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IMPLEMENTATION OF HIV/ADS POLICY IN THE GAUTENG DEPARTMENT OF ROADS AND TRANSPORT

BY

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A RESEARCH REPORT SUBMITTED TO THE WITS SCHOOL OF GOVERNANCE IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR A MASTER OF MANAGEMENT DEGREE IN PUBLIC AND DEVELOPMENT MANAGEMENT

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ABSTRACT

HIV and AIDS impact severely on the capacity of the state, its skills base and the efficient use of public funds to render high quality services to the broad populace. Public sector institutions are under immense pressure to implement policies and programmes to mitigate the impact of HIV and AIDS in the workplace (Public Service Commission, 2006). In this context, the purpose of this research is to assess the implementation of HIV and AIDS policy in the Gauteng Department of Roads and Transport to determine if employees are benefiting from this policy. To accomplish this goal, the study employed qualitative interviews and observations to obtain the necessary data from DRT managers, programme officials and employees in June 2014.

An examination of the data confirmed that efforts had been made to implement the HIV/AIDS policy in the DRT, although the scope and intensity of these initiatives varied across occupational levels. It was found that an internal policy on HIV and AIDS has been developed; some employees had been informed about the risks of HIV and AIDS; some line managers had been trained on HIV/AIDS management; health screening including HIV counseling and testing takes place regularly; employees have access to 24 hour counseling services; and some units had been supplied with educative messages including pamphlets and brochures. However, the findings also revealed gaps in the current implementation
strategy, including limited communications, poor participation in campaigns, lack of leadership commitment, lack of resources and time constraints. In light of this, it was concluded that the current HIV/AIDS management strategy suffers from lack of capacity and coordination.

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DECLARATION

I declare that this is my own unaided work submitted to the Wits School of Governance in partial fulfillment of the requirements for the Master's Degree in Public and Development Management. I further declare that this work has not been submitted to any other university for examination. This work is a culmination of the research conducted in the Gauteng Department of Transport between May and June 2014.

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STUDENT NUMBER 428191

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OCTOBER 2015

DEDICATION

I dedicate this work to beloved husband, Kweku, our lovely children, Takyiwa, Tsholofelo and Bogolo, for their continued support and encouragement. Thank you for the sacrifices you made when you allowed me to spend time away from the family. I thank God the Almighty for giving me the wisdom I needed to complete this assignment.

A special dedication goes to my friend, Selebaleng Selemela, who supported me throughout this journey. To my late parents, Siako and Bella Mathe, thank you for making me realise the value of education. I know you would be proud of me.

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ABBREVIATION AND ACRONYMS

AIDS	Acquired Immune-deficiency Syndrome
ART	Antiretroviral Therapy/Treatment
ARV	Anti-retroviral
ARVT	Antiretroviral Therapy
BCC	Behaviour Change Communication
BRICS	Brazil, Russia, India, China and South Africa
DPSA	Department of Public Service and Administration
DRT	Department of Roads and Transport
EAP	Employee Assistance Programme
GEMS	Government Medical-Aid Scheme
GSP	Gauteng Strategic Plan on HIV & AIDS 2012-2016
HIV	Human Immune-deficiency Virus
HRM	Human Resources Management
HSRC	Human Sciences Research Council
IEC	Independent Electoral Commission
ILO	International Labour Organisation
KAPB	Knowledge, Attitudes, Practices and Beliefs
LRA	Labour Relations Act
M&E	Monitoring and Evaluation
OIs	Opportunistic Infections
PLWHA	People Living With HIV and AIDS
PEP	Post Exposure Prophylaxis
PET	Peer Education and Training
PSC	Public Service Commission
SABCOHA	South African Business Coalition on HIV and AIDS
SANAC	South African National AIDS Council
STDs	Sexually Transmitted Diseases

STI	Sexually Transmitted Infections
VCT	Voluntary Counseling and Testing
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organisation

CHAPTER ONE

1 INTRODUCTION TO THE STUDY

1.1 INTRODUCTION

According to the Public Service Commission (2006), HIV and AIDS impact severely on the capacity of the state, its skills base and the efficient use of public funds to render high quality services to the broad populace. Public sector organisations are under immense pressure to implement policies and programmes to mitigate the impact of HIV and AIDS in the workplace. Against this backdrop, this study was intended to understand the implementation of the HIV and AIDS policy in Gauteng Department of Roads and Transport (DRT). The intention was to determine if employees are benefiting from HIV and AIDS services as they are at the forefront of service delivery.

1.2 BACKGROUND

A worldwide response to address the epidemic was put in place by the United Nations, which many countries have benefitted from. A joint United Nations Programme on HIV and AIDS (UNAIDS) plays a major role in ensuring that nations develop and implement plans to address the epidemic. The role of political leaders in addressing the epidemic through policies and programme implementation has been highlighted as essential by UNAIDS. As one of its objectives, UNAIDS provide leadership and advocacy for effective action on the epidemic. Governments, particularly those struggling to respond positively to the epidemic, are assisted in development and implementation of detailed action plans to fight HIV and AIDS

UNAIDS aims to keep HIV and AIDS at the top of the global and national agendas: promoting effective leadership and intensifying commitment at all levels. Member states of the United Nations General Assembly have all endorsed and signed the Declaration of Commitment on HIV and AIDS. The Declaration has time frames and performance target to be met by nations in the fight against HIV and AIDS. To ensure coordination

and leadership, support is provided to government-led national AIDS Councils established and led by heads of states or their deputies.

Greatest achievements in preventing the spread of HIV and AIDS have been realized by those countries with leadership that demonstrated strong political will and firm commitment to respond to the epidemic as a national priority (Onge'wen Okuro, 2009). It is reported that many countries have accelerated the drive to achieve the United Nations Millennium Goals and the United Nations Political Declarations on HIV and AIDS vision of zero new infections. According to UNAIDS report on the Global AIDS epidemic (2012), domestic investments have, for the very first time, surpassed global funding for AIDS, rising from US$3,9 billion to US$8.6 billion. A total number of 81 countries have increased their domestic investment by 50%, with Brazil, Russia, India, China and South Africa (BRICS countries) partnership jointly leading by contributing more than half of all domestic spending on AIDS in low-and-middle-income countries.

According to the World Health Organization (WHO), there were approximately 35 million people worldwide living with HIV and AIDS in 2013. Of these, 3.2 million were children (<15 years old). In addition, an estimated 2.1 million individuals worldwide became newly infected with HIV in 2013. This includes over 240,000 children (<15 years). Most of these children live in sub-Saharan Africa and were infected by their HIV-positive mothers during pregnancy, childbirth or breastfeeding. A UNAIDS report shows that 19 million of the 35 million people living with HIV today do not know that they have the virus. The vast majority of people living with HIV are in low- and middle-income countries. According to the WHO, sub-Saharan Africa is the most affected region, with 24.7 million people living with HIV in 2013. Seventy-one percent of all people who are living with HIV in the world live in this region (UNAIDS, 2013).

In light of the above, UNAIDS (2014) suggests that if the world is to end the AIDS epidemic by 2030, rapid progress must be made by 2020. Quickening the pace for essential HIV prevention and treatment approaches will limit the epidemic to more

manageable levels and enable countries to move towards the elimination phase. If the response is too slow, the AIDS epidemic will continue to grow, with a heavy human and financial toll of increasing demand for antiretroviral therapy and expanding costs for HIV prevention and treatment. The discussion on global HIV and AIDS trends would not be complete without consideration of experiences from a few countries such as Brazil and the United States.

1.2.1 The Nature of The Epidemic in International Countries

(a) Brazil

Brazil is seen as having one of the best HIV and AIDS prevention programmes in the world. The country has stabilized adult HIV prevalence to around 0, 5% in recent years. This response was initiated by non-government organisations and strongly supported by government. Condom use was vigorously promoted, through explicit mass media campaigns. Combating of homophobia and the stigma related to HIV were other prevention strategies the government introduced to prevent the spread of HIV and AIDS in Brazil (http://www.avert.org/global-hiv-prevention.htm).

(b) United States of America

In the United States, the HIV and AIDS epidemic was first associated most widely with a group that by many definitions was economically advantaged, though often socially stigmatized—white gay males. Partly as a result, research has tended to focus on the psychological and medical plight of infected individuals and has somewhat neglected the employment, economic, and social consequences of the epidemic. But rates of HIV and AIDS infection are now rising disproportionately among low-income black men and women, who have very different social experiences, family circumstances, and employment histories and prospects from those who have historically received the most attention from researchers and policymakers. Researchers are just beginning to ask how they can best address the complex social, economic, and cultural contexts of this

epidemic for economically disadvantaged groups and for racial and ethnic minorities (Johnson & Raphael, 2006).

According to Johnson and Raphael (2006), African Americans represent about 12.5 percent of the U.S. population, but have disproportionately high rates of HIV and AIDS infection. Among black men, the annual rate of infection between 2000 and 2003 was 100 per 100,000, compared to fewer than 15 among non-Hispanic white men. Among black women, the rate of infection (55 per 100,000) was 19 times that among white women, and the numbers carrying the infection were much larger. Rates of infection show little sign of slackening. Blacks accounted for 49 percent of all HIV and AIDS cases diagnosed in 2005.The disparate incidence of HIV infection suggests that groups that have been socially or economically marginalized are particularly vulnerable to HIV and AIDS (Johnson & Raphael, 2006).

In the USA, government response to the epidemic is illustrated by the Ryan White HIV and AIDS Programme (1998-2009), which provides primary medical care including dentistry and support services to individuals living with the disease who lack health insurance or personal financial resources to pay for their own care. For most, it is the “program of last resort," covering those who do not qualify for any other health benefits program, including Medicare or Medicaid. While clinical care and support services are central issues here, the programme also funds training and technical assistance for medical professionals as well as demonstration projects aimed at identifying and slowing the epidemic in high-risk populations.

The services are intended to reduce the use of costly in-patient care, extend screening and treatment into medically underserved populations, and improve the quality of life for those affected by the epidemic. The program achieves these goals by funding HIV and AIDS care and services through grants to state and local governments, health care providers and community- based organizations (Ryan White HIV/AIDS Programme, 1998-2009).

1.2.2 The Nature Of The Epidemic In Southern African Development Countries

One of the greatest challenges facing the Southern African Development Community (SADC) as it moves towards greater integration is the adverse effect of HIV and AIDS on social, political and economic development. The region has the highest levels of HIV infection to be found globally (SADC, HIV/AIDS Framework (2010-2015).

As at the end of 2007, the SADC region had an estimated 12 million People Living with HIV and AIDS (PLWHAs), accounting for about 36% of all PLWHA globally. Additionally, the region accounted for over a third of new infections and AIDS deaths per year. HIV transmission in the region is mainly heterosexual, and an estimated 92% of all infections are attributed to this mode of transmission. HIV is thus most prevalent in sexually active people in the 20-39 year age group. However, infections with HIV, and the effects of illness and deaths due to the epidemic, reach into all age and population groups. The distribution of HIV varies within SADC countries, but urban populations are often more affected than rural communities (SADC, HIV/AIDS Framework, 2010-2015).

More women are infected than men, and they are infected at earlier ages. Young women aged 15-24 years are particularly vulnerable to becoming infected, for biological reasons and also due to social and economic factors. These make them less informed about HIV prevention, less able to insist on safer sex, and more likely to have older sexual partners who are infected already. Currently in sub-Saharan Africa, 76% of young people (15-24 years) living with HIV are female (SADC, HIV/AIDS Framework, 2010-2015).

1.2.2.1 Contributing factors

The effect of these key drivers is reinforced by a range of social circumstances that predispose many SADC communities to high risk of HIV transmission. These include:

a. Cultural practices and social norms conducive to multiple concurrent sexual partners, and intergenerational and transactional sex.
b. Stigma and discrimination, and lack of open communication, around HIV and sex.
c. Gender based violence and male dominance in sexual decision-making
d. High levels of untreated sexually transmitted infections (STI)
e. Alcohol and drug abuse
f. Cultural practices such as, forced sexual initiation of girls or boys.

However, Africa has reduced AIDS-related deaths by one third in the past six years. Countries with concurrent scale up of HIV prevention and treatment programmes are said to be making significant inroads in reduction of new infections at a faster pace than in the past ten years. Achievements made in the past two years are far better than what was achieved a decade ago. According to UNAIDS World AIDS Day report (2012), these positive changes are attributed to the sustained investment and increased political leadership in many nations.

According to UNAIDS Report (2012), in addition to South Africa, other African countries that have put massive injections of funds into health budget include Kenya, Togo and Zambia. Many other middle-income countries are said to be also taking responsibility by funding their AIDS response programmes with large funds. The Kenyan example below illustrates some of the success stories achieved in Africa regarding the fight against HIV/AIDS.

1.2.2.2 Kenya

Kenya is home to one of the world's highest HIV and AIDS epidemics. An estimated 1.6 million people are living with HIV, around 1.1 million children have been orphaned by AIDS and in 2011 nearly 62,000 people died from AIDS-related illnesses. Kenya's HIV prevalence peaked during the late 1990s and, according to the latest figures, has dramatically reduced to around 6.2 percent. This decline is thought to be partially due to an increase in education and awareness, but also from high death rates. Whilst many people in Kenya are still not being reached with HIV prevention and treatment services,

access to treatment is increasing. 72 percent of adults who need treatment are receiving it, with around 200,000 additional people on treatment in 2011 than in 2009.

A principle aim of the 2009/10-2013/14 Kenyan National HIV and AIDS Strategic Plan (KNASP III) is to reduce the number of new HIV infections by using evidence-based approaches to HIV prevention. Six main outcomes are outlined to be achieved in the latest Strategic Plan:

a. Reduced risky behaviour among the general, infected, most-at-risk and vulnerable populations.
b. Proportion of eligible PLHIV (people living with HIV) on care and treatment increased and sustained.
c. Health systems deliver comprehensive HIV services.
d. HIV mainstreamed in sector-specific policies and sector strategies.
e. Communities and PLHIV networks respond to HIV within their local context.
f. KNASP III stakeholders aligned and held accountable for results.

Following a study in 2009, it was identified that the epidemic was changing and that transmission between discordant couples, where one partner is positive and one partner is negative, accounted for the majority of new infections. As a result, prevention for positive people is to be a central element of Kenya's new approach to prevention which will, among other approaches, include couple-based testing and encourage partner disclosure and condom use (http://www.avert.org/hiv-aids-kenya.htm).

1.2.2.3 South Africa

In South Africa, there has been a rapid transition from the failed leadership of former President Thabo Mbeki and the failed policies of the former minister of health Tshabalala-Msimang to the much desired leadership shown by health minister Aaron Motsoaledi and his predecessor, Barbra Hogan. The two ministers have brought tremendous changes and took decisive actions by accelerating spending on

antiretroviral drugs and developing the new strategic plan 2012-2016. South Africa has since demonstrated exceptional strategic leadership by becoming a leading country that has made the highest domestic investment in AIDS among all low and middle income countries, investing US$1, 9 billion in 2011 from public sources, and resulting in a five-fold increase between 2006 and 2011. Various sectors including business, civil society, non-government, and lobby groups have put measures in place to contribute towards the reduction of the impact of HIV and AIDS.

The latest Strategic plan (NSP) 2012-2016 on HIV and AIDS, STI and TB was launched in 2012 to provide policy guideline on managing HIV and AIDS in the country. The main goals of NSP 2012-2016 are: to reduce new infections by 50%, to provide treatment and care to 80% of the people in need, to halve the number of new TB infections and deaths resulting from TB, to ensure that the rights of people living with HIV are protected, and halving the stigma to HIV and TB (NSP 2012-2016).

1.2.2.4 Overview of HIV and AIDS policy in the Public Service

In South Africa, the Public Service is the largest employer, with approximately 1.1 million employees – with about 30% of employees in national departments, and 70% in provincial departments. Women now constitute 51% of the total Public Service, only one per cent short of their proportion in the total population. The Department of Public Administration has developed a National Strategic Framework on Employee Health and wellness and called for all government departments to commit to the implementation of this framework. Government department are required to commit to implementation of the NSP 2012-2016 by developing an operational plan and mainstream HIV and AIDS in its core mandate. It has further developed a National Policy on HIV and AIDS, STI and TB. It is therefore required that department specific HIV and AIDS policies are developed and implemented in line with the DPSA policy framework

1.2.2.5 Overview of HIV and AIDS policy in Gauteng

Gauteng Provincial government has established a provincial AIDS Council where all heads of departments, Members of Executive Councils, representatives from civil society and non-government organizations are members. Local AIDS Councils also exist at local levels of all municipalities. AIDS councils are responsible for provision of leadership and political oversight in the province and local level. A multi-sectoral approach, led by the Department of Health Provincial has been adopted by Gauteng Provincial Government in strengthening partnership and joint effort in addressing HIV and AIDS.

