Organization Management Journal

Volume 9 | Issue 4 Article 8

12-1-2012

Health Professionals' Challenges in Managing HIV/AIDS in South Africa

Lynette Louw
Rhodes University

Claude-Helene Mayer

Organization Management Journal, 9: 268–279, 2012

ISSN: 1541-6518 online
DOI: 10.1080/15416518.2012.738533

Routledge
Taylor & Francis Group

OUTSTANDING ARTICLE ORIGINATING FROM THE EAM-I CONFERENCE IN BRAZIL

Health Professionals' Challenges in Managing HIV/AIDS in South Africa

Lynette Louw[1] and Claude-Hélène Mayer[1]
[1]*Department of Management, Rhodes University, Grahamstown, South Africa*

The unprecedented human immune deficiency virus and acquired immune deficiency syndrome (HIV/AIDS) crisis worldwide, and specifically in Africa, requires new thinking, new practices, and new research into health management. Identifying the challenges in managing HIV/AIDS from a health professional's perspective would bring new opportunities and uncertainties to health management. Being able to use the opportunities and to better cope with the uncertainties would require a fundamental change and transformation in organizational health management, thinking, and practices. This case study presents selected research findings from a more comprehensive qualitative research study conducted in a selected health organization in South Africa. The aim is to assess managerial perspectives by (a) introducing the theoretical aspects on challenges in health management in South Africa and (b) presenting selected qualitative research findings from a selected health organization in the Eastern Cape, South Africa. Research findings indicate that health management is strongly influenced by national and provincial health policies, donors, funders, communication processes, and culture-related stigmatization, all of which impact strongly on managing the disease. *Organization Management Journal*, 9: 268–279, 2012. doi: 10.1080/15416518.2012.738533

Keywords HIV/AIDS; health concepts; cultural perspective; qualitative study; health delivery

> The global HIV/AIDS epidemic is an unprecedented crisis that requires an unprecedented response. In particular it requires solidarity between the healthy and the sick, between rich and poor, and above all, between richer and poorer nations. We have 30 million orphans already. How many more do we have to get, to wake up? (Kofi Annan, United Nations Secretary General, n.d.)

HIV stands for the human immune deficiency virus, which destroys a type of defense cell in the body, called a CD4 helper lymphocyte, which is part of the body's immune system, the defense system that fights infectious diseases. HIV is the virus that destroys these lymphocytes and causes the acquired immune deficiency syndrome (AIDS; Dowshen, 2007). The unprecedented HIV/AIDS crisis worldwide, and specifically in Africa, requires new thinking, new practices, and new research into health management. Identifying the challenges in managing HIV/AIDS from a health professional's perspective would bring new opportunities and uncertainties to health management (Harris, Brewster, & Sparrow, 2003, pp. 2–3). Being able to use the opportunities and to better cope with the uncertainties would require a fundamental change and transformation in organizational health management, thinking, and practices (Bass, 1997, p. 130; Voelpel, Leibold, & Tekie, 2006, p. 257).

The South African government established South Africa's first HIV/AIDS Advisory Group in 1985 in response to the increasingly apparent presence of HIV/AIDS among South Africans. The first recorded case of HIV/AIDS in South Africa was diagnosed in 1982, and while initially HIV/AIDS infections seemed mainly to be occurring among homosexual men, it soon became obvious that other sectors of society were also affected (Fourie, 2005, p. iii).

The HIV/AIDS epidemic impacts on all societal areas, including the economy and the political and social arenas (Report on the Global HIV/AIDS Epidemic, 2006, p. 3). The dramatic increase of the disease since the 1980s has been ascribed to many different factors, including extreme poverty (Barnett & Whiteside, 2002, p. 81; Tadli, 2006, p. 369); migration (Fourie, 2005, p. 87); the history of the country (Orkin & O'Meara, 1989); diverse social, economic, and political factors (Fourie, 2005, p. 83), such as rapid urbanization and population density (Meidany, Horikoshi, & Rohde, 2000); lack of medical services and access thereto (Benatar, 2004, p. 81; Coovadia, 2000, pp. 57–63); and cultural aspects regarding the perception and interpretation of concepts of gender, power, and humanity (Leclerc-Madlala, 1997, p. 363). There has consequently been an increase in HIV/AIDS-related research in South Africa (Connolly, Colvin, Shishana, & Stoker, 2004,

Address correspondence to Lynette Louw, Rhodes University, Department of Management, P.O. Box 94, Grahamstown, 6140, South Africa. E-mail: l.louw@ru.ac.za

p. 776), particularly during the past few years (HIV/AIDS, 2008, pp. 39–40).

The South African government has exceeded most expectations regarding management of HIV/AIDS in the recent past (Navario, 2010). The new minister of health publicly acknowledged the failed policies of the past administration and has advanced new, evidence-based policies, which include starting treatment earlier for pregnant women, patients co-infected with TB, and infected children. The budget support for HIV/AIDS was increased and the epidemic appears to have stabilized, as HIV prevalence has held steady for the past 2 years. However, there are still major challenges to achieving universal access to proven HIV prevention and treatment interventions (Navario, 2010).

In South Africa, health professionals in health organizations are particularly challenged by the need to manage the epidemic, chronic diseases and shifting health care needs with regard to micro (patient and family), meso (health care organization and community), and macro (policy) levels (Epping-Jordan, Pruitt, Bengoa, & Wagner, 2004, pp. 299–305). At the same time, they are challenged by the double transition (Mayer, 2011), referring to the globalization processes and the changes with regard to the post-apartheid era. Booysen, Nkomo, and Beaty (2002) are of the opinion that there is a definite lack of "cultural awareness"—in a broad sense—in organizations in South Africa and that only 24% of the organizations have implemented diversity management programs. Recent studies (Jackson, 2011; Mayer, 2011), however, show that issues of culture and diversity are gaining interest in organizations in South Africa.

This article seeks to contribute to creating knowledge and awareness among health and non-health professionals regarding challenges faced by health professionals in a specific organization in the Eastern Cape Province in South Africa. More specifically, the article provides insights into emic perspectives on the challenges at the macro, meso, and micro levels and is aimed at health and non-health professionals who are not familiar with the South African health care system.

The main aim is to assess the managerial perspectives of medical health professionals in a selected organization by (a) introducing the theoretical aspects on challenges in health management in the specific organizational context and (b) presenting selected qualitative research findings from this health organization. Despite this, lessons learned could still be applied in organizations in the health care sector. To achieve these aims, the following research questions are answered:

- What challenges do health professionals experience in health professions in South Africa, specifically with regard to health delivery structures and cooperation with organizations on international, national, regional, and local levels?
- What challenges do South African health professionals in a selected organization experience regarding communication and health concepts in the organization (micro, macro, and meso level)?

The following sections provide theoretical background information and an introduction to the research study, followed by the presentation of the research findings. Finally, a conclusion is drawn.

HIV/AIDS IN SOUTHERN AFRICA

It has been established that Southern Africa remains the worst affected HIV/AIDS infected region in the world (Dowshen, 2007). Sub-Saharan Africa (African countries south of the Saharan desert) has more HIV positive people and AIDS deaths than any other part of the world: 67% of all HIV positive people and 72% of all AIDS deaths were in Sub-Saharan Africa in 2008 (UNAIDS, 2008). The infection rate in Sub-Saharan Africa may be ascribed to multifactorial causes, as referred to previously, such as poverty and social instability, high levels of sexually transmitted infections, sexual violence, high mobility (particularly migrant labor), and a lack of good governance.

