

**KNOWLEDGE, ATTITUDES AND PRACTICES  
REGARDING HIV/AIDS OF HOTEL STAFF  
FROM A SELECTED HOTEL GROUP  
IN CAPE TOWN**

**BY**

**AMINA MOHAMMED**

**MINI-THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE  
REQUIREMENTS FOR THE  
M.TECH TOURISM & HOSPITALITY**

**IN THE FACULTY OF BUSINESS**

**AT THE  
CAPE PENINSULA UNIVERSITY OF TECHNOLOGY**

**SUPERVISOR: DR K. SWART  
CAPE PENINSULA UNIVERSITY OF TECHNOLOGY**

**CO-SUPERVISOR: PROF S. NAIDOO  
UNIVERSITY OF THE WESTERN CAPE**

**CAPE TOWN  
2006**

**DECLARATION**

I, the undersigned, **AMINA MOHAMMED**, hereby declare that the contents of this thesis represent my own unaided work, and that the thesis has not previously been submitted for academic examination towards any qualification.

Furthermore, it represents my own opinions and not necessarily those of the Cape Peninsula University of Technology.

*Aminahammed*

Signature

*March 2006*

Date

## **ABSTRACT**

The HIV/AIDS pandemic poses one of the greatest challenges to business development in South Africa. The hotel industry is growing rapidly and will be significantly affected by the HIV/AIDS pandemic. The purpose of this study was to determine the *Knowledge, Attitudes and Practices* (KAP) regarding HIV/AIDS of staff from nine Protea group hotels in Cape Town. A sample of 200 hotel staff was randomly selected to participate. A structured self-administered anonymous questionnaire was the instrument used to collect the data.

The response rate was 81%. There were more females than males, and the majority of the respondents were between the ages of 21-30 years. More than half of the respondents were single, hotel managers and with matriculation as the highest qualification. The respondents demonstrated a reasonably good knowledge on the transmission of HIV/AIDS. Almost half of the respondents believed that HIV/AIDS would not affect the hotel industry. The survey revealed conflicting results on whether HIV-infected staff should be involved in food preparation, and whether staff should serve food to HIV positive hotel guests. There were also concerns of the risk of infection when handling dirty linen used by HIV-infected hotel guests.

More males than females were currently sexually active and reported having more than one partner in the past three years. The majority of the respondents believed that condoms were effective, but only one third reported the use of a condom every time they had a sexual encounter. There was a significant relationship between knowledge and attitudes ( $p$ -value $<0.05$ , but none between knowledge and practice and attitude and practice.

It is recommended that the hotel industry develop effective workplace policies and supportive environments, and that on-going HIV/AIDS education and prevention programmes be implemented to change high risk sexual behaviour and practices.

## **DEDICATION**

This thesis is dedicated to all the students whom I have taught at the Cape Town Hotel School over the past many years, and who are now employed in the hotel industry locally, nationally and abroad. It is hoped that as employers or employees they will play a pivotal role in the successful management and prevention of the HIV/AIDS epidemic in the hotel industry.

## **ACKNOWLEDGEMENTS**

I hereby would like to express my very sincere thanks and appreciation towards each of the following who assisted me with this Mini-thesis:

**Supervisor: Dr Kamilla Swart.** Centre of Tourism Research in Africa, Faculty of Business, Cape Peninsula University of Technology, Cape Town Campus.

**Co-Supervisor: Dr Sudeshni Naidoo.** Dept of Community Oral Health, Faculty of Dentistry, University of the Western Cape, Cape Town.

**Consultant: Mr Ashraf Mohammed.** Institutional HIV/AIDS Co-ordinator, HIV/AIDS Unit, Cape Peninsula University of Technology, Cape Town Campus.

**Statistician: Ms Corrie Stumpfher.** Department of E-Business, Cape Peninsula University of Technology, Cape Town Campus

**Librarian: Ms Zaba Tshabalala.** Senior Librarian. Cape Peninsula University of Technology, Cape Town Campus.

## **TABLE OF CONTENTS**

	<b>Page Nos.</b>
<b>DECLARATION</b>	ii
<b>ABSTRACT</b>	iii
<b>DEDICATION</b>	iv
<b>ACKNOWLEDGEMENTS</b>	v
<b>LIST OF FIGURES AND TABLES</b>	ix
<b>CHAPTER ONE</b>	
<b>THE PROBLEM AND ITS SETTING</b>	<b>1</b>
1.1 Introduction	1
1.2 Background to the research problem	1
1.3 Statement of the research problem	3
1.4 Research questions	3
1.5 Objectives of the study	3
1.6 Clarification of the basic terms and concepts	4
<b>CHAPTER TWO</b>	
<b>LITERATURE REVIEW</b>	<b>5</b>
2.1 Introduction	5
2.2 HIV/AIDS the global pandemic	6
2.3 HIV/AIDS epidemic in South Africa	8
2.4 <b>Knowledge of HIV/AIDS</b>	<b>10</b>
2.4.1 How HIV/AIDS is transmitted	11
2.4.2 How HIV/AIDS is <i>not</i> transmitted	12
2.4.3 Progress from HIV to AIDS	13
2.5 <b>Attitude towards HIV/AIDS</b>	<b>14</b>
2.5.1 Stigmatisation, discrimination & misconceptions regarding HIV/AIDS	14
2.6 <b>Sexual behaviour and practices</b>	<b>15</b>
2.6.1 Sexual behaviour amongst young adults	16
2.6.2 The role of gender in sexual behaviour	17
2.6.3 HIV sexual risk behaviours	18

<b>2.7</b>	<b>KAP surveys on HIV/AIDS</b>	<b>19</b>
<b>2.8</b>	<b>Treatment, control &amp; prevention strategies for HIV/AIDS</b>	<b>22</b>
2.8.1	HIV/AIDS education and training	24
2.8.2	HIV/AIDS prevention programmes	24
2.8.3	Voluntary counselling and testing	25
2.8.4	Behaviour change	26
2.8.5	A-B-C preventive strategy	27
2.8.6	Antiretroviral therapy	29
<b>2.9</b>	<b>Workplace &amp; policy guidelines on HIV/AIDS in South Africa</b>	<b>30</b>
2.9.1	Impact of HIV/AIDS on the South African economy	31
2.9.2	Basic human rights of employees & HIV testing in the workplace	33
2.9.3	Workplace & organisational responses HIV/AIDS	35
2.9.4	Employers' obligations to HIV/AIDS employees	35
2.9.5	Challenges in managing HIV/AIDS in South Africa	36
<b>2.10</b>	<b>HIV/AIDS in the hotel industry</b>	<b>37</b>
2.10.1	The impact of HIV/AIDS on the hotel industry	37
2.10.2	HIV/AIDS concerns for the hotel industry	39
2.10.3	Addressing HIV/AIDS in the hotel industry	40
<b>2.11</b>	<b>Conclusion</b>	<b>42</b>
<b>CHAPTER THREE</b>		
<b>RESEARCH METHODOLOGY</b>		<b>44</b>
3.1	Introduction	44
3.2	Study design	44
3.3	Sample	45
3.4	Instruments	45
3.5	Data analysis	46
3.6	Ethics	46
<b>CHAPTER FOUR</b>		
<b>RESULTS</b>		<b>47</b>
4.1	Introduction	47
4.2	Demographic data	47
4.3	Knowledge of HIV/AIDS	49
4.4	Attitudes towards HIV/AIDS	51
4.5	Sexual behaviour and practices regarding HIV/AIDS	52
4.5.1	Gender in relation to sexual activity	52
4.5.2	Gender in relation to multiple sexual partners	53
4.5.3	Age in relation to sexual activity	53

4.5.4	Age in relation to multiple sexual partners	54
4.5.5	Condom use	54
4.5.6	Effectiveness of condoms and frequency of condom use	55
4.5.7	Gender in relation to sexual activity & frequency of condom use	55
4.5.8	Age in relation to sexual activity & frequency of condom use	56
4.5.9	The 'ABC' preventive strategy	57
4.5.10	Relationship between knowledge, attitudes and sexual practices	57
<b>CHAPTER FIVE</b>		
<b>DISCUSSION</b>		<b>59</b>
<b>CHAPTER SIX</b>		
<b>CONCLUSIONS AND RECOMMENDATIONS</b>		<b>64</b>
<b>REFERENCES</b>		<b>70</b>
<b>APPENDICES</b>		
Appendix I	- Letter of permission from Protea Hotel	76
Appendix II	- Research Questionnaire	77



**LIST OF FIGURES**

	Page Nos.
Figure 1: Estimated and projected deaths at 5-34, with and without AIDS in South Africa: 1980-2025	7
Figures 2: Changes in life expectancy in countries with high and low HIV prevalence: 1950-2005	8
Figure 3: Percentage of workforce lost to AIDS by 2005 and 2020	10
Figure 4: The impact of HIV/AIDS on industries: an overview	32
Figure 5: Gender and age distribution	47
Figure 6: Marital status	48
Figure 7: Employment position at hotel	49
Figure 8: Myths about AIDS	50
Figure 9: Attitude towards HIV/AIDS	52
Figure10: The 'ABC' preventive strategy	57

**LIST OF TABLES**

	Page Nos.
Table 1: HIV/AIDS transmission	50
Table 2: HIV/AIDS prevention	51
Table 3: HIV/AIDS prevention	51
Table 4: Gender & sexual activity	53
Table 5: Gender & multiple sexual partners in three years	53
Table 6: Age & sexual activity	53
Table 7: Age & multiple sexual partners in three years	54
Table 8: Marital status and condom use	54
Table 9: Employment position and condom use	55
Table 10: Condom effectiveness and condom use	55
Table 11: Gender & frequency of condom use	56
Table 12: Age & frequency of condom use	56
Table 13: Correlations between knowledge, attitude and sexual practice	58

# **CHAPTER ONE**

## **THE PROBLEM AND ITS SETTING**

### **1.1 INTRODUCTION**

AIDS is the most globalised epidemic in history, and the HIV/AIDS epidemic poses one of the greatest challenges to business development in South Africa. The epidemic erodes economic growth and HIV-related absenteeism, loss of productivity and the cost of replacing workers lost to AIDS threaten the survival of businesses and other sectors of the economy (Whiteside & Sunter, 2001:36). The International Labour Organisation (ILO) projects that the labour force in 38 countries (all but four in Africa) will be between five percent and thirty-five percent smaller by 2020 because of AIDS. The Global Health Organisations supported by the South African Department of Health, have confirmed that the HIV/AIDS epidemic is no longer a distance threat, but an immediate reality (UNAIDS, 2004:56).

### **1.2 BACKGROUND TO THE RESEARCH PROBLEM**

The hotel industry is growing rapidly and will be significantly affected by the HIV/AIDS pandemic. The growing presence of HIV/AIDS has forced many hoteliers to examine more closely the challenges and its total impact on their businesses. Employers cannot discriminate against employees who have AIDS, are HIV-positive or are perceived to have the infection. Executives in the hospitality industry know that public misconceptions about HIV/AIDS can seriously affect the food and beverage industry, where myths persist suggesting that HIV/AIDS can be transmitted by casual contact. This was evident when a well-known Californian restaurant executive chef died of AIDS and the owner watched patron numbers plunge after the media released the news (Barrows, Gallow & Mulleady, 1996:5-9).

Global instability is placing hotel operators worldwide under tremendous pressure. In South Africa, there is an increased pressure as the industry is further boosted by increased tourism and high-profile forthcoming events such as the Cricket World Cup and the 2010 Soccer World Cup (Demes, 2004). The growing awareness of HIV/AIDS within the business community worldwide and in the hospitality industry means that all employers must take some action in light of the growing threat that HIV poses to their workforce, and to the profitability of the business environment. HIV/AIDS will seriously impact on economic growth and as the business sector becomes a major stakeholder, the hotel industry cannot renege on its responsibility with regard to the AIDS epidemic. The action, or lack of it, to address the ways this disease affects the hotel or restaurant, will make a difference to the company's immediate and long term viability (IH&RA & UNAIDS, 1999:32).

As the impact of HIV/AIDS on the workplace becomes more evident, increasing numbers of businesses, including those in the hospitality industry will need to provide on-the-job employee training and education programmes on how to avoid becoming infected by HIV. Given the diverse range of people infected and affected by AIDS and AIDS-related illnesses, many hotels have to employ people who are HIV-positive, have AIDS or have an AIDS-related illness (Barth, 2001:9). The hospitality industry would do well to equip itself and empower its staff with the most current facts and trends about AIDS and to initiate and launch a HIV/AIDS/STI and TB programmes. These programmes need to exceed any existing statues of workplace sanitation and personal hygiene procedures, as well as employee Voluntary Screening Tests (VST) and training methods that are relevant, applicable and acceptable by the workforce based on the hotel industry (Metelka, 1986:7). By confronting HIV/AIDS directly and responsibly, hoteliers, restaurateurs and all businesses around the world will need to lead the fight against HIV/AIDS by providing accurate information to employees and their families, as well as developing effective workplace policies in a supportive environment (IH&RA & UNAIDS, 1999:5).

### 1.3 STATEMENT OF THE RESEARCH PROBLEM

Like other business sectors, the HIV/AIDS epidemic has and will continue to affect South Africa's hospitality and tourism sector (Thornton, 2005:6). The growing HIV/AIDS pandemic has forced the hospitality industry to investigate more closely the impact of HIV/AIDS on their business (ILO, 2000:1). HIV will impact on the hospitality industry in terms of low productivity, increased employee benefits and low staff morale (IH&RA & UNAIDS, 1999:17). Due to the dearth of research in the area of HIV/AIDS in the hotel industry generally, and especially in South Africa, the present study investigated the "*Knowledge, Attitudes and Practices (KAP) towards HIV/AIDS among hotel staff from a selected hotel group in Cape Town*", namely the Protea groups of hotels in Cape Town.

### 1.4 RESEARCH QUESTIONS

- What is the level of *knowledge* of HIV/AIDS of staff working in the hotel industry in Cape Town?
- What is the *attitude* of hotel staff towards HIV-infected staff and towards guests in the hotel industry in Cape Town?
- What is the level of *sexual practices* regarding HIV/AIDS of staff working in the hotel industry in Cape Town?

### 1.5 OBJECTIVES OF THE STUDY

The specific research objectives of the study are:

- To determine the level of *knowledge* of HIV/AIDS of hotel staff from the selected hotel group in Cape Town.
- To determine the *attitudes and* beliefs towards HIV/AIDS of hotel staff from the selected hotel group in Cape Town.
- To determine the sexual *practices* and behaviour regarding HIV/AIDS of hotel staff from the selected hotel group in Cape Town.
- To determine if any HIV/AIDS prevention programmes or policies exist within the hotel group and where possible to make recommendations.

## **1.6 CLARIFICATION OF THE BASIC TERMS AND CONCEPTS**

**HIV:** Human Immunodeficiency Virus. This blood-borne virus attacks the white blood cells known as T-cells. T-cells are a special type of white blood cells that helps the body fight disease. When the T-cell count falls below 200 parts per 1,000 millilitres of blood, the patient is in the final stage of AIDS.

**HIV-positive:** Having antibodies to HIV in the blood and therefore having HIV infection.

**HIV-negative:** Having no antibodies to HIV or not HIV present.

**AIDS:** Acquired Immune Deficiency Syndrome. AIDS represents an array of opportunistic diseases and infections that invade a body with a weakened immune system as a result of HIV infection.

**AIDS-related disease or HIV-related disease:** Symptoms as a result of HIV infection, for example, swollen lymph, long-lasting diarrhoea, fever, tiredness, that progresses over a period of time, into 'full-blown' AIDS.

**STD or STI:** Sexually Transmitted Diseases or infections

**Safer Sex:** Practising safer sex in order to reduce the transmission of HIV.

**TB:** Tuberculosis, a curable and preventable disease caused by bacteria *Mycobacterium Tuberculosis*.

**IH&RA:** International Hotel & Restaurant Association.

**UNAIDS:** Joint United Nations Programme on HIV/AIDS.

## CHAPTER TWO

### LITERATURE REVIEW

#### 2.1 INTRODUCTION

*“When AIDS emerged from the shadows two decades ago, few people could predict how the epidemic would evolve, and fewer still could describe with any certainty the best ways of combating it. Now, at the start of a new millennium, we are past the stage of conjecture. We know from experience that AIDS can devastate whole regions, knock decades off national development, widen the gulf between rich and poor nations and push already-stigmatised groups closer to the margins of society” (UNAIDS, 2000:8).*

Different professional and academic disciplines have addressed the HIV and AIDS pandemic from a variety of perspectives, using different analytical approaches. This review aims to provide a more complete picture of this multi-faceted disease, from the biological and social factors that facilitate HIV transmission to the powerful cultural and political forces that fuel the pandemic. The review will give an overview of AIDS as a global pandemic in the world and in Africa, focusing in particular on the South African context and its implications on the workplace and the South African economy. It will discuss the knowledge, attitudes and sexual practices of employees in the hotel industry, namely the Protea hotels in Cape Town, and various KAP studies that have been conducted in the hospitality sector and various other sectors. The review will also present ways of managing HIV/AIDS in the workplace. Intervention strategies, like, HIV/AIDS awareness and education will be discussed and the implementation of the AIDS policy in the South African workplace, with special focus on the hospitality industry, and the effect the pandemic will have on the hotel industry in the future should intervention strategies not be put into effect.

## 2.2 HIV/AIDS THE GLOBAL PANDEMIC

AIDS has now become a global pandemic and is continuing to spread throughout the world at alarming levels (UNAIDS, 2004:8). Infection with HIV is having an increasingly serious impact on personal lives, society, and the economy (UNAIDS, 1999:9). The global summary of the AIDS epidemic for December 2004 reports that 39.4 million people living with HIV, of which most were adults, and more than half were women (UNAIDS, 2004:10). In addition, 4,9 million newly infected cases and 3,1 million AIDS deaths were reported. Sub-Saharan Africa remains by far the region worst affected by HIV/AIDS. South Africa could face a national emergency of an unimaginable magnitude regarding the HIV/AIDS pandemic, unless immediate and drastic action is implemented, warned Mohammed (2004), as the country will not be prepared enough to deal with HIV/AIDS.

Nattrass (2004:23) argues that AIDS is diabolical in that it affects mainly prime-age adults and has a long incubation period between stage one, where no symptoms are present, until stage four, full-blown AIDS. Unless people get tested, they can pass on the virus through sexual intercourse without knowing it, which makes the disease very hard to contain. These biological and socio-economic aspects of AIDS make the disease a worthy target for special policy attention. Interventions, therefore, must be quantitatively and qualitatively commensurate with the magnitude of the threat posed by the disease.

