines. These guidelines are recommendations to assist in standardising treatment regimens and routine clinical care (National Department of Health, 2019).

The effective implementation of public policy is beneficial for citizens. Its effectiveness and success are positively correlated with how well it is translated into practice (Hofmann & Türk, 2018). The best policy is worth little if it is poorly implemented. Policy implementation that lacks proper direction or guidelines becomes challenging to put into practice. The implementation of a policy is specific to its context because it depends on attitudinal, economic, organisational, political, and social, factors that influence how well or poorly a policy or programme is implemented (Hofmann & Türk, 2018).

Although there are continuous intentions regarding the implementation of policy, research shows that there is a gap between policymaking and policy implementation; this gap has rendered past HIV policies suboptimal. (Orange, 2018). The HIV managers are responsible for ensuring that policies are filtered to the healthcare workers and implemented effectively. The focus of this research study is on obtaining a better understanding of the process of HIV policy implementation and its challenges. This is done by exploring the perceptions and experiences of HIV managers implementing HIV policies within the PHC facilities in the Western Cape.

1.2 Background

Globally, more than 37.7 million people are living with HIV (World Health Organization [WHO], 2021). Approximately 1.5 million people die every year from Acquired Immunodeficiency Disease Syndrome (AIDS) globally, making it one of the leading causes of death (WHO, 2021). HIV prevalence is the highest in sub-Saharan African countries, with South Africa carrying a burden of approximately 7.7 million living with HIV (United Nations Programme on HIV/AIDS [UNAIDS], 2020).

HIV impacts negatively the socio-economic development of individual societies because it is associated with adult mortality, especially in sub-Saharan Africa (Ward, Garnett, Mayer & Dallabetta, 2019). Despite the progress made with the availability and initiation of treatment as a response to HIV, the pandemic remains a serious challenge to global health, and will possibly remain this way for the next few decades (Ford, Vitoria & Doherty, 2018).

There have been major developments in treating HIV because of the availability and rapid scale-up of antiretroviral therapy (ART); nevertheless, there is still no cure or vaccine for prevention. However, ART has transformed HIV into a chronic, yet manageable condition, leading to notable declines in the worldwide rate of AIDS-related deaths (Kharsany & Karim, 2016).

To ensure a permanent decline in the incidence and mortality rates of HIV, national and district health levels have introduced the 95-95-95 goals as recommended by the World Health Organization (WHO). This means that 95% of all people living with HIV should know their status, 95% of all people tested must be on treatment, and 95% of all people living with HIV should be virologically suppressed. To ensure that this 95-95-95 goal is met, the global Universal Test and Treat (UTT) policy (WHO, 2016) was adopted. This policy states that all people living with HIV can be initiated on ART regardless of their CD4 count and initiation of treatment should take place immediately. The 95-95-95 goals and UTT are targets interlinked and achievable when the policy is implemented effectively (UNAIDS, 2021).

According to UNAIDS (2020), South Africa has the largest ART programme in the world. Because of the large number of people requiring treatment for HIV, a decentralised HIV care programme was introduced in 2010, so that HIV treatment could be provided in PHCs throughout South Africa (South African History Online [SAHO], 2019). To facilitate decentralisation, healthcare workers (medical doctors, professional nurses, and pharmacists) who work in PHC facilities were tasked with initiating treatment of low-risk patients who are eligible for ART and they were called upon to refer complex cases to the secondary-level hospitals (Makhado, Davhana-Maselesele, Lebese & Maputle, 2020).

Since PHC facilities are the first point of entry into the health care system for most patients with HIV, successful treatment requires staff who are up to date with current ART treatment, policies, and guidelines. Policies are updated regularly out of necessity, for various reasons, such as the required changes in drug regimens, cost containment, changes due to side effects of certain drugs, and drug interaction arising from co-morbidity treatment such as tuberculosis. Successful implementation of HIV policy can influence the delivery of high-quality HIV care and treatment services by decreasing the incidence of infections, and HIV-related morbidity

and mortality; this improves the ability of the government to meet global HIV targets for HIV prevention (National Department of Health, 2016).

Although policies and guidelines are updated, there is little evidence that their implementation is efficient; inefficient implementation renders policies and guidelines less effective (Wang, Grundy, Parker & Bero, 2019). According to the Cape Metro District Plan, (Western Cape Government, 2018), based on quality assurance audits, the Northern Tygerberg sub-district has not met its HIV programme performance indicators and targets. These poor results could be due to several factors including poor policy implementation, but research has not been conducted to explore this. Therefore, it is imperative for the researcher to explore the challenges facing HIV policy implementation in this context, from the perspective of HIV managers (Western Cape Government, 2018).

1.3 Problem statement

Previous audits have indicated that the Tygerberg sub-district were not meeting HIV policy implementation indicators and targets (Western Cape Government, 2018). A lack of guidance, in-service training, and support from district HAST coordinators, when interpreting and implementing new policies, can lead to misinterpretation of new and updated policies, which means that they are not implemented optimally (Farokhzadian, Nayeri & Borhani, 2018). One may argue that a lack of planning combined with poor quality assurance systems leads to ineffective policy implementation (Ajulor, 2018). Furthermore, inadequate communication to stakeholders, such as HIV managers, healthcare workers and non-profit organisations (NGOs), about the changes to HIV policies leads to inconsistent implementation across facilities (Shariff, 2014).

Many factors could contribute to poor or ineffective policy implementation (Khan, 2016), but currently, there were not enough evidence in the context of the Northern Tygerberg sub-district.

Therefore, there is a knowledge gap. This provides an opportunity to research HIV managers' perceptions and experiences regarding the HIV policy implementation processes and challenges at PHC facilities in the Western Cape.

1.4 Research question

The main research question for the study was as follows:

What are the HIV managers' perceptions and experiences regarding the implementation of HIV policies at PHC facilities within the Northern Tygerberg sub-district in the Cape Metropole of the Western Cape?

1.5 Study purpose

The purpose of this study was to explore and describe the HIV managers' perceptions and experiences regarding the implementation of HIV policies at PHC facilities within the Northern Tygerberg sub-district in the Cape Metropole of the Western Cape.

1.6 Study objectives

The objectives of this study were:

1. To explore the process followed by HIV managers in implementing HIV policies at PHC facilities.
2. To describe the challenges experienced by HIV managers during the implementation of HIV policies at PHC facilities.

1.7 Significance of the study

The findings of this study can assist in the appropriate implementation of HIV policy by offering recommendations on the effective implementation of HIV policy specific to the PHC facility level. The findings of this study have implications for nursing education in so far as they can be used to inform undergraduate and postgraduate curriculum topics regarding HIV

policy implementation. The findings of the study can also be used as a baseline for future research.

1.8 Operational definitions of key concepts

Challenges – According to the Cambridge dictionary (2022), defines challenge as a situation that is deemed difficult that acquires a needs great mental or physical effort in order to be done successfully.With context to this study, 'challenges' relates to the various challenges that HIV managers experience when implementing HIV policies in PHC facilities. Challenges range from staff shortages, information, and technology, as well as training.

Experience – According to the Cambridge dictionary (2022), the term 'experience' is described as the process of acquiring knowledge or skill by doing, feeling or seeing things: this is described as the knowledge and skill that individual gains by doing something for a period. Within the context of this study, the term 'experiences' relates to those of the HIV managers, from receiving the policy to the planning phase. It includes their experiences when putting logistics in place and the possible barriers or challenges of ensuring the implementation of HIV policies at PHC facilities.

HIV Managers - According to the South African Nursing Council (SANC, 2020), a manager is a registered nurse who has obtained an additional post-basic qualification in Nursing Administration. In this study, the term 'HIV managers' refers to a manager of an infectious disease department dealing with HIV, TB, and other infectious diseases within a PHC facility. These managers are responsible for guiding, overseeing, and reviewing the process of the operational implementation of HIV policies at PHC facilities.

Perceptions - Perception is mediated through the interconnectedness of mind and body and is an individual's access to experience and interpretation in the world (Given, 2020). Perception is a mode of apprehending reality and experience through the senses, thus enabling discernment

of figure, form, action, behaviour, and language. An individual's perceptions influence that person's judgement, opinion, and understanding of a situation or person, as well as the meaning of an experience, and how one responds to a situation. In this study, the researcher aims to identify the individual perceptions of the participants to understand their interpretation of the implementation of HIV policies in their PHC facilities.

Primary Health Care Facilities - Primary health care facilities are described as the first level of care that patients receive within the health system in South Africa (Tshililo, Mangena-Netshikweta, Nemathaga, & Maluleke, 2019). With reference to this study, HIV policies are implemented at PHC facilities within the Western Cape.

Policy and HIV Policy – A policy is described as a set of ideas or a plan of what to do in situations that have been officially agreed to by a government, a group of people, or a political party (Ward et al., 2019). In this study, the researcher specifically focused on new and/or updated HIV policies and the perceptions and experiences relating to their operational implementation. HIV policy refers to the plan of action used to manage patients living with HIV, which results in standardised care regardless of the PHC facility (National Department of Health, 2019).

Policy Implementation - Policy implementation involves translating the goals and objectives of a policy into an action (Hofmann & Türk, 2016). In this study, policy implementation will focus on the processes that are currently followed when implementing HIV policies operationally, and the exploration of the optimal implementation of new policies and policy updates.

1.9 Theoretical framework

The term 'theoretical framework' refers to the analytical structure that directs a research study (Creswell & Creswell, 2018). Policy implementation involves five steps as indicated in Figure

1.1. These steps are: 1) Identification of the problem; 2) Developing the policy intentions; 3) Government drafts new or updated policies; 4) Implement policy and 5) Evaluate policy. The researcher will be focusing specifically on step four: implementing policy.

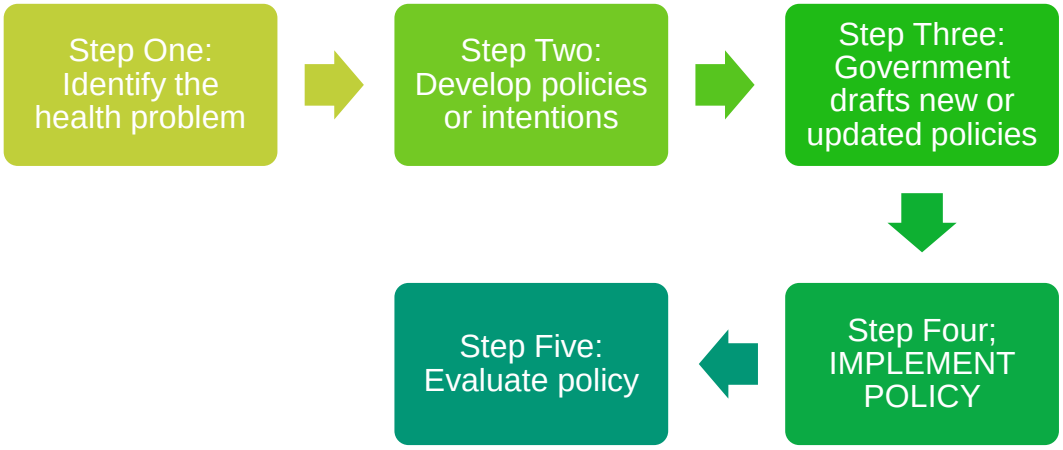


Figure 1.1: Process of policy implementation

(Adapted from National Health Act, 2003)

There are various models to guide policy implementation; these include the Rational, Management, Organisational Development, Political and Bureaucratic models. Each of these models has its own strengths and weaknesses that potentially affect the outcome of the policy implementation process (Khan & Khandaker, 2016). In this study, the researcher adopted the Management Model of policy implementation (Khan & Khandaker, 2016).

The researcher chose the Management Model as it is the one most pertinent to this study. Thus, the factors influencing policy implementation included in this model are organisational structure, personnel and human resources, the activities of front-line implementers, equipment and technology, the levels of coordination and cooperation, the exercise of authority, and place/location, and implementation infrastructure. All these factors align well with the context of the present study (Khan & Khandaker, 2016).

The Management Model outlined various factors that influence successful policy implementation. The researcher used this model as a framework for analysing and interpreting the perceptions and experiences of HIV managers regarding challenges facing the policy implementation processes (Khan & Khandaker, 2016).

1.9.1 Management Model of policy implementation

The Management Model (see Figure 1.2) is based on the performance of policy implementation, and the model facilitates successful policy implementation.

The following factors are highlighted as challenges to the implementation of policies:

- Organisational structure,
- Personnel and human resources,
- The activities of front-line implementers,
- Equipment and technology,
- The levels of coordination and cooperation,
- Exercise of authority, and
- Implementation infrastructure.

1.9.2 Organisational structure

Organisational structure refers to the steps or tasks taken to achieve an objective of an organisation (Western Cape Government, 2018). The organisational structure includes accountability measures, guidance, and enforcement mechanisms that need to be well-defined and formally agreed on if they are to ensure clarity on roles and responsibilities within the implementation process (Wright, 2017).

Organisational culture is crucial for policy implementation because clinicians have a significant level of autonomy and are not entirely under administrative control. These elements of the

policy influence how organisations will interpret and then actually implement that policy. For example, lengthy decision-making processes, organisational resistance to change, risk avoidance, and lack of coordination between HIV clinicians can be barriers to implementation (Wright, 2017). Therefore, the Management Model identifies an effective organisational structure as a significant contributor towards a positive policy implementation outcome.

1.9.3 Personnel and human resources

Personnel and human resources are terms used to refer to the people within an organisation who make up the workforce (National Department of Health, 2020). The South African National Strategic Plan (2017- 2022) is aligned with the Management Model regarding the importance of having sufficient and appropriately trained human resources to implement policy successfully (SANAC, 2017). HIV treatment and care are labour-intensive and require input by many people playing multiple roles within a team context. The required human resources include administrative clerks, registered nurses, pharmacists, and clinicians as well as supply chain management and HIV managers. In view of the ambitious nature of the clinical targets and the increased workload in HIV care, a resilient system of human resources is needed to implement HIV policies adequately and competently. Furthermore, appropriately trained, supported, and fully integrated clinical practitioners in HIV care and treatment will ensure that the workforce is sufficiently capacitated. In this context, all factors should be working together to support the goals and objectives of any intended HIV policy (SANAC, 2017). The lack of sufficient staff will have implications for the outcome of any HIV policy implementation.

1.9.4 Equipment and technology

Equipment and technology are defined as a set of physical resources that equip an individual to perform a task. Equipment can be fixed or moveable and includes computers, blood pressure machines, electronic cardio machines (ECG), glucose monitors and blood pressure machines

(Azline, Khairul Anuar, Iszaid, Syahira, & Hisham Awad, 2018) Successful HIV programmes and the efficient implementation of services require adequate equipment and the integration of the latest technology and software to care for HIV patients. A lack of medical equipment and devices, technology and resources has led to failure in implementing policy programmes (Farokhzadian et al., 2018).

1.9.5 Level of coordination and exercise of authority

According to Khan & Khandaker (2016), coordination and exercise of authority is the responsibility of one individual only; that person coordinates tasks and ensures that all plans are executed according to the predetermined goals. The effective implementation of the policy requires ongoing support from regional and national governments and organisations, as well as from relevant individuals. A lack of authority and leadership can be a barrier to policy implementation. There is evidence to suggest that supporting local and regional leaders such as HIV coordinators, in driving implementation processes, can lead to effective policy implementation. These HIV coordinators can guide what policy action plans are valued and can influence the general culture towards clinicians implementing policies adequately (Wright, 2017). A lack of clear guidance about expectations and responsibilities for implementing policy can present a significant challenge from the outset.

1.9.6 Location of implementation infrastructure

The term ‘implementation infrastructure’ refers to the infrastructure put in place for implementation to proceed successfully (Farokhzadian et al., 2018). The correct implementation infrastructure involves clear communication, improved involvement of all parties working together, adequate resources and the correct conditions for starting the implementation processes. If all this is in place, then it will decrease delays and enhance the successful implementation of HIV policies (Khan & Khandaker, 2016). Essential HIV care

and treatment services, as well as infrastructural and managerial support, are key components for ensuring quality services (Tshililo et al., 2019). The availability of sufficient consulting rooms, with all the resources needed to treat patients, together with sufficient medication supplies, will allow for the successful implementation of HIV policies. Therefore, the implementation infrastructure is important in planning the implementation of policy to ensure positive output.

Figure 1.2: Management model: Factors that determine policy implementation.

Adapted from Khan & Khandaker, 2016

1.10 Outline of the study

The outline of the chapters provides an overview of information that will be covered in chapter one to five.

Chapter 1

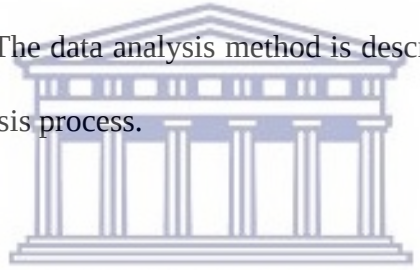
The first chapter gives the reader the background to this study as well as its purpose and the operational definitions used in the study. The chapter briefly explains the background, problem statement, and research question applied to articulate the research. The theoretical framework, based on the Management Model, is also discussed.

Chapter 2

This chapter provides an overview of the literature review that was conducted to describe policy implementation and the factors that may influence the process.

Chapter 3

This chapter introduces the qualitative methodology that was used in this study and describes the process of data collection. The data analysis method is described as well as the steps that were followed in the data analysis process.



Chapter 4

This chapter presents the findings of this study including the literature that correspondence to achieved themes.

Chapter 5

This chapter presents the findings in relation to evidence-based literature. The conclusions and recommendations of this study are then presented.

1.11 Summary

In chapter one the researcher provided an introduction and background to this study. This chapter described the problem statement, as well as the aim and objectives of the study. It incorporates the research question to be answered. The significance of the study was explained. The following chapter provides an overview of the literature review relating to the study as

well as the theoretical framework used. Concepts that will be used in this study were also described.

CHAPTER 2: LITERATURE REVIEW

In chapter one, the research problem and the context of this study were reviewed. Chapter two focuses on the literature review conducted for this study; this review examines the literature on the perceptions and experiences of HIV managers implementing HIV policies as well as the challenges they encounter while implementing these policies. The purpose of any literature review is to document the current knowledge regarding the problem being investigated and as such, it includes the sources used to develop the study and interpret the findings (Burns, Grove & Gray, 2021). A literature review assists the researcher to identify the current theoretical and scientific knowledge regarding a research topic. It indicates the possible gaps in that knowledge and motivates the significance of the study in contributing to building knowledge within the research community (Burns et al., 2021). The literature review in qualitative research is a written narrative that assists the researcher to determine whether the topic is relevant and worth studying. It assists with narrowing the scope of the study to the phenomena being researched (Creswell & Creswell, 2018). In this study, a preliminary literature review was performed to inform the study background and problem statement. A more detailed review was performed following the data analysis, and this is presented in this chapter.

This literature review was performed using the following electronic databases: Academic search elite, EBSCOhost, Elsevier, Google Scholar, SAGE journals, PubMed and Science Direct, and relevant online e-books and other grey literature were included. Keywords used for searching literature included: HIV manager, PHC managers, policy and HIV policy, implementation, challenges, and factors influencing policy implementation.

This literature review is organised and presented as follows:

- International HIV policies

- South African HIV policies
- Theory of policy implementation
- Process of policy implementation in South Africa
- Importance of policy implementation in the context of HIV
- Challenges and factors that influence HIV policy implementation applied to the Management Model:
    - Personnel and human resources
    - Implementation infrastructure, location, and place
    - Equipment and technology
    - Levels of coordination and planning
    - Activities of frontline implementers and training, and
    - Exercise of authority

2.1 International HIV policies

The year 2021 marked 40 years since the first HIV cases were reported. The United Nations Programme on HIV (UNAIDS) was officially created in 1994 and this launched the global response to HIV (UNAIDS, 2020; WHO, 2019). UNAIDS has developed many international policies and guidelines on HIV and AIDS that nations have since adopted in their respective countries over the years. These policies cover a range of issues including orphans and vulnerable children; HIV prevention and treatment; gender and HIV; Prevention of Mother to Child Transmission (PMTCT); women and girls; and HIV testing and counselling (UNAIDS, 2018).