South Africa's new National Antenatal Sentinel HIV and Syphilis Prevalence survey (Agence France Press, 2011) shows an increase in HIV among pregnant 24- to 39-year-olds. The rate of older pregnant women with HIV is up to 30.2% from 29.4% in 2010. New UNAIDS data indicate South Africa continues to have the world's largest HIV/AIDS caseload, 5.6 million people. Improved disease-fighting efforts decreased infections by 22% between 2001 and 2009 and deaths by 21% between 2001 and 2010 (Agence France Press, 2011).

However, South Africa is still regarded as severely affected by the epidemic and effective health management is therefore seriously needed: The estimates on HIV-positive population in South Africa counts 38% (Statistical Release, 2011, p. 5). Thirty-two percent of all children in South Africa will have lost one or both parents to AIDS by 2015 (*Business Day*, 2009). An estimated 16.6% of the adult population between 15 and 49 years of age is HIV-positive (Statistical Release, 2011, p. 3).

Provincial HIV/AIDS estimates show geographic variations in the epidemic in the country's provinces. Significant decreases were recorded in 2006 for the three provinces of Mpumalanga, North West, and Gauteng (National HIV and Syphilis Prevalence Survey South Africa, 2006, 2007, p. 3). All other provinces remained at a statistically stable level in comparison with those recorded in 2005, although the general tendency was toward a reduction in the number of infections. The Free State was the only province which remained virtually stable, though it showed a tendency toward an increase (National HIV and Syphilis Prevalence Survey South Africa, 2006, 2007, p. 3).

According to Dorrington, Bradshaw, and Budlender (2002, p. 2), the antenatal data reveal that the spread of the epidemic has differed between the provinces. In this regard the provinces differ in terms of ultimate plateaus, ranging from a low of 14% for the Western Cape to a high of nearly 40% for KwaZulu Natal. Four of the nine provinces appear to be following similar patterns, while the epidemic in KwaZulu Natal appears to have started earliest and is expected to peak at the highest level. The

epidemic in the Northern Province, Northern Cape, and Western Cape is expected to level off at levels lower than those of the other provinces. The Eastern Cape is beginning to reveal a distinctive pattern, with a much slower increase and no plateau expected by the year 2010 (Dorrington et al., 2002, p. 10). However, the trend in the pattern has not been able to be traced since the official statistics have not been updated (Statistical Release, 2011). Two Eastern Cape universities have revealed that 6.4% of the student population in the Eastern Cape is living with HIV/AIDS (Sokopo, 2010). Despite the epidemic still growing in the Eastern Cape, the number of people accessing antiretroviral treatment (ART) is not increasing proportionately; for example, in the Eastern Cape the total number of people in need of ART is 111,000, while only 49,000 people access ART (Nicolay, 2008, pp. 4–5). Proactive management could slow down this epidemic. Interventions that could be used in managing proactively include, for example, talking openly about the HIV/AIDS epidemic; addressing social and political issues around the epidemic; raising awareness of the effects of the disease; discussing how to combat the disease; encouraging the affected to know and understand their HIV status through counseling and testing programs; and providing proactive treatment and making available antiretroviral drugs to those in need (Da Silvia & Wayburne, 2008, p. 36). These interventions should be implemented by means of HIV/AIDS programs offered by government and partnering nongovernmental organizations (NGOs) that provide HIV/AIDS services to those in need and to the society as a whole. For example, the strategic plan for the Eastern Cape (PGDP, 2007) addresses the priority areas on managing HIV/AIDS through prevention (testing and counseling, risk management), treatment, care and support (community home-based care, traditional and alternative health therapies, antiretroviral therapy, etc.), impact mitigation (e.g., orphans and vulnerable children), promoting human and legal rights (mobilizing people living with HIV/AIDS), managing provincial responses (planning and program responses to HIV/AIDS), and improving HIV/AIDS research (implement and support research).

Managing HIV/AIDS in South Africa

The official policy response to managing HIV/AIDS began in 1992 with the establishment of a South African national coordinating committee to develop an HIV/AIDS strategy. The aims of the strategy were defined in 1994 (reviewed in 1997 and 2005) both to combat the disease by improving public awareness and to treat the disease at public health facilities. "By 1992 it was portrayed as a significant threat to South Africa, although one that could still be averted. By 1996, the threat to productivity posed by AIDS was being addressed in detail" (Dickinson, 2004, p. 4). Controversial political discussions include the discourse on government provision of antiretroviral (ARV) therapies through the public health system (Schneider, 2002); the decision in 2003 to provide ARVs (Willan, 2004, Nattrass, 2006, p. 2); and the authorities' long-standing concerns with weaknesses in health and laboratory infrastructure, high drug and testing costs, complex treatment regimes, and potential toxicity of the drugs (Willan, 2004). Four priority areas were addressed in 2005, namely, public awareness and prevention; treatment and support; research and monitoring; and legal and human rights (Horton, 2006, p. 113). In March 2005 at least one service point for HIV/AIDS-related care and treatment had been established in each of 53 districts in South Africa, meeting the government's 2003 target (HIV, 2008). Furthermore, the Operational Plan obligated the government to providing ARV treatment to 1,650,000 people by March 2008 (AIDS Foundation South Africa, 2005). Nevertheless, health-professional, government, and civil-society organizations in South Africa still face major challenges in the fight to control the HIV/AIDS epidemic (Brown & Eberdt, 2007, p. 26).

In the Eastern Cape, particularly, challenges are experienced regarding the implementation of new policies, such as the National Disability Grant and the ARV program (Brown & Eberdt, 2007, p. 26). Difficulties in restructuring processes in the health care system have occurred owing to the lack of a comprehensive response to the disease (Schneider & Stein, 2001, p. 723). Research on HIV/AIDS treatment and access to ARV in South Africa and other African countries have grown during recent years (Metzler, 2007; Schneider, Blaauw, Gilson, Chabikuli, & Goudge, 2006, p. 12). The increase in access to HIV/AIDS treatment is reflected by the growing pharmaceutical market in South Africa, which is expected to double in the next 6 years due to profitable governmental contracts for HIV/AIDS and tuberculosis medications (Smith, 2012).

With regard to the role of local health organizations, a need exists for counselors and counseling facilities; palliative care; professionalization processes, for example, health-management training regarding managing the stigma associated with the disease; teamwork; and efficient logistics (Duffy, 2005, p. 13; Uys, 2003, p. 271). HIV/AIDS and HIV-related stigma have potential implications for treatment, care, and support for individuals at different stages of HIV infection. Organizations are also encouraged to integrate findings into HIV stigma interventions and social support programs (Logie & Gadalla, 2009).

