



**THE IMPLEMENTATION OF HIV/AIDS POLICIES IN LOCAL MUNICIPALITIES:  
A CASE STUDY OF MERAUFONG CITY LOCAL MUNICIPALITY**

A Research Report submitted in partial fulfilment of the Degree of  
Master of Commerce (Development Theory and Policy)  
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## ABSTRACT

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The 2017-2022 National Strategic Plan is South Africa's fourth generation Plan for HIV, TB and STIs since the polarised politicisation over suitable responses to the management of the epidemic. Over the years, AIDS policy planning has become relatively transparent and equally consultative among state and non-state actors. Despite this, policy analysis on this subject has predominantly been appraised at a national level with limited knowledge of how the Plan is operationalised at a subnational level, where implementation has proven to be the Achilles heel of policy. In this study, observational analyses together with interviews from a sample of eleven practitioners were conducted to consider how the National Strategic Plan cascades and translates into subnational plans, with a particular focus on Merafong City Local Municipality. The method of triangulation validated the congruence of document analysis with primary sources of data collected to ensure credibility and reliability. The findings indicate that the HIV/AIDS policy approach is top-down with NSP goals structuring implementation at the subnational level. However, challenges to implementation are attributed to weak AIDS council structures, a missing HIV/AIDS Coordinator, lack of political support for the HIV/AIDS programme, diminishing social behaviour change interventions which are attributed to a spike in risky sexual behaviour and the absence of an HIV/AIDS legislative framework to govern the country level response. Based on these results, the paper argues that the HIV/AIDS policy environment in Merafong hampers the development of a local plan and is not supportive of implementation that is responsive to the epidemic in the locality.

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## DECLARATION

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I declare that this is my own unaided work submitted in partial fulfilment of the Degree of Master of Commerce (Development Theory and Policy) in the School of Economic and Business Sciences, University of the Witwatersrand. I have acknowledged and referenced all sources that I have used and quoted. I further admit that this report has not been submitted for degree or examination purposes to any other institution.



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Khumo Modiba

Johannesburg, 20 February 2020

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## ACRONYMS AND ABBREVIATIONS

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|       |                                           |
|-------|-------------------------------------------|
| ART   | Antiretroviral Therapy                    |
| AIDS  | Acquired Immune Deficiency Syndrome       |
| DAC   | District AIDS Council                     |
| DBE   | Department of Basic Education             |
| DIP   | District Implementation Plan              |
| DoH   | Department of Health                      |
| DSD   | Department of Social Development          |
| GSIP  | Gauteng Strategic Implementation Plan     |
| GST   | General Systems Theory                    |
| HIV   | Human Immunodeficiency Virus              |
| IDP   | Integrated Development Plan               |
| LAC   | Local AIDS Council                        |
| MDIP  | Multi-sector District Implementation Plan |
| NSP   | National Strategic Plan                   |
| PCA   | Provincial Council on AIDS                |
| PIP   | Provincial Implementation Plan            |
| PLHIV | People Living With HIV                    |
| SANAC | South African National AIDS Council       |
| SBCC  | Social Behaviour Change Communication     |

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## 1 INTRODUCTION

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### 1.1 Background

The study focuses on the implementation of the national HIV/AIDS guiding framework in local municipalities, the sphere of government closest to the communities affected by the epidemic. Municipalities marshal public policies at a local level, therefore, focusing on how AIDS policy is operationalised at the subnational level may shed light on how the epidemic is managed and identify drivers and obstacles to effective implementation. The exercise contributes to understanding subnational policy-making and local choices.

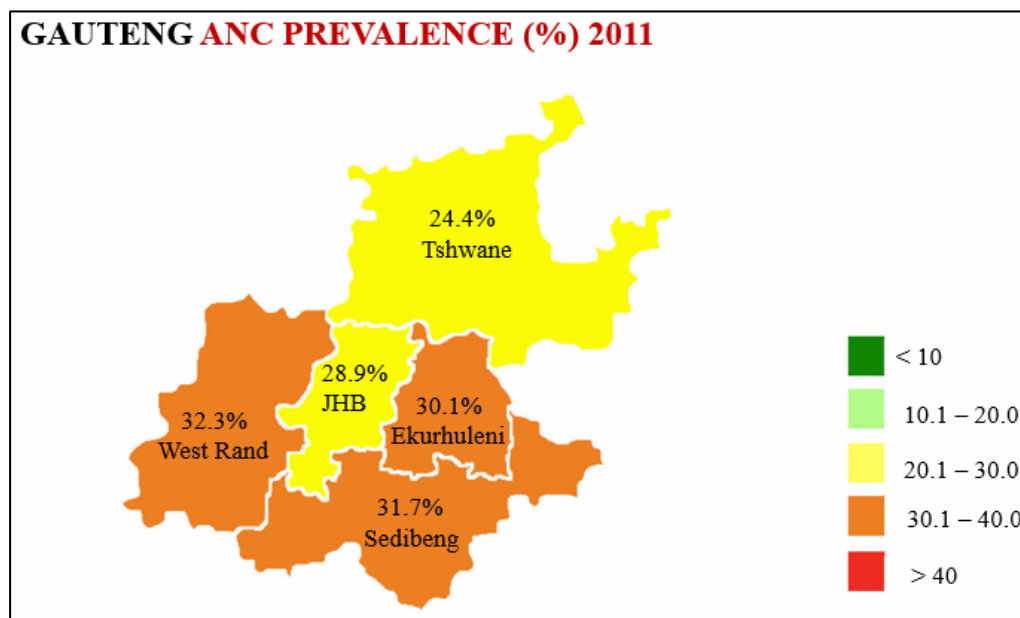
Despite HIV/AIDS being primarily a health issue, its documented impact on development and other socioeconomic indicators is undeniable. This was evidenced by the declining life expectancy at birth between 1999 and 2006 as recorded in the Statistics South Africa mid-year population reports (StatsSA, 2019). Moreover, early studies by Marais (2007) and Nattrass (2002) have attributed HIV as a cause and consequence of poverty, inequality and a declining standard of living as measured by the gross domestic product per head. According to Whiteside (2002) and Nkomo (2010) the virus has eroded some of the efforts made by African states towards sustainable development. Its initial impact threatened to derail the governments' goals of alleviating poverty and hunger, achieving universal primary education, promoting gender equality, reducing child and maternal mortality, and ensuring environmental sustainability" (Boutayeb, 2009:3).

The deteriorating conditions were also noticeable in South Africa particularly at the individual and household levels as measured by the Human Development Index (Boutayeb, 2009). To respond to the global epidemic crisis, the World Health Organisation set up a Commission on Macroeconomics and Health in 2001 to highlight the relationship between health and development and to promote investment in the sector to achieve economic growth (Sachs, 2001). The increase in South African domestic spending on health and HIV/AIDS research together with funding from international donor organisations since the early 2000s has steadily turned the tide against the virus by expanding health programmes to prevent mother to child transmission and improving access to antiretroviral treatment. Hickey (2004) and Hickey and Ndlovu (2005) show that the (South African) budget allocated for HIV/AIDS

increased from R213 million in 2000/1 to R1.439 billion in 2004/5. The initiatives have seen life expectancy at birth for males improve gradually from 53.5 years in 2009 to 61.5 years in 2019 and 57.2 years (2009) to 67.7 years (2019) for females (StatsSA, 2019).

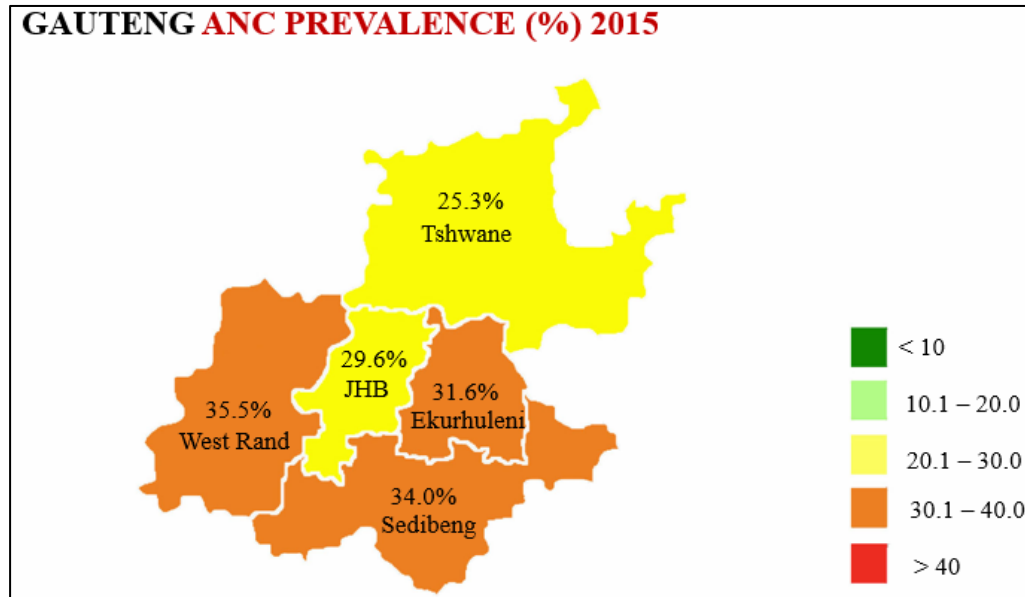
The relationship between health care, life expectancy and human capability development is also well documented, with it being impossible for a country to develop without a healthy workforce (Fukuda-Parr, 2003; Marais, 2007). Health therefore is a significant determinant of well-being and is central to the concept of human capabilities which is an alternative approach to welfare economics (Mavrotas et al., 2007; Todaro et al., 2009). As such, it is crucial for national health policy to translate into benefits for communities at a subnational level.

Merafong City Local Municipality, the site of this research, is located within the jurisdiction of the West Rand District Municipality in the west of Johannesburg, Gauteng. Between 2011 and 2015, the National Antenatal Sentinel HIV Prevalence Survey (2015) reported a 9.9% increase in HIV prevalence in the district. It was the highest increase of the five district municipalities in Gauteng province as visible in Figures 1 and 2, which show the prevalence rate increasing from 32.3% in 2011 (Figure 1) to 35.5% in 2016 (Figure 2).



**Figure 1:** District HIV point prevalence estimates, Gauteng - 2011

**Source:** Directorate: Epidemiology and Surveillance, (NDOH); GIS: National Health Information Systems, (NDOH)



**Figure 2:** District HIV point prevalence estimates, Gauteng – 2015

**Source:** Directorate: Epidemiology and Surveillance, (NDOH); GIS: National Health Information Systems, (NDOH)

The increasing prevalence in the West Rand does not signal a worsening epidemic but is attributed to ongoing HIV infection and a decline in the mortality rate of persons living with HIV (PLHIV) due to a wider coverage of ART and treatment adherence (Hopkins et al., 2018; Zaidi et al., 2013). Moreover, and of significance, is that the growing prevalence points to the success of the country's HIV/AIDS programmes. The ART programme, in particular, was fundamental to a comprehensive AIDS Plan and in achieving healthy lives and wellbeing (through treatment adherence and viral load suppression) which is key for sustainable development and underlies Goal 3 (Good health and well-being) of the United Nations Sustainable Development Goals (United Nations, 2015).

In South Africa, the guiding framework for HIV/AIDS is known as the National Strategic Plan (NSP). It is produced 5-yearly by the South African National AIDS Council (SANAC), which is a multi-stakeholder advisory body to the government on how to combat and manage HIV/AIDS, TB and STIs (Mahlangu et al., 2017; Hopkins et al., 2018). Its initiation, formulation and resourcing primarily occur at the national level, and thereafter, it is cascaded to subnational structures where it is translated into context-specific plans. The structures of SANAC are replicated at a subnational level to intensify the battle against the virus by providing leadership, building consensus around AIDS policy and strategic matters,

promoting a multi-sectoral collaboration and overseeing the overall implementation and review of the AIDS policy (SANAC, 2016)..

Between 1999 and 2005, the implementation of the NSP was ineffective due to the polarised politicisation of the right to treatment and the denialism of AIDS by the Mbeki administration, which led to poor responses by government to HIV/AIDS and the neglect of policy (Schneider, 2002; Fourie, 2006). The divergent views on treatment strategies between state and non-state actors undermined the responsiveness of HIV/AIDS policy to the national epidemic; this was a prime example of how policy ambiguity and conflict can undermine decision making and implementation (as cited by Matland, 1995). Subsequently, there have been developments and policy shifts, which translated into HIV/AIDS policy-making becoming networked and government and civil society sectors collaborating on HIV/AIDS initiatives.

In the current dispensation, challenges exist regarding how to intensify the AIDS response at a subnational level by eliminating barriers to policy implementation and access to local data to help us focus for impact and identify areas that are HIV underserved (Chibango, 2013).

The AIDS response at a local level is led by Executive Mayors together with representatives of civil society sectors and heads of departments, supported by AIDS council secretariats. The AIDS policy-making process, from initiation to evaluation stages is connected, continuous and involves multiple stakeholders. However, competing agendas among the implementing actors, coupled with a shortage of municipal personnel and a lack of political will to galvanise AIDS plans, hinders implementation (Parkhurst, 2004; Stewart et al., 2005; Evensen et al., 2010).

To better understand how responsibilities are divided among the implementing actors and the extent to which their functions are coordinated, this study is anchored in “general systems theory” (Von Bertalanffy, 1972). The systems approach looks at how components that make up a system are organised to ensure the system functions optimally. The theory is based on the analogy that the whole is greater than the sum of its parts. Therefore, the process of policy-making requires a concerted effort from multiple stakeholders, especially when it is operationalised in a complex environment where the structures of SANAC are replicated at all levels of government.

Section 2 of this Chapter outlines the research problem and justifications for undertaking the study at the local level, followed by the research questions. The remainder of the paper is divided into five chapters. Chapter 2 provides a detailed literature review of the South African HIV/AIDS policy and areas of further study in the contemporary context, followed by a description of the conceptual framework (general systems theory), and the hypotheses. Chapter 3 describes the research methodology, the research design and techniques used for data collection. Chapter 4 presents the findings by comparing policy on paper versus what happens in practice. It includes a discussion of the findings by drawing on the literature review and conceptual framework. Chapter 5 presents the summary and conclusion of the thesis by highlighting the main findings, their implications on HIV/AIDS policy, the limitations of the study, and areas suggested for further research.

## **1.2 Research Problem and Questions**

### **1.2.1 Research Rationale**

More research is needed on how to enhance approaches to HIV/AIDS multi-sectoral planning and implementation processes (Kintu, 2010). In this context, the study uses a top-down approach to understand how HIV/AIDS policy cascades from national to subnational structures, where it is translated into action plans and programmes. Not enough is known about how these plans divide responsibilities and the relations between various actors at a municipal level. Exploring the local level implementation of the NSP helps interrogate the extent of successful transmission of HIV policies at a local level. It gives a practical example of how development theories underlying policy objectives are applied in practice, particularly in HIV-burdened localities. Merafong is a case in point because it is the municipality with the highest HIV burden in the West Rand as evidenced in the review of the District's Integrated Development Plan (2016).

Inquiry into this case is essential because HIV/AIDS is a systemic problem that warrants prioritisation on the public policy agenda. It poses developmental and governance challenges in high-risk wards and has the potential to exacerbate the precarious conditions under which the infected poor find themselves (Marais, 2005; Nattrass, 2002). Health is crucial for development and substantial economic literature on human capital shows that poor health conditions are detrimental to productivity, wage earnings and to the livelihoods of the HIV-infected working-age population and their households (Bachmann et al., 2003; Marais, 2007).

The HIV burden in Merafong raises questions over the interplay between policy content, implementation processes and the role of various plan implementation actors.

### **1.2.3 Goals and Objectives**

The overarching goal of the research is to understand the process of NSP translation and implementation at a local level so that insight can be gained on whether policy content can achieve the stated objectives when it is operationalised. Such efforts are aimed at generating research-based insights necessary to evaluate and improve current AIDS policy planning and implementation in local municipalities. The objectives of the study are:

- To explore the nature of AIDS policy transmission and translation at a subnational level
- To explore the role of the municipality during the AIDS policy-making process
- To identify gaps or competing agendas among the implementing actors that hinder effective planning and implementation of the AIDS plan.
- To explore ways in which the policy-making process can be capacitated.
- To determine the implications of the epidemic on public policy and national development outcomes and frameworks.

### **1.2.4 Main Question**

Does Merafong City Municipality facilitate the translation and implementation of the National Strategic Plan in a manner responsive to the locality's HIV/AIDS epidemic?

#### **1.2.4.1 Sub Questions**

- Is there consensus among the various actors regarding policy approaches and methods suitable for keeping the epidemic under control?
- How do AIDS plans at a subnational level divide responsibilities and reinforce relations between various actors?
- How does this relate, frame or translate into local policy implementation?
- Can any general conclusions be drawn or are there general lessons to be learned?

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## 2 LITERATURE REVIEW

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The research is informed by the literature on HIV/AIDS policy-making in South Africa, which suggests that policy analysis on this subject has predominantly been appraised at a national level where the NSP is initiated and resourced. This existing literature analyses the various stages in the process of AIDS policy-making; these include problem identification, agenda setting, policy formulation, policy adoption, policy implementation, and policy evaluation. The literature also identifies blockages to policy implementation, which include, but are not limited to, inconsistencies and ambiguities in policy content, autocratic political leadership, a fragmented multi-sector response, centralised decision-making processes and a conservative macroeconomic environment.

The process of AIDS policy-making is contingent upon strong links between government, business and civil society sectors and how their mandates relate to the national plan. If how the process of AIDS policy-making unfolds at the local level can be understood, then we can gain insight into how regional data on HIV/AIDS informs local plans and evidence-based interventions as well as the overall management of the epidemic. The following section provides an in-depth analysis of the various stages in the HIV/AIDS policy-making process.

### 2.1 Problem Identification

This stage in the policy process involves identifying and evaluating a problem to determine whether the capacity to address it exists before it is prioritised on the public policy agenda.

Fourie (2006) found that the problem identification stage hindered implementation. The polarising debates over the correlation between HIV and AIDS during the late 1990s proved to be problematic for the establishment of a unified response to the epidemic. Furthermore, this was compounded by the politicisation of the right to treatment and debates about drug affordability. According to Fourie (2006), the conceptualisation of the AIDS problem in South Africa rendered the other stages of the policy-making process ineffective and weakened the government's response to the epidemic.

The socio-economic and behavioural problems that exacerbate the spread of the epidemic have crystallised over the years, and as a result, it is much easier to decipher where along the

age, gender, sexuality, social, and economic spectrum the disease is most prevalent. Such advances have increased the responsiveness of policy interventions to problems identified at the ground level. Moving from the premise that policy problems are identified at the ground level, proponents of bottom-up and mixed-method approaches to policy-making assert that the conceptualisation of a policy problem in public documents should be informed by the aggregation of contextual issues at an operational level (Sabatier, 1986; Matland, 1995). Therefore, problems that are articulated with certainty find expression in the plans. According to Sabatier and Mazmanian (1980:544), problems identified at a local level are manageable if, “there is minimal variation in the behavioural practices which cause the problem; the target group constitutes an easily identifiable minority of the population within a political jurisdiction, and the amount of behavioural change is modest”. This has been true in the current dispensation of HIV/AIDS in South Africa; the most common method of HIV transmission is through sexual intercourse, with young women and girls most vulnerable to infection. The existing interventions are aimed at containing and minimising behaviour change in the target group and assist people to remain engaged in HIV services and to adhere to prescribed prevention and treatment regimens (NSP, 2017). The multisector response has laid a solid foundation for the governance of HIV/AIDS in South Africa, however, more still needs to be done at the district, local and facility level to support HIV burdened regions.