The global guidelines and responses to HIV have evolved over the years and included a range of prevention and treatment strategies. The response to fighting HIV was initiated in 1985, with the availability of antibody testing. This was followed, in 1994, by the establishment of the

first PMTCT programme. In 1996, a treatment was introduced that involved a combination of drugs and three anti-retroviral (UNAIDS, 2021). In the year 2000, HIV was identified as a global security threat by the United Nations (UN) and in 2002, the Global Fund to fight AIDS, TB and Malaria were created. In 2005, the Group of Eight (G8) countries committed to universal access to HIV treatment to eradicate HIV as part of the Millennium Development Goals (MDGs). In high-prevalence settings, voluntary male medical circumcision was recommended as a prevention strategy by WHO and UNAIDS in 2007 (UNAIDS, 2021).

HIV prevention strategies later evolved to include the use of ART for post-exposure prevention (PEP) and pre-exposure prevention (PrEP). The inclusion of PrEP was aimed to further decrease the incidence rate of HIV infections particularly among at risk population groups. One example of an at-risk population is serodiscordant couples (one partner is HIV negative and one partner is HIV positive). In the case of serodiscordant couples the HIV negative partner needs PrEP, while the HIV positive partner needs ART. In 2012, ART was approved as a prevention method for serodiscordant couples (UNAIDS, 2020; WHO, 2012B). The approval of the use of PrEP in all HIV-negative people at risk of acquiring HIV took place in 2013. Following the PrEP policy, the HIV post-exposure prophylaxis (PEP) policy was amended in December 2014 by revising and expanding the eligibility criteria for PEP (WHO, 2016). For example, in the previous policy on persons with high-risk exposure were given PEP, but this was expanded to all persons with exposure to HIV (WHO, 2016). In 2015, the United Nations General Assembly announced the Sustainable Development Goals, with the goal three as the target to eradicate and end AIDS as a public health threat by 2030 (UNAIDS, 2021) and thereby placing more emphasis on the implementation of PEP and PrEP.

In addition to revising guidelines for prevention, global guidelines expanded to include ART for all people living with HIV; this became known as the Universal Test and Treat (UTT)

strategy. In 2016, the UTT strategy was recommended to all people living with HIV. That strategy was directed at reaching the 95-95-95 goals aimed towards ensuring that more people have access to ART and are virally suppressed to reduce the spread of HIV and end the HIV pandemic by 2030 (WHO, 2016).

Most countries throughout the world implemented the WHO (2016) UTT recommendations. The WHO continually provides a platform for guidelines and clinical support to countries in collaboration with UNAIDS, to meet the Sustainable Development Goals (SDG) 3 of good health and well-being by combating HIV (UNAIDS, 2021).

2.2 South African HIV policies

South African HIV policies and guidelines are based on the political and clinical guidance and recommendations made by WHO and UNAIDS (Simelela & Venter, 2014). Since the inception of the HIV pandemic, South Africa has needed to revise its HIV policies to align with international guidelines.

The first case of HIV in South Africa was diagnosed in 1982 (SAHO, 2019). In 1988, two structures known as the South African National Aids Council (SANAC), and the National Advisory Group, were formed within the Department of Health to promote awareness about HIV/AIDS.

In the early 2000s and prior to South Africa's first ART rollout, the HIV wellness programme commenced; this entailed six monthly follow-ups at the PHC clinics. Visits to the wellness clinic included drawing blood for CD4, opportunistic infection screening, prevention of TB treatment, annual cervical smears for women and provision of co-trimoxazole to prevent potential opportunistic infections (Department of Health, 2000). The use of ART for HIV prevention in South Africa started with the use of Zidovudine (AZT) and Nevirapine (NVP) in pregnant women as a prophylaxis to prevent PMTCT. This practice was initiated after the

Treatment Action Campaign (TAC) won a court case against the South African government in 2002 to make ART available for PMTCT as a human right (Minister of Health v Treatment Action Campaign [TAC], 2002, 5 SA 721 [CC]). This was expanded in 2004 when the ART programme was rolled out. The HIV programme continued to expand as eligibility criteria changed from being based on CD4 count and WHO staging criteria to the UTT approach (WHO, 2012).

Today, South Africa is known for having one of the largest ART programmes in the world (WHO, 2020). Thus, in 2020 there were 7.7 million people in South Africa living with HIV (UNAIDS, 2020). South Africa has tried to keep policy aligned with WHO recommendations to decrease the HIV incidence and mortality rates. The first National Strategic Plan (NSP) for HIV/STI and TB was launched in 2007 to align with the ART rollout and to ensure that goals and objectives related to HIV/STI, and TB are met (Chibango, 2013). The NSP provides plans for the journey towards a future where HIV, TB and STIs are no longer public health problems. This plan sets goals and establishes landmarks in the form of specific measurable objectives. Therefore, it is updated and revised every five years; the latest approved strategic plan is for the period 2017-2022 (Department of Health, 2020; SANAC, 2017).

In 2007, the Department of Health committed itself to help in the fight against HIV, by aligning all health policies to the first NSP which focused on four key areas: 1) Prevention strategies such as the PTMCT programme; 2) Treatment and care aimed at increasing the amount of voluntary counselling and testing; 3) Research, monitoring and surveillance of programmes in place; and to improve care, and 4) To advocate for access for justice and human rights for all people living with HIV. (Department of Health, 2007; SANAC, 2017). Table 2.1 indicates how the key goals of the NSPs have changed over the years. Currently, the NDoH is aligned with

the WHO 95-95-95 strategy, and it is declared in the latest NDoH NSP for 2017-2022 (Department of Health, 2020).

Table 2.1: Changes in National Strategic Plans for HIV/STI and TB from 2000 to 2022.

	KEY GOALS OF THE NSP
2000	The commencement of a series of strategic plans that guide the response to HIV/STI and TB.
2000-2005	To develop the structures and mechanisms to support the national response.
2007- 2011	To proceed decisively to stimulate a massive expansion in the provision of antiretroviral therapy.
2012-2016	Enhanced access to HIV treatment by the delivery of comprehensive HIV prevention services, prioritised action in relation to the national response. Recommend steps to address social and structural drivers of HIV/STI and TB.
2017-2022	Strengthening the focus on geographic areas and populations most severely affected by the epidemics. Using a combination of interventions that have been shown to deliver high impact. Strengthening systems and initiating monitoring and evaluation processes.

(Table adapted from 2017-2022 NSP, Department of Health (2017)

In order to achieve the NSP target of decentralisation of HIV care in 2010, the South African NDoH implemented HIV treatment, care, and support of HIV patients in PHC facilities. The aim of this strategy was to manage the provision of antiretroviral treatment for stable HIV patients so that they could have access to treatment whilst avoiding overloading secondary hospitals (Plazy et al., 2017; SANAC, 2017). As part of this strategy, nurses were trained to initiate ART, Nurse Initiated Antiretroviral Treatment (NIMART) and provide follow-up care at these decentralised facilities. In addition, guidelines were amended to include better, and simpler treatment regimens as scientific data became available; for example, fixed dose combinations (SAHO, 2019). The fixed-dose combination (FDC) of tenofovir, emtricitabine, and efavirenz availability was beneficial, because of the increased number of patients with HIV requiring treatment. It was also easier for people to adhere to taking one tablet per day (Department of Health, 2019; WHO, 2013).

On 1st September 2016, the UTT policy was introduced as part of the strategy to provide comprehensive prevention services and to use ART as a prevention strategy. The reasoning was that HIV incidence and transmission rates would be reduced if more people were on ART. The UTT policy meant that the initiation of ART was no longer dependent on the patient meeting specific eligibility criteria such as CD4 counts (Department of Health, 2016). This policy made ART available to all people living with HIV. Same-day initiation, advocating ART initiation on the day of a patient's initial HIV diagnosis, came into effect on 1st September 2017 (Department of Health, 2016).

2.3 Theory of policy implementation

The WHO defines policy as the decisions, plans, and acts that are embarked upon to achieve specific healthcare goals within a civilization (WHO, 2012A). The purpose of any HIV policy is to set objectives for action designed to guide the national response to HIV internationally and nationally (Department of Health, 2020). The policy is important as it facilitates the development of set standards and objectives related to specific outcomes, to promote awareness and aid prevention (Department of Labour, 2018). Policies are important in terms of informing the public of the government's intentions and visions. There is a need to ensure that the intentions respond to challenges and that the regulation of law and democratic values are respected and maintained (Department of Presidency, 2020). Strategic plans are developed to implement the relevant HIV objectives and targets of a policy, thus ensuring standardised treatment recommendations for people living with HIV.

In chapter one, the researcher discussed the Management Model as adapted from Khan and Khandaker (2016). That model assumes that policy implementation inputs have a direct influence on successful policy implementation; as indicated in chapter one, those inputs include personnel and human resource's organisational structure, the activities of front-line

implementers, equipment and technology, the levels of coordination and cooperation, the exercise of authority, and place/location, and implementation infrastructure. These inputs are needed to ensure that policy implementation outputs are met; for example, meeting projected indicators and targets set for that intended policy (Khan & Khandaker, 2016).

Successful and adequate implementation of policy is essential to standardise quality-of-care outcome measures. After all, if a policy is to be successful then it needs to be implemented as intended if it is to have the expected outcome; however, not all policies are feasible (Ajulor, 2018). Clinicians are encouraged to give input, preferably based on evidence-based practice, to explain why a specific policy was not as effective as expected. Potential changes that need to be made to ensure the optimal implementation of each policy should be communicated to policy reviewers to prevent good policies from being underutilised because of inadequate implementation (Plazy et al., 2017).

2.4 The process of policy implementation in South Africa

The process of policy implementation consists of the following phases: problem identification, policy formulation, policy implementation and policy evaluation (Azline et al., 2018). Once a policy is in place, it is implementation and then evaluation takes place to identify any gaps and quantify the success of that policy. Stakeholders involved in the planning process for implementation should evaluate its effectiveness. Wright (2017) suggests that relevant stakeholders should be included in the planning processes at legislative and regional levels to help reduce gaps and errors in policy implementation.

When a new policy is formulated, the government has two functions: legislative and administrative. The legislative function involves ensuring that the policy goals are implemented, by ensuring that there are adequate resources and funds available for

implementation. The administrative function involves ensuring that the policy is sustainable and beneficial to the identified population group or group of interest (Tebele, 2016).

Following a directive received from the NDoH, the process of implementing the policy is filtered to the provincial departments of health, where HIV programme coordinators and HAST managers will ensure that all requirements are in place for clinicians to implement the HIV policy. For policy implementation to be successful, the following factors should be in place: human resources, equipment and technology, support from higher structures and adequate planning (Khan & Khandaker, 2016). Therefore, implementation studies are essential as these serve to emphasise the importance of understanding the success or failure of public policy by elaborating on factors that affect it (Khan, 2016).

2.5 Importance of policy implementation in the context of HIV

International and national targets can only be reached if policies are implemented successfully. It is essential for policies related to HIV testing, care, and treatment to be implemented successfully if there is to be a reduction in the morbidity and mortality that those policies are designed to target (McRobie et al., 2017).

A scientific review of HIV patients indicates that significant progress has been made in the fight against HIV, with evolving HIV policies playing a role; nevertheless, there are still several barriers that hinder progress (Western Cape, 2018). For a policy to be considered successful as per the WHO's international goals and recommendations, it needs to be reviewed in terms of its expected outcomes and long-term sustainability. This must be done in different countries, bearing in mind the socio-economic needs of the target group (McRobie et. al, 2017). Resources such as infrastructure, equipment, and the staff needed to care for and treat patients, need to be taken into consideration. If any gaps are identified, or if the feasibility of the policy is disputed, then the policy implementation and any contributing influences need to be assessed.

This process is critical for ensuring a more effective policy cycle, while any reformulation needs to take place with recommendations for relevant stakeholders (McRobie et. al., 2017). Evidence indicating that HIV policies are not fully effective in practice is supported by research performed by Plazy et al. (2017). These authors state that although the UTT policy recommends same-day initiation, the high HIV incidence rate in South Africa suggests that this does not occur in practice. There may be various reasons for this. Any lack of proper implementation of the policies contained in the NSP, WHO guidelines and recommendations will have implications in terms of the indicators pertaining to reduced mortality and lower incidence of HIV as per SDG three by 2030 (WHO, 2016). Equally, HIV policies are not being optimally implemented in the Western Cape, which affects the patients insofar as they do not initiate treatment timeously. A lack of treatment leads to faster progression of the virus, leading to a high viral load and the concurrent development of opportunistic infections (Cawley et al., 2017).

Internationally and locally, there are various challenges facing the implementation of HIV policy. These include barriers against staff integration, issues of functional logistics, supply chain management and lack of managerial support. All these challenges need to be dealt with if the implementation of policies is to run effectively and proficiently (Tshililo, Mangena-Netshikweta, Nemathaga, & Maluleke, 2019).

Healthcare services in developed countries are assumed to provide a better quality of care and more effective health service management than those in less-developed countries; however, challenges have been identified in all countries, irrespective of the country's development status. Some issues that threaten system implementation in the health sector involve economic resources, income disparities, exorbitant costs of usage fees, and excessive costs for health

information systems, a lack of trained human resources, and a lack of governmental policies that address a well-defined health system (Brieux et al., 2015)

Therefore, policies are amended as needed, both internationally and nationally, to improve implementation and to reach the policy objectives and targets.

2.6 Challenges and factors that influence HIV policy implementation according to the Management Model

In this section, the researcher will discuss factors that influence HIV policy implementation according to the Management Model.

2.6.1 Personnel and Human Resources

Human resources play a significant role in the policy implementation process. Without clinical and non-clinical staff, a policy cannot be put into practice. Staff are required to implement the policies with a substantial HIV programme in South Africa. According to Kirigia and Barry (2013), inefficiencies in resource allocation and extreme shortages of health workers represent a crisis which has been exacerbated by inequities in the workforce; therefore, detailed situational needs analyses and adequate policy implementation are essential. There is a threat to the quality of care in government clinics because of inadequate efforts by the health care management in terms of providing human resources and health equipment (Department of Health, 2020). These challenges cause major problems in the public health system, where funds are limited, and human resources are essential for treating patients.

The HIV programme expanded from 3,8 million in 2004 to 7,7 million in 2022. During this time, various additional HIV services such as PrEP, PMTCT and voluntary medical male circumcision (VMMC) (SAHO, 2019; UNAIDS, 2020) were introduced. However, there was not an increase in the human resources providing these services. A lack of human resources has a negative impact on policy implementation. Also, patient health outcomes and service

standards are compromised by shortages of staff because HIV policies have several clinical requirements and lengthy follow-up routines which need to be completed when rendering HIV services (Practical Approach to Care Kit [PACK], 2021). It is not always possible to implement policy adequately in a situation where service needs are greater than the capacity of the staff available to render the service Cancedda, Farmer, Kerry, Nuthulaganti, Scott, Goosby, & Binagwaho., (2015). McRobie et al. (2017) refer to a study based in Uganda pertaining to HIV implementation and policy review; they found that the barriers to the effective implementation of the policy included limited human resources, poor infrastructure, and inadequate health management information systems.

2.6.2 Implementation infrastructure, location, and place

The term 'infrastructure' is defined as including physical structures and spaces, essential equipment and information and communication tools (Department of Health, 2016). Adequate infrastructure needs to be in place to ensure successful policy implementation and this includes a full-service package, and functional IT equipment and systems (Department of Health, 2016).

Adequate infrastructure is a prerequisite for ensuring improved standards of care and well-being for all patients. Crowley and Stellenberg (2014) reported that in KwaZulu-Natal, logistical and infrastructural constraints and additional tasks placed on overloaded staff, all form barriers against the successful integration of HIV care into primary health care.

The physical location of PHC facilities can have a detrimental impact on policy implementation. For example, if the PHC facility is far from where its clients live or work, or is inconveniently situated, then those clients might not access the services available there, thereby impacting the optimal implementation of policy (WHO, 2018).

2.6.3 Equipment and technology

If the frontline staff are to implement policy successfully then they need all the relevant clinical equipment, stationery, and information technology to strengthen the implementation process. A study conducted by Muthelo et al., (2021) in Limpopo focussed on equipment audit requirements for PHC facilities implementation; these writers found that the maintenance of equipment, as well as the replacement of broken furniture and machinery, affected the policy implementation process. Plazy et al., (2017) studied the experiences of staff implementing UTT in rural Kwa-Zulu Natal. These writers found that healthcare providers such as HIV clinicians were concerned about staff experiencing a high workload exacerbated by the ripple effect of backlogs of laboratory results and a lack of equipment to perform baseline tests. A study by Crowley & Stellenberg (2014) in the uMgungundlovu district, Kwa-Zulu-Natal used the provision of basic HIV services rendered and laboratory capacity and equipment as indicators to evaluate whether clinics were equipped for integrated HIV services. These writers found that none of the clinics was fully equipped for integrated HIV services. Equipment and laboratory challenges, such as long turn-around times for laboratory tests were reported. The laboratory system could also not be accessed electronically in any of the clinics, making effective implementation a challenging task.

A study conducted in Saudi Arabia indicated that a high level of dependency on paper-based medical records created difficulties in attempting to integrate electronic PHC records across different facilities within the system. (Saffer, Al-Ghaith, Alshehri, Al-Mohammed, Homidi, & Hamza, 2021). If electronic medical records (EMR) are to be used successfully, then the information technology systems should be working effectively and maintained to ensure the effective implementation of policy related to technological aspects. WHO (2018) recommended that technologies should be suitable for primary care workflow and that they

should be in working condition; thus, ensuring and maintaining the quality of clinical care improves policy implementation.

2.6.4 Levels of coordination and planning

Proper coordination and planning are crucial for the success of the implementation process. Planning stipulates the direction of how the implementation process should proceed, while coordination ensures that each stakeholder knows its function and allows the coordinator to monitor the implementation process. According to Ajulor (2018), challenges in policy implementation could be linked to inadequate planning, political instability, and administrative bottlenecks. A lack of policy planning could lead to civil servants being saddled with the burden of implementing policies that would not be successful. Ajulor (2018) and Tshililo et al. (2019) identified the lack of precise initial planning such as coordination, administrative roles, and feedback reporting as contributing to challenges in policy implementation. The challenges related to the planning phase include staff resources, infrastructure, and comprehensive care. Clear role identification is needed as part of the planning process of implementation to ensure accountability of continual monitoring and evaluation within that process (Shariff, 2014). A study conducted by Makhado, Davhana-Maselesele, and Farley (2018) in the KwaZulu-Natal and Northwest provinces examined the implementation of decentralised care and NIMART. These writers found that there is a need for improved but supportive supervision of NIMART nurses by organisational management and improved communication. Adequate coordination, planning, and problem identification can avoid potential challenges before actual implementation commences. A study by Campos and Reich (2019) concluded that policy implementation calls for persistence, discipline, and rigor as far as organisational structures, staff, and relationships with stakeholders are concerned, to ensure that the implementation occurs as planned. The participation of non-governmental organisations (NGOs), as stakeholders, can assist in bridging the gap between government and society. However, due to

the lack of knowledge of NGOs, by various stakeholders, their specific role in policy rollout is not always recognised (Dasgupta, Wringea, Crampina, Chisambob, Koolea, Makombec, Sunganid, Todda & Churcha, 2016).

2.6.5 Activities of frontline implementers and training

Inadequate training capacity, lack of continuous development of staff and strengthening staff competencies in the clinician's environment limits policy implementation (Cancedda et al., 2015). Successful policy implementation requires adequate levels of staff who have received the training needed to render the services; this is not always the case (Ajulor, 2018). In countries such as South Africa, where the criteria for ART eligibility have been widened, there are still designated HIV facilities within clinic settings which do not have HIV services functioning as part of the comprehensive services which should be offered at PHC clinics; this is because of a lack of the trained health care workers needed to implement the policy (Tshililo et al., 2019). A study by Khan (2016) examined policy implementation and performance and concluded that frontline implementers are crucial resources in policy implementation in terms of skills and commitment. They need to be committed to policy objectives and need the necessary skills in using available resources if they are to achieve policy objectives; if frontline implementers are incompetent then this situation will lead to implementation failure. Staff who know that they lack training tend to fear and resist the implementation of new policies; generally speaking, policies are not implemented effectively if staff have poor levels of ability and skills (Muthelo et al., 2021).

All staff should have the relevant HIV care training to ensure integration of care and quality of care (Crowley & Stellenberg, 2014). Ideally, all staff should receive the same training, allowing facilities to distribute patients equally; this leads to reductions in patient waiting times and high quality of care and holistic management for each patient (Plazy et al., 2017). According to

SANAC (2017), appropriately trained and supported personnel and human resources, fully integrated into HIV care and treatment will ensure that the workforce is sufficient. If staff are properly trained in a policy, then this increases the likelihood of its successful implementation, although minor barriers and challenges might still occur.