Every country around the world has been affected by the AIDS pandemic and while the epidemic is not homogenous within regions, some countries are more affected than others (UNAIDS, 2004:23). International Population Reports show that over 90 percent of people infected with HIV live in the developing world (U.S. Census Bureau, 2002:11). Data published in UNAIDS (the Joint United Nations programme on HIV/AIDS, 2002:5) show that HIV/AIDS has been diagnosed in every continent on the globe. Worldwide figures show two million people in the United States were reported to be infected with HIV. In North America 950,000 people were living with HIV/AIDS, Western Europe 550,000, while in Australia and

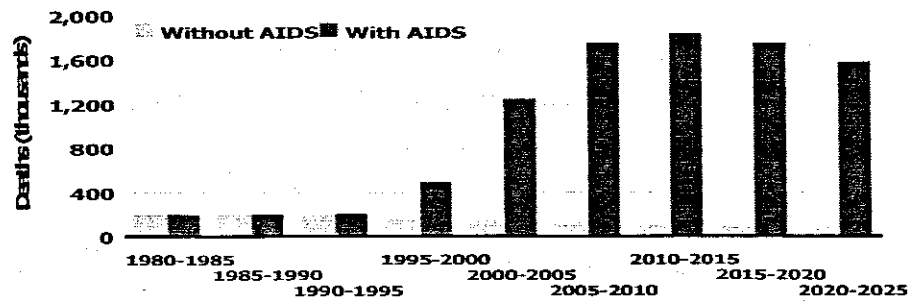


New Zealand the numbers infected stands at 15,000 (UNAIDS, 2004:23-38). HIV infection rates have recently been rising in India, China, Eastern Europe and in some western countries.

HIV and AIDS are having more devastating effects on the demographic landscape particularly in sub-Saharan Africa (Kopelman & van Niekerk, 2002:219-233) where an estimated 28.5 million people are infected with HIV in sub-Saharan Africa (UNAIDS, 2002:3). The AIDS pandemic now spreading throughout southern Africa is without parallel in modern times in terms of probable long-run impact (Ellison, Parker & Campbell, 2003:102-239). The countries in southern Africa currently at the epicentre of the HIV pandemic are experiencing even more severe epidemics (UNAIDS, 2002:45), and are beginning to suffer unprecedented high mortality and socio-demographic consequences. Figure 1 shows the estimated projected deaths with and without AIDS from 1980 until 2025 in South Africa.

Figure 1: Estimated and projected deaths at 5-34 with and without AIDS in South Africa: 1980-2025

**Estimated and projected deaths at 5-34, with and without AIDS South Africa: 1980-2025**

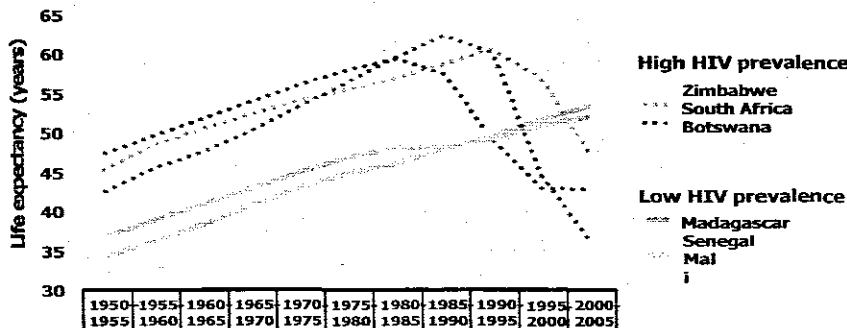


Source: Department of Economic and Social Affairs (2002) World Population Prospects, 2000 Revision

The life expectancy in Southern Africa, the world's hardest hit region by AIDS, has dropped to forty-nine, and in the absence of large-scale treatment programmes, could plummet to thirty-five years (UNAIDS, 2004:30). Figure 2 below, shows the life expectancy patterns between 1950 and 2005, with South Africa having the second highest HIV prevalence after Zimbabwe followed by Botswana.

Figure 2: Changes in life expectancy in countries with high and low HIV prevalence: 1950-2005

### Changes in life expectancy in countries with high and low HIV prevalence: 1950-2005



Source: Department of Economic and Social Affairs (2001) World Population Prospects, 2000 Revision

At the recent International AIDS conference in Bangkok in July 2004, the United Nations warned that the AIDS pandemic has threatened a 'tidal wave' of child deaths worldwide while the number of orphans in sub-Saharan Africa is expected to exceed eighteen million by 2010. In 2002, South Africa was estimated to have 5.3 million HIV-positive people, the largest number of people living with HIV/AIDS (UNAIDS, 2004:42).

### 2.3 HIV/AIDS EPIDEMIC IN SOUTH AFRICA

The World Health Organisation (1999) reports that at the beginning of the 21<sup>st</sup> century, AIDS was the number one cause of death in Africa and number four globally. South Africa has experienced one of the fastest growing HIV epidemics in the world and currently bears about ten percent of the global burden of HIV infection (Gouws & Abdool-Karim 2005:48). The growth of HIV/AIDS in South Africa between 1982 and 2004 is a matter of grave concern. Statistics show that in South Africa, an estimated 1700 people are newly infected with HIV every day (Abdool-Karim & Abdool-Karim, 2005:1) and HIV/AIDS is undoubtedly the most formidable public health problem facing South Africa today (Evian, 1991:7). An alarming six hundred AIDS-related deaths were reported in South Africa a day in 2005, where one in nine people have HIV, one of the highest in the world

(UNAIDS 2004:25). The United Nations AIDS Global Report showed an estimation of between 270,000 and 520,000 AIDS-related deaths per day in 2003. Based on antenatal data from the National Department of Health, the study estimated that 6.29 million South Africans were HIV-positive at the end of 2004 which included 3.3 million women and 104,863 babies (Galloway, 2005:3-4).

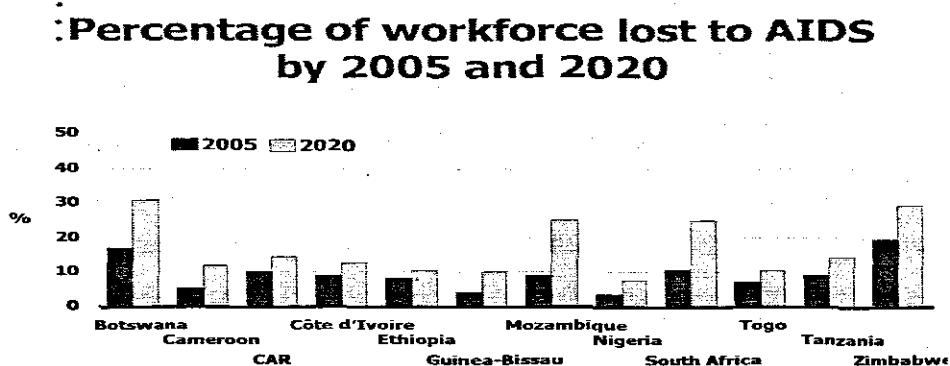
From a political perspective, South Africa's response to the epidemic has been characterised by a unique form of denialism in the highest echelons of political power (Abdool-Karim, 2005:35). President Thabo Mbeki is still adamant about his 'dissident' view that HIV does not cause AIDS, and his resulting reluctance to admit to the scale and nature of the pandemic and the need to respond to it has received wide criticisms (Ellison *et al.*, 2003:258).

In South Africa the HIV epidemic is well established in the general heterosexual population. Not only do more women have HIV infection compared to men in South Africa, but they also acquire infection with HIV at a younger age (Whiteside & Sunter, 2001:58). The highest rates of infection are reported to be among people aged between 20 and 44 years old and hence AIDS has the potential to have a devastating effect on social, economic and human development.

The International Labour Organisation (2000:5) reports that the AIDS pandemic cost the South African economy a staggering seventy-two million dollars in the ten years to 2002, the loss resulting mainly from deaths, absenteeism and lower productivity. Recruitment and the training of new employees carry huge financial strains, but the need to appoint extra employees to compensate for the impact of HIV/AIDS on labour productivity, absenteeism and mortality is unavoidable. The nature of the demographic effects of HIV and AIDS could be modified as voluntary counselling and testing and antiretroviral treatment become more widely available (Weinhardt, Carery, Johnson, & Bickham, 1999:1397-1405).

Figure 3 below shows the percentage of workforce lost to AIDS by 2005 and the projected figures to 2020 with the highest impact affecting Botswana, Zimbabwe, followed closely by South Africa (ILO, 2000).

Figure 3: Percentage of workforce lost to AIDS by 2005 and 2020



Source: ILO (2000) POPILO population and labour force projection; UN Department of Economic and Social Affairs, Population Division (1998) *World Population Prospects: the 1998 Revision*

Before KAP studies in the hospitality industry and various other sectors are discussed, the following sections will focus on the knowledge, attitudes, and sexual behaviour and practices relating to HIV/AIDS, the progression of HIV infection to AIDS and addresses the stigmatisation, discrimination and misconceptions associated with the HIV/AIDS pandemic.

## 2.4 KNOWLEDGE OF HIV/AIDS

HIV is the acronym for *Human Immunodeficiency Virus*. AIDS, *acquired immune deficiency syndrome*, is the result of the late stages of the HIV infection. HIV attacks the body's immune system, and over time the body's defense mechanism is gradually and systematically paralysed which results in 'immunodeficiency' (Jackson, 2002:37). It is estimated that 90% of all HIV-infected people worldwide do not know they have the virus (UNAIDS, 2004:3). Individuals with HIV are infected for life and will probably die from opportunistic infections caused by the weakening of their immune system. Knowledge about HIV/AIDS transmission modes is based on awareness of the disease of its asymptomatic transmission and of different modes of transmission. Today, more than twenty years into the

epidemic, HIV specialists still encounter widespread ignorance and a general lack of awareness about HIV/AIDS (Ellison *et al.*, 2003:125).

#### **2.4.1 How HIV/AIDS is transmitted**

HIV infection is transmitted primarily:

- by having unprotected sexual intercourse with a person who is HIV positive.
- by getting HIV-infected blood into one's bloodstream. This can also happen through a blood transfusion, although in South Africa all blood is tested for HIV before it is used.
- by an HIV positive mother to her baby during pregnancy or childbirth, or as a result of breastfeeding (van Dyk, 2005:23).
- by intravenous drug use with contaminated needles. This can happen by using unsterilised needles, razor blades, dental equipment. (Whiteside & Sunter, 2001:10).

Since the principal route of HIV/AIDS transmission is sexual transmission between infected and susceptible individuals, injecting drug use and via blood products, a basic understanding of the factors that drive the transmission of the infection is a pre-requisite to designing intervention and control programmes Ellison *et al.* (2003:61). The three major known sources of infection are sexual contact, exposure to infected blood and vertical transmission or from mother to child. To effect its transmission from one person to another, the HI virus needs the most intimate of human contact and the exchange of sexual fluids (semen, vaginal fluid) from one infected person to another (Evian, 1991:10-11) and this fluid is an ideal transport medium for HIV. Since HIV is also transmitted through infected blood, the infected blood must be fresh and pass directly into the body through open wounds or sores, or via blood transfusion or needles.

The risk of acquiring HIV through blood transfusion is particularly high in the developing countries. Blood transfusions are considered to be safe in South Africa, as they are routinely tested for HIV (Heyns & Swanevelder 2005:207).

South Africa is fortunate that it has a model blood service based on voluntary non-remunerated donors with HIV prevalence much lower than the general population. Sharing needles for injecting drugs is a potent vector for the transmission of blood-borne diseases because infected blood is injected directly into the user's system. According to Leggett (2005:217), South Africa does not appear to have a major intravenous drug use problem at present, so it is easy to become complacent about issues such as needle exchange.

In all the plagues which have swept the world it is often women and children who are most affected, and HIV/AIDS is no different. Most children with HIV infection have contracted their disease through Mother-To-child Transmission (MTCT). HIV/AIDS is a significant contributor to infant mortality in Africa where the overall transmission rates are 25% to 45% of all children born to HIV positive women in Africa (Coovadia, 2005:183). A growing amount of research has been conducted into the cause and possible prevention of MTCT with significant results (Whiteside & Sunter, 2001:149), where MTCT of HIV occurs in the intrauterine period, during labour and delivery and postnatally through breastfeeding.

#### **2.4.2 How HIV/AIDS is *not* transmitted**

Almost three decades of practical experience and research into the epidemic have shown that HIV is *not* transmitted through the following:

- Airborne routes such as coughing and sneezing,
- Casual skin contact between individuals, such as handshaking, hugging and touching, as the virus cannot penetrate normal intact skin.
- Sharing food, water, plates, cups, spoons, toilet seats, showers or baths with an HIV-positive individual, as the HI virus does not survive for long periods outside the human body.
- Sharing clothing, towels and bed linen with an infected individual, provided that the linen is clean.
- Public swimming pools, as chlorine destroys and water dilutes the virus.
- Pets or insects such as mosquitoes, bedbugs and moths.

- Playing team sports, provided that there is no contact with blood.
- Restaurants and cafeterias, as exposure to heat, air and gastric juices destroys the HI virus.
- Sharing telephones, drinking fountains and public transport with HIV-positive people.
- Living with an AIDS patient and sharing household equipment, provided the rules of basic hygiene, like not sharing razors and toothbrushes, and avoiding contact with body fluids are followed.
- Social contact between schoolchildren and sharing school facilities.
- Kissing, as the virus occurs in very low concentrations in saliva and kissing appears to be safe, although caution is to be taken in French or deep kissing.
- Donating blood. A person cannot become infected through the process of donating or giving blood, provided that the instruments used during the process is clean (van Dyk, 2005:35-36).

#### **2.4.3 Progress from HIV to AIDS**

HIV progresses to AIDS in five stages over a period of time (Thornton, 2005:4).

- *Stage 1: Initial infection.* This is usually a symptom-free stage when the HI virus first enters the blood stream.
- *Stage 2: Window period.* This refers to a symptom-free period before laboratory tests will show that a person is HIV positive.
- *Stage 3: Asymptomatic HIV infection.* This is still a symptom-free stage, but the results of an HIV test will show that a person is definitely HIV positive.
- *Stage 4: Symptomatic infection.* This is the stage when an HIV positive person will have symptoms and periods of illness.
- *Stage 5: AIDS.* This is the stage when an HIV positive person becomes very ill due to opportunistic infections.

## **2.5 ATTITUDES TOWARDS HIV/AIDS**

There still remain many myths, negative attitudes and discrimination towards HIV/AIDS, and people living with HIV/AIDS, which create many challenges in various personal, social and business environments in the management of the disease, which still have to be addressed (van Dyk, 2005:35-36).

### **2.5.1 Stigmatisation, discrimination & misconceptions regarding HIV/AIDS**

HIV/AIDS is still a disease surrounded by ignorance, prejudice, discrimination and stigma. Stigma has been a pervasive dimension of HIV/AIDS since the beginning of the pandemic and is a social construction which dramatically affects the life experiences of the individuals infected with HIV and their partners, family and friends (Alonzo & Reynolds, 1995:303-315). In South Africa, as elsewhere, stigma has gone hand in hand with discrimination. Discrimination against HIV positive people hinges on a variety of perceptions and misconceptions of their gender, their race, their socioeconomic status, their HIV positive status, and their sexuality. It has tangible consequences, such as segregation and denial of rights to find or retain employment, to marry and to obtain life insurance, and these may affect them at an individual, community or societal level. According to Frohlich (2005:351-370), fear of stigma can produce extreme anxiety about sharing one's HIV status with another, and non-disclosure of HIV status is extremely common. In South Africa, people who openly admit that they are HIV positive are often treated as outcasts, fired from their jobs, and sometimes even chased from their homes or even killed (Jackson, 2002:205).

In the workplace unfair discrimination against people living with HIV and AIDS has been perpetuated through practices such as pre-employment HIV testing, dismissals for being HIV positive and the denial of employee benefits, (Swanepoel *et al.*, 2003:588). Since employment provides an important source of psychological support for many people with HIV (Goss & Adam-Smith, 1995:4), it is often regarded more important than the material benefits the job brings. Although such attachments may be undermined by expressions of prejudice and



discrimination, for many people with HIV, work is likely to remain an important component of their lives. From services providing advice and guidance to people with HIV/AIDS, discrimination, prejudice and harassment within the workplace often results in the loss of the job, either through dismissal or forced resignation. In terms of South Africa's Constitution, people living with HIV and AIDS are guaranteed the same basic human rights and responsibilities as all other citizens of this country (van Dyk, 2005:333). Employers, health care professionals, teachers or any other person may not discriminate against people on the grounds of their HIV status. The code of good practice regarding HIV/AIDS in the workplace seeks to assist with the attainment of the broader goals of eliminating unfair discrimination in the workplace based on HIV status, allowing people living with the virus to be open about their HIV status without fear of stigma or rejection, thereby providing a non-discriminatory work environment and promoting appropriate and effective ways of managing HIV in the workplace (Swanepoel *et al.*, 2003:588-589). At a workplace level, AIDS threatens economic security and development because it primarily strikes the working-age population. When workers are found to be HIV positive, they are replaced by younger, less-experienced men and women (UNAIDS, 2004:56).

## **2.6 SEXUAL BEHAVIOUR AND PRACTICES**

Early in the HIV/AIDS epidemic in sub-Saharan Africa, much discussion occurred on the differences in sexual behaviour between different populations and those of Western countries, with such differences often cited as the reason for the explosive epidemic of HIV/AIDS in sub-Saharan (Ellison *et al.*, 2003:66). While in any given society there are many different kinds of masculinity and femininity that vary by age, ethnicity, social class and sexuality, it is the dominant ideology that influences women's and men's attitudes and behaviours, making both vulnerable in the context of the HIV epidemic. Abdool-Karim (2005:259) reports that the past decade has resulted in an enormous growth in our knowledge about the gender-related determinants of risk and vulnerability to HIV and the consequences of AIDS, but translating this knowledge into action at a policy and programme level

has remained a major challenge. In sub-Saharan Africa, HIV/AIDS is very much an epidemic of young people, especially women and UNAIDS estimates show between 10% and 15% of the 15-24 age group is HIV infected in this region (Harrison, 2005:262).

### **2.6.1 Sexual behaviour amongst young adults**

Young people, between the ages of 15 and 24 are both the most threatened, globally accounting for half of all new cases of HIV and the greatest hope for turning the tide against AIDS. Among young people in high-prevalence sub-Saharan Africa, the HIV epidemic is super-imposed on already poor sexual health outcomes, including high levels of unintended pregnancy where the main mode of transmission is heterosexual intercourse (UNAIDS, 2004:10). In South Africa, gender role norms contribute to the pronounced gap between HIV awareness and practices and social processes that influence young women's disproportionate risk of HIV.