## **2.2 Agenda Setting**

This stage entails defining the “problem” in layman's terms and motivating why it warrants prioritisation in the national framework. This is done to attract buy-in from different sectors of society, for example from government, labour, academic and research institutions, individuals and from the civil society sector. According to Sabatier and Mazmanian (1979), support for a policy problem or objective is sustained over time provided that it is not undermined by the emergence of other socio-economic challenges and public policies. This speaks to the importance of having national frameworks or policies that are aligned and supportive of each other without compromising the overarching development project. This is highlighted by Schneider (2002) and Wouters et al. (2009) who found that the 1996 macroeconomic policies of Growth Employment and Redistribution (GEAR) and their emphasis on budget cuts placed enormous pressure on the public sector and limited the implementation scope of AIDS plans, thereby contributing to debates over drug pricing and affordability.

The literature on how non-state actors influenced policy is vast, Ndinda (2011), Nunn et al. (2012), and Parkhurst (2004) show the impact of the civil society sector in mobilising society at large and lobbying the government to prioritise HIV/AIDS on the public-policy agenda. The case of the rising mortality rate among the working-age population from the late 1990s to mid-2000s was used to justify why HIV/AIDS should be declared a national crisis. Despite AIDS denialism at the highest echelons of government, which led to an inadequate response or inaction by the government to the epidemic, civil society organisations influenced AIDS policy through public mobilisation and litigation by advocating for the rights of people living with HIV, in particular drug overpricing and the provision of treatment in public health institutions.

Sabatier and Mazmanian's (1980) study propose conditions that should be adhered to if a policy is to be effectively implemented and one of them includes unwavering support from constituent advocacy groups to hold policy implementers accountable for the mandated objectives and the support of impartial and unbiased courts. However, it must be reiterated that policy problems that tend to linger for a prolonged period tend to lose support over time. Therefore, the ongoing work by civil society, in collaboration with government, as well as renewed commitment from political actors at all levels of government is vital in the agenda-setting stage.

### **2.3 Policy Formulation**

This stage involves using problem-specific data to design an appropriate response. Proposed strategies for solving the problem by various advocacy groups are incorporated into the policy based on their implementation feasibility.

Fourie (2006), Schneider (2002), and Wouters et al. (2009) conducted research on the formulation of AIDS policy in South Africa and the challenges encountered between state and non-state actors during the drafting phase of AIDS policy. Their research looked at the agenda-setting processes and typical government approaches to plan formulation. This generally occurred at a national level where policy is initiated and resourced. First, we look at studies on policy formulation at a subnational level before giving a chronological account of AIDS policy initiation at a national level.

Studies by Chibango (2013), Evensen et al. (2010) and Stewart et al. (2005), show that policies are designed at a subnational level to inform decision-making, support, and effect the goals in the AIDS Plan. The studies were conducted in response to the release of the 2003

Operational Plan, as a supplementary document to the 2000-2005 AIDS Plan, detailing treatment strategies for HIV/AIDS. They looked at the feasibility of scaling-up ART services and the governance of HIV/AIDS programmes in localities. Despite improving the number of people on ART, the operational plan fell short to achieve its targets which were deemed unrealistic because of the existing gaps in the health system and the limited capacity to render services to the scores of people who were HIV diagnosed. Nonetheless, by 2005 progress was made towards the administration of ART in 122 sites nationally earmarked by National Department of Health (DoH). However, operational inefficiencies such as limited human resources, drug stockouts at service stations, non-cooperation of service providers and a weak public-private partnership were some of the realities confronting policymakers about programme implementation at a local level (Stewart et al., 2005; Evensen et al., 2010). The challenges identified are a reminder of the importance of context analysis during the formulation of responsive plans and helps us to design contingency frameworks to improve plan efficiency. For Chibango (2013), the proposed amendments of policies and legislation to expand access to treatment and the better management of HIV/AIDS is an indication of the prospects South Africa has at fighting the epidemic.

In 1994, the formulation of the National AIDS Plan (NAP) was applauded for being inclusive and for consulting with various civil society stakeholders and key implementing ministries (Health, Welfare, Education and Defence) (Nattrass, 2004; Mahlangu et al., 2017). However, the Plan was also deemed too idealistic to achieve its targets given the social and political transition of that time and the expectations of the new government of national unity to advance the mandate of public sector restructuring (Wouters et al., 2009). Moreover, the policy environment witnessed a shift in economic guiding frameworks from a pluralist Reconstruction and Development Programme (RDP) to a neoliberal Growth, Employment and Redistribution (GEAR). The latter did not reflect the ideals of the NAP in that it imposed a tight fiscal environment and hampered plans to restructure the health system and improve its capacity. The failure of NAP was reflected in the antenatal survey series which showed that, between 1994 and 1999, the HIV prevalence rate increased by 8.3 percentage points when extrapolated nationally, which was contrary to the goal of preventing the spread of the epidemic (Fourie, 2006; Wouters et al., 2009).

Nattrass (2005) and Schneider (2002) show that policy content between 1999 and 2004 was ideal and comprehensive, but it primarily focused on prevention and education methods,

which included the ABCs of HIV (Abstain, Be faithful, and Condomise) and little attention was paid to treatment interventions. The implementation of the Strategic Plan was tainted by AIDS denialism, a constrained budget for plan execution and government's undermining of the scientific evidence on HIV and antiretroviral drugs (ARVs). Despite the denialism by national government, some subnational structures, particularly Gauteng and Western Cape provincial governments, went against the grain and initiated the provision of ART and PMTCT. The scenario reflected a disjuncture between national and provincial policy content, which is customarily structured and influenced by national directives.

The political actors at a national level legitimised themselves as the principal implementers of AIDS policy since they considered themselves the custodians of the plans. They used power and "capitals" to silence opposing views from civil society organisations and the medical or scientific fraternity. Schneider (2002:153) defines "capitals" as "resources which yield power and include economic (material resources), cultural (educational credentials) and social capital (durable networks of relationships of mutual acquaintance and recognition)". When the Presidency established SANAC in the year 2000, civil society organisations and key medical researchers were excluded from the multi-sector response. The result was a national AIDS policy document devoid of biomedical interventions to treatment that the non-state actors were lobbying for. It was therefore inevitable that non-consultative AIDS policy planning would render the structures of SANAC redundant and the policy ineffective. During this period 1999-2004, HIV prevalence increased from 11.9% to 15.2% (StatsSA, 2004).

According to Sabatier and Mazmanian (1979 and 1980), successful implementation is contingent upon the formulation of clear and definite statutes and policy directives that structure implementation at lower levels. Contrary to this argument, Matland (1995) suggests that policy objectives should be vague and ambiguous to allow for subnational interpretation that accounts for contextual variations; because of this, central policy actors can only influence the institutional setting of local implementation indirectly. The argument by Sabatier and Mazmanian implies that uniform policy format increases commitment to plan goals and reduces ambiguity and indecisiveness at the subnational level. According to Barrett (2004), her review of first- and second-generation implementation studies show that much of public policy provides discretion to subnational structures to formulate innovative and contextual action plans that advance policy goals and objectives from the top. Barrett asserts that it is only in exceptional cases like "regulatory policy, for example, health and safety" that

performance is judged in terms of compliance to policy targets (2004:255). Nevertheless, clear policy objectives are ideal in circumstances where there is limited capacity for policy execution.

During the period of animosity between political and civil society actors, the latter exerted pressure to have ARVs and PMTCT provided in the public sector through the process of litigation. The efforts culminated into the 2003 Comprehensive Plan announced by Cabinet, which was supplementary to the 2000-2005 Strategic plan (devoid of treatment options) and sought to initiate the provision of HIV drugs nationally (Wouters et al., 2009). The provision of ARVs and PMTCT was a step in the right direction to concretise the goal of prolonging life and preventing mother to child transmission despite the initial slow rollout.

The HIV policy formulation process leading up to the formation of the 2007-2011 plan suggests that even after the tragic mistakes of the past, a sound policy environment based on collaboration between government and civil society could be forged to enable the creation of a dynamic and comprehensive plan founded on the goals of prevention, treatment, care and support, research, monitoring and surveillance (Achmat and Simcock, 2007; SANAC, 2007). All the goals were underpinned by a human rights-based approach and a multisector implementation framework. Around this period, the trend in HIV prevalence among women visiting antenatal clinics was nearing stabilisation and by 2011 the number of PLHIV on ART had increased to 1.79 million (Johnson, 2012).

## **2.4 Policy Adoption**

This stage relates to the legitimisation of the plan by relevant stakeholders as official policy to address the identified problem.

Research done on policy adoption in the HIV/AIDS field by Fourie (2006) and Schneider (2002) found that a policy is likely to be approved and adopted by the government if it aligns with the interests of the political elites. In some instances, the interests were based on forecasting and cost-benefit analysis. The government would then promote the policy and seek buy-in from various stakeholders. However, this was not always the case as was demonstrated by the non-inclusive and non-consultative AIDS policy planning process in 1999. The government exercised its agency to a significant degree by formalising policy without having established a consensus with other stakeholders linked to AIDS policy-making. It can, therefore be deduced that the process of AIDS policy formulation and the decision-making around this period was highly centralised and non-consultative. This meant

that the plan was adopted without any participatory reviews. The history of AIDS policy planning in South Africa helps us to understand the significance of a transparent and participatory policy consultation in forging a uniform outlook and promoting policy ownership both at a national and local level.

## **2.5 Policy Implementation**

This stage involves actioning the plan, it represents the interface between policy strategies and the identified problem.

Policy implementation processes are primarily the concern of policy actors at a subnational level. This is the transitional phase of policy which involves the movement from paper to practice and it is reliant on service delivery and how plans are interpreted and translated to programs aimed at modifying the behaviour of target groups. According to Fourie (2006:14), this stage is “distinctly political in nature dealing directly with the questions of who implements policy, where, when and how?”.

Some implementation studies (Barrett, 2004; Matland, 1995; Sabatier, 1986) argue that street-level bureaucrats are likely to subvert policy directed from the centre during the implementation stage; hence the top-down approach proposes that the number of veto points at local level must be minimised and that only officials and agencies supportive of policy objectives be included. On the contrary, cases within the HIV/AIDS policy environment have shown that actions of implementing officials at the centre were detrimental to policy success and that active buy-in from local level actors is essential for effective implementation. The following sections outline challenges encountered during the implementation stage.

### **2.5.1 Policy Implementation Challenges**

Research indicates that interruptions in the AIDS policy-making process exist and were classified as blockages to implementation and are documented in Chibango (2013), Evensen et al. (2010), Johnson (2004), Parkhurst (2004), Stewart et al. (2005), and Wouters et al. (2009). The studies show that blockages to implementation are attributed to four interlinked elements: content, actors, process, and context. Each element is explored below.

#### **2.5.1.1 Content**

The content of HIV/AIDS policy between 1994 and 1999 was lauded for being comprehensive at addressing HIV/AIDS. The drafting of the NAP was a concerted and collaborative effort which included the government, civil society, academia, business and

trade unions amongst other stakeholders. There was an understanding of HIV as a developmental issue and therefore it was not only defined as a health challenge. The broadbased and human-rights approach to thinking about HIV was reflected by the goals of the plan, which included prevention programmes and awareness campaigns, treatment options and mobilising subnational structures in the fight against the epidemic. However, in implementation, the virus was still largely conceptualised as a health problem and as a result the HIV/AIDS programme was addressed as a biomedical issue in the National Department of Health (Mahlangu et al., 2017). Moreover, the goals were not modelled on the absorptive capacity of a health system of a country facing a rising epidemic and undergoing a political transition and as a result were considered farfetched and idealistic.

The content of the Strategic Plan of 2000-2005 did not holistically reflect the biomedical, behavioural and socio-structural dynamics of HIV/AIDS in the country. The irony in this is that the concept of strategic planning is influenced by systems thinking to emphasise planning and policy development as a holistic process of response to changes in the environment characterized by on-going monitoring and review of policy performance (Barrett, 2004:251). The planning process was politicised and polarised over strategies effective in addressing the epidemic and this prompted political actors to use powers and privileges (as custodians of AIDS policy) at their disposal to exclude civil society organisations (proponents of treatment strategies) from the planning process. The outcome was a plan devoid of treatment strategies and one that was non-responsive in implementation. This coincided with the country witnessing a rapid increase in the rate of infection.

After a process of litigation by civil society, a ruling was made to have ARVs rolled out nationally. According to Stewart et al. (2005), a Comprehensive Plan was developed in 2003 to build on and complement the 2000-2005 Strategic Plan which did not include the provision of ART (Antiretroviral Therapy) as a treatment option. It was the first comprehensive plan with a multi-sector response to the management of the epidemic and it was definitive in shaping implementation (Wouters et al., 2009).

The Comprehensive Plan laid the foundation for coordination and collaboration in planning and this characterised the development of the 2007-2011 plan which was multisectoral and saw government and civil society come together to forge new partnerships. The policy content was deemed dynamic and comprehensive and was informed by lessons learnt from past policies despite there being a limited budget to fully implement it. HIV was now

conceptualised as a developmental issue with a heavy emphasis on the provision of ARV drugs (McNeil, 2012). The plan goals included: (1) Prevention; (2) Treatment, care and support; (3) Human and legal rights; and (4) Monitoring, research and surveillance. SANAC lead and supervised the implementation of the AIDS programme in its capacity as a multisectoral body.

A review of HIV/AIDS policies shows that the development of the plans is incremental with slight augmentations to the previous national goals. This is evidenced by the 2012-2016 Plan whose content is largely influenced by previous Plan goals. Sabatier and Mazmanian (1979) stated that policy orientation stays relatively the same over time and it changes incrementally as a result of alternative strategies proposed by various advocacy groups within the structures of the policy system. Reflections on the implementation of the plan reveals that the goals were unrealistic and as a result unattainable. For example, only 27.5% (from 367 946 to 266 618) of new HIV infections between 2012 and 2016 were reduced as opposed to the 50% envisaged in the plan. Moreover, goal 2 stressed that at the minimum 80% of eligible patients (CD4 count less than or equal to 350 from the year 2010) should be initiated on ART (SANAC, 2016). On 1 September 2016 the eligibility guidelines were revised by national DoH with the introduction of Universal Test and Treat (UTT) policy which enrolls persons testing HIV positive on ART regardless of CD4 count (Beery et al., 2018). Months before the implementation of UTT South Africa recorded 3.7 million people, out of the 7 million estimated to be living with HIV, to be on ART programme both in the public and private sector which highlights a major delay between diagnosis and treatment initiation.

In a critical appraisal of the 2017 – 2022 NSP, Hopkins et al. (2018) identifies inconsistencies in the content whose discussion is framed around WHO's health systems building blocks which include service delivery and supply chain management, health workforce, health information systems and financing and governance. First, a barrier to reaching the test and treat targets in light of the introduction of UTT policy is drug stock-outs at service stations. The authors citing from the Stock Outs National Survey (June 2016) reveal that "one in five facilities reported a stock-out of adult antiretrovirals (ARVs) (472/1875), and 70% of facilities reported the stock-out lasting longer than one month (529/760)" (Hopkins et al., 2018:4). This problem is associated with inefficient procurement and supply chain management issues which are frequent in Mpumalanga, Gauteng and Free State provinces and is likely to delay treatment initiation and adherence (Hopkins et al., 2018).

Second, Hopkins et al. (2018) recognises the commitment made in the NSP to ensure a diverse human resource is available, trained and located where it is needed the most to carry out the objectives of the plan. This is one of the critical enablers of the NSP (2017), however, the authors (Hopkins et al., 2018) allude to the plan failing to address some of the challenges linked to the current shortage of health workers. The doctor-patient ratio is low and places immense pressure on the health system to deliver services with better efficiency.

Third, the NSP is subject to mid-term and end-term evaluations during its 5-yearly implementation period to measure progress made towards the achievement of the goals and objectives of the plan. A health information system is therefore crucial for an improved clinical service delivery where patient data is timely collected and analysed to identify existing service utilisation gaps. A major criticism of the monitoring and evaluation framework of the 2017 – 2022 NSP is that it is missing core indicators to track linkage to prevention, care and treatment as well as retaining patients to care after treatment initiation (Hopkins et al., 2018). According to the authors' observation, the monitoring and evaluation indicators do not define "loss to follow up" or give guidance on how to track patients on care. This problem is prevalent among migrant and sex workers who are geographically mobile and as a result may encounter structural barriers to accessing care (Taylor et al., 2014). A migration from a paper-based to an electronic data capturing system (e.g. the Primary Health Care Information System) as seen implemented in select health facilities across the Western Cape may strengthen surveillance to support monitoring and evaluation (Hopkins et al., 2018).

The last issue is concerned with the financing and under-costing of the implementation of the plan goals which will be discussed in the "context" section below.

#### **2.5.1.2 Actors**

Actors are intrinsic to every stage in the AIDS policy-making process, they shape and influence Plan content through a series of decisions taken to achieve a particular result. An account of the role of actors in the HIV/AIDS policy environment reveal that they either assumed the role of enabler and acted to advance the goals in the Plans or as inhibitor and subverted the goals. The role played by actors in the policy-making process has thus received considerable attention in the literature and will be discussed below.

HIV/AIDS was a unifier among policy actors under the government of national unity and this was evidenced by the broad consultation that went into the planning and drafting of the

National AIDS Plan (Wouters et al., 2009; McNeil, 2012). There was political commitment to not only combat the scourge of the virus but to transform and build the health system's capacity to service the growing demand caused by the burgeoning epidemic. Despite the national development framework (RDP) during this period supporting the transformation ideals of the AIDS Plan, the epidemic was conceived by the actors as only a health issue in implementation and therefore jeopardising the multisector approach (Wouter et al., 2009). Around this time, Fourie (2006) explains that the Sarafina debacle was another implementation blunder exacerbated by health officials who followed irregular tendering processes by awarding funds totalling a significant portion of the national AIDS budget for a stage production intended to raise HIV/AIDS awareness among the youth. The production was criticised by the civil society sector, who were not consulted on the decision, for lacking the requisite content to reach the targeted audience (Fourie, 2006).

The Sarafina incident was later followed by a series of controversies about the interpretation of the AIDS Plan by political actors at the national level. In 1997 government actors overrode the Medicines Control Council's (MCC) ruling on the locally produced anti-AIDS drug (Virodene) failure to pass clinical trials that deemed it safe for consumption (McNiel, 2012; Simelela et al., 2014). Opposition to the government's decision to hasten the approval of the drug was met with harsh criticism from political actors who disbanded and reconstituted the Medicines Council thereby appearing to be tempering with the scientific findings by the MCC (Fourie, 2006). At this stage we see government dominate the HIV/AIDS policy space and abandon the principles of a multisector framework in implementation. Decision-making around Plan implementation was polarising and set a contentious tone between government and civil society over the provision of ART which continued into the next phase (2000 – 2005) of policy making.