The Gauteng Strategic Plan (GSP) on HIV, TB and STIs for 2012 to 2016 is the framework for implementation of a focused response to the HIV, STIs and TB epidemics in Gauteng province. The goals of the GSP are to:

a. Reduce the rate of new HIV infections by at least 50% using combination prevention approaches;
b. Initiate at least 80% of eligible patients on antiretroviral treatment (ART), with 70% alive and on treatment five years after initiation;
c. Reduce the number of new TB infections, and TB deaths by 50%;
d. Ensure an enabling and accessible legal environment that protects and promotes human rights in order to support implementation of the GSP; and
e. Reduce self-reported stigma and discrimination related to HIV and TB by 50%.

In terms of this Strategy, all departments should implement internal workplace responses through employee wellness programmes, and also “mainstream” HIV and TB externally into its core business. The mainstreaming of HIV/AIDS into the main programmes is of particular significance to the study as it provides the basis for determining whether there is a link between HIV/AIDS management policy and the strategic goals of the DRT. More is said on this point in chapter five.

Against this backdrop, this research sought to assess the implementation of the HIV/AIDS policy in the DRT in order to determine opportunities and constraints in this

regard and to see if employees benefited from these services. The next section explains HIV/AIDS policy implementation in DRT.

1.2.3 Gauteng Department Of Roads And Transport

DRT has developed an HIV and AIDs policy in line with the provisions of the provincial government and DPSA. A dedicated unit, known as Employee Health and Wellness, has been established within the human resource directorate to implement this policy. The team is constituted by health professionals and administrators who work in collaboration with the Transversal Employee Health and Wellness Unit in the Department of Finance, the Transport Sector HIV and AIDS Response forum managed by the National Department of Transport; and the Multi-sectoral AIDS Unit in the Department of Health. Externally, a partnership has been established with the taxi and bus industry councils to implement the policy in this industry as part of mainstreaming of HIV and AIDS in the core business of the department. The policy is implemented throughout the organization with the assistance of regional coordinators (both internally and externally) and peer educators. DRT has a staff compliment of 1 200 employees in 16 regional and head offices throughout the province.

The main objective of the HIV departmental policy is to provide guidance in responding to the epidemic in the manner that (i) Provide prevention strategies and programmes where all employees in DRT are actively participating; (ii) Educate the departmental staff about HIV and AIDS, STIs and TB; (iii) Create a non-discriminatory environment in the workplace; (iv) Create a safe working environment for all staff members by reducing risks related to HIV and TB; (v) Strengthen partnerships with other government departments and key stakeholders in the transport sector; and (vi) Establish and implement a research agenda.

Purpose of the policy

To outline the commitment of Gauteng Department of Roads and Transport towards HIV and AIDS,STI and TB and its planned activities in compliance with the DPSA

and all legislative frameworks and protocols within the public service and other key international protocols.

Scope of applicability

The policy is applicable to the employees of the Department as well as Transport sector partners.

Objectives

To provide guidance in order to:

- ✓ Provide prevention strategies and programmes where all employees in the Department are actively participating
- ✓ Educate the Departmental staff about HIV and AIDS, STI and TB
- ✓ Create a non-discriminatory environment in the workplace
- ✓ Create a safe working environment for all staff members by reducing risks related to HIV and TB
- ✓ Strengthen partnerships with other government departments and key stakeholders in the transport sector
- ✓ Establish and implement research agenda

Principle

The following is a summary of policy principles:

- Respect for human rights and dignity
- Non-discriminatory workplace practices
- Recognition of HIV and AIDS, and TB co-infection as a workplace issue
- Confidentiality
- Gender mainstreaming
- Healthy and safe work environment
- Alignment to national protocols
- Continuity of care and partnership

Implementation: roles and responsibilities

The head of the Department

Head of the Department is responsible for, (a) establishing the steering committee for the department with representation from all stakeholders including organized labour, (b) ensuring that all interventions in the NSP 2012-16 that aims at reducing the number of new infections through education and increasing access to HIV testing are supported in the workplace, (c) designate a member of the senior management with adequate skills and seniority and support to implementation of the HAST programme, (d) allocate adequate human and financial resources to implement the policy.

The designated senior manager

The designated senior manager is responsible for the following;

a. Establish HAST steering committee and obtain stakeholder commitment and

development
b. Act as a chairperson of the steering committee in the absence of the HOD
c. Assist in popularizing the policy within the organization and its stakeholders
d. Ensure alignment of the policy to strategic objectives of the National Strategic Plan
e. Manage and liaise with external service providers
f. Develop monitoring and evaluation tools
g. Ensure adequate financial resources

The HAST specialist is responsible for:

- Planning, monitoring and managing the workplace programme
- Ensure availability of condoms and other promotional material
- Arrange HIV counselling and testing for employees and their immediate families
- Coordinate peer education programme
- Develop standard operating procedures on key health issues like universal precautions

The HAST steering Committee is responsible:

1. Coordinating, collaborating and communicating issues pertaining to HIV, AIDS, STI and TB
2. Monitor implementation of the policy and strategies of the departmental HAST initiatives
3. Lobbying for provision of resources needed for implementation of the programme
4. Propose the development of HAST research agenda

The peer educators and coordinators are responsible for the following:

a. Implement awareness activities within the department
b. Facilitate HIV, AIDS, STI and TB peer education activities within the department
c. Assist in distributing IEC material and condoms
d. Informally refer employees to relevant personnel as well as programmes within and outside the department
e. Provide monthly report

Implementation of this policy focuses on both employees (through internal programmes) and the taxi, truck and bus drivers (through external programmes).

Mission and Vision of the DRT

Mission

To promote accessibility and the safe, affordable movement of people, goods and services and to render efficient and cost-effective public works services in Gauteng.

Vision

An integrated transport system and a client-centered public works service which satisfies the needs of the people while supporting and facilitating social and economic growth and the development of all the people of Gauteng.

The core functions and responsibilities of the department have been defined as:

- Manage transport infrastructure
- Manage transportation management
- Render a public works service to the Province

Strategic objectives of the DRT

a. To sustain delivery for economic growth and development
b. To target areas and groups for poverty alleviation, social and economic up-liftment
c. To maintain capital infrastructure investment for optimal resource utilization
d. To enhance financial accountability through budget control and elimination of fraud and corruption
e. To develop mechanisms for communication, monitoring and feedback
f. To implement institutional transformation through targeted programmes of affirmative action and human resources development

It is important to note that the department is currently in the process of reviewing its strategic plan. The inclusion of poverty alleviation, development, and human resource development strategic goals provide an ideal opportunity to determine if these are aligned with the implementation of the HIV/AIDS policy to ensure success and sustainability of HIV/AIDS services within the DRT. The analysis in chapter five sheds more light on this point.

In addition to the above, the Compliance with the Minimum Standards on HIV/AIDS states that a head of department shall introduce appropriate measures for monitoring and evaluating the impact of the health promotion programme among the employees of the department. This principle suggests that government departments should conduct monitoring and evaluation activities to determine whether HIV/AIDS programmes are achieving the desired outcomes and take corrective action to mitigate gaps to enhance policy practice. The analysis in chapter 4 sheds more light on this point.

1.3 PROBLEM STATEMENT

In the South African Public Service many HIV and AIDS policies and programmes have been implemented with varying levels of success. While in some of the Public Service departments very little has been done to mitigate the impact of HIV and AIDS, in others there are best practice case studies of what can be achieved through committed effort. According to human rights principle, for programming to be meaningful, it must be available, accessible, acceptable and of high quality (DPSA, 2011). Participation is said to be a critical first step to ensuring that the groups that are differently affected by the epidemic are meaningfully involved in the development, execution and evaluation of AIDS strategies (DPSA, 2011). HIV interventions must be evidence-informed and adapted to the relevant epidemiological, economic, social, and structural contexts in which they are implemented.

According to DPSA (2011), public sector response to the HIV/AIDS and TB epidemic is not aligned with the nature and character of heterogeneous local HIV/AIDS and TB epidemics. The sector is not resourced, engendered, right based and not addressing both internal and external dimensions of mainstreaming as defined by the UNAIDS and provided in the HIV/AIDS Management policy for public service. A “know your epidemic” and “know your response” campaign were deliberately put in place for the country to begin to address not only the biomedical response but also the social and structural interventions to address the drivers of the epidemic. It is therefore important for DRT to constantly evaluate implementation of its policy to align it with the provision of the

national policy on HIV/AIDS and determine its success and failures on the extent to which this is done. In addition, regular feedback on implementation is crucial in developing appropriate interventions for the beneficiaries. Currently in DRT, little is known about how successful implementation of HIV/AIDS policy has been.

1.4 PURPOSE STATEMENT

In light of the above, the purpose of this research is to assess the implementation of HIV/AIDS policy in the DRT to determine if employees benefit from this intervention. The study hopes to provide valuable insights and lessons that may enhance HIV/AIDS policy practice in government departments.

1.5 RESEARCH QUESTIONS

The research aims to address the following questions:

a. To what extent is HIV/AIDS policy implementation in DRT successful?
b. What are the trends in the implementation of HIV/AIDS policy in the DRT?
c. What are the experiences of employees regarding HIV/AIDS implementation in the DRT?
d. What can be done to improve implementation of this policy?

1.6 SIGNIFICANCE OF THE STUDY

This study will contribute towards implementation of the HIV policy as stipulated by the DPSA. The study will also provide valuable insights on opportunities and constraints faced by the DRT in managing HIV/AIDS in the workplace and possible solutions to enhance policy practice in future. It will contribute towards a progress review since the previous study conducted by Human Sciences Research Council (HSRC) in 2012. It also serves as a benchmark for DRT as HSRC study focused on the entire province. This study will contribute towards the “know your response” campaign by providing beneficiaries with opportunity to participate in influencing programming, which is a

critical step in developing appropriate response. At academic level, this research contributes towards understanding models of policy development and evaluation and important aspects of managing people.

1.7 SUMMARY OF THE CHAPTERS

Chapter one introduces the study by explaining its context and purpose regarding the implementation of HIV/AIDS policy in the DRT.

Chapter two reviews the literature on HIV/AIDS management to provide a conceptual and theoretical framework for the study and to inform the analysis in chapter five.

Chapter three outlines the methodology applied to achieve the goals of the study, with particular emphasis on qualitative approach, sampling, case study, and interviews.

Chapter four presents and explains the data on the implementation of HIV/AIDS policy in the DRT and provides a summary of the key themes emerging from these data

Chapter five analyses and interrogates the data to determine if HIV/AIDS policy is being implemented in accordance with national policy and relevant theoretical principles

Chapter six rounds up the discussion by providing conclusions and recommendations on the implementation of the HIV/AIDS policy in the DRT, and highlights future research

1.8 CONCLUSION

Chapter one has provided an overview of HIV and AIDS including global trends, and best practices in addressing the epidemic. The chapter has presented the context and rationale for assessing the implementation of the HIV/AIDS policy in the DRT. HIV/AIDS, it was argued, has a devastating impact on productivity, staff morale and skills formation in the workplace. The DRT has a mandate to provide efficient and

effective transport services to the people of Gauteng and for this reason it cannot overlook the negative impact of HIV/AIDS on its workforce. It is precisely this challenge that prompted the researcher to look at how HIV/AIDS policy is implemented in the DRT and to see if these services benefit the workforce. The next chapter focuses on the literature review.

CHAPTER 2

2 LITERATURE REVIEW

2.1 INTRODUCTION

While chapter one explained the background and purpose of the study, this chapter provides the conceptual and theoretical framework of the study. It scans the literature with a view to explore further contributions to the existing knowledge on the implementation of HIV/AIDS policy; what is already known about the HIV/AIDS epidemic and the approaches used to manage HIV/AIDS in the workplace.

According to Leedy and Ormrod (2010), the literature review is the process of reading, analyzing, evaluating and summarizing scholarly material regarding a specific topic. Literature review describes the theoretical perspectives and research findings of others. Its main function is to look again at what other researchers have done about the topic. It provides one with a broader perspective about the topic and related subjects

Reading the work of other people provides the following benefits: It provides new ideas, perspectives and approaches, provides more information about what others have done in the area and who to contact for advice or feedback, it broadens one's perspective and sets work in context, it helps to legitimize the arguments, it assists in providing effective criticism and bolsters one's confidence about the worth of the study (Leedy, 1997; Blaxter, Hughes, & Tight, 2010).

2.2 DEFINITION OF KEY CONCEPTS

According to Miles and Huberman (1984) a conceptual framework is the current version of the researcher's map of the territory being investigated. In this study, it is important to unpack and contextualize the concepts of HIV/AIDS. Similarly, Robson (1993) notes that the conceptual frameworks help the researcher to be selective; to decide which

are the important features; which relationships are likely to be of importance or meaning; and hence, what data you are going to collect and analyse.

Human Immunodeficiency Virus is abbreviated as HIV. AIDS is Acquired Immune Deficiency Syndrome. It is a relatively new disease that was first diagnosed in 1981, and its cause was only determined in 1984. HIV is transmitted through body fluids. It has a window of 5-15 years. During this period, persons carrying the virus may affect many others. HIV differs from other epidemics and requires a broader and different approach in how to deal with it (Du Toit, Knipe, Van Niekerk, Van Der Waldt & Doyle, 2002). There is currently no cure for HIV and AIDS, however, available treatment, known as antiretroviral treatment is yielding positive results in slowing disease progression

HIV and AIDS and its effect on the human body, society and family members

HIV affect two main types of cells in the human immune system: the lymphocytes, particularly the CD4 lymphocytes and the monocytes. The CD4 cells' function is to regulate the immune system, whilst the monocytes' function is to rid the body of foreign proteins. These results in the immune system being enable to mount an immune response against an attack (Murphy, R.L., Taiwo, B. O., and Flaherty J.P.2009).If a person is HIV infected; the virus replicates itself in these cells without causing any harm, resulting in a reservoir of infectious virus in the body. The presence of the virus has devastating effects on the body and depletes the human immune system. This immunosuppression state leads to profound conditions which include profound weight-loss, chronic diarrhea or chronically elevated temperatures and many other opportunistic infections, which will ultimately cause death. The most common infections are Herpes, shingles, TB and pneumonia (Murphy, R.L. et al, 2009).

According to Schoub(1999), HIV and AIDS has devastating effects on infected individuals as well as their families. It puts a strain on the health care systems of resource poor countries and non-industrialized societies. The response to the pandemic is complicated by a combination of socio-psychologic effects of the diagnosis, the

economic impact on society and the political-public policy implications of the pandemic.

2.2.1 The Impact Of HIV In The Workplace

The National Policy on Managing HIV in the Workplace (2002) outlines the impact of the epidemic in the workplace as follows:

Morbidity and absenteeism

Absenteeism due to sick leave may rise in an organization. More qualified and experienced workers affected by the disease create a gap in service delivery. Employees, particularly women, are over burdened by having to take care of their sick family members in addition to their work,

Mortality and retirement

Loss of skilled workers results in organisations having to recruit and retrain other people to continue with the work. Costs related to death and retirement benefits increase expenditures.

Staff morale

HIV negatively impact on staff morale. It creates fear amongst employees to participate in HIV education for fear of stigma and discrimination.

Benefits

Increased costs of benefits such as medical aid become a burden for both employer and employees.

2.2.2 Epidemiological Scenarios Of HIV

Knowing who is at risk with HIV, the extent to which HIV is prevalent amongst different population groups, and the risk behaviours, laws and policies that may facilitate the transmission of HIV is key to planning an effective HIV prevention response (UNAIDS). UNAIDS categorizes the epidemic in our scenarios, namely: low level, concentrated, generalized and hyper endemic.