2.6.6 Exercise of authority

The proper exercise of authority is important as this allows the HIV managers to advise, oversee, and monitor the policy implementation process. For a team to be successful and committed, they require exemplary and committed leadership (Farokhzadian et al., 2018). The integration of organisational culture will not be successful without thoughtful, transformational, and committed leaders. The results of a study conducted in the Middle East-Africa by Farokhzadian et al., (2018) showed that several factors have a negative influence on policy implementation: these include poor-quality supervision, poor leadership practices, absence of resource allocation, and lack of integrated management working culture. In that study, nurses claimed that managers and programme coordinators did not have the commitment or creativity required to strengthen the working culture (Farokhzadian et al, 2018). It has been established that clinicians need guidance and mentorship from their managers if they are to implement what is expected from them. A South African study conducted by Makhado et al. (2018) showed that NIMART-trained nurses might adhere better to treatment guidelines and then produce better outcomes if they received adequate support and managerial supervision.

Furthermore, a study by Kirigia and Barry (2013) concluded that weak public health leadership and management, as well as poor monitoring of health services, makes it difficult to identify whether an HIV programme or policy implementation has been successful or not.

2.7 Conclusion

This literature review included national and international studies. The literature addressed various aspects of policy implementation, including an overview of international and South African HIV policies, their importance, and the challenges affecting policy implementation. Some studies have explored the health workers' experiences, public policy challenges and experiences related to HIV policies and policy implementation. The gap in knowledge identified by the researcher is that no studies specifically identified policy implementation challenges from the perspective of HIV managers.

This literature review revealed that there is good progress being made, with numerous policy changes having been made over the years; nevertheless, there are several factors that may hinder policy implementation in the context of HIV which could lead to failure in reaching set goals. Within the South African context, challenges hindering policy implementation include human resources, implementation infrastructure, equipment and technology, and training.

The following chapter provides an overview of the research methodology relating to the study, gaining ethical approval, and ensuring trustworthiness of the study.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

In chapter two, the researcher reviewed the literature on the implementation of policy and the factors that may influence the implementation process. The outline of this chapter intends to discuss the methodology used in this study. The researcher commenced by outlining the researcher's philosophical assumptions. The research design and research methods are then described. Furthermore, the activities and steps taken to ensure adherence and academic rigour to the ethical requirements of research are presented.

3.1.1 Philosophical assumptions

The philosophical worldview assumptions that the researcher brings to the study are defined as a general orientation about the world, the nature of research, the research design related to this worldview and the specific research methods used in the study (Creswell & Creswell, 2018).

The constructivism paradigm is the belief that individuals seek an understanding of the world they live and work in (Creswell & Creswell, 2018). The researcher used this paradigm in this study. According to Adom, Yeboah and Ankrah (2016), the constructivist paradigm affirms that it is through experiencing and reflecting on a phenomenon that knowledge and understanding of the world are constructed. Constructivist researchers seek to understand the subjective meanings of the individual; therefore, the researcher used the HIV managers' perceptions and experiences when implementing HIV policy and adopted a methodology that relies on a subjective relationship between the researcher and each participant. The researcher used a qualitative research approach as this interlinks with the constructivism paradigm as both focus on individual perceptions and experiences.

The researcher has a clinical background and experience in HIV care and policy implementation. Although the researcher is not currently working in the clinical setting, she experienced challenges when implementing HIV policies in that setting. The researcher, therefore, had to bracket preconceived ideas and thoughts of challenges regarding policy implementation and possible recommendations. The researcher's position in relation to the participants is that she worked with some of the participating managers when conducting HIV audits and engaged in clinical guidance as a NIMART mentor. The researcher reflected carefully on the influence of her past experiences and position throughout the research process.

3.2 Research Approach and Design

Qualitative research explores and seeks to understand individual or group views pertaining to a human or social issue (Creswell & Creswell, 2018). This study applied a qualitative research approach in which the researcher explored and described the perceptions and experiences of the HIV managers in PHC facilities in implementing HIV policies at PHC facilities within the Northern Tygerberg sub-district of the Cape Metropole in the Western Cape. A qualitative research approach allowed the researcher to apply a methodical approach to describe the situation from the perspective of the person in the setting using word narratives (Burns, Grove & Gray, 2021). In addition, the use of qualitative methods allowed the researcher to probe the participants' responses and facilitate the collection of narratives about the participants' experiences with policy implementation.

3.3 Research Design

A research design provides direction and a plan for answering the research questions by explaining the procedures in the research study (Burns et al., 2021). The research design applied in the present study is described below.

3.3.1 Exploratory research design

An exploratory research design is used in this study and it aims to provide information and insight into clinical or practice problems (Burns et al., 2021). The reason for selecting this exploratory design is because the phenomenon being studied is mainly unexplored; this design can allow the researcher to discover and explore new knowledge from the perspective of the HIV managers, regarding policy implementation within PHC facilities (Brink, van der Walt & van Rensburg, 2018). Furthermore, the design provided insights into the problem under investigation as the managers were free to express themselves fully without bias or interference. In addition, the experiences and challenges of HIV managers were explored in depth.

3.3.2 Descriptive research

Descriptive research entails the exploration and description of phenomena in real-life situations. Descriptive studies provide accurate characteristics of particular individuals, groups or situations (Burns et al., 2021). A descriptive design is used to establish current problems, especially where more information is required (Brink et al., 2018). In this study, the descriptive research design allowed the researcher to highlight and accurately represent the HIV manager's situation. The researcher explored the HIV manager's challenges while implementing the HIV policy at PHC facilities. Furthermore, a descriptive design relevant to this study could bring new information to overcome these challenges.

3.4 Research Setting

The term ‘research setting’ refers to the place where the research is conducted (Brink et al., 2018). This study was conducted in the Western Cape Province, South Africa. This Province is located in the southwest of the Republic of South Africa and is divided into five rural district municipalities: Central Karoo, Cape Winelands, Garden Route, Overberg, West Coast, and the

metropolitan district of the City of Cape Town (Western Cape Government, 2016). The Metropolitan area consists of eight sub-structures: Khayelitsha- Eastern, Southern-Western, Klipfontein-Mitchells Plain and the Northern-Tygerberg substructure as illustrated in Figure 3.1 (Western Cape, 2018). The study was conducted in the Northern-Tygerberg substructure where there are fourteen DOH PHC facilities and four City of Cape Town PHC-administrated facilities. The areas served by these facilities include Parow, Bellville-South, Bothasig, Bishop Lavis, Elsies River, Delft, Durbanville, Goodwood, Reed Street, Ruyterwatcht, Kraaifontein, Scottsdene, Ravensmead, and Symphony Way.

Figure 3.1: Map of Cape Metropole health districts

(Source: Governmental website of the City of Cape Town)

The HIV services offered in the PHC clinics include the following:

- The initiation of treatment in the case of newly diagnosed people living with HIV.
- The re-initiation of treatment for HIV clients who discontinued treatment.
- Monthly follow-ups.

- Basic Antenatal Care (BANC) including Prevention of Mother to Child Transmission (PMTCT).
- STI treatments.
- TB prevention and treatment services; and.
- HIV chronic club services.

Additional services were offered from February 2022: these include the initiation of Pre-Exposure Prophylaxis (PrEP) for clients (National Department of Health, 2016).

To delimit the study for this master's degree, the researcher chose the Northern Tygerberg sub-district because previous audits have indicated that the Tygerberg sub-district is not meeting HIV policy implementation indicators and targets (Western Cape, 2018). That sub-district's HIV treatment initiation rate is greater than 71%, but the retaining in care after 12 to 48 months declines significantly to 49% (Western Cape Government, 2018). The decline in people living with HIV and retention in care is a potential indicator of challenges concerning the implementation of continuous policy. According to the Cape Metro District Plan, there are currently 28 000 patients receiving HIV services in the Northern Tygerberg sub-district (Western Cape Government, 2018).

3.5 Research population

The population is defined as a particular group of elements, events, individuals, or objects that is the focus of the study (Burns et al., 2021). The total population in this study consisted of 14 male and female HIV managers, based at PHC facilities, in the Northern Tygerberg sub-district.

3.6 Sampling method

The term 'sampling' refers to the selection of research participants from an entire population for a specific research purpose (Bhardwaj, 2019). In this study, the researcher chose the

purposive sampling method to sample HIV managers in PHC facilities. In purposive sampling, the researcher consciously selects certain participants, elements, events, or incidents to include in the study (Burns et al., 2018). Purposive sampling allowed the researcher to focus on participants who are experienced and have in-depth knowledge of the phenomenon being studied. Therefore, the researcher purposively selected HIV managers according to their management level in the organisational hierarchy. As a result, the researcher obtained a group of participants who all had experience, knowledge, and understanding of the topic being studied (Bhardwaj, 2019). Homogeneous sampling focuses on one subgroup in which all the sample associates are similar, such as having a certain occupation or being on a certain level in an organisation's hierarchy (Saunders, Lewis & Thornhill, 2012).

In this study, the benefit of homogeneous purposive sampling is that all the participants are HIV managers and as such, the researcher can explore their experiences related to policy implementation.

3.6.1 Sample size

The sample size is defined as the number of participants or field of study who participated in the study (Burns et al., 2021). The researcher anticipated including between eight and twelve managers in the study. The final sample size was ten, with data saturation occurring at interview number eight. Two additional interviews were conducted to verify that no new themes emerged. Because of the homogenous nature of the sample, data saturation probably occurred earlier than interview eight, although it only became evident at that point. Data saturation occurs when it becomes evident that further data collection is not required, because all aspects of the topic have been covered; in other words, no new information or themes are emerging (Saunders et al., 2018).

3.7 Inclusion criteria

The two inclusion criteria for this study were:

- HIV managers working in the HIV department of PHC facilities for two years or more; and
- HIV managers who verify monthly quality assurance HIV audits regarding the efficacy of HIV policies at PHC facilities.

3.8 Exclusion criteria

- HIV managers with less than 2 years' experience, because they do not have relevant experience required.

3.9 Pilot study

A pilot study is a small-scale research project conducted before the final full-scale research study. A pilot study was conducted because the researcher was fully aware that its results would be needed for verifying, and if necessary amending, the interview guide used in the research data collection process (Ismail, Kinchin & Edward, 2017). That pilot study helped the researcher to determine and then ensure that the interview questions explored and described what the research was designed for (Creswell & Creswell, 2018). Furthermore, the pilot study assisted the researcher to identify the type of environment in which the data was collected and then identifying any problems with the data collection process so that any such problems could be avoided. The researcher initially conducted two pilot interviews in May 2021, the facilities included was Reed Street Community Day Clinic and Bishop Lavis Community Day Clinic. The interviews were reviewed by the study supervisors and excluded from the main study because the flow of interview guide questions needed to be revised according to the research objectives, with additional probing questions being added.

In May 2022, the pilot study continued with an additional two pilot interviews performed. On this occasion, the researcher included two participants, one from each facility namely Scottsdene Community Day Centre and Kraaifontein Community Health Centre; both these participants met the inclusion criteria, and they understood the questions. No changes were made to the revised interview guide following this continuation of the pilot study and therefore these two pilot interviews were included in the main study. The researcher was unable to access any secluded, quiet space within the facility to perform these interviews and as a result, the audio recordings have some background noise. The researcher had to pause the interview whenever the background noises were too loud.

3.10 Data Collection Method

In the context of this study 'data collection' refers to the process of collecting data from the identified research population (Creswell & Creswell, 2018). The data collection method used in this study consisted of individual semi-structured interviews which were conducted with HIV managers working in the Western Cape Department of Health (WCDOH) facilities in the Northern Tygerberg sub-district.

3.10.1 Data collection instrument

The researcher asked the participants predetermined open-ended questions using an interview guide and allowed the participants to express themselves freely. An interview guide contains predetermined questions, and the participants' answers are expected to shed light on the issues being studied (Creswell & Creswell, 2018). The interview guide required the researcher to control the interview sessions properly and it allowed the participants to share their views and opinions (Creswell & Creswell, 2018). The first set of questions related to the policy implementation processes and the support structures within the policy implementation phase. The second set of questions focused on the challenges and limitations of policy

implementation, and finally, on the best-practice recommendations for future policies. Moreover, the researcher developed additional probing questions to ensure an adequate exploration of the phenomenon being studied.

3.10.2 Recruitment of participants

After receiving ethical approval from the University of Western Cape Ethics Department, ethics number BM20/10/6 **(Annexure D).** The researcher requested permission from the Western Cape Department of Health (WCDOH), ethics number WC202112_013 **(Annexure E)** to proceed with the data collection process at the PHC facilities. After permission was granted, the researcher asked for the sub-district PHC manager and facility managers of the sub-district to act as the gatekeepers between the researcher and potential participants. The rationale for a gatekeeper is that they are in direct contact with the HIV managers and can ask them to participate, ensuring no pressure on potential participants from the researcher (Singh & Wassenaar, 2016). The sub-district PHC manager role as gatekeeper ensured that only potential participant meeting the criteria would be contacted to participate in the study. The sub-district PHC manager forwarded all the information regarding the study to the HIV managers informing them that the researcher would be contacting them in accordance with the details provided in the Western Cape Department ethics letter and encouraging HIV managers to participate. Thereafter the researcher sent an email to each HIV manager inviting them to take part in the study. The email provided details of the research study, an information letter explaining the inclusion and exclusion criteria, an outline of the format of the individual semi-structured interview discussion, and an invitation to attend the individual semi-structured interview. Once the sub-district PHC manager identified how many HIV managers met the inclusion criteria, requests for interviews were sent out by the researcher.

3.10.3 Data collection process

Fourteen participants were approached, of whom ten agreed to participate. One refused to take part and one of the potential participants worked at a clinic that only offered HIV testing and therefore did not meet the study inclusion criteria. Furthermore, the DoH did not grant approval to conduct research at that site as it was only a testing site. The researcher conducted ten interviews. Before the interviews commenced, the researcher ensured that participants had read the information sheet, understood the aim of the study, and sign the informed consent form (**Annexure C**).

The researcher was the primary researcher and as such, performed the face-to-face semi-structured individual interviews. These were conducted in English, as preferred by all the participants, although some of their home languages included Afrikaans. Semi-structured interviews entail a specific number of set questions, with additional probing questions, and use open-ended and closed questions (Brink et al., 2018). The researcher used semi-structured interviews because these are flexible, and minimal guidance is needed with initial questions being posed. Moreover, the researcher can prompt questions based on a participant's previous answers to narrow specific aspects of the phenomena being studied (Creswell & Creswell.,2018). The researcher recorded the interviews with each participant's consent and made field notes during and after each interview to collect all the information possible; these were attached to the corresponding interview session.

According to Burns et al, (2021), field notes can be defined as those notes that are taken during or shortly after observations of the interview. Field notes allowed the researcher to record observations made while the participant was talking. The researcher used the interview guide's sub-headings in the field notes and therefore made notes under those specific sub-headings. The researcher chose the face-to-face, individual data collection method because participants

could provide rich and in-depth data about their experiences without external influences. The researcher used a private room to conduct the interviews with minimal noise interference at times. Interviews were conducted at a time convenient to the participants and care was taken to ensure that the interview did not interfere with daily operational needs in the PHC facilities. The average duration of the interviews was between 45 minutes and an hour. The researcher ensured that every participant had sufficient opportunity to express themselves by using open-ended questions, probing questions, clarifying, and summarising as the interview proceeded. The timeframe of the data collection was May to August 2022, the extended duration of data collection will be discussed in the limitations of the study.

3.11 Data Management and Analysis

Qualitative analysis involves applying techniques to synthesise, reduce, organise and give meaning to data (Burns et al.,2021). After each interview was finished, the audio recording was transcribed verbatim. The data was stored on the researcher's university Google Drive account and various folders were created for audio recordings, transcriptions, and coding files. After the recordings were transcribed, the data analysis process began; this started with descriptive coding employing words or sentences, merging similar codes into categories and categories into themes. For the coding process, the researcher used manual coding with the use of the Microsoft Word program. The researcher conducted the data analysis process, by herself and her supervisors verified the coding process. Here, an inductive thematic analysis technique was used to identify and report patterns and themes within data (Anderson et al., 2014).

Braun and Clarke's (2006) thematic analysis were applied, which entails implementing the six phases of thematic analysis:

- Step 1: Familiarisation: getting to know the data by listening to audio tapes and transcribing data.

- Step 2: Coding: assigning preliminary coding to describe and organise the data.
- Step 3: Generating themes: identify themes from the coding from the different interviews.
- Step 4: Reviewing the themes; identifying sub-themes under main themes, some data might fall into different themes,
- Step 5: Defining and naming themes: identified from reviewing the themes.
- Step 6: Writing up the analysis and generating a comprehensive report on the findings (Vaismoradi, Turunen & Bondas, 2013).

The researcher used the following steps through the analysis process:

3.11.1 Step 1: Familiarisation:

Data were collected by conducting face-to-face interviews; the record of the interview was transcribed by a transcriber and later verified by the researcher who listened to the audio and compared transcripts. Graphic images were drafted to represent the policy implementation process and challenges. The researcher searched for any similarities present across all interviews and looked for differences; this process assisted the researcher to immerse herself in the data and developing a coding frame. The study supervisors reviewed the audio recordings and a sample of the transcripts and assisted the researcher to develop a coding frame.

3.11.2 Step 2: Coding of data:

This is the process of naming or labelling raw data to establish themes (Burns et al.,2021). For example, the researcher named and labelled phrases by highlighting them in different colours and then assigned codes according to the coding frame (see Box 3.1). The researcher coded one interview using the coding frame. The supervisors then reviewed the coding and made recommendations for revising the coding frame and coding. The researcher then revised the coding frame and recoded the transcripts.

Box 3.1 Example of coding of the transcript.

When it comes from national it moves from national to province and from the province, it comes down to the substructure and from the substructure, it comes down to the facilities and it's been managed by when you come to our side to the facilities:	**Process of policy sharing**

3.11.3 Steps 3 to 5: Generating, reviewing, and defining themes:

Themes are established from the coding process; the researcher used the most descriptive words from the coding to develop multiple categories, from which the main theme was developed. These themes represent significant findings of the study while sub-themes can emerge from themes. In this study, the researcher used communication as one theme, with its sub-themes being the process of policy communication and types of communication for policy implementation.

3.11.4 Step 6: Writing up the analysis and generating a comprehensive report on the findings:

The findings are discussed in detail in chapter four using a written narrative of verbatim quotes to support the interpretations of the findings. The interpretation stage involves making sense of the data, including reflections and the researcher's personal views (Creswell & Creswell, 2018). After the data had been analysed, the researcher wrote up the research study's findings, integrating recent literature to support those findings (Creswell & Creswell, 2018). Chapter four is dedicated to the discussion of the findings of the study.

3.12 Trustworthiness of the study

The researcher adhered to all the principles of trustworthiness applicable to qualitative research, to ensure the soundness of the study. Those principles are based on the model of Lincoln and Guba (1985) as cited in Polit and Beck (2017) and consist of the criteria to ensure credibility, dependability, confirmability, and transferability.

Credibility refers to the truthfulness of the data collected and interpreted in the research process. The researcher ensured credibility by conducting a member check, which is the process of participant validation (Mandal, 2018). Thus, member checking requires the participants to read and then confirm the transcribed transcripts from their interviews. Moreover, the researcher conducted member checking throughout each interview, by summarising what the participant had said, to verify the information. Peer debriefing sessions took place with supervisors to discuss what was experienced during interviews.

Dependability is ensured by transparently describing the steps taken from the start of a research project to the reporting of the findings (Korstjens & Moser, 2018). This ensures the stability of the data over time (Brink et al., 2018). A complete description of the research design and methodology, data collection, and data analysis methods used in the research process is recorded, ensuring that the procedures followed by the researcher are the same for all participants.

Confirmability refers to establishing that the researcher's interpretations and findings are derived from the data logically; this requires the researcher to establish how conclusions and interpretations have been reached (Mandal, 2018). To ensure confirmability, there is a need to be able to make available, on request, all the raw data, field notes from interviews, reflective reports, audio recordings and data acquired throughout the research process. A graphic image framework was produced after each interview to identify any similarities with preceding interviews, as well as any notable differences. To ensure the objectivity of the data analysis process, the researcher's supervisors checked and verified the coding and the themes to ensure that raw data was not changed or incorrectly interpreted (Burns et al., 2021). Verbatim quotes were used in writing up the report of the findings.