The Impact of Donors on HIV/AIDS in South Africa

According to Raval (2007), South Africa has been one of the top five HIV/AIDS donor-funding recipient countries in the world. At the same time, local organizations still carry most of the responsibilities in the fight against HIV/AIDS (Raval, 2007). Bilateral and multilateral international donors have assisted the government with capacity-building, training, health economics, and support for organizations providing home-based care (Horton, 2006, p. 15). International donor programs include the Joint United Nations Program on HIV/AIDS (Report, 2006), the European Union (EU), and aid agencies of EU member countries, Canada, Japan, Norway, and the United States.

Health professionals have supported the investment of these funds in introducing sophisticated awareness programs, prevention efforts, and voluntary counseling, as well as testing programs and provision of antiretroviral drugs (ARV) to employees infected by retroviruses, primarily HIV/AIDS (Hellriegel et al. 2012). For instance, many large international and South African enterprises and NGOs in South Africa have begun offering HIV/AIDS prevention and treatment services to employees, while many multinationals in South Africa are increasingly involved in HIV/AIDS initiatives in both the supply chain and employees communities (Overseas Development Institute, 2007, pp. 1–4).

Trade unions have also launched HIV/AIDS-awareness initiatives and have urged the adoption of equitable HIV/AIDS policies, including the preparation of codes of good practice, as well as educational programs (Bollinger and Stover, 1999, p. 15). NGOs, such as the Treatment Action Campaign (TAC) and the organization of Médecins Sans Frontières (MSF), have been instrumental in securing access to drug treatments, both through obtaining court decisions and by operating township treatment facilities (Heywood, 2003, p. 278).

The vast majority of small and medium-sized enterprises, however, have not demonstrated such support (Rosen & Connelly, 2004). The second report of the King Committee on Corporate Governance (2002) warns of the growing threat of HIV/AIDS to the South African economy and South African businesses. The increase in illness and death in the South African population inevitably has economic consequences, "affecting not only health employees, but also the customer base of organisations" (Hellriegel et al., 2012, p. 583). HIV/AIDS affects skilled and unskilled labor in South Africa by a decline in the level of experience in the workforce and deterioration of the quality of education in the organizations (Haacker, 2002). HIV/AIDS has impacts in the workplace through increasing absenteeism, as well as accidents and health care costs. It also has impacts by decreasing motivation, productivity, and morale (Hellriegel et al., 2012).

Health professionals in the health care system experience challenges at macro, meso, and micro levels, specifically with regard to global and international networking, funding, and donors. In addition, challenges are experienced with regard to national policies and socioeconomic, political, and infrastructural issues on the meso level, as well as interpersonal relations on the micro level (Epping-Jordan et al., 2004, p. 299).

RESEARCH DESIGN AND METHODOLOGY

Given the qualitative nature of this research, the phenomenological and interpretative paradigms were the most relevant approaches (Collis & Hussey, 2003, p. 47). Within these paradigms, the theoretical and methodological approaches are based on both the epistemological tradition of constructivism (Berger & Luckmann, 2000) and interpretative hermeneutics (Habermas, 1999), focusing on gaining a deeper understanding of the research issue (Cheldelin, Druckman, & Fast, 2003, p. 25) and "thick descriptions" (Geertz, 1987).

A qualitative research methodology was chosen because of the nature of research: Access to the organization could only be gained by using an interpersonal research approach. The qualitative approach enabled the researcher also to gain access to in-depth information, with quality and richness of data, particularly as regards this topic.

Data Collection

Data were gathered through:

- Conducting in-depth interviews with selected interviewees.
- Conducting observations in the field.
- Taking field notes of collateral talks, interactions, and observations.
- Studying confidential organizational documents on managing conflicts and conflict management processes, organizational visions and aims, organizational structures and organization management, and change implementation.

The interview structure centered around health management on the macro, meso, and micro level and included, for example, the following questions:

- Please explain the story of the ARV clinic at the hospital.
- Please highlight what is important with regard to the macro, meso, and micro level of health care and health management.
- Please describe the goals of your organization.
- What is the overall organizational structure of the clinic?
- Please describe the training facilities for employees at the organization.
- How does the clinic relate to the municipality and health delivery structure of the province?
- What government or other policies influence your work?
- How does international/national/provincial policy influence your access to funds, and the way you formulate and carry out projects?
- What are the management styles of the organization?
- What improvements in management structures would you suggest for the future?
- How does the issue of culture come into play in this organization?

Data Analysis

Explanations and interpretations of the described subject were developed according to the following levels of text reconstruction (Ricoeur, 1979, p. 252; Wolff, 2000, p. 87):

- Level 1: The manager experienced challenges in the selected health organization.
- Level 2: The manager narrated the experienced challenges during the interview.
- Level 3: The researcher transcribed the interview and categorized this transcribed text through content and key word analyses. Key terms are defined as words that occupy key positions in text through the import of their content, their significance in the text structure and conception, or repetition or other emphasis. The transcripts were viewed as selective constructions that reproduced aspects of the conversation and that were transcribed, according to Steinke (2000, p. 327), in a "manageable" way that is "simple to write, easy to read, easy to learn and to interpret." The transcription procedure focused primarily on the verbal aspects of the communication in the interest of analysis and evaluation controlled by factual words. Analytical data evaluation was applied (Level 4), subsequent to the texts being transcribed.
- Level 4: The researcher interpreted the categorized text through content analysis (Mayring, 2003), based on a systematic approach to "accidental perceptions." This approach culminates in the construction of categories; hence, "content analysis" serves as a technique of research that leads to conclusions that can be generalized (Kromrey, 1998, p. 298).

Research findings were created through the interdependent relationship between the "issue of research" and the "process of research" (Stellrecht, 1993, p. 36). In this study, the issue of research pertained to the challenges narrated, while the "process of research" encompassed the identification of keywords with regard to health delivery, roles of organizations, communication, health concepts and the management thereof, hermeneutical reconstruction, and the presentation and interpretation of the concepts mentioned.

Sample and Sampling Procedure

An explanatory case study was used to understand and explain challenges from the viewpoint of the health professionals concerned (Yin, 2002). Data were gathered by means of in-depth individual interviews and data analyses, within the guidelines of case-study research (Babbie & Mouton, 2006, p. 291), from among a sample of seven health professionals (identified as I-1 to I-7; see Table 1) working in the selected health organization. These health professionals' interviews were recorded in full to ensure precise transcription. The health professionals, representative of the top, middle, and lower management levels, volunteered to participate in the interviews. This sample exclusively comprised South African male and female health professionals, to whom anonymity and confidentiality were guaranteed.

TABLE 1
Details of interviewees

Interviewee number (I)	Occupation	Gender	Race
I-1	Project manager	Female	White
I-2	Medical officer	Female	White
I-3	Social worker	Male	Black
I-4	Head nurse	Female	White
I-5	Chief pharmacist	Male	White
I-6	Professional nurse	Female	Black
I-7	Volunteer	Female	Colored

Limitations of Research

This qualitative research study is an exploratory single case study and is limited with regard to its organizational context. Therefore, no generalizations can be made from this research with regard to South Africa. However, it is possible to "generalise from one setting to another" in qualitative research (Collis & Hussey, 2003, p. 55). Based on this, it is suggested that generalizations from this exploratory study could be made to similar organizations in the Eastern Cape Province.