Table 1 Monitoring and Evaluation of Prevention Programmes for “Most –at-Risk populations"

Scenario	Nature of the scenario
Low level	In this scenario, HIV has not spread to significant levels in any sub-population. Networks are either diffused or virus has been lately introduced. Basic information on the most vulnerable and risk populations is needed
Concentrated	HIV is high in one or more sub-populations (such as men having sex with men, commercial sex workers and their clients) but the virus is not circulating in the general populations. The future of the course will be determined by the size of the sub-population and the extent to which they interact amongst each other or with the general population
Generalized	The epidemic is prevalent in more than one percent of the general population. Serodiscordant couples and multi partners’ relationships give rise to sexual networks. In generalized epidemic where adult prevalence is more than 5%, no sexually active person is at low risk
Hyper endemic	HIV is established in the general population, yet differences in both the level and the drivers and risk factors of the epidemic require additional strategies for effective HIV prevention. HIV has spread to a level above 15% in the adult population, through extensive heterosexual multiple concurrent partner relations with low and inconsistent condom use. All sexually active persons have an

	elevated risk of HIV infection. The drivers and risk factors of this predominantly heterosexual epidemic are complex and diverse, but may include behaviours such as early sexual debut, high levels of longer-term multiple concurrent sexual partnerships—especially for men, inter-generational sex, gaps in consistent condom use with casual and longer-term partners, low acceptability of condom use in cohabiting couples and biological co-factors such as low levels of male circumcision and the presence of sexually transmitted infections especially viral infections which are difficult to treat

(Source, UNAIDS, 2006)

South Africa is one of the countries with generalized hyper endemic epidemic. This means that policy must not just address HIV in general but have specific intervention for various key populations

2.2.3 HIV Key Populations

Key populations are essential partners in addressing the HIV dynamics in a specific setting. The World Health Organisation and UNAIDS define key population as population disproportionately impacted by HIV when compared with the general population. Key populations are divided into vulnerable and most at risk populations. Gay men, men having sex with other men, women and men who inject drugs, sex workers and transgender people are regarded as the most at risk population. Vulnerable population is defined as people who are most vulnerable to HIV in certain circumstances or settings. These are adolescent, particularly girls, orphans, prisoners, migrant workers and mobile population. In South Africa, people with disabilities, people living along the corridors, truck drivers and people living in informal settlement are classified as vulnerable population. People living with HIV are regarded as key population in all contexts of HIV epidemic.

It is important to note that DRT core mandate include road construction, road maintenance and development of public transport policy. In its settings, the above-

mentioned populations such as truck drivers, taxi drivers, sex workers and people living along the corridors and in informal settlement are stakeholders.

2.2.4 HIV Mainstreaming

HIV mainstreaming is defined as the process through which development actors effectively and sustainably address the causes and consequences of HIV as they relate to their area of work through adapting and improving their workplace practices and their core mandate (UNAIDS, 2004).

SADC outlines mainstreaming as doing the following

- Understand the impact of the epidemic and the impact of development efforts on the epidemic, including the aspects of development that facilitate and mitigate the spread of HIV
- Place the response to HIV in the core agenda of the public and private sector of all SADC member states, so that it is integrated into their normal routine function
- Use comparative advantage of different stakeholders to put in place strategies and programmes to address the epidemic, and
- Recognize the complementarities amongst the stakeholders and their mandates as a prerequisite for preventing duplication and ensuring that money works optimally.

This definition provides guidelines on how government departments must implement HIV policy both internally and externally.

Mainstreaming is also defined as taking ownership of adequate prioritization of HIV/AIDS interventions in the day-to-day activities of all sectors of society (Kenyon, Heywood & Conway; 2001)

Barriers to HIV mainstreaming

The following are defined as barriers for HIV mainstreaming (DPSA, 2012):

- Perception that AIDS is a health issue
- Lack of knowledge about HIV and AIDS
- Denial in the face of enormity of the epidemic
- Limited capacity, particularly human resources
- Reluctance to take unfunded mandates
- No processes to identify comparative advantage

2.2.5 HIV Counseling And Testing

Voluntary counseling and testing is described as a process of learning about one's HIV status. It is a voluntary process and should adhere to what is referred by WHO as five C's. These are: Consent, Confidentiality, Counseling, Correct test result and Connections to care, treatment and prevention services. There are now many different approaches to providing community HIV testing and counseling. Provider-initiated testing and counseling is HIV testing recommended by a health care provider in a clinical setting while a client-initiated testing is HIV testing undertaken by an individual and is often provided in a community setting. All forms of HIV counseling and testing should be voluntary and adhere to the five C's described earlier (UNAIDS, 2013.)

Combination prevention refers to a combination of behavioural, biomedical and structural approaches to HIV prevention to achieve maximum impact on reducing HIV transmission and acquisition (UNAIDS, 2013; WHO)

Benefits of HIV Counseling and Testing

HIV testing and counseling is one of the important prevention strategy in HIV epidemic. Gersovitz (2011) outlines benefits that can be derived from knowing one's HIV status as follows:

- For a person testing HIV positive:
- It can be used to stop the spread to either a spouse or other partner
- The information can be used to initiate prenatal treatment in women (PMTCT)
- It is a prerequisite for timely treatment
- It can be used for planning for the future. For example a decision about provision for family or having children can be made
- HIV negative people can use this information to increase effort to remain negative. Trust between a couple can be reinforced

Deterrents for testing

According to Gersovitz (2011) people are at all times faced with having to take decisions about whether to test for HIV or not. Stigma and discrimination is still a major deterrent for HIV testing. The majority of people fear for being discriminated or being rejected by their loved ones. UNAIDS HIV report (2013) highlighted stigma and discrimination as one of challenges still faced by many countries. According to Gersovitz, HIV negative people may want to break a marriage with a spouse who is HIV positive. People may feel that interacting with someone presumed to have a shortened life span is of less value to them. HIV negative people may make inferences about past sexual history of their HIV positive partner.

Having defined the conceptual framework underpinning the study, attention will now be focused on the approaches used to implement public policy. An understanding of these approaches is important here as the study attempts to assess the implementation of HIV/AIDS policy in a specific organisation (i.e. Department of Roads and Transport).

2.3 LEGISLATIVE FRAMEWORK

There are a number of important labour statutes, though only one of them, the Employment Equity Act, specifically refers to HIV and AIDS. However, all are general enough to cover most HIV and AIDS related problems that may arise in the workplace. These Acts apply to all employees except those employed by the South African National Defence Force, the National Intelligence Agency and the Secret Service. The relevant labour statutes are covered in the table below.

Table 2 Laws Linked To HIV/AIDS Management In The Workplace

Legislation	Implications for HIV/AIDS management in the workplace
The Employment Equity Act, No. 55 of 1998,	Ensuring equality and non-discrimination in the workplace through anti-discrimination measures and affirmative action provisions. It also has two clauses which expressly refer to HIV/AIDS:A prohibition on unfair discrimination based on 'HIV status'; and a prohibition on HIV testing without Labour Court authorisation.
The Labour Relations Act, No. 66 of 1995,	Regulates the relationships between employees, trade unions and employers, for example by setting out when trade unions may meet with their members at the workplace. It also regulates the resolution of disputes between employers and employees and sets out the rights of workers with regard to dismissal.
The Occupational Health and Safety Act, No. 29 of 1996,	Places a duty on all employers to ensure that, as far as is reasonably practicable, the working environment is safe and healthy for employees. For example, employers are required to provide safety equipment such as latex gloves to prevent the transmission of HIV during an accident involving a blood spill in the workplace.
The Compensation for Occupational Injuries Act, No. 130 of 1993	Gives every employee the right to apply for compensation if injured in the course and scope of their employment. This would include compensation for HIV infection if it can be shown that the employee was infected in the course and scope of their employment.
The Promotion of Equality and the Prevention of Unfair Discrimination Act, No. 4 of 2000,	Sets out measures for dealing with various forms of unfair discrimination and inequality. It also sets out the steps that must be taken to promote equality. This Act is broad enough to cover unfair discrimination based on HIV status. It applies to all agencies, including those not covered by existing labour legislation, namely the SANDF, the Secret Service and the National Intelligence Agency, providing protection against discrimination against employees living with HIV/AIDS.
The Medical Schemes Act, No. 131 of 1998,	Regulates medical schemes. It provides that a medical scheme may not unfairly discriminate, directly or indirectly, against any person on the basis of their HIV status. This Act also allows the Minister of Health to gazette a minimum standard of benefits to be provided to members of the medical scheme.

Source: DPSA, 2002

Guiding policies

There are a number of policies that define good practice related to aspects that have HIV/AIDS implications. These include:

Table 3 Guiding Principles

Policy	Implications for HIV/AIDS management in the workplace
The Code of Good Practice on Key Aspects of HIV/AIDS and Employment	Attached to both the Labour Relations and Employment Equity Acts, this Code is essentially a standard setting out the content and scope of an appropriate response to HIV/AIDS in the workplace. The Code has two objectives: To set out guidelines for employers and trade unions to implement so as to ensure that individuals infected with HIV are not unfairly discriminated against in the workplace; and To provide guidelines for employers, employees and trade unions on how to manage HIV/AIDS within the workplace.
The Code of Good Practice on Dismissal,	Is also linked to the Labour Relations Act and provides guidelines, for example, on when and how an employer may dismiss an employee for incapacity.
The Draft Code of Good Practice on Key Aspects of Disability and Employment,	This code gives detailed guidelines on how to accommodate disabled employees, such as those with advanced HIV disease and how to adapt their working environments.

Source: DPSA, 2002

2.4 THEORETICAL FRAMEWORK

According to Vithal and Jansen (2010), a theoretical framework could be described as a well-developed, coherent explanation for an event. The aim of having a theoretical framework is to locate the research, that is, to signal where the research is coming from; to test a theory, that is, to assess the validity of a theory's propositions in the study being undertaken, or to apply a theory, that is, to use a theory's propositions in the design and conduct of the study. This section outlines the theoretical framework underpinning the implementation of HIV/AIDS policy within the context of the DRT.

2.4.1 Models for the Implementation of HIV/Aids Policy in the Workplace

As defined by Buse, Mays, and Walt (2005), policy implementation is the process of turning policy into practice. However, it is common to observe a gap between what was

planned and what actually occurred as a result of a policy. Anderson (1998) states that policy implementation can have unintended consequences, which is why managers need to understand the various approaches and alternatives to policy implementation.

2.4.1.1 HEIDS six-step model for implementing HIV/AIDS policy

A six-step model has been suggested to help improve implementation of HIV/AIDS programmes in the workplace (HEIDS, 2010). Apart from its relevance to the DRT, this model also shows clearly, the specific action steps that need to be taken at each stage to ensure effective implementation of HIV/AIDS programmes, as outlined below.



Figure 1- HEIDS Six-Step Model for Implementing HIV/AIDS Policy
Adapted from the HEIDS, 2010

Area 1: Strategic Leadership, Decision-Making

First, an executive champion is appointed to handle HIV and AIDS within the organisation and this is reflected in their job description and performance agreement. Second, an HIV and AIDS Workplace Coordinator is assigned and this is reflected in the job description and performance agreement of the position. Third, an audit is conducted regularly to ensure that HIV and AIDS activities go according to plan. Fourth, an annual HIV and AIDS Strategy is developed and implementation is written into the role and responsibilities of the person responsible for HIV and AIDS programme coordination. HIV and AIDS becomes a budget line item and a budget is given annually as part of the normal budget process. Reporting structures are in place to monitor the HIV and AIDS initiative within the organisation. Lastly, the development and implementation of an annual HIV and AIDS Communication plan is assigned to a staff member as part of the job description and performance agreement. An audit of all policies has been done to ensure the HIV and AIDS issue has been included (HEIDS, 2010).

Area 2: Research and Analysis

A situational analysis is a tool used in order to establish current activities that are being implemented in the organisation and identifying any gaps that might exist in the provision of HIV/AIDS management services. Ultimately the situational analysis will be used as a benchmark at the end of the programme to assess progress. Specifically, the situational analysis enables management to determine where the organisation is in terms HIV/AIDS service needs, funding requirements, roles and responsibilities, implementation and support structures, readiness and skills for HIV/AIDS management. Information and inputs from this process informs programme design and development. Areas to be analysed include the following:

- ✓ Financial impact
- ✓ Current HIV and AIDS practices and interventions
- ✓ Current and potential resources for an intervention
- ✓ Institutional and individual's perception of the impact of HIV and AIDS
- ✓ HIV prevalence
- ✓ Risk profile of the institution

The important principle highlighted in this model is that you cannot manage what you cannot measure (HEAIDS, 2010).

Area 3: Workplace HIV and AIDS Policy

The implementation process begins with formulation of an appropriate HIV/AIDS policy. Here, senior management work jointly with all key stakeholders to develop the HIV/AIDS policy based on national and provincial policy guidelines and strategies and communicate this to all levels of the organisation. As indicated in chapter one, the DRT does have an HIV/AIDS policy in place, although the degree of success in this regard cannot be confirmed as yet.

Area 4: HIV and AIDS Prevention Programme

This stage involves providing training to managers and peer educators at all levels of the organisation. This training sensitises these stakeholders about HIV/AIDS management issues and equips them with relevant skills so that they may be able to provide HIV/AIDS services in their respective functions or units as planned. After the training, members spread the message in their units to improve understanding of HIV/AIDS in the workplace.

Area 5: Provide HIV and AIDS Treatment programmes

This stage entails conducting a voluntary HIV testing campaign and referring affected employees to treatment programmes. Again, this requires proper dissemination of relevant information so that all employees know where and how to access treatment and support services in the organisation.

Area 6: Monitoring and evaluation programme

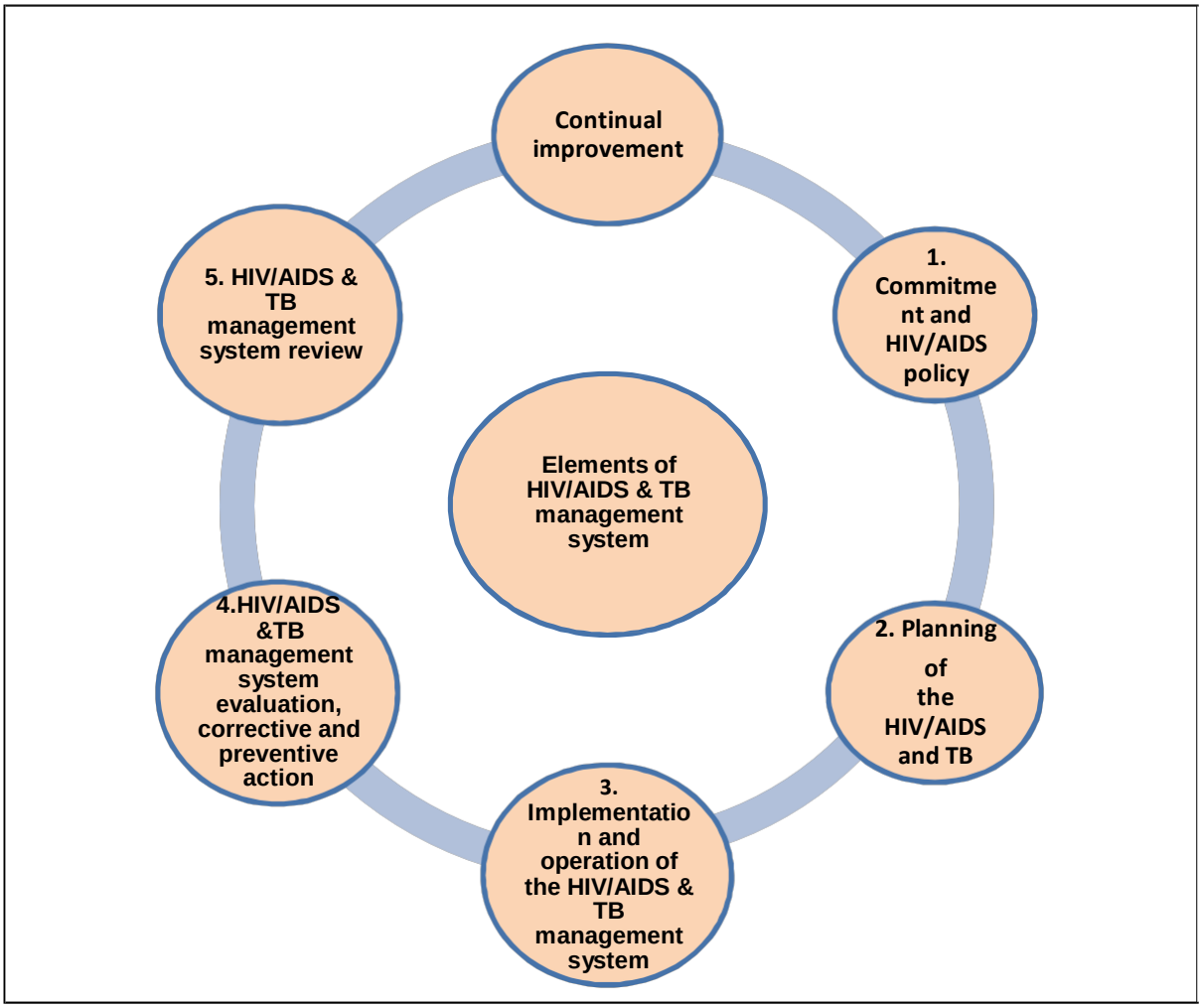
The Monitoring and evaluation programme involves assessing and re-planning HIV/AIDS programmes annually to ensure that they remain relevant and that they adequately address the needs of stakeholders at all levels of the organisation.