The initial stages of the 2000 – 2005 policy making phase were characterised by AIDS denialism among government officials and controversial debates over the provision of ART and PMTCT which was criticised by the African National Congress (ANC) alliance partners, South African Communist Party (SACP) and Congress of South African Trade Union (COSATU) (Fourie, 2006). Policy interpretation and implementation was inconsistent both at the national and subnational level and this was evidenced by the issuance of treatment drugs in select provinces (Gauteng and Western Cape) without the approval of national health structures (Stewart et al., 2005). Such an act of defiance was the first instance of bottom-up

approaches to decision-making followed by a process of task shifting which delegated the issuance of ARV drugs to less specialised health workers to overcome the challenge of staff shortage (Evensen et al., 2010). At the national level, Treatment Action Campaign emerged as a formidable civil society actor to lobby for universal access to ART through a process of litigation (McNeil, 2012). The civil society group put forth compelling scientific evidence for the provision of ART which culminated into an Operational Plan produced in 2003 as a guiding framework for treatment implementation across sites identified by the National Department of Health (Fourie, 2006; Wouters, 2009; McNeil, 2012) .

Treatment roll-out and coverage was initially slower and lower than the targets set out in the Operational Plan, with an estimation of fifty thousand (50 000) patients on the public sector ART programme in April 2005 (Stewart et al., 2005). Government dissent on HIV persisted by 2005 with the then Health Minister Tshabalala-Msimang citing the toxicity of ARV drugs much to the astonishment of the HIV/AIDS community and proposing nutrition and palliative care as alternative modes of treatment.

In 2006, HIV/AIDS policy entered a new phase of policy planning characterised by political buy-in and collaboration among the different implementing partners. At a national level, there was a shift in government attitudes towards HIV whose response was managed and steered by the then Deputy President and Chairperson of SANAC Phumzile Mlambo-Ngcuka, who declared an intensified battle against the epidemic (McNeil, 2012). Government and civil society relations were further strengthened after the resignation of State President Thabo Mbeki from public office in 2008 and a cabinet reshuffle which saw Tshabalala-Msimang being replaced by Barbara Hogan (Simelela and Venter, 2014). The changing face of HIV/AIDS policy in South Africa paved a way for the renewal of government and civil society relations.

After the 2009 general elections Jacob Zuma was elected president of the Republic of South Africa with the 2007 – 2011 HIV/AIDS policy in its second year of implementation. A cabinet reshuffle saw Hogan being replaced with Dr Aaron Motsoaledi as the new Minister of Health (Simelela et al., 2014). The announcement was accompanied by historical scepticism from the HIV/AIDS community who rather than being despondent about the replacement adopted a “wait and see attitude towards the fairly unknown Motsoaledi” (Wouters et al., 2009:179). During this policy phase it had become clear that dissenting views and HIV denialism was a thing of the past and actors at the national level were committed to tackle the

scourge of the epidemic with a renewed perspective. By 2009 national government actors had committed to improve treatment coverage for children and women in accordance with the targets set out in the 2007 – 2011 HIV Plan (Chibango, 2013). According to McNeil (2012), “coverage of HIV-positive mothers with AZT treatment was estimated at over 95 percent by 2010, as a result mother to child transmission was reduced to 3.5 percent”. In the same year, government launched a door-to-door initiative to heighten HIV/AIDS awareness in communities and increase HIV testing and counselling services. The programme is delivered by community health workers who according to Mottiar et al. (2018) and Lodge (2018) remain partly integrated in the public health sector.

A study by Karan et al. (2017:2) exploring the potential avenues for political involvement and leadership in HIV/AIDS communication campaigns reveals that political buy-in of national actors in HIV/AIDS educational campaigns can serve to “legitimise and strengthen public backing and acceptance of local and national health movements”. A Historical account of the epidemic by Simelela et al. (2014) indicates that the release of the 2012-2016 AIDS Plan was preceded by public declarations and announcements of HIV/AIDS as a development challenge and efforts at normalising the disease to reduce discrimination and stigma. The declarations were accompanied by public participation of political actors (President Jacob Zuma in particular) in HIV testing in a bid to encourage the citizens do the same (Karan et al., 2017). The planning of the 2012 -2016 HIV/AIDS guiding framework witnessed the understanding and embrace of scientific evidence by political actors as the basis to inform policy decisions, and as a result the 2012 – 2016 NSP became the most widely consulted AIDS plan since the days of denialism (Simelela et al., 2014; Shisana et al., 2014). One of the highlights from the plan was the implementation of the UTT policy meant to increase treatment coverage and achieve viral suppression among PLHIV (Beery et al., 2018). According to Hopkins et al. (2018) we can expect a decline in the rate of HIV infection because of the increasing number of PLHIV on ART (3.9 million by December 2016).

Because policy actors are central to policy implementation, Sabatier and Mazmanian (1979:495) proposed that officials need to possess strong political and managerial abilities. They defined political skills as the ability to build sustainable networks in a system, unify opposing schools of thought among implementing actors, and champion and mobilise support behind policy objectives; while managerial skills entailed the ability to monitor implementation targets against performance outcomes to avoid fiscal mismanagement of a

programme and to maintain high moral and manage conflict in the collaborative (Sabatier and Mazmanian, 1979).

### **2.5.1.3 Context**

The outcomes of a policy-making process are not generated in a vacuum but are a product of pre-existing issues in the external environment. Context in the HIV/AIDS policy environment is understood as the conditions and circumstances under which the NSP is implemented, these include the political climate, the state of the public health system, and the economic milieu. All these variables determine the extent of successful policy implementation.

The implementation of HIV/AIDS policy under the GNU was characterised by a transition in economic ideologies from a populist RDP policy framework whose core tenets included the redistribution of resources to spaces of urban and rural poverty and economic expansion and capacity building of state institutions to serve all citizens, to a market liberal GEAR policy underpinned by austerity measures (Wouters et al., 2009; McNeil, 2012). The inclusion of HIV/AIDS in the presidential lead projects of the RDP and a commitment at restructuring and capacitating the healthcare system in 1994 reflected a macroeconomic environment supportive of a country undergoing transformation and facing a health crisis at the same time (Mahlangu et al., 2017). According to Fourie (2006:106) “RDP was held up as the broad public policy blueprint that would improve the country’s socio-political equity . . . it also served as the ideological foundation of other policy measures including the National AIDS Plan (NAP)”.

The economic policy reform (from RDP to GEAR) of 1996 ushered in a second phase of the implementation of NAP. The context was characterised by privatisation of healthcare and the monetarisation of the epidemic which raised questions about drug affordability among political actors who largely believed in preventative measures to fight HIV/AIDS (Fourie, 2006; McNeil, 2012). The neo-liberal climate put enormous pressure on government spending and fuelled debates around drug affordability which has become a defining feature of South Africa’s HIV/AIDS policy environment and influenced how the Plan is implemented (Fourie, 2006; Wouters et al., 2009). The impact of contractionary fiscal policy was evidenced by a decline in the share of government spending on health as a percentage of GDP from 3.3% in 1994 to 3.1% in 2001 (Black et al., 2012). This period coincided with the planning and implementation of the 2000 – 2005 AIDS Plan whose policy environment became polarised because of the denialism over the link between HIV and AIDS by

politicians. The studies highlight that internally, the widening schism between state and non-state actors created an environment that undermined a coordinated response to policy implementation (Fourie, 2006). However, the presence of unbiased and supportive courts was instrumental in the promulgation of a 2003 landmark ruling that led to the national provision of HIV/AIDS treatment (Fourie, 2006; Simelela, 2014). The ruling was accompanied by a substantial increase in government spending on health sector HIV/AIDS programmes from R74 million in 1999/0 to R1.8 billion in 2003/4 (Wouters et al., 2012). According to Sabitier and Mazmanian (1979), the role of the courts in the implementation process is indirect, yet they possess the discretion to either strengthen or weaken programmes through favourable and unfavourable rulings.

The changing face of HIV/AIDS policy at the national level ushered a unified context that was fundamental to the development of a comprehensive and multisector 2007 – 2011 strategic plan. During this period, economic conditions were not favourable for a rapid scale up of ARV treatment. Government spending on health from 2001 to 2009 facilitated a slow growth in GDP shares (3.1% and 3.5% respectively) which was offset by the 2008 global recession (Black et al., 2012). In order to minimise the effects of a recession on social sector spending levels, government embarked on a counter-cyclical fiscal policy because of its commitment to expand the ART programme (Blecher et al., 2017). According to McNeil (2012) “by the end of 2010 only 55% of people who needed ARV treatment were receiving it, falling significantly short of the government’s goal of 80% coverage”.

The 2007 – 2011 national strategic plan focused on destigmatising HIV/AIDS, at the same time, perceptions about the virus being a death sentence were changing because of access to ARV treatment (McNeil, 2012). In 2012 the government released the National Development Plan (NDP), a neo-liberal policy framework aimed at achieving growth and prosperity and alleviating poverty and inequality by 2030. Despite the NDP’s commitment at expanding treatment coverage, it was acknowledged that the public health system lacks capacity to meet demand and sustain quality (Simelela., 2014; Hopkins et al., 2018). The 2012 – 2016 AIDS Plan was allocated an increased budget to expand treatment coverage, however, Wouters et al. (2012:180) emphasises that “if funds mobilised for treatment access are oriented towards short-term goals like vertical implementation of ART programmes rather than towards long-term targets such as strengthening and transforming the health system, the chances of successful ART scale-up seem slim”. This explains the reason why it has been daunting

reaching treatment coverage targets and tracking prevention, care and treatment services or retention in care (Hopkins et al., 2018).

South Africa's HIV/AIDS programme is funded by various sources (domestic funds plus concessional grants as part of Official Development Assistance) through blended financing, but the majority of resources are drawn from the national fiscus whose stability is tied to the performance of the economy and its ability to weather external shocks (Hopkins et al., 2018). The implementation of the 2017 -2022 NSP was costed at R207 billion with an annual cost estimate rising from R35.1 billion in 2017/2018 to R45.7 billion in 2021/2022 due to the expanding treatment coverage (SANAC, 2017). In contrast, the 2016 health sector share of the national budget was 13% (R159.4 billion, increased to R205.4 billion in 2018) and of that share, R17.5 billion was allocated to HIV/AIDS programmes (Hopkins et al., 2018). The major funding gap indicates that the NSP is not costed according to scale given the low economic growth rates, fiscal constraints, and receding grants from development partners (Global Fund and President's Emergency Plan for AIDS Relief).

#### **2.5.1.4 Process**

Process refers to a series of decisions taken during the planning and implementation of AIDS plans. It is connected with the "how" of operationalising the plan which has been a contested field in the HIV/AIDS policy environment.

As alluded previously, the National AIDS Plan of 1994 – 1999 rightly classified HIV/AIDS as a development challenge, however, in implementation the programme was located in the Department of Health where it was addressed within the confines of public health (Wouters et al., 2009; McNeil, 2012). The approach tended to negate the socio-economic aspects of the epidemic which make people vulnerable to infection.

In 1996 the macroeconomic policy orientation changed without much consultation with the broader policy community. According to Wouters et al. (2012) decision-making around the adoption of GEAR was centralised, authoritarian, and unilateral. The parameters of the conservative free-market policy were non-negotiable despite assertions that it was premised on the goals of the RDP and sought a strategy to rebuild and restructure the economy (Mosala et al., 2017). GEAR was successful in stabilising national prices, lowering interest rates, reducing budget deficits and trade liberalisation to mention but a few (Isaacs, 2014; Mosala et al., 2017). However, it did not achieve the anticipated growth targets which meant that the benefits of economic gains did not trickle down thereby increasing poverty and inequality

and compromising the level of government spending on social services like health (Mosala et al., 2017). The conservative GEAR policy framework has since become the blueprint for subsequent macroeconomic policy planning (Accelerated and Shared Growth Initiative – South Africa; New Growth Path; National Development Plan) and has influenced the extent of HIV/AIDS policy implementation.

In a bid to circumvent excessive drug prices, the government of national unity embarked on a legislative led policy implementation process. In 1997 the National Department of Health passed the Medicines and Related Substances Control Amendment Act (Medicines Act) which allowed for the parallel-importation of ARV drugs from third countries and enabled the government to acquire a license which transfers intellectual property rights of international pharmaceutical companies to local manufacturers to produce generic HIV/AIDS drugs (Fourie, 2006; Wouters et al., 2012). However, these efforts were insufficient at fostering a united and coordinated policy response. In 1998 the government put forth numerous claims for not providing the ARV drug AZT; first, it was supposedly toxic and secondly, the cost of its administration was high (Fourie, 2006; McNeil, 2012). It was around this time that the government abandoned treatment strategies and declared a primary focus on preventative measures to fight HIV/AIDS. This decision was the beginning of a polarised and politicised HIV/AIDS policy environment that would remain an important feature of the next policy-making phase.

The hostile policy environment between 2000 and 2005 witnessed a new policy-making process characterised by litigation. In reaction to debates about AIDS denialism and unaffordable drug prices in the highest echelons of government, civil society actors initiated a bottom-up policy-making process through court litigation in a bid to have national government provide ARVs at public health facilities (McNeil, 2012; Simelela et al., 2014). The 2002 court judgement was a catalyst for transforming HIV/AIDS policy-making into a networked and coordinated process involving actors from varied sectors. The united front displayed both in policy formulation and implementation bodes well with the multisector framework proposed for 2007 – 2011 NSP. Simelela et al. (2014) notes the highly consultative process that went into the planning of the 5-yearly plan despite it being politically charged. SANAC was appointed principal overseer of the national AIDS plan and will henceforth monitor and coordinate the implementation efforts of all stakeholders (Wouters et al., 2012; Simelela et al., 2014).

To sum up the debates and issues that have shaped AIDS policy-making in South Africa, we can conclude that factors internal and external to the AIDS policy environment have a bearing on the policy outcomes realised in implementation. The application of the NSP is therefore an outcome of social, political and economic factors that have to be considered at every stage of the policy-making process because no policy is produced in a vacuum. The chronological account of AIDS policy revealed best and worst practices that have been used over the years to strengthen the AIDS response at a national level. To date, South Africa has the world's largest ART programme as a consequence of a higher HIV epidemic and health investment efforts to mitigate the impact of the virus and increase the average life expectancy. However, milestones achieved in the HIV/AIDS field should not encourage complacency but should prompt a greater and intensified response in HIV-burdened regions at a subnational level.

## **2.6 Areas for Further Research**

As a result of a breakdown between policy and practice, Fourie (2006) highlighted that research is needed at a subnational level to inform decision-making on HIV/AIDS policy and to track local-specific developments on the epidemic. Because policy is operationalised at a subnational level, understanding the local HIV/AIDS profile could yield a lasting impact on how the epidemic is managed. The voluminous literature on the South African AIDS policy spans over the 2000s and has predominantly been appraised at a national level. However, its density lessened after the establishment of a coordinated response at a national level which witnessed a scale-up of the ART programme and a stabilising national HIV prevalence over the years.

In the contemporary context, little has been documented about the process of AIDS policy-making due to the less publicly contentious environment. Therefore, this makes it difficult to infer what debates emerged over AIDS policy. However, the increased prevalence in Merafong City between 2011 and 2015 makes a good case as to why it is necessary to expand the contemporary literature and probe into how the process of AIDS policy-making unfolds and the disjuncture between this and the implementation process as well as how this may account for the rising prevalence in the locality.

In this respect, this research looks at the formulation, adoption, and implementation stages that are involved when the NSP is translated into a local plan since this is the sphere of government where the AIDS plan is articulated in terms of the epidemic profile in the

locality. Exploring this in Merafong City Municipality may reveal nuances in how the local plans are formulated and potential gaps that may hinder the responsiveness of policies to the state of HIV/AIDS.

## **2.7 Conceptual Framework**

This section introduces the general systems theory to explain the multisector approach to HIV/AIDS response. We draw parallels between the two and show that the concept of multisector collaboration is fast becoming a key instrument in addressing complex health and development challenges. We reflect on the history of multisector collaborations in the HIV/AIDS policy environment using principles or tenets of the general systems theory.

### **2.7.1 Defining General Systems Theory**

The “General Systems Theory” (GST) is an interdisciplinary framework which details how components of a system interlink to ensure maximum functionality (Boulding, 1956; Kast et al., 1972). Ludwig Von Bertalanffy coined the term in the 1930s in a quest to discover laws governing biological and natural systems (Von Bertalanffy, 1972). In an attempt to find the theoretical foundations of biology, Von Bertalanffy (1972:410) pointed out that the essence of a living thing is encapsulated by how its single parts are organised and coordinated to provide a complete explanation of the vital phenomenon. The essence of the theory is embodied by the adage, “the whole is greater than the sum of its parts”. Therefore, coordination between the disaggregated components is mandatory for the efficient functioning of the system.

### **2.7.2 Application of General Systems Theory**

The systems approach is used interchangeably with theoretical constructs from other disciplines that reflect systems concepts. It is applied to multisectoral action, which is a central tenant of HIV/AIDS response in South Africa and “is required when a problem is beyond the scope and resources of a single sector” (Mahlangu et al., 2019: 1). The approach is useful in three respects. Firstly, like in approaches to scientific management, it considers organisations as systems composed of complex, yet interrelated components engaged in linking processes and goals to ensure functionality. This is relevant to our research because the process of AIDS policy-making involves multiple sectors and extends to multiple levels of government. The process of multisector collaboration is complex and continuous allowing for learning and improvement as it happens in context (Mahlangu et al., 2019). This explains why it has taken long to strengthen and diversify stakeholder participation in the AIDS

councils in spite of existing challenges in practise. The historical account of HIV/AIDS policy indicates that the governance of the epidemic was conceived as a multisector exercise on paper, however, in implementation the response was thwarted by the placement of the epidemic under the National Department of Health (Wouters et al., 2009). The idea of multisector collaboration only took shape in the years leading up to the drafting of the 2007 NSP which was widely consulted both in planning and implementation. However, as alluded, challenges pertaining to the operation of AIDS councils (who are responsible for the management of HIV/AIDS) exist and these are identified by Mahlangu et al. (2017) in the district AIDS councils of Mpumalanga province. The authors attribute the weak HIV/AIDS response to low composition of AIDS councils, missing guidelines on the operation of AIDS councils, limited capacity to coordinate the multisector action, poor relations between sectors, institutional challenges at the national AIDS council, unstable political leadership and support in the AIDS response, and financial constraints impeding the operation of AIDS councils and implementation of HIV/AIDS programmes (Mahlangu et al., 2017). These challenges relate to structure and mechanism of the AIDS councils as they compromise the system's functionality and governance of HIV/AIDS in Mpumalanga province.