RESEARCH FINDINGS

Health professionals in the selected organization in the Eastern Cape Province highlighted the considerable influence of the organization; the relationships between the organization and partner institutions, such as the government, NGOs, funders, donors, and commercial enterprises; health delivery; and governance structures. Aspects of intraorganizational relationships, culture, and values represented challenges for managerial health professionals with regard to managing health and HIV/AIDS in the selected organization. Additionally, aspects reflecting the organizational culture, such as remuneration of health professionals, training, and goal setting, were mentioned as challenging.

In this section the challenges of health professionals are presented with regard to the macro, meso, and micro level. On the macro level, the different levels of cooperation are introduced. Thereafter, relationships on the meso level are evaluated and finally challenging relationships and structures on the micro level are analyzed.

The macro level is defined as the policy level, where the focus is on the challenging interrelationships with regard to cooperation on a national, regional, and/or interorganizational level.

The meso level is the level that addresses intraorganizational aspects, the health care organization, and the local community.

The micro level refers to the interpersonal and intrapersonal level, focusing on the patient, the doctor–patient interaction, and the patient's family interrelationships.

The Macro Level: Challenging Interrelationships on Different Levels of Cooperation

The health professionals of the organization felt "challenged" (I-1, I-5) by international and global trends that forced them to manage and distribute international funds on national and provincial levels, while remaining independent at the same time (I-1): "Global trends have an influence on the sites' access to funding and funding goes to national level which is then distributed to the different provinces." Health management was, therefore, considered greatly influenced by "Western approaches that are imposed by the funders" (I-1). This often represented a challenge with regard to combining it with local and provincial health-delivery structures.

Relationships with funders and donors were generally valued positively and respectfully (I-1): "The funders and donors come from the government at national and provincial levels. Funding also comes from private organizations." I-1 felt challenged by the attitude that the organization is seen as an "employee of their funders" (I-1), which sometimes led to misunderstanding and miscommunication, particularly with regard to monthly reports that were submitted to the funders.

Governmental and other national policies are restricted by international fund distribution, as well as by national and provincial guidelines and health structures (I-1, I-2, I-4, I-5). A comprehensive health plan was provided by the province. This health plan stipulated guidelines for health professionals that restricted flexible work (I-1), and also included policies formulated by the Council for Health Service Accreditation of Southern Africa (COHASA), the body that helps to formulate policies in the region of Southern Africa (Claassens, 2003, p. 4). The restriction on flexible work imposed by the comprehensive health plan also included adherence policies, policy on referrals, policy for community mobilization (I-3), infection control policy, ARV policy including CD4 count, which is a "a measure of the number of helper T cells per cubic millimeter of blood, used to analyze the prognosis of patients infected with HIV" (*American Heritage Dictionary*, 2003, http://www.thefreedictionary.com/CD4+count) (I-2), and the Safe Disposal policy (I-4), thereby providing strict guidelines on the management of HIV/AIDS in the province. Health professionals also felt challenged by financial restrictions (I-2); slow bureaucratic processes (I-4); human resource processes (I-2); and drug policies and drug lists (I-5), including ARV restrictions, drug availability, and governmentally provided drugs. Qualification for ARV treatment only includes patients with a CD4 count less than 200. At this stage of HIV/AIDS the aim of health professionals to take care of the general health and psychological and medical well-being of the patient is hardly realizable any longer (I-2); there are also union policies and the South African Nursing Council (I-4), a strong influence from provinces (I-5), and Batho Pele policies that stated that the patient came first and that a high standard of public service delivery was essential (I-3, I-7). The Batho Pele concept was conceived with the intention of transforming public service delivery to ensure both customer and employee satisfaction and embraced the following principles: (a) consultation, (b) service standards, (c) courtesy, (d) access, (e) information, (f) openness and transparency, (g) dealing with complaints, and (h) giving best value (*COHSASA News*, 2003, p. 5). In Table 2 a summary is provided of the challenging relationships at the macro level, as well as the statements of interviewees and challenges addressed.

The Meso Level: Relationship With Provincial and Municipal Health Structures

Generally, the health delivery structure and cooperation between different actors at provincial level was described as "effective and continuously flowing" (I-4) by the health professionals, particularly with regard to regular meetings with decision makers at different organizational levels (I-1) and the provision of medication and research activities (I-6). Frustrations included a lack of funding (I-1); ways of intraorganizational decision making, and a "dictating communication style" with a top-down approach from the provincial office (I-5, I-7); health professionals' employment (I-5); and lack of transparency (I-5).

The relationship between the organization and the municipality was valued as essential, extremely important, and progressing (I-1). It provided a strong, cooperative base with a supportive educational service (I-1, I-2, I-3), particularly via meetings, training sessions, and mentorship (I-1, I-6). The communication was described as being "very effective" (I-3, I-7):

> The municipality organizations do the basic work with regard to the referral of patients to ARV organization. Then, when the patient is doing well there is a down referral of patients to the organizations. The ARV organization keeps the patients for about 5 to 6 months. There are weekly meetings with other organizations where they discuss qualified patients, defaulters and strategies on how to ensure that patients adhere to the medication. It is, therefore, an effective relationship as they provide advice on many different issues.

I-5, however, criticized challenges created by health-professional shortages, "bad infrastructure and unfulfilled expectations" between the organization and the municipalities.

The Meso Level: Relationships With Churches, NGOs, and Commercial Enterprises

Relationships with churches, NGOs, and commercial enterprises were considered particularly effective because of flexibility and relatively low bureaucracy. These organizations provide food, as well as advice on social issues, such as disability grants. NGOs include, for example, GADRA (poverty alleviation program), FAMSA (long-term relationship for therapeutic needs), Child Welfare (for child-related cases), and Social Development (extremely good relationship gained by assisting those at the ARV organization who need a social grant). Certain commercial companies donate medication and provide access to the latest research (I-5). The Treatment Action Campaign (TAC) also

TABLE 2
Macro level

Level	Statement	Challenge
Macro: Challenging interrelationships on different levels of cooperation	International donors dictate how funds should be spent (Western approaches imposed by funders)	Not addressing local needs
	Donor funding allocated by national level to provincial and local levels	Distribution allocation, determined by statistics that are often incorrect and restricted by national policies as determined by international funding distribution policies (Western approach), nonalignment between national, provincial, and local health delivery structures
	Misunderstanding and miscommunication between national, provincial, and local health delivery structures	Monthly reports are in incorrect form and do not comply with international funding reports
	Provincial health plan	Financial restrictions, slow bureaucratic processes, drug policy restrictions, union policies
	Batho Pele policies	Inequalities in applying Batho Pele principles

impacts on the organization, according to three interviewees (I-2, I-6, I-7), offering service training, new information (I-6), and HIV/AIDS education (I-7).

Most of the health professionals agreed that the health management systems worked effectively in their organization (I-2, I-3, I-5, I-6) and that successful relationships were based on the "two-way-flow of information" (I-3); a "holistic approach" (medical and social aspects were seen) to treating people (I-4); and good communication, teamwork, and meeting structures (I-3, I-6, I-7).