Transferability refers to the applicability of the study's results, within the context of its intended purpose. Data saturation occurs at the point when new data becomes redundant because the information has already been found; in this situation, no new themes can emerge (Creswell & Creswell, 2018). Data saturation indicates to the researcher that the data already acquired is sufficient to answer the research question. At this point, rich and meaningful data allows the researcher can stop collecting data because the study objectives have been reached (Creswell & Creswell, 2018). The researcher utilised the thick description method. A full description of the context of the research process from purpose, data collection, and inclusion criteria used were provided, to evaluate whether the study's findings are transferable to other studies or clinical situations.

Ensuring the honesty of the participant: participants were invited to participate in the interview voluntarily, and were reassured that they had the right to withdraw at any point; also their withdrawal will not affect their professional standing in any manner (National Department of Health, 2015). The researcher aimed to ensure a relaxing atmosphere that allowed for open discussion of the respondents' experiences, assuring them of confidentiality. Confidentiality was ensured by allocating each respondent a number, known only to the researcher, and referring to them by their number only and never by name.

3.13 Ethical considerations

The ethical principles used to guide clinical practice must also apply to conducting nursing research (Burns et al., 2021). The protection of human rights is an important consideration when planning research. Therefore, the relevant accredited research ethics committee needs to evaluate ethical issues relating to the research and then, if satisfied, grant approval to proceed with that research (Brink et al., 2018).

Ethical clearance for this study was sought from the Biomedical Research and Ethics

Committee of the University of the Western Cape, [ethics number BM20/10/6] and the Western Cape Department of Health [ethics number WC202112_013] (**Annexure D and Annexure E**). The researcher conducted the study by adhering to the principles and processes of health research as prescribed by the guidelines of the Department of Health (National Department of Health, 2015).

The principle of autonomy ensures the ability to deliberate upon and act upon a decision (National Department of Health, 2015). When participants signed the consent form, the researcher ensured autonomy by informing the participants that they had the right to decide whether to participate in the study. The participants were also informed and assured that they could withdraw from the study at any time. Only one participant withdrew before the scheduled interview; that participant felt that their workload was too great and did not want the additional responsibility of taking part in an interview.

The principle of beneficence refers to the moral obligation to act for, or maximise, the benefit of others (National Department of Health, 2015). A referral was made available for health care assistance in the event of a participant feels that they were subjected to any emotional or psychological distress during their participation in the research. In addition, counselling and support could be arranged for the participants with the service provider Metropolitan for employee wellness should this be required. However, no participant asked for a referral for counselling after their interview.

According to the ***principle of non-maleficence,*** there is an obligation not to inflict harm on others. This requires the researcher to minimise any risk of harm to the participants (National Department of Health, 2015). In this study, the researcher did not use any findings in any way that might cause any harm to the participants. Thus, the participant who withdrew from the study was not affected in any negative way for not participating. The potential risk that could

have occurred was emotional risk due to anxiety or distress of sharing experiences and physical risk was the possible exposure to Covid-19. The potential benefit of participating in this research study contributes to overcoming possible future challenges in implementing policy. Some participants appreciated that the research focused on their point of view. The researcher adhered to COVID-19 protocols by sitting a meter away from the respondent and sanitising regularly; masks were worn throughout the interview. Flavoured water was served, and a token of appreciation was given to each participant for making themselves available for an interview; this was in form of self-care kits which included body lotions and washes.

The principle of justice refers to the right to fair selection and treatment of participants. Justice is defined in the context of this study as treating participants fairly and ensuring privacy (National Department of Health, 2015). In practice, participants must be selected using criteria which will logically achieve the goals of the research, and all participants must have similar treatment (Burns et al., 2015. In this study, justice was ensured because only HIV managers offering HIV services were selected; no other management levels were included.

Informed consent refers to the researcher ensuring that all participants sign a consent form to provide evidence that they have voluntarily chosen to participate in the research project (Burns et al., 2021). Thus, everybody who agreed to participate in the study was asked to provide signed consent (Annexure B, Annexure C) (National Department of Health, 2015).

Privacy of research participants and confidentiality were strictly observed during all semi-structured individual interviews. The researcher emphasised that every person has the right to confidentiality when partaking in the study, and each participant's privacy was protected by signing an informed consent, which highlighted that the information discussed in the interviews was confidential. As mentioned in 3.12, above, each participant was allocated a participant number which was known only to the researcher; participants were referred to by their number

and never by name, to ensure confidentiality and anonymity in data collection and dissemination of results.

For data management and protection in accordance with the Protection of Personal Information Act (POPI Act, 2013), the researcher ensured that all formal data was password protected and saved on Google Drive for five years in accordance with the University of Western Cape's data management plan for verification of data; this includes audio recordings, transcriptions, and password protected electronic data such as coding, (University of Western Cape, 2021). Informal data such as field notes will be kept in a secure, locked cupboard in the researcher's office for five years and will then be destroyed using incineration or shredding hard copy documents. Electronic data will be available for open access for future research (University of the Western Cape, 2021).

3.14 Summary

In this chapter, the researcher discussed the research design, setting, population selected, sampling and data collection and analysis methods. The measures taken to ensure the ethical compliance and trustworthiness of this study were then described. In the next chapter, the researcher will discuss the analysis of the findings of this study, including literature that correspondence to achieved themes.

CHAPTER 4: FINDINGS

4.1 Introduction

Chapter three outlined the research methodology used in the study. This chapter presents and describes the results, in detail. It is organised into two sections of which the first gives an overview of the participants' characteristics: and the second section presents the findings of the study in line with the two objectives of the study.

Interviews were analysed and coded by the researcher and the coded data was analysed, organised, and then synthesised into themes and categories. Seven themes were organised according to the policy implementation process and the factors/challenges influencing implementation, while sixteen sub-themes were generated from the data analysed. Themes are described in detail focusing on the policy implementation process and the challenges to policy implementation. Verbatim quotes from the participants are used in this chapter to give meaning to the categories and to enhance the credibility and trustworthiness of the findings. The participants' quotes are coded by the participant number, gender, and years of experience. The themes with relevant categories are presented in detail in this chapter. The representation of the findings is aligned with the perceptions and experiences of the HIV managers within PHC facilities implementing HIV policies.

4.2 Demographic characteristics

Ten HIV managers were interviewed individually using a semi-structured interview guide, and the number of participants was determined by the point at which data saturation became evident. The sample consisted of one male and nine females and included the four -participants recruited for the pilot interview.

Those HIV managers who participated in the study had between 2 and 17 years of HIV management experience. Table 4.1, below, provides demographic data relating to the participants.

Table 4.1: Demographic data of participants

Participant	Gender	Years of experience
Participant 1	Female	11
Participant 2	Female	15
Participant 3	Female	10
Participant 4	Female	17
Participant 5	Male	7
Participant 6	Female	12
Participant 7	Female	9
Participant 8	Female	2
Participant 9	Female	6
Participant 10	Female	12

4.3 Presentation of the findings

This section presents the results pertaining to the objectives of the study: these objectives were to explore the process followed by HIV managers in implementing HIV policies at PHC facilities and to describe the challenges they experienced during implementation. Seven themes emerged from the collected data, and these are presented under each objective. These seven themes were divided further into sixteen subthemes. Extracts from the participants' responses were used to support the descriptions of the themes. The exact language and phrases that were used by the participants were maintained, but for clarity, some grammatical amendments were made. Table 4.2 presents the summary of the themes, subthemes, and categories that emerged from the collected data.

Table 4.2: Themes, subthemes, and categories

Themes	Subthemes	Categories
Objective 1: Policy implementation process		
Theme 1: The responsibilities of the role players within the policy implementation process	HAST team responsibilities PHC manager / HIV manager responsibilities Stakeholder engagement (Non-Profit Organisational (NPO) & Community Based Services (CBS) Clinicians within the HAST team at facility level (HAST medical officers and NIMART)	• Communication to the facilities • Monitoring and evaluation of the policies • Provision of the training • Support function to staff • Clinical and technical support to HAST team • Coaching, mentoring, and training • Community outreach • Implementation of policies and information sharing • Clinical guidance • Continuum of care
Theme 2: Support structures for policy implementation	Multipronged support services HIV service restructuring	• HIV hotline and application • Community outreaches and involvement • Family physician -clinical guidance • Tygerberg Infectious Disease clinic • Total service package • Re-arranging patient flow • Different models of care • Innovative healthcare services • Fast-tracking health services
Theme 3: Training of personnel	Planning training for health care personnel Training needs for implementation readiness	• Training analysis • Training post implementation • NIMART training being essential • Various types of training External vs internal service providers • Clinical updates (BANC&PTMCT)
Objective 2: Factors/challenges influencing policy implementation		
Theme 4: Human resources challenges	Staff shortages Staff increased workload	• Absenteeism, leave, sick leave • Decreased clinical output in number of patients seen • Inadequate staff ratio • Increased patient numbers • Additional tasks • Service delivery pressure • Time constraints with clinical output in the number of patients seen

Theme 5: Staff knowledge and attitudes	Resistance to change	• Fear of implementing new policy/unknown • Lack of exposure • Fear of implementing new skills
	Clinical competency	• Lack of clinical experience or training • Fear of initiation of new services • Lack of integration of knowledge and clinical experience
Theme 6: Infrastructure, equipment, stationery, and health information systems	Inadequate building and facility, and equipment infrastructure challenges	• Inadequate building space • Lack of IT equipment • IT software challenges • Supply chain challenges • Stationery and logistics
	Operational challenges	• Loadshedding • Network points problems • Pharmacy challenges • Delays in the policy implementation process
Theme 7: Training	Logistical training challenges	• Administrative challenges • Lack of continuous training availability • Delay in training processes
	Training attendance challenges	• Inadequate training before implementation • Service requirements • Types of training available • Financial implications of training

4.3.1 Objective 1: Policy implementation process

Three themes highlight the policy implementation process:

1. The responsibilities of the role players within the policy implementation process
2. Support structures for policy implementation
3. Training of personnel.

4.3.1.1 Theme 1: The responsibilities of the role players within the implementation process

This was the first theme that emerged from the study, and it focuses on the essential processes contributing to policy implementation. The process of policy implementation starts with the

National Department of Health (NDoH) sending the policy to provincial health and the departments and directorates that are affected by the policy. Afterwards, the policy is circulated to the sub-structure office.

The various role players ensure that policy implementation descends from the substructure to the facility level. Those role players include the HAST team at the substructure office which consists of the HAST medical officer, HAST director and HAST coordinators, the PHC and HIV managers, NGO stakeholders and the clinicians who implement the policy. A collaborative approach is required to ensure the best outcome of effective policy implementation. Under this theme, four sub-themes emerged and will be discussed in the following paragraphs.

4.3.1.1.1 HAST team responsibilities

The roles and responsibilities of the HAST team in the process of policy implementation are to ensure that policies are filtered to the facilities and supportive stakeholders. Most participants mentioned that the responsibility of the HAST team includes sharing policies with the HIV managers, the multiple disciplinary teams and support structures involved in policy implementation.

> *"There is a team the HAST manager and in the HAST manager there's a doctor MO. So, and she takes that responsibility to see that the information has been coming to the facilities and they see also to the HAST team, they communicate with the primary health managers to see the primary health managers can also send down their circulars or guidelines to the different facilities in the Northern Tygerberg substructure."* [Participant 1, female, 11 years of experience]

The communication process of policy sharing is a vital key to a successful and timeous implementation process. An efficient communication process is important because

stakeholders need to be informed and up to date with the latest changes. Various methods of communication are used to share information on policies. For example, the NdoH makes use of platforms such as conferences for sharing information regarding upcoming policy changes as mentioned by one participant:

> *"National also do formal conferences where we attend, where they manage these different policies and guidelines…. attend this conference so that you have then the understanding of seeing okay, they said this is the plan that they want to do before even before you need to come in over … is first do their planning and how they will implement at the facility."* [Participant 1, female, 11 years of experience]

The HAST team at the substructure office uses various modes of communication including physical methods such as sharing on notice boards, and printed hard copies in the offices, and electronic methods such as email, WhatsApp groups or Microsoft Teams meetings. One participant mentioned that they use whatever method is felt to be the most suitable one for the situation at the time.

> *"Forward the emails, electronic conversations to our staff, because most of them [have] got email, email addresses and then sometimes you also make use of WhatsApp because I think most of or all the staff got nowadays, they've got cell phones. So, which is the quickest way to get through to them? Then, at our meetings or monthly meetings we will inform them about the new guidelines, circulars, and policies."* [Participant 6, female, 12 years of experience]

The challenge during the COVID-19 pandemic was that they did not have face-to-face meetings. Policy changes were relayed via Microsoft Teams meetings by the HAST medical officer.

"During the COVID period now, we did not do face-to-face, but we did it online where she [went] through the different changes that took place." [Participant 1, female, 11 years of experience].

One participant opposed the physical method of sharing hard copy policies and argued that giving it to the staff is an old way of communication.

"I almost feel like it might be selfish. I almost feel like that's old school… like you give them a hard copy." [Participant 5, male, 7 years of experience]

It is evident that there is a move towards electronic forms of communication, especially since policies are available electronically and clinicians are encouraged to use personal computers.

According to most of the participants, the HAST team ensures training on new policies and provides clinical guidance and support where needed. The HAST team must ensure quarterly meetings with various stakeholders, and implementation of the quality assurance process, by performing the HAST audits at the facilities each year.

"The quarterly ART meetings are the whole component that the HAST team covers, so the HAST team covers the HIV; they cover the ART antiretroviral part, they cover the STI part, they cover TB and yeah. So, they cover the PMTCT. So, in that meeting, they cover all the areas. So, in that quarterly meeting…they will do updates like guidelines, and they will inform the staff about the training, and current training that is coming down. So, in that way, they evaluate the facilities to see where the needs are where people still need to get training." [Participant 1, female,11 years of experience]

Two participants confirmed that the HAST team performs quality assurance by monitoring and evaluating audits at the facilities after the policy has been implemented. During the HAST team

visits, potential challenges or policy gaps are identified to assist staff to implement policy more effectively.

> "*Say after a month, to see because they come to see are we doing; are we implementing it? And are we coping and if there's any problem? Because now we would have maybe detect[ed] some problems and we will tell her, yes, this is what we've done."* [Participant 2, female, 15 years' experience]

> *"The HAST MO, she makes sure that we get the data monthly, and quarterly of the HAST indicators and targets. And what she also does, she then compliments the staff, which even encourages them to use their policies more effectively."* [Participant 4, female, 17 years of experience]

Another role of the HAST MO, as described by a participant, is NIMART authorisation of the nursing staff within the substructure so that professional nurses can implement relevant HIV policies when treating clients.

> *".... the NIMART sister is authorised by the HAST MO, and then we've also the family physician that does the authorisation that we have the right to issue medication to the client."* [Participant 1, female, 11 years of experience]

Most of the participants stated that the HAST team fulfils its designated role and responsibilities. However, two participants had a contrasting view and stated that there is not enough support from the substructure office and that the staff require more support from the HAST team by being visible in the facilities.

> *"I said earlier, maybe just a little more support from … look at our substructure do give support."* [Participant 7, female, 9 years of experience]

"What can add more support from your coordinators … to come … you know …. more support from your training team, coordinators because many times it's easy to implement a policy or guideline but you need that support. You as the manager need the coordinators who will come and support you." [Participant 9, female, 6 years of experience]

4.3.1.1.2 PHC manager/HIV manager responsibilities

The PHC Manager and HIV manager can be either a combined role or two separate positions in the PHC facilities. In the smaller community day centres (CDC), the PHC manager will also oversee HIV policy implementation whereas, in the community health centres (CHC), there will be a separate HIV manager. Ultimately both managers are responsible for overseeing the implementation of HIV policy, meeting all indicators and targets, and managing the staff in the relevant HIV departments. In this study, one participant worked at a 24-hour facility and the rest worked at 8-hour facilities. The HIV manager oversees HIV facility-based services. Their role and responsibilities overlap with some functions of the HAST team such as policy sharing, guidelines, and circulars to staff. Meetings with the various stakeholders allow an opportunity to clarify and identify possible challenges and gaps in the implementation stage. Action plans are put in place for "rolling out" the implementation. The HIV managers are responsible for sharing policies with their staff and for informing them timeously of the changes that will happen.

"... And then they will send it down to the facility managers and to the operational managers of the HAST programme. And before it's implemented." [Participant 6, female, 12 years of experience]

"Information sharing is quite vigorous amongst our substructure colleagues and at facility level." [Participant 4, female, 17 years of experience]

All the participants in this study agreed regarding the process of policy communication sharing and the importance of the policy communication process. Moreover, they all confirmed that information is shared continuously from substructure level to facility-based level.

HIV managers share the policies with staff and put action plans in place to implement policies.

> *"You need to project manage all of those, and with everything that goes with it: infrastructure, IT, skill of staff, training."* [Participant 7, female, 9 years of experience]

Two of the key roles of HIV managers are to ensure the appropriate training of staff and to provide a general support role for the staff. HIV managers ensure staff readiness by sending them for the training they need for implementation purposes as indicated by a participant:

> *"They want us to come ready for a one-day training or a two-day training or a three day ... and then it will be specific around the guidelines or the implementation or they will say there is now a new programme that they want to start so then they call us up."* [Participant 2, female, 15 years of experience].

Another important role is the quality assurance which involves signing off monthly statistics and chairing meetings to evaluate whether service indicators were met. In this regard, some participants described their role as a manager as being very hands-on; thus, it entailed physically monitoring procedures by signing off registers, visiting areas in person, pre-empting possible gaps, and encouraging staff engagement and inputs so that a contingency plan can be implemented.

> *"When I do the data sign off, I want the actual HIV test and treat (HTT) register and I want all the registers to see where we are actually going wrong, and what are the challenges so that we can plug that gap in the meantime. So that is what we tend to do."* [Participant 8, female, 2 years of experience]

In this study, most of the participants confirm that the HIV manager is responsible for policy implementation; this includes identifying gaps and challenges and making quality improvement plans to ensure the expected outcome of the policy. A participant alluded to this by making the following statement:

> *"I do regular visits to the areas. So, if there's a policy that needs to be implemented, then I will go and check and see is it being done? How can I assist because if it's something that I need to work with them for a while to see if it's working so that I can experience first-hand whether there's challenges."* [Participant 3, female, 10 years of experience]

4.3.1.2 Stakeholder engagement

Stakeholders include non-profit organisations (NPOs) and community-based services (CBS). They support stakeholders in ensuring policy implementation; for example, the non-profit organisations ANOVA and Touching Nations have a collaborative agreement with the government. Their responsibility is to be a support system for the HAST component, doing community information outreaches, coaching, and mentoring of clinical NIMART staff and clinical and giving technical support as stated by a participant:

> *"...Where ANOVA [referring to the non-profit organisation] comes in and gives us the clinical support, technical support. So, they will come; they will show us the statistics. They will show how we improved because we now say we must not change or implement the policy …. they will show on the stats this is so many people say it's a test that so many people started."* [Participant 3, female, 10 years of experience].

NGO stakeholders have additional roles such as assisting with training, capturing data on the information systems, and assisting the HIV managers with quality improvement plans once

gaps have been identified. One participant mentioned that they play a vital role in implementing policies and ensuring in-service training:

> *"They really do assist us very well. In implementation then also, when that comes the information systems because most of the time it needs to be uploaded on our information system and identifying grey areas for us to put quality improvement plans in place."* [Participant 3, female, 10 years of experience]

All the participants in this study praised the NGOs for the good work they are doing; the participants reported that NGOs are always available to assist.

Furthermore, the CBS team is under the substructure directorate and collaborates with the HAST component by providing the following services: community home visits and patient recalls coming back to the facility, delivering chronic/ART medication to the community at home, and providing a continuum of care and processes to support clients in HIV care. One participant said:

> *"CSB will assist us by lessening the pressure on the clinics by doing home visits, delivering sometimes medication, assessing home assessments and then they will report back to the facilities."* [Participant 6, female, 12 years of experience]

According to all the participants in the study, CBS is a great support to the PHC services.