For young South Africans, sexual activity is the predominant mode of HIV transmission. Initiation of sexual intercourse places young people in a high risk group for HIV, other STIs, and unplanned pregnancy. In the context of HIV/AIDS, age at sexual debut is an important marker of risk as it determines length of exposure to infection. Patterns of sexual networking, including type of partner, age differences between partners, number of partners and a partner's broader sexual contacts, are among the key determinants of risk for HIV infection (Harrison, 2005:268). Levels of pregnancy are very high among teenage and young adult women in South Africa where the HIV epidemic is severe, disproportionately affecting teenage women and men slightly older than them. Several studies demonstrate that some young women often form partnerships with older men who have some source of income and who are able to provide them with personal gifts and favours as well as money for household necessities and school fee (Harrison, 2005:266-267). While many young women are in consensual sexual relationships, large numbers of young women are coerced into

being sexually active. Harrison (2005:266-267) also found that high levels of unprotected sexually active underscore the high level of sexual risk faced by young South African women. In addition non-use of contraception by those who have recently become sexual active means that opportunities for counselling regarding condom use and dual protection against HIV and pregnancy are missed, leaving young women vulnerable to both HIV and pregnancy.

### **2.6.2 The role of gender in sexual behaviour**

Cultural prescriptions of masculinity and femininity control and determine what men and women know, how they communicate with each other and how they behave within their relationships, significantly affect not only men's and women's sexual behaviours and attitudes. Ironically, the very behavioural strategies that are likely to be most effective for reducing the spread of HIV are the least in the control of women, which is condom use and faithfulness to one partner (Makahye, 2005:313-318).

Abdool-Karim (2005:253) outlines the findings of studies which illustrate how prevailing cultural norms place South African women at risk of HIV. In some settings in South Africa, sex is viewed as a conjugal right and a male prerogative and in other parts of Africa and the developing world, simply being married is one of the biggest risk factors for acquiring HIV infection. Many women experience sexual and economic subordination in their marriages or relationships, and are therefore unable to negotiate safe sex or refuse unsafe sex. Abdool-Karim (2005:260) suggests that a challenge in reducing HIV risk in women and young women would be to refine current safer sex options and to convey to married women the risk they face if their partners are not in mutually monogamous relationships with them. In addition, the explosion of the AIDS epidemic coupled with the high incidence of rape in the country makes women and girls more vulnerable to the disease.

### 2.6.3 HIV Sexual risk behaviours

Sexual behaviour is shaped by personal, interpersonal, environmental, cultural and structural forces. Factors related to interpersonal relationships, such as negotiating condom use, coercive male-dominated sexual partnerships and peer pressure to be sexually active, are also important (Halperin & Epstein, 2004:4-6). Surveys of sexual practices and behaviour within different African populations have not revealed dramatically different patterns of behaviour, with most individuals reporting a limited number of sexual partners (Carael, Cleland, Deheneffe, Ferry & Ingham, 1995:1171-1175).

A study investigating the trends between violence and HIV sexual risk behaviours showed that women who are raped, physically assaulted or threatened with assault were more likely to have multiple sex partners and engage in unprotected intercourse (Harrison, 2005:275). Fear of violence prevents women even from discussing HIV risk with their partners, let alone requesting condom use.

Dominant ideologies define for women that sexual practices linked to reproduction are moral and those linked to pleasure are immoral, and for men they endorse variety in number of sexual partners. These double standards for men and women in acceptable sexual behaviour seriously challenges HIV prevention efforts targeted at promoting monogamy and fidelity. Halperin and Epstein (2004:4-6) reports in 43%-80% of the most recent incidents of sexual activities among sexually active women and men, condoms were not used.

In South Africa, the HIV/AIDS epidemic is driven primarily by sexual behaviours that expose individuals to the risk of infection. In addressing the epidemic, the most difficult challenge is trying to change sexual risk behaviour. Driven by poverty and the desire for a better life, many women and girls find themselves using sex as a commodity in exchange for goods, services, money, accommodation, or other basic necessities, often with older men (Halperin & Epstein, 2004:4-6).

The following KAP surveys conducted in the hotel industry and in a variety of other settings will provide information on the respondents' knowledge and understanding of HIV/AIDS, their attitudes towards HIV/AIDS and people living with HIV, and also their lifestyles and sexual practices.

## **2.7 KAP SURVEYS ON HIV/AIDS**

*Knowledge, Attitudes and Practices* (KAP) surveys conducted in various environments, though not all specific to the hotel industry, nevertheless provide meaningful insights into knowledge, attitudes and sexual practices regarding HIV/AIDS.

In Madras, South India, different levels of hotels were identified for the KAP study using an interview schedule of 40 questions in two languages (one in the local language Tamil and the other in English) among 100 employees, both male and females from various departments to assess the level of awareness of HIV/AIDS among the hotel employees. Although it was found that there was high level awareness of HIV/AIDS, many hotel employees continue to have multipartnered sex without using condoms. 21 respondents were not aware of condom use, and although 79 persons were aware of condoms only 55 agreed that condom can prevent AIDS. There was a dire need for HIV/AIDS intervention programmes and strategies at the hotels (Kumar, 1993:6-11).

In another study to formulate, implement and evaluate an AIDS education intervention in a multinational hotel industry, Zazayokwe, Christie, Metz and Sher (1989:4-9) adopted a three-phase intervention strategy to assess the awareness of HIV/AIDS among hotel employees, and to certify certain hotel staff to become AIDS educators in order to disseminate information to all hotel employees. Members of the executive management were asked to attend an AIDS seminar, after which a multidisciplinary team of professionals visited the different hotel regions to address senior, middle and supervisor management about AIDS, to plan for preventive education. Thirty hotel employees, 20 black and 10 white with

an even ratio of male to female were selected for HIV/AIDS training. The objective of the course was to certify them as AIDS educators so that they could disseminate information to all hotel employees. A follow up survey using questionnaire reflected increased AIDS knowledge and awareness. Additional research would be undertaken to evaluate attitude and behaviour change.

A KAP survey at 12 hotels in Puerto Plata, Dominican Republic was conducted amongst 239 hotel workers, (Forsythe, Hasbun & De Lister, 1998:277-286). The survey included confidential interviews with both male and female staff, as well as a self-administered questionnaire of 15 close-ended and two open-ended questions to determine their interactions with other Dominicans and with tourists in the hotels. The hotel staff was categorised into their specialty areas in the hotel, namely: food and beverage; rooms division; activities; administration; reception; maintenance; and entertainment. Interestingly the KAP survey among the hotel workers revealed that the entertainment staff was engaging in most of the high risk sexual activities with tourists at the hotels (Forsythe, *et al.*, 1998:277-286).

The survey also showed that the average working in the hotel industry is young, with 62% of the workers between 17 and 29 years of age. The risk of being infected with HIV was perceived to be very high by hotel workers. Having multiple sexual partners appeared to be fairly common among hotel workers and 39% reported that they have had more than one sexual partner over the last year. The category of workers reporting the highest number of different sexual partners was the hotel's entertainment staff, 52% of whom reported having sex with tourists with 95% reporting condom use.

In a national KAP survey conducted by a Business company in South Africa, using a mailed questionnaire to 4,500 employees in the hospitality industry, Thornton (2005:3) reported low levels of HIV/AIDS knowledge, and little change in people's attitudes towards HIV/AIDS as well as their sexual practices and behaviour. In a further survey where the impact of HIV/AIDS on 450 businesses was assessed,

Thornton (2005:3) further reported that 75% of the employers in the hospitality sector were found not have a person responsible for managing HIV/AIDS in the workplace. In addition 92% of all companies operating in South Africa's hospitality sector do not have an HIV/AIDS workplace policy in place and did not provide any HIV/AIDS related training for their employees.

A survey conducted in Nairobi, Kenya of HIV/AIDS among students and teachers indicated that 95% of the respondents were aware of HIV/AIDS and its clinical symptoms, but only 80% of the respondents had knowledge of preventive measures, (Ndegwa *et al.*, 2002:56-60). However, Rahman (1999:35) found in a KAP survey conducted among people from Bangladesh seeking work overseas, that only 26% of the respondents knew of AIDS, most of which reporting false beliefs about the mode of HIV transmission. Mohammed (1999:203) reported a study that was conducted among Indiana (USA) residents where HIV/AIDS knowledge score was low, despite the fact that they perceived to know a great deal about AIDS.

In another study in Udupi District, Karnataka, India, a cross-sectional descriptive study was carried out using a self-administered, anonymous questionnaire with mostly close-ended, among 990 students of grade 12 level from randomly selected schools. The study also included 46 trainee teachers from one teacher training college to investigate their knowledge of and attitudes to HIV/AIDS (Agrawal, Rao, Chandrashekar & Coulter, 1999:143-149). Findings of the study demonstrated a lack of essential knowledge and many misconceptions about HIV/AIDS amongst the school students and trainee teachers. In India, the main source of knowledge about HIV/AIDS is still the mass media and there is no formal sex education. Students' knowledge seemed fair but much needs to be done to expand health education. Most respondents knew the main modes of transmission of HIV infection but there are still many misconceptions about transmission, prevention and cure. There is an urgent need to introduce a health

education programme involving teachers and including sex education and counselling (Agrawal, *et al.*, 1999:143-149).

Over 500 university students, both male and female, in Ankara, Turkey were surveyed to determine their knowledge, attitudes and perceptions or risk related to HIV/AIDS using a pre-tested structured questionnaire. Findings of this study show that there were a significant number of sexually active students among the Turkish university participants who were studied. These students engaged in various forms of sexual experiences and some indicated they had unprotected sexual intercourse. There were also a significant number of the students who displayed glaring gaps in their factual knowledge about HIV/AIDS. These findings point to the importance of accurate and specific HIV/AIDS education for Turkish university students. It was reported that by the provision of accurate and objective information, university students can begin the first steps of behavioural change. Education will also help address unnecessary fears that contribute to unaccepting attitudes toward people with AIDS (Cok, Gray & Ersever, 2001:81-99).

Since young people are especially vulnerable to HIV, they are also the greatest hope for changing the course of the AIDS epidemic. The global community is now at a crossroads in expanding access to HIV treatment and care (UNAIDS, 2004:101).

## **2.8 TREATMENT, CONTROL & PREVENTION STRATEGIES FOR HIV/AIDS**

AIDS is now claiming more lives in Africa than the sum total of all wars, famines and floods to date, leaving many hundreds of thousands of orphaned children. Sub-Saharan Africa is home to roughly 90% of the 800,000 infants who contracted HIV from their mothers before or during birth or as a result of breastfeeding (Abdool-Karim & Abdool-Karim, 2005:40). Prior to the emergence of AIDS, South Africa was already experiencing a major Tuberculosis epidemic. The AIDS epidemic has exacerbated this, and TB is now a leading cause of mortality in South Africa, the two epidemics running in parallel. In South Africa the burden of



TB is increasing because of HIV infection (Churchyard & Corbet, 2005:433-453). South Africa not only has the highest number of HIV-infected individuals in the world, but has the eighth highest burden of TB worldwide (Abdool-Karim & Abdool-Karim, 2005:44), and HIV-infected TB patients are at increased risk of dying during treatment.

The rapid global spread of the HIV/AIDS pandemic resulted in a wide range of initiatives to control transmission and prevent new infections (Ellison *et al.*, 2003:71-79). These include behavioural interventions, including safer sex campaigns, condom promotion, needle exchange programmes and controversial debates regarding male circumcision, population-level interventions, such as attempts to reduce STIs through mass treatment, vaccine development and the development of antiretroviral treatment for HIV infection. One of the ongoing goals of HIV research has been the development of a safe and efficacious vaccine, particularly given the high prevalence of infection in the developing world and the poor access to medical care and new antiretroviral drugs (Ellison (*et al.*, 2003:172) . Some people oppose scaling up treatment with a prevention-versus-treatment 'cost-effectiveness' argument. Cost-effectiveness analysis comparing HIV prevention and treatment provide a simplistic and outdated view that prevention should be funded to the exclusion of treatment, merely because prevention programmes may be cheaper (UNAIDS, 2004:105).

There are a number of ways in which the spread of HIV/AIDS in a company, organization or hotel can be prevented. These include HIV/AIDS education and training; peer education; condom distribution; voluntary counselling and testing (VCT); practicing safe first aid; and by treatment of sexually transmitted infections (STIs). An ideal HIV/AIDS control and prevention model includes voluntary counselling and testing, education and awareness, preferably by peers, provision of condoms, efforts to overcome denial, stigma and discrimination, and care and treatment for people living with HIV and AIDS, and the prevention of mother-to-child transmission (MTCT) of HIV and treatment of STIs (Ellison *et al.*, 2003:254).

Ensuring widespread knowledge of HIV status is the gateway to HIV treatment and prevention. People have the right to know how to protect them from being infected with HIV and they have the right to know how to obtain treatment, care and support (UNAIDS, 2004:121).

### **2.8.1 HIV/AIDS education and training**

Workplace information and education programmes are essential to combat the spread of the epidemic and to foster greater tolerance for workers with HIV/AIDS. The purpose of HIV/AIDS education is not only to disseminate information, but also to change attitudes and behaviour, to equip people with the necessary skills, to empower them to prevent the spread of HIV infection and to help them care for people who are already infected (Ellison *et al.*, 2003:148). Educators should ask themselves what role the social, cultural and economic context plays in inhibiting or promoting behaviour change, and what social changes are required to bring about individual change.

### **2.8.2 HIV prevention programmes**

HIV prevention programmes are very important in reducing sexual risk behaviour and changing the extent and the shape of the HIV/AIDS epidemic. The association between sexually transmitted infections (STIs) and HIV transmission is well established, making the treatment of STIs an important prevention mechanism. Supporting workplace prevention programmes for employees and management makes good economic and developmental sense, as well as providing health care in workplace settings, and endorsing policies of non-discrimination against employees living with HIV (UNAIDS, 2004:96).

The promotion of accurate knowledge about HIV transmission and prevention, and prevention skills, should be the requisites of HIV prevention programmes, where these prevention programmes are sought to promote sexual behaviour change at the individual level, through providing people with knowledge about sexual health risks, and training them in the behavioural skills necessary for the performance of

new behaviours. Successful programmes should impart knowledge, counter stigma and discrimination, create social consensus on safer behaviour, and boost HIV prevention and care skills. These can be cost-effectively accomplished through mass media campaigns, through peer or outreach education, through life-skills programmes in schools and workplaces, and by ensuring that voluntary counselling and HIV testing are available.

HIV prevention programmes should include HIV/AIDS awareness programmes and education, condom distribution, universal precautions and STD management. Ellison et al. (2003:18) makes reference to an effective HIV prevention programme, a model of voluntarism and community participation that is founded on voluntary counselling and testing, education, preferably by peers, provision of condoms, efforts to overcome denial, stigma and discrimination, and care and treatment for people living with HIV and AIDS and the prevention of mother-to-child transmission of HIV and treatment of STI.

BMW Motor Vehicle Company in South Africa claims to have conducted successful HIV/AIDS prevention programmes which were the result of changing the attitude of employees towards the disease and to encourage their staff to find out their HIV status by means of voluntary testing. This has ensured that prevention programmes are implemented in the workplace to minimise the risk associated with the epidemic (BMW, 2004).

### **2.8.3 Voluntary counselling and testing**

Voluntary HIV counselling and testing can be effective in modifying sexual behaviour in developing countries (Nattrass, 2004:102), and this has emerged as a major strategy for the prevention of HIV infection and AIDS in Africa. VCT enables an individual undergoing counselling to make informed decisions about being tested for HIV antibodies, and van Dyk (2005:103) believes that knowing one's HIV status, whether positive or negative, is instrumental in affecting behaviour change and the adoption of safer sex practices.

Within care programmes, HIV tests results and follow-up counselling mean people can be directed towards relevant care and support, for example, treatment for sexually transmitted infections, TB and other opportunistic diseases, access to antiretroviral therapy, counselling about family planning and prevention of mother-to-child transmission, and support for adherence to medication. Wider access to VCT may also lead to great openness about HIV/AIDS, raised awareness and less stigmas and discrimination (UNAIDS, 2002:122).

#### **2.8.4 Behaviour change**

Changing unsafe behaviour and practices is crucial in addressing the HIV/AIDS epidemic. In the fight against HIV/AIDS, it is important to be concerned with the physical aspects of HIV and AIDS, and how the virus is transmitted and what effect it has on the body. Behaviour change remains the most important means of preventing the spread of this disease while no real cure or effective vaccine is available (van Dyk, 2005:87).

A further motivation for people to change their sexual behaviour is if they:

- realise the need for behaviour change or feel vulnerable to HIV infection during unprotected sex with multiple sex partners;
- know exactly what specific behaviour needs changing, as in using a new condom for every sex act;
- have positive attitudes to the behaviour, for example, they have to believe that condom use will prevent HIV infection, and that they are comfortable to use;
- have a high self-efficacy in their ability to perform the specific required behaviour, like knowing exactly how to use condoms effectively and easily;
- perceive that the benefits and rewards from the new behaviour;
- have the necessary skills to perform and maintain the behaviour, like communication, negotiation and problem-solving skills to make condom use an acceptable behaviour (van Dyk, 2005:87).

In Kampala, Uganda, HIV prevalence fell to eight percent in 2002 (van Dyk, 2005:9). Uganda's success story in the effective control of HIV/AIDS can be seen as a political icon for Africa's HIV/AIDS campaign pointing to a successful example in which HIV infection rates have undoubtedly fallen over a decade (Parkhurst, 2002:78-80). President Yoweri Museveni of Uganda educated himself about HIV/AIDS and launched Africa's first campaign against the disease. The vibrancy and success of the campaign increased Ugandans' awareness about HIV/AIDS and resulted in its reduction of HIV transmission. An increase in age at first sex is now commonly cited as a contributing factor in the decline in HIV infection in Uganda (Harrison, 2005:273), where increased abstinence among the young is cited as one of the factors that has led to lower overall HIV prevalence. This highlighted to heads of state and Africa's leadership the challenge in confronting the epidemic in contrast to South Africa's leadership. The South African government's highly controversial response to HIV/AIDS and its failure to act decisively with conviction in implementing programmes that prevent or treat HIV infection by using antiretroviral drugs has drawn much national and international criticism (Heywood, 2005:371-383).

Efforts to promote behavioural change have been coupled with biological interventions for preventing the spread of HIV infection. Al-Owaish et al. (1999:163-173) found that most of the people in Kuwait were aware of the main modes of AIDS transmission but a gap existed about how the disease was not transmitted. This was reflected in their attitudes and practices towards AIDS patients. They concluded that there was a need for a role for medical professionals, mass media, and religion in AIDS prevention and control.