Negative influences were experienced with regard to social-grant issues; some relationships hindering "project implementation" (I-1); and too few resources supporting local organizations and the hospice (I-2). In addition, "slight difficulties with communication channels at present" (I-4) were experienced. Social welfare had given clear directives and guidelines; however, the relationship was still "seen to be a bit slow und slightly unreliable as the supply of resources is not always accessible, which, in turn, hinders project implementation" (I-4). I-5 mentioned that "relationships at provincial levels are not very good as it is confusing and health professional members are unsure of who is responsible for what aspects."

In Table 3 a summary is provided of the challenging relationships at the meso level, as well as the statements of interviewees and challenges addressed.

The Micro Level: Intraorganizational and Intercultural Relationships

With regard to intraorganizational relationships and aspects of race and gender, three health professionals were of the opinion that there were "no impacts of race" on the organization or the work (I-1, I-2, I-3). This was highlighted by two White female interviewees and one Black male interviewee. These health professionals highlighted that there were no differences between White and Black health professionals, or patients in general, and how they conducted work (I-1). However, the other four health professionals (I-4, I-5, I-6, I-7)—who are a female White, a male White, a female Black, and a female Colored—stated that culture played a significant role in the communication processes of health professionals and patients, as well as between patients.

A significant cultural awareness (I-3, I-4) existed in the team, highlighted by a male Black professional and a female White health professional, and there were open discussions on how cultural issues were solved with patients of different cultural backgrounds (I-3). I-3, the Black male social worker, pointed out the existence of a problem in the broader community where HIV/AIDS was considered race related and defined as a "Black-person's-disease." This led to a situation where "White people also have the disease within the community, however, due to the stigma related to the disease White people do not come to the organization" (I-3). This impacted negatively on HIV/AIDS education among White patients, as they felt too threatened to be educated, as highlighted by a Colored female volunteer (I-7).

At the same time, there were "some HIV-infected individuals who are not willing to disclose their disease due to the fear of stigmatization and thus don't receive treatment" (I-3). In addition to the "Black-person's-disease" stigma associated with HIV/AIDS, I-6 further experienced differences in health, professional skills and approaches, and communication styles,

TABLE 3
Meso level

Level	Statement	Challenge
The meso level: relationship with provincial and municipal health structures	Frustrations: lack of funding, intraorganizational decision making, top-down managerial approach, lack of transparency	Train managers and address conflict issues
	Bad infrastructure with municipalities	Rebuild infrastructure
Relationships with churches, NGOs, and commercial enterprises	Effective cooperation	Further develop the cooperation
	Social grant issues and project implementation	Foster reliability of external resources

such as direct and indirect communication styles, in the health professionals team.

Generally, a high level of cultural awareness, together with a high acceptance of diversity, was evident among the team members (I-4). A problem did, however, exist because "some persons with some cultures feel left out" as a result of differences in both mother tongue and language skills (I-4). The organization therefore used interpreters to improve communication between health professionals and patients with different cultural backgrounds.

The Micro Level: Value Priorities of Health Professionals

The health professionals mentioned that their value priorities were intricately bound up with their interrelationship with the organization and the people involved in their work. This showed equality to be one of the most important values (I-1, I-3, I-5), particularly in the fight against HIV/AIDS, a disease that should not divide people culturally. Connected to this value of equality were values such as "caring for the patient" and "the patient always comes first" (I-1, I-2, I-4, I-5, I-6, I-7), even when a strong results orientation (I-4, I-5) and a focus on the health professionals' needs existed (I-2). Results orientation is defined by the interviewed health professionals in terms of improving mortality of patients through adherence counseling (I-2); offering a comfortable and relaxed environment for the patient (I-3); improving lives of patients and providing quality and sustainable services to as many people as they can (I-4); being goal driven and achieving results (I-5); making patients adhere to the medication (I-6); and reaching the community (I-7).

Further relationship values considered important by the health professionals included informal (I-1) and formal (I-1, I-6) communication. "Formal communication occurs through the discussions of memorandums and policies. Informal communication occurs through an open-door style which takes place during general meetings and management reviews" (I-1). Effective communication was related to "inter-disciplinary teamwork and health professionals' equity" (I-2), as well as "open channel communication" (I-4); working closely together (I-5); and "open communication and sharing most secretive problems" (I-7). Interorganizational communication was viewed as "well co-ordinated and effective" (I-3). With regard to communication and decision-making, I-1 felt that "sometimes top-down decisions are made, but with regard to organization-related issues all health professionals and team members are involved" (I-1). Generally, health professionals viewed the intraorganizational decision-making approach as a team-oriented one (I-2, I-6, I-7) in which all professionals are respected (I-3) and are given the opportunity to express their opinions (I-3, I-6, I-7): "Very open, locally driven, communication is good, options are expressed" (I-5).

Most of the health professionals were of the opinion that the organization was hierarchically organized, because only "senior health professionals perform certain functions" (I-1); "everyone has a separately defined position in the organization" (I-6); and "one can seek advice from a superior" (I-3). Four health professionals, however, were of the opinion that the organization was not hierarchical (I-2, I-4, I-5, I-7), because all health professionals were approachable (I-4) and team oriented (I-5). Nearly all the health professionals defined the organization as "rule-bound" (I-1 to I-6) with regard to certain policies and guidelines, which sometimes presented a challenge to these health professionals. Related to these rules was the perception of ethnic belonging with regard to particular values, such as confidentiality and medical treatment (I-1), which was seen as an imperative in the organization (I-7).

An additional challenge to the health professionals was that of the remuneration paid by the government, "without any benefits, such as medical aid, housing allowance and full leave" (I-1). Health professionals, therefore, needed to be intrinsically motivated through enthusiasm (I-4). Extrinsic motivational aspects, such as merit bonus increases for outstanding performance, remuneration increases, or team-building exercises, were rare. I-7 commented that the "organization has not kept their promises with regard to offering training sessions."

Most of the health professionals felt motivated and rewarded through achieving good results and success with patients (I-2, I-6); good teamwork (I-2); a positive contribution to society (I-2); and the experience of a good working environment with open, honest, and easy communication (I-3, I-4). Finally, health

TABLE 4
Micro level

Level	Statement	Challenge
Micro: intraorganizational and intercultural relationships	Impacts of race and gender on communication among health professionals and between health professionals and patients	Develop coping strategies to deal with aspects of race and gender
	Stereotyping and stigmatization	Open discussions and culture awareness
	Mother tongue and linguistic ability	Language training
The micro level: value priorities of health professionals	Remuneration and benefits	Merit bonuses, team-building exercises
The micro level: value priorities of health professionals	Health risks	Hygienic standards
Micro: organizational goals and changes	Poor funding and lack of resources	Gain funds and resources
	Mismanagement and misappropriation	Allocate fundings appropriately
	Organizational goals to reduce HIV/AIDS	Change health care structures and processes

professionals identified a challenge concerning health risks they faced in the organization: "The organization is prepared to take risks to a certain degree, however, not in areas which involve their conduct of work with regard to safety" (I-4). Two health professionals stated that one could not afford to take risks when administering either medication or medical treatment (I-5, I-6), while another felt at risk when treating tuberculosis patients (I-7).