Secondly, communication and information gathering processes are essential in the development of sequence and organisation, which are inherent in every system and raise questions of order and goal-directedness (Boulding, 1956). This is relevant to our research because much of what happens in a system or how it functions stems from how responsibilities are divided amongst its members as well as how the responsibilities are understood in relation to the actors' roles. Meaningful participation and contribution by various actors to the AIDS response is dependent on clear and defined roles and responsibilities. Similarly, communication and interactions improve collaboration when expectations from all implementing actors are clear. According to Mahlangu et al (2019), roles and responsibilities of the implementing actors should be linked to the mandate of the collaborative and the latter should in turn optimise the comparative advantage of each participating stakeholder. These issues pertain to the design of structure and they determine sequence and organisation in the AIDS councils. Based on the Mpumalanga district AIDS council study by Mahlangu et al. (2017), missing AIDS council operating guidelines meant that the HIV/AIDS response is haphazard; while at the national level the overlapping roles and responsibilities are attributed to the multitude of actors whose contribution to the response is not harmonised. According to Salunke et al. (2017), Rasanathan et al. (2017) and

Kanchanachitra et al. (2018) cited in Mahlangu et al. (2019), “design of structure has attracted interest in public health literature and highlights the need for actors to share a common vision, and setting up systems for communication, coordination and conflict resolution”. According to Sabatier and Mazmanian (1979), the implications of the extent to which components of a system<sup>1</sup> are integrated are twofold: firstly, there is variation in the degree of behavioural compliance of implementing actors and targets groups and secondly, there is variation in the achievement of policy objectives.

Lastly, a system’s behaviour reflects the setting within which it operates and how it tries to cope with the external environment (Easton, 1957). AIDS policy is not developed in a vacuum, but is the outcome of complex social, political and economic interactions which actors at various levels of government must grapple with when formulating and implementing programmes. Evidence from the Mpumalanga study shows that performance outcomes of HIV/AIDS programmes improves when political leadership and support is central to the response, programmes are budgeted and costed according to scale, and the coordinating structure (AIDS council) at all levels is funded to carry out the functions of the collaborative (Mahlangu et al., 2017). All these are external variables determined outside of the HIV/AIDS policy environment yet their impact is profound on the functioning of the multisector structure and the implementation of the National Strategic Plan.

Systems theory is therefore used to synthesise and analyse complex relationships between subsystems in an organisation and their interface with the external environment. What the systems approach does fundamentally is illustrate how the components of an institution are organised and managed to increase the likelihood of appropriate action. For example, if components in a system are not coordinated or harmonised, it inadvertently renders the whole collaborative inoperative because experience has shown that no single sector (government, private, or civil society) effort has successfully addressed the drivers of HIV/AIDS which are both biomedical and socio-structural in nature (O’Laughlin, 2013; Mahlangu et al., 2019). As such, implementing actors should have a common vision of what the collaborative is trying to achieve and build a relationship based on interdependencies modelled on recognising the value of working together to mitigate the impact of HIV/AIDS at various level of government. Essentially, what the interdependencies do is strengthen and reinforce relations between actors in the collaborative.

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<sup>1</sup> Components in this context is used to refer to the various actors from multiple sectors involved in the AIDS response, while the system refers to the AIDS councils or multisector governing structures.

## 2.8 Hypotheses

The following hypotheses were inferred from the review of the literature and conceptual framework to investigate their reliability and validity when applied to the HIV/AIDS policy environment and the Merafong case.

- 1) The HIV/AIDS policy-making process is expected to follow a top-down approach, where the national plan is cascaded to the subnational level for implementation.
- 2) It is likely that national HIV/AIDS policy objectives are clear and structure implementation at a subnational level with considerable discretion to formulate and adapt the national plan to local context.
- 3) The implementation of local plans is contingent on the presence of plan compliant and dedicated individuals without whom can be predicted that the plans will fail or cease to exist.
- 4) It can be predicted that behavioural compliance with policy objectives among implementing officials and agencies will be influenced by the degree of integration of different subsystems in the HIV/AIDS policy environment.

It was apparent in this chapter that the HIV/AIDS policy environment resembles a system with interconnected and interdependent functions to ensure that ultimately, policy is successfully implemented. However, much of the literature was appraised at a national level with little knowledge of how the national AIDS plan is operationalised at a subnational level. The subsequent chapters will reveal how the NSP cascades and is adapted in localities by examining the case of Merafong City municipality which is the highest HIV burdened municipality in the West Rand district.

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### 3 RESEARCH METHODS AND TECHNIQUES

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This chapter outlines the various forms of qualitative research design used to explore the different facets of the research inquiry. Section 3.2 then outlines research techniques, including methods of data collection, sampling techniques, analysis of data and its credibility and reliability. This is followed by Section 3.3 that highlights some of the ethical considerations of the research method. Lastly, the limitations of the research method are discussed in Section 3.4.

#### 3.1 Research Design

The research approach is qualitative, exploratory-descriptive and contextual. The research question was explored qualitatively to illicit “open-ended responses” based on the experiences and perspectives of HIV/AIDS policy practitioners (Janesick, 2000). Furthermore, a comprehensive review of literature from multiple disciplines (Economics, Health, and Management) was consulted to give an in-depth understanding of the study. Janesick (2000) describes the method of incorporation of multiple disciplines to understanding qualitative research inquiries as “crystallisation”.

The focus of the exploratory-descriptive design is to gain insight and familiarity on a research problem where there are few or no earlier studies to refer to or rely on to predict an outcome (de Vaus, 2001). As was alluded to in the literature section, not much is known about the process of HIV/AIDS policy-making, with regards to how it cascades and is interpreted into local plans. Descriptive research is subsequently conducted to provide additional information about the phenomenon under study and increase the body of knowledge on it. It is through a case-oriented strategy that we can holistically explore the depth of a phenomenon and gain an understanding of “particular circumstances” to make informed propositions (Bless et al., 2013; Flyvbjerg, 2001). The case approach, systems theory, combines all “constituent elements” to explain the phenomenon under study (de Vaus, 2001).

Cases are context-dependent and therefore difficult to generalise from (Ragin, 2000). However, de Vaus (2001) shows that case generalisation is possible if a theory is used as a standard of assessment; the author further asserts that the more a case resembles characteristics of a theory during testing, the higher are its chances of replicability. For this

reason, it is possible that the hypotheses proposed for Merafong City will apply to a wider class of cases.

### **3.2 Research Techniques**

This section explains the relevance of research techniques and instruments used for data collection to the research design and assesses the reliability of the data in answering the research question and testing the validity of the hypotheses proposed. Moreover, an examination of the techniques which were used for sample selection and the steps taken to protect the anonymity of the research participants is discussed.

#### **3.2.1 Primary Data Collection**

The study follows a top-down approach for the analysis of AIDS policy-making. Therefore, “non-scheduled structured interviews” (Bless et al., 2013) and in-depth interviews were conducted with key HIV/AIDS policy practitioners from national to local levels. The two interview techniques were ideal to solicit experiences about the process of policy-making. Both forms of interviews are qualitative. The “non-scheduled” component implies that the interviewer was free to formulate new questions as and when issues of interest, unexplored before the commencement of fieldwork, emerged during the interview (Bless et al., 2013). Through this technique, respondents are not subjected to pre-defined concepts and are at liberty to express their views to questions posed. The technique is most suitable for exploratory research designs and was used in this study to explore in how the NSP and PIP relate, frame or translate into local policy implementation.

In-depth interview techniques, like non-scheduled structured interviews, are ideal when seeking a deep understanding to enhance knowledge on a particular research inquiry (Johnson, 2002). The duration of such interviews is extended because it explores multiple facets of a case or phenomenon under study (Johnson, 2002). Both interview techniques are based more on perceptions and interpretations than fact-finding (Warren, 2002).

The in-depth interviews were conducted using an interview schedule (see Appendix 1) over eight weeks. Before conducting the interviews, a series of questions were formulated and thematised to facilitate a comparison of responses amongst the participants (Bless et al., 2013). The interviews had no fixed time limit and the structure of the interview schedule was almost always adhered to except for when unconsidered aspects of the phenomenon under study emerged and required that they be explored in detail.

In spite of interviews being an effective mode of collecting qualitative data, the technique is disadvantageous because participation is voluntary and respondents can withdraw from the study at any point as outlined in the participation consent form. This can jeopardise the quality and reliability of data collected. A scenario emerged in Merafong where one respondent discontinued the interview. This affected the response rate in the locality and reduced the sample size and population representation (de Vaus, 2002). The situation was addressed through different strategies, firstly was the presence of a key informant with deep knowledge of the local dynamics, secondly, data was collected through the observation of the West Rand DAC where Merafong City Municipality participates as a stakeholder and lastly, secondary data comprising of past local plans shed some light on how the epidemic was managed in the locality.

As alluded above, the study relied on non-participatory observation techniques to counteract the challenges posed by the withdrawal of a respondent from the sample. According to Angrosino et al., (2000) and Bless et al., (2013) non-participant observation is a method of data collection which involves the examination of the behaviour and interactions of the observed by an outsider. On two occasions permission was granted to collect data by observing interactions of policy stakeholders at the West Rand District Aids council where Merafong City, Mogale City and Rand West City municipalities report on their implementation progress towards the HIV/AIDS programme targets. Apart from the municipalities mentioned above, the council was attended by civil society sectors, representatives from the district's Basic Education and Health and Social Development departments. The same technique was used to observe interactions among five HIV/AIDS policy stakeholders and a moderator at a symposium titled "From paper to provinces: Tracking SA's HIV/TB plan" in Johannesburg which was open for the public to attend.

### **3.2.2 Secondary Data Collection**

Qualitative research tends to combine a variety of data collection techniques (interviews, observations and document analysis) to ensure rigour and data triangulation (Janesick, 2000). Bless et al. (2013) define triangulation as a method of verifying data reliability and showing that different strategies used for data collection can yield similar results. Analysis of secondary data for this study entailed document reviews, not only to enhance the credibility of data collected but also to highlight the disjuncture between "paper and practice" that may

exist. The following documents were used to enrich and supplement the primary data collected:

### **1. National Documents**

- Quality Assurance Resource Book for Local AIDS Councils
- South Africa's National Strategic Plan for HIV, TB and STIs 2017-2022
- The 2015 National Antenatal Sentinel HIV and Syphilis Survey Report
- National Strategic Plan on HIV, TB and STIs 2012-2016

### **2. Provincial Documents**

- Gauteng Strategic Implementation Plan for 2017-2022
- Gauteng Provincial Strategic Plan 2012-2016: Annual Progress Report 2014/2015
- Gauteng AIDS Council Multi-Sector Report from 2011/2012 to 2013/2014
- Limpopo Provincial Implementation Plan for 2017-2022

### **3. District Documents**

- West Rand District Municipality Integrated Development Plan Review 2015/2016

### **4. Local Documents**

- Merafong City Local Municipality HIV/AIDS Strategy 2012/2016
- Framework for an Integrated Local Government Response to HIV/AIDS (2007)

#### **3.2.3 Sampling**

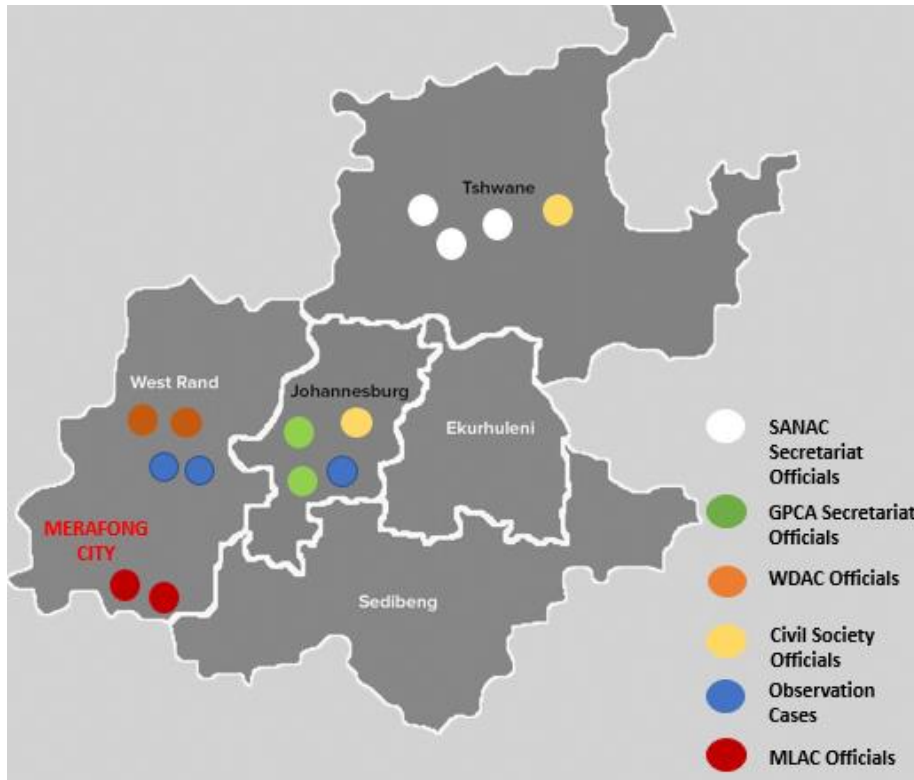
In this section, we explore how the research aims, design and the nature of the phenomenon under study influenced the size and type of sample which in turn determined the quality of data collected.

The selection of the geographical case of analysis was influenced by the HIV prevalence rate in the locality and the convenience and relative accessibility of the area. The positioning of Merafong City local municipality along the Witwatersrand mining belt presupposes that the locality will be prone to challenges of HIV/AIDS management. This is because of the history of the mining-migration-HIV complex in Southern Africa (Corno et al., 2012; Stuckler et al., 2013). Under the circumstances, it was imperative that an understanding of how national and provincial AIDS plans are tailored to address the dynamics of the epidemic in the locality. Bless et al. (2013) call this method of non-probability sampling “critical case sampling”

because it is “purposive” (de Vaus, 2002) and can assist in explaining causal relationships between variables. Furthermore, the sampling technique can narrow the focus of analysis and produce a set of more refined results. It is for this reason that smaller geographical units of analysis yield reliable and credible results, and these were used in the current research.

The second method of sampling entailed identifying a population within the HIV/AIDS policy environment from which a sampling frame was drawn. Moreover, a narrower sample representative of the population was then selected from the sampling frame to participate in the study (de Vaus, 2002). Bless et al. (2013) refers to the small sample as the “unit of analysis”. As noted above, SANAC is a multisector body and the same structures are replicated at a subnational level to the extent that their contexts and resources allow (SANAC, 2016).

Information about the composition of the West Rand DAC and Merafong LAC was unavailable and this was necessary to build a precise and voluminous sample before conducting interviews. As a result, interview referrals were made based on the initial general sample. According to Bless et al. (2013) and Janesick (2000), this referral technique is known as “snowballing” and it is likely to increase the sample size when the prevailing circumstances make it impossible to structure a stable target population. The technique complements the study’s research design which is partly exploratory and suitable for case studies where there are few or no earlier studies to refer to. Figure 3 represents the geographical mapping of research participants, most of whom were identified through referrals.



**Figure 3:** Geographical mapping of respondents

**Source:** Author

A collapsed LAC in Merafong City meant that the response and participation rate was low. In that event, the scope of participants had to be widened to include the national structures of the AIDS council. As demonstrated in Figure 3, a total of 11 interviews and 3 cases of non-participant observations were carried out over two months. In the diagram above, the white dots represent interviews conducted with three officials from SANAC secretariat at the Tshwane headquarters, whose mandate includes coordinating and overseeing the country's response to the epidemic. The green dots in the diagram represent interviews conducted with two officials from the Gauteng AIDS council secretariat, which is responsible for developing a provincial AIDS plan in line with the national strategic plan and in response to direction received from district and local AIDS councils (SANAC, 2016). The orange dots symbolise interviews conducted with two stakeholders of the West Rand DAC, which, in addition to acting as the link between PCAs and LACs, monitor the implementation of the provincial plans, identify gaps and support the development of strategies to address these gaps (SANAC, 2016). In Merafong, interviews were conducted with two officials, represented by the red dots, one of the respondents was an HIV/AIDS coordinator and was responsible for coordinating the HIV response in the locality, while the second respondent remains an active

LAC stakeholder representing the Department of Health in the locality. The yellow dots on the diagram indicate interviews conducted with representatives from the civil society sector. The Tshwane located organisation is NACOSA and is responsible for providing technical and capacity support for HIV/AIDS and TB service delivery by a network of over 1,500 civil society organisations. The second organisation is the AURUM Institute, headquartered in Johannesburg, and its mandate includes researching, supporting and implementing innovative, integrated and high impact programmes to eradicate HIV and TB in disease-burdened districts.

In addition to counteracting the lack of participation at the local level, the observation technique was used to legitimise the credibility of data collected. According to Bless et al. (2013), the sample size in qualitative research is determined through the intersection of multiple sampling techniques that are intended to yield data congruence and saturation. The three blue dots represent the observation cases whose composition and location was discussed above. Despite the issues emerging from the discussions correlating with the inquiry of this research study, the data used was selectively chosen based on its applicability to the Merafong City case and to limit the scope of discussion from overlapping to areas beyond the ambit of the research focus. According to Flyvbjerg (2001), cases are context dependent, however, this does not mean that the contextual dynamics influencing the phenomenon under study cannot be generalised to cases exhibiting similar behaviour especially when the dynamics are underpinned by theory. That being the case, data collected through observation strategies was used to mitigate and supplement the lack of participation in Merafong.

The combined sampling strategies were thus ideal for an exploratory research design to establish an agreement and consistency between data collected and secondary sources due to the unfamiliarity of how HIV/AIDS policy translates and is adapted at subnational levels.

### **3.2.3 Data Analysis**

This section outlines the preliminary processing of data collected through interviews and document reviews. The data was presented by comparing policy documents and the experiences of practitioners in implementing the plan to highlight gaps between policy and practice. A thematic content analysis was used to identify and cluster recurring themes emerging from the interview transcripts and document reviews (van Zyl, 2018). According to Janesick (2000) identifying themes and patterns inferred from the data is synonymous with inductive research approaches. The analytic procedure entailed reducing the volume of the

data through vertical and horizontal analysis (van Zyl, 2018). The former involved summarising and paraphrasing each interview, while the latter involved comparing the summarised transcripts against each other to find “areas of agreement and disagreement” among the respondents (Bless et al., 2013:347). The presentation of data into themes was supported by verbatim quotations to amplify the voices of the respondents (Bless et al., 2013).

The non-scheduled structured interviews produced organised data which facilitated the ease with which the text was thematised. The following codes were used to cluster data that shared a common characteristic: Policy-making process, Local Policy Implementation, and Multisector Framework. Each of the codes are described in greater detail in Chapter 4, they were arranged hierarchically to reveal findings which were broad in scope like the cascading and adaption of the Plan at a subnational level, to those which are more detailed and narrow, about the operationalisation of the Plan in Merafong.

### **3.2.4 Data Reliability and Validity**

This section explains saturation and triangulation as tools used to uphold quality criteria both in data collected and research findings. To reiterate, a paper to practice comparison was conducted to show the “full range and depth” of the research problem and to improve saturation coverage and increase the reliability of data collected (Bless et al., 2013:238). Equally so, different techniques which were used for data collection yielded similar findings, with interviews giving more nuance and explanation to the findings of document reviews and observation cases.

The credibility of findings was measured by the degree to which they validated the hypotheses and the extent to which the research questions were answered. According to Salkind et al. (2013), the research findings are neither valid nor invalid; their validity ranges in degree from high to low. As such, the hypotheses made were retained confirming a moderate to high validity in the research findings. The accuracy of the findings were ascertained by the preciseness with which the research questions were answerable, which in turn increased their reliability.