> *"CBS, that is a very important extension of our hands in the community…community-orientated primary care learning site so we work very closely with our community-based service. The Caring Network will help to make sure that we recall that patient to come back for their treatment."* [Participant 4, female, 17 years of experience]

4.3.1.3 Clinicians within the HAST team at the facility level

The HIV clinicians within the PHC facilities are the medical officers and the NIMART-trained staff performing HIV services. Clinicians are responsible for implementing HIV policies at their facilities, sharing policy information and education with patients, and ensuring a continuum of their care in the PHC services; as such, they play a supportive role to other members of the team. The medical officer is responsible for training and providing clinical guidance to the NIMART staff and counsellors. One participant stated the following:

> *"Family physician that is really hands on and assists with policy sharing, information sharing the medical treatment guidance for our patients."* [Participant 4, female, 17 years of experience]

> *"We have our doctors as back- up so if we don't know or not sure we go to them. We ask, especially if it's a new like Universal Test and Treat."* [Participant 2, female, 15 years of experience]

Most participants in this study agreed on the role and responsibility of clinicians regarding the process of policy implementation.

4.3.1.4 Theme 2: Support structures for policy implementation

The second theme that emerged from the study was the support structures for policy implementation. The participants mentioned that support structures play a vital role in implementing policy. These structures include multipronged support services and the restructuring of HIV services; this enables a collaborative approach as clinicians rely on their support role to strengthen the policy implementation process.

4.3.1.4.1 Multipronged support services

The multipronged support services include the HIV telephone hotline or Application that provides clinical guidance and support to clinicians for complicated HIV client management; that guidance and support are provided either by phone or electronically and it is available 24 hours a day. Also, support is provided by the CBS, and NGO community outreaches which engage in community involvement. Likewise, family physicians and tertiary services such as Tygerberg Hospital infectious disease clinics are present in a supportive and guiding capacity if complicated clinical cases arise. Thus, according to one participant:

> *"Then we also have clinical support from the Tygerberg team because they have a tertiary level. So, we have Dr (name mentioned) and Dr (name mentioned) so if doctor is unsure, she would also fax the patient's information to the Tygerberg team and then they will send us back. We must refer the patient to them. They will manage the patient at Tygerberg until the patient is stable."* [Participant 2, female, 15 years of experience]

The PHC information tracking system assists in tracking patients and information to provide monthly indicators. The HIV managers conduct clinical support visits to ensure that the implementation of policies is proceeding according to plan. One participant mentioned that she makes clinical visits to see how staff are implementing policy and if support is needed:

> *"I do regular visits to the areas. So, if there's a policy that needs to be implemented, then I will go and check and see is it being done. How can I assist because if it's something that I need to work with them?"* [Participant 3, female, 10 years of experience]

It is evident that most participants are aware of all multipronged support systems available to clinicians and facilities when implementing policies. The engagement with these support systems is encouraged by HIV managers to promote effective implementation processes.

4.3.1.4.2 HIV service restructuring

HIV service restructuring is deemed necessary when new policies need to be implemented while other policies remain in place. HIV service restructuring entails rendering a total service package and integration of care by re-arranging patient flow and ensuring specific indicators are met. Embracing different models of care and establishing innovative healthcare services were mentioned by a participant who stated that not all care has to take place within the facility.

> *"We need to look at different, like I said, different models to look at those that are well, it doesn't need to come in. Can we do the preventative care outside of the facility?... what can we do now - take services out into the communities where we render services off premises."* [Participant 7, female, 9 years of experience]

Methods of service restructuring can save time and reduce the inflow and outflow of patients in the facilities. These methods include the integration of services to reduce HIV stigmatisation, fast tracking of stable clients, same-day ART initiations and dispensing medication and using the ART chronic dispensing unit.

> *"Very important, the patient flow for the day you plan and discuss it, because especially when you're implementing a new thing, you want to fast-track the people to get them in the system. And once you do that, it also leads to quick and effective implementation."* [Participant 6, female, 12 years of experience]

Most of the participants had similar descriptions of services restructuring, with three participants stating that embracing innovative health care services will be beneficial in terms of improving time management and service delivery with policy implementation.

4.3.1.5 Theme 3: Training of personnel

Training of personnel was identified as the third theme. Training is regarded as one of the essential resources and requirements needed for policy implementation. When staff are equipped and trained on the policy outcomes, the implementation phase should follow effortlessly. The subtheme include planning training needs is essential for clinicians to be ready for policy implementation.

4.3.1.5.1 Planning training for healthcare personnel

The phase of planning allows the HIV managers to perform a needs analysis to determine what training is needed; this could include computer training or training in data capture or clinical updates. One participant stated the training requirements should be in place before implementation occurs. NIMART training is essential and so it should be included in the staff needs analysis, especially for the integration of services.

> *"We've got the integrated team; our staff are supposed to be able to work anywhere. So, if you are NIMART-trained, you can work on the general side and you work on the IDC (infectious disease clinic) side so our aim is to make sure that all our staff are fully NIMART-trained to make sure they can work anywhere."* [Participant 4, female, 17 years of experience]

> *"Because if I look at PrEP, it was only for NIMART-training sisters. So, to implement something like that, with one NIMART-trained sister, maybe in an area, that's very difficult, because how will you continue with the service if that person is not there? So yeah, like getting the training before implementation."* [Participant 3, female, 10 years of experience]

Some participants felt that there should be continuous training available after implementation, as clinicians identify challenges that they address. Three participants shared the sentiments that an HIV manager who is NIMART-trained leads to better policy implementation.

> *"The managers also need to be NIMART-trained, because a trained manager gives a better output of policy implementation because then they have an understanding also of what is expected. And then it gives just quality care so when it comes to audits and evaluation, then the policy would be obviously implemented better."* [Participant 1, female, 11 years of experience]

Most of the participants agreed that staff and managers should be NIMART-trained as this improves the likelihood of a better outcome for policy implementation.

4.3.1.5.2 Training needs for policy implementation readiness

The training needs of clinicians and healthcare workers, in preparing for policy implementation, differ from one facility to another. The HIV managers need to identify training needs according to their staff capacity. One participant emphasised that staff levels could differ in terms of competency and expertise:

> *"We need to look at that. Are people skilled? Do they have what they need to implement a new policy? That is where you as the manager need to come in to see and need to know the staff levels of competence, expertise and training."* [Participant 7, female, 9 years of experience]

Several participants said that the training could be in the form of in-service training, formal and informal training, and essential updates such as PMTCT and BANC. Participants identified the type of trainers needed: these included ANOVA, the HAST team conducting in-service training, and external trainers providing informal courses and formal training. Most participants

shared the view that HIV managers need to evaluate their staff to identify their training gaps and needs. One participant felt that HIV managers should make an analysis of the trained and untrained staff according to implementation requirements.

> *"When it comes to new policies, I would suggest that before we implement, to make sure do an analysis to see how many people are trained and how we can get them trained before implementation."* [Participant 3, female, 10 years of experience]

4.3.2 Objective 2: Factors/challenges influencing policy implementation

Four themes were identified, regarding the factors influencing policy implementation. These were: 1) Human resources, 2.) Staff knowledge and attitudes, 3) Infrastructure, equipment, stationery, and health information systems, and 4) Training.

Policies are drafted to ensure the standardisation of care. Sometimes, however, draft policies are based on an ideal situation which does not always prevail at all PHC facilities. Identifying challenges is part of the implementation process and therefore failure to do so can sometimes lead to ineffective policy implementation. The following sections discuss the subthemes and categories outlining the challenges faced within PHC facilities when implementing HIV policies.

4.3.2.1 Theme 4: Human resources challenges

Human resources play an essential role in the implementation process. Effective policy implementation calls for adequate staffing who have the required abilities and skills.

4.3.2.1.1 Staff shortages

Most of the participants in this study agreed that shortages of staff and staff constraints because of ordinary leave, sick leave and absenteeism are always major challenges. A lack of adequate

staffing affects the service delivery and puts pressure on the clinical output because the quality of care might not always be according to standard; therefore, set targets are affected as well.

> *"We struggle with staff, because sometimes the amount of staff allocated to the ART area …. it's just enough to get through the day. So, if it is that there's new things, you might need more staff, so staff, in general becomes a challenge."* [Participant 3, female, 10 years of experience]

Challenges that exacerbate staff shortages, as described by participants, include the increased number of patients causing congested clinics; staff shortages limit the daily intake of patients that can be seen. Accommodating clients without appointments is difficult. One participant mentioned that the facilities had enough staff to start the implementation of ART. However, as the number of patients increases, staff must rotate daily to overcome the staffing challenges and to ensure that all services are provided; sometimes, the daily target might not be met.

> *"As you have your day-to-day, you have your service pressures, there is a continuous increase [in the] flow of things... Staff structures, that has been adjusted."* [Participant 7, female, 9 years of experience]

4.3.2.1.2 Staff increased workload

The shortage of staff and increased workload have a negative effect on ensuring effective service delivery and in implementing policies. Staff are expected to have a higher clinical output by seeing more patients per day to meet the policy targets; this is not feasible as new policies are more time-consuming to implement. A participant explained the effects of time constraints, workload, and clinical output.

> *"Time constraints sometimes are against us. If staff have implemented this new policy, it sometimes takes a little bit longer for them to spend… they spend a bit more time*

with a client resulting in extended waiting time for the patients and their workload is also influenced because they often can see a little bit less." [Participant 6, female, 12 years of experience]

Most participants stated that their increased workload is caused by additional tasks assigned to staff and the same staff members providing multiple services.

"Hundreds coming through the gate before you could see them, and we had to explain it to the patients. The very same sister who is screening is the one that is seeing you inside. So yes, there's not somebody else. It is the very same staff that was for PREP." [Participant 7, female, 9 years of experience]

HIV managers are fully aware of their staff challenges, and some try to assist clinically, if possible, to lessen the patient load.

"How can I assist because if it's something that I need to work with them for a while to see if it's working so that I can experience first-hand whether there's challenges. So, I won't just throw it out to them, I will physically work with them and see what the challenges are and how I can assist them." [Participant 3, female, 10 years of experience]

4.3.2.1.3 Theme 5: Staff knowledge and attitudes

Staff knowledge and attitudes affect how they engage with policy implementation. Members of staff who have immense clinical knowledge and experience could embrace the new policy outcomes effortlessly if given the applicable training. Staff attitudes, which can be positive or negative, have a direct impact on policy implementation. Negative attitudes could lead to ineffective implementation because of a lack of commitment to the process combined with a

lack of diligence. Positive attitudes make the adjustment of policy implementation easier despite the challenges that occur.

4.3.2.1.4 Resistance to change

Resistance to change occurs because staff are afraid of implementing something new; for example, they could fear commencing a new and unknown ART medication or learning a new skill with minimal exposure. Many of the participants commented that staff resist implementing a policy that they are not convinced will work; they want the reassurance that it will be effective. One participant substantiated this:

> *"Especially if it's new, people aren't sure, and people don't want to be associated with something that will not work. So sometimes people first want to see it has worked somewhere else before they implement it. Many times, people don't want to be the first ones to start something."* [Participant 7, female, 9 years of experience]

Two participants suggested that listening to staff, supporting them where needed and acknowledging their fears could be the solution to overcoming the resistance issue.

> *"It also depends a lot on the leadership and the willingness and how much information is transferred or filtered down to staff, and to listen to their concerns, their fears, and to address it accordingly."* [Participant 7, female, 9 years of experience]

4.3.2.1.5 Clinical competency

Clinical competency is associated with providing accurate care and critical thinking skills within a safe clinical environment; thus, ensuring the quality of care and patient satisfaction. Challenges associated with clinical competency could be derived from a lack of clinical experience or in-service training, fear of introducing new services and a lack of integration of

knowledge and clinical experience. A manager stated that you must look at the staff member's skills and expertise when implementation needs to occur.

> *"We need to look at that. Are people skilled? Do they have what they need to implement a new policy? That is where you as the manager need to come in to see and need to know the staff levels of competence, expertise and training."* [Participant 7, female, 9 years of experience]

Participants have been consistent in citing a fear of the unknown or possible complications of commencing ART medication. Participants stated that certain staff members should be provided with additional support and clinical exposure until they are competent.

> *"I pick up [that] it was more of a fear thing among the staff to start …. in specific, also fear of I'm starting a client and I'm not sure if the client has TB-IRIS, experience the immune reconstitution inflammatory syndrome (IRIS) is common after initiation of ART. Known as compilation of inflammatory disorders associated with worsening of established infectious processes. So, also I've seen that so and then I think for me my years of experience at the facility in the ART medication they could feel comfortable."* [Participant 1, female, 11 years of experience]

4.3.2.2 Theme 6: Infrastructure, equipment, stationery, and health information systems

Various contributing factors should be in place to ensure the effective implementation of policy, and these include infrastructure, equipment, necessary stationery, and information systems to support the process.

4.3.2.2.1 Inadequate building, facility, and equipment infrastructure challenges

Infrastructure is one of the major challenges facing policy implementation. Most participants reported that facilities have limited space and inadequate building capacity for expansion. The influx of clients leads to the use of alternative infrastructure such as prefabricated structures. In addition, logistical services, and a lack IT of equipment, stationery and supply chain challenges related to orders and tenders, were found to be among the challenges that the PHC facilities encounter when implementing policy.

Two participants expressed challenges with infrastructure:

> *"Now as our clientele increase daily, we don't have enough space to put the extra clinician in the area. So, they become overloaded and overwhelmed with the number of patients coming to that specific area. So, infrastructure is a major challenge."* [Participant 3, female, 10 years of experience]

> *"That all support services and programmes speak to each other, and you have the necessary requirements to implement the policy .... specifically supply chain management [needs to] be geared up."* [Participant 7, female, 9 years of experience]

IT poses several challenges. For example, IT equipment, hardware, and software are often incompatible, and software is often outdated, all of this, together with faulty network points, has a negative impact on patient management systems. In many facilities, there is a lack of personal computers in each consulting room and staff are not computer literate.

> *"With everything being computerised, you often are stuck with network problems or software problems, or you often can get a staff member that is not computer literate. So, then you must make sure that that staff are trained and that also can slow down*

your progress of implementing a policy." [Participant 4, female, 17 years of experience]

4.3.2.2.2 Operational challenges

Operational challenges have a major impact on service delivery and therefore implementation of policies. One participant mentioned the challenge of increasing loadshedding affecting operational flow; everything comes to a standstill not only during loadshedding but also afterwards, as networks remain off.

> *"You have power outages, and we know load shedding is one of the things that …everybody rather prepares them for load shedding, but one of the things that is affected with load shedding is your networks. So, the networks are off when there's load shedding."* [Participant 7, female, 9 years of experience]

Pharmacy plays an essential role in policy implementation as most policies are related to medication management. One challenge identified by the participants was the increased number of patients at the pharmacy, requiring changes in medications; this led to the pharmacy being overloaded and at times, the medication was out of stock. One participant stated that their facility has no pharmacy services and experienced authorisation challenges because it did not have a pharmacist. The Ideal clinic requirement is a continuous audit process, monitoring elements that need to be placed to run a government institution ranging from infrastructure, supply chain and pharmacy, allowed them to solve that challenge.

> *"Then you also need to think of your medication. When you look specifically at this facility, the implementation for ART was not so easy. If I can talk specifically about our facility because we don't have a pharmacy at our facility……Ideal clinic has an extensive list of medication that they indicate that you must have; it's like a must essential factor at the facility. So, then I saw that the ART medication is included. You*

see, so that could not make me not to have that medication for my clients at the facility." [Participant 1, female, 11 years of experience]

Additional challenges are the limited time frame to implement policies, leading to delays in the policy implementation process at facilities.

"You will hear on the news there's a new policy that's been implemented on the first of April. And you are called for training on the 30th of March. So, it's quite difficult then to get people to implement that policy in the time that the national government expects of you to filter it to, to implement the policy." [Participant 4, female, 17 years of experience]

4.3.2.3 Theme 7: Training

Challenges relating to training can have a negative effect on the policy implementation process. The policy indicators and targets could be met from the beginning if adequate, timeous, and correct training is given.

4.3.2.3.1 Logistical training challenges

In this study, the participants mentioned various logistical challenges that prevent staff from receiving training before the policy is implemented. Four participants said that all the professional nurses in their facility are NIMART-trained, whilst the other participants stated that not all the professional nurses are NIMART-trained. The following logistical training challenges were identified: lack of availability of continuous training, delays in the training process, administrative challenges in submitting training forms, and no self-registration training process in place from the substructure. One participant stated that a self-registration process would make training more accessible.

"Even if you can also register yourself like you want to go and register yourself this is always whereby you need to complete the form and you need access, and all these little restrictions. If it's needed at the primary healthcare level, why aren't you just making it open where you can self-register?" [Participant 8, female, 2 years' experience]

Some participants said that a lack of training before implementation leads to a delay in the policy implementation process at facilities.

"Not enough time to implement. It is just the challenges that we might have at the facility level that may be prolonged." [Participant 3, female, years of experience]

4.3.2.3.2 Training attendance challenges

Challenges pertaining to the attendance of staff at training were discussed by the participants. For example, when training becomes available, services are often unable to send staff because of service needs and pressures; therefore, sending staff for training has financial implications especially if locum staff need to be employed. Initially, a skills development fund paid for locums when staff needed to attend training but now its locums divert from the facilities budget, which causes financial complications in paying locums when staff attend training. There is insufficient availability of online training that could replace formal face-to-face training and even when online training is available, the links did not work properly. Most of the participants supported online training as this was less likely to overburden services.

"I prefer actually the online because they can then do it in their own time, and you can structure it versus the physical one which is a long time out. That just presents a massive problem because then you have to cut your numbers here and then your patient complaints go up. So that really is a bit of a struggle. [Participant 8, female, 2 years' experience]

Contrasting views were raised by some participants who felt that there should be more innovative training strategies such as webinars, e-learning modules that are automatically assessed and virtual simulation of procedures; all of these should be available with modern technology.

> *"I want you to do this and then by this time you need to complete and provide me with the evidence that you've actually done the completion but now it is this form and that form and what and send it to substructure. No innovative training in place."* [Participant 8, female, 2 years of experience]

4.4 Summary

In this chapter, the findings of the study were discussed. Those findings relate to the process of HIV policy implementation, and then describe the challenges that HIV managers experience when implementing HIV policies at PHC facilities, despite the challenges some participants expressed they were satisfied with processes such as communication of policies. These challenges may lead to prolonged processes or may prevent effective policy implementation with PHC facilities. The next chapter will provide an overview of the discussions of the study findings, conclusions, limitations that occurred as well as recommendations for policy implementation and future research.

CHAPTER 5: DISCUSSIONS, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

In Chapter four, the researcher reported on the findings of this study. This chapter will discuss and interpret the main themes presented in Chapter four, in conjunction with evidence-based literature. To answer the research question for the study, the first step was to conduct interviews that explored and described the HIV managers' perceptions and experiences regarding the implementation of HIV policies at primary healthcare facilities; those facilities were within the Northern Tygerberg sub-district in the Cape Metropole in the Western Cape. The findings obtained from those interviews were then used to derive conclusions. Recommendations for policy implementation and recommendations to minimise challenges related to implementation and future research are made. Finally, the limitations of this study are described.

5.2 Discussion

The purpose of this study was to explore HIV managers' perceptions and experiences regarding implementing HIV policies at primary healthcare facilities in the Western Cape. The researcher used a descriptive explorative design to explore the process of policy implementation and to identify the challenges that the HIV managers face. The literature review revealed a lack of research studies of HIV managers' perceptions and experiences of policy implementation in South Africa. Therefore, the researcher saw an opportunity to explore this matter. The discussion is aligned with the objectives, themes, and findings of the study.

The study demographics indicate that only one male participated in the study. In this specific subdistrict, there are mostly female HIV managers. It has been suggested that management

styles and gender demographics can have an impact on policy implementation. For example, males tend to have task-driven implementation styles. Ploeg, Wong, Hassani, Yous and Fortin (2019) highlighted that male middle managers focus on strategic plans to implement policies. Therefore, one could imply that because the sample was predominantly female, the implementation processes and challenges reflected here might not reflect those of males. However, the researcher did not identify any marked differences between the information shared by the female participants and the one male participant.