### **2.8.5 A-B-C preventive strategy**

At a programmes level, the 'A-B-C' approach, which entails the promotion of abstinence, behaviour change and promotion of male condoms has been most widely promoted in HIV prevention (Abdool-Karim, 2005:243-261). Avoiding AIDS

is as easy as ABC, '*Abstain, Be faithful, Condomise*' which is likely to induce appropriate 'risk-controlling' behaviour (Heald, 1995:489-505).

The only 100% effective way to protect oneself against sexual transmission of HIV is total abstinence from sex (van Dyk, 2005:130) or delay a sexual relationship for as long as possible. Abstinence is not always realistic, and several studies show that almost half of teenage men and women are sexually active, with a steady increase level of sexual activity reported throughout the teen years (Harrison, 2005:273). Abstinence and lifelong mutually faithful monogamous relationships are critical to reduce the number of discordant sexual acts, and should be promoted as part of any comprehensive prevention strategy. However, this should be to the exclusion of all else as abstinence and monogamy may not be an option for many, such as migrants, who are at risk of acquiring infection with HIV (Abdool-Karim, 2005:251).

Condoms remain a pivotal part of the fight against HIV/AIDS, insists Myer (2005:166) and consistent male condom usage will reduce HIV incidence by at least 80% within the context of the varying levels of effectiveness. Resistance to condom use has been a factor in many areas of Africa (Ellison *et al.*, 2003:225) and many women are simply not in a position to insist that their partners use condoms because they fear rejection or a violent reaction from their partners if they do so (van Dyk, 2005:26). The 'safe/r sex' model of prevention was initially developed in the West and used successfully among a particular groups of Westerners, that of homosexual men.

The distribution of public sector condoms has been a key part of the National Department of Health's HIV prevention strategy. Myer (2005:170) informs that male and female condoms are available in South Africa through three general sources: free of charge through the public sector; through social marketing programmes operated by non-governmental organisations (NGOs); and through commercial distributors. Public sector condoms are purchased by the National

Department of Health and are distributed free of charge to the public. Myers (2005:176) is of the opinion that condom use between casual partners is usually more common than between partners in a long-term monogamous relationship, a finding which emphasises the role of perceived risk in shaping behaviours. Until alternative methods become available, male and female condoms will remain the principle technology for preventing the sexual transmission of HIV in South Africa.

### **2.8.6 Antiretroviral therapy**

Treating and caring for the millions of South Africans living with HIV/AIDS poses an enormous challenge. An AIDS vaccine remains an important hope for the control of HIV/AIDS. Antiretroviral therapy (ART) is used to treat established HIV infection and to try to prevent HIV infection (van Dyk, 2005:73), including:

- The prevention of mother-to-child transmission of HIV;
- The prevention of HIV infection after occupational exposure;
- The prevention of HIV infection after rape or sexual assault.

The main aim of ART is to delay or prevent the progression to AIDS and death of HIV-infected patients (Wood, 2005:504). ART is beneficial to both HIV positive employees and the company and is by far the biggest cost saver upon the introduction of anti-retroviral treatment in the workplace in the reduction of death and disability benefits (Nicolay, 2005:2). Antiretroviral therapy appears to be even more effective at reducing the incidence of TB among HIV-infected individuals than TB preventative therapy (Churchyard & Corbet, 2005:433-453), although there have been no formal clinical trials. Equally important, is the use of highly active antiretroviral therapy to prevent opportunistic infections (Maartens, 2005:454-462), and to improve the level of immune function in HIV-infected patients, since almost all the morbidity and mortality associated with HIV infection is a consequence of opportunistic disease that occur when immunity is impaired. Exposure to opportunistic infections should be prevented wherever possible by attention to safe water supplies, food hygiene, TB prevention and safe sex.

Morris and Cilliers (2005:79) believe that an HIV vaccine is considered the best hope for controlling the HIV pandemic, and Abdool-Karim and Abdool-Karim (2005:45) argue that highly active antiretroviral therapy can transform the course of HIV infection into a manageable disease. Drug procurement, use of generics, and monitoring of drug resistance all pose equally daunting challenges, but Abdool-Karim and Baxter (2005:226) argue that interventions for protection from HIV infection beyond behaviour modification and barrier methods are urgently required if it were to alter the course of the epidemic.

Addressing aspects of HIV/AIDS in any workplace will enable employers, including employers in the hospitality sector to actively contribute efforts to prevent and control HIV/AIDS (Swanepoel *et al.*, 2003:588-589). It is important that policy guidelines on HIV/AIDS are in place for HIV-infected employees in the hospitality industry for the successful management of the disease.

## **2.9 WORKPLACE & POLICY GUIDELINES ON HIV/AIDS IN SOUTH AFRICA**

The worldwide AIDS epidemic has had a profound effect on people in all types of work organisations, including the hospitality sector, (Miller, Baker & Rogers, 1997:78-86). Infection with HIV is having an increasingly serious impact on personal lives, society and the economy. It is predicted that AIDS will have devastating effects on the South African labour market within the next 5-7 years (Krautkramer, 2004). The South African Business Council has aimed to create universal strategies for fighting the disease in the workplace in the face of the infection rate in South Africa and the cost of the impact of HIV/AIDS on the South African economy (Gouws & Abdool-Karim, 2005:49). McDonald (2003) found that only 41% of businesses had implemented an HIV/AIDS awareness programme in the workplace, while Barrows, Gallow and Mulleady (1996:5-9) report that 71% of companies surveyed in the United States indicated that they did not have an AIDS policy, and Thornton (2005:18) reports that 92% of all companies operating in South Africa's hospitality sector do not have an HIV/AIDS workplace policy in place.



Employers in general and those in the hospitality industry can play an important part in sponsoring AIDS awareness programmes (Swanepoel, *et al.*, 1998:593), and provide informative training to educate employees and management alike about AIDS and thereby make an AIDS policy effective (Krautkramer, 2004). The International Labour Organisation (ILO) of Practice on HIV/AIDS document (2000) refers to an HIV/AIDS workplace policy as a set of guidelines for HIV infected employees. The primary objective of the Code of Good Practice on key aspects of HIV/AIDS and employment, under the Labour Relations and Employment Equity Acts, (2000) outlines set guidelines for employers and trade unions on how to manage HIV/AIDS within the workplace (van Dyk, 2005:348). The Code recognizes that the HIV/AIDS epidemic will affect every workplace with prolonged staff illness, absenteeism and death, impacting on productivity, employee benefits, occupational health and safety, production costs and workplace morale (Swanepoel *et al.*, (2003:588-589).

### **2.9.1 Impact of HIV/AIDS on the South African economy**

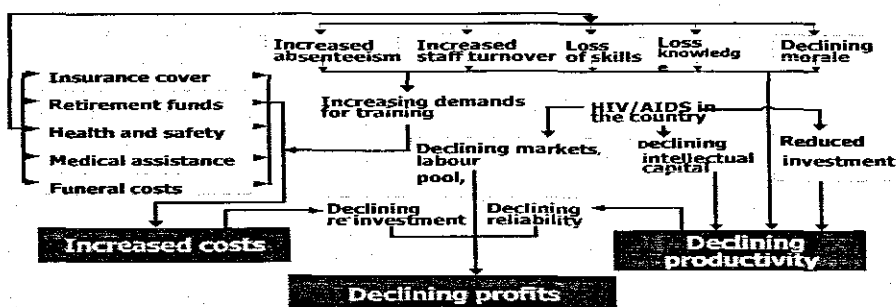
HIV/AIDS is having a devastating impact on development in Africa. South Africa is a middle-income economy and AIDS is affecting the South African economy (Whiteside, 2005:405-418). The current epidemic poses a major challenge to all, but in the business sector, HIV/AIDS impacts both directly and indirectly, resulting in increased costs and reduced productivity. A loss in revenue attributable to HIV/AIDS can occur when infected workers take leave due to illness, the need to care for other infected family members, or the need to attend the funerals of co-workers or loved ones (Nattrass, 2004:24). A direct affect of absenteeism is that it results in extra work for other healthy employees who have to stand in for sick colleagues. At a company level, labour costs will rise, productivity decrease and markets will be affected (Whiteside, 2005:405-418), while AIDS reduces productivity at work and increases production cost for companies.

In a business environment, like the hospitality environment, AIDS may lead to skills shortages, absenteeism, and reduced outputs (Nel *et al.*, 2001:169). Like

many other business sectors, HIV/AIDS is shrinking the size of the tourism and hospitality market and many companies in this business sector do not realise how South Africa's HIV/AIDS epidemic impacts on their guests/clients (Thornton, 2005:49). Besides potential guests dying or being too ill to travel or go to restaurants, many households affected by HIV/AIDS are spending more money on medical and health services and insurance. As a result, many households have less to spend on holidays, leisure activities and other luxuries. In Figure 4 below, the impact of HIV/AIDS on the economy is illustrated in terms of increased costs, declining profits and productivity.

Figure 4: The Impact of HIV/AIDS on industries: an overview

### The impact of HIV/AIDS on industries: an overview



Source: UNAIDS (2000) Adapted from *The Business Response to HIV/AIDS: Impact and lessons learned*

AIDS reduces the economic security of households by reducing the productivity and eventually killing income-earners, while simultaneously diverting scarce household resources towards medical expenditure (Nattrass 2004:24). South Africa is more dependent on skilled labour than other countries in the region and loss of skilled and professional staff could hamper business and government operations, and possibly slow economic growth (Whiteside & Sunter, 2001:67). Heywood (2005:382) believes that the disruption of livelihoods, and the diversion of scarce resources to fill gaps left by those who have died, will rob the millions of poor people of prospects for income accumulation and social improvement.

Knowing one's HIV/AIDS status is important, and there is a strong consensus against mandatory HIV testing (Puren, 2005:89). The leading organisation in the world-wide efforts to contain the epidemic, the Joint United Nations Programme on HIV/AIDS (UNAIDS) continues to support only voluntary and confidential HIV/AIDS testing (IH&RA & UNAIDS, 1999:22).

### **2.9.2 Basic human rights of employees & HIV/AIDS testing in the workplace**

The HIV/AIDS pandemic has given rise to a vast myriad of ethical, moral and legal issues. The South African legislation and policies are based on the basic human rights that apply to all citizens and therefore people living with HIV or AIDS have the same basic rights and responsibilities as all other citizens. The human rights principles in the *Charter of Rights on AIDS and HIV*, launched in 1992 are essential to ensure non-discrimination and public health in South Africa (van Dyk, 2005:334). Thornton (2005:16) found that many employers and employees did not know that the Constitution includes human rights for people living with HIV/AIDS. HIV or AIDS does not, by themselves, justify termination of employment or demotion, transfer or discrimination in employment and HIV positive employees have the same rights to housing, food, social security, medical assistance and welfare.

The code of ethics states that no employer may require an employee or an applicant for employment, to undertake an HIV test in order to ascertain that employee's HIV status (van Dyk, 2005:349), and an employee would be unfairly discriminated if an employer refuses to employ a person who is known or suspected to be HIV positive. An employee is therefore not legally required to disclose his or her HIV status to their employer or to other employees (Swanepoel *et al.*, 2003:588). The three 'C's are the underpinning principles advocated for HIV testing of individuals, are *confidentiality*; testing accompanied by *counselling* and testing only with informed *consent*, (UNAIDS, 2004:86). The management of the BMW Motor Company in South Africa acknowledges the sensitivity of requiring associates to have HIV tests (BMW, 2004) and testing is conducted only upon the

individual's request, with the informed consent of the individual, and subject to both pre-test and post-test counselling.

The National policy for HIV testing indicates HIV testing should not be included in any employment policy or used as grounds for refusing employment, unless: (i) upon individual request for diagnostic and treatment purposes with the informed consent of that individual; (ii) on the recommendation of a medical doctor; (iii) as part of HIV testing for research purposes with informed consent of the individual; (iv) as part of screening blood donations with informed consent of the individual; (v) as part of unlinked and anonymous testing for epidemiological purposes undertaken by national, provincial or local health authority or an agency authorized by any of these bodies; and (vi) where an existing blood sample is available, and an emergency situation necessitates testing the source patient's blood, for example risk-bearing accident such as a needle stick injury (van Dyk, 2005:338).

There are a number of specific settings in which HIV testing is indicated: (i) when a person believes that they are at risk of infection through unprotected sexual activity, needle-stick injury or unsafe infection drug use; (ii) when a pregnant woman wishes to know her status to protect her unborn child; (iii) when mother-to-child transmission of HIV is suspected; (iv) for public health and infection control and public health policy implementation, and (v) as a requirement for certain types of short-term insurance (Puren, 2005:91). Pre-HIV test counselling is important and should be seen not only as preparation for the HIV test, but also as an opportunity to educate people about HIV/AIDS and safer sex (Mathews, 2005:155).

A serious workplace and organisational response to the HIV/AIDS epidemic will assist in the effective management of the disease in terms of providing HIV prevention education in the workplace, creating an HIV policy for the business and implementing fair employment practices (IH&RA & UNAIDS; 1999:19).

### **2.9.3 Workplace and organisational responses HIV/AIDS**

Miller et al. (1997:78-86) found that businesses in the United States resisted to the AIDS epidemic and that many executives believed that: (i) their companies would not be affected by AIDS, (ii) that an AIDS education programme was expensive, (iii) that it may reflect a negative company image, and (iv) that the programmes could increase employee fears, upset the workplace and decrease productivity. Six years later, results from a survey by the South African Business Coalition of HIV/AIDS (SABCOHA) showed that most companies in South Africa have failed to respond to the HIV/AIDS epidemic (McDonald, 2003:2). Only 25% of all the companies surveyed have implemented a formal HIV/AIDS policy, while less than fifty percent have a voluntary counseling and testing programme, or provide care, treatment and support to infected workers.

In the South African hospitality sector, Thornton (2005:3) reports alarming statistics that 75% of the employers do not have a person responsible for managing HIV/AIDS in the workplace, and 93% of businesses in this sector do not have a company HIV/AIDS policy, of which 92% of employers have not provided any HIV/AIDS, related training for their employees.

### **2.9.4 Employers' obligations to HIV/AIDS employees**

It is recognised that HIV/AIDS epidemic will affect every workplace, including the hospitality industry with prolonged staff illness, absenteeism, and death impacting on productivity, employee benefits, occupational health and safety, production costs and workplace morale (Swanepoel *et al.*, 2003:588:589). The most effective way of reducing and managing the impact of HIV/AIDS in any workplace, including the hospitality industry is through the implementation of an HIV/AIDS policy and programme (IH&RA & UNAIDS, 1999:19), and should be seen as a priority, with the aim of preventing new infections, providing care and support for employees who are infected or affected, and managing the impact of the epidemic in the organization (Evian, 1991:11). Issues to be addressed include holding regular HIV/AIDS awareness programmes, encouraging voluntary testing, conducting

education and training on HIV/AIDS, promoting condom distribution and use, encouraging health seeking behaviour for STD's, enforcing the use of universal infection control measures, creating an environment that is conducive to openness, disclosure and acceptance amongst all staff (Swanepoel *et al.*, 2003:588:589). Copies of the Code of Ethics for HIV/AIDS are obtainable from the Department of Labour (Swanepoel *et al.*, 2003:588:589). However, Goss and Adam-Smith (1995:4) report that against the evidence of discrimination there is also the need to recognise that some employing organisations have been in the forefront of countering prejudice and providing practical assistance to people affected by the virus, both through constructive policies and procedures and support for health education aimed at preventing further infection.

McDonald (2003) reports that employer responses to an HIV/AIDS policy appear to be linked to company size, with most large companies having an HIV/AIDS policy in place, while those businesses with less than one hundred employees have shown to have done very little in the way of action against the epidemic. Small and medium enterprises are an important source of employment in South Africa, and while their existence may be threatened as the epidemic peaks, it is imperative that they react strategically to HIV/AIDS. Every company is obliged to have a detailed HIV/AIDS policy statement which will declare responsibility of the employer towards employees who become infected with HIV (van Dyk, 2005:340). This policy will inform the employee about the guidelines to follow in the event of the employee having occupational exposure as this will also ensure the infected employee is insured against the consequences of infections of HIV.

### **2.9.5 Challenges in managing HIV/AIDS in South Africa**

Knowledge and implementation is needed in order to plan effectively for the management and mitigation of the personal, social and economic consequences of the epidemic, including the impact on human resources. South Africa is undergoing a period of profound socioeconomic development (Wilson & Fairall,

2005:477-503) and the HIV epidemic presents the medical system with extraordinary health care challenges.

With the polarisation of the AIDS debate between nutrition versus antiretroviral treatment in 2003 (Deane, 2005:538-547), Minister, Manto Tshabalala-Msimang put emphasis on nutrition as the best treatment for people with HIV. After the controversy over her dissident comments of the 'toxicity' of antiretroviral drugs, the health minister, extolling the benefits of a Mediterranean concoction of lemon, ginger, olive oil, garlic and beetroot, was met with much ridicule by the media and AIDS activists. Although she defended her support for the herbal remedies her emphasis on nutrition rather than antiretroviral treatment reinforced the perception that she still felt that antiretrovirals are not the best option.

## **2.10 HIV/AIDS IN THE HOTEL INDUSTRY**

The hotel industry is at particular risk of the pandemic because of the mobility of the workforce, the presence of sex tourists, and the heavy reliance of many countries upon tourism revenues (Forsythe, 1999:4-6). The industry takes pride in being a 'high-touch, people-intensive' service sector. The many well-trained and motivated personnel provide services to millions of guests each year as the industry is built on dedication to quality service and satisfaction. Like other business sectors the HIV/AIDS epidemic has and will continue to affect South Africa's hospitality and tourism sector. There are some male and female tourists who engage in sexual encounters with sex workers and hotel staff (Forsythe *et al.*, 1998:277-286). A study in Torbay, England found that half of all tourists had made at least one new boy/girlfriend during their vacation and about one quarter of respondents had engaged in sexual activity with a person whom they had only just met (Ford, 1991:30).

### **2.10.1 The impact of HIV/AIDS on the hotel industry**

Like many business sectors, HIV/AIDS is shrinking the size of the hospitality industry, and will continue to do so. HIV/AIDS impacts on all businesses,

including the hospitality industry, both directly and indirectly, resulting in increased costs and reduced productivity in terms of recruitment and training new skilled and unskilled employees, who have been lost to HIV/AIDS (Thornton, 2005:6). Premiums for pension funds, insurance premiums and medical aid premiums will increase. Reduced productivity will negatively impact on the hotel industry when employees who are ill due to HIV/AIDS will require more sick leave or work less efficiently. Training new employees to fill the skills gap, caused by employees lost or absent due to HIV/AIDS, are time consuming and will slow down productivity. More compassionate and funeral leave results in reduced productivity. Moreover, high staff turnover and frequent loss of co-workers impacts on staff moral and motivation.