### **3.3 Ethical Considerations**

This section considers and evaluates codes of “good practise” that were adhered to during data collection. Moreover, we consider the relationship between ethical practices and research design.

At the centre of qualitative research are respondents who relay their experiences, beliefs and opinions about the subject matter of inquiry, therefore, their personhood and responses must be protected. According to de Vaus (2002), keeping the anonymity and maintaining the confidentiality of the respondent promotes participation, improves the quality of data collected, and ensures the privacy of the respondent. For this study, privacy was guaranteed by eliminating titles associated with the participants, these included names and positions occupied. Participants were therefore assigned codes based on the organisation they represent (Bless et al. 2013): SANAC Secretariat officials were coded SANAC(x) – x representing a number associated with an official participant; Gauteng PCA Secretariat officials were coded GPCA(x), West Rand DAC stakeholders were coded WDAC(x), and Merafong LAC stakeholders were coded MLAC(x). Finally, the NACOSA and AURUM Institute representatives were respectively coded NACOSA(x) and AURUM(x).

The initiation of research participation was voluntary and for that reason, the privacy and autonomy of the respondents were at no point violated, this included the decision to discontinue the interview in one case (Bless et al. 2013). The concept of voluntary participation coexists with the principle of consent. For every interview conducted, informed consent was sought, and in most cases, this typically involved a brief explanation about the nature of the study before the respondent decided on whether to participate or not. It was unlikely that a participant was thoroughly acquainted with the nuances of the research project. De Vaus (2002) and Bless et al. (2013) suggest that the respondent is to be provided with necessary information, offered clarity if the need arises and have the benefits and risks outlined that were associated with participating (see Appendix C).

Another aspect of ethical procedure related to voluntary participation and informed consent involved tools used for data collection. This refers to devices that were used to record data from the site of research. In qualitative research, experiences and opinions of respondents are a source of data that should be reported verbatim (Bless et al. 2013). In this case, interviews were recorded through a mobile phone built-in recorder. A copy of a consent form for interview recording, appended to the research, was issued to respondents who consented for their responses to be used for educational purposes on condition that their privacy was protected. During the interview recording, respondents were requested not to reveal their identities and job titles or refer to anyone by name as that could constitute an invasion and violation of privacy.

An additional aspect to ethical conduct that was adhered to during and after the research project pertained to data storage and safekeeping. All primary data collected was anonymised before being archived. The interview recordings and transcripts were saved on an online cloud storage provider to prevent unauthorised access and uphold the confidentiality of the respondents.

### **3.4 Limitations of Research Approach**

This section explains how the research design might have compromised the quality of data collected and what was done to overcome the limitations.

A collapsed LAC in Merafong reduced the sample representation in the locality and this compromised the volume, reliability and legitimacy of data collected at the local level. The limitation was, however, overcome firstly by the presence of a key informant with deep insight and knowledge on the history of HIV/AIDS policy programme in the locality, secondly the sample size was increased to include HIV/AIDS Coordinators of other municipalities in the West Rand district who were willing to share their experiences of the HIV/AIDS programme in Merafong over the years since they all participate on and report to the district AIDS council, and lastly through the method of triangulation, various data collection techniques such as non-participation observation of the AIDS council meetings and document reviews were used to explore the full depth of the research problem.

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## **4 FROM PAPER TO PRACTISE: RESEARCH FINDINGS AND DISCUSSION**

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This chapter presents the research findings by juxtaposing evidence gathered through desktop and document reviews with evidence from observations and interviews with policy practitioners. The contrast between paper and practice was used to explore the relationship between policy content and its implementation, focusing specifically on how the AIDS plan cascades and is operationalised at a subnational level. This is accompanied by interpretation and a discussion of the findings drawing on the literature review and conceptual framework. Section 4.1 presents the findings through a thematic content analysis with an illustration of verbatim quotations from respondents and extracts from policy documents. Section 4.2 provides a summary of Chapter 4 and highlights the major findings and their significance to the research inquiry.

### **4.1 Presentation of Findings**

This section is divided into the three themes emerging from the data collected, which was fragmented and clustered into categories that share a common characteristic. They include, (1) Tracking the transmission and translation of the NSP at a subnational level, (2) Understanding contextual issues within the frame of local policy implementation and (3) Examining the sustainability of a multi-sector HIV/AIDS response at a subnational level. We discuss each in the proceeding sections.

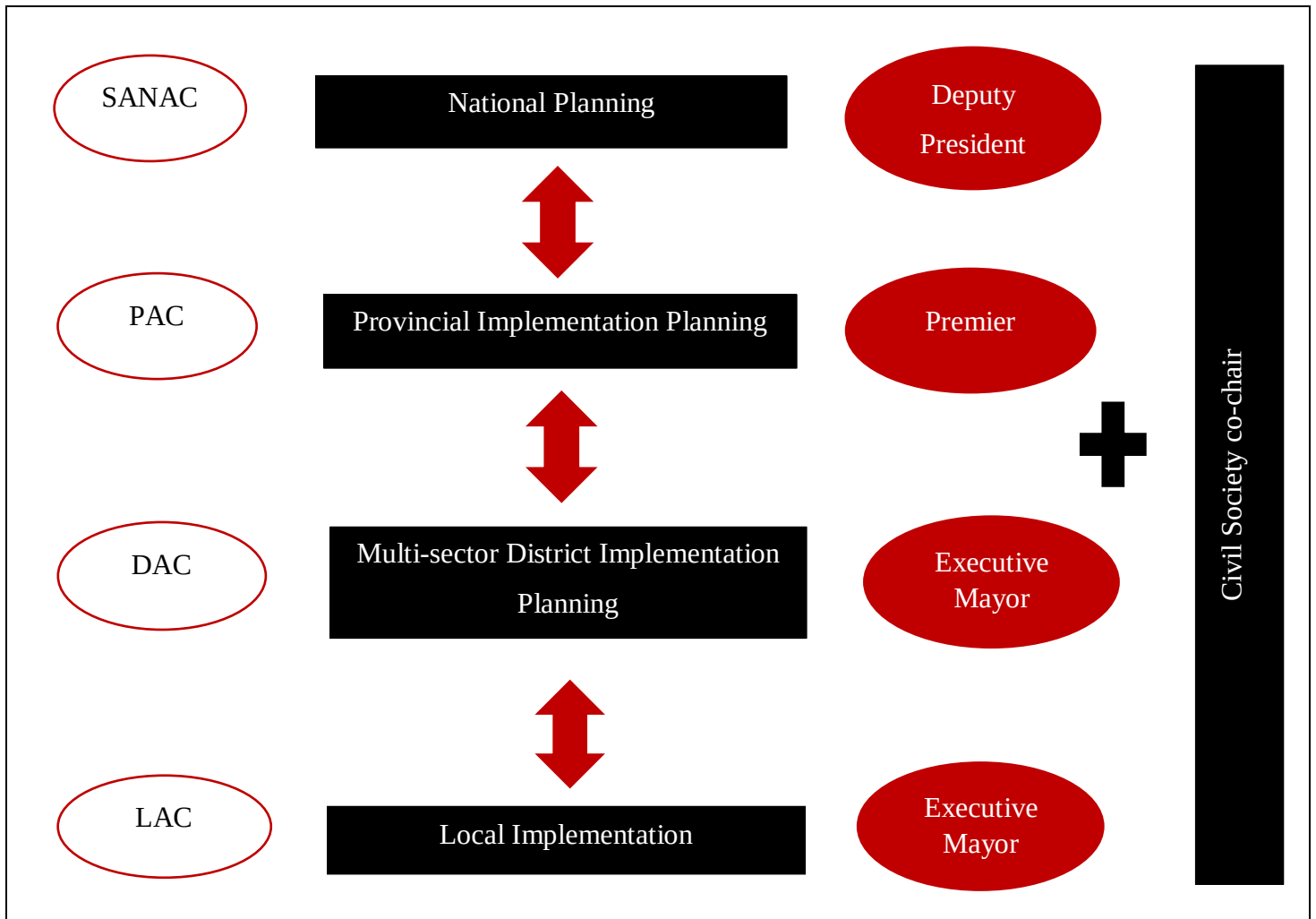
#### **4.1.1 Tracking the transmission and translation of the NSP at a subnational level**

The theme refers to the planning and development of subnational plans and how they align with the NSP. The section will elaborate on some of the HIV mitigation strategies in the plan, how it cascades down from a national level and is adapted at a local level.

##### **4.1.1.1 From Paper - Evidence from desktop and document reviews**

##### **Cascades of the NSP from national to local structures**

The NSP cascades from national to local AIDS council structures as illustrated in Figure 4, which shows the nature of NSP transmission and how it is adapted at the subnational level.



**Figure 4:** AIDS councils structures and a representation of the flow of the National Strategic Plan  
**Source:** Buthelezi, S., 2018. Managing the HIV/TB/STI response in South Africa. Bhekisisa Policy Dialogue,

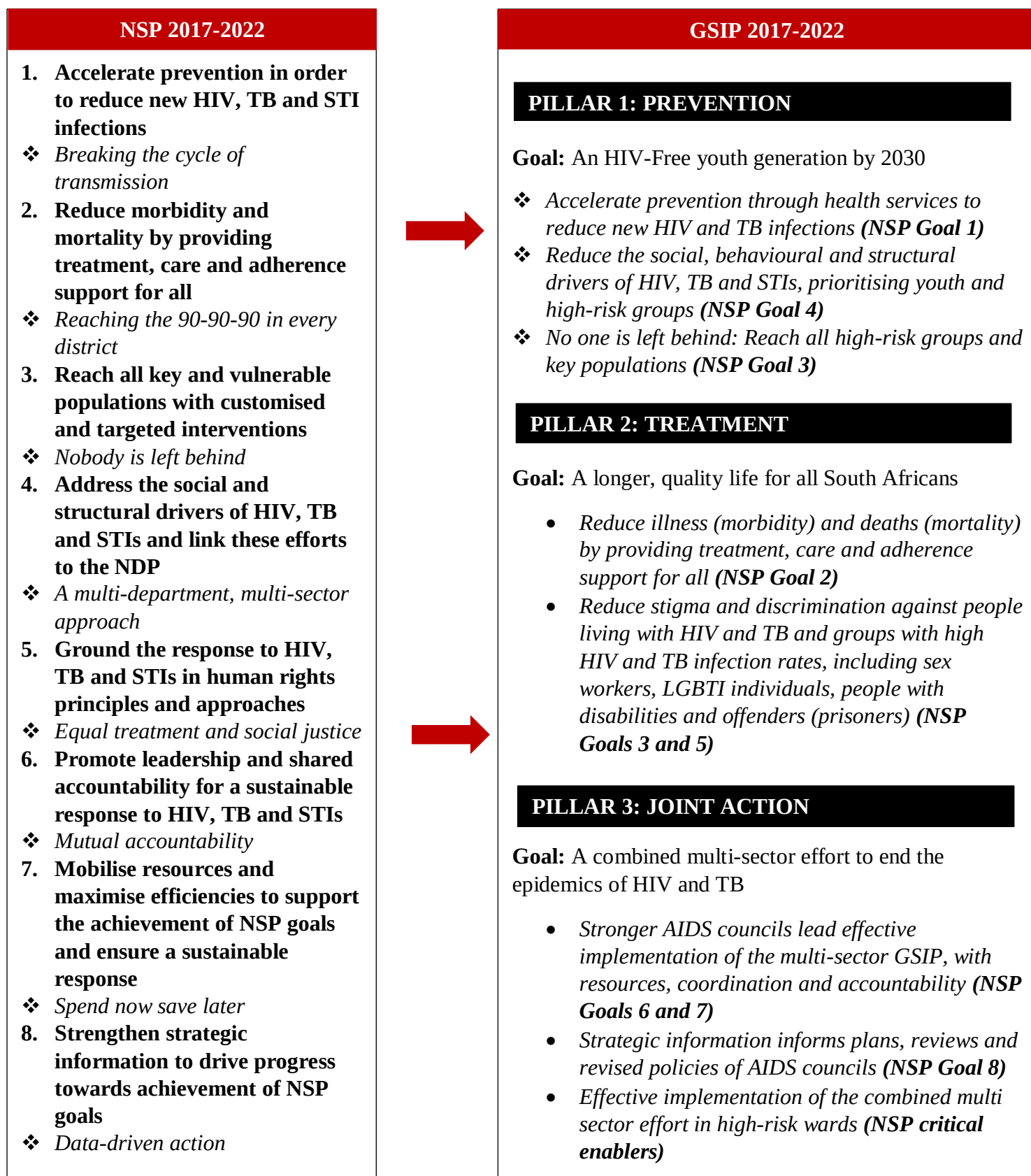
The interlinking structures of the AIDS council facilitate a coordinated response to HIV. The Quality Assurance Resource Book (2016:18-20) indicates that, “PCAs are expected to provide province-specific information and recommendations to SANAC”. Moreover, the document defines DACs as, “intermediary structures, responsible for providing the link between the PCAs and LACs”. It points out that DACs “co-ordinate, monitor and support the activities of the LACs”. The interaction between AIDS council structures, therefore, resembles a continuous process of communication channels used to streamline information on implementation progress to inform the development of subsequent plans.

## **Translation and adaptation of the NSP to subnational dynamics**

The NSP comprises of eight goals and corresponding objectives and according to the Plan (2017) Provinces are expected to adopt the same goal setting format and formulate Provincial Implementation Plans (PIP) with corresponding province-specific strategic approaches to operationalise the eight goals in greater detail. Likewise, stakeholders (Government departments, civil society and private sector) in the AIDS response are also expected to develop their sectoral implementation plans. However, the standardised format is detailed for subnational implementation where plans are meant to be simple to facilitate a less-complicated implementation process. As a result, the Gauteng AIDS council (GAC) produced a three-goal plan titled, “Gauteng Strategic Implementation Plan (GSIP)” whose strategic objectives match the eight NSP goals as well as multi-sector indicators for each level of the plan (GSIP, 2017: 7). Figure 5 (below) illustrates the translation of the NSP into a GSIP in more detail.

The decision to reduce the goals was, according to the GSIP (2017: 7) prompted by the need for a simple and accessible plan at a provincial level. This accords with the argument that simple plans promote policy ownership and improve the interface between policy and communities. They articulate policy direction with clarity and foster commitment to policy goals among various advocacy groups.

The findings on NSP translation in Gauteng and other provinces highlight a stark difference in provincial plan formats. All provinces adopted the NSP format of eight goals except for Gauteng whose plan comprised three goals. The scenario underlines two concepts involved in the translation of the NSP; plan replication and plan adaptation. The former relates to reproducing the NSP format at a provincial level, while the latter entails changing the format to suit the provincial context without subverting policy direction. The difference between the two concepts relates to the degree of modification involved in contextualising the plan, which is more intensified for plan adaptation and requires a great deal of policy planning capacity.



**Figure 5:** Translation of NSP into GSIP

**Source:** Gauteng Strategic Implementation Plan 2017-2022

Multi-sector District Implementation Plan (MDIP) is an annual HIV/AIDS service delivery plan with eight goals formatted by SANAC to structure implementation at a district level. Like all AIDS plans it divides implementing responsibilities according to the orientation of the goal and the mandate of the implementing stakeholder.

The 2012-2016 Merafong AIDS plan prioritised three goals – prevention, treatment and care among those infected and affected by the virus – out of the five 2012-2016 national goals, in order to simplify the implementation of the plan at a local level. The plan identified the mining and sex industries as a cause of vulnerability and susceptibility to the virus in the locality. However, it was devoid of a clear strategic approach to address the vulnerabilities caused by the industries mentioned above and deploy more services in areas identified as hotspots.

### **Strategies and methods approved in national and local plans to address the epidemic**

Issues pertaining to the strategic approaches used to control and manage the transmission of HIV will be discussed below.

The overarching strategic approach for the 2017-2022 National Plan is to “focus for impact” in HIV burdened districts and using available information and insights to target key populations evaluated to be at risk of infection (NSP, 2017). The strategy is opportune for Merafong, which did not have a 2017-2022 AIDS response plan when the data was collected, as the need to dedicate resources to areas evaluated to be heavily burdened by HIV is apparent.

The current dispensation of AIDS policy planning has witnessed a decline in SBCC (social behaviour change communication) programmes that are aimed at changing attitudes and sexual behaviour by increasing awareness of prevention and treatment services. The GAC Multi-Sector Report (2014: 84) notes that, “there is a good national consensus on the nature of the drivers, but there are serious differences of opinion on the most effective methodologies and models to use to intervene effectively on the social and behavioural drivers”. Moreover, “the Human Sciences Research Council (HSRC) noted a reduction in overall HIV media coverage after 2008. Testing, treatment and circumcision were the focus of media from 2010 to 2012” (Ibid., 83).

The GAC Multi-Sector Report (2014:92) further asserts that “medical experts have between 2008 and 2012 overlooked social behaviour change interventions in addressing HIV, and

because of this, knowledge on HIV prevention has declined and risky sexual behaviours were on the rise as shown by a reduction of 17.9% in condom use at last sex”. The report suggested that “HIV infections would as a result increase between 2012 and 2016 in Gauteng province” (Ibid., 22).

Influencing behaviour change is not easy, but SBCC programmes have in the past improved HIV outcomes by increasing awareness of both prevention and treatment services. The NSP (2017: 52) states that “SBCC is an especially important component of an effective response to HIV, TB and STIs, as growing evidence suggests that young people are less informed about HIV than in the past and less likely to take steps to reduce sexual risk. Results from three national surveys indicate that fewer South Africans are reached by SBCC interventions, with the proportion of people reporting having been reached falling from 92.5% in 2006 to 82% in 2012”.

#### **4.1.1.2 To Practice - Evidence from observations and interviews**

##### **Cascades of the NSP from national to local structures**

There was a broad consensus among policy practitioners at various levels of government that the process of HIV policy-making was top-down and consisted of two streams. The information stream was bottom-up and involved reporting on the epidemiological patterns of the epidemic in the locality to inform district, province and national policy planning and design; the planning and design stream was top-down and involved conceptualising and drafting of the plan which, when finalised, is cascaded to and implemented at subnational structures. The findings highlight the nature of AIDS policy transmission and correlate with the policy documents which describe PCAs and DACs as intermediary structures between SANAC and LACs that streamline information up and down to facilitate the design of plans at a national level and implementation at a local level.

##### **Translation and adaptation of the NSP to subnational dynamics**

In practice, the translation of the NSP to GSIP was not as seamless as depicted on paper, despite a general agreement among the respondents regarding the degree of agency that PCAs can exercise to develop contextual plans aligned to the national policy direction. This was conceded by **SANAC001** who asserted that, “we must acknowledge that the provinces have got their dynamics and they’ve got their challenges and though there might be some

similarities in terms of social and structural drivers of HIV, their priorities might differ and because of that we expect that there would not be similarities in their cascade of the policy”.

SANAC developed a standardised PIP format for the formulation of provincial AIDS plans and this was done in response to calls by the “UNAIDS to set up a single country structure that coordinates the AIDS response, have a single country plan and a single M&E system/framework nationally” said **SANAC001**. Moving from the premise that plans at the subnational level should be simplified to promote ownership among the constituency and to facilitate easy implementation, the Gauteng PCA formulated a three-pillared plan with sub-objectives that corresponded with the eight goals of the NSP which, according to **GPCA001**, are “sort of province-specific priorities”. Because of this, the GSIP was deemed by the SANAC plenary, the highest decision-making structure of the AIDS council, to be illegitimate. The decision to reject the Gauteng plan was contingent on its nonconformity to the standardised format of the PIP. This elicited dissent from **GPCA002** who expressed that, “SANAC dustbinned that plan, they really did and it was purely a question of format”.