5.2.1 Objective one: To explore the process followed by HIV managers in implementing HIV policies at PHC facilities

The following discussion is based on the process of policy implementation. That process includes communication to ensure sharing of policies by sending them to the relevant stakeholders. Each stakeholder must accept responsibility for ensuring the success of the planning process. Various support structures such as NGOs, CBS, and clinical support teams are the foundation of successful policy rollout, and they strengthen the continuous implementation processes. Restructuring of services is sometimes necessary to accommodate the implementation of a new policy whilst maintaining high standards of service delivery. A detailed needs analysis of training is required to identify the training needs of staff. In addition, various resources to support implementation must be identified.

5.2.1.1 Theme 1: The responsibilities of the role players within the policy implementation process

The study found that a collaborative approach is used to establish effective implementation of policy. This starts with the National Department of Health (NDoH) dispatching the policy to provincial health, various departments, and directorates that are affected by the policy. The policy is then circulated to the sub-structure office where various role players ensure that policy

implementation descends to the facility level. The study confirmed each stakeholder in the planning phase is responsible for ensuring team cohesion and accountability. One of the HAST and PHC managers' responsibilities is to ensure that all staff are fully trained, because trained staff ensure better policy outcomes. The HAST and PHC managers provide effective support to staff by leading the implementation process and by providing guidance and knowledge. Similarly, in London, Campos & Reich (2019), found that for health policy implementation to be successful, strong, innovative leaders with strategic vision, knowledge, and ethical orientation are needed to direct every role-player to perform within their maximum capacity.

Planning, monitoring, and evaluation processes are key parts of the implementation phase of the policy implementation cycle and are recommended in the National Policy Development Framework (Republic of South Africa, 2020). Performing, monitoring and evaluation takes place through clinical audits, monthly data sign-off, and drafting quality improvement plans. These were some of the responsibilities of the HAST and PHC managers. These implementation actions assist managers in evaluating the performance of indicators and identifying potential challenges or gaps that can hinder the achievement of policy targets and therefore hinder policy implementation. Furthermore, the HAST and PHC managers are responsible for sharing policy information, involving the various stakeholders providing support, and acting as the frontline implementers within the process. These issues all relate to the input of coordination and planning in the Management Model (Khan & Khandaker, 2016). A study conducted in the Middle East and Africa by Farokhzadian et al., (2018) revealed that poor-quality supervision, poor leadership practices, and lack of an integrated management working culture all had a negative influence on policy implementation.

HAST and PHC managers constantly ensure that information is shared using effective communication processes. Communication is centralised and multiple modes of

communication are used; these include formal notices on notice boards, electronic mail, and the Microsoft Teams platform, as well as social media groups such as WhatsApp. The study found that communication methods are trending towards more use of electronic formats; for example, by using more digital platforms within the healthcare system. It is evident that when changes occur, these are communicated to the implementers in advance, for example through WhatsApp groups, and not just during the start of the implementation phase. Similarly, a study by Makhado et al., (2020) identified that NIMART staff perceived effective levels of communication between the implementers, programme managers, coordinators, and managers.

The present study found that clinicians, consisting of medical officers and NIMART staff, were the frontline implementers of the policies. As such, they are responsible for patient education and ensuring the continuation of HIV care. Likewise, a study conducted in Kenya by Cawley et al., (2017), identified clinicians as being responsible for putting HIV policies into practice at the health facility levels. The role of clinicians can influence health outcomes through various pathways including service access, coordination of care and quality of care (Cawley et al., 2017). However, clear role identification is a key issue, and implementers such as clinicians require some autonomy based on their clinical knowledge and competency when implementing policies (Cawley et., 2017). Likewise, a study conducted in Bangladesh by Khan (2016) found that frontline implementers must have enough discretion in executing their responsibilities but that there should be a balance between lack of discretion and excessive use of power. That study confirmed that the balance in managing the behavior of frontline implementers will safeguard against all kinds of intended non-compliance. Therefore, although the HAST and PHC managers play a key role, there should be a balance between managing the behavior of the clinicians and supporting them during the implementation process. The Management Model aspect component of the 'exercise of authority' emphasises the importance of managerial

guidance, leadership, and support to ensure effective implementation (Khan & Khandaker, 2016).

This study also found that stakeholders play an instrumental role in policy implementation. Their main roles include engaging with the PHC manager during the planning phase, as well as in the implementation of policy, and assisting with the support services to reduce the pressure within the facilities. The study highlighted that if policy implementation is to be effective, then the engagement of stakeholders from the planning phase of policy drafting is imperative. This finding concurs with those of Ahmat et al. (2022) who found that if the policy is to be implemented effectively, then continuous planning and re-evaluation of action plans is needed, with engagement with all stakeholders, to identify and address challenges upfront. One of the gaps in strategic policy implementation was a lack of embracing innovative health models. The participants in the study recommended that stakeholders and clients should be open to innovative healthcare systems to overcome challenges related to implementation such as infrastructural space. There should be an increased uptake of alternative health service delivery to ensure that policy outcomes are met, and their implementation deemed effective (Department of Health, 2020).

This study determined that from substructure to facility level, a clear allocation of roles existed. If indicators were not met, then quality improvement plans would be established to improve the implementation process and eliminate any identified gaps or grey areas; progress would be monitored subsequently.

5.2.1.2 Theme 2: Support structures for policy implementation

The findings of this study showed that policy implementation is strengthened with the multipronged support roles such as the following:

- Clinical: family physicians, Tygerberg hospital infectious disease clinics.

- Technical: the HIV 24-hour hotline application; and
- community-based organisations (CBS, ANOVA) that provide community outreaches, share information, and perform home visits.

A collective support structure strengthens implementation as it allows policy outcomes to be targeted with multiple support inputs. This finding is in line with a comparative international study performed by Theobald, Brandes, Gyapong, El-Saharty, and Proctor, (2018); that study emphasised the importance of understanding the support role of the multidisciplinary team, which allows the implementation of the policy by ensuring that interventions have an impact.

In this study, a collaboration between the multi-disciplinary team and community-based organisations was seen as a prerequisite for successful policy implementation. This view is supported by the NDoH Strategic Plan for Health 2020-2025, which states that community participation must be promoted to ensure health system responsiveness and effective management of health needs (Department of Health, 2020). Implementing policies without community participation and engagement would be relatively less effective. This view is confirmed by the results of a study by Plazy et al., (2017) who found that the involvement of the community and traditional leaders increase opportunities for HIV awareness and participation within the community.

The present study found that HIV managers are encouraging the use of innovative health models to engage with various stakeholders. Similarly, Morton (2021) confirmed that the use of advanced and innovative healthcare delivery models maximises equitable and efficient access to HIV prevention and treatment regimens.

A key strategic aim of the South African government is to encourage its citizens to accept accountability for their own health needs. According to the Strategic Plan for Health of 2020-

2025, the South African Government encourages the promotion of cooperation and shared responsibility by the public, and private health professionals and providers as well as with other relevant sectors within the context of national, provincial and district health plans (Department of Health, 2020). In general, most participants reported effective support structures. However, some HIV managers who participated in this study revealed that the substructure HAST team is not present on the facility level when new policies are implemented; in this situation, they do not provide additional support and guidance to ensure quality assurance from the commencement of the policy.

The findings of this study confirmed that stakeholder support for policies increases the probability of their successful implementation. According to WHO, (2018), a forcible approach to implementation, while lacking some basic level of support, leads to unenthusiastic healthcare personnel and the risk of low-quality of care. Furthermore, one can argue that a poor support structure can lead to ineffective policy implementation, as the clinicians are dependent on the collaborative approach of other stakeholders to sustain and continue the policy implementation process that they have commenced. A study by Makhado et al., (2020) supported this view and found that a positive working association between nurses and other allied healthcare providers could lead to higher levels of adherence to policy implementation. Therefore, engaging various stakeholders and partners helps to ensure effective implementation processes working towards achieving national goals (Ahmat et al., 2022).

5.2.1.3 Theme 3: Training of personnel

The training of personnel is crucial when preparing for policy implementation; after all, appropriate training will provide clarity on the policy objectives and how to achieve them. The findings of the study confirmed that an analysis of staff training requirements should be done before the policy implementation phase. This analysis includes determining the type of training

needed and identifying the training gaps as well as obtaining clinical updates and recurrent in-service training. Furthermore, the needs analysis should allow for the prioritisation of training. These findings agree with the results from a study by Muthelo et al., (2021), which acknowledged that professional nurses implementing a policy need to be trained and tested on their knowledge regarding a programme's content before implementation began. That study suggested that training can be presented through short- and long-term courses on the implementation of a policy; this indicates the importance of the in-service training that should be conducted at PHC facilities to make sure that all professional nurses are prepared and ready for implementation (Muthelo, 2021).

Additionally, the present study showed that the staff need ongoing updates after formal training as well as during the post-implementation phase, to ensure that they meet the policy indicators and targets. The National Policy Development Framework (Republic of South Africa, 2020), states that the implementation of the policy framework and continued capacity development, through training and policy briefs, ensure the best practice of policy implementation. The findings of the present study are supported by a study conducted by Makhado et al., (2020), showing that staff require continuous guidelines updates such as refresher courses, post-implementation updates, continuous in-service training, and follow-up training for NIMART nurses. Therefore, an analysis of staff training needs is an important step towards updating knowledge and skills. In contrast, the implications of inadequate training or updates were identified in a study by Dasgupta et al, (2016). That study showed that poor adherence to policy and poor implementation were attributable to inadequate refresher training for HIV care providers.

All these studies show that trained staff are important for HIV policy implementation while the success of implementation depends on providing staff with knowledge and skills.

Mwakatumbula (2021) confirmed that routine training is vital for service providers to become familiar and comfortable with interventions.

5.2.2 Objective Two: To describe the challenges experienced by HIV managers during the implementation of HIV policies at PHC facilities

The following discussions are based on the challenges that HIV managers experience with policy implementation. Human resources challenges include absenteeism and a shortage of staff, leading to overburdened staff. A lack of clinical knowledge and skills can hinder implementation. The following discussion will also focus on the infrastructural, equipment and IT challenges and training challenges based on the logistical and attendance of training adversities, and the implications for the policy implementation process.

5.2.2.1 Theme 4: Human resources challenges

Under this theme, it was found that human resources are very limited because of absenteeism, a shortage of staff and an increase in patient numbers. Therefore, staff are overburdened with work and cannot always offer integrated care, which may impact meeting the set targets as indicated in the Strategic Plan for Health (Department of Health, 2020). Plazy et al., (2017), found that with an increased number of patients receiving care, health providers feared a deterioration in the quality of care in government clinics. In this present study, the HIV managers were concerned about clinical staff experiencing a high workload and being overburdened because of a shortage of staff. All the human resource processes that need to be followed to acquire more staff might be beyond the managers' control. The Management Model identifies human resources as a crucial input for effective policy implementation (Khan & Khadaker, 2016). Also, the National Policy Development Framework highlights the importance of resources and capacity within the policy implementation cycle (Republic of South Africa, 2020).

This study found that HIV services are still understaffed, leading to a lack of integrated care; also, not all staff are equipped with NIMART training. Attempts to implement a policy with insufficient human resources will hinder comprehensive HIV management according to that policy and will cause additional tasks and workload for clinicians. This is illustrated in a study conducted in Vhembe, Limpopo by Tshililo, et al., (2019), who found that a shortage of staff is related to difficulties in providing quality services such as obtaining extensive history taking, comprehensive examination, and excluding opportunistic infections. Therefore, the insufficient staff is a barrier to the integration of HIV services into PHC and therefore effective policy implementation. By developing a workforce with adequate staff, skills, and training in HIV programmes, responsible managers can ensure that there is optimal functioning of the HIV department at PHC clinics where all patients can be treated by all nurses (Plazy et al., 2017).

According to most HIV managers in this study, staff shortages highlight the need for adequate staff allocation within health systems built on comprehensive primary health care; this will increase productivity, promote good team cohesion, and reduce waiting time for clients. An additional challenge identified in the study, which contributed to the shortage of staff, was absenteeism. This places more pressure on the staff who are at work and increases the clinician-to-patient ratios and increases the client waiting time. Strasser, Kam and Regalado (2016), found that absenteeism from work is a challenge, as the remaining staff must cover the workload of the absent staff by attending to the booked appointments for the day. Thus, absenteeism implies that the quality-of-care decreases and targets are not met.

In this study, some HIV managers felt that having more trained staff allows more people to be treated while ensuring improved care, saving costs, and potentially leading to improved patient outcomes. Makhado et al., (2020) found that the effectiveness of policy implementation depends on the organisational structure; this includes factors such as adequate human

resources, appropriate and acceptable workload, and effective operational staff management. The present study found that the availability of sufficient human resources is mandatory to create an enabling environment for HIV service integration into PHC. The study concluded that insufficient staff and resources will hinder service delivery and will make the implementation of the policy less effective. This is also seen in the study by Tshililo et al., (2019).

5.2.2.2 Theme 5: Staff knowledge and attitudes

This study identified that staff knowledge and attitudes were determining factors when implementing HIV policies; moreover, these factors might affect policy implementation either positively or negatively. Less knowledgeable staff tend to be intimidated or unsure, and therefore resistant towards implementing a new policy. In addition, staff with negative attitudes such as feeling unsupported tended to resist policy implementation. On the other hand, those who were more experienced tended to embrace the process. Similarly, Muthelo et al. (2021) found that the lack of adequate knowledge and inadequate involvement of professional nurses in implementing policy resulted from negative attitudes and behavior by these nurses. According to a scoping review by WHO, (2018), policies that might not have the support of those directly involved, such as physicians working in rural and unequipped resources, will encounter resistance from physicians who fear diffusion of these policies. This finding concurs with a report by the Department of Health (2020), which found that the negative experiences related to the implementation of the Ideal Clinic policy were attributable to a knowledge gap and a lack of training of frontline implementers.

A study conducted by Makhado et al. (2020) revealed that nurses who resist change and lack motivation and commitment towards adhering to the use of clinical practice guidelines were less inclined to implement them. Staff should be empowered to integrate acquired knowledge

and skills that will lead to clinical competency and should overcome any possible resistance caused by fear of an unknown policy (Cancedda et al., 2015). HIV managers should therefore make an additional effort to involve all staff on all levels in the policy implementation process.

5.2.2.3 Theme 6: Infrastructure, equipment, stationery, and health information systems

The Management Model of Khan and Khandaker (2016) identifies infrastructure, equipment, technologies, and health information systems as essential inputs for policy implementation. Infrastructure challenges identified in the present study include inadequate rooms, limited spaces for all clinicians, IT equipment (hardware and software that are incompatible), and network points problems. One consequence of poor infrastructure and IT challenges, such as faulty equipment and slow networks, is prolonged waiting times for clients. As a result, service delivery targets may not be met. Alternative infrastructure such as the use of prefabricated units and outside mobile tents may lack equipment such as blood pressure machines, otoscopes, glucose, haemoglobin, and electro-cardio monitors; in that environment, also, the provision of comprehensive examinations might be compromised, and policy implementation targets may be hindered. A study by Tshililo, et al. (2019) found that despite the government's efforts in integrating HIV services into PHC, an insufficient number of PHC staff and inadequate infrastructure hindered the integration of HIV services at PHC facilities. The present study found that the need for expansion of facilities leads to the use of alternative infrastructure that may not meet the standards of the Ideal Clinic policy; such infrastructure may lack the necessary examination equipment, ventilation, and stationery (Department of Health, 2021).

This study also revealed that the implementation of new HIV policies, in addition to policies already in place, is affected by operational challenges such as load shedding, pharmacy supply shortages, authorisation challenges and overburdened pharmacy workload. Most operational

challenges arise from congested services caused by the increased patient numbers and added workload, because of a shortage of staff and inadequate space**.** This finding is supported by the conclusions of a study conducted by Crowley and Stellenberg (2014), in KwaZulu-Natal; thus, it found challenges such as logistical and infrastructural constraints, and adding tasks to overburdened staff, were barriers to the successful integration of HIV services.

Fast-tracking of patients is suggested as a solution for infrastructural challenges. However, operational issues such as load shedding in facilities limit the provision of care by delaying the clerking of folders and preventing access to information management systems and printing stickers. The study found that HIV managers used daily rotation systems to overcome the gap in the operational challenges within the PHC facilities. However, load shedding is an issue beyond the HIV manager's control because not all facilities have generators to take over when load shedding commences, and so service delivery is heavily compromised during load shedding. In the case of challenges concerning the information management system, the Government is committed to upgrading the Health Information systems within the next 5 years, to have an integrated system that makes managing clients from any location possible (Strategic Plan for Health 2020-2025; Department of Health, (2020). Khan (2016) noted that proper technology leads to implementation success.

Pharmacy-related challenges within PHC facilities were found to pose another hindrance to the effective implementation of HIV policy. This challenge stems from needing the authorisation to dispense medication without having a pharmacist at the facility. A shortage of pharmacy staff has a negative impact on issuing ART medication (SANAC, 2017). Therefore, this shortage leads to task shifting of the various healthcare staff, to issue medication at times. The present study found that some facilities had to overcome this challenge by pre-packing medication at another facility that has a registered pharmacist, who would then sign off the

issued medication before patient appointments. A study conducted in the Eastern Cape, South Africa, examined the challenges and opportunities of pharmaceutical service practice in PHC facilities. That study was conducted by Bobbins, Burton, and Forgarty (2020) and found that a shortage of pharmacists in PHC facilities resulted in task shifting and allocating pharmaceutical tasks to a pharmacist assistant or a professional nurse.

Pharmacy-related challenges have a direct impact on the operational flow of the PHC facility if processes are not in place. For example, these challenges compromise the effective implementation of new policies such as PrEP. Also, an inadequate supply of medication hinders the intention of the UTT policy and the provision of same-day initiation of ART (WHO, 2016). Essentially all the processes and structures of the pharmacy should be fully in place before implementation begins, to reduce any potential challenges.

5.2.2.4 Theme 7: Training

Under this theme, logistical training challenges were identified. These included a lack of availability of continuous training, delays in training processes, administrative challenges in attending the training, and limited availability of training before implementation. Logistical challenges can delay, from the outset, the readiness of clinical staff to implement policy effectively if they have not been exposed to a particular policy. Therefore, quality assurance processes need to be monitored closely to ensure that target indicators are met; inadequate training can hinder the effective implementation of policy. Any delay in training will have an impact on the time needed to train all staff in a specific course when certificates are issued. The participants in this study mentioned moving towards embracing modern technology through electronic devices and recommended more online training and cutting down on paper-based training applications. A study by Zhang et al., (2018) demonstrated that various simulation

techniques such as online training could be used for educational purposes and that these may be more suitable than others, for health services subject to operational constraints.

Although electronic-based training might be more accommodating to the needs of the clinical staff, the challenge of computer literacy was mentioned. A lack of computer literacy makes challenges for policy implementation, and these are made greater because the government is using various electronic platforms, such as the HIV hotline and the VULA application (an electronic online referral system by PHC facilities to refer to specialists at secondary or tertiary facilities) to improve the quality of care. Therefore, if the staff are not computer literate, then they hesitate to use electronic devices which affects the quality of care and impacts policy implementation at large. In Canada, Morton et al. (2021) recommended that alternative ways of training healthcare workers are needed to reduce implicit biases, practice skills, and optimise new technology models of training. Despite the benefits of using technology in health care, this study found that there are various limitations such as poor networks, load shedding, and incompatible hardware and software. Therefore, early identification of potential challenges can help professionals make strategic decisions about the use and development of electronic technologies in the healthcare sector. This finding agrees with the results of the study conducted by Baniasadi et al., (2019); thus, it was found that people who are unfamiliar with IT may resist the use of new technologies and cannot trust the use of IT-based tools, especially if they do not have the required IT skills.

Other training challenges include staff not being available to attend training, misalignment between training needs and the proposed training and ineffective staff replacement strategies. The study findings highlighted that in the past, locum staff could be motivated and funded whenever staff attended training, through the skills development fund. This funding is no longer available because of financial and budgeting constraints which indirectly pose

restrictions on the number of staff that HIV managers can send for training at a specific time. This finding corresponds to the results obtained from studies indicating that financial resources should be invested to ensure effective training (Ahmat, 2022; Cometto et al., 2018).

It was evident from the study results that HIV managers are recommending alternative modes of training, such as self-registration webinars and the Department of Health Knowledge Hub online practical manuals; this is intended to overcome obstacles in obtaining training and to ensure that staff are trained adequately (Department of Health,2022).