Relevance to the six key performance areas mentioned above, suggest that implementation of the HIV/AIDS policy in the workplace requires a systematic and holistic approach involving senior management, support structures, supervisors and employees at all levels of the organisation. Most importantly, communication should permeate all levels to ensure that managers and employees understand their roles and responsibilities in the HIV/AIDS programme.

2.4.1.2 Public Service HIV/AIDS and TB Management Policy and Its Implementation Guide

Implementation of HIV/AIDS and TB management policy is guided by the Public service HIV/AIDS step-by-step guide provided in the policy as developed by DPSA. This model is based on the current legislation and various policies of government. The policy forms part of the Public Service Employee Health and Wellness Framework. This framework was developed as a result of a review of previous EAP model which was found lacking integration of all aspects of wellness. Consultation with various stakeholders including employees, EAP practitioners, health professionals, health risk companies and managers in the public service were held (DPSA, 2002). Like HEAIDS model, the DPSA has provided a step-by-step guide into implementing HIV/AIDS and TB management policy which has the following elements:

Figure 2 - Element of the HIV/AIDS & TB management system



Source: DPSA, 2002

Element 1: Commitment and HIV/AIDS and TB management policy

The department is required to develop a policy on HIV/AIDS and TB management which should be authorized by the Head of the Department. Such policy should reflect the following:

- ✓ Be appropriate to the nature and scale of the organisation's HIV related risks
- ✓ Address assistance to employees and their immediate family members, spouses, children and orphans
- ✓ Include commitment to continual improvement and compliance with current applicable legislation

- ✓ Address workplace issues such as recruitment, performance evaluation, grievance procedures and benefits
- ✓ Be communicated to all parties
- ✓ Be reviewed periodically

Element 2: Planning of the HIV/AIDS and TB management system

Ongoing risk assessments and other relevant audits are important in identifying factors that subtly promote the possibility of HIV/AIDS and TB risk exposure. This is applicable to all work of the department including activities, products and services that may impact on the HIV/AIDS and TB management system. Necessary education measures should be put in place to address such exposure.

Element 3: Implementation and operation of the HIV/AIDS and TB management system

Implementing and operationalising the system include establishing structures with clearly defined roles and responsibilities, developing and implementing education and awareness programmes, communicating and documenting all the work done. Operational controls and emergency planning and response plans are other activities for implementation.

Element 4: HIV/AIDS & TB management system evaluation, corrective and preventive action

Departments are encouraged to put monitoring measures in place to measure the performance of the system. Management system records must be kept indicating nonconformance, and corrective and preventive actions to be taken.

Element 5: HIV/AIDS &TB management system review

To ensure continuous sustainability, adequacy and effectiveness, the system must be subjected to periodic review. Review is necessary to allow possible need for changes to policy, objectives and other elements of the system.

2.4.1.3 A comparison of the HEAIDS and DPSA models

Whilst the two models recognize leadership as the important and first step towards developing a successful response plan, there is a distinct difference on how leaders may play this role. HEAIDS model clearly spells out specific actions that all role players must play, from the onset, an important distinction when considering the international trends and South African policy on HIV. This means that setting up of relevant structures and making strategic decisions to develop HIV and AIDS programme epidemic is key to a successful respond. Role clarification is also seen as key in ensuring that there is no gap in implementation. Appointment of a champion at executive level, with good understanding of the project and clear view of what is required is also another distinction. Whilst this is recognized in DPSA model, it is not emphasized by the guide. Consultation and communication are also identified as first steps in implementing a positive response by the HEAIDS model. Whilst DPSA identifies these actions as important, they are only reflected as activities to be outlined during policy development. In other words, there is no clear distinction between policy development stage and the role the executive management must play in developing a response.

Another major difference in the two models is that DPSA views policy development as the first step towards a successful response, whilst HEIDS views policy development as a step that should follow strategic leadership and decision making, including understanding the environment and the impact that HIV has on its day to day operation. The model also highlights the need to assess the impact, available and required resource, HIV prevalence, and attitudes and knowledge employees have about HIV before developing interventions. This approach is in line with UNAIDS (2012) know your epidemic you're your response campaign.

2.5 APPROACHES TO POLICY IMPLEMENTATION

According to Buse, Mays, and Walt (2005), implementation is the process of turning policy into practice. However, it is common to observe a gap between what was planned

and what actually occurred as a result of a policy. And there are three major theoretical models of policy implementation. These include top-down approach, Bottom-up approach and Principal-Agent Theory. Brief consideration of these models is important as the study pertains to policy implementation in a public organization. Discussion of these three policy implementation models follows below.

2.5.1 The Top-Down Approach

The Top-down approach sees policy formation and policy execution as distinct activities. Policies are set at higher levels in a political process and are then communicated to subordinate levels which are then charged with the technical, managerial, and administrative tasks of putting policy into practice. Political scientists have theorized that the top-down approach requires that certain conditions be in place for policy implementation to be effective. These include: clear and logically consistent objectives; adequate causal theory (to how particular actions would lead to desired outcomes; an implementation process structured to enhance compliance by implementers (incentives and sanctions) committed, skillful implementing officials; support from interest groups and legislature; no changes in socio-economic conditions that undermine political support or the causal theory underlying the policy; adequate time and sufficient resources available, and good coordination and communication.

Like all other policy implementation models, the top-down approach has its own drawbacks: First, it is unlikely that all pre-conditions would be present at the same time; Second, it only adopts the perspective of those in higher levels of government and neglects the role of other actors; Third, it risks over-estimating the impact of government action (neglects other factors); Fourth, it is difficult to apply where no single, dominant policy or agency is involved, and, finally, policies change as they are being implemented (Steinbach, 2009).

2.5.2 The Bottom-Up Approach

According to Steinbach (2009), the Bottom-up approach recognizes that individuals at subordinate levels are likely to play an active part in implementation and may have some discretion to reshape objectives of the policy and change the way it is implemented. The bottom-up approach sees policy implementation as an interactive process involving policy makers, implementers from various levels of government, and other actors. Policy may change during implementation.

Shortcomings of this approach are as follows: Firstly, evaluating the effects of a policy becomes difficult and time consuming when multiple stakeholders are involved. Secondly, it may be difficult to separate the influence of individuals and different levels of government on policy decisions and consequences, which may undermine bureaucratic accountability in the implementation of public policy.

2.5.3 The Principal-Agent Theory

This theory postulates that in each situation, there will be a relationship between principals (those who define policy) and agents (those who implement policy), which may include contracts or agreements that enable the principal to specify what is provided and check that this has been accomplished. The amount of discretion given to the agents and complexity of the principal-agent relationship are affected by the nature of the policy problem - including scale of change required, size of affected group, simple versus complex intervention, ill-defined versus clear policy, many cause versus single cause, degree of political sensitivity, length of time before changes become apparent; the context or circumstances surrounding the problem - political and economic climate, technological change, and, lastly, the organization of the machinery required to implement the policy – the number of formal and informal agencies, amount of skills and resources required (Steinbach, 2009).

Whether policies are implemented from the top-down, bottom-up or according to the principal-agent theory, policy implementation involves three activities, and these are:

Interpretation, which involves translation of the policy into administrative directives; Organization: establishment of administrative units and methods necessary to put a programme into effect and Application: routine administering of the service (Anderson & Sotir Hussey, 2006)

2.5.4 Common Barriers To Policy Implementation

Despite the implementation guidelines mentioned above, it is important to note that policy implementation is not immune to challenges. Gunn (in Steinbach, 2009) identified ten common barriers to effective policy implementation and these include: the circumstances external to the implementing agency impose crippling constraints; lack of adequate time and sufficient resources; the required combination of resources is not available; the policy to be implemented is not based on a valid theory of cause and effect; the relationship between cause and effect is indirect and there are multiple intervening links; dependency relationships are multiple; there is a poor understanding of, and disagreement on, objectives; tasks are not fully specified in the correct sequence; there is imperfect communication and coordination, and, those in authority are unable to demand or obtain perfect compliance.

2.5.5 Implications For The Study

A review of the approaches to policy implementation revealed that although they differ in emphasis, these three approaches, however, complement each other and thus provide useful guidelines for policy implementers in government departments. The top down approach suggests that policy implementation sometimes requires management to make tough decisions quickly and timeously to get results. This approach is particularly useful when lives are at stake and when the organisation is under immense pressure to meet the needs of its customers. The downside of this approach is that it discourages employee participation and ownership, which may lead to poor outcomes. The analysis in chapter five provides a clearer picture on this point.

By contrast, the bottom-up approach emphasises the need to include employees in decision making and programme implementation. This increases the chances of success as employees become key stakeholders in planning, execution and monitoring of policy implementation. As indicated in chapter one, the study sought to determine whether the implementation of the HIV and AIDS policy produced real benefits for employees.

The Principal-agent approach, on the other hand, emphasises the relationship between the principals i.e. those who define the policy and the agents i.e. those who implement policy. Thus, the working relationship between these stakeholders and the complexity of the policy problem may determine success or failure of policy implementation in an organisation. This theory highlights the importance of coordinating stakeholder roles and responsibilities during policy implementation. Management also needs to think about the amount of power, decision making and resources delegated to the implementing agents on the ground to ensure accountability and good results.

The review also highlighted certain barriers which, if not properly managed, could derail policy implementation in an organisation. These include, but are not limited to: lack of resources; communication break-down; disagreement over objectives and priorities; and poor clarification of roles and responsibilities. Taken together, these issues provide a useful basis for assessing the implementation of the HIV and AIDS policy in the DRT. The next chapter describes the research methodology underpinning this study.

2.5.6 Applicable Theoretical Framework For The Study

Although other policy implementation theories, such as top-down and the principal agent, may be relevant to the study to some extent, bottom-up theory is more appropriate to the research, as it puts service deliverers and beneficiaries at the centre of policy implementation. This theory also recognizes the role played by the central planners at a macro level, which, to some extent, influence the micro level implementation. The argument made by the bottom up theorist is that a more realistic understanding of implementation can be gained by looking at a policy from the view of the target population and the service deliverers. In addition, most implementation

problems emanate from the interaction of a policy with the micro level institutional setting (Matland, 2010). This argument is supported by the notion that emphasizes the importance of knowing who is at higher risk of HIV and the extent to which HIV is prevalent amongst different populations (UNAIDS, 2006).

In addition to the selection of bottom-up approach as an appropriate approach to the study, DPSA guide on implementation of HIV policy is also more appropriate in determining how well the policy has been successfully implemented. This model is relevant in that it is a tool against which government measures DRT's performance on implementation of DPSA framework. More importantly, the study seeks to find out how DRT policy has been implemented against prescribed guidelines. Earlier on in this chapter, it was mentioned that there were gaps in certain elements including the role of leadership, the importance of communication and specific research that need to be undertaken prior to policy development. It was further mentioned that these gaps will have implications for policy implication in DRT.

2.6 CONCLUSION

Chapter two has been concerned with the literature review. Although there is no consensus in literature regarding policy implementation approaches, there is however, a clear realisation that the involvement of employees and fair allocation of resources and clarification of stakeholder roles and responsibilities are central to effective implementation of HIV/AIDS policy in the workplace. The next chapter discusses the research methodology.

CHAPTER 3

3 RESEARCH METHODOLOGY

3.1 INTRODUCTION

This section details and justifies the preferred research design, the approach underpinning the research, the case study method as it applies to this research; data collection strategy, the sampling technique employed to construct the desired sample; and data analysis procedures. The remainder of this section addresses issues of reliability and validity, limitations of the study, as well as research ethics. The aim is to show what steps will be followed to conduct the study and to report its key findings regarding the role of leadership in the implementation of HIV and AIDS policy in the DRT.

3.2 RESEARCH DESIGN

Broadly, research design refers to the research plan. It shows how the researcher will go about meeting the objectives of the study. It details the process that will be followed to collect the required data; the target group from which such data will be obtained as well as the strategy that will be used to report the results (Mouton, 1996). Informed by qualitative research theory, this study will use the case study method to understand the implementation of HIV and AIDS policy in the DRT. The case study method is supplemented with semi-structured interviews to collect data from senior, middle and lower level managers and staff within the department. Prior knowledge of the situation enabled selection of this sample.

3.2.1 Research Methods

There are two methods of research, namely qualitative and quantitative approach. While quantitative research applies statistical methods and hypotheses to understand research problems, qualitative research uses inductive reasoning to understand the underlying social issues that affect people in their world. In other words, qualitative

research focuses on context and meaning and not so much on causal relationships (Neuman, 2012; Babbie, 2014).

3.2.1.1 Quantitative Approach

Quantitative research is based on measurement of quantity or amount, and the result is a number or set of numbers. It is numerical, non-descriptive with conclusive results often presented in graphs and tables (Rajasekar,Philominathan & Chinnathambi, 2013). This method will not be used in this research as it does not answer questions of how and why, which are vital if one wants to understand policy implementation, especially in HIV and AIDS management contexts. The differences between these two approaches are given below, with more emphasis on qualitative research as it informs the study.

3.2.1.2 Qualitative Approach

While quantitative research provides hard data, i.e. statistics and measurements, qualitative research, on the other hand, aims to understand research phenomena from the perspectives of the respondents (Merriam 2006; Creswell 1998; Leedy, 1997). Because it focuses on meaning, qualitative research provides an ideal opportunity for the researcher to understand how stakeholders within the DRT feel about the implementation of the HIV/AIDS policy. Furthermore, since qualitative interviews facilitate close interactions between the researcher and the respondents, it will therefore be easier to detect underlying issues and concerns that participants might have about the HIV and AIDS management programme in the DRT.

3.3 DATA COLLECTION

3.3.1 Primary Data

The data collection phase represents a critical moment in any research project as it puts the research design to the test. First-hand information (primary data) from the respondents was gathered by means of semi-structured interviews. This enabled use of both closed and open-ended questions during the data gathering process. While closed questions helped to elicit specific answers, open-ended questions enabled free and flexible discussions about the implementation of the HIV/AIDS policy in the DRT. This flexibility provided an ideal opportunity for the researcher to pose follow-up questions in order to generate more data and to verify participants' claims and experiences on the HIV/AIDS services that they receive from the DRT.

3.3.2 Secondary Data

In addition to interviews, secondary data in the form of documents including reports, operational plans, HIV and AIDS policy provided valuable information required to complete this study. The information was collected from the Employee Health and Wellness Unit.

3.3.3 Interview Process

Interviews were conducted with senior management representatives, leadership, management and staff about implementation of the HIV/AIDS policy in June 2014. Management representatives were interviewed in their respective offices, while employees were interviewed individually in the board room. Ensuring the privacy of participants was crucial, given the sensitive nature of the research problem i.e. HIV/AIDS management in the workplace. Each interview session lasted for thirty minutes and participants were assured of anonymity.

3.4 SAMPLING

As defined by Roussouw (2003), sampling is the process through which it is decided who will be observed. Given the highly sensitive nature of HIV/AIDS in the workplace and society generally, it was therefore vital to use one's prior knowledge of and familiarity with the organization (DRT) to ensure that people who are conversant with the implementation of HIV/AIDS policy are identified and persuaded to provide the necessary information. Only purposive sampling allows researchers to decide before hand who will be selected to participate in the study (Neuman, 2011; Creswell, 1998; Merriam, 2003).

The sample consisted of senior management representatives, programme officials, middle level managers and employees. Purposive sampling was used to design this sample. As shown in table 4 below, fifteen (15) different stakeholders were included in the final sample to ensure validity and reliability of the research findings.