Despite the GSIP adhering to the policy direction of the NSP, **GPCA002** provides the following explanations to the difference in plan format, “firstly, the GSIP prioritised youth with a focus on key populations which include young women and girls (15-24yrs), sex workers, men who have sex with men, transgender people, inmates and people who use drugs. While the NSP prioritised key populations only”. The prioritisation of the youth by GSIP follows from the logic that HIV infection has historically been high among the youth: “So, we [GAC] put youth and key populations at the top of our agenda, but you can’t have a plan that’s only key population.”

Secondly, some objectives particularly the 90% targets listed under Goal 2 of the NSP to ensure that 90% of all people living with HIV know their status, 90% of all people with an HIV diagnosis receive sustained ART, and that 90% of all people receiving ART are virally suppressed were argued to be illogically specified. **GPCA002** indicates that the first two 90% targets are, “process coverage” and not “outcomes-based” like the third. The respondent maintains that, “this is not even planning on government standards” because using process coverage as a metric is counter-productive and hinders quality improvement and implementation. The respondent further asserts that, “the Department of Planning, Monitoring and Evaluation (who sat on the planning committee of the current NSP) uses logical framework so that outcome is driven”. **NACOSA001** concurs with this view and

posits that: “you should be able to get core outputs in straight figures and then at a certain level of analytics you are then able to talk about percentages.”

Lastly, plans must be simple and accessible. “You have got to simplify it (provincial AIDS plan), at this time we are not looking for a whole complicated plan”. To justify this claim, **GPAC002** gave the following scenario, “if the Premier stands up in the community meeting and presents the plan, how many goals can it have? Can’t have eight; people switch off after four”. This is supported by **WDAC002** and **MLAC001** who explained that it would be unrealistic to prioritise all the eight goals at a local level. Therefore, the LACs prioritise three goals and align them to the local context, as was the case with the 2012-2016 Merafong Plan.

According to the Quality Assurance Resource Book (2016: 18), “PCAs are responsible for developing a provincial AIDS plan in line with the national strategic plan and in response to direction received from district and local AIDS councils”. Therefore, not only does the NSP structure planning at the provincial level but standardising provincial plans constrains the scope and agency of policy planning at a provincial level. **GPAC002** argues that “policy planning is art” and restricting its scope is contradictory to what PCAs are mandated to do on paper.

Having taken stock of contentions surrounding policy translation from NSP to GSIP, it is fitting to review the extent of planning capacity bestowed on PCAs. Where capacity challenges to translating the plan exist, SANAC is mandated to provide technical support to PCAs; nevertheless, this is done in a way that promotes agency in planning because according to **SANAC002**, “you want to have sustainable responses in the provinces, you don’t want national running sub-national spaces”. However, in practice, the technical support disempowered the Gauteng response by dictating a policy format because it suited SANAC’s reporting needs rather than a bottom-up demand.

We now turn to how the NSP was translated at a district level and focus on issues that are likely to discourage the district multi-sector response as relayed by the respondents. MDIPs were introduced for the 2017-2022 plan period to promote the multi-sector framework at a district level. **SANAC001** notes that, “health has a similar system at a district level called District Implementation Plan (DIP)” and because health has a clinical approach to HIV/AIDS, the district AIDS plan was named MDIP to encourage a multi-stakeholder response. However, **GPAC002** refutes the use of the term “district” (which has a constitutional bearing) to title a plan that is intended to be multi-sectoral. The respondent

posits that, “DACs shouldn’t use the term “district” because we have Metros, for us, it is a “Multi-sector Metro Implementation Plan” because “district” is a health term or if it is in education it is talking about something different. So, if you are a multi-Sector and AIDS council you must use municipal boundaries, the constitution tells you”.

The DIP facilitates the overarching goal of the District Health System model which is to deliver primary health care at district level by all health care providing institutions and individuals, whether governmental, social security, non-governmental, private or traditional. It is without a doubt that HIV/AIDS is predominantly a health issue, but it is located in the broader struggle for economic and social development because the drivers of the epidemic are structural and systemic. Therefore, using the term “district” to title a multi-sector AIDS plan creates a perception that HIV/AIDS service delivery is the sole responsibility of health care providing institutions and individuals which is likely to compromise the multi-sector framework, thereby loosely integrating other sectors in the response. **GPCA002** expressed that the MDIP was predominantly health oriented. The respondent indicates that: “80% of it (MDIP) is Health Services. I think there are two or three interventions on Social Development and one or two by Education and then you got SASSA grants.”

The implementation of the 2012-2016 Merafong plan and the development of a 2017-2022 plan was interrupted by a collapsed AIDS council which immobilised the multi-sector framework and participation of stakeholders on the LAC. **MLAC002** alluded to the existence of a 2012-2016 Merafong AIDS plan but indicated that the progress on implementation was unknown due to collapsed AIDS council structures: “it [the local AIDS plan] is there in black and white, but it is not happening on the ground.” When asked about the development of a 2017-2022 local AIDS plan the respondent explained that the absence of an HIV/AIDS Coordinator hinders the development of a local AIDS plan. The role and implications of not having a Coordinator in the HIV/AIDS response will be explored in the following themes.

The debates that emerged from policy translation can be summed up by emphasising that the standardisation of the NSP format at provincial level lessens the interface of the plan with implementers at a subnational level where plans are supposed to be simple to facilitate a thorough implementation. Moreover, the discrepancies in policy translation are borne out of a dismal understanding of government and constitutional procedures, particularly with the development of the MDIPs which are likely to immobilise the multi-sector response. Furthermore, the 90%-90%-90% targets are service coverage and not designed according to

government's outcome-based logical framework. This raises questions over the extent to which SANAC is integrated into government structures since it is its advisory body on HIV/AIDS management.

### **Strategies and methods approved in the national and local plans to address the epidemic**

The experiences of policy practitioners observed and interviewed are congruent with what is reflected on paper about SBCC interventions declining over the years.

**SANAC001** and **PANELLIST1** confirmed this, the former expressing that, "prevention is one of the hardest things, it is one of the places where we are grappling with the most". The challenge for **GPAC001** is that prevention strategies have failed to evolve in the past years and the respondent further asserts that, "How is it that more than 20 years since the elevation of HIV as a policy we are still doing prevention the same way we did it 20 years ago? We need to be innovative to capture the attention of the people, but we have failed to do that". Despite widespread HIV/AIDS awareness, **MLAC001** rhetorically states that, "what we must concentrate on is encouraging behavioural change because awareness, we are done. I believe we are aware. But then how are we going to try to enforce, for lack of a better word, behavioural change?"

As the HIV prevalence rate expands, it is expected that more resources will be directed to treatment which **MLAC002**, **WDAC002**, and **GPAC002** attribute to the declining focus on prevention. **GPCA002** stated that, "The resources now go into treatment [rather] than prevention which is extremely neglected and that is why we see increases in HIV again and the drivers of HIV infection in young women are social and economic". The evidence from policy documents on this issue shows that the allocation of resources to prevention strategies have remained the same in relative terms over the years.

**GPCA002** expounded on a point mentioned on paper about the medical experts undermining the non-medical interventions to social drivers and behaviour change. The respondent asserted that medical experts are, "very ignorant on prevention, they are hostile to social, behavioural and structural interventions; they are kind of academicism when they use their research and I think there was an initiative where they said okay, so we have done well on our ART and we need to take lessons from our ART and apply them to prevention."

The implications on the declining social and behaviour change interventions are dire, as indicated on paper and they marginalise stakeholders that are responsible for implementing

such interventions, therefore, leading to a weak response to the epidemic. There was a consensus among the respondents that it would be impossible to treat our way out of the epidemic if we continue to neglect the social and behavioural component of HIV and this will consequently degenerate the response into a narrow outlook.

#### **4.1.1.3 Discussion**

##### **Cascades of the NSP from national to local structures**

The general observation from the findings is that the nature of HIV/AIDS policy transmission is top-down with interlinking structures of the AIDS council facilitating a coordinated response to policy formulation. The respondents indicated that HIV policy-making involves communication and design streams to channel information from the local to the national structures where policy is designed and cascaded down for implementation. The process resembles a system which, according to Boulding (1956) and Kast et al. (1972), details how components interlink to ensure maximum functionality. Moreover, Boulding (1956) asserts that communication and information processes are essential in the development of sequence and organisation.

It can, therefore, be hypothesised from the findings that the HIV/AIDS policy-making process follows a top-down approach, where the national plan is cascaded to the subnational level for implementation. This is present in Merafong where policy planning at the local level is shown to be minimal and only involved adapting the national and provincial plans to the local context. Municipalities by their nature are the administrative sphere of government and are therefore responsible for implementing or executing national directives. This corroborates with Fourie (2006) who asserts that HIV/AIDS policy planning is predominantly appraised at a national level. The various components in the HIV/AIDS policy environment perform different functions and link processes to maximise the system's functionality (Boulding, 1956; Kast et al., 1972). Therefore, the division of responsibilities between the national and subnational AIDS councils is clear and indicates that the former is responsible for planning while the latter implements the decisions taken at the national level. The top-down approach speaks to the arrangement of and relations between the different components in the system. The hierarchal relations, especially between the AIDS council structures, explains the rejection of the Gauteng AIDS plan by the national AIDS council.

## **Translation and adaptation of the NSP to subnational dynamics**

It was broadly observed from the findings that the NSP makes some provision for local context adaptation. As hypothesised, reproducing the plan format at a subnational level with some discretion for contextualisation implies a low degree of ambiguity in AIDS policy content and a modest policy disagreement along the policy-making continuum. From a plan replication perspective, Sabatier and Mazmanian (1979 and 1980), argue that successful implementation is contingent on clear and unambiguous statutes and policy directives that structure implementation at lower levels. This is certainly true in the case of the PIP format which operationalises the NSP in greater detail as each goal is adapted to the prevailing health and socio-economic conditions in each province. This explains why SANAC plenary invalidated the GSIP which departed from the standardised eight goal format of the NSP. The findings appear to indicate that this decision was based on improving “goal-directedness” and thus establishing a common policy outlook within the HIV/AIDS policy continuum (Boulding, 1956).

To avoid street-level bureaucrats from subverting policy direction, Sabatier (1986) states that the number of veto points (policy making authority) at the local level are minimised. The lower the number of veto points the easier it is to reject proposals for policy change thus making the system’s response to identified health and social drivers of HIV less problematic. However, moving from the premise that the NSP is a high-level document and must be simplified at the subnational level to facilitate ownership and the ease of implementation, it is justifiable to lessen the number of goals at that level. This argument is supported by Barrett (2004) who asserts that much of public policy provides discretion to subnational structures to formulate innovative and contextual action plans that advance policy goals and objectives from the top. If capacity for policy-making exists at the subnational level, policy actors should be allowed the discretion to formulate innovative action plans within the scope of national policy direction on the basis that they have a comprehensive grasp on contextual issues and how best to address them. This way, policy-making authority delegated to actors at the subnational level can be increased while central policy actors retain indirect influence over the institutional setting of local implementation.

The findings on the translation of the district plan and the perceptions surrounding its titling indicates that by using the term “district” to title a multi-sector AIDS plan, this can undermine the multi-sector response and thereby loosely integrate other government

departments and sectors (business and civil society) in the HIV/AIDS system. The implications of this are captured by Sabatier and Mazmanian (1979) who indicate that the extent to which components of a system are integrated are twofold; firstly, there is variation in the degree of behavioural compliance of implementing actors and targets groups and secondly there is variation in the achievement of policy objectives. This confirms and corresponds with the hypothesis that, behavioural compliance with policy objectives among implementing officials and agencies is influenced by the degree to which they are integrated into the HIV/AIDS policy environment.

### **Strategies and methods approved in national and local plans to address the epidemic**

Despite uniform policy direction subsequent to the polarising of the HIV/AIDS policy environment that was highlighted in Schneider (2002) and Fourie (2006), the findings point to the existence of competing agendas in the current dispensation that pertains to the differences of opinion on the most effective methodologies to use to intervene on the social and behavioural drivers of the epidemic. Both the findings on paper and practice indicate that medical experts undermine the non-medical interventions on social drivers and behaviour change. This was evidenced by the decline in the general reach of SBCC programmes and a reduction of knowledge on HIV prevention and safe sex behaviours from 2008 to 2012. Because of this, the GAC Multisector report suggested that “HIV infections would increase from 2012 to 2016” (2014: 22).

#### **4.1.2 Understanding contextual issues within the frame of local policy implementation**

The data presented under this theme outlines the guidelines for local policy implementation to strengthen the HIV/AIDS response in localities. The practice section will elaborate on the existing dynamics in Merafong and processes involved in local implementation.

##### **4.1.2.1 From Paper – Evidence from desktop and document reviews**

Policies are designed to resolve pertinent issues and it is at the local level that they can address the problems they are intended for. Policies at this level are simplified to facilitate the ease with which they are implemented. Because local government is the closest governance structure to communities, there is an expectation that municipalities will play an active role in the response to HIV. According to the 2012-2016 Merafong AIDS strategy, “Municipalities, together with organisations on the ground, have to provide the type of leadership and direction that will lead to real change in people’s attitudes and behaviour”.

The extent of the response to HIV by local municipalities will, therefore, depend on the municipal capacity and the magnitude of the epidemic. This corroborates with the Quality Assurance Resource Book (2016: 8), which stated that, “there are geographic variations with some provinces more severely affected than others. These differences also reflect a background in socio-economic conditions as demonstrated by the district level HIV surveillance data.”

Merafong City poses specific challenges, some already mentioned above. The GAC Multi-sector Report shows HIV prevalence in 2011 to be high among the mining areas of the West Rand district, with Merafong City as the highest burdened municipality. The locality’s 2012-2016 AIDS strategy attributes the prevalence rate to socio-economic and structural factors which are systemic, “There are informal settlements located on the periphery of the mining land where there is a population of highly mobile women who come to the mines in search of work but end up being commercial sex workers” (2012: 12). The Gauteng Strategic Plan Annual Progress Report for 2014-2015 similarly identified sex workers and migrant workers to be at high risk of infection. The report indicated that, “HIV prevalence for sex workers was estimated to be over 50%, migrant workers in mining, transport and hostels (20 to 24%) and their female partners” (2016: 25).

It would appear that the NSP, in theory, supports specific targeting in such instances. The current plan includes a “focusing for impact” strategy to maximise the reach and effectiveness of the plan. It states that, “Tailoring the response to specific locations and populations is critical to optimise outcomes. Districts must define their responses for implementing the NSP, with provincial and national leadership supporting this decentralised approach” (2017: 34).

Similar planning frameworks focusing on a holistic approach to development exist at the local level, this includes the Integrated Development Plan (IDP) which is a multi-stakeholder plan and accounts for existing conditions, problems and resources available for development in the locality. According to the Quality Assurance Resource Book (2016: 21):

“The district planning processes, including the inclusion of the local AIDS council in the development of the Integrated Development Plan (IDP), allow for an adequate understanding of the district-specific characteristics, nature and the extent of socio-cultural determinants of HIV and TB epidemics. This allows the districts to develop more appropriate plans and to

mobilise sufficient resources (human, financial and material) for the district HIV, TB and STI programme.”

This is intended to promote HIV/AIDS as a development challenge and aims to analyse how different government departments and non-governmental actors can address the socioeconomic drivers that increase vulnerability to infection. The multi-sector orientation reinforces a coordinated approach to implementation. There is also supposed to be alignment between NSP indicators and department annual performance plans in all spheres of government to increase accountability to committed targets. According to the NSP (2017: 48), “The Plan will detail the roles and responsibilities of all stakeholders and the reporting timelines and will define core indicators, data sources, collection tools and flow mechanisms.” Furthermore, “national, provincial and local government departments will reflect relevant NSP indicators and targets in their Annual Performance Plans (APP) and IDPs” (Ibid., 48).

The Framework for Integrated Local Government Response to HIV/AIDS (2007: I) indicates that, “an effective government response to HIV/AIDS must have a strong local governance component which will complement the existing initiatives by other government departments and stakeholders”. As an equal stakeholder on the LAC, municipalities have governance and mobilisation capabilities that allow them to assume a more civic and engaging role. The Framework suggests the following role for municipalities in the HIV/AIDS response, “The municipality can opt to coordinate the activities to be undertaken by other role players, such as provincial and national government departments, NGOs, CBOs, traditional authorities and the private sectors. Municipalities have a responsibility to ensure that services are provided to communities that require them. This means that they can identify where there is an over-supply of services, such as home-and-community-based care and areas that are facing service gaps” (2007: 29).

Despite the policy guidelines outlining the implementation procedures to be followed at a local level, the Quality Assurance Resource Book (2016: 12) signals to the existence of leakages in the implementation of the plan, “The reality is that, despite all of these well-intended interventions, the response of local municipalities is not always as good as it could be. The need to strengthen and support local AIDS councils as a means to achieve better implementation of the NSP has prompted the development of this manual.” The observation was supported by GSIP (2017:4) which asserted that, “The capacity of AIDS councils,

community sectors and secretariats has reduced [since 2012] due to a lack of prioritisation, funding and support”.

The policy documents profiled the local response to HIV/AIDS broadly, outlining the nature of the epidemic in Merafong and the significance of the contribution by various stakeholders to the response. The practice section will explore some of the leakages attributed to poor implementation of the plan in localities.

#### **4.1.2.2 To Practice – Evidence from observations and interviews**

This section describes in detail the HIV/AIDS policy environment in Merafong and identifies gaps that hinder local policy implementation.

There was consensus among the respondents that the high HIV prevalence in the West Rand district, notwithstanding the expanded ART programme in the country, was due to its position along the Witwatersrand mining belt. Despite the fact that the National Antenatal Sentinel Survey (2015) reported a 9.9% increase (the highest among the five Gauteng districts) in HIV prevalence in the West Rand between 2011 and 2015, the NSP prioritised the district only for TB while City of Johannesburg, Ekurhuleni and City of Tshwane were accounted for both TB and HIV. The districts that were evaluated to be TB burdened showed a strong correlation with a high HIV prevalence. **GPCA002** provides case history and background knowledge of HIV in the mining towns of the West Rand and why the region is prioritised in the Gauteng AIDS plan:

“The mining towns have by far the highest HIV rates and if you look at the rest of the country and look at mining, that is where the highest (prevalence) is and continues to be. So, you have got the legacy of the mining epidemic even in areas where mines have closed. There was a time when mine workers lived in hostels but as things changed men would move particularly to informal settlements not necessarily in the historical townships. So, if you go to a place like Westonaria [Sub-district of West Rand] a lot of people who are living in the townships and informal settlements are mine workers or ex-mineworkers. They might get retrenched, but that does not mean that they go home because their families are dependent on them and then the women who come to town and become sex workers are going to stay. So, you may find that mining areas are not booming as they were at some stage, but the legacy is now in the population.”

The respondent identified the same trend in Merafong, with **MLAC002** in agreement, asserting that: “Merafong is a mining town, it is a highly mobile community and you do get a lot of sex workers.”