5.3 Conclusions

The study was underpinned by the Khan and Khandaker (2016) Management Model in which policy inputs directly impact policy implementation outputs. When all the inputs are in place with the commencement of policy implementation, the process is deemed to be effective. The aim of this study was to explore and describe the HIV managers' perceptions and experiences regarding the implementation of HIV policies at PHC facilities within the Northern Tygerberg sub-district. The findings of this study revealed that that the processes of policy implementation, communication, and policy sharing are occurring as they should. For example, frontline implementers are informed in good time about policy implementation, by means of information sharing. Various support structures are in place to strengthen implementation processes, and these include technical, clinical, and community-based structures. Each stakeholder appears to be aware of, and well-informed about, their responsibilities within the implementation process. An analysis of training needs is of the utmost importance to ensure readiness of staff for policy implementation. However, HIV managers still experience several challenges which are not always under their control, notably a lack of human resources. There are obstacles against motivating for more staff and these include submitting daily patients' statistics and monitoring and evaluation reports.

The operational challenges faced by HIV managers are related to equipment, and an increased influx of patients, as well as pharmacy challenges such as changes in medication regimen policies and medication stock-outs. Health care systems are evolving and are moving towards electronic systems to ensure a continuum of care; as such, information technology challenges are very present in the PHC facilities. Training issues occur mostly because of staff shortages, a lack of availability of online training and a lack of engagement with online training strategies when these are available.

HIV nursing managers generally had positive experiences of the process of policy implementation and are following the relevant steps including planning, monitoring, and evaluating; however, their key challenges were in resources and capacity, and infrastructure. As indicated in the Management Model, these key factors are essential for effective policy implementation; therefore, although progress in implementation has occurred, there is opportunity for greater improvement.

The limitations of the study will be discussed below, followed by the recommendations related to policy implementation and its associated challenges. Finally, possible issues for future research will be outlined.

5.4 Limitation of this study

Creswell & Creswell (2018) define the limitation of a study as the acknowledgment of any weaknesses in its research methods. By discussing the limitation of the study, the researcher highlights any methodological issues that might limit the potential to generalise the findings to other settings.

The researcher encountered various challenges. Because of the Covid-19 pandemic and its restriction levels fluctuating between 5 and 3, the data collection process was delayed until 2021 and had to re-commence in 2022 to ensure face-to-face interviews with participants as

per the ethics letter pertaining to this study. Some managers made appointments but cancelled at the last minute, not once but several times. The researcher had to follow up continuously by phone, and email those managers who cancelled, to reschedule. The data collection timeframe extended the projected timeline by an additional month. As a result, the duration of the study was longer than expected. However, this did not impact the rigour and trustworthiness of the study.

An additional limitation was the noise levels at some facilities, which made it difficult to ensure a calm and relaxed setting throughout the interview process, interview was paused when noise levels was too loud. This noise hinderance did not affect the rigour of the study. One limitation is that the researcher could not include more males in the study because most of the HIV managers in the subdistrict are female.

5.5 Recommendations

Recommendations will provide an overview of several recommendations related to policy implementation process, challenges to policy implementation as well as future research recommendation that is supported by relevant literature.

5.5.1 Recommendations related to the policy implementation processes

The present study found that the communication of policy sharing is mostly done electronically, with only a few facilities still utilising printed hard copies. Mc Robie et al. (2017) stated that communication can be highly effective if communicated via various methods. Therefore, the researcher recommends establishing an electronic, smartphone application and policy platform that notifies people of policy changes and allows them to review the policy. Questions can then be asked, based on the changes or updates of policy. This might allow clinicians to stay up to date with the latest clinical developments and at the same time, increase their familiarisation with electronic means of communication.

Facility reorganisation allows HIV managers to restructure the flow of service delivery. Thus, provision can be made for fast-tracking health services such as reboarding of chronic HIV prescriptions and the collection of medication. This might allow more time to serve the clients who need extensive medical attention, especially newly diagnosed TB-HIV patients. Recommendations of innovative healthcare models could include electronic lockers for receiving medication and mobile medication dispensaries for stable patients living with HIV (Bobbins et al., 2020). In this study it was evident that there is a need for community-based preventive care such as wellness screening at churches and community halls, involving the community health forums and care services such as health talks and issuing of pre-packaged chronic medication outside the usual healthcare services; the community should be engaged to strengthen this initiative. Morton et al. (2021) stated new modes of service delivery are needed to reduce retention barriers and deliver care equitably and efficiently to people living with HIV.

This study found the need for a detailed analysis of training requirements, bearing in mind the minimal use by clinicians of electronic platforms and engagement of applications such as the HIV Hotline and VULA. Moreover, staff should be more accountable for updating their skills and knowledge. It is recommended that HIV managers conduct quarterly analyses of staff training needs and then send staff for training, by making use of alternative training methods. Muller et al., (2021) stated that the influence of the training for transformation expansion initiative with the current staff has the potential to improve capacity and competence in patient management. Furthermore, the researcher recommends there should be more widespread use of those electronic platforms, such as open clinical webinars and PACK manual online training that issue certificates of completion (PACK, 2021). Also, a self-registration process should be developed to make training more accessible to staff who need more IT and computer literacy exposure.

5.5.2 Recommendations related to challenges affecting the policy implementation process

To overcome staff fears and their resistance to implementation, negative staff attitudes need to be addressed. The researcher, therefore, recommends that training initiatives should prioritise the acquisition of competencies through sustained mentorship and supervision rather than just the acquisition of knowledge through formal training. Mentorship groups for clinical staff can be established to provide clinical guidance and identify areas that provide possible training opportunities. Ploeg et al. (2019) stated that if team members perceive leadership as consisting of supportive mentorship, then this perception leads to trusting relationships between providers in clinical environments. The researcher recommends ensuring that all staff are NIMART-trained as this will enable the rotation of staff which will enhance the clinical competency and skills of the staff to ensure effective outcomes and that targets are met.

This study found that some staff members lack computer literacy. Because of this, HIV managers should ensure that all staff attend courses providing a basic introduction to computer literacy which will allow them to embrace the changes in the health care system; here, one should bear in mind the move away from paper-based services, with all clinical visits to be electronic. According to Ideal clinic, (Department of Health, 2016) [element 153-155 of the Ideal clinic], each consulting room should have a functional computer, with web access. Facilities are advised to utilise the district training plan, and request training for facility staff in the correct use of the ICT equipment (Department of Health, 2016).

This study found that the only way to overcome service pressures and the increased patient influx is to introduce alternative service models, which will expand health services beyond just face-to-face services; one alternative is telehealth consultation for stable patients. Telehealth would reduce the number of patients within a facility and motivate patients to take

accountability for their health. Rabe (2022) stated that within the South African public health context, telehealth consultation does not occur although it is present within the private health sector. Prerequisites for telehealth include having IT equipment and internet connectivity in place, for the clinicians and the patients. HIV-stable patients in the chronic clubs can utilise the telehealth platform by drawing blood to have the results available before renewal of the script. Those patients can then have a telehealth consultation with the clinician as long as they have access to a google account; the renewed script will be sent to the pharmacy for CDU collection. The Strategic Plan for Health encourages the development and sustaining of innovative healthcare models engaging all stakeholders, and enhancing community accountability (Department of Health, 2020).

The study found that the integration of comprehensive care would help to eradicate the stigma of HIV patients, as they would no longer have a designated treatment area. Tshililo, et al (2019) stated that the integration of HIV services into primary healthcare has the benefit of promoting coherent and holistic services. Therefore, the researcher recommends that all registered nurses working within PHC facilities should be able to screen, manage, treat, and identify possible complications of HIV as a chronic disease. Tshililo et al., (2019) said that all trained NIMART staff should attend additional courses that ensure an integrated full-service package; they can then rotate through the various departments, fully equipped with skills and by doing so, enhance the quality-of-service delivery.

5.5.3 Recommendation for future research

- This study was limited to participation by HIV managers only. Future research could broaden participation, in the form of a qualitative study focussing on the challenges of HAST and district managers when implementing HIV policies within PHC facilities.
- There is a need for an explorative study examining the impact of having more nurses trained in the integration of care; this is because not all facilities are practising the integration of services fully.
- A qualitative study is required, based on the importance of a multidisciplinary needs analysis for strengthening HIV policy implementation. This current study has identified strong multipronged support systems, with a collaborative approach, as being essential for successful policy implementation; a subsequent study could explore how the multidisciplinary team can strengthen HIV policy implementation.

5.6 Dissemination

The findings of this study will be disseminated to the facilities within the Northern Tygerberg subdistrict. A report on the findings and recommendations for improving the policy implementation process and describing the challenges affecting the process will be shared. It will enable HIV managers to consider the feasibility of introducing the recommended actions at their facility. A post-research feedback report will be submitted to the National Department of Health.

An electronic copy of this thesis will be shared with those participants who indicated an interest in the study topic and who requested to see the findings and final product of the thesis. A printed and electronic copy will be donated to the library of the Western Cape College of Nursing; this is expected from lecturers completing their master's degrees. An electronic version of this thesis will be uploaded onto the University of Western Cape electronic platform

Ikamva to enable the academic sharing of prospective students' research studies. The researcher plans to publish an article on this study and its findings to share the perceptions and experiences of HIV managers when implementing HIV policies at PHC facilities.

5.7 Conclusion

This study aimed to explore and describe the perceptions and experiences of HIV managers regarding the implementation of HIV policies at PHC facilities within the Northern Tygerberg sub-district in the Cape Metropole of the Western Cape. The key findings of the study suggest that the implementation of policies is not as effective as it should be because of several challenges affecting the process. According to the Management Model, it is essential to emphasise the importance of policy inputs: these include

- Personnel and human resources.
- Implementation infrastructure, location, and place.
- Equipment and technology.
- Levels of coordination and planning.
- Activities of frontline implementers and training, and
- The exercise of authority.

Furthermore, improving the inputs might lead to achieving the outputs such as the policy outcomes in terms of targets and indicators. The recommendations in this study suggested using innovative care models to reduce service pressures and enhance the integration of care. In addition, it is important to empower staff to use electronic platforms for training and providing clinical care to clients.

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ANNEXURES

ANNEXURE A: INTERVIEW GUIDE

UNIVERSITY OF THE WESTERN CAPE
Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-684 1254
E-mail: 2539746@uwc.ac.za

INTERVIEW GUIDE

SCHOOL OF NURSING

Preamble

I am Verinia Titus, a master's in nursing student (2539746) at the University of the Western Cape who wants to conduct a research study on the managers' perceptions and experiences to implementing HIV/AIDS policies at PHC facilities within the Northern Tygerberg subdistrict Western Cape

HIV/AIDS policies are defined as set goals and ideas set by government for universal treatment of HIV care. e.g Universal Test and Treat -2016

HIV guidelines is a recommended clinical guide that is standardised trying to ensure with specific outcome, in this regard a HIV negative child. E.g PTMCT 2019 update / ART Clinical guideline update- 2019 and PrEP guideline 2021

Topic: HIV managers' perceptions and experiences regarding implementing of HIV policies at primary health care facilities in the Western Cape

Research Question

The research question that will guide the proposed study is: "What are the HIV managers' perceptions and experiences to implementing HIV/AIDS policies at primary health care facilities in the Northern Tygerberg sub-district, Western Cape"?

Demographic questions

1. How many years of experience do you have in HIV care?
2. How many years of work experience do you have as an HIV manager?

Semi-structured Interview questions

Primary/opening Interview Question:

Can you tell me how is it for you (as HIV manager) to implement HIV/AIDS policies at the PHC facility where you are working?

The following questions will be utilised to keep the conversation active and guide the conversation:

1. Can you tell me what is the process of policy implementation from subdistrict level to facility level?
2. Are there support structures / processes in place, to assist you should you require clarity on the implementation of a specific policy? Can you tell me about these structures and processes?
3. How do you support your staff to ensure the optimal implementation of new or updated HIV policies?
4. Can you tell me what challenges/barriers occur in your clinic when policies need to be implemented?
5. Have you experienced any limitations while trying to implement new policies?
6. Do you have any recommendations to share regarding best practices which you have used to implement new HIV policies?

Probing questions:

Tell me more about these challenges organisation structures, personnel, implementation structures, level of authority?

What are the challenges within the support structures to assist you?

What could be the cause of this limitations to implement policies?

ANNEXURE B: CONSENT FORM

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

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CONSENT FORM

SCHOOL OF NURSING

Title of Research Project: **HIV MANAGERS' PERCEPTIONS AND EXPERIENCES REGARDING IMPLEMENTING HIV POLICIES AT PRIMARY HEALTH CARE FACILITIES IN THE WESTERN CAPE**

The study has been described to me in a language that I understand. My questions about the study have been answered. I understand what my participation will involve, and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits. This research project involves making audiotapes of the interviews. The interviews are recorded for the researcher to transcribe exactly what you as the participant have said, to provide evidence-based findings of the research study. The recording of the interviews will be transferred to a computer and the file will be saved in a password protected, which only the researcher will only have access to.

___ I agree to be audiotaped during my participation in this study.

___ I do not agree to be audiotaped during my participation in this study.

In terms of the requirements of the Protection of Personal Information Act (Act 4 of 2013), personal information will be collected and processed:

____ I hereby give consent for my personal information to be collected, stored, processed, and shared as described in the information sheet

___I do not give consent for my personal information to be collected, stored, processed, and shared as described in the information sheet.

Participant's name……

Participant's signature……..

Date ……

ANNEXURE C: INFORMATION SHEET

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

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SCHOOL OF NURSING

PARTICIPANT INFORMATION SHEET

Project Title: HIV MANAGERS' PERCEPTIONS AND EXPERIENCES REGARDING IMPLEMENTING HIV POLICIES AT PRIMARY HEALTH CARE FACILITIES IN THE WESTERN CAPE

What is this study about?

This is a research project being conducted by Verinia Titus at the University of the Western Cape. I am currently registered for a master's programme in nursing research at the University of the Western Cape and I am doing my research under the supervision of Dr F. Akimanimpaye and Prof T. Crowley. I am inviting you to participate in this research project because you are working in a primary health care clinic in the speciality area of HIV, as an operational manager overseeing the HIV programme within the facility in which you are working. One of the requirements of your job is to ensure that new and updated HIV policies are implemented correctly and optimally in your clinic. Your perceptions and experiences regarding implementing HIV policies at PHC facilities will be beneficial to the study because the results could assist in formulating recommendations for improvement in treatment and care of patients with HIV, based on the information you have shared. Recommendations could be disseminated to the appropriate stakeholders to facilitate future implementation of HIV policies at PHC

facilities in the Western Cape**.** The purpose of this research project is to describe and explore HIV managers' perceptions and experiences regarding implementing HIV policies at PHC facilities.

What will I be asked to do if I agree to participate?

You will be required to join the researcher in a one-on-one semi-structured interview, where the researcher will commence with an overall question followed by questions to ensure that all the requisite information for this study is obtained. The entire interview will be audio recorded so for analysis of the interview afterwards. These individual interviews will occur between May 2022 – August 2022. The time duration of the individual interviews will be approximately 45 minutes, the researcher will ensure you understand the process before commencing interviews. The overall questions that will be asked will be related to policy implementation, challenges of policy implementation, the perceptions of HIV Policies, and support systems in the policy implementation process. The researcher will encourage you to talk about all facets that you have encountered whilst implementing new or updated HIV policies. To ensure that she has all the information she requires.

Would my participation in this study be kept confidential?

The researchers undertake to protect your identity and the nature of your contribution. To ensure your anonymity, your identity will not be revealed at any time during the individual interview, and the consent form which you are required to sign will be kept by the researcher and locked away. You will be identified according to a participant number which will be provided to you at the time of the interview. The researcher will not use your name during the interview, so the recording will only indicate that you are participant # 1 (for example) throughout the data collection process.

To ensure your confidentiality, the recording of the interviews will be transferred to a computer and the file will be password protected. The transcripts of the interviews will be done electronically and saved in a password protected computer file which only the researchers will only have access to. If a report or article is written about this research project, your identity will continue to be protected.

What are the risks of this research?

There may be some risks from participating in this research study such as the potential emotional risks that could arise due to feeling uncomfortable or anxious about sharing information. There could be some fear of disclosing actual practices, incidents or involvements occurring during the implementation of new or updated HIV policies.

All human interactions and talking about self or others carry some amount of risk, in this study feeling concerned and worried is therefore possible. The researchers will minimise such risks and act promptly to assist you if you experience any tension or discomfort during the process of your participation in this study. Where necessary, should the interview elicit adverse reactions of an emotional nature, an appropriate referral will be made to a suitable professional such as Metropolitan employee wellness for further assistance or intervention.

What are the benefits of this research?

The benefits to you include:

Identifying possible barriers or gaps in the implementation of new or updated HIV policies. Ensuring optimal performance in audits through the successful implementation of new or updated HIV policies.

This research is not specifically designed to assist you personally, but the results may help the researcher learn more about manager's perceptions regarding implementing HIV policies at

PHC facilities. We hope that, in the future, other people might benefit from this study through improved understanding of the perceptions of managers regarding implementing policies, to guide them future managers to implement HIV policies adequately and effectively at PHC facilities.

Do I have to be in this research, and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research and change your mind at any time during the proceedings, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits for which you would otherwise qualify. Should you choose to withdraw all data which may have been collected at that time will be discarded and permanently disposed of and will not be used for the purposes of the study.

What if I have questions?

This research is being conducted by Verinia Titus, School of Nursing Department at the University of the Western Cape. If you have any questions about the research study itself, please contact Verinia Titus *at*: c/o Klipfontein Road, Athlone, 7764, telephonically at 021 684 1254 or email at 2539746@uwc.ac.za

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Prof. J. Chipps

Head of Department: School of Nursing

University of the Western Cape

Private Bag X17

Bellville 7535

jchipps@uwc.ac.za

Prof Anthea Rhoda

Dean of the Faculty of Community and Health Sciences

University of the Western Cape

Private Bag X17

Bellville 7535

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BMREC/HSSREC

Research Development Office,

Tel: 021 959 4111

email: research-ethics@uwc.ac.za.This research has been approved by the University of the Western Cape's Research Ethics Committee**. (BM 20/10/6)**

ANNEXURE D: UNIVERSITY OF WESTERN CAPE ETHICS APPROVAL

UNIVERSITY of the WESTERN CAPE

Department of Institutional Advancement
University of the Western Cape
Robert Sobukwe Road
Bellville 7535
Republic of South Africa

11 January 2021

Mrs V Titus
School of Nursing
Faculty of Community and Health Sciences

Ethics Reference Number: BM20/10/6

Project Title: HIV managers' perceptions and experiences regarding implementing HIV policies at primary health care facilities in the Western Cape.

Approval Period: 20 November 2020 – 20 November 2023

I hereby certify that the Biomedical Science Research Ethics Committee of the University of the Western Cape approved the scientific methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

Please remember to submit a progress report annually by 30 November for the duration of the project.

Permission to conduct the study must be submitted to BMREC for record-keeping.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

Director: Research Development
University of the Western Cape
Private Bag X 17
Bellville 7535
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NHREC Registration Number: BMREC-130416-050

ANNEXURE E: ETHICS APPROVAL FROM DEPARTMENT OF HEALTH

Western Cape Government
Health

STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
tel: +27 21 483 0866: fax: +27 21 483 6058
5th Floor, Norton Rose House,, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za)

REFERENCE: WC_202012_013
ENQUIRIES: Dr Sabela Petros

Private Bag X 17
Bellville
7535
Republic of South Africa

For attention: Mrs Verinia Titus, Prof Margaret Williams

Re: HIV MANAGERS PERCEPTIONS AND EXPERIENCES REGARDING IMPLEMENTING HIV POLICIES AT PRIMARY HEALTH CARE FACILITIES IN THE WESTERN CAPE

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.
Please contact the following people to assist you with any further enquiries in accessing the following sites:

Bishop Lavis CDC	**Dr Mumtaz Abbas**	**021 927 1147**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. In the event where the research project goes beyond the *estimated completion* date which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
4. The reference number above should be quoted in all future correspondence.

Yours sincerely

DR M MOODLEY
DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE:
CC

Dr Melvin Moodley
Director: Health Impact Assessment
09 MAR 2021

ANNEXURE F: EDITORS LETTER OF CERTIFICATION

CERTIFICATE OF EDITING

HIV MANAGERS' PERCEPTIONS AND EXPERIENCES REGARDING IMPLEMENTING HIV

POLICIES AT PRIMARY HEALTH CARE FACILITIES IN THE WESTERN CAPE.

by

VERINIA TITUS

Student number: 2539746

Philip Murton [Editor] has edited the above-mentioned document produced by Verinia Titus [Author].