While the HIV epidemic is projected to peak around 2010 (Whiteside & Sunter, 2001:83), it will impact very heavily on the 2010 Soccer World Cup. Nattrass (2004:1) reports that, presently, one in five adults South Africans are HIV-positive and AIDS deaths are expected to rise sharply until 2010. As South Africa is already battling with a skills shortage, AIDS will exacerbate this and raise remuneration and replacement costs for the companies including the hotel industry. There will be a smaller labour force with lower productivity and income at the same time as demand grows for services. The AIDS pandemic has now forced the hotel industry to examine more closely the social and economic impact of HIV/AIDS on their businesses. Removing an employee from the workplace after being found to have AIDS exposes the organisation to a possible job discrimination suit, while the dilemma of diminishing customers and co-workers' morale also presents a challenge. With regard to the food and beverage staff, all evidence from epidemiological and laboratory studies indicate that blood-borne and sexually transmitted infections, such as AIDS are not transmitted with preparation or serving of food or beverages (Barrows, *et al.*, 1996:5-9). Food and beverage workers known to be infected with the AIDS virus need not be restricted from work, unless they show evidence of another infection, condition or illness which could be transmitted casually, or they are carriers of disease or infection.



Given the diverse range of people affected or infected by HIV and AIDS-related illnesses, most hotels will have to at some stage in the future, either employ people who are HIV-positive, have AIDS or have an AIDS-related complex (Barth, 2001:9). As a hotel cannot make an HIV test a requirement for hire or continued employment, a developed HIV/AIDS policy based on sound medical information will address these issues. Of equal importance are awareness and prevention programmes for management and staff, and a uniform human resources policy that treats employees with AIDS or an AIDS-related complex in the same way as any other employee with a life-threatening illness is treated.

The impact on production and employees will be devastating (Whiteside & Sunter (2001:113). In order to ensure that the production process is not vulnerable to staff losses, responses might include multiskilling, recruiting and training additional labour, contracting out, and capital intensification. To mitigate the stigmatisation and discrimination of HIV/AIDS and to reduce HIV transmission at any hotel, a HIV/AIDS programme in place and implemented will prevent, control and manage HIV/AIDS in the hotel industry. However, before any such programme is launched, a KAP survey would have to be conducted at the hotel to assess the needs and planned intervention.

#### **2.10.2 HIV/AIDS concerns for the hotel industry**

The IH&RA has attempted to address the concerns of HIV/AIDS in the hospitality industry at an international level in their *White Paper on the Global Hospitality Industry "Into the New Millennium"* published in 1996 (IH&RA & UNAIDS, 1999:5). Employees in the hotel industry need to understand how the HI virus is spread and also how HIV is not transmitted. Hotel employees may often encounter body fluids and blood which may be HIV infected in guest rooms and staff must be properly educated on safety measures, such as handling used hypodermic needles, disposing of syringes and razors, blood-soiled linen and garments, sanitary bins, handling knife cuts, even if these accidents are known to pose no transmission risk of HIV/AIDS, but having adequate knowledge of HIV/AIDS will

enable them to deal with these circumstances. Hotel employees need to answer guests concerns about HIV/AIDS around perceived risk of sharing cutlery, crockery, toilets, food, and eating food prepared by an HIV positive staff and employees should have sufficient first aid knowledge to know how to deal safely with injured guests and co-workers.

There is speculation that potential tourists' fear of AIDS could discourage them from visiting certain countries, while others have suggested that the hospitality and tourism industry contributes to the spread of HIV/AIDS (Forsythe, 1999:4-6). With the rapid increase in HIV/AIDS in South Africa, there is a potential risk of foreign tourists not to choose South Africa as their tourist destination because of their concerns about the country's HIV/AIDS statistics, and how the high statistics might impact on their visit. Sex tourism is often seen as a factor that contributes to the spread of HIV/AIDS and studies show that there are high levels of sexual activity between hospitality employees and tourists (Thornton, 2005:7). When tourists have sex with prostitutes, hotel staff, and others in the local population, a bridge can be created for HIV to cross back and forth between the tourist's home country and the tourist destination (Forsythe, 1999:4-6). Without practicing safe and protected sex, staff and guests are exposed to the risk of HIV infection.

There is a concern among hotel managers that AIDS prevention campaigns seen by tourists could result in the stigmatisation of the entire tourism industry and a large proportion of tourists (89%) would not look unfavourably upon an HIV/AIDS prevention campaign (Forsythe *et al.*, 1998:277-286). Those who perceived themselves to be most at risk of becoming infected while on holiday were the group most supportive of HIV/AIDS prevention campaigns.

### **2.10.3 Addressing HIV/AIDS in the hotel industry**

The IH&RA and the Federated Hospitality Association of South Africa (FEDHSA) launched a joint initiative in the fight against HIV/AIDS in Southern Africa. The International Hotel and Restaurant Association (IH&RA) made available a guide to

a workplace policy document on HIV/AIDS for the hospitality industry. The document defines how the company will consistently and fairly treat employees who are living with HIV/AIDS, as well as employees who are indirectly affected by the epidemic. Not having an HIV/AIDS workplace policy in the hotel industry, makes it difficult to standardise and control practices and procedures and ensure employees living with HIV/AIDS are treated in a fair and consistent way.

The International Hotel and Restaurant Association (IH&RA) and UNAIDS Guide (1999:10) outlines practical steps for hotels and restaurants to protect the workforce and the viability of the business in the face of the HIV epidemic. To achieve this objective, the Guide provides suggestions for steps that can be taken in three areas of action as outlined below:

- Action 1 – *Create a policy* on HIV-related issues that is appropriate for the workplace;
- Action 2 – *Provide HIV-prevention education and training* for all employees on how to avoid HIV infections, whether on or off the job; and
- Action 3 – *Treat with fairness* all your employees, especially those who are living with HIV or AIDS.

According to Mr Benjamin Memani (2005), Protea Hotels new group Human Resource Director, the Protea group of hotels has developed a policy guide on HIV/AIDS for the hospitality industry and the hotel group has made available a copy of the document. It has also been established that HIV/AIDS training at the Protea group of hotels does take place, and is not compulsory, but rather optional. However, HIV/AIDS training programmes are only recommended to staff amongst a list of other training programmes. Hotel employees determine their own needs for training in any course once the company conducts an annual skills audit among their employees.

## 2.11 CONCLUSION

The global spread of HIV/AIDS worldwide has led to it being designated a global epidemic. Although the full demographic impact is not expected to be felt for several more years, and perhaps will not be completely measured at the pandemic's epicenter in Sub-Saharan Africa, the emerging downward trends in life expectancy and population growth, the distortions in age structures, and the breakdown in support systems are already being seen in some countries (U.S. Census Bureau, 2002). HIV is having an increasingly serious impact on personal lives, society and the economy. Garrett (2000:287) refers to AIDS, as the first great pandemic of the twenty-first century, since neither the pandemic nor the lived experiences of people with HIV/AIDS, their families and communities can be understood in isolation from their social and historical contexts. It is now imperative that all businesses have to respond proactively to the many challenges of AIDS.

AIDS is the number four cause of death globally, but the number one cause of death in Africa (U.S. Census Bureau, 2002). With the rising HIV prevalence and clear evidence of the adverse impact of the epidemic on business in South Africa, companies should not be seen lagging behind with regard to the implementation of HIV/AIDS policies and programmes. The South African Business Coalition on HIV/AIDS (SABCOHA) insists that the response of businesses towards HIV/AIDS needs to be speeded up (McDonald, 2003). It is hoped that the results of the survey conducted by SABCOHA will force the business sector, in particular the hospitality sector to take more serious further action against HIV/AIDS in the workplace. The importance of health issues, such as HIV/AIDS, and their potential impact on the hospitality industry has been underlined in IH&RA research and high level 'think-tanks' on human resources and safety and security. By confronting HIV/AIDS directly and responsibly, hoteliers and restaurateurs must join the many businesses around the world already leading the fight against HIV/AIDS by developing effective workplace policies and supportive environments.

To design effective educational interventions, it is critical that the programme be geared towards changing knowledge, attitudes, beliefs and practices (Mohammed, 1999:203). It is also important that the employees be fully informed in order to understand the epidemic, reduce risky behaviours, and protect themselves from further spread of the infection. Hertog and Fan (1995:545-574) suggest that educational programmes on HIV/AIDS should focus on clarifying specific misunderstandings, misconceptions, and myths related to mode of transmission.

The success of any AIDS programme requires the support of senior management, (Barrows, *et al.*, 1996:5-9). Once the programme is supported by top management, the next step is to develop a policy on AIDS in collaboration with representatives of the levels of the workforce and trade unions. Despite the business impact and widespread concern about AIDS, many organisations are reluctant to develop policies or educational programmes. Some of the reasons for this complacency vary from the belief that AIDS will not affect their employees, but these attitudes will need to change, as AIDS in the workplace becomes a more serious issue.

## CHAPTER THREE

### RESEARCH METHODOLOGY

#### 3.1 INTRODUCTION

A baseline KAP study was conducted to investigate the *Knowledge, Attitudes and sexual and Practices* (KAP) of HIV/AIDS among hotel staff, at the Protea group of hotels in Cape Town. The study was also limited to hotel staff only and did not include hotel guests. The objectives of the study were to obtain:

- The employees' current *knowledge and understanding* of HIV/AIDS
- Their *attitudes* towards HIV/AIDS and people living with HIV
- Their *lifestyles and their sexual behaviour and practices*

The benefits of conducting the baseline KAP survey will assist the Protea hotel group to develop intervention HIV/AIDS programmes where necessary and address the main issues relating to their HIV/AIDS strategies. A future KAP survey will also measure the employees' knowledge, attitudes and behaviour changes that result from the HIV/AIDS training and education programmes. Furthermore, since there is a dearth of research in the area of HIV/AIDS in the hospitality industry generally, and specifically in South Africa, the researcher was motivated to conduct this specific study.

This chapter outlines the research methodology used in the KAP survey at the Protea group of hotels.

#### 3.2 STUDY DESIGN

A cross-sectional descriptive study was conducted to collect the data from staff members of nine hotels in the Protea Group of Hotels in Cape Town, namely:

- Protea Head Office, Sea Point
- Protea Hotel Riviera
- Protea Hotel Breakwater Lodge
- Protea Hotel Cape Castle
- Protea Hotel President Hotel
- Protea Hotel Pier Place
- Protea Hotel Sea Point
- Protea Hotel Tygervalley
- Protea Hotel Victoria Junction

### 3.3 SAMPLE

There were a total number of 525 staff members at the nine hotels of the Protea Group of Hotels in Cape Town. A survey sample size of 38% (n=200) was identified using the formula of the stratified random sampling method and the random sample number table (Fleiss, 1981:45):

*Number of employees at the hotel X sample size (200) / total number of employees (525).*

### 3.4 INSTRUMENTS

The study was conducted to investigate their *knowledge of, attitudes towards, and sexual practices* regarding HIV/AIDS in order to generate data relating to the research objectives of the study. A structured anonymous questionnaire, in English (Appendix II), was administered to 200 hotel employees at their respective hotels, from nine Protea hotels in Cape Town. The questionnaire consisted of mostly closed-ended questions and nine open-ended questions, and comprised of three sections. Section A comprised of general demographic questions. Section B comprised of KAP questions, where data could be obtained about respondents' knowledge, attitudes and sexual practices relating to HIV/AIDS. Questions in Section C were to determine the respondents own HIV/AIDS risk.

In order to improve internal validity, the questionnaire was piloted to ensure that participants understood the content of the questions and provided appropriate responses, and where necessary, the adjustments to the questionnaire were made.

### **3.5 DATA ANALYSIS**

Standard qualitative and quantitative research methods were applied to generate the data using the Microsoft Excel computer software programme and the statistical computer package (SPSS) for Social Sciences. With the assistance of a qualified statistician, the quantitative data was analysed using (SPSS) for various statistical tests, which generated tables, bar charts, histograms, chi-square test and Pearson's correlations (Wisniewski, 2004:38-54). The qualitative data was analysed into conceptual categories using the constant comparative method.

### **3.6 ETHICS**

Written permission was granted to the researcher in July 2004, by the Human Resources Director, Mr Gary Walker of the Protea Group of Hotels, (Appendix I), to conduct the study within the Protea Group of Hotels in Cape Town in terms of the research proposal forwarded to the Company.

The Cape Peninsula University of Technology (formerly the Cape Technikon) Ethics Committee approved the Research Proposal in August 2004. Strict confidentiality was maintained in administering the questionnaire to the hotel staff at the Protea Hotels. Participants responding to the questionnaires have remained anonymous. Participants placed the completed questionnaires in unmarked sealed envelopes provided by the researcher. Three days after the questionnaire was administered, a research assistant was assigned by the researcher to collect the sealed envelopes containing the completed questionnaires from the general managers or their secretaries of the nine respective Protea Hotels.



## CHAPTER FOUR

### RESULTS

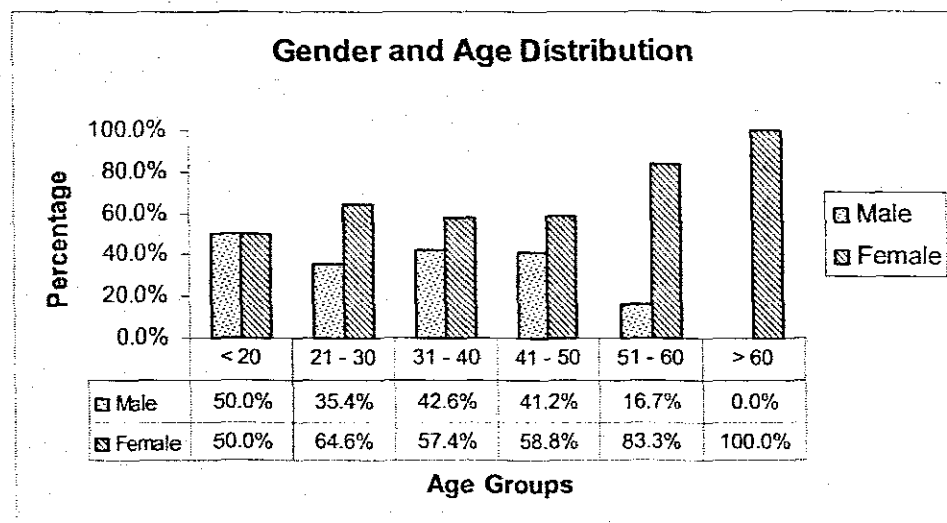
#### 4.1 INTRODUCTION

A sample of 200 hotel staff (38%) was selected from a total of 525 staff members from nine hotels of the Protea Group of Hotels in Cape Town. The objective of the study was to investigate the *Knowledge, Attitudes and Practices* regarding HIV/AIDS among the hotel staff, using the stratified random sampling method (Fleiss, 1981:45). A response rate of 161 (81%) was achieved from the anonymous questionnaire administered to the hotel staff employees. It is important to note that some of the respondents did not respond to all the questions.

#### 4.2 DEMOGRAPHIC DATA

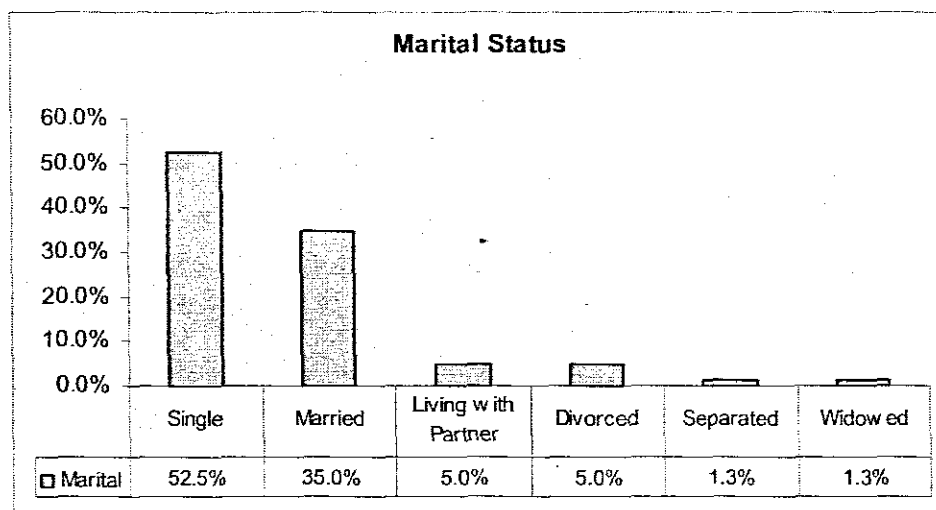
The gender distribution was (61.7%) female and (37.8%) male. The majority (49.1%) of the respondents was between the age group of 21-30 years, with more females (64.6%) than males (35.4%) in this group; followed by the 31-40 year age group (33.5%). The gender and age distribution of the respondents is shown in Figure 5.

Figure 5: Gender and Age Distribution



The historical racial classification of the respondents ranged from Coloured (45.0%), Black (28.1%), White (25.0%), Indian (1.3%) and other (.6%). More than half of the respondents were single (52.5%), married (35.0%), living with a partner (5.0%), divorced (5.0%), separated (1.3%) and widowed (1.3%) (Figure 6).

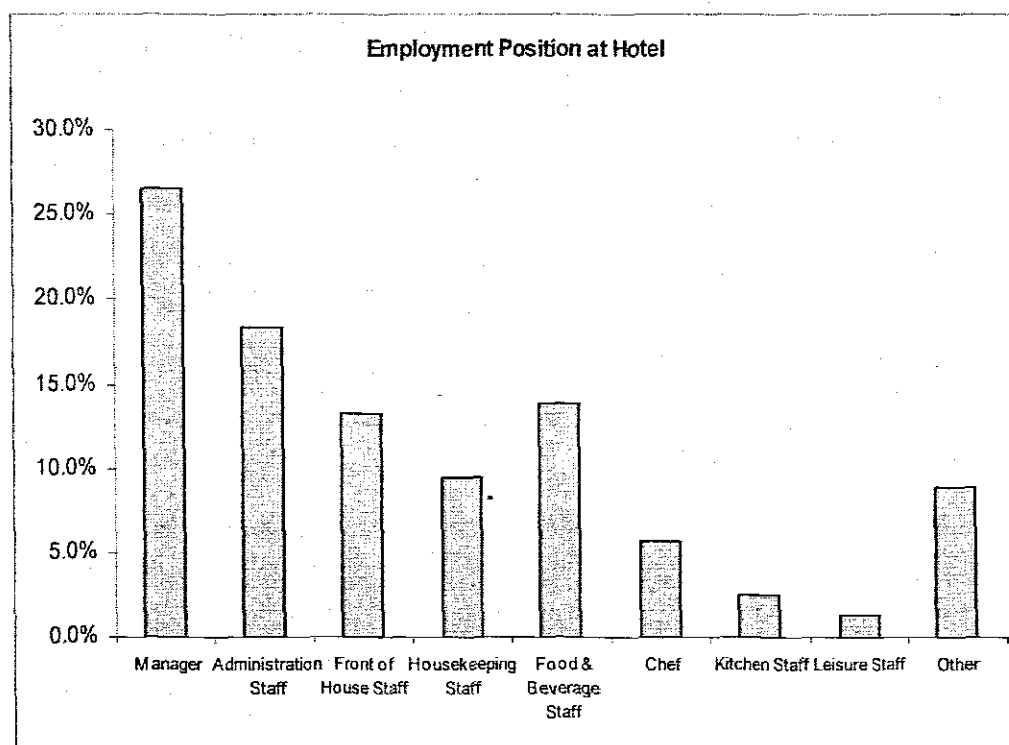
Figure 6: Marital Status



The majority of the respondents (73.1%) were the bread winners of their family. The highest educational qualification was matriculation (50.3%), a diploma (21.4%), followed by a certificate (12.6%), degree (6.9%), and other (8.8%).