From as early as the year 2000 the response to the epidemic was, according to **GPAC002**, supported by political actors and for that reason, “resources were pushed into mining and we [Gauteng AIDS council] proactively setup sex worker projects in those areas”. Merafong LAC was subsequently set up to promote a coordinated multi-sector response to the epidemic with the assistance from Gauteng and North West PCAs from whom the structure of the LAC was benchmarked as narrated by **MLAC001**. The LAC was co-chaired by the Mayor and a civil society representative with stakeholder participation from government, mining houses and civil society sectors. The respondent adds that the development of a local plan received technical support from the Education and Training Unit. The Merafong case exemplified standard best practice. This was attested by **WDAC001** and **GPCA002** who stated respectively that, “when I started working in Randfontein [sub-district of West Rand], we went to Merafong to benchmark their LAC” and “for a while, and I don’t know what it is like now, they [Merafong] are the only local council in the Province that set aside a dedicated budget for HIV. That’s how serious they took HIV”.

A well-constituted and robust LAC was cited as the reason for an efficient AIDS response. It was through the LAC that stakeholders reported on the implementation progress of their plans and assessed whether their systems and strategies were working based on the NSP indicators and targets that were set. The multi-sector approach facilitated coordinated implementation and there was joint agreement among the respondents that the LAC’s strength was partly due to a strong provincial AIDS council. **SANAC002** and **MLAC001** contest that, there is a strong correlation between district strength and the organisation of the provincial AIDS council structure.

Despite the cited success in Merafong, **GPCA002** stated that the capacity of the AIDS response in Gauteng was reduced in 2014 after the Department of Health (DoH) took over the provincial AIDS council secretariat and closed all the civil society sector projects that were funded by the provincial government which gravely affected the reach of sex worker programmes in Merafong. The observation was concurred to by **WDAC001** who argued that, “before 2012 these sectors were vibrant and active and there was funding for them. Then things changed after 2014, some NGO’s and sectors were not funded”. **GPAC002** explains

that, “the Gauteng AIDS council secretariat [which existed under its separate structures] was put under the Chief Director for Health Service Management [in 2012], the budget for the multi-sector response was redirected to health services management and that which was set aside for campaigns was used for medical agenda.”

The situation uncovered during the current research in Merafong is very revealing. It indicates not only contention over resourcing of medical versus socio-behavioural interventions to prevention, but also highlights the issue of the placement of AIDS council structures showing that this has profound implications on the multi-sector framework. AIDS council secretariats are mandated to be in political structures (situated in the office of the Premier or Mayor depending on the operational sphere of the AIDS council) where the multi-sector approach is concretely embodied. However, the Gauteng PCA secretariat is located in the provincial DoH, and the Premier rightfully chairs the council. The West Rand DAC is in the Department of Health and Social Development and the Mayor delegated a member of the municipal council to chair the council. Merafong LAC was previously operated under the Department of Community Services and the Mayor headed the council, however, after the collapse of the programme the secretariat was placed under political administration (the Mayor’s office). **SANAC002** highlighted that the reason why it took the subnational AIDS councils long to move out of ministerial departments (particularly Health) was that SANAC was historically under the custodianship of the national DoH and the same structures were replicated at a subnational level. However, upon the reconceptualisation of HIV as a developmental challenge, SANAC became an independent body but remained in the national DoH. It was only in 2015 that the council moved out of Health to acquire its separate structure under the chairmanship of the Deputy President. This was done in efforts to increase the council’s visibility and to represent different sectors and work with all departments despite Health being the biggest funder of the HIV/AIDS response.

Despite the AIDS councils being independent bodies, the process of repositioning from ministerial departments at a subnational level was lagging and discouraged the multi-sector participation and reporting on the council. The challenge with AIDS council positioning under ministerial departments was that the latter have a specific mandate and according to **SANAC002** this created a perception that the AIDS council was established by and shared a mandate with that particular ministry under which it was located. Moreover, **GPCA001** added that, constitutionally, government departments do not account to each other or account

directly to the Premier or Mayor who chairs the AIDS council at a subnational level, therefore reporting and robust participation on the council tended to be somewhat poor. However, this does not mean that the initiatives of non-participating stakeholders went unreported, some government departments reported on the progress of their AIDS response indirectly through the members of the executive council and municipal council of their respective ministerial portfolios, who then report to the Premier or Mayor. Because the process of reporting to the AIDS council is not legislated, **GPCA001** posited that cooperation and accountability by stakeholders to the AIDS council, “is done on a gentleman’s agreement”. This is agreed to by **PANELLIST1** who stated that departments were likely to prioritise and report on their Annual Performance Plans because they are statutory unlike the performance indicators and targets of the HIV/AIDS plans. The respondent further added that participation by stakeholders on the AIDS council is voluntary in spite of government departments having streamlined HIV/AIDS in their line functions, to which **GPCA002** confirmed that, “SANAC is negotiated and not regulated by design, it is an Independent Trust”, which means it is not a juristic or legal person.

Contrary to this, placement in political structures is likely to promote a coordinated multi-sector approach and stakeholder accountability. However, there are also dangers in this regard. **GPCA002** highlighted blind spots associated with political placement in the following analogy:

“Look at Merafong, its secretariat is in the Mayor’s office, so they are doing the Mayor’s business. So, put us (Gauteng AIDS council secretariat) in the office of the Premier we won’t have an operational budget, they will halve our staff, our budget will be a quarter if we are lucky. When the Premier has a crisis, we will be pulled out of being the AIDS Secretariat, or we will have a narrow definition. So, it may correct some things, but it will undermine other things.”

This was corroborated by **MLAC001** who asserted that, “HIV/AIDS management by its nature is supposed to be sitting in a political office. Unfortunately, it gets most of its blows from there.” The milestones that have been achieved over the years in reversing HIV infection and mortality rates have fostered complacency among the political actors and led to the neglect of the HIV/AIDS response in Merafong. As a result, other pressing issues might have taken precedence over HIV/AIDS on the municipal agenda.

The respondents acknowledged the significance of AIDS council placement in the political office and its implications on the coordination of the multi-sector framework. However, they stated that political commitment to achieve the goals set out in the AIDS plan and the will to galvanise stakeholders into action strengthened the HIV response irrespective of where the AIDS council is located. They assert that getting buy-in to the response is much easier when the epidemic is presented as more than a public health issue. This is argued by **MLAC001** who stated that, “to get people to participate (on the AIDS council) they must understand the importance of that plan and where it comes from. And if they give their buy-in, I find it was very easy for them to offer their commitment”.

Merafong demonstrated how the degree of political commitment impacted on the response to the epidemic and it was in the absence of political support that the programme lost capacity, exacerbated by the reduced participation of the civil society sector on the LAC due to the events discussed above. **MLAC001** supported by **WDAC001** describes the events that led to the demise of Merafong LAC and its political response to HIV as follows:

“We used to have a brilliant Mayor, all the HIV and AIDS structures were strengthened because of their insights, passion and commitment to the HIV/AIDS programme. After their departure, the Mayors succeeding them undermined the programme and became absent, which frustrated the entire process and led to other actors being despondent because they can see that there is no commitment shown towards the programme.”

Moreover, the absence of an HIV/AIDS coordinator was also cited by the respondents to have contributed to the weakening of the LAC. The coordinator is an employee of the municipality who ensures that sufficient HIV/AIDS funding is made available through submissions of budget requirements to the municipality. The coordinator manages the volunteer teams (who facilitate the ward-based door-to-door prevention programme in the locality), mobilises stakeholder participation on the LAC and coordinates the implementation of HIV/AIDS programmes in the locality to ensure that response efforts are directed to areas of greatest need and implemented without duplication. According to **MLAC001** and **MLAC002**, the position in Merafong has been vacant since 2012 which means that the LAC has not been convened since then. As a result, **WDAC001** indicated that stakeholders have been working haphazardly in the response to the epidemic. It is therefore incumbent upon the municipality and the Mayor as the political champion of the AIDS response to see that a coordinator is hired. However, it is a challenge to enforce such compliance when the

HIV/AIDS policy environment is unregulated, to which **MLAC001** concurs that, “because you don't have anything that holds us to account, we get away with murder”.

#### **4.1.2.3 Discussion**

The findings emanating from this theme indicate that implementation is the Achilles heel of policy. The above events influence the HIV/AIDS policy environment in Merafong and determine the kind of implementation outcomes. This is conceded by Easton (1957) who asserted that a system's behaviour reflects the setting within which it operates and how it tries to cope with the external environment.

Firstly, the burden of the epidemic in Merafong as indicated by the antenatal surveys on paper reflected the socio-economic conditions that increase susceptibility to the virus. The respondents suggest that the positioning of Merafong along the Witwatersrand mining belt and an active sex work industry are some of the factors attributed to the high HIV burden in the municipality. According to Sabatier and Mazmanian (1980:544), problems identified at a local level are manageable if, “there is minimal variation in the behavioural practices which cause the problem, the target group constitutes an easily identifiable minority of the population within a political jurisdiction and the amount of behavioural change is modest”. The progress made towards containing HIV/AIDS over the years has enabled the ease with which to track behavioural patterns, however, the 9.9% increase in the HIV prevalence rate might indicate the incapacity of the district and the local AIDS councils to address the behavioural practices causing the problem.

Secondly, the extent of the HIV response in Merafong will depend on the municipal capacity and the magnitude of the epidemic. The findings indicate that a missing HIV/AIDS Coordinator in Merafong was a major disruption to the AIDS response and was attributed to a collapsed LAC whose sustainability depends on human and financial resources. According to Sabatier and Mazmanian (1979), successful implementation is contingent on the presence of implementing actors with strong managerial capabilities to prevent the programme implemented from charges of fiscal mismanagement and the overall malfunction of the implementing structure.

Moreover, local politicians must ensure that the LAC's advice on HIV/AIDS policy reaches the agenda of the municipality, however, in their absence, the programme loses priority. This was explained by **MLAC001** who indicated that the diminished support from political actors in Merafong undermined the HIV/AIDS programme and the necessity of hiring a

Coordinator. Despite acknowledging the importance of political support for policy, Sabatier and Mazmanian (1979) state that support for a policy problem or objective is sustained over time provided that the emergence of other socio-economic challenges and public policy effects on the identified problem are kept at bay.

The absence of a Coordinator and political support has rendered Merafong LAC inoperative, and the implications have been profound on the development of a local plan and on how the municipality responds to the epidemic. This corresponds with the hypothesis that the formulation and implementation of local plans are contingent on the presence of plan compliant and dedicated individuals without whom we can predict the plan to fail or cease to exist. Therefore, if a coordinator is missing from the system, it can become uncoordinated and fall apart.

The findings under this theme also highlighted a pressing issue about the placement of AIDS council structures. The HIV/AIDS response is mandated on paper to be driven from political structures (offices of the Premier or Mayor depending on the operational sphere of the AIDS council) where the multi-sector approach is represented. However, **MLAC001** and **GPCA002** stated that the placement argument can be quite trivial especially when the AIDS response has strong political support which can mobilise all sectors to participate. They further highlighted that it was in the absence of a Coordinator and political support in Merafong that the AIDS programme was moved under the administrative oversight of the Mayor's office. This is where it, unfortunately, suffered a great deal because the focus of the local AIDS secretariat shifted from HIV/AIDS to political work. **GPCA002** cited the same argument to justify the placement of Gauteng PCA in the Department of Health and not in the Premier's office. However, the respondent indicated that the placement of the Gauteng PCA was not without its challenges. The respondent explained that, "the Gauteng AIDS council secretariat was put under the Chief Director for Health Service Management and (consequently) the budget for the multi-sector response was redirected to health services management, and that which was set aside for campaigns was used for medical agenda". This is congruous with Pelser et al. cited in Wouter et al. (2009) who argue that placing the National AIDS Programme Director in the Department of Health during the 1994 AIDS policy planning was problematic and compromised the multi-sector response which perceived HIV as a health instead of a developmental issue. The neglect of the HIV/AIDS response in Merafong by the Mayor's office (on account of **MLAC001** and **GPCA002**) suggests that

political actors at the local level had a sparse understanding of the mandate of the LAC, particularly in its advisory role to government on HIV/AIDS policy and as a platform for monitoring local implementation of the AIDS plan. Despite this, political actors remain key players in the AIDS response because through their active involvement, the relevance of HIV/AIDS on the public policy agenda can be sustained; moreover, they possess the power to galvanise sectors and strengthen the multi-sector response. Therefore, it is imperative that the AIDS council secretariat at a subnational level exist in a separate structure that retains the chairmanship of political actors. The set-up will ensure that the mandate and resources of the AIDS councils are not undermined by other ministerial portfolios or the political office as illustrated above. Moreover, it is proposed that AIDS councils become legislated bodies to understand their purpose and how they advance and guide AIDS responses in the country.

The absence of a national Act to provide a legal framework and support the management of HIV/AIDS was cited as a fundamental issue affecting the compliance to plan goals and implement these. The findings show that SANAC was established with exclusive jurisdiction over HIV/AIDS; however, there was no accompanying legislative framework to regulate implementation and compliance to attain goals, this is in spite of the council being governed and controlled by a Board of Trustees which was established in terms of the Trust Property Control Act, 1988. **GPCA002** indicates that SANAC was not regulated by design and as a result, **GPCA001** noted that cooperation and accountability by stakeholders was done on a “gentleman’s handshake”. The effects of not having an Act governing the implementation of HIV/AIDS policy were more apparent at a local level, where political actors participated voluntarily in the AIDS response without accounting for the poor implementation of the local plan. **MLAC001** emphasised that if nothing held them accountable, then they would get away with murder. Sabatier and Mazmanian (1979) and (1980) argue that successful implementation is partly the result of a statute that structures implementation and ensures compliance to goals.

#### **4.1.3 Examining the sustainability of a multi-sector response at a subnational level**

The structural drivers of HIV/AIDS are systemic and necessitate a multi-sector response. Under this theme, an analysis of the AIDS council as a collaborative structure for the HIV response is made. The paper section outlines broadly the need for a coordinated response in localities where implementation is key. The practice section will in turn show instances of strong and weak coordination of the multisector responses in the West Rand and Merafong.

#### **4.1.3.1 From Paper – Evidence from desktop and document reviews**

The HIV/AIDS response is generally contingent upon strong links between implementing actors. As such, a comprehensive multi-sector framework is heralded as central to a coordinated response which fosters integration across different sectors. The national plan is cardinal to the planning of local and department-specific programmes and is fundamental for the establishment of a coherent response and a shared strategic vision. This is encapsulated in the NSP (2017: 35) which asserts that, “Every department in the tiers of government needs to recognise the value of the unique role they can play. Achieving epidemic control requires an all-of-government approach, with each department contributing in line with departmental mandates and coordinating and collaborating across the three tiers of government.”

The multi-sector coordination process is conducted through the AIDS councils as derived from their mandate to provide a platform to stakeholders to report on their implementation progress. However, a breakdown in communication channels is common, specifically at district and local level where participation and reporting to the AIDS council is infrequent. Distorted channels are in some cases attributed to collapsed AIDS council structures, which has pronounced implications on the development of a local plan, on information reporting and on coordination of stakeholder activities. Strengthening the system at the subnational level is, for this reason, the key to achieving the ambitious targets of the NSP. On account of this, the NSP (2017:34) notes that, “At the national level, there is a strong platform and collaboration, but more attention has to be paid to the provincial and district level systems where implementation is key.”

#### **4.1.3.2 To Practice – Evidence from observations and interviews**

The coordination of the multi-sector response is hampered by the composition of the AIDS council structure. According to **SANAC002**, “there are twenty-one departments that are supposed to be part of SANAC, but approximately six or seven are always engaged and contribute money to HIV/AIDS work”. The respondent indicated that there is a strong presence and visibility of the civil society sector at a national level despite questions over how they are selected and who they represent.

The same challenges with the AIDS council composition persist at a subnational level. The West Rand DAC is a case in point, with only Departments of Health, Basic Education and Social Development participating and reporting consistently. Civil society participation was weak with a missing representative to co-chair the DAC. As a result, the multi-sector

collaborative degenerates somewhat into an Interdepartmental Coordination Committee without civil society and business sector voices. In Merafong, as was discussed previously, the LAC at its peak was well constituted and co-chaired by the Mayor and a civil society representative with stakeholder participation from government, mining houses and civil society sectors. However, since its collapse implementing actors have been working separately and out of the collaborative system.

Municipalities are also failing to budget for the coordination function appropriately to implement the plan. **GPAC002** and **MLAC002** indicated that more often than not, municipalities did not have an HIV/AIDS component in their budget. In Merafong the function was weakened by the reduced support of the HIV/AIDS programme from political actors. **NACOSA001** suggested that, “it is very important for districts to look at the response as part of service provision because there is no direct support which is coming from SANAC to districts and local municipalities. Which means they must be proactive and make resources available and budget for it.” Because the AIDS response was the Mayor’s project at the district and local level, **SANAC002** and **SANAC003** indicated that the function of the national and provincial structures was to only provide policy planning and technical support to district and local AIDS councils.

In local municipalities where the coordination arm of HIV/AIDS is resourced, **PANELLIST4** indicated that a mapping technique was used to deploy resources to areas of greatest need and it facilitated tracking who the service providers in the region were and the services which they provided so that implementation was harmonised and duplication minimised. In worst case scenarios, like Merafong, where the AIDS council is non-functional, there is a lack of operating procedures in the collaborative and undefined roles and responsibilities between and among the implementing actors.

The findings in practice confirm the assertion made on paper that the poor composition of DACs and LACs compromised the coordination of the multi-sector response. Apart from this, it is difficult to ascertain whether stakeholder programmes align with the NSP when participation and reporting on the AIDS council was poor.

#### **4.1.3.3 Discussion**

The practice section has shown that the multi-sector approach is partially developed at a subnational level, nevertheless, many sectors have streamlined HIV in their line functions. The findings indicate that the NSP facilitates the ease with which HIV is streamlined and aligned

with the functions of sector stakeholders. It does this by dividing implementing responsibilities according to the orientation of the goal and the mandate of the implementing stakeholder. For example, all health-oriented goals are implemented by the Department of Health and all civil society organisations with a health and biomedical mandate. This is congruous with Chibango (2013), Evensen et al. (2010) and Stewart et al. (2005), who stated that policies are designed at a subnational level and across government departments to support and effect the goals in the AIDS Plan. Therefore, as a single country plan, the NSP structures and coordinates subnational and stakeholder-specific plans to establish a uniform policy direction.

However, there seems to be a weak connection between government and non-governmental sectors at a subnational level as evidenced by the poor participation of and relations between implementing actors on the DAC and LAC. Sabatier and Mazmanian (1980) emphasise that if policy is to be effectively implemented, unwavering support from constituent advocacy groups is needed to hold policy implementers accountable for the mandated objectives. The civil society sector, as a constituent advocacy group in the HIV response, has historically been the watchdog of the AIDS councils overseeing whether the implementation of HIV/AIDS programmes adheres to the national guiding framework. The poor composition of the DAC and LAC signify that some components in the HIV/AIDS policy environment are not adequately integrated into the system and because of this, **SANAC001** indicated that, “the system chokes”. **GPCA002** confirmed this by stating that, “stakeholders are not trained on the multi-sector framework and I think it is one of the most difficult frameworks, our leadership wants it and get excited about it. Our politicians love having civil society in on it. However, the officials do not like it because it is difficult.”