The edit covered:

Chapters 1- 5 and references

The Editor declares that:

- He has edited the document for grammar and consistency in spelling.
- He has pointed out instances where the meaning of the text seems unclear.
- All citations have been checked to see that they have been referenced and if not, the Author has been advised.
- All references have been checked to see that they comply with the format stated in the Guidelines provided. If there are issues, then these have been pointed out. Any references not cited have been highlighted.
- All comments have been made in the Track Changes function of Word, and it is up to the Author to decide whether to accept the comments or not.

The Editor:

- Has 15 years' experience in editing theses and papers in scientific, legal, medical and other disciplines.
- Has graduated with a BSc [UCT] and later and LLB [UNISA].
- Is a member of the Professional Editors Group.
- Is available at 079 642 3514 to deal with any issues and
- Is contactable at pmurton@mweb.co.za

Thus declared at Plettenberg Bay on 14 November 2022.

Philip Murton LLB BSc

ANNEXURE G: EXAMPLE OF TRANSCRIBED INTERVIEW 4

Time: 39:18

I Good morning. I'm Verinia Titus from the University of the Western Cape. And I'm currently busy with my Master's in Nursing. And my research topic is HIV managers' perceptions and experiences when implementing HIV policies at primary healthcare level, but specifically, the Northern Tygerberg subdistrict. So, when I refer to HIV policies, it's just defined as set goals and ideas set by government for universal treatment, so that the clients can have the same clinical output. So, we will just think just refer back to like the Universal Test and Treat policy that came in when I'm referring to policies. So, my first question that I want to ask you have signed the consent form?

P Yes, I did sign the consent form.

I Can you tell me what today's date is, please?

P Today is the 19th of May 2022.

I Thank you, and can you tell me what your participant number is?

P My participant number is number four.

I Okay, thank you. Before we start, can you also tell me how much years have you been in management?

P I am currently from 2005. So that gives us 20.

I Almost 20. Yes. Yes,

P Between 2000 and

I 17 years.

P 17 years. I'm 17 years.

I Thank you so much. Now we're going to formally start with the questions. As I said, the topic is about HIV managers' perceptions and experiences when implementing policies. So can you tell

me a little about the process of policy implementation from national level when we receive the policy to subdistrict level, please?

P So any policy that is new policy that is implemented, we will normally hear from national level that is implemented. From national it will be go down to provincial level, provincial will then filter it down to the substructure level. At substructure level, we normally, we do have our HAST team, or our HIV HAST team who is manned by a HAST medical officer and also a HAST director, HAST medical officer, and there's coordinators that manages the different programmes. Somebody's managing TB, HIV, Child Health, Mental Health. So, any policies that is filtered down to us HIV/AIDS policy that is filtered down to us, it normally comes via our HAST coordinators. Implementation of the policy, communication is normally via email. Training, normally the HAST coordinators will assist with a training we also have trainers in our substructure that will also help with training. At facility level, we normally then sensitise that policy because that policy will influence our patient outcome. And we are also subsequently monitored by our patient outcome or our patient success rate. So, we need, at facility level we then inform our staff first in a staff meeting, we have a Monday morning staff meeting where we then inform our staff. We normally have a document that they signed that they were informed. At our substructure level, we also are informed in our primary healthcare meeting. We have a special HAST meeting where we are informed about the new changes. We also have a people's forum management meeting who also inform us about any changes or any policies, new policies that is implemented. So, information sharing are quite vigorous amongst our substructure colleagues and at facility level, we then also need to make sure that our information sharing is vigorous amongst our patients or about amongst our staff, if we want to achieve to the desired outcome. So, once we have feedback to our head of departments, because that is ultimately where the information need to filter down to so that our head of departments first know, especially the operational manager who is directly responsible to ensure that staff implement the policy. So, in our monthly staff meeting we have of information sharing, we can send it via email, we can print the policy, we normally print the policy for each staff member in the HIV department. But we also make sure that our TB department, give them printed policies. We also make sure that we have special training sessions for the staff that is directly involved in that training. We have in-service training at facility level. We have our HAST coordinators who also come down to give training to the staff. We make sure that all the stakeholders in the facility, our clerks, our counsellors, our pharmacists, the NPOs are aware of the necessary policy changes. What we also do at facility level, in our monthly staff meeting, we will follow up and make sure that staff

is still aware. We make sure that we monitor them, or do our staffing our folder audits, to make sure that staff do adhere to the policy. We also have a monthly data sign-off meeting that we can check what our patient outcomes is. For example, if it's the initiation policy or test and treat policy that influenced directly our remaining in care head count. So, if we notice a drop in our remaining care, we will call the staff member and that is how we also keep them accountable of making sure the policy is implemented. Because if the policy is not implemented, it gives us a negative outcome.

I Thank you for that. Is there anything else you would like to add before I just summarise that… what you mentioned the two processes, the one from national level and then the one from the OPM to the healthcare staff.

P I think I've summed it up. Yeah, and other than that, it's just that each staff member in that area will get the policy so that they can have it on their disk to be able to implement it.

I Okay, thank you so much for that. So, the first process was the policy implementation process from national to substructure that you mentioned, it goes from national to provincial, to sub structure level. And then that composes from a HAST team which has the HAST MO, the HAS director and the various coordinators for TB, HIV STI. The communication for the policy to be filtered down is via email. The HAST coordinator then does training depending on the training needs. There's a primary healthcare meeting where it gets filtered down to the primary healthcare operational managers, but also a HAST meeting where you get informed of the different changes. There's personnel forum meeting, that the information is also shared. And then obviously, it gets to the OPM and the process of filtering down the policy and then planning for policy implementation from the operational managers to the clinicians or healthcare workers, you said, you have monthly meetings, which usually happens on a Monday. You guys get to sign the document that all staff saw the new policy. It gets filtered down to the HODs of the various departments and components. There's information sharing, printed document policies and get end to the clinicians or the healthcare worker so that they can have it in their desk. There's special training sessions done at facility level, but also through the HAST, coordinators, and then you inform the stakeholders like the pharmacy and the clerks and the counsellors, everyone that's going to be involved in this policy implementation, depending on what the policy is. Then you have your own monitoring and evaluation meetings in terms of folder audits. And then you said, the monthly data signing off where this can also be used as an evaluation tool for clients

remaining in care. It's also a tool for accountability, to check where the policies has been implemented effectively. Can I say, especially with the data sign off for the monthly meetings, and in terms of remaining in care, this would then obviously have a reflection in terms of our universal test and treat because then you can measure how much was started.

P Yes, yes, so it definitely has an effect. I must also add Verinia, we also have our quarterly HAST meetings. And in the HAST meetings, they look at data across the substructure, that is also then filtered down to us. So, we can also see how we were doing over the quarter. Because of that HAST meetings and Dr Kalawe, the HAST MO, she really makes sure that we get the data monthly; quarterly. And what she also does, she then compliments the staff, which even encourage them to use their policies more effectively. And Bishop Lavis was one of the facilities that normally gets, they get every month they will get a [compliment].

I Okay, so my next thing I would like to ask when you are planning to implement policies, support structures and processes are very important for staff or your HAST team, to implement the policy effectively. Are there any support structures put in place to assist staff when they have to implement and can you tell me a little bit more about the support structures put in place, please?

P The support structures in Bishop Lavis, basically, if it comes down to test and treat, it influence our pharmacy, so our pharmacists manager, are directly involved to ensure that staff get the right medication or patients are start on the medication. We also have support via our NGOs, which is Anova and Touching Nations because they also need to know, especially Touching Nations, if the counsellor counsel the patient, and the patient tests positive, they need to be able to refer the patient to the sister or the doctor to treatment to be initiated. So, our NGOs, Anova and Caring Network and Touching Nations are directly involved in making sure that we implement the new policies. Anova also assists with training, they especially concentrate on the training of the clubs to make sure that people that are doing well on their treatment are referred into the clubs. So, training will happen in-service training. We will also have formal training. Our pharmacist also assists to make sure that formal training is given on to the medication use of the patients. CBS, that is a very important extension of our hands in the community. Bishop Lavis is a community-orient primary care learning site so we work very closely with our community-based services. So, if we maybe I must to start a patient on a dosage or a patient has defaulted, the Caring Network will help to make sure that we recall that patient to come back for their treatment. So, if information

systems in this case is very important, so our computer systems that we are using is TIER.net where the clerk, the data capturer make sure that if a patient has attended on the day that it is recorded the patient has attended, the patient's viral load is recorded. If the patient is initiated, it's a new patient that is recorded. If any bloods was taken or any results was taken that is recorded on the TIER.net for the client. They also have the remaining in care where they can see whether they have a system where they have a week loss to follow up. In after seven days they check again, they have a 30-day follow up. They can continuously check if the patient comes back for their treatment. They can also capitalise on our JAC system, the pharmacy system if we need some information to see what medication the patient was on, and if the patient comes regularly for their medication. Our primary healthcare information system assists us to make sure that our patients don't shop around. Because often patients will attend Bishop Lavis. They will attend at Ruyterwacht. They will attend in the Delft. So, if we punch in and we want to have a service history, the primary healthcare information system basically can show us where this patient was over…it actually tracked the patient back quite far. So, we also have support from our Tygerberg, IDC, our infectious disease clinic. If all fails and nobody at the facility or we don't have our family physician here, we have Dr. Taljaard and Dr. Meintjies to assist us with clinical guidance in any management aspect. Or the staff don't understand the policy they can always phone the IDC clinic to get information from doctor, from the two doctors there. Another way they can also get assistance is our HIV hotline. It's actually 24 hours available to our staff and I think our staff is really grateful for that. At our facility we are fortunate to have a family physician that is really hands on and assists with policy sharing, information sharing, guidance on, treatment guidance for our patients. For Bishop Lavis, we've got the integrated team, our staff are supposed to be able to work in anywhere. So, if you are NIMART trained, you can work on the general side and you work on the IDC(infectious disease clinic) side so our aim is to make sure that all our staff are fully NIMART trained to make sure they can work anywhere.

I Okay, thank you very much for that. If there's nothing else that you want to add, can I just summarise the support systems that is put in place. So first you mentioned the pharmacy which assists with the medication but also for training for the staff of the medication use. And then we have our NGOs which is Anova and Touching Nations. So they train the counsellors but also trying them how to refer in line with the Universal Test and Treat so that the clinician can start them and then also they assist you in terms of training. Then we have our community-based services, which is a collaborative approach to help recall clients or missed clients. It's also a caring network. So in terms

of CBS, the community-based service, I just like to now how do we make sure that they are getting out to the clients that has defaulted or missed opportunities?

P So the data capturer will take the folders out. The data capturer will then give the folders to the counsellor. The counsellor will write out. They will first phone because our first point of entry to see if we can get all that the client is phone the client. So the counsellor will first phone the client to find out if the client remembers or forgot his appointment. And mostly that actually happens regularly that they respond to the phone calls when we call them. If the client for some or the other reason don't respond to the call a recall slip is sent out to Caring Network. They will then feed back, come back to us to say If they managed to get the client. On a monthly basis, they then give feedback on their stats, how many patients was recalled, or how many patients were successfully recalled. They give stats to our substructure to say, how many patients were they able to recall from our side. We on our side again, also expect our clerk will send us the emails that Caring Networks send them if there is successful recalls. We often get clients that also don't stay in Bishop Lavis. At first, it was a problem, but not anymore, because we do send our out of area recalls to our substructure office, and the substructure office will then send out to the appropriate NGO in that particular area. So, we really try to make sure we keep our clients in care.

I Wow that's really good that there's an out of area one, especially still with the stigma of HIV where people are scared to go in their area. So for monitoring purposes, there is a monthly feedback meeting in terms and there's emails to help them track the success rates of the recalls.

P Just on that Verinia, because we are community-oriented primary care site and that is the way the future healthcare services are going to function in the whole of the Western Cape, we are actually on WhatsApp with our caring network. And if you have an urgent recall or if they have an urgent matter in the community that needs attention, they will send a WhatsApp and somebody in the facility will respond to say, we've got hold of the client or the client is not staying there or can we bring the client in or whatever communication there is with the community, with the caring network and between Bishop Lavis, we've got a very good communication between the two teams.

I Wow, that is that is very good. And it's also worth keeping with modern times and also give the community the responsibility to look out for each other. Then you mentioned IT systems and structures, which is the TIER.net, which helps capture patients daily. It

also gets use as a monitoring tool, because you can see how much initiations, how much lost to follow or early miss there is. Then we have our JAC system, which shows whether your HIV client has come to fetch their medication regularly. And then the primary healthcare information system which tracks their history for a long while. Then the support of the Tygerberg infectious disease clinic Dr. Taljaard and Dr. Meintjies, which is there for clinical guidance and management. And then you mentioned the HIV hotline which is available 24 hours. And that you guys are privileged to have a family physician, which is a senior doctor, but also that you are one of the facilities that don't train your staff in silos. So, everyone is trained to work different areas and it's integrated. And everyone is mostly NIMART trained. So, my next question that we will get to is the challenges when it comes to policy implementation. So that you have experienced that your facility or in general challenges when it comes to implementing policies.

P Like any other project or anything that you like you would like to implement, you always have, you might have your challenges where you do have your challenges. Challenges that we experience is sometimes resistant to change. Some people that just continue in the old way. When we do experience that we will call the client in or if we do pick it up during our audits we will call the staff member in and just try to find out what is the problem that the person is still not implementing the new policy. It often happens and that particular staff member maybe was on leave or couldn't come to the meeting or information didn't go down to that person. So, it's a very tough, tough task to make sure that policies are implemented and make sure that everybody understands what is it all about. With new policy, some policy, sometimes the information doesn't get to the facility, when it's supposed to when the policy is supposed to be implemented. Say, for example, you will hear on the news there's a new policy that's been implemented on the first of April. And you are called for training on the 30th of May, the 30th of March. So, it's quite difficult then to get people to do implement that policy on the time that the national government expects of you to filter it in order to, to implement the policy. So yeah, some of our limitations are also the fact that the patient sometimes in the community, sometimes don't understand why do I have to now change, they get used to a treatment regime. And you have to talk to them more than once. And you have to say, but this is the new treatment plan that we now have, people often don't understand and they will find an excuse not to start, or not to continue with a new thing. And they would like to use the old thing. On our staff, if you do experience the staff resistance, it's just a matter of sitting with a staff and trying to explain the new the new way of doing things. And some other challenges that we might experience in the implementation is your staff turnover is also something that has

a big impact on implementation of new policies. And you constantly have to go back to make sure that the staff member is updated on the new policy. Infrastructure, sometimes the policy doesn't talk to the, to your space that you have or to the equipment that you have. Now you have to strategise, to see how can you make sure that your infrastructure allows you to implement the policies. On equipment, nowadays, everything is becoming electronic. And sometimes people don't have the necessary computers and especially printers to print results. With everything being computerised, you often are stuck with network problems or software problems, or you often can get a staff member that is not computer literate. So, then you have to make sure that that staff is trained and that also can slow down your progress of implementing a policy. The stationery, we also need to make sure that we have the necessary stationery. With new tenders in the government, it often happens that your stationery gets depleted and now you have to go back to the old stationery that you used to use. Our training needs, it is important that you continuously make sure that we update our staff and by doing our monthly audits we can capture whether staff is not implementing. Time constraints sometimes is against us. If staff has implemented this new policy it sometimes takes a little bit longer for them to spend… they spend a bit more time with a client resulting in the extended waiting time for the patients and their workload are also influenced because they often can see a little bit less than what they should see because of the new policy implementation because the patient also needs to understand why am I getting one pill now? I used to get for both. Yeah. I think that is it.

I Okay, thank you. That was a comprehensive list of challenges mentioned. So, I'm just going to summarise. So the first one could obviously be resistant to change because of fear for the clients and staff. Sometimes we just need more information or how… you mentioned that staff sometimes it's just missed information due to being on leave or just not being away from the facility for training or something. Then it's the sharing of information. Sometimes national will release it on the news before this actually, a set date is communicated for implementation at facility. Then there's time constraints on the planning, and also sometimes lack of sharing of of information to our clients like, they don't understand why it is now the same tablet that they use the four, but it's just put into one, which has an effect, like on that adherence to that. So, it's just about educating. Then there's time constraints. So, when a new policy is implemented, our staff tends to spend more time with the patient so that they can understand the changes. Workload is sometimes then decrease and then the total patient output due to the new policies, then, obviously, for that, while when you monitor it, it could be decrease, and then staff turnover when you want to implement, you then either have

to determine do you take from your own staff or do you need more staff. And then infrastructure, space is a problem everywhere. Sometimes the policy doesn't speak to the infrastructure that's been here for many years, and then you obviously have to make other plans. Equipment, I like this, how you elaborated on everything going digital and modern. So, PCs and printers might be a problem, and the networks and the software and then computer literacy of staff because they're used to manually writing everything and now we are updating to electronic versions. And then when it comes to stationery, we have new tenders, sometimes the old stationery or the current station is depleted. And then that's obviously, the confusion between using old versus new but as long as there is record keeping. And then training could be a challenge. So, there's monthly audits, if through the data, like you explain that meeting you have, and you can identify problem areas, and you call in and then try to identify why poor implementation obviously, then happen. I would just like you actually touched on something. So, the next thing would be limitations. And resistance from the community is one of the limitations that we could put under there. Is information sharing also one of the things that could fall under limitations for the community itself?

P Yeah, I think often the community doesn't understand they we're not really so sensitive as to how the community perceive what we want them to do. And that can also be a stumbling block, if we don't make things clear, or if we don't involve the structures in the community – the health committees, the churches, the old age groups, homes that we have. So if we don't make sure that information go into the community, it can also be a stumbling block. The knowledge of staff, staff often don't have the skill or might be resistant, because nobody's told them I was off for the day I couldn't make it to that training. And sometimes that can be overlooked. If we don't make the time to ensure that everybody's trained, because if you want to have a good outcome, it's important that everybody's on board.

I Okay, so thank you for that. So, the limitations which we could divide between community and staff, so the community again, is just the initial understanding and that they maybe need more information and a collaborative approach from all the stakeholders in the community like the health committee, the old age home, churches, all different denominations, like even the Muslim community. And then in terms of the staff, just to identify isn't maybe resistance due to skill or knowledge or is it due to fear and if everyone is trained, then it usually leads to a good outcome and then people will be more on board to implement the policy. So now we've come to our last question of this interview. I would like to know, are there any recommendations to share recording your advice for best practices for policy implementation for the future?

P I think the best thing to do is to make sure that the policy reached implementation on time. So, if the policy is supposed to be implemented, first of April, we at least need to know by February, the policy needs to be implemented. Best practice also is to make sure that you share that with your staff as quickly as possible. And once you've shared it with your staff, is to make sure that you have a system in place to follow up and support that staff member. So, you need to make sure that you at least have an audit system in place to go check, and a monitoring system to make sure that you'll get a good outcome. The support to the staff I think is most important for the implementation. We can also make sure that the implementation or the new policies are incorporated in curriculum in training courses that staff have. So, by the time they come to the facility, they also know that the policy was changed or the medication was changed with a new way to treat a patient. There is a new way to treat a patient. On provincial level, it will be quite good if people on the ground, if they if they come to the ground level to find out, what do you think and how do you think should we implement new policies, and that people on the ground level, nurses especially on the ground level, have input when policies are changed or new ways of working needs to be implemented?

I Okay, so thank you for that. Apology, I was just making my field note. So, the advice for best practices for future policy implementation, it would be for the policy to reach the implementers on time to share it with your staff to have a follow up system like an audit and a monitoring system to identify like problem areas, and then just work on that. And then in terms of training, and the curriculum, is to incorporate HIV policies early already so that when staff are coming back to the facilities, they can know that the continual changes in the guidelines or the policies. And then on provincial level for the policymakers or drafters to come down to the ground level and more nurses to give their input before the policy actually gets released. So, before I conclude the interview, I would just like to know, is there anything else that you would like to mention before we conclude the interview?

P I would just like to thank you for choosing me to give a little bit of input or insight into what we are doing at this level. Thank you so much.

I Thank you. And I would like to take the opportunity to say thank you for taking out your time to contribute to this and I'm very excited to see the recommendations that come out there so that we can have more effective policy implementation in the Northern Tygerberg subdistrict. Thank you.

P Thank you.

---End of recording---