Table 4 - Sample Size

Category	Rank /Position	Number of respondents
Senior management	• DDG's, Chief directors and directors	3
Middle managers	• Deputy and assistant directors	3
Programme officials	• Specialists, • Human resource manager • Training manager and	4
Employees / beneficiaries	• Professional staff • Clerical staff • Officers	5
Total		15

Source: Own

3.5 DATA ANALYSIS

Practically, data analysis entails reporting the research findings to the scientific community (Neuman, 2011; Pirrow, 1993). In this study, data was organized in an orderly way to create logic between parts and to identify similarities, variations and key themes regarding the role of leadership in the implementation of the HIV/AIDS policy in the DRT. This approach resonates with Creswell's (1998) view that data analysis in qualitative research is a cyclical process involving interrelated steps. Data sets from senior management, managers and staff were compared and contrasted to test their reliability and consistency with the literature in chapter two.

3.6 RELIABILITY AND VALIDITY

The quality of research results is important for both readers and users of research information respectively. This places a duty on researchers to ensure that the information they generate through research is not only useful but also accurate and truthful. Strategies that were used to enhance validity and reliability of the results in this research project included cross-checking answers from participants; note taking, follow-up calls to obtain missing information; probing questions to gain deeper understanding of hidden issues that might be relevant to the study; and linking data analysis to the policy implementation approaches and principles cited under the literature review to determine similarities, key learnings, deviations and contrasts.

3.7 LIMITATIONS OF THE STUDY

As pointed out earlier, HIV and AIDS is a very sensitive and heavily regulated subject in the workplace. This imposes limitations on research design and data collection. When designing the interview questions, the researcher had to anticipate the potential conflict and resistance that such questions might evoke from the respondents. Ultimately, this imposed constraints on the quantity and quality of data that might have been collected from management and staff in the DRT. Addressing this limitation required pre-testing of

the interview schedule to determine if there were any thorny questions that needed revision or replacement before conducting the study.

Although the results are generalized, only employees working at head office (except for coordinators) participated and those in the regions were excluded. This study was therefore biased towards those who are working at head office. Another challenge is how to maintain confidentiality and privacy of those who do not want to disclose their HIV status. In mitigating this challenge, no personal information was asked to the participants or any other person dealing with HIV and AIDS programme in the department. It is assumed that professionals serving in human resource unit are also knowledgeable about the cornerstone principles of confidentiality and privacy.

3.8 ANONYMITY AND CONFIDENTIALITY

The literature emphasises that research should be conducted in a professional and ethical manner to avoid potential harm to clients, participants and society. Therefore, it is imperative for researchers to include ethical guidelines in their studies. Bearing these principles in mind, permission was sought from the DRT before conducting the interviews in June 2014.

In addition to securing permission, respondents were not compelled to participate or disclose their HIV-status during the interviews. Participants were interviewed individually in a private environment to avoid violation of their privacy. Code names were also allocated to each category of respondents to conceal their real names. This coding is also reflected in data presentation (Chapter four) and data analysis (Chapter five). Table 5 below shows how coding was done for each category of respondents:

Table 5 - Coding of Respondents

Category of respondents	Coding used
Senior management representatives	A1, A2, A,3
Programme officials	B1, B2, B3
Middle level managers	C1, C2, C3
Employees	D1, D2, D3, D4, D5

Source: Own

In addition to this coding (table 5), HIV and AIDS management policy guidelines applicable to DRT workplaces were also checked to ensure that the interview fully conforms to established norms and standards in the public service.

3.9 CONCLUSION

Effective implementation of HIV/AIDS policy is an important consideration in the South African public service, given the negative impact of the epidemic on staff morale, productivity, skills formation, organizational performance and customer service. In view of this, the study, therefore, aimed to use a case study design to determine the potential constraints which limit the contribution of leaders to implementation of HIV/AIDS policy in the DRT. The value of this research is that it may produce benchmark data, which can be used to enhance policy design and leadership commitment to the execution of HIV/AIDS interventions, not just within the DRT environment, but also in other public sector institutions.

CHAPTER 4

4 PRESENTATION OF FINDINGS

4.1 INTRODUCTION

As the heading suggests, chapter four presents and explains the findings concerning the implementation of HIV and AIDS policy in the DRT. These findings aim to address the broad research questions tabled in chapter one: How well is HIV/AIDS policy implemented in the DRT? Do employees benefit from this Intervention? The results are presented in this format: Senior management perspective, Programme officials' perspective, Middle management perspective and employees' experience on the provision of HIV/AIDS services within the DRT.

4.2 DATA PRESENTATION GUIDELINES

The results are presented using both verbatim and explanation for all categories. And all categories of respondents have been coded to ensure compliance with research ethics. The coding process is set out as follows: Senior management (Code A1-3), Programme officials (Code B1-4), Middle level managers (Code C1-3) and employees (Code D1-5). Where necessary, tables and illustrations are used to illuminate the data presentation.

4.2.1 Senior Management Responses (Code A1-3)

4.2.1.1 Understanding of Objectives of the Policies: Senior Management Perspective

These findings suggest that majority of senior management representatives understood the objectives of the HIV/AIDS programme and how they related to the strategic imperatives of the DRT – for example, creating a flexible, healthy and skilled workforce that can help the department to meet its mandate of providing efficient transport services in the Gauteng province.

4.2.1.2 Alignment of objectives with strategic goals

The aim of this question was to determine if HIV/AIDS policy objectives were linked to the strategic goals of the DRT, given the devastating impact of the epidemic on the morale of the workforce and productivity. The three senior management representatives differed on this issue, with one responding that HIV/AIDS is treated as a strategic matter within the organisation; the other respondent reckons that HIV/AIDS objectives are linked to budgeting and there is a budget for HIV/AIDS; whilst the last respondent disagreed and indicated that there are too many programmes and HIV/AIDS is sometimes not prioritized.

From these findings, it appears that alignment of HIV/AIDS activities with the strategic goals of the DRT has not been adequately addressed. This is exemplified by the last comment that due to competition for resources, HIV/AIDS sometimes do not receive the kind of financial support that it requires.

4.2.1.3 Role in HIV/AIDS programme

This question was intended to determine if senior management was involved in the implementation of HIV/AIDS policy in the DRT. All three respondents confirmed their respective roles in the HIV/AIDS programme. These are summarised below:

Table 6 Roles and responsibilities for HIV and AIDS

Respondent	Role in HIV/AIDS programme
Respondent A1	"I encourage my staff to go for counseling and coordinate wellness activities e.g. voluntary testing and counseling"
Respondent A2	"I serve in the Steering Committee and assist with information/advice and scheduling of training workshops"
Respondent A3	" I recommend managers for training and help with employee counseling"

Source: Own

4.2.1.4 Performance of these roles

In a follow-up question, senior management representatives were asked if they were able to perform their roles satisfactorily in order to improve delivery of HIV/AIDS services within the DRT. All three respondents conceded that they could not perform their roles effectively due to the following issues: demanding work schedules and time pressures, limited budget – which hampered HIV/AIDS campaigns, cultural differences, negative perceptions about HIV/AIDS, and fear of the stigma associated with HIV/AIDS.

4.2.1.5 Challenges hindering performance of these roles

Senior management representatives were also required to mention the problems which they felt impeded implementation of the HIV/AIDS policy in the DRT, and this is what they had to say:

Table 7 Perceived challenges in HIV/AIDS programme

Respondent	Perceived challenges
Respondent A1	"HIV/AIDS is not well understood by managers and employees. This hampers participation and ownership"
Respondent A2	"When it comes to the budget, the DRT is under pressure to improve the transport system, and it is difficult to balance these issues"
Respondent A3	"There is a perception that HIV/AIDS programmes are for people living with HIV/AIDS and this needs to change"

Source: Own

4.2.1.6 Working relations in the HIV/AIDS programme

Participants were required to indicate whether working relations supported the implementation of the HIV/AIDS policy in their respective areas. The overall impression was that the level of cooperation between the various stakeholders e.g. line managers, staff and unions was not satisfactory. This problem was attributed to lack of education and training outside Corporate Services. However, respondent A3 was optimistic that this situation would change – because the steering committee included representatives from all sections/departments. However, nearly all the respondents agreed that working relations needed serious improvement if HIV/AIDS efforts are to succeed in the DRT.

4.2.1.7 Support from the Leadership

This question was designed to establish senior management supported implementers of the HIV/AIDS programme. The first respondent (A1) conceded that support for HIV/AIDS was not enough, because there were no incentives for implementers and that most senior people had demanding work schedules that kept them away from the DRT most of the time. He said this created the impression that senior management was not supporting HIV/AIDS efforts within the DRT, which is not true. The second respondent (A2) pointed out that senior management supported HIV/AIDS efforts by sending line managers to HIV/AIDS management workshops. He said although this was happening at a slow pace, however, it illustrated management's commitment to support the implementation of the HIV/AIDS policy in the DRT environment. The third respondent (A3) reported that senior management supported HIV/AIDS campaigns through the budget, even though this was very little in some areas but it made the difference – as the DRT was able to host wellness days as part of its HIV/AIDS management strategy.

4.2.1.8 Approach followed to implement HIV/AIDS policy

The first respondent (A1) said that the DRT used a bottom-up approach involving employees at all levels of the organisation. And the reason for this is that "we believe that our people should play a key role in decision making", he said. The second respondent (A2) differed slightly, saying that the current approach to HIV/AIDS management was not well coordinated across functions and as a result, it was not easy to determine the exact approach used to implement the HIV/ADS policy within the DRT. The third respondent (A3) concurred with the second respondent, saying that "units within the DRT are not doing the same thing. Others have done well, while others are lagging behind, meaning that we are not working as a team".

4.2.1.9 Budget allocation

The aim of this question was to determine if sufficient financial resources had been set aside to support the implementation of HIV/AIDS programmes within the DRT. All three respondents conceded that the budget for HIV/AIDS was not sufficient. Respondent A2 in particular, made it clear that in some cases, HIV/AIDS programme did not receive

funding – mainly because “there are many service delivery issues that require huge amounts of money within the DRT”. The third respondent admitted openly that he was not aware of a budget allocation for HIV/AIDS in his unit.

4.2.1.10 Steps taken to improve implementation of HIV/AIDS policy

The last question for senior management representatives was: What do you think can be done to improve the implementation of HIV/AIDS within the DRT environment? All three respondents wanted to see greater improvement in the provision of HIV/AIDS services, and their suggestions were as follows:

Table 8 Solutions suggested by the respondents

Respondent	Suggested solution
A1	“Teamwork, effective coordination, and more funding for HIV/AIDS to ensure that all units implement HIV/AIDS policy as planned?”
A2	“Ensure that everyone attends steering committee meetings and give recognition to people who are committed to HIV/AIDS management in the department”
A3	“More training for line managers and staff to improve negative perceptions about HIV/AIDS issues in the department”

Source: Own

To some extent, the suggestions in table 8 prove that more still need to be done to improve the implementation of the HIV/AIDS policy in the DRT. The emphasis on training suggests that skills for managing HIV/AIDS are lacking and that unless this is done, negative perceptions about HIV/AIDS will be hard to tackle.

4.2.2 Programme Officials (Code B1-4)

4.2.2.1 Your Roles and responsibilities in HIV/AIDS programme

The research also elicited the views of programme officials on the implementation of the HIV/AIDS policy within the DRT environment. These included coordinators of HIVAIDS campaigns and selected managers from the Wellness Centre and human resources department. Their responses are as follows:

Table 9 Programme officials' role in HIV/AIDS programme

Respondent	Roles and responsibilities
B1	"I help with coordination of awareness campaigns"
B2	"Policy research and review, and I also represent my department in the steering committee"
B3	"Research HIV/AIDS issues and feed this information into the programme"
B4	"I help with counseling during wellness days and provide information to my staff"

Source: Own

The comments in table 9 above suggests that even though the roles are not clearly spelt out, however, programme officials do contribute to the implementation of the HIV/AIDS policy in the DRT. The participation of programme officials in HIV/AIDS-related research activities holds promise for the DRT, as it demonstrates the organisation's commitment to learn new HIV/AIDS management methods and practices.

4.2.2.2 Support and guidance

The four officials were also required to indicate if they received support from senior management to improve provision of HIV/AIDS services in the Department. Respondent B1 felt that senior management support was inadequate and sometimes not visible, especially outside Corporate Services. This sentiment was also echoed by respondent B2, who said that senior management hardly talks about HIV/AIDS issues in the organisation, and as a result, some employees do not take HIV/AIDS programmes seriously. The third respondent (B3) confirmed that he received support from management, including a budget and training on HIV/AIDS management. The fourth respondent (B4) denied having received support from management, saying that he takes the initiative to educate his staff about HIV/AIDS issues during wellness days.

4.2.2.3 Policy communications

All four officials (Respondents B1 to B4) conceded that information about HIV/AIDS did not reach all employees. This, they said, fueled negative perceptions about HIV/AIDS within the Department. Respondent B3 in particular, stated that some employees do not know what HIV/AIDS stand for and were hesitant to participate because of the stigma

associated with HIV/AIDS. Respondent B4 concurred with this view by stating "awareness programmes happen slowly, especially outside corporate services". She said "not much is being done to improve this situation, and that is why participation in HIV/AIDS programmes is poor in the Department".

4.2.2.4 Understanding of HIV/AIDS issues by employees

The four officials were asked to indicate whether their teams understood HIV/AIDS within the Department. Respondents B1, B2 and B3 conceded that most employees avoid talking about HIV/AIDS issues and as a result, very few understand the importance and benefits of managing HIV/AIDS in the workplace. Respondent B4 took a defensive position, saying that the reason for poor perceptions about HIV/AIDS can be attributed to lack of support. She felt strongly that employees can contribute to HIVAIDS management if they understood their roles and are given the necessary resources to perform these roles.

4.2.2.5 Key stakeholders in the implementation of HIV/AIDS policy

The four Programme officials cited a number of key stakeholders that are supposed to help with the implementation of the HIV/AIDS policy in the DRT. These included: senior management, programme officials, coordinators, research unit, human resources (HR) and wellness unit. However, the officials were quick to point out that there is very little cooperation between these stakeholders, which makes it difficult for them to implement the HIV/AIDS policy within the Department.

4.2.2.6 Stakeholder roles and responsibilities

In a follow-up question, officials were asked to describe the functions of the various stakeholders in the HIV/AIDS management programme. Their inputs are summarised in table 10 below:

Table 10 Stakeholder roles in HIV and AIDS programme

Stakeholder	Role/Responsibility
Senior management	Policy making and review, and budget Allocation
Programme officials and middle managers	Facilitate implementation of HIV/AIDS programmes, including awareness campaigns
Coordinators	Work with line managers in different units to drive awareness campaigns
Human resources	Expert advice on policy and legislation relating to HIV/AIDS
Wellness Unit	Organise wellness activities including employee testing and counseling

Source: Own

Table 10 reveals a wide range of stakeholders that are expected to contribute to the implementation of the HIV/AIDS policy in the DRT, but, as indicated earlier, the efforts of these stakeholders are not well coordinated and as a result, implementation activities are not consistent across levels; and these impacts negatively on policy outcomes.

4.2.2.7 Financial and materials resources

The respondents (B1-B4) unanimously agreed that the current funding mechanism for HIV/AIDS services is inappropriate and that immediate steps are required to correct this situation. There was concern that some units do receive financial support, while others spend months waiting for support. This finding suggests that financial resources for HIV/AIDS programmes are not evenly spread across functions.