The Micro Level: Organizational Goals and Changes

Managing HIV/AIDS by using significant resources has had good results, "not in terms of numbers, but in terms of heath care and improvement in a patient's life. However, a gap is assumed because the ARV program is a new program, which was only implemented a few years ago. It can't immediately achieve results, will take some time in terms of numbers" (I-1). Most of the health professionals were "disappointed by the results of the HIV/HIV/AIDS management" because of "poor funding and resources at provincial level" (I-1, I-2); the "mismanagement of finances and misappropriation" (I-4); and the focus on investing the money (I-6). I-5 proposed that research and statistical reporting, as well as the planning of funds and distribution thereof, should be improved.

Health professionals formulated goals for the development of the organization. These goals were viewed as challenges, and comprised the following: a decrease in HIV/AIDS-related morbidity and mortality; a reduction in the incidence of HIV/AIDS-related illnesses among patients; a rise in patients' CD4 count remaining above the base count; the achievement and maintenance of an undetectable patient viral load (less than 400 copies) on ARV (I-1); a decrease in the incidence of HIV/AIDS through both increasing voluntary testing and counseling, and the number of people being informed of their status and practising safe sex; a reduction of transmission in discordant couples (one partner with a positive HIV status and one negative) and reduced risks of HIV/AIDS transmission from mother to child; treatment of the patient at both the organizational and emotional level; provision of a holistic medical diagnosis and continuation of medical care (I-2); provision to the community of access to ARVs, thereby extending lives (I-4); effective management of the virus; and emphasis on compliance/adherence (I-6).

The health professionals pointed out that significant changes are required in the organization to give effect to these goals, as "the overall success of the project is not where it should be yet. There are huge problems with infrastructure and there is room for more improvements to be made" (I-2). These changes included accreditation of more fully functional sites to support more patients (I-1); stabilization of changes and reevaluations (I-2); decentralization (I-2); expansion of human resources (I-2, I-3, I-6); changes in medication regularities (I-2, I-5); a changed focus to one of wellness and health management (I-3); a restructuring of governance structures and two-way-communication (I-4); changes of registration procedures (I-5); and an increase in volunteers' salaries (I-7).

In Table 4 a summary is provided of the challenging relationships at the micro level, as well as the statements of interviewees and challenges addressed.

CONCLUSION

This article aimed at creating awareness among health and non-health professionals of the challenges faced by health professionals in a specific organization in the Eastern Cape Province in South Africa. It shows that health professionals in the selected organization experienced health management challenges on the macro, meso, and micro levels. The research findings were presented from contemporary emic perspectives,

thereby contributing toward creating an awareness of unique insights of South African health professionals.

With regard to the macro level of health management, health professionals state that there are challenges with regard to international donors dictating Western approaches and allocation of funds, the allocation of funds from national to provincial and local levels, misunderstanding and miscommunication between provincial and local health delivery structures, the provincial health plan, and applying Batho Pele policies. From the emic perspective of the health professionals, challenges on the macro level are found in the fact that local needs are not addressed, that levels of distribution allocations are not aligned, and that the ways of communication need to be changed. Health professionals are challenged by financial restrictions, slow bureaucratic processes, drug policy restrictions, and union policies. They also experience Batho Pele policies as challenging. Health professionals feel that the challenges on the macro level need to be addressed on international, national, and provincial levels mainly and can hardly be resolved on a local level.

The uniqueness to South Africa of the macro-level challenges mentioned includes the perception of international donors that the health care structures operate according to Western standards and processes. However, due to the transitional state of management practices in South Africa, alternate ways of managing are beginning to emerge. Managing within this transitional period is influenced by the merging of different cultural perspectives and expectations with regard to management practices and processes. The challenges in merging different cultural perspectives require a polychromic way of health management practices. This polychromic approach could be a contributing factor to the misunderstanding of donor expectations and miscommunication across the different health delivery structures. An additional element of frustration in South African would be the integration of the Batho Pele principles. According to the Batho Pele principles, health professionals' priority should be the patients and a humanistic way of communication.

Challenges experienced by health professionals on the meso level include frustrations due to lack of funding, conflicts due to decision-making processes, the top-down managerial approach, and the lack of transparency. Health professionals feel challenged to deal with the situation, to address conflicts openly, and to be trained professionally to deal with occurring frustrations. The interviewees complain about the infrastructure and feel challenged by the urge to rebuild infrastructure with regard to the provincial and municipal health structures. With regard to the meso level, health professionals are highly content with the cooperation with churches, NGOs, and commercial enterprises, and see the challenge only in developing and expanding these cooperations, particularly by fostering reliabilities of external resources.

At the meso level, the search for a South African management model leads to interorganizational irritations and disturbances in decision-making processes across the different decision-making strata. It is interesting to note the highly cooperative structures with the broader stakeholders, such as churches, NGOs, and commercial enterprises, and it is evident that the community is willing to facilitate and support the governmental bodies with health care delivery.

Finally, on the micro level, health professionals experience the impact of race and gender on their work environment; they experience stereotypization and stigmatization particularly with regard to race, as well as mother tongue and linguistic ability. They are challenged by developing coping strategies to deal with issues of race and gender, to address these issues openly, and to develop cultural awareness and sensitivity within the organization. Health professionals also feel challenged by the multilingual environment, which demands high and multiple language competencies to communicate properly with patients and colleagues from different cultural backgrounds. Health professionals feel challenged by their value priorities, by the high health risks that their profession includes, by the poor funding and lack of resources, by mismanagement and misappropriation, and by the organizational goals to reduce HIV/AIDS. They see a need to allocate funding appropriately, to gain new funds and resources, to increase the hygienic standards, to increase team-building exercises, and to change health care as well as remuneration structures.

Given these mentioned challenges at the micro level, it can be seen that together with the transition to a South African management philosophy, the limited resources, the mismanagement and misappropriation of funds, and the stereotyping contribute toward a complex management model for this organization. Particularly unique is the HIV/AIDS stereotypization related to race. A further concern in communication is based on mother tongue and linguistic ability, exacerbated by the 11 official languages in South Africa, with English being the language of communication. In this research it was expected that health professionals should be able to communicate in at least one local African language, and the experienced disability of health professionals led to frustrations and conflicts.

This research shows that health professionals in the investigated organization experience challenges that might occur on global levels, as well as in other South African health organizations. However, they also experience challenges that might be specific with regard to the context researched. It further indicates that more research on health management and health delivery is needed across different health management organizations in South Africa to be able to address global and local health management challenges within the described context. It is suggested that the lessons learned be integrated into and addressed by practice.

Although many of the statements and problems addressed in this study might be previously stated and well known, this article emphasizes the following aspects:

- Despite the discussion and implementation of policies and strategies at macro, meso, and micro levels,

the impact of implementation is not realized by the professionals in this study and at the grass-roots level, in general.

- Even though progress has been made in South Africa in combating HIV/AIDS at a political level, the implementation at the grass-roots level is still questionable.
- Politicians, professionals, and patients need to relearn that systemic approaches are needed to address the supercomplex issues related to HIV/AIDS.
- There is a need to rethink how health and health promotion should be based on humanity and humanistic values instead of competition and power struggles, as indicated by the interviewees.