In response to the years of service given to the hotel industry, the responses ranged in terms of years from 5-10 (30.0%), 3-5 (25.0%), in excess of 10 years (22.5%), between 1-2 years (16.3%) and less than one year of service (6.3%). The majority of the respondents were managers (26.6%), administrative staff (18.4%), front of house staff (13.3%), housekeeping staff (9.5%), food and beverage staff (13.9%), chef (5.7%) kitchen staff (2.5%) leisure (1.3%) and other (8.9%) (Figure 7).

Figure7: Employment position at hotel



### 4.3 KNOWLEDGE OF HIV/AIDS

The following tables and figure refer to the respondents' knowledge of HIV/AIDS in terms of how the disease can be transmitted (Table 1), the myths about HIV/AIDS (Figure 8) and their perceptions of how HIV/AIDS could be prevented (Table 2 and Table 3). It is important to note that not all the respondents completed all the questions relating to their knowledge of HIV/AIDS.

From Table 1, it can be seen that the hotel staff have a reasonably good knowledge on how HIV/AIDS is transmitted. Table 4 dispels some of the myths about HIV/AIDS, that the HI virus cannot be transmitted by everyday casual and physical contact such as touching, kissing, hugging, sharing food and cooking utensils or using the same toilet of an infected person. It is, however, observable that 13% believed that by kissing an HIV-infected person, the disease could be transmitted, as illustrated in Figure 8.

Table 1: HIV/AIDS transmission

HIV/AIDS CAN BE TRANSMITTED BY:	NO. OF RESPONDENTS	YES	NO	DON'T KNOW
Unprotected sex	157	155(98.7%)	1(.6%)	1(.6%)
Rape	146	143(97.9%)	1(.7%)	2(1.4%)
Sharing needles in intravenous drug abuse	143	138(96.5%)	1(.7%)	4(2.8%)
Mother to child	141	132(93.6%)	5(3.5%)	4(2.5%)
Blood transfusion	141	130(92.2%)	8(5.7%)	3(2.1%)
Needle stick injury	130	105(80.8%)	9(6.9%)	16(12.3%)
Sharing the same razor blades	132	105(79.5%)	15(11.4%)	12(9.1%)
Breastfeeding	128	87(67.9%)	20(15.6%)	21(16.4%)
Tattoos and ear-piercing	129	82(63.6%)	25(19.4%)	22(17.1%)
Cultural/tribal circumcision	122	57(46.7%)	34(27.9%)	31(25.4%)

Figure 8: Myths about AIDS

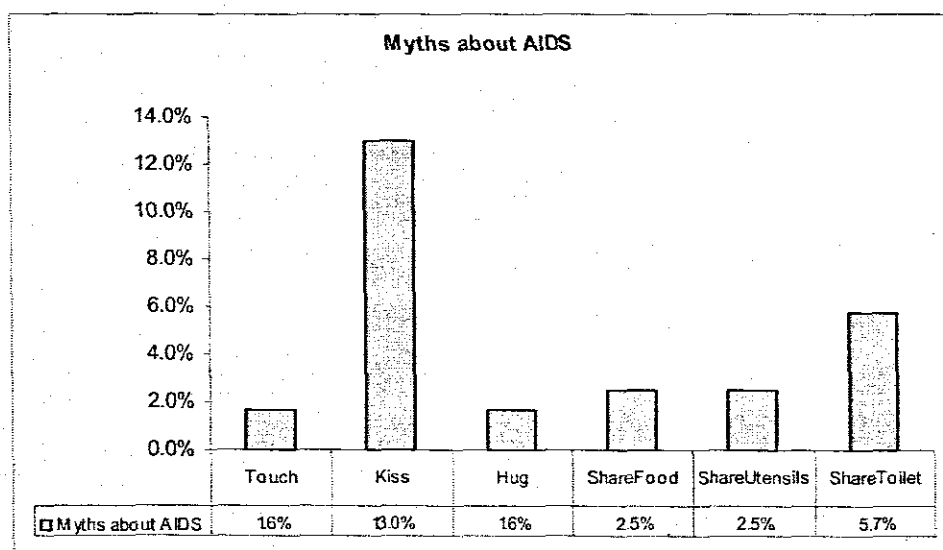


Table 2 shows the frequency with which the respondents believed that HIV/AIDS can be prevented by treating sexually transmitted diseases (74.6%), by taking antibiotics (33.9%), eating good healthy nutritional meals (61.8%), and doing regular exercise (39.5%).

Table 2: HIV/AIDS prevention

HIV/AIDS CAN BE PREVENTED BY:	NO. OF RESPONDENTS	YES	NO	DON'T KNOW
Treating sexually transmitted diseases without delay	130	97(74.6%)	28(21.5%)	5(3.8%)
Taking antibiotics	118	40(33.9%)	63(53.4%)	15(12.7%)
Eating good healthy nutritional meals	123	76(61.8%)	45(36.6%)	2(1.6%)
Doing regular exercise	114	45(39.5%)	61(53.5%)	8(7.0%)

Table 3 indicates that the respondents strongly believe that HIV/AIDS could be prevented with the relevant education and training in schools, colleges, universities (98.5%), religious institutions (97.7%), and the workplace (98.5%).

Table 3: HIV/AIDS prevention

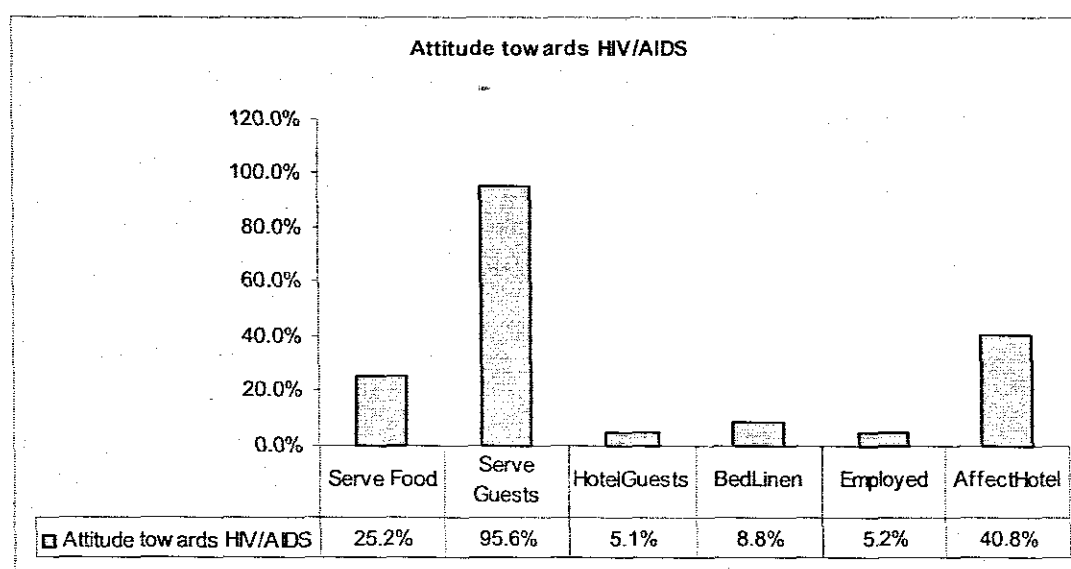
HIV/AIDS COULD BE PREVENTED BY:	NO. OF RESPONDENTS	YES	NO	DON'T KNOW
HIV/AIDS education at schools/colleges/universities	130	128(98.5%)	2(1.5%)	0%
HIV/AIDS education at religious institutions	128	125(97.7%)	2(1.6%)	1(.8%)
HIV/AIDS education at workplace	131	129(98.5%)	2(1.5%)	0%

#### 4.4 ATTITUDES TOWARDS HIV/AIDS

Less than half (40.8%) of the respondents believed that the HIV/AIDS pandemic would affect the hotel industry. The remaining participants responded negatively or did not know whether the hotel industry would be affected by the HIV/AIDS pandemic.

A quarter of the respondents (25.2%) of the respondents did not want an HIV positive staff to prepare or serve food. Nearly all (95.6%) indicated that would include the serving of food to HIV positive guests in the restaurant or hotel. Only 5.2% objected to HIV positive or AIDS infected guests checking into the hotel, and 8.8% of the respondents had concerns about being infected by handling dirty bed linen from HIV infected guests. A small minority of (5.2%) had reservations about the hotel employing HIV positive individuals in their department or hotel (Figure 9).

Figure 9: Attitude towards HIV/AIDS



#### 4.5 SEXUAL BEHAVIOUR AND PRACTICES REGARDING HIV/AIDS

Over two thirds (62.9%) of the respondents reported having been tested for HIV/AIDS, 37.7% disclosed the results to a partner, friend (21%), family member (32.1%), and to colleagues (16%).

##### 4.5.1 Gender in relation to sexual activity

Table 4 shows that the males (88.0%) were currently more sexually active than the females (64.9%).

*There is a significant relationship between gender and being sexually active (p-value <0,01) using Pearson Chi-Square.*

**Table 4: Gender and sexual activity (Cross tabulation)**

		Sexual Activity		Total
		Yes	No	
Gender	Male	53	7	60 (88.0%)
	Female	63	34	97
Total		116	41	157

#### 4.5.2 Gender in relation to multiple sexual partners

Table 5 shows that the more males (42.9%) than females (26.6%) had more than one sexual partners in the past three years.

*There is a significant relationship between gender and the number of sexual partners ( $p$ -value  $< 0,01$ ) using the Pearson Chi-Square.*

**Table 5: Gender and multiple sexual partners in the past three years (Cross tabulation)**

		Multiple sexual partners in the past three years		Total
		Yes	No	
Gender	Male	24	32	56 (42.9%)
	Female	20	55	75
Total		44	87	131

#### 4.5.3 Age in relation to sexual activity

Table 6 shows that 74.3% of the respondents in the age group of 21-30 years and 77.7% of the 31-40 years age group were sexually active.

*There is no significant relationship between age and being sexually active using Pearson Chi-Square.*

**Table 6: Age and sexual activity (Cross tabulation)**

		Currently sexually active		Total
		Yes	No	
Age	< 20 years	2	2	4
	21 – 30	58	20	78 (74.3%)
	31 – 40	42	12	54 (77.7%)
	41 – 50	10	5	15
	51 – 60	4	1	5
	> 60	0	1	1
Total		116	41	157

#### 4.5.4 Age in relation to multiple sexual partners

21-30 year old age group (46.7%) had more than one sexual partner in the past three years. *There was a significant relationship between age and the number of sexual partners (p-value <0.05) using the Pearson Chi-Square.*

**Table 7: Age and multiple sexual partners in the past three years (Cross tabulation)**

	Multiple sexual partners in the past three years		Total
	Yes	No	
<b>Age</b>			
<20	1	1	2
(21-30)	29	33	62 (46.7%)
(31-40)	9	40	49
(41-50)	5	8	13
(51-60)	0	4	4
>60	0	1	1
<b>Total</b>	44	87	131

#### 4.5.5 Condom use

Although single people (87.5%) and the highest rank in the hotel, managers (90%) reported the use of condoms, Tables 8 and Table 9 show that there is no significant relationship between marital status and condom use and employment position and condom use.

**Table 8: Marital status and condom use (Cross tabulation)**

	Condom Usage		Total
	Yes	No	
<b>Marital status</b>			
Single	70	10	80 (87.5%)
Married	43	12	55
Living with Partner	7	1	8
Divorced	5	1	6
Separated	2	0	2
Widowed	1	1	2
<b>Total</b>	128	25	153



**Table 9: Employment position and condom use (Cross tabulation)**

	Condom Use		Total
	Yes	No	
<b>Employment Position at Hotel</b>			
Manager	36	4	40 (90%)
Administration staff	24	5	29
Front of house staff	16	3	19
Housekeeping staff	12	3	15
Food & Beverage staff	18	3	21
Chef	7	2	9
Kitchen staff	2	1	3
Leisure staff	2	0	2
Other	10	3	13
<b>Total</b>	127	24	151

#### 4.5.6 Effectiveness of condoms and frequency of condom use

In response to the effectiveness of condoms, 80.9% of respondents believed that condoms were effective, but not 100% safe in the prevention of HIV/AIDS but only 32.7% of the respondents indicated that they used a condom every time when sexually active (Table 10). *There seems to be no significant relationship between condom effectiveness and condom use.*

**Table 10: Belief of condom effectiveness and use of condom (Cross tabulation)**

		Condom Use			Total
		Every time	Sometimes	Never	
<b>Condom effectiveness</b>	100% Effective	3	3	0	6
	Effective, but not 100%	18	29	8	55 (32.7%)
	Only slightly effective	0	1	1	2
	Not effective at all	1	0	0	1
	Don't know	2	1	3	6
<b>Total</b>		24	34	12	70

#### 4.5.7 Gender in relation to sexual activity and frequency of condom usage

In response to being sexually active, the affirmative responses were followed by whether they had more than one partner in the past three years, and then followed by whether they used a condom every time, sometimes or never. Only 71 persons responded to all three questions and 33.8% indicated having used a condom every time they were sexually active, while 47.9% sometimes and 18.3% responded to never having used a condom.

Table 11 shows that males are more sexually active than females and only 37.5% used a condom every time, 46.9% used it sometimes, while 15.6% never used one. *There is no significant relationship between gender, sexually active and condom use.*

**Table 11: Gender and frequency of condom use (Cross tabulation)**

Gender			Frequency of condom use			Total
			Every time	Sometimes	Never	
Male	Are you currently sexually active?	Yes	12	15	5	32 (37.5%)
		No	1	1	0	2
	Total		13	16	5	34
Female	Are you currently sexually active?	Yes	9	12	6	27
		No	2	6	2	10
	Total		11	18	8	37

#### 4.5.8 Age in relation to sexual activity and frequency of condom use

In the age-group 21-30 years, only 33.3% use a condom every time, 60.6% use a condom sometimes and 6.1% never, (Table 12). *Although 60.6% use a condom sometimes when sexually active, there is no significant relationship between age, being sexually active and frequency of frequency condom use.*

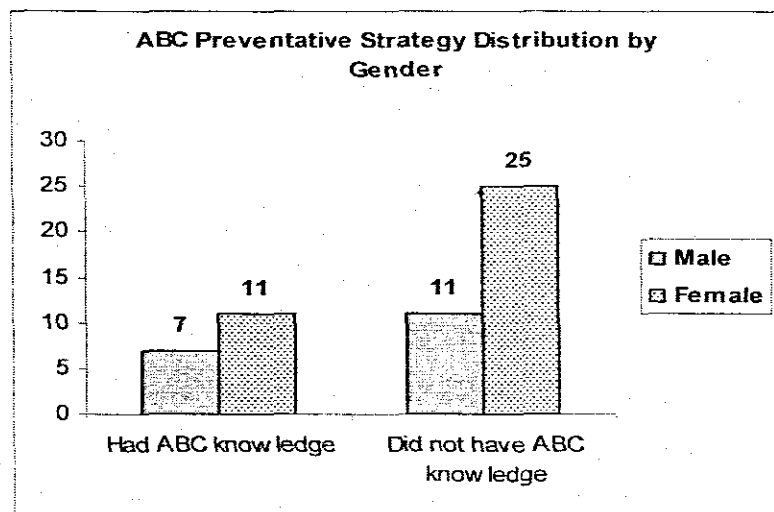
**Table 12: Age and frequency of condom use (Cross tabulation)**

Age			Frequency of condom use			Total
			Every time	Sometimes	Never	
< 20 years	Are you currently sexually active?	Yes	1	1		2
		Total	1	1		2
	21 – 30	Are you currently sexually active?	Yes	11	20	2
No			2	2	1	5
Total			13	22	3	38
31 – 40	Are you currently sexually active?	Yes	6	5	6	17
		No	0	5	0	5
	Total		6	10	6	22
41 – 50	Are you currently sexually active?	Yes	3		1	4
		No	1		1	2
	Total		4		2	6
51 – 60	Are you currently sexually active?	Yes		1	2	3
	Total			1	2	3

#### 4.5.9 The 'ABC' preventive strategy

Figure 10 depicts the level of knowledge of the 'ABC' preventive strategy, where A (Abstinence), B (Be faithful) and C (Condomise), in relation to gender distribution. Only 54 persons responded to all three questions of which (33.3%) had knowledge of the 'ABC' preventive strategy, (38.8%) males and (61.1%) females.

Figure 10: ABC Preventive strategy distribution by gender



#### 4.5.10 Relationship between Knowledge, Attitudes and Sexual Practices

The following variables representing Knowledge (K), Attitude (A) and Practice (P) were created using categorical principle components using the SPSS Categorical Principal Components Analysis (CATPCA). Values of the three variables were calculated for each respondent and bivariate correlations were calculated for the three variables using the factor analysis technique to reduce *knowledge* variable to one single variable. This technique assigned a value based on the results to all 161 respondents, and the same technique was used for the variable *attitude* and sexual practice. Only 39 cases were used to calculate these three variables, being the total responses to all three variables, but scores were assigned to all 161 cases and the correlations below are based on all the scores (Table 13). There is a *significant relationship between the knowledge and attitude variables* ( $p$ -value  $< 0.05$ ). However there is no significant relationship between knowledge and practice and between attitude and practice.

**Table 13: Correlations between Knowledge, Attitude and Sexual Practice**

		Knowledge	Attitude	Practice
<b>Knowledge</b>	Pearson Correlation	1	0.174	-0.008
	p-value		<b>0.028</b>	0.925
	N	161	161	161
<b>Attitude</b>	Pearson Correlation	0.174	1	0.065
	p-value	0.028		0.412
	N	161	161	161
<b>Practice</b>	Pearson Correlation	-0.008	0.065	1
	p-value	0.925	0.412	
	N	161	161	161

Correlation is significant at the 0.05 level (2-tailed).

The study has provided the following information about the hotel staff:

- Their current *knowledge* and understanding of HIV/AIDS;
- Their *attitudes* towards HIV/AIDS and people living with HIV;
- Their lifestyles and *sexual practices* and behaviour; and
- Their own health risk in terms of being *sexually active* and *condom usage*.

## CHAPTER FIVE

### DISCUSSION

#### Demographic data

In all KAP studies respondents were males and females. In the present study, the demographic data of the Protea hotel staff represents more females than males. The majority of the respondents at the nine hotels surveyed were between the ages 21 and 30 years. This can be compared to the survey conducted at twelve hotels in Dominican Republic, where the majority of the respondents were between the ages 17 and 29, (Forsythe *et al.*, 1998:277-286). The two surveys show that the average hotel worker in the hospitality sector is young, and not older than 30 years.

#### Knowledge of HIV/AIDS

The hotel staff in the present study demonstrated a reasonably good knowledge of HIV/AIDS. However, in another study in the hospitality sector in South Africa, nationally, low levels of HIV/AIDS knowledge were reported among 4,500 employees (Thornton, (2005:3). In the hospitality sector in Madras, India, studies reported high levels of HIV/AIDS awareness among hotel employees (Kumar, 1993:6-11), but in a further study in Madras, senior hotel management staff demonstrated increased knowledge and awareness of HIV/AIDS after attending an HIV/AIDS preventive education seminar (Zazayokwe *et al.*, 1989:4-9).

In KAP studies conducted in various formal educational settings, Ndegwa, *et al.* (2002:56-60) reported high levels of knowledge of HIV/AIDS, and its clinical symptoms among a group of students and teachers in Nairobi, Kenya, but only 80% had knowledge of preventive measures. Another study among school students and trainee teachers in Karnataka, India, demonstrated a lack of essential knowledge of HIV/AIDS and had many misconceptions about HIV/AIDS

(Agrawal, *et al.*, 1998:143-149). Findings of a study displayed glaring gaps in the factual knowledge about HIV/AIDS among 500 university students in Ankara, Turkey (Cok, *et al.*, 2001:81-99).

KAP studies in various other sectors reported that the HIV/AIDS knowledge score of residents in Indiana (USA) was low, despite the fact that they perceived to know much about AIDS (Mohammed, 1999:203). Very little knowledge of HIV/AIDS was reported by Bangladesh people seeking work overseas with false beliefs about the mode of HIV transmission (Rahman, (1999:35).

Today, more than twenty years into the epidemic, HIV specialists still encounter widespread ignorance of how HIV/AIDS is transmitted, and a general lack of awareness about HIV/AIDS (Ellison *et al.*, 2003:125). It is estimated that 90% of all HIV-infected people worldwide do *not* even know they have the virus (UNAIDS, 2004:3). A basic understanding of the factors that drive the transmission of the infection is a pre-requisite to designing any intervention and control programmes (Ellison *et al.*, 2003:61).

### **Attitudes towards HIV/AIDS**

In the present study, almost half of the hotel staff believed that the HIV/AIDS pandemic would not affect the hotel industry. HIV/AIDS is shrinking the size of the tourism and hospitality market, but Thornton (2005:6) found that more than two thirds of the employers in the hospitality sector did not have a person responsible for managing HIV/AIDS in the workplace.

McDonald (2003) reports that nine per cent of the companies surveyed nationally, showed that HIV/AIDS had a significant adverse impact on their businesses, in terms of profits, reduced labour productivity and increased absenteeism. According to Natrass (2004:1), one in five adult South Africans is HIV-positive, and AIDS deaths are expected to rise sharply until 2010. This will, no doubt, impact heavily on the 2010 Soccer World Cup (Whiteside & Sunter, 2001:83).

The present study revealed conflicting results on whether HIV-infected staff should prepare and serve food, (and to guests who were HIV positive). According to (UNAIDS & IH&RA, 1999:14), if HIV-infected blood were to be introduced to eating utensils or into food consumed by another employee or a guest, there is no danger of infection as the HIV is a fragile virus and is rapidly killed by the digestive acids. Health guidelines for hospitality sector is illustrated by Marriott International Life Threatening Disease Policy (2000:3) that an immuno-compromised person may have increased susceptibility to food borne illnesses and should be especially careful to wash their hands effectively, prepare food with proper precautions and be aware of potential entry points into their systems like open cuts and sores.

The present study showed respondents' concerns about being infected with HIV/AIDS when handling dirty linen used by HIV-infected hotel guests. The risk of disease transmission through soiled linen is negligible (UNAIDS & IH&RA, 1999:40-42), and individuals cleaning up any body fluid spills, blood spillage or blood-soiled linen are encouraged to wear disposable gloves and wash their hands after removing them. Hotel staff were also advised to follow the Basic First Aid and HIV/AIDS guidelines outlined in the Universal Precautions on HIV/AIDS.

### **Sexual practices regarding HIV/AIDS**

The present KAP study showed that more males than females were sexually active and had more than one partner in three years. More than two thirds of the hotel staff in the age group of 21-30 years were found to sexually active and less than half of that age group had more than one partner in three years, but did not use a condom every time when sexually active.

In South Africa, the HIV/AIDS epidemic is driven primarily by sexual behaviours that expose individuals to the risk of infection (Halperin & Epstein, 2004:4-6), and in this study the respondents fall into the high risk age group. In this present KAP study the hotel staff were categorised into their speciality areas. The findings showed that the majority of the hotel staff were managers, followed by

administrative staff, front of house, housekeeping, food and beverage, kitchen, leisure and entertainment staff. In a survey of hotels in Dominican Republic, hotel workers were also categorised into their specialty areas in the hotel, but the results showed that entertainment staff were engaging in most of the high risk sexual activities (Forsythe *et al.*, 1998:277-286).

In comparing the findings of the present KAP study in South Africa with the KAP survey conducted among hotel workers, in the Dominican Republic, the high risk sexually active age group is similar, with multiple sexual partners and not using condoms during sexual encounters. The KAP survey conducted in Madras, India, also showed high risk sexual behaviour amongst hotel staff with multipartnered sex without using condoms (Kumar, 1993:6-11).

Similar findings of a study in Ankara, Turkey among 500 male and female university students, showed a significant number of sexually active students, many engaging in high risk sexual activities by having unprotected sex (Cok *et al.*, 2001:81-99). High levels of unprotected sexual activity underscore the high level of sexual risk faced by young people (Harrison, 2005:266-267).

The present study showed that two thirds of the Protea hotel staff in the survey had been tested for HIV/AIDS. HIV testing was found to be effective in reducing HIV-related risk behaviour (Mathews, 2005:155), and to be instrumental in the adoption of safer sex practices (van Dyk, 2005:103).

Widespread education and associated high levels of knowledge have done little so far to contribute to a decline in HIV prevalence (Harrison, 2005:268). The present KAP study showed that there was no significant relationship between knowledge and sexual practice among staff at the Protea hotels. The findings of the study showed that although the hotel staff, majority managers, had a good level of HIV/AIDS knowledge, they continued to engage in high risk sexual activities, by having multiple partners and not using condoms. In many KAP surveys



conducted in other hospitality sectors, where a good level of HIV/AIDS awareness was reported, the hotel staff continued to show high risk sexual behaviour.

Condoms remain a pivotal part of the fight against HIV/AIDS (Myer, 2005:166) and people were more likely to change their sexual behaviour if they believed that condom use will prevent HIV infection (Van Dyk, 2005:98). In a recent study in South Africa, Mathews (2005:145) reported that among sexually active men and women, condoms were not used during most recent incidents of sexual intercourse. Many studies in sub-Saharan Africa have shown that negative attitudes of both men and women towards condoms (Myer, 2005:166). Besides abstinence, lifelong mutually faithful monogamous relationships, as well as condom usage are critical to reduce the number of discordant sexual acts, and should be promoted as part of any comprehensive prevention strategy (Abdool-Karim, 2005:251).

HIV/AIDS prevention programmes are important to increase HIV/AIDS awareness and reduce sexual risk behaviour in the hotel industry (UNAIDS, 2004:96). In a study to implement and evaluate an AIDS education intervention in a multinational hotel industry, Zazayokwe et al. (1989:4-9) adopted a three-phase intervention strategy to assess the awareness of HIV/AIDS among hotel employees, and to certify certain hotel staff to become AIDS educators in order to disseminate information to all hotel employees. Members of the management team attended an AIDS seminar to plan for preventive education and a follow up survey reflected increased AIDS knowledge and awareness. Additional research would be undertaken to evaluate attitude and behaviour change. In a South African setting outside that of the hotel industry, BMW Motor Vehicle Company, conducted successful HIV/AIDS prevention programmes which increased the level of HIV/AIDS awareness and changed the attitude of the staff towards the disease.

## CHAPTER SIX

### CONCLUSIONS AND RECOMMENDATIONS

#### CONCLUSIONS

There were more females than males that participated in the KAP survey of hotel staff at the Protea hotels in Cape Town. The average age of the respondents was between 21 and 30 years. The majority of the participants in the survey were managers.

There was a significant relationship between knowledge and attitudes ( $p$ -value $<0.05$ ), but no significance between knowledge and practice and between attitude and practice. The hotel staff demonstrated a reasonably good knowledge of HIV/AIDS, but continued to engage in high risk sexual behaviour. There were conflicting views about HIV/AIDS being transmitted by food preparation and food handling, and concerns when handling linen soiled by HIV-infected guests at the hotel. Almost half the hotel staff believed that the HIV/AIDS pandemic would not affect the hotel industry.

More males than females were currently sexually active, had more than one partner in three years and did not use a condom every time when sexually active. Although the majority of the respondents believed that condoms were effective, only one third reported the use of a condom every time they had a sexual encounter. Two thirds of the hotel staff in the survey had been tested for HIV/AIDS.

HIV/AIDS prevention programmes are important to increase HIV/AIDS awareness and reduce sexual risk behaviour in the hotel industry (UNAIDS, 2004:96). Mr Benjamin Memani, the Protea Group's new Human Resource Manager (2005 –

personal communication), confirmed that HIV/AIDS awareness education programmes do exist at the Protea group of hotels, but are not compulsory.

The results of the study concur with other studies, that the hotel industry needs to develop comprehensive HIV/AIDS strategies with appropriate programmes and interventions or be prepared to plan for future absenteeism, compassionate leave, recruitment and training of new staff and increased costs. (Thornton, 2005:45).

### **LIMITATIONS**

Although the study sample was 161 (81%), all the respondents did not answer all the questions on the questionnaire. This could be attributed to the fact that they did not know the correct answers to some of the questions, or they were not willing to reveal information. Other reasons could be that the questionnaire was lengthy and that it was self-administered, hence the researcher could not ensure that all the questions were answered. The way to have overcome this would have been to have done an administered or qualitative survey. An ideal study would have been to conduct personal interviews with the hotel staff and to have included hotel guests in the survey.

### **RECOMMENDATIONS**

By confronting HIV/AIDS directly and responsibly, hoteliers and restaurateurs must join the many businesses around the world already leading the fight against HIV/AIDS by developing effective workplace policies and supportive environments. IH&RA and UNAIDS Guide (1999:10) outline practical steps for hotels and restaurants to protect the workforce and the viability of the business in the face of the HIV epidemic. To achieve this objective, the Guide provides steps to be taken in three areas of action, (1) create a policy on HIV-related issues that is appropriate for the workplace; (2) provide HIV-prevention education and training for all employees on how to avoid HIV infections; and (3) treat with fairness all employees, especially those who are living with HIV or AIDS.

It is recommended that the management of the Protea group of hotels address the HIV/AIDS growing pandemic in the following areas:

### **1. Implement on-going HIV/AIDS education and prevention programmes**

It is recommended that HIV/AIDS prevention programmes be implemented at the Protea group of hotels, and that they should include HIV/AIDS awareness programmes and education, condom distribution, universal precautions and STD management.

These HIV/AIDS programmes may reduce sexual risk behaviour. The promotion of accurate knowledge about HIV prevention programmes to promote sexual behaviour change at the individual level, through providing people with knowledge about sexual health risks, and training them in the behavioural skills are necessary for the performance of new behaviours. An ideal HIV/AIDS control and prevention model includes voluntary counselling and testing, education and awareness, preferably by peers, provision of condoms, efforts to overcome denial, stigma and discrimination, care and treatment for people living with HIV and AIDS, the prevention of mother-to-child transmission (MTCT) of HIV and treatment of STIs.

### **2. Change unsafe behaviour and practices**

It is recommended that the Protea group of hotels promote the 'ABC' preventive strategy amongst the hotel staff.

The 'ABC' preventive strategy entails abstinence, behaviour change and promotion of male condoms. This is likely to induce appropriate 'risk-controlling' behaviour (Abdool-Karim, 2005:243-261). Promoting abstinence, safe sex and the use of condoms and ensuring the early treatment of sexually transmitted diseases are some of the steps needed. Abstinence and lifelong mutually faithful monogamous relationships are critical to reduce the number of discordant sexual acts, and should be promoted as part of any comprehensive prevention strategy.

It would also be advised to make use of 'Love Life', an organisation dealing with healthy living and sexuality. Their programmes were successfully implemented by hotel staff from the Southern Sun Hotel group.

### **3. Condom distribution among hotel staff and guests**

It is recommended that condoms be easily accessible to both men and women, distributed free of charge, if possible, in places where individuals will feel a *maximum sense of privacy and minimum embarrassment*.

Condoms are essential for safe, protected sex. They are vital for preventing the spread of HIV and all Sexually Transmitted Infections (STIs). Making condoms freely available to both employees and guests is definitely one very easy and cost-free way in which the Protea hotel group can help reduce the spread of HIV and STIS. Condoms can be distributed by installing the dispensers in the staff toilet areas, staff canteen and public cloakrooms used by guests, including guests' rooms and bathrooms. The distribution of public sector condoms has been a key part of the National Department of Health's HIV prevention strategy (Myers, 2005:170).

### **4. Obtain management/leadership buy-in to workplace programmes**

It is recommended that the management and leadership at the Protea group of hotels buy-in to the workplace programmes.

Research shows that HIV/AIDS workplace programmes are only successful if they are driven and supported by the leaders of the business, that is, the people who have the most influence (Thornton, 2005:11). The Protea hotel group could evaluate the three-phase intervention strategy used in the multinational hotel industry in Madras (Zazayokwe *et al.*, 1989:4-9). This intervention strategy was used to assess the awareness of HIV/AIDS among hotel staff to certify certain hotel staff to become AIDS educators in order to disseminate information to all hotel staff.

Members of the executive management attended an HIV/AIDS seminar, and then addressed senior, middle and supervisor management about HIV/AIDS and to plan for preventive education.

#### **5. Appoint an HIV/AIDS manager at the hotel**

It is recommended that the Protea hotel group appoints an HIV/AIDS manager and/or a task team to ensure that HIV/AIDS strategies work and delivers results, that will be responsible and accountable for successful implementation of the programmes.

#### **6. Evaluate and implement the HIV/AIDS workplace policy document**

The HIV/AIDS workplace policy defines how the company will treat employees who are living with HIV/AIDS, as well as employees who are indirectly affected by the epidemic. It has already been established that the Protea hotel group has an HIV/AIDS workplace policy in place, according to Mr Benjamin Memani (2005). It is recommended that this HIV/AIDS document be evaluated and then implemented effectively in order to achieve the desired outputs in terms of knowledge, attitudes and sexual practices of the hotel staff. It is further recommended that copies of the HIV/AIDS workplace policy be made available to all the hotel staff and that posters be displayed highlighting the key points.

#### **7. Voluntary counselling and testing**

It is recommended that the Protea hotel group provide Voluntary Counselling and Testing (VCT) for all their hotel staff. This includes confidential HIV testing, together with pre-and post-test counselling.

#### **8. First aid and healthcare education for hotel staff**

The Protea hotel group should ensure that all hotel staff are educated regarding HIV and AIDS infections, as well as other potentially infectious diseases, and that they understand and adhere to the standard operating procedures. Where

necessary the hotel will provide all relevant employees with appropriate protective clothing.

All hotel staff should receive training to help them deal with HIV/AIDS in the workplace, in terms of:

- how to deal with body fluids;
- how to deal with stained linen;
- how to deal with sanitary bins;
- how to deal with used hypodermic needles;
- how to deal with guest queries regarding HIV/AIDS and food;
- how to deal with guest queries regarding HIV/AIDS in general;
- knowledge about HIV/AIDS and cutlery, crockery, food preparation;
- knowledge about HIV/AIDS and sharing toilets; and
- how to deal with a colleague or guest who may be wounded.

#### **9. Multiskilling, recruiting and training additional labour**

In order to ensure that the production process is not vulnerable to staff losses, the Protea hotels include multiskilling, recruiting and training additional labour, contracting out, and capital intensification. The hotel employer will have to look at employee benefits, medical costs, training and recruitment costs, increased absenteeism, employee morbidity, loss of productivity, a general decline in workplace morale and possible workplace disruption.

A further recommendation would be for the Protea hotel group to conduct a follow-up KAP survey in the future, following the above recommendations, in order to assess the effectiveness of the intervention programmes.

## REFERENCES

- Abdool-Karim, Q. 1998. Epidemiology of HIV infection: new and emerging epidemics. In: *Oral Paper presented to the 12<sup>th</sup> World AIDS Conference, Geneva: 28 June – 3 July, 1998.*
- Abdool-Karim, Q. 2005. Heterosexual transmission of HIV – the importance of a gendered perspective in HIV prevention. In *HIV/AIDS in South Africa*. 1<sup>st</sup> Ed. Abdool-Karim, S.S. & Abdool-Karim, Q. South Africa: Cambridge University Press. 243-261.
- Abdool-Karim, S.S & Abdool-Karim, Q. 2005. The future of the HIV epidemic in South Africa. In *HIV/AIDS in South Africa*. 1<sup>st</sup> Ed. Abdool-Karim, S.S. & Abdool-Karim, Q. South Africa: Cambridge University Press. 567-572.
- Abdool-Karim, S.S. & Baxter, C. 2005. New prevention strategies under development and investigation. In *HIV/AIDS in South Africa*. 1<sup>st</sup> Ed. Abdool-Karim, S.S. & Abdool-Karim, Q. South Africa: Cambridge University Press. 226-240.
- Agrawal, H.K., Rao, R.S., Chandrashekar, S. & Coulter, J.B.S. 1999. Knowledge of and attitudes to HIV/AIDS of senior secondary school pupils and trainee teachers in Udupi District, Karnataka, India. *Annals of Tropical Paediatrics*. 19. 143-149.
- Alonzo, A.A. & Reynolds, N.R. 1995. Stigma, HIV and AIDS: An exploration and elaboration of a stigma trajectory. *Social Science Medicine*. 41(3) 303-315.
- Al-Owaish, R., Moussa, M.A., Anwar, S., Al-Shoumer, H., & Sharma, P. 1999. AIDS Education and Prevention: *International Society for AIDS Education*. Apr. 11(2)163-173.
- Barth, S. 2001. What you need to know about HIV. *Lodging Hospitality*. 57(7):9 June.
- Barrows, C.W., Gallo, M.; & Mulleady, T. 1996. AIDS in the US hospitality industry: recommendations for education and policy formulations. *International Journal of Contemporary Hospitality Management*. 8(1):5-9.
- BMW. 2004. *Up in arms against the spread of HIV/AIDS*. BMW South Africa HIV/AIDS Policy. [www.weforum.org/globalhealth/cases](http://www.weforum.org/globalhealth/cases)
- Campbell, C. & Cornish, F. 2003. How has the HIV/AIDS pandemic contributed to our understanding of behaviour change and health promotion? *In Learning from HIV and AIDS*. Ellison, G., Parker, M. & Campbell. United Kingdom: Cambridge University Press.