The loosely integrated components in the HIV/AIDS policy environment, particularly in Merafong where the coordinating structure is inoperative, distorts communication and information processes that are essential in tracking and understanding HIV/AIDS developments in the locality. This is conceded by Von Bertalanffy (1972), in reference to the general systems theory, who argues that the way single parts of a system are organised and coordinated impacts on the explanation of the phenomenon in question. Because of the weak connections between the implementing sectors and the poorly composed AIDS councils we can hypothesise that behavioural compliance to policy objectives among implementing

officials and agencies will be influenced by the degree of integration of different subsystems (stakeholders) in the HIV/AIDS policy environment.

#### **4.2 Summary of Findings and Discussion**

According to Fourie (2006:14), the implementation stage of HIV/AIDS policy is, “distinctly political in nature – dealing directly with the questions of who implements policy, where, when and how.” The findings indicate that the HIV/AIDS policy approach is top-down with the National Strategic Plan structuring implementation at a subnational level. However, blockages to implementation are attributed to, a weak multi-sector collaborative structure, placement of AIDS councils, a missing HIV/AIDS Coordinator, diminished support from political actors, and the absence of an Act governing the implementation of HIV/AIDS policy. Furthermore, a collapsed LAC in Merafong has undermined the development of a local plan that is responsive to the locality’s HIV/AIDS epidemic. Based on these findings it was deduced that the impact of HIV/AIDS responses in Merafong seems to have gradually declined, after fervent support of the issue on the municipal agenda, as crucial parts in the integrated system were undermined. The impact was illustrated by a 9.9% increase in HIV prevalence between 2011 and 2015, the latter was also a result of declining behaviour change interventions between 2008 and 2012 as hypothesised by the GAC Multisector Report (2014).

It was highlighted in earlier sections that policy problems that linger for a prolonged period tend to result in the loss of support over time and this is more apparent at a local level as evidenced by the eroding political buy-in for the HIV/AIDS programme in Merafong. This is exacerbated by the absence of a national Act for addressing HIV/AIDS, which could also act as an instrument for holding implementing actors accountable for their contribution to the response.

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## 5 SUMMARY AND CONCLUSION

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In this chapter, key lessons are highlighted from exploring how HIV/AIDS policy cascades and translates in Merafong municipality where it is operationalised according to the locality's epidemic profile. Section 5.1 outlines the summary of the thesis by drawing on the key findings and the material from Chapter 1 to show how the goals and objectives were achieved. In Section 5.2 the implications of the study on HIV/AIDS policy are presented, followed by Section 5.3 which highlights some of the limitations of the research. Lastly, recommendations for policy and practice with some suggestions for further research in Section 5.4 are outlined.

### 5.1 Summary and Principal Findings

The study set out to explore how the NSP cascades and is adapted at a subnational level. This was done through a case study of Merafong City Municipality which is the highest HIV burdened municipality in the West Rand District. The latter showed a 9.9% increase in HIV prevalence between 2011 and 2015 as illustrated by the National Antenatal Sentinel HIV Prevalence Survey (2015). The literature review presented a chronological account of HIV/AIDS policy in South Africa, analysed the stages involved in HIV/AIDS policy-making and identified content, actors, context and processes as blockages to effective implementation. However, it was indicated that most HIV/AIDS policy studies had been appraised at the national level with limited knowledge of how the plan is operationalised at a subnational level.

The key findings reflected the research goals and objectives and revealed that:

- 1) The HIV/AIDS policy-making process follows a top-down approach with plan goals structuring implementation at a subnational level.
- 2) The municipality's role in the AIDS response is fulfilled through a Coordinator who ensures that sufficient budget is made available through submissions of budget requirements to the municipality. They manage the volunteer teams (who facilitate the ward-based door-to-door prevention programme in the locality), mobilise stakeholder participation on the LAC

and coordinate the implementation of HIV/AIDS programmes in the locality to ensure that response efforts are directed to areas of greatest need and implemented without duplication.

3) A missing HIV/AIDS Coordinator in Merafong, a collapsed LAC, the lack of political support for the HIV/AIDS programme and the absence of a national legal framework for addressing HIV/AIDS were some of the gaps attributed to a weak policy environment. Moreover, there are competing agendas over suitable approaches to HIV prevention, with medical experts undermining SBCC interventions. The implications were evidenced by a decline in prevention awareness, a reduced rates of condom usage between 2008 and 2012 and a 9.9% increase in HIV prevalence in the West Rand district.

4) It was apparent at a local level that policy problems that tend to linger for a prolonged period tend to result in loss of support over time, despite there being political support and commitment to plan goals at a national level. The national level support for HIV/AIDS on the public policy agenda was evidenced by the alignment of the NSP to and the reflection of HIV/AIDS in the National Development Plan.

The general systems theory was used to frame local policy planning and implementation to understand how different components in the HIV/AIDS policy environment interlink to ensure a common policy direction. The theory indicated that components which were loosely integrated into the system showed poor compliance to plan goals and objectives. This assertion reflected the fourth hypothesis which was corroborated by the research findings. The latter provided conclusive support about the HIV/AIDS policy environment in Merafong and its inability to support the development of a plan that is responsive to the locality's epidemic profile.

## **5.2 Implications for HIV/AIDS Policy**

It was inferred from the study that the NSP be simple and less elaborate at a subnational level to facilitate the ease of implementation and promote policy ownership among the implementers and communities and that national actors should encourage and allow for this. It was apparent from the findings that the multisector structures were weak and if functional it was never guaranteed that they would be sustainable because participation by stakeholders on the AIDS council was voluntary. The collaborative approach was heralded as a major turning point in the fight against HIV/AIDS, however, there are missing guidelines in the NSP on how to implement the multisector framework. A national legislative framework

governing the HIV/AIDS response could improve accountability and reporting to the AIDS council and strengthen connections and relations between the implementing actors.

The increase in HIV prevalence in the West Rand points to a rising trend in risky sexual behaviour which was preceded by a declining HIV awareness and social behaviour change interventions between 2008 and 2012. The situation was addressed in the 2017-2022 NSP which highlighted that HIV/AIDS interventions are more responsive to the complexities of the epidemic when a combination prevention approach of both medical and behaviour change strategies are equally utilised to reduce transmissions.

### **5.3 Limitations of the Research**

In as far as the limitations of the study are concerned, a few were identified in the initial stages of research during the gathering of literature, some were methodological, and the findings revealed others.

The literature on HIV/AIDS policy implementation is predominantly appraised at a national level and does not detail the complexities of how the NSP is adapted at a subnational level. The situation made it difficult to identify gaps and debates emerging from policy studies, hence an exploratory research method was applied.

The case in Merafong City municipality represents a partial picture of how the NSP translates at a local level and the findings are specific to the case and do not necessarily reflect a general practice of the implementation process. The alternative would have been to identify a municipality that is excelling in HIV/AIDS policy implementation and compare it with Merafong to provide a more balanced picture of what happens at the municipal level.

At the time of writing, data from the 2015 HIV antenatal survey was used as part of the analysis of the increase in HIV prevalence in the West Rand district because of a delay in the publication of the recent HIV/AIDS estimates. As such, some conclusions might be offset by the trends emerging from recent publications of the antenatal survey, for example, based on the 2015 prevalence estimates it is not clear why the West Rand is not identified as a priority district for HIV, however, it may become clear in the next antenatal survey which was probably used to inform the 2017-2020 NSP.

#### **5.4 Recommendations and Suggestions for Further Research**

The following recommendations are made to improve HIV/AIDS responses in Merafong. To begin with, we propose that the municipality fill the vacant position of HIV/AIDS Coordinator because the LAC cannot be convened without one. Furthermore, it is proposed that the multi-sector coordination be strengthened through consistent participation and reporting on the LAC to get a sense of how different stakeholders are responding to the epidemic. Political actors in the municipality must be actively involved in the response to ensure that the LAC's advice on HIV/AIDS policy reaches the agenda of the municipality and that the response receives adequate funding to implement activities of the AIDS council. Last but not least, it is recommended that social behaviour change interventions be scaled-up because successful reduction in HIV transmission requires a mix of prevention strategies.

Further research is encouraged after it was discovered that the technicalities surrounding the establishment of SANAC as an Independent Trust were not extensively explored because it pertained to the discipline of administrative law which was beyond the scope of the study, but it contributed vital information to the findings. It was discovered that AIDS councils were not legislated bodies and there was no Act governing the HIV/AIDS response in South Africa, as such it is worth researching the impact of an HIV/AIDS legislative framework on the management of HIV responses in other countries and how the key findings can be applied in the South African context to improve implementation and compliance to plan goals and objectives.

More research is needed on worst and best policy implementation practices at a subnational that can assist SANAC strengthen the response along the policy continuum. The study should look into financial capacity building and expenditure tracking of the equitable share and conditional grant earmarked for HIV/AIDS activities at the province, district and the locality to ensure that subnational plans are costed according to scale and that performance targets are reached with the allocated budget.

#### **5.5 Conclusion**

The research inquiry was a result of an increasing HIV prevalence in the West Rand district between 2011 and 2015. It set out to investigate how the local AIDS plan was used as an instrument to address the identified problem through a case analysis of the Merafong City municipality, which is the highest HIV burdened sub-district in the West Rand. The research design was ideal for exploring how the National Strategic Plan for HIV/AIDS cascades to and

translates at the local level because little information was available on how the NSP is operationalised at a subnational level. It was concluded that locating HIV/AIDS in the broader struggle for economic and social development would entail slight variations in how policy is analysed and interpreted at a local level. Therefore, the positioning of Merafong on the Witwatersrand mining belt has historically given rise to high migration and sex work which persists and presupposes that the profile of HIV/AIDS in the locality should be understood in this context to focus policy for impact and leverage resources in areas of greatest need.

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## 7 APPENDICES

### Appendix A: Ethics Certificate

|                                                                                                                                                                                                 |                                                                                      |                                                                                     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| <b>Faculty of Commerce, Law and Management</b><br><b>University of the Witwatersrand, Johannesburg</b>                                                                                          |                                                                                      |  |
| School of Economic and Business Sciences<br>Private Bag X3, WITS, 2050, South Africa • Telephone: +27 11 717 3004 •<br>email: Elyse@wits.ac.za                                                  |                                                                                      |                                                                                     |
| <b><u>CLEARANCE CERTIFICATE</u></b>                                                                                                                                                             |                                                                                      | <b><u>PROTOCOL NUMBER:</u></b> CECON/1120                                           |
| <b><u>PROJECT:</u></b> THE IMPLEMENTATION OF HIV/AIDS POLICIES IN LOCAL MUNICIPALITIES: A<br>CASE ANALYSIS OF MERA FONG CITY LOCAL MUNICIPALITY                                                 |                                                                                      |                                                                                     |
| <b><u>INVESTIGATOR:</u></b>                                                                                                                                                                     | Khumo Modiba                                                                         |                                                                                     |
| <b><u>STUDENT NUMBER:</u></b>                                                                                                                                                                   | 1537772                                                                              |                                                                                     |
| <b><u>SCHOOL:</u></b>                                                                                                                                                                           | SEBS                                                                                 |                                                                                     |
| <b><u>DATE CONSIDERED:</u></b>                                                                                                                                                                  | 25 September 2018                                                                    |                                                                                     |
| <b><u>DECISION OF THE ETHICS COMMITTEE:</u></b>                                                                                                                                                 | Approved                                                                             |                                                                                     |
| <b><u>NOTE</u></b>                                                                                                                                                                              |                                                                                      |                                                                                     |
| Unless otherwise specified this ethics clearance is valid for 1 year and may be renewed upon application.<br>Please remember to include the protocol number above to your participation letter. |                                                                                      |                                                                                     |
| <b><u>DATE:</u></b> 11/10/2018                                                                                                                                                                  | <b><u>CHAIRPERSON:</u></b> Jean-Marie Bancelihon                                     |                                                                                     |
| cc: Supervisor:<br>Dr Gild Isaac and Dr Dorina Onyiah                                                                                                                                           |  |                                                                                     |
|                                                                                                                                                                                                 |                                                                                      | <b><u>SCHOOL OF ECONOMIC<br/>&amp; BUSINESS SCIENCES</u></b>                        |

## Appendix B: Research Participation Letter



RE: Research Participation Letter

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Date:

Good Day

My name is Khumo Modiba and I am a Masters student in Development Theory and Policy at the University of the Witwatersrand. I am conducting a case analysis research on the translation and operationalisation of HIV/AIDS policy in Merafong City Local Municipality. The study looks at how the National Strategical Plan is cascaded to the local structures where it is translated into plans and programmes that divide responsibilities among various implementing actors.

As stakeholders and implementers of the HIV/AIDS policy, you are invited to take part in a face to face interview conducted by the researcher. The purpose of the interview is to find out whether Merafong City Local Municipality facilitates the translation and implementation of the National Strategic Plan in a manner responsive to the locality's HIV/AIDS epidemic.

Your response is important and there are no right or wrong answers. This interview is both confidential and anonymous. Anonymity and confidentiality are guaranteed by not needing to enter your name on the consent form or make mention of it at any point during the interview recording. Your participation is completely voluntary and involves no risk, penalty, or loss of benefits whether or not you participate. You may withdraw from the interview at any stage.

The interview questions are open-ended, and the duration of each interview is expected to be 60 minutes. The interview schedule was approved by the School of Economic and Business Sciences (SEBS) Ethics Committee (Non-Medical), Protocol Number: CECON/1120



Thank you for considering participating. Should you have any questions, or should you wish to obtain a copy of the results emanating from the interview, please contact me on:

Email: [1537772@students.wits.ac.za](mailto:1537772@students.wits.ac.za) & Cell number: 072 4652303

My supervisors names and email are: Dr Gilad Isaacs ([gilad.isaacs@wits.co.za](mailto:gilad.isaacs@wits.co.za)) & Dr Dorina Onoya ([donoya@heroza.org](mailto:donoya@heroza.org)).

A handwritten signature in black ink, appearing to read "Khumo Modiba", written over a horizontal line.

Kind regards

Khumo Modiba

## Appendix C: Consent Form for Interview Recording



**Title of research project:** The Implementation of HIV/AIDS Policies in Local Municipalities: A Case Analysis of Merafong City Local Municipality

**Name/s of principal researcher/s:** Khumo Modiba

**Department/research group address:** Economic and Business Sciences, University of the Witwatersrand, Private Bag 3, Wits, 2050

**Telephone:** 27 11 717-8241

**Email:** [1537772@students.wits.ac.za/khumo.modiba88@gmail.com](mailto:1537772@students.wits.ac.za/khumo.modiba88@gmail.com)

**Name of participant:**

**Nature of the research:** Academic research

**Participant's involvement:** Interviewees/Informants

What's involved?

**Benefits:** Help identify gaps that hinder effective planning and implementation of AIDS policy in Merafong City Local Municipality and exploring ways of how to capacitate the process of AIDS policy-making.

**Risks:** None

**I acknowledge the following:**

- I agree to participate in this research project.
- I agree that the interview will be recorded
- I have read this consent form and the information it contains and had the opportunity to ask questions about them.

- I agree to my responses being used for education and research on condition that my privacy is respected, subject to the following:
  - I understand that my personal details will not be personally identifiable.
  - I understand that I am under no obligation to take part in this project.
  - I understand I have the right to withdraw from this project at any stage.

Signature of Participant:

Name of Participant:

Signature of person who sought consent:

Name of person who sought consent: **Khumo Modiba (153772)**

Date:

## Appendix D: West Rand District Municipality – Permission to Conduct Interviews



**WEST RAND  
DISTRICT MUNICIPALITY**



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### **HEALTH & SOCIAL DEVELOPMENT**

#### **Permission to conduct interviews**

**Municipality Name:** West Rand District Municipality

**Date:** 20 September 2018

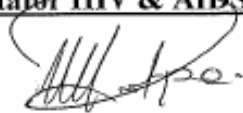
We hereby support Mr. Khumo Modiba's application, a Development Theory and Policy Masters student from the University of the Witwatersrand, to conduct interviews with our clients for a period of 1 month, starting from Monday the 8th of October to Monday the 12th of November.

Permission is granted to Mr. Khumo Modiba subject to his obtaining ethical clearance to conduct research from the Ethics Committee of the University of the Witwatersrand, Johannesburg and by abiding to its terms.

Interviews will be conducted in consultation with the relevant HIV & AIDS Coordinator or manager in charge.

**Name:** Reuben Motsepe  
Facilitator HIV & AIDS Programme

**Signature:**



**Date:** 21 September 2018

## Appendix E: Merafong City Local Municipality – Permission to Conduct Interviews



OFFICE

HIV/AIDS OFFICE

HIV/AIDS CO- ORDINATOR

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E-mail: [SMboniswa@merafong.gov.za](mailto:SMboniswa@merafong.gov.za)

Tel: (018) 788 9545  
Fax: (018) 788 9562

Company Name: Merafong City Local Municipality

Date: 20 September 2018

We hereby support Mr Khumo Modiba's application, a Development Theory and Policy Masters student from the University of the Witwatersrand, to conduct interviews with our clients for a period of 1 month, starting from Monday the 8th of October to Monday the 12th of November. Permission is granted to Mr Khumo Modiba subject to his obtaining ethical clearance to conduct research from the Ethics Committee of the University of the Witwatersrand, Johannesburg and by abiding to its terms.

I have been informed of Mr Khumo Modiba's line of research and of the nature of the intervention (e.g. Respondents participating in a series of interviews).

Name:

Signature:

A handwritten signature in black ink, appearing to be "S. Mboniswa", written over a horizontal line.

## **Appendix F: Interview Schedule**

### ***1 Policy transmission, interpretation, and translation***

- 1.1 Describe the process of AIDS policy transmission from the national to the local level.
- 1.2 Is the process of AIDS policy translation consultative and equally representative of both state and non-state actors?
- 1.3 Do the municipal actors have agency over the choice of AIDS strategy?
- 1.4 What are these strategies and what underlies their choice?
- 1.5 How do you understand these strategies in relation to your roles and responsibilities?

### ***2 Local policy formulation***

- 2.1 What are the behavioural and structural drivers of HIV in the locality?
- 2.2 What can the rising HIV incidence rate be attributed to and how is this problem addressed in policy, plans, and implementation programmes?
- 2.3 How would you define an appropriate response to the drivers of HIV/AIDS in the locality?
- 2.4 What public policies have been formulated to combat the disease?<sup>2</sup>
- 2.5 How effective are the plans?
- 2.6 How do these plans divide responsibilities and reinforce relations between various actors?
- 2.7 How does this relate, frame, or translate into local policy implementation?
- 2.8 Which yardsticks are used to measure plan impact and effectiveness?

### ***3 Implementation and coordination***

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<sup>2</sup> Question 2.4 is drawn from Fourie (2006:174).

- 3.1 Since the implementation of AIDS policy entails a multi-sector and multi-stakeholder collaboration, how are the programmes coordinated?
- 3.2 Who oversees the process of coordination?
- 3.3 How would you describe the channels of communication between the provincial and local structures, and among the local actors in the formulation and implementation of policy?
- 3.4 What kind of support do the provincial structures provide to the local structures during the formulation and implementation of local plans?