REFERENCES

Agence France Press. (2011). *Nearly third of South Africa's pregnant women carry HIV: Report*. U.S. Centers for Disease Control and Prevention. Retrieved from http://www.thebodypro.com/content/65040/nearly-third-of-south-africas-pregnant-women-carry.html

Annan, K. (n.d.). *AIDS/HIV facts and issues*. Retrieved from http://www.ncsu.edu/csleps/service/Resource_Sheets_Service/Facts%20on%20HIV-AIDS.pdf

AIDS epidemic update: Special report on HIV/AIDS. (2006). Retrieved from http://data.unAIDS.org/pub/EpiReport/2006/2006_EpiUpdate_en.pdf

AIDS Foundation South Africa. (2005). Treatment, care and support. Retrieved from http://www.AIDS.org.za/page/treatment-care-and-support

Babbie, E., & Mouton, J. (2006). *The practice of social research*. Oxford, UK: University Press.

Barnett, T., & Whiteside, A. (2002) *HIV/AIDS in the twenty-first century: Disease and globalisation*. Basingstoke, Hants, UK: Palgrave McMillan.

Bass, B. M. (1997). Does the transactional-transformational leadership paradigm transcend organizational and national boundaries? *American Psychologist*, *52*(2), 130–139.

Benatar, S. R. (2004). Health care reform and the crisis of HIV and HIV/AIDS in South Africa. *New England Journal of Medicine*, *351*(1): 81–92.

Berger, P. L., & Luckmann, T. (2000). *Die gesellschaftliche Konstruktion der Wirklichkeit. Eine Theorie der Wissenssoziologie* (17th ed.). Frankfurt, Germany: Fischer.

Bollinger, L., & Stover, J. (1999). *The economic impact of HIV/AIDS in South Africa*. Retrieved from http://www.policyproject.com/pubs/seimpact/southafr.pdf

Booysen, L., Nkomo, S., & Beaty, D. (2002). Breaking through the numbers game: High impact diversity. *Management Today*, *18*(9), 22–24.

Brown, L. T., & Eberdt, C. (2007). The endemic epidemic: New challenges in the battle against HIV/HIV/AIDS in South Africa. *International Health*, *4*(1), 26–30.

Business Day. (2009, November 20). *32 Percent of S. African children to lose a parent to AIDS by 2015*. U.S. Centers for Disease Control and Prevention. Retrieved from http://www.thebodypro.com/content/65040/nearly-third-of-south-africas-pregnant-women-carry.html

Cheldelin, S., Druckman, D., & Fast, L. (2003). *Conflict: From analysis to intervention*. New York, NY: Continuum.

Claassens, L. (2003). Closer collaboration between COHSASA and National Directorate towards measuring standards. *Quality Health Care*, *1*, 4.

Collis, J., & Hussey, R. (2003). *Business research: A practical guide for undergraduate and postgraduate students* (2nd ed.). New York, NY: Palgrave MacMillian.

Connolly, C., Colvin, M., Shishana, O., & Stoker, D. (2004). Epidemiology of HIV in South Africa—Results of a national, community-based survey. *South African Medical Journal*, *94*(9), 776–781.

Coovadia, H. M. (2000). Access to voluntary counseling and testing for HIV in developing countries. *Annals of the New York Academy of Sciences*, *918*, 57–63.

Da Silvia, R., & Wayburne, L. (2008). The effects of HIV? AIDS on medical schemes in South Africa. *South African Actuarial Journal*, *8*, 35–91.

Dickinson, D. (2004). Corporate South Africa's response to HIV/AIDS: Why so slow? *Journal of Southern African Studies*, *30*(3), 1–22.

Dorrington, R. E., Bradshaw, D., & Budlender, D. (2002). *HIV/HIV/AIDS profile of the provinces of South Africa—Indicators for 2002*. Centre for Actuarial Research, Medical Research Council and the Actuarial Society of South Africa. Cape Town, South Africa: University of Cape Town. Retrieved from http://www.mrc.co.za/bod/AIDSindicators2002.pdf

Dowshen, S. (2007). *HIV and HIV/AIDS*. Retrieved from http://www.kidshealth.org/teen/infections/stds/std_hiv.html

Duffy, L. (2005). Suffering, shame and silence: The stigma of HIV/HIV/AIDS. *Journal of the Association of Nurses in HIV/AIDS Care*, *16*(1), 13–20.

Epping-Jordan, J. E., Pruitt, S. D., Bengoa, R., & Wagner, E. H. (2004). Improving the quality of health care for chronic conditions. *Quality and Safety in Health Care*, *13*, 299–305.

Fourie, P. P. (2005). *One burden too many: Public policy making on HIV/HIV/AIDS in South Africa 1982–2004*. Retrieved from http://etd.rau.ac.za/theses/available/etd-08102005-122617/restricted/THESIS22.pdf

Geertz, C. (1987). *Dichte Beschreibung. Beiträge zum Verstehen kultureller Systeme*. Frankfurt, Germany: Suhrkamp.

Haacker, M. (2002). *The economic consequences of HIV/AIDS in Southern Africa* (IMF Working Paper 02/38). Washington, DC: IMF, African Department.

Habermas, J. (1999). *Theorie des Kommunikativen Handelns* (3rd ed.). Frankfurt, Germany: Suhrkamp.

Harris, H., Brewster, C., & Sparrow, P. (2003). *International human resource management*. London, UK: CIPD.

Hellriegel, D., Slocum, J., Jackson, S. E., Louw, L., Staude, G., Amos, T., . . . Zindiye, S. (2012). *Management* (4th ed.). Cape Town, South Africa: Oxford University Press Southern Africa.

Heywood, M. (2003). Preventing mother-to-child HIV transmission in South Africa: Background, strategies and outcomes of the Treatment Action Campaign case against the Minister of Health. *South African Journal of Human Rights*, *19*, 278–315.

HIV/AIDS in South Africa. (2008). Retrieved from http://www.avert.org/AIDSsouthafrica.htm

HIV treatment provision in South Africa. (2008). Retrieved from http://www.avert.org/AIDS-south-africa.htm

Horton, M. (2006). *HIV/HIV/AIDS in South Africa*. Retrieved from http://www.imf.org/external/pubs/nft/2006/soafrica/eng/pasoafr/sach7.pdf

Jackson, T. (2011). *International management ethics. A critical, cross-cultural perspective*. Cambridge, UK: Cambridge University Press.

King Committee on Corporate Governance. (2002). *King report on corporate governance for South Africa*. Retrieved from http://www.cliffedekker.co.za/files/CD_King2.pdf

Kromrey, H. (1998). *Empirische Sozialforschung* (8th ed.). Opladen, Germany: Leske und Budrich.

Leclerc-Madlala, S. (1997). Infect one, infect all: Zulu youth response to the HIV/AIDS epidemic in South Africa. *Medical Anthropology*, *17*(4), 363–380.

Logie, C., & Gadalla, T. M. (2009). Meta-analysis of health and demographic correlates of stigma towards people living with HIV. *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV*, *21*(6), 742–753.

Mayer, C.-H. (2011). *The meaning of sense of coherence in transcultural management*. Muenster, Germany: Waxmann.

Mayring, P. (2003). *Qualitative Inhaltsanalyse* (8th ed.). Weinheim, Germany: Beltz Verlag.