4.2.2.8 Potential challenges hindering implementation of HIV/AIDS policy

The four programme officials were required to indicate if there were challenges or constraints that hinder implementation of the HIV/AIDS policy in their respective units. Almost all the respondents (B1-B4) accepted that there were challenges in the HIV/AIDS management programme. These included:

a. Reluctance to participate in HIV/AIDS programmes (mainly staff)
b. Lack of HIV/AIDS management skills
c. Skewed allocation of financial resources in HIV/AIDS programmes

d. Difficulty of accessing HIV/AIDS information in some departments
e. Limited coordination efforts, which weakened awareness campaigns
f. Weak link between HIV/AIDS and other human resources programmes
g. Slow progress in training line managers and staff on HIV/AIDS issues
h. Heavy reliance on the steering committee as the driver of HIV/AIDS policy
i. Inadequate support from senior management
j. Cultural and religious barriers, which prevented some employees from talking about HIV/AIDS issues openly

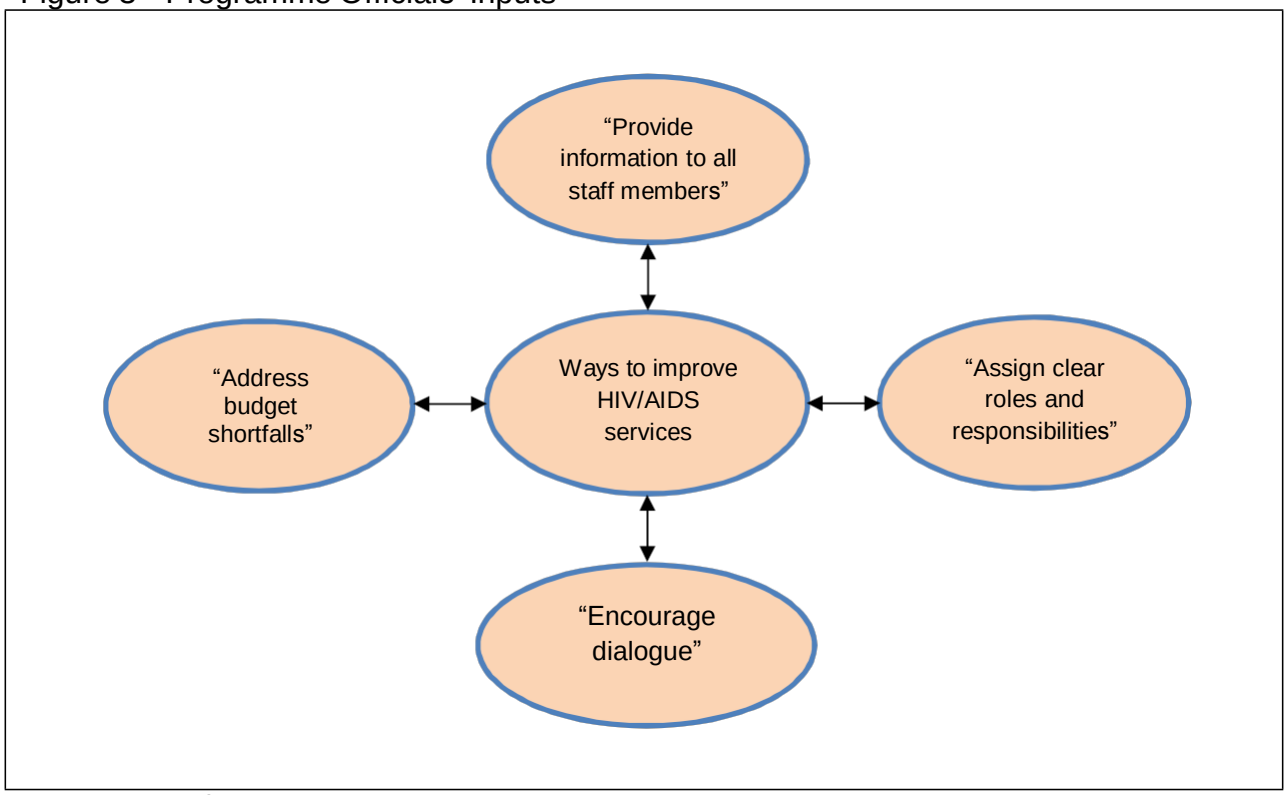
Looking at this list, it is evident that the HIV/AIDS programme faces formidable challenges within the DRT. In part, this explains why programme officials wanted to see significant improvement in education and training of line managers, so that the programme can be implemented consistently across all levels.

4.2.2.9 Progress in implementation of HIV/AIDS policy

As they are directly responsible for the day to day implementation of HIV/AIDS management activities within the DRT, programme officials were asked to indicate if they had made progress in this regard. Despite the challenges, all four officials (Respondents B1-B4) were pleased with the progress made, including:

a. establishment of the steering committee; appointment of coordinators; training of managers in Corporate Services, although this was not enough;
b. involvement of senior management in the steering committee; wellness days – which are becoming popular in the DRT; and
c. joint planning sessions where managers and employees work together to plan and carry out HIV/AIDS awareness campaigns, although this is still confined to the Corporate Services Centre'

Figure 3 - Programme Officials' Inputs



Source: Interviews, June 2014

Looking at the suggestions in figure 1, it is clear that programme officials were keen to see greater improvement in the provision of HIV/AIDS services in the DRT. The need to inform all staff about HIV/AIDS services is encouraging, considering that employees are the key beneficiaries in this programme. The need to encourage dialogue means that the culture of the organisation should allow open communication where managers and employees are able to talk about HIV/AIDS issues freely and constructively without fear of degradation and humiliation. Below is a summary of middle management perspectives and inputs on the implementation of the HIV/AIDS policy in the DRT.

4.2.3 Middle Management (Code C1-4)

The study also gauged the experiences of middle managers to find out how they felt about the provision of HIV/AIDS services in the DRT. Like their counterparts in other levels, these respondents (C1, C2 and C3), were not happy with the current HIV/AIDS management efforts within the organisation. The overall impression was that coverage

is limited and thus not sufficient to cover the needs of all staff members. Their inputs are summarised in table 11 below:

Table 11 Middle managers' perspectives

Respondent	Responsibilities in HIV/AIDS programmes	Providing information and support to employees	Training on management of HIV/AIDS	Support from senior management	Protection of people living with HIV/AIDS	How to improve HIV/AIDS services
C1	"I organise campaigns"	"I do pass information to staff and encourage them to attend workshops"	"Not much, except briefings and wellness days"	It is there but is not enough, they must visit all branches"	"Yes, the DRT policy prohibits discriminati on"	"All of us must help, not just few staff members"
C2	"Prepare staff for wellness days"	"Yes, when they give us new information I give it to staff"	"Not yet, but I think they will give us a chance to attend"	"I think they want to talk about it but they are busy"	"Yes, they are given leave if they are sick"	"They must put more funds in HIV/AIDS services"
C3	"I sit in the steering committee and help with planning"	'I try, but it's not easy because people avoid these issues".	"Yes, I once attended a workshop on HIV/AIDS".	"We are not there yet, we need to improve in this area"	"Yes, testing and counseling are done confidentiall y"	"We must learn from others how it is done".

Source: Own

The data inputs in table 11 suggest that middle managers almost all had similar experiences when it comes to provision of HIV/AIDS services in the DRT. For example, they all had specific responsibilities in the HIV/AIDS programmes; very few had received full training on HIV/AIDS management; and all of them confirmed that the rights of people living with HIV/AIDS are protected.

In addition to the above, all three respondents had ideas on how to improve provision of HIV/AIDS services in the DRT. Of particular significance in this regard is the realisation that the DRT can learn a lot about implementation of HIV/AIDS policy from other

departments. This finding highlights the importance of benchmarking HIV/AIDS programmes with those of leading organisations to improve the quality of outcomes.

4.2.4 Employees' Experience on HIV/Aids Services (Code D1-5)

As beneficiaries of the HIV/AIDS programme, respondents D1, D2, D3, D4 and D5 were asked to indicate if they firstly, knew about HIV/AIDS services, secondly, if they had access to these services, thirdly, if they participated in HIV/AIDS management campaigns; and, lastly, if they were satisfied with the quality of these services. Their responses are summarised in table 12 below.

Table 12 Employees' experiences on HIV/AIDS services

Respondents	Knowledge of HIV/AIDS services	Access to HIV/AIDS services	Participation in HIV/AIDS campaigns	Satisfaction with services rendered
D1	"Yes, through my manager and wellness days", I have learnt more about HIV/AIDS"	"You can get help during wellness days, they help with testing and counseling"	"Yes, I help with coordination of HIV/AIDS campaigns"	"Not really, I think we still need to do more workshops to increase awareness"
D2	"No, not in my unit, I only know about HIV/AIDS through friends"	"I do not know, may be in other departments they get help"	"No, but I can help if I get a chance, we are very busy here."	"Not at all. We are behind and this must change"
D3	"Very little, because there is no information about HIV/AIDS"	"Our manager encourages us to attend wellness days"	"I would say yes, because I have gone to wellness workshops"	"Certainly not, I think we are not doing it the right way"
D4	"Yes, HR talks about these issues in staff meetings	"Yes, you can get information from managers & coordinators"	"Yes, I attend meetings and discuss HIV issues with friends sometimes"	"They are trying, but it is not enough because the DRT is a big organisation"
D5	"No, I only learn about it through Internet, radio and television"	"I have not heard about it here, may be in other departments"	"No, I wish I could but there is no time in my job."	"No, because other people still don't understand HIV/AIDS here."

Source: Own

Looking at table 12 above, it is evident that employees have different experiences when it comes to HIV/AIDS services. For example, respondents D2 and D5 have not been able to access HIV/AIDS in the Department. However, it is pleasing to note, despite the difficulties, other employees (i.e. respondents D1, D3 and D4) had been able to access HIV/AIDS services and participated in HIV/AIDS awareness campaigns.

The positive comments in table 12 show that efforts to implement the HIV/AIDS policy are beginning to bear fruit in some sections of the DRT. Overall, these results show that many employees are not satisfied with the quality of services they have received so far. There is a strong feeling that these services are not enough and that more still needs to be done to improve delivery of these services within the DRT.

4.2.5 Emerging Themes

From the data presented so far, it is possible to identify important themes which, if carefully examined, may help shed more light on the implementation of HIV/AIDS policy in the DRT environment. These include mainstreaming of HIV/AIDS programmes; capacity and resources; programmes' responsiveness to the needs of employees and employee experiences on HIV/AIDS services. Together, these themes form the gist of the analysis in chapter five. Below is a summary of the main findings of the study regarding the implementation of the HIV/AIDS policy in the DRT.

4.5 SUMMARY OF FINDINGS AND CONCLUSION

As stated in Chapter one, the critical questions that this study sought to address are:

- To what extent is HIV and AIDS policy implementation in DRT successful?
- What are the trends in the implementation of HIV and AIDS policy in DRT?
- What are the experiences of employees?
- What can be done to improve the implementation of HIV/AIDS policy within the DRT environment?

Deducing from the results presented so far, it appears that implementation of HIV/AIDS policy is intermittent and not fully integrated with other strategic programmes of the DRT. This was attributed to the fact that the HIV/AIDS programme had to compete for resources, and as a result, it could not be prioritised.

Knowledge of HIV/AIDS among managers and employees appears to be limited, suggesting a gap in the provision of HIV/AIDS education and training services within the DRT. In some cases, it was assumed that HIV/AIDS is only about counseling and testing. This created the impression that the HIV/AIDS programme is for affected employees only and not the whole organisation. This had a negative impact on employee participation in HIV/AIDS awareness campaigns.

Roles and responsibilities for implementing the HIV/AIDS programme had been defined, particularly in the Corporate Services Unit. Examples include Steering Committee, coordinators and peer support groups, but these roles were not clearly understood outside Corporate Services due to lack of information and support from management. Some line managers indicated that they had not been formally briefed about their roles and responsibilities in the HIV/AIDS programme.

In respect of the capacity and resources needed to implement HIV/AIDS policy, the Steering Committee holds promise as it includes management and employee representatives. But this is negated by the lack of HIV/AIDS management skills and financial resources. Nearly all the respondents admitted that this problem undermined implementation of the HIV/AIDS policy within the DRT environment

Concerning improvements, the majority of participants felt strongly that senior management support, along with increased budget allocation and continued training for line managers and employees would boost implementation of HIV/AIDS policy in the DRT. Some middle level managers (respondents C1 and C3) even suggested that the

culture of the DRT should be adapted to enable people to talk openly and exchange information about HIV/AIDS issues without fear of ridicule, isolation and discrimination.

With regard to employee experiences on HIV/AIDS services, the results showed that while some employees were fully aware of these services and knew where to find them, others complained about lack of information and education on HIV/AIDS. Sources of HIV/AIDS information included peer groups, wellness days and supervisors.

Others reported that they had obtained this information through the media e.g. Internet, Radio and Television. The overall impression among participants (i.e. Respondents D1, D2, D3, D4 and D5) was that the DRT was behind other departments when it comes to promotion of HIV/AID issues. Because of this, it was felt that senior management should allocate more funding so that staff and line managers can be educated and trained properly on how to manage HIV/AIDS in the department.

Now that the findings of the study have been presented and explained, attention is focused on the analysis of these findings to determine their implications for the problem statement and the research questions. This is accomplished in chapter five.

CHAPTER 5

5 INTEPRETATION AND ANALYSIS OF FINDINGS

5.1 INTRODUCTION

While chapter four focused on data presentation, chapter five unpacks these data to determine if HIV/AIDS policy is being implemented within the DRT environment. The analysis is accomplished under the following themes: Mainstreaming of HIV/AIDS programmes; capacity and resources, Roles and responsibilities for HIV/AIDS management, and programme responsiveness to employee needs, and experiences of employees on HIV/AIDS services within the DRT.

5.2 ANALYSIS OF FINDINGS

The analysis is based on five themes derived from the previous chapter, namely mainstreaming of HIV/AIDS programme, resources, roles and responsibilities, programme responsiveness, and challenges and opportunities. These issues are central to understanding the implementation of HIV/AIDS in the DRT. According to Fourie (2006), policy implementation entails the translation of decisions into action. It is distinctively political in nature, dealing directly with the questions of who implements policy, where, when and how. Data analysis follows below.

5.2.1 Mainstreaming Of HIV/AIDS Programme

In this context, mainstreaming refers to integration of HIV/AIDS programmes with other strategic interventions/objectives of the DRT. As indicated in Chapter four, participants admitted that alignment of HIV/AIDS initiatives with the broader objectives of the organisation was not consistent across functions. The lack of integration was attributed to the lack of cooperation between units and implementers. However, some respondents (A1 and A3) reported that efforts had been made to align HIV/AIDS programmes with strategic goals of the DRT. Table 13 below provides examples of this.

Table 13 Mainstreaming of HIV/AIDS programmes

Examples of mainstreaming activities	Implications for HIV/AIDS management
Wellness days	They are used to promote not only basic health and nutrition but also HIV/AIDS testing and counseling
Employee assistance programmes	HIV/AIDS education and training is included in as part of EAPs in Corporate services
Budgeting	Some units do receive financial support to promote HIV/AIDS awareness. The HR budget faces constraints

5.2.2 Capacity and Resources

In this context, resources include the things needed to support implementation of HIV/AIDS programmes. Examples include IEC material, condoms, condo cans, posters, stationery, flip charts, computer technology, websites, machinery and equipment needed to promote awareness. The data in chapter four suggest that in some cases, promotion of HIV/AIDS awareness campaigns is sometimes hampered by lack of these resources. Again this problem is attributed to tight budgets, which are, according to some respondents (B2 &B3), not sufficient to address HIV/AIDS needs throughout the department. Table 14 below shows how the shortage of requisite skills affects implementation of HIV/AIDS policy in the DRT.

Table 14 Requisite Skills for HIV/AIDS management

Examples of skills needed	Importance/Significance
Diversity management skills	These skills would enable Coordinators to reach out to employees from different social backgrounds and talk about their experiences on HIV/IDS services
Communication skills	Public speaking and writing skills are key to planning and delivering clear and relevant messages about HIV/AIDS
Counseling skills	HIV/AIDS is a delicate subject that needs implementers to treat employees with empathy, sensitivity and dignity
Team skills	The ability to adapt and function well in a team environment – sharing information and resources to facilitate policy implementation
Negotiation skills	These skills may be required to persuade, motivate and convince employees and unions to participate and contribute to

	implementation of HIV/AIDS policy
HIV management in the workplace skills	These skills would help managers on how to manage employees affected or infected with HIV and AIDS

The data in table 14 suggests the critical skills for managing HIV/AIDS relate to diversity management, communication, counseling, teamwork and negotiation. Policy implementers need to be conversant with these skills as they deal directly with employees who are beneficiaries of the HIV/AIDS programme. Inputs from both senior management representatives (A1-A3) and programme officials (B1-3) suggest that a shortage of these skills retards implementation of the HIV/AIDS programme in the DRT. Figure 2 below provides a breakdown of the material resources that also impact provision of HIV/AIDS services in the department:

Figure 2 Material resources

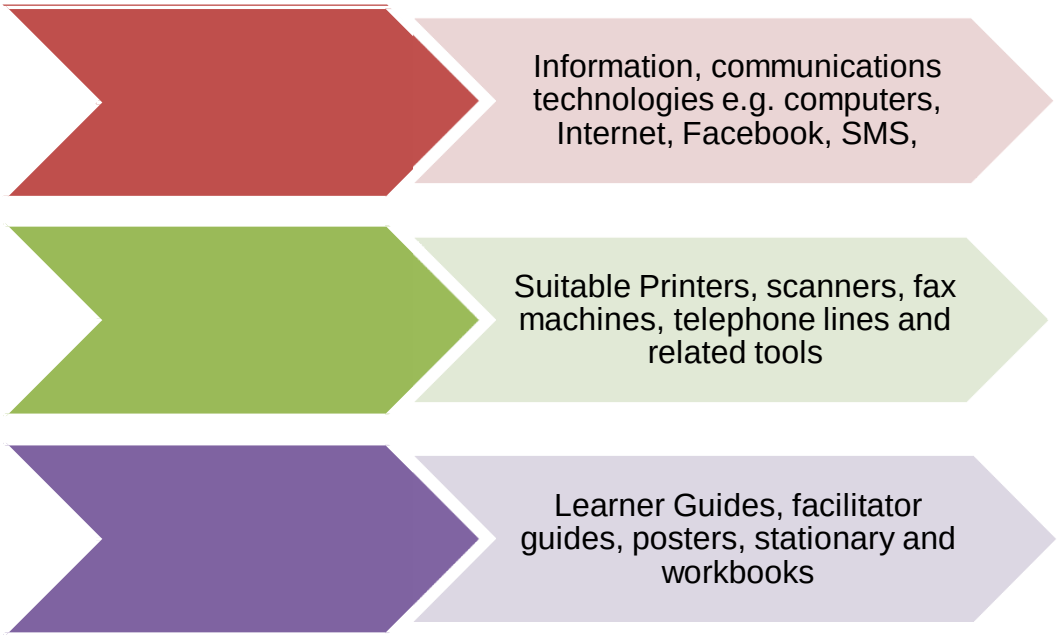


Figure 2 suggests three types of resources are needed to support implementation of the HIV/AIDS policy in the DRT. The first category includes technology, for example, the role that the Intranet and extranet and dedicated websites can play in raising awareness

about HIV/AIDS within the Department. However, this cannot be realised unless employees are trained on how to use computer technology.

The second category relates to equipment i.e. the tools needed to produce HIV/AIDS awareness campaigns and training materials. These include printers, scanners, fax machines, telephone lines and related tools. Availability of these resources is key to the supply of HIV/AIDS messages and support materials. In fact, trainers and counselors would not be able to do their job without these resources.

The third category concerns learning resources. Facilitators of HIV/AIDS workshops need relevant materials and guidelines to be able to do their jobs well. The same principle applies to trainees: they also need well-designed learner guides with rich and practical information that they can use to protect themselves and their families against HIV/AIDs. As indicated in chapter four, some of the respondents (A1, B2 and C3) were concerned about the slow pace of training which they attributed to lack of resources and training opportunities for managers and employees.

5.2.3 Roles and Responsibilities

Successful policy implementation depends on clear allocation of roles and responsibilities to all those involved (Anderson, 1998; Cloete & Wissink, 2006). Inputs from senior managers, programme officials and middle level managers suggested that, despite the confusion and uncertainty around roles and responsibilities for HIV/AIDS in the DRT, however, some participants knew what was expected of them. Figure 3 below gives an indication of the responsibilities in HIV/AIDs services.

Figure 3 Responsibilities per level



Source: Own

The data in Figure 3 suggests that all levels of the organisation contribute to the implementation of the HIV/AIDS policy. Topping the list is senior management, whose responsibility is to provide leadership, support and direction i.e. defining the vision of the organisation and ensuring that people, resources and programmes are aligned to it, but the findings suggest that support for HIV/AIDS programmes is inadequate.

Next are programme officials, who are expected to work with line managers and employees to plan and carry out HIV/AIDS awareness campaigns. The data indicated that this is hampered by cooperation between the stakeholders. Officials are therefore at the coal face of the HIV/AIDS campaign. But their efforts seem to be whittled down by capacity constraints e.g. lack of knowledge and skills about HIV/AIDS issues.

In addition to programme officials, there are line managers, whose responsibility is to disseminate information to staff about HIV/AIDS services. However, inputs from respondents D1 to D5 suggests that information services are not satisfactory as some units do not get the necessary information on time. Other respondents complained

about the fact that even where this is done, not all staff members get this information. This finding conflicts with communication principles in the literature (Cronje & Vrbra, 2008), which states that, for information to be useful, it should meet these criteria:

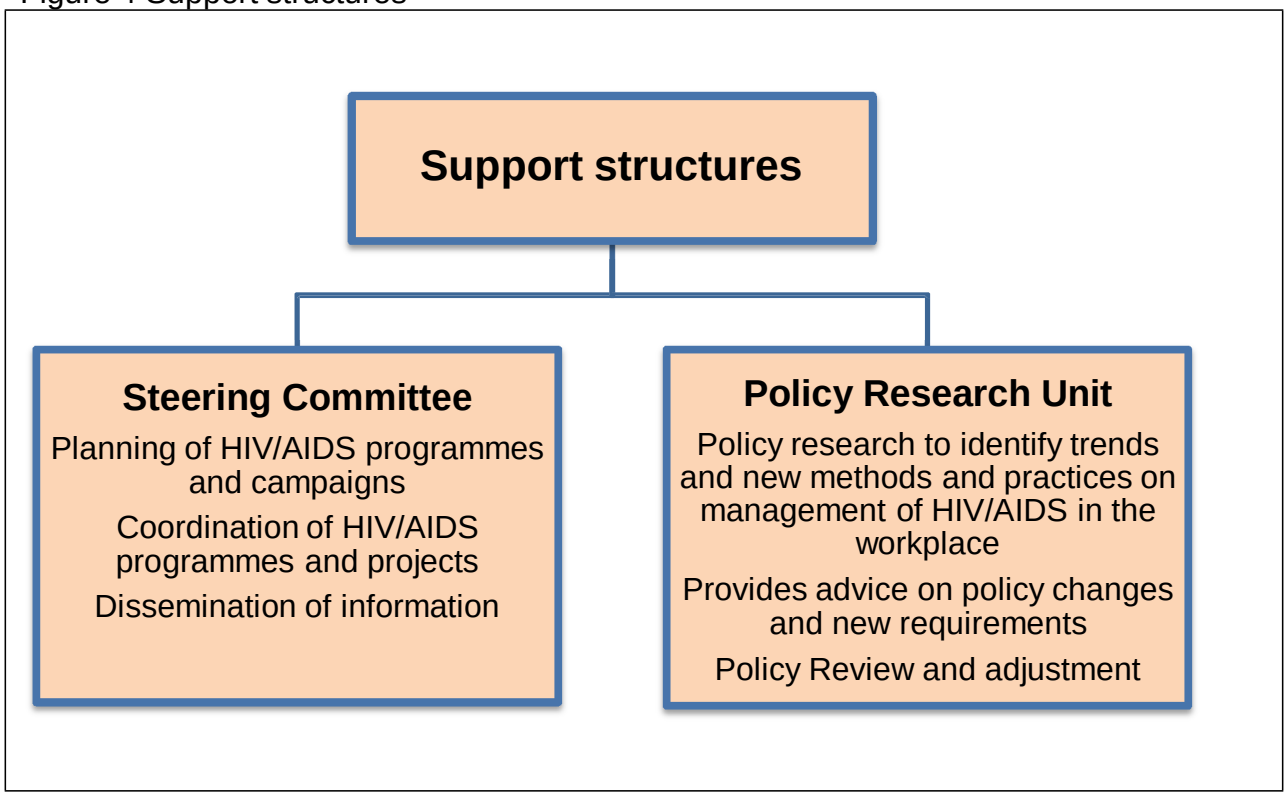
a. Time-bound – information must be provided at the right time
b. Relevant – information must be pertinent to the situation at hand
c. Current –information must be up to date and authentic
d. Accurate – information must be factual and correct
e. Feedback – information is exchanged by the sender and recipients, e.g. staff, to ensure mutual understanding and to avoid confusion/uncertainty.

Figure 3 further shows that employees also have a role to play in the implementation of HIV/AIDS policy in the organisation. These include cooperating with their managers, attending HIV/AIDS counseling workshops and contributing to HIV/AIDS awareness campaigns. The data in chapter four has shown that this goal can be achieved if employees are motivated, guided and supported to participate in HIV/AIDS programmes.

5.2.4 Support Structures

Beside the responsibilities mentioned above, it was also pleasing to see that support structures had been created to boost implementation of the HIV/AIDS policy in the DRT. These include the steering committee, which included senior management representatives and employees; and the Policy research unit, which constitutes a vital link between the HIV/AIDS programme and the external environment. Figure 4 below demonstrates how these two structures contribute to the roll out of HIV/AIDS services in the DRT:

Figure 4 Support structures



Source: Own

Looking at figure 4, it is clear that even though the DRT faces challenges in terms of capacity and resources, however, there are positive developments in this area. The Steering Committee and the Research Unit are contributing to the implementation of the HIV/AIDS policy through planning, advice and dissemination of relevant policy information to stakeholders, but these gains are reversed by the uneven supply of materials and resources at the different levels of the organisation. Consequently, some departments/units are better informed about HIV/AIDS issues than others.

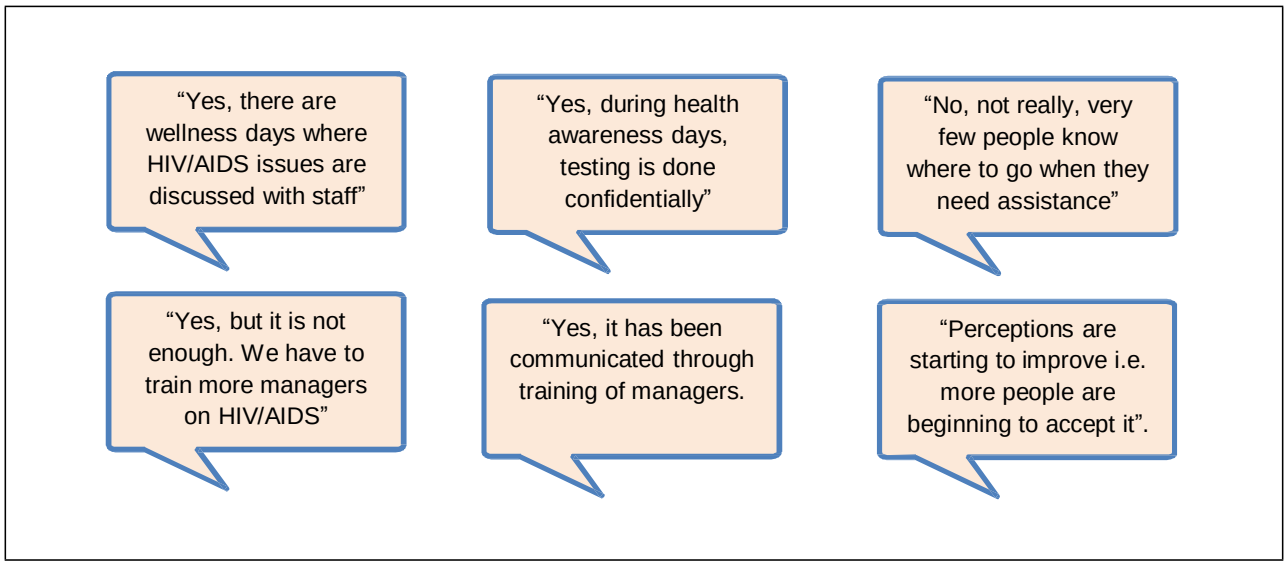
5.2.5 Programme Responsiveness

This theme relates to the second research question: Do employees benefit from the HIV/AIDS programme in the DRT? Responsiveness means the ability of a policy, programme or project to meet the needs of beneficiaries or customers as planned (Cloete & Wissink, 2006). It concerns issues such as:

- **Accessibility:** Is it easy for clients to find information and assistance?
- **Availability:** Is the supply of services consistent across levels
- **Dependability:** Are services free from interruptions and shortages
- **Speed:** How quick and efficient is the service?
- **Coverage:** Does the programme reach all intended clients as planned?

Figure 5 below provides an indication of how some employees (respondents D1-D5) felt about the quality of HIV/AIDS services within the DRT environment.

Figure 5 Experiences on HIV/AIDS services



Source: Own

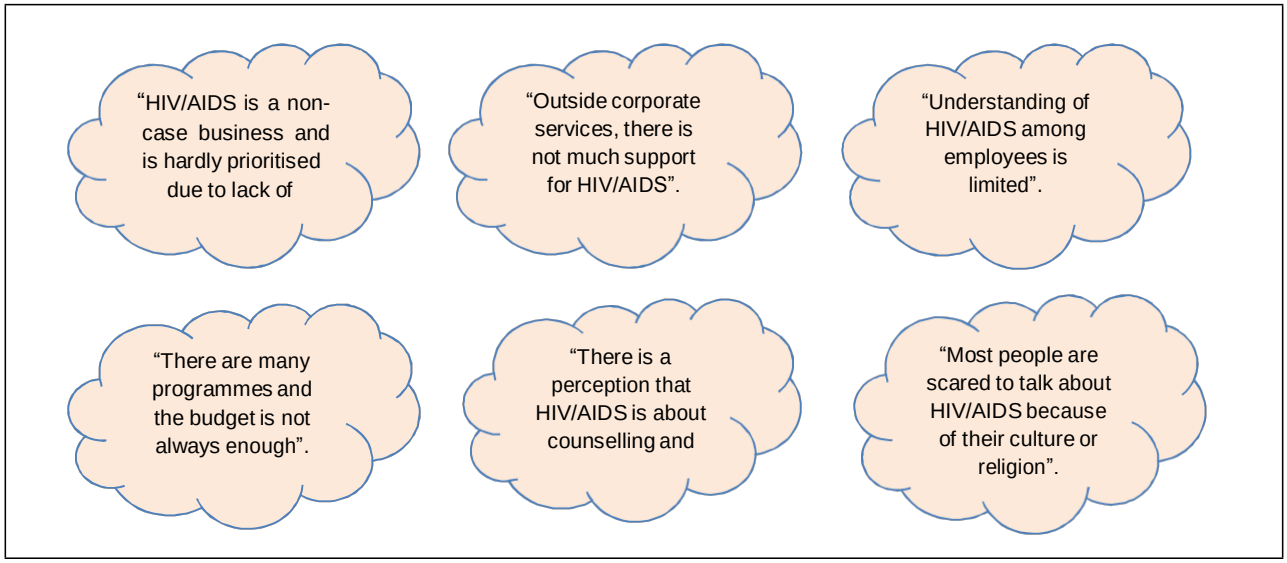
Deducing from figure 5, it can be inferred that employees had different perceptions on the provision of HIV/AIDS services in the DRT environment. For example, while some employees had participated in these services, others were concerned about the lack of information and the difficulty of accessing these services when they needed them. Aligned to this issue is the uncertainty around service delivery points, that is, the specific areas where HIV/AIDS services are located within the organisation. Some employees expressed concerns about this, saying that not everyone knows where to find them.

The finding that some employees are unable to access HIV/AIDS services suggests problems in monitoring and evaluation of HIV/AIDS in the DRT. According to the Public Service and Administration Report (2002), monitoring and evaluation have a significant role to play in any HIV/AIDS workplace intervention as they assist in assessing whether a programme is: appropriate; cost effective; effective; and meeting the set objectives. In an environment where departments struggle with maintaining commitment to HIV/AIDS, reporting, monitoring and evaluation often fulfill a more basic function of determining whether HIV/AIDS policies and programmes are being implemented at all.

5.2.6 Challenges

As pointed out in chapter four, the study also required participants to identify the challenges or constraints hindering implementation of the HIV/AIDS policy within the DRT environment. The aim of this question was to determine if participants knew the stumbling blocks impacting provision of HIV/AIDS services in their respective departments or units. Their comments are depicted in figure 6 below:

Figure 6 Perceived challenges



Source: Own

From figure 6, it seems that the challenges include the difficulty of prioritising HIV/AIDS programmes in light of diminishing resources; lack of support for HIV/AIDS services outside Corporate Services; misperceptions about HIV/AIDS, especially among employees; and cultural barriers. These are analysed below:

a. The difficulty of prioritising HIV/AIDS services in light of diminishing resources

Senior management representatives (respondents A1-3) and programme officials (respondents B1-4) admitted that it was difficult to prioritise HIV/AIDS programmes as the DRT faced severe budgetary constraints due to competing policy programmes i.e. the need to improve transport services in the Gauteng Province. This finding suggests that HIV/AIDS programmes are not receiving a fair share of the HR budget.