- Carael, M., Cleland, J., Deheneffe, J.C., Ferry, B & Ingham, R. 1995. Sexual behaviour in developing countries: Implications for HIV control. *AIDS*. 9:1171-1175.
- Churchyard, G. & Corbet, E. 2005. TB and HIV. In *HIV/AIDS in South Africa*. 1<sup>st</sup> Ed. Abdool-Karim, S.S. & Abdool-Karim, Q. South Africa: Cambridge University Press. 433-453.
- Cok, F., Gray, L.A. & Ersever, H. 2001. Turkish university students' sexual behaviour, knowledge, attitudes and perceptions of risk related to HIV/AIDS. *Culture, Health & Sexuality*. 3(1). 81-99.
- Coovadia, H.J. 2005. Mother-to-child transmission (MTCT) of HIV-1. In *HIV/AIDS in South Africa*. 1<sup>st</sup> Ed. Abdool Karim, S.S. & Abdool Karim, Q. South Africa: Cambridge University Press. 183-192.
- Deane, N. 2005. The political history of AIDS treatment. In *HIV/AIDS in South Africa*. 1<sup>st</sup> Ed. Abdool-Karim, S.S. & Abdool-Karim, Q. South Africa: Cambridge University Press. 538-547.
- Department of Economic and Social Affairs. 2002. *World population prospects, 2000 Revision*.
- Ellison, G.; Parker, M.; & Campbell, C. 2003. *Learning from HIV and AIDS*. United Kingdom: Cambridge University Press.
- Evian, C. 1991. *AIDS in the Workplace in Southern Africa*. South Africa: Goldfields Press.
- Fleiss, J.L. 1981. *Statistical methods for rates and proportions*. New York: John Wiley and Sons.
- Ford, N. 1991. Sex on holiday. *The HIV-related sexual interaction of young tourists visiting Torbay*. United Kingdom: University of Exeter.
- Forsythe, S., Hasbun, J. & M.B. De Lister. 1998. Protecting paradise: tourism and AIDS in the Dominican Republic. *Health Policy and Planning*. 13(3): 277-286. Oxford University Press.
- Forsythe, S. 1999. *HIV/AIDS and tourism*. *AIDS. Anal Afr.* April-May. 9(6)4-6.
- Frohlich, J. 2005. The impact of AIDS on the community. In *HIV/AIDS in South Africa*. 1<sup>st</sup> Ed. Abdool-Karim, S.S. & Abdool-Karim, Q. South Africa: Cambridge University Press. 351-370.

Galloway, M.R. 2005. 2004 antenatal survey results released. *AIDS*. Vol.14 (3)3-4.

Garrett, L. 2000. *Betrayal of Trust. The collapse of Global Public Health*. New York: Hyperion.

Gouws, E. & Abdool-Karim, Q. 2005. *HIV infection in South Africa: the evolving epidemic*. In *HIV/AIDS in South Africa*. 1<sup>st</sup> Ed. Abdool-Karim, S.S. & Abdool-Karim, Q. South Africa: Cambridge University Press. 48-66.

Gross, D & Adam-Smith D. 1995. *Organizing AIDS. Workplace and Organizational Responses to the HIV/aids Epidemic*. London: Taylor & Francis Ltd.

Halperin, D.T. & Epstein, H. 2004. Concurrent sexual partnerships help to explain Africa's high HIV prevalence: Implications for prevention. *Lancet*, 364:4-6. 3 July.

Harrison, A. 2005. Young people and HIV/AIDS in South Africa: Prevalence of infection, risk factors and social context. In *HIV/AIDS in South Africa*. 1<sup>st</sup> Ed. Abdool-Karim, S.S. & Abdool-Karim, Q. South Africa: Cambridge University Press. 262-284.

Heald, S. 1995. The power sex: reflections on the Caldwell 'African sexuality' thesis'. *Africa*. 65:489-505.

Hertog, J.K. & Fan, D.P. 1995. The Impact of Press Coverage on Social Beliefs: The Case of HIV transmission. *Communication Research*. 22(5):545-574.

Heyns, A. & Swanevelder, J.P. 2005. Safe blood supplies. In *HIV/AIDS in South Africa* 1<sup>st</sup> Ed. Abdool-Karim, S.S. & Abdool-Karim, Q. South Africa: Cambridge University Press. 203-216.

Heywood, M. 2005. The impact of HIV/AIDS on democracy in South Africa. In *HIV/AIDS in South Africa* 1<sup>st</sup> Ed. Abdool-Karim, S.S. & Abdool-Karim, Q. South Africa: Cambridge University Press. 371-383.

Hospitality Net. Industry News. IH&RA Congress. *Initiative highlights critical role of business in combating HIV/AIDS in Southern Africa*.

<http://www.hospitalitynet.org/news/html>

[19 October 1999] [An Internet citation].

International Labour Organisation (ILO). 2000. POPILO population and labour force projection; UN Department of Economic and social Affairs, Population Division (1998). *World Population Prospects: The 1998 Revision*.

Jackson, H. 2002. *AIDS Africa. – Continent in Crisis*. Zimbabwe: SAFAIDS.

Kopelman, L.M., & van Niekerk, A.A. 2002. AIDS and Africa. *Journal of Medicine and Philosophy*. 27:139-142.

Krautkramer, R. 2004. *AIDS Seminar*. Lawco (Pty) Ltd. a company specialising in HIV/AIDS in the workplace. [addaman@mweb.co.za](mailto:addaman@mweb.co.za)

Kumar, U.S. 1993: KAP study on AIDS awareness among hotel employees. *International Conference on AIDS*, 9(2): 843 June 6-11.

Leggett, T. 2005. Intravenous drug use in South Africa. In *HIV/AIDS in South Africa*. 1<sup>st</sup> Ed. Abdool-Karim, S.S. & Abdool-Karim, Q. South Africa: Cambridge University Press. 217-225.

London, L. & Myers, J.E. 1996: HIV testing in the workplace. *South African Medical Journal*. 86(4): 329-330.

Maartens, G. 2005. Prevention of opportunistic infections in adults. In *HIV/AIDS in South Africa*. 1<sup>st</sup> Ed. Abdool-Karim, S.S. & Abdool-Karim, Q. South Africa: Cambridge University Press. 454-462.

Makahye, G. 2005. Young men. In *HIV/AIDS in South Africa* 1<sup>st</sup> Ed. Abdool-Karim, S.S. & Abdool-Karim, Q. South Africa: Cambridge University Press. 313-318.

Marriott Hotel International Life Threatening Disease Policy, 2000. June. [www.weforum.org/globalhealth/cases](http://www.weforum.org/globalhealth/cases) [20 October 2004]. [An Internet citation].

Mathews, C. 2005: Reducing sexual risk behaviours: Theory and research, successes and challenges. In *HIV/AIDS in South Africa*. 1<sup>st</sup> Ed. Abdool-Karim, S.S. & Abdool-Karim, Q. South Africa: Cambridge University Press. 143-165.

McDonald, L. 2003. SA business already hit by adverse impact of HIV/AIDS. *South African Business Coalition of HIV/AIDS*. Johannesburg: Bureau for Economic Research.

Memani, B. 2005. *HIV/AIDS policy document at Protea group of hotels*. Personal communication on 25 October 2005, Cape Town, South Africa.

Metelka, C. 1986. AIDS fear could cripple Hospitality Industry. *Nation's Restaurant News*. 20(1):7 January.

Miller, A.N. Backer, T.E. & Rogers, E.M. 1997. Business education and the AIDS epidemic: responding in the workplace. *Business Horizons*. July/August. 78-86.

Mohammed, T.R. 1999. Trends of Public Knowledge and Attitudes related to HIV/AIDS in Indiana. *American Journal of Health Studies*. 15(4):203.

Mohammed, Ashraf. 2004. Interview with Cape University of Technology HIV/AIDS Institutional Co-ordinator 15 August 2004. Cape Town.

Morris, L. & Cilliers, T. 2005. Viral structure, replication, tropism, pathogenesis and natural history. In *HIV/AIDS in South Africa*. 1<sup>st</sup> Ed. Abdool-Karim, S.S. & Abdool Karim, Q. South Africa: Cambridge University Press. 79-88.

Myer, L. 2005. Barrier methods. In *HIV/AIDS in South Africa*. 1<sup>st</sup> Ed. Abdool-Karim, S.S. & Abdool-Karim, Q. South Africa: Cambridge University Press. 166-182.

Nattrass, N. 2004. *The moral economy of AIDS in South Africa*. South Africa: Cambridge University Press.

Ndegwa, D.M.; Wangechi, L.K.; Makohaa, A.; Kijungu, M.; Nyongesa, J.; Nkonge, C.; Osawa, N.; Osaki, Y.; & Muthwii, S.M. 2002. Knowledge, attitudes and practices towards HIV/AIDS among students and teachers. *Journal of National Institute of Public Health*. 51(1):56-60.

Nel, P.S., Gerber, P.D., van Dyk, P.S., Haasbroek, G.D., Schultz, H.B., Sono, T., & Werner, A. 2001. *Human Resources Management*. 5<sup>th</sup> Ed. South Africa: Oxford University Press.

Nicolay, N. 2005. Has anti-retroviral treatment worked for companies? *Metropolitan AIDS solutions communiqué*. [aidssolutions@metropolitan.co.za](mailto:aidssolutions@metropolitan.co.za).

Parkhurst, J. 2002. The Ugandan success story? Evidence and claims of HIV-1 prevention. *Lancet*. 360:78-80.

Puren, A.J. 2005. HIV diagnostics. In *HIV/AIDS in South Africa*. 1<sup>st</sup> Ed. Abdool-Karim, S.S. & Abdool-Karim, Q. South Africa: Cambridge University Press. 89-108.

Rahman, M. 1999. Knowledge, attitudes, beliefs and practices about HIV/AIDS among the overseas job seekers in Bangladesh. *Public Health*. 113(1):35.

Swanepoel, B.J., Erasmus, B.J., Van Wyk, M.W., & Schenk, H.W. 1998: *South African Human Resource Management*. Kenwyn: Juta & Co.

Swanepoel, B., Erasmus, B., Van Wyk, M., & Schenk, H. 2003: *South African Human Resource Management. Theory & Practice*. Lansdowne: Juta & Co.

Thornton, G. 2005. *HIV/AIDS Handbook for South African tourism and hospitality companies*. Cape Town: Department of Health, Theta, Fedhasa & Prodigy Business Services.

IH&RA & UNAIDS. 1999. *The Challenge of HIV/AIDS in the Workplace: A guide for the Hospitality Industry*. Geneva: UNAIDS.

UNAIDS. 2000. *Report on the Global HIV/AIDS Epidemic*. June. Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS. 2002. Joint United Nations Programme on HIV/AIDS. *Report on the Global HIV/AIDS Epidemic*. July. Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS. 2004. *Report on the global AIDS epidemic*. 4<sup>th</sup> Global Report. June. Geneva: Joint United Nations Programme on HIV/AIDS.

U.S. Census Bureau. 2002. *The AIDS pandemic in the 21<sup>st</sup> century*. International Population Reports. U.S. Agency for Internal Development. Bureau for Global Health. Office of HIV/AIDS.

Van Dyk, A. 2005. *HIV/AIDS Care & Counselling. A Multidisciplinary Approach*. South Africa: Maskew Miller Longman (Pty)Ltd.

Weinhardt, L.S., Carey, M.P., Johnson, B.T., & Bickham, N.L. 1999. Effects of HIV counseling and testing on sexual risk behaviour: a meta-analytic review of published research, 1985-1997. *American Journal of Public Health*. 89: 1397-1405.

Whiteside, A. 2005. The economic impact of AIDS. In *HIV/AIDS in South Africa*. 1<sup>st</sup> Ed. Abdool-Karim, S.S. & Abdool-Karim, Q. South Africa: Cambridge University Press. 405-418.

Whiteside, A., Sunter, C. 2001. *AIDS. The challenge for South Africa*. Cape Town: Tafelberg Publishers Ltd.

Wilson, D. & Fairall, L. 2005. Challenges in managing AIDS in South Africa. In *HIV/AIDS in South Africa* 1<sup>st</sup> Ed. Abdool-Karim, S.S. & Abdool-Karim, Q. South Africa: Cambridge University Press. 477-503.

Wisniewski, M. 2002. *Quantitative methods for decision makers*. 3<sup>rd</sup> Ed. London: Prentice Hall.

Zazayokwe, M., Christie, G., Metz, J. & Sher, R. 1989. An AIDS education. Intervention in a multinational hotel industry. *AIDS*. June 4-9.



# PROTEA HOTELS

31 August 2004

To Whom It May Concern

This letter serves to confirm that Protea Hotels has granted permission to Amina Mohammed, a Lecturer at the Cape Town Hotel School, to conduct research on HIV/ AIDS within Hotels in Cape Town managed or franchised by Protea Hotels, in terms of the Research Proposal forwarded to the Company.

Yours sincerely

G.S. WALKER  
Human Resources Director

---

HUMAN RESOURCES AND QUALITY SERVICES DEPARTMENT  
TEL: (021) 430 5000 \* FAX: (021) 430 5320  
PO BOX 75 SEA POINT 8060

This message is intended only for the use of the addressee and may contain confidential information which is subject to legal privilege. If you are not the intended recipient, you are hereby notified that any use, copying, distribution or dissemination of this communication is strictly prohibited. If you have received this message in error, please notify the sender.

**ANONYMOUS QUESTIONNAIRE  
FOR STAFF EMPLOYED IN THE HOTEL INDUSTRY**

**Introduction**

I am a post-graduate student in the Faculty of Management at the Cape Technikon, conducting research in the field of Hospitality & Tourism. I am conducting a survey on the *knowledge, attitudes and practices* (KAP) regarding HIV/AIDS among hotel staff in Cape Town, as part of the requirements for my M.Tech. in Hospitality & Tourism. Could I please have a few minutes of your time to complete this survey questionnaire so that I could use this information to assist me in the development of an effective strategy to prevent and reduce the number of HIV/AIDS cases among staff in the hotel industry.

**The objectives of the questionnaire for this KAP study is to:**

- Obtain accurate information from staff employed in the hotel industry, about their knowledge, attitudes & practices regarding HIV/AIDS.
- Evaluate data from this KAP survey, with the purpose of determining the status of the HIV/AIDS campaign in the selected hotel group in Cape Town.
- Design and develop an appropriate and effective HIV/AIDS strategy to prevent HIV/AIDS in the hotel industry based on the outcome of the KAP study.

Your participation in this study will provide invaluable information and contribute to future strategic planning for the prevention, control and management of HIV/AIDS in the hotel industry.

The questionnaire focuses on the following three areas:

- Section A: Personal details  
Section B: Knowledge, attitudes & practices regarding HIV/AIDS  
Section C: Your perceived HIV/AIDS risk

All information from the self-administered questionnaire will remain *anonymous, strictly confidential and private*. Please do not place your name on the questionnaire. Once you have filled in the questionnaire, *please place it in the unmarked envelope provided*.

Please feel free to contact me should if you require any clarification on the questions or the KAP survey.

**Amina Mohammed, Lecturer, Cape Town Hotel School, Cape Technikon  
021-440-5717 or 082-4268407**

**Thank you very much for your participation and co-operation.  
It is much appreciated.**

**ANONYMOUS QUESTIONNAIRE  
FOR STAFF EMPLOYED IN THE HOTEL INDUSTRY**

**Introduction**

I am a post-graduate student in the Faculty of Management at the Cape Technikon, conducting research in the field of Hospitality & Tourism. I am conducting a survey on the *knowledge, attitudes and practices (KAP)* regarding HIV/AIDS among hotel staff in Cape Town, as part of the requirements for my M.Tech. in Hospitality & Tourism. Could I please have a few minutes of your time to complete this survey questionnaire so that I could use this information to assist me in the development of an effective strategy to prevent and reduce the number of HIV/AIDS cases among staff in the hotel industry.

**The objectives of the questionnaire for this KAP study is to:**

- Obtain accurate information from staff employed in the hotel industry, about their knowledge, attitudes & practices regarding HIV/AIDS.
- Evaluate data from this KAP survey, with the purpose of determining the status of the HIV/AIDS campaign in the selected hotel group in Cape Town.
- Design and develop an appropriate and effective HIV/AIDS strategy to prevent HIV/AIDS in the hotel industry based on the outcome of the KAP study.

Your participation in this study will provide invaluable information and contribute to future strategic planning for the prevention, control and management of HIV/AIDS in the hotel industry.

The questionnaire focuses on the following three areas:

- |            |   |
|------------|---|
| Section A: | Personal details                                    |
| Section B: | Knowledge, attitudes & practices regarding HIV/AIDS |
| Section C: | Your perceived HIV/AIDS risk                        |

All information from the self-administered questionnaire will remain *anonymous, strictly confidential and private*. Please do not place your name on the questionnaire. Once you have filled in the questionnaire, *please place it in the unmarked envelope provided*.

Please feel free to contact me should if you require any clarification on the questions or the KAP survey.

**Amina Mohammed, Lecturer, Cape Town Hotel School, Cape Technikon  
021-440-5717 or 082-4268407**

**Thank you very much for your participation and co-operation.  
It is much appreciated.**



<b>ANONYMOUS QUESTIONNAIRE FOR THE HOTEL INDUSTRY SECTION A - DEMOGRAPHY</b>
--

**1. Gender (Tick ONE response)**

a.	Male	
b.	Female	

**2. Age (Tick ONE response)**

a.	<20	
b.	21-30	
c.	31-40	
d.	41-50	
e.	51-60	
f.	>60	

**3. Historical racial classification (Tick ONE response)