Meidany, F., Horikoshi, Y., & Rohde, J. (2000). *HIV prevalence rate and population density: Eastern Cape experience, South Africa*. Paper presented at the International Conference on HIV/AIDS, Durban. Retrieved from http://gateway.nlm.nih.gov/MeetingAbstracts/102237973.html

Metzler, I. (2007). *Antiretroviral adherence in South Africa*. Unpublished honours thesis, University of Oregon, Eugene.

National HIV and syphilis prevalence survey, South Africa. (2006). Summary report. National Department of Health. Retrieved from http://www.doh.gov.za/docs/hivsummary-f.html

Nattrass, N. (2006). *HIV/AIDS, science and governance: The battle over antiretroviral therapy in post-apartheid South Africa*. Retrieved from http://www.HIV/AIDStruth.org/nattrass.pdf

Navario, P. (2010). *HIV/AIDS in South Africa: Improved prognosis*. Council on Foreign Relations. http://www.cfr.org/foreign-aid/hivaids-south-africa-improved-prognosis/p21492

Orkin, A., & O'Meara, D. (1989). *The imprint of apartheid on HIV/HIV/AIDS in Southern Africa*. Paper presented at the International Conference on HIV/AIDS, Durban. Retrieved from http://gateway.nlm.nih.gov/MeetingAbstracts/102237973.html

Overseas Development Institute. (2007). *HIV/AIDS and the private sector: The case of South Africa. Private action for the public good: Moving HIV programmes into the community*. Briefing paper 30. London, UK: Overseas Development Institute.

PGDP. (2007). *The Eastern Cape Provincial HIV/AIDS and STI strategic plan of action 2007–2011*. HIV AIDS South Africa Statistics Provinces 2011. Retrieved from http://www.ecsecc.org/files/library/documents/PSP_2007___2011.pdf

Raval, G. (2007). *The Khululeka Men's Support Group: An ethnographic case study for the Map the Gap Project*. Unpublished research report for the Management and Change in Africa project, Centre for Cross Cultural Management Research, Middlesex University, London, UK.

Report on the global HIV/AIDS epidemic: HIV/HIV/AIDS estimates and data. (2005). Retrieved from http://data.unHIV/AIDS.org/pub/GlobalReport/2006/2006_GR-ExecutiveSummary_en.pdf

Ricoeur, P. (1979). Der Text als Modell: hermeneutisches Verstehen. In W. L. Bruehl (Ed.), *Verstehende Soziologie. Grundzuege und Entwicklungstendenzen* (pp. 252–283). München, Germany: Nymphenburger Verlag.

Rosen, S. B., & Connelly, P. J. (2004, July). *HIV/HIV/AIDS services for small and medium enterprises in South Africa: A market analysis*. Paper presented at the 15th AIDS International Conference, Thailand, Bangkok. Retrieved from http://ww1.aegis.org/conferences/iac/2004/MoPeD3683.html

Smith, A. (2012, June 7). *South Africa's pharmaceutical market booms. African business review*. Retrieved from http://www.africanbusinessreview.co.za/money_matters/south-africas-pharmaceutical-market-booms

Schneider, H. (2002). On the fault-line: The politics of HIV/AIDS policy in contemporary South Africa. *African Studies*, *61*(1), 145–167.

Schneider, H., Blaauw, D., Gilson, D., Chabikuli, N., & Goudge, J. (2006). Health systems and access to antiretroviral drugs for HIV in Southern Africa: Service delivery and human resources challenges. *Reproductive Health Matters*, *14*(27), 12–23.

Schneider, H., & Stein, J. (2001). Implementing HIV/AIDS policy in post-apartheid South Africa. *Social Science & Medicine*, *52*(5), 723–731.

Sokopo, A. (2010). *EC universities reveal current HIV/AIDS stats*. Retrieved from http://www.hsrc.ac.za/News-document-1259.phtml

Statistical Release. (2011). *Mid-year population estimates 2011*. Statistics South Africa. Retrieved from http://www.statssa.gov.za/publications/P0302/P03022011.pdf

Steinke, I. (2000). Gütekriterien qualitativer Forschung. In U. V. Flick, E. Von Kardoff, & I. Steinke (Eds.), *Qualitative Forschung. Ein Handbuch* (pp. 319–331). Hamburg, Germany: Rowohlts Enzyklopaedie.

Stellrecht, I. (1993). Interpretative Ethnologie: Eine Orientierung. In T. Schweizer, M. Schweizer, & W. Kokot (Eds.), *Handbuch der Ethnologie* (pp. 29–73). Berlin, Germany: Reimer.

Tadli, S. (2006). Poverty and HIV/HIV/AIDS in South Africa: An empirical contribution. *Journal des Aspects Sociaux du VIH/SIDA*, *2*(1), 369–381.

The macroeconomic impact of HIV/HIV/AIDS in South Africa. (2001). *BER Economic Research Note*, *10*, 1–45.

UNAIDS. (2008). *Report on the global HIV/AIDS epidemic 2008: Executive summary*. Retrieved from http://data.unaids.org/pub/GlobalReport/2008/jc1511_gr08_executivesummary_en.pdf

Uys, L. R. (2003). Aspects of the care of people with HIV/HIV/AIDS in South Africa. *Public Health Nursing*, *20*(4), 271–280.

Voelpel, S. C., Leibold, M., & Tekie, E. B. (2006). Managing purposeful organizational misfit: Exploring the nature of industry and organizational misfit to enable strategic change. *Journal of Change Management*, *6*(3), 257–276.

Willan, S. (2004). Briefing: Recent changes in the South African government's HIV/HIV/AIDS policy and its implementation. *African Affairs*, *103*, 109–117.

Wolff, S. (2000). Cliffort Geertz. In U. Flick, E. Kardoff, & I. Von Steinke (Eds.), *Qualitative Forschung. Ein Handbuch* (pp. 84–96). Hamburg, Germany: Rowohlts Enzyklopädie.

Yin, R. K. (2002). *Case study research: Design and methods* (2nd ed.). London, UK: Sage.

ABOUT THE AUTHORS

Lynette Louw was appointed the Raymond Ackerman Chair of Management in the Department of Management and the Deputy Dean, Faculty of Commerce at Rhodes University in Grahamstown, South Africa. She obtained her Doctor Commercii in Business Management at the University of Port Elizabeth in South Africa. She is the recipient of research awards, serves on journal editorial boards, and is co-author and editor of management and strategic management textbooks. Her areas of specialty include strategic management, international organizational behavior, and intercultural and cross-cultural management. She may be reached at l.louw@ru.ac.za.

Claude-Hélène Mayer earned her doctorate in cultural anthropology at Georg-August-University Göttingen and her PhD in management at Rhodes University, South Africa. Her area of study was habilitation in psychology with a focus on industrial, organizational and cultural psychology. She is Professor of Intercultural Business Communication (HAW, Hamburg), Senior Research Associate, Rhodes University, Grahamstown, South Africa, and Visiting Professor, UNISA, Pretoria, South Africa. Claude-Hélène Mayer is a mediator and trainer in mediation (BM), and a systemic consultant and therapist (SG) as well as hypnotherapist (TIM). Her research areas are transcultural health management and salutogenesis, transcultural conflict management and mediation, and values and managerial identity construction across cultures. She may be reached at claudemayer@gmx.net.