This finding confirms the point raised by Fourie (2006) that successful implementation of a policy depends on a wide range of variables, including correct definition of the problem, accurate identification of the causal links, just determination of objectives, etc.

b. Lack of support for HIV/AIDS services outside Corporate Services

A common concern expressed by almost all the respondents was that the HIV/AIDS programme is not receiving adequate support from senior management. Some of the respondents (A2, B3 and C4) attributed this problem to the lack of time, as many senior managers face hectic work schedules, with little time to focus on operational issues.

c. Misperceptions about HIV/AIDS

Nearly all the respondents, including beneficiaries (i.e. respondents D1-D5) conceded that HIV/AIDS management efforts were hampered by misperceptions about these services. This was attributed to lack of effective education about HIV/AIDS issues within the DRT. For example, as shown in figure 6 above, some employees thought that the HIV/AIDS programme is meant for counseling and testing during wellness days. As a result, some were not keen to participate in HIV/AIDS awareness campaigns.

d. Cultural barriers

Culture refers to the common values, beliefs, traditions, and practices shared by a group of people. With the advent of democracy, the South African workforce has undergone tremendous change, resulting in multicultural work environments (Grobler, 2006). One of the perceptions revealed by figure 6 above is that the reason for low participation in HIV/AIDS services is probably due to different cultural and religious orientations. For example, while some people may be free to talk openly about sexual topics, others may see this as an infringement of their religion or cultural values. To some degree, this finding suggests gaps in HIV/AIDS education within the DRT.

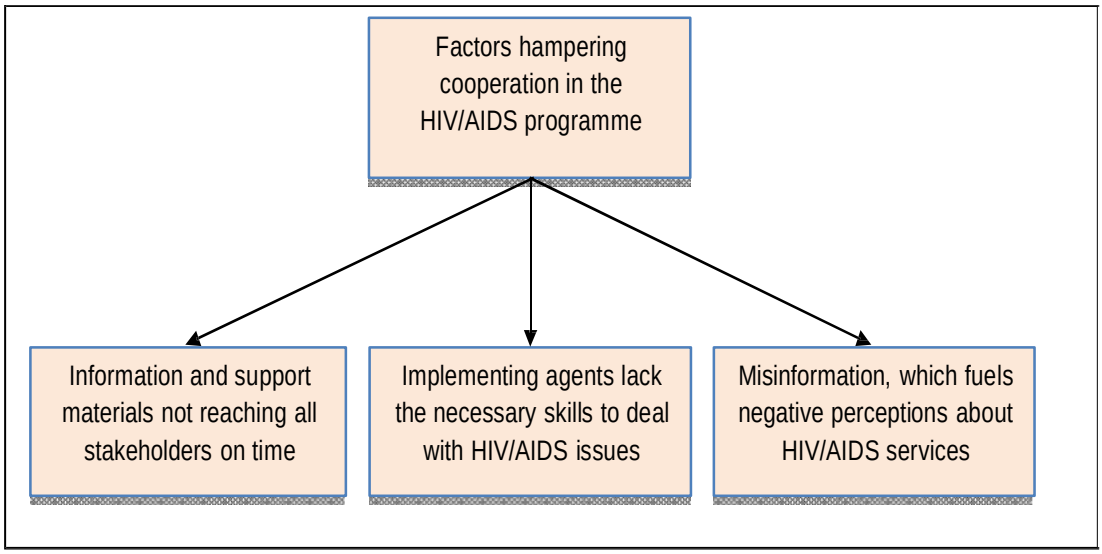
To some extent, the above findings corroborate the observation made by Karim and Karim (2008) that cultural prescriptions of what men and women should and should not do affect implementation of HIV/AIDS programmes in organisations.

Overall these findings corroborate the research conducted by the PSC in 2006 to look into management of HIV/AIDS in government departments. This study found that: HIV and AIDS committees are in place; there is a lack of health programmes targeting HIV and AIDS; counseling and support aspects of VCT not in place; EAPs in workplace can improve capacity to deal with HIV and AIDS but are still weakly integrated into dealing with HIV and AIDS; many public officials fall in the high risk category for HIV and AIDS; HIV and AIDS policies require strengthening and, finally, that efficacy of HIV and AIDS programmes require improvement.

e. Lack of cooperation

Harmonious and productive working relations are at the core of programme effectiveness and sustainability. Building and maintaining sound coalitions with all key stakeholders provide the social capital needed to implement public policies (Cloete & Wissink, 2006). The findings revealed that there is not enough cooperation between the various stakeholders in the HIV/AIDS programme. Figure 7 below depicts some of the potential factors contributing to this problem.

Figure 7 Factors contributing to non-cooperation



Source: Own

Figure 7 above suggests that uneven supply of information about HIV/AIDS services could be one of the factors hampering working relations and participation in the HIV/AIDS programme. This is even more pronounced where departments have to compete for small budget allocations. The unintended consequence of this (uneven supply of policy information) is that some units become more knowledgeable about HIV/AIDS issues while others struggle to access these services. Lack of sufficient and accurate information about these services is more likely to lead to misinformation in some parts of the organisation.

These findings conflict with the Principal-agent approach in chapter two, which suggests that policy implementation requires close cooperation between the principal (those defining the policy) and the agents (those responsible for implementing the policy).

5.3 CONCLUSION

On the whole, the analysis in this chapter suggests that the current HIV/AIDS implementation strategy is limited in both scope and intensity, as evidenced by the relatively low levels of commitment and participation in HIV/AIDS activities in many parts of the organisation. The next chapter covers conclusions and recommendations regarding implementation of the HIV/AIDS policy in the DRT.

CHAPTER SIX

6 CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

In this chapter, the findings of the study are judged on the basis of the three broad research questions tabled in chapter one and the insights gleaned from the literature review as well as the analysis in chapter five. With this in mind, the conclusions of the study regarding the implementation of HIV/AIDS policy in the DRT are as follows:

The literature review in Chapter two demonstrated that involvement of employees and fair allocation of resources and clarification of stakeholder roles and responsibilities are central to the effective implementation of HIV/AIDS policy in the workplace.

In Chapter three, it was reported that a case study design, along with interviews and purposive sampling, was used to understand the implementation of HIV/AIDS policy in the Gauteng Department of Roads and Transport.

Data presentation was covered in Chapter four. Overall, the findings here confirmed the implementation of the HIV/AIDS policy within the DRT, although such efforts were hampered by weak communications and slow progress in training of managers.

The analysis in chapter five revealed that the current HIV/AIDS implementation strategy adopted by the DRT is limited in both scope and intensity, as evidenced by the relatively low levels of commitment and participation, especially at the employee level.

6.2 CONCLUSIONS

Efforts to integrate HIV/AIDS management with the business strategy of the DRT appear to be limited. The only positive aspect in this regard was the inclusion of senior management representatives in the Steering Committee. Mainstreaming of HIV/AIDS is

apparently stifled by the lack of funds. This could mean that HIV/AIDS issues are not receiving adequate attention during the budgeting process. There is also no clear link between HIV/AIDS policy and employee assistance programmes.

Furthermore, while the roles and responsibilities for HIV/AIDS have been defined in the Corporate Services Centre, this however, does not span all functions. As a result, not all employees know exactly what they should do to support HIV/AIDS management efforts in the DRT. To a larger extent, lack of clarity on roles and responsibilities impacts negatively on the roll out of HIV/AIDS policy in the DRT environment.

In respect of progress made, there are a few good examples that indicate the DRT's commitment to implement HIV/AIDS policy. These include wellness days; availability of testing and counseling services, which are provided to all staff; granting sick leave to affected employees; appointment of some employees as coordinators of HIV/AIDS campaigns in some units; and the training of managers on HIV/AIDS management.

In relation to programme communications, it appears that HIV/AIDS messages currently do not reach all employees, suggesting limited coverage. This problem was confirmed by all the respondents including top management, programme officials, middle managers and employee representatives. Lack of information about HIV/AIDS issues was seen as one of the major challenges impeding policy implementation in the DRT.

6.3 RECOMMENDATIONS

From the conclusions above, it appears that implementation of HIV/AIDS policy in the DRT is affected by lack of leadership support and involvement; unclear roles and responsibilities for HIV/AIDS; and lack of HIV/AIDS management skills.

Addressing these issues requires multi-level strategies that span all levels of the DRT, i.e. national, provincial, programme, and client level. Here are some of the steps that may be taken to improve implementation of the HIV/AIDS policy in the DRT:

6.3.1 National Level

(a) Improve strategic leadership, decision-making, policy analysis, leadership involvement and support and interdepartmental relations to lay a strong foundation for the implementation of the HIV/AID policy within the DRT environment.

(b) Align HIV/AIDS with the strategic goals of the Department, for example, human resource development, talent retention, diversity management and service delivery. This alignment should be explained to all managers, supervisors and staff in all units.

These proposals are consistent with the King II Report which recommends, among other things, that executive managers create awareness, both amongst themselves, and among subordinates concerning the effect that HIV and AIDS is having in the workplace.

6.3.2 Provincial Level

(a) Improve policy coordination across branches to ensure that all units of the DRT use the same approach to improve roll out of HIV/AIDS policy in the workplace.

(b) Invest more time and effort in policy research to gain fresh insights and perspectives on the implementation and monitoring of HIV/AIDS policy in the workplace.

(c) Beef up implementation capacity by encouraging units within the DRT to share information, success stories and best practices on provision of HIV/AIDS services.

6.3.3 Programme Level

(a) Scale up provision of HIV/AIDS management services by providing adequate, up to date and relevant information to supervisors and employees and strengthening coordination mechanisms to standardise provision across functions.

(b) Accelerate education, advocacy and reach out programmes to ensure that HIV/AIDS management services reach all DRT employees and stakeholders. This should be preceded by proper training of team leaders and supervisors at all levels.

(c) Bench HIV/AIDS management services with leading organisations in the private and public sectors. Benchmarking should cover planning, support structures, programme content, implementation process, and monitoring and evaluation.

(d) Review the HIV/AIDS management programme to identify strengths and weaknesses and take corrective action to improve programme responsiveness and effectiveness. This review should have the inputs of all stakeholders.

(e) Set up coordination mechanisms and support structures to enhance implementation of HIV/AIDS programme at all levels of the DRT. Examples include appointing a project manager and Coordinator, and creating a Steering Committee

(f) Provide meaningful support and incentives to implementers and beneficiaries to ensure commitment, support and ownership. HIV/AIDS management teams should be recognised to encourage participation, commitment and ownership at all levels.

(g) Improve access to support services. The comment that “It is not enough”, and that “Not everyone understands HIV/AIDS” suggest that access to HIV/AIDS services is limited; highlighting the need for decentralisation of these services across functions.

6.3.4 Client Level

(a) Improve policy communications to sensitise all staff on HIV/AIDS issues and to prepare people for participation in HIV/AIDS management activities at all levels of the organisation. Programme specific information should be provided to all stakeholders.

(b) Increase education efforts to create positive perceptions and to overcome the stigma and discrimination suffered by people living with HIV/AIDS (PLWA). For example, there was a feeling that testing and counseling apply only to affected employees.

(c) Review and adjust current implementation strategy so that HIV/AIDS services can extend beyond Corporate Services to other units of the DRT. The aim is to encourage Collaboration and partnerships between units.

(d) Conduct regular quality audits to determine client satisfaction with HIV/AIDS management services. Customer surveys, interviews and focus groups may be used to collect data from managers, supervisors, team leaders and staff across functions,

In conclusion, the results have demonstrated that efforts are underway to implement the HIV/AIDS policy in the DRT, although the scope and intensity of these efforts differ significantly across functions; suggesting gaps in the current implementation strategy.

6.3.5 Future Research

The study has shown that efforts to implement HIV/AIDS policy in the DRT are limited in scope, resulting in misinformation about HIV/AIDS. Further research is therefore needed to establish whether current monitoring and evaluation mechanisms are helping to improve accountability and outcomes on the HIV/AIDS programme at all levels of the organisation. This would require a comprehensive study involving qualitative and quantitative tools (i.e. mixed approach) to ensure that both soft and hard data is generated to support implementation of the HIV/AIDS policy in the DRT.

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8 APPENDIX 1 INTERVIEW GUIDE

1. SENIOR MANAGEMENT PERSPECTIVE

1.1 What are the objectives of the HIV/AIDS programme? Give examples.

1.2 Are these objectives are aligned with the strategic goals of the department? Explain.

1.3 What is your role in the implementation of the HIV/AIDS Programme in the DORT?

1.4 Are you able to perform these roles meaningfully? Give reasons.

1.5 Are there any challenges that prevent you from exercising these roles? Explain.

1.6 How would you describe working relations between management and staff in the HIV/AIDS programme? Motivate.

1.7 Do you provide enough support (i.e. material, financial and moral support) to implementers of the HIV/AIDS policy in the Department? Explain.

1.8 What approaches (i.e. top-down or bottom-up) does the Department follow to implement the HIV/AIDS policy, and are these working? Explain

1.9 How would you describe budget allocation for the HIV/AIDS programme? Motivate.

1.10 What steps, if any, are being taken to improve implementation of the HIV/AIDS programme in the DORT? Give examples.

2. PROGRAMME OFFICIALS

2.1 What are your roles and responsibilities in the implementation of HIV/AIDS policy in the department? Give examples.

2.2 Do you receive enough support from senior management to be able to perform these roles effectively in the HIV/AIDS programme? Explain.

2.3 Has the HIV/AIDS programme been communicated to managers and staff? Explain.

2.3 Would you say that the HIV/AIDS programme is well understood by employees at all levels of the organisation? Give reasons.

2.4 Are you satisfied with the contributions of senior management to the implementation of the HIV/AIDS policy in the department? Motivate.

2.5 Who are the key stakeholders in the implementation of the HIV/AIDS Policy? Give examples.

2.6 What are the roles and responsibilities of these stakeholders in the HIV/AIDS programme? Give examples.

2.7 In your view, are there adequate financial and material resources to support implementation of the HIV/AIDS in the DORT? Give reasons.

2.8 What challenges, if any, hinder the implementation of the HIV/AIDS programme in the DORT? Give examples

2.9 Have you made progress in the implementation of the HIV/AIDS policy in the DORT? Motivate

2.10 In your view, what can be done to improve implementation of the HIV/AIDS policy in the Department? Give examples.

3. LOWER MANAGEMENT PERSPECTIVE

3.1 Do you play any role in the implementation of HIV/AIDS Policy in the DORT? Comment.

3.2 Are staff members under your supervision informed about HIV/AIDS and support services? Explain.

3.3 Do you provide counseling and support to affected employees? Give examples.

3.4 Do you receive support from senior management to be able to perform your roles well in the HIV/AIDS programme? Comment.

3.5 Have you been trained on how to handle HIV/AIDS issues in the DORT? Motivate.

3.6 Based on your experience in dealing with staff in the DORT, would you say that people living with HIV/AIDS are protected against stigmatization and discrimination here? Give reasons

3.7 In your opinion, what can be done to improve delivery of HIV/AIDS services in the DORT environment? Give examples.

3.8 Is there any useful information that you would like to share with the researcher regarding the implementation of the HIV/AIDS programme in the DORT?

1. EMPLOYEE PERSPECTIVE

4.1 Have you been informed about the dangers of HIV/AIDS in your unit? Comment.

4.2 How do you get information about HIV/AIDS in the DORT? Give examples.

4.3 Do you know where to find support services on HIV/AIDS in the Department? Explain.

4.4 Have you received counseling, training or advice on how to cope with HIV/AIDS? Explain.

4.5 Have you noticed or heard any claims of discrimination against HIV-positive people in the DORT? Explain.

4.6 Have you been addressed by senior management on HIV/AIDS issues since joining the DORT? Comment.

4.7 From your experience, what is the general mood or feeling among staff regarding supply of HIV/AIDS services to employees in the DORT? Motivate.

4.8 In your opinion, what can be done to improve supply of HIV/AIDS services to staff in this Department? Give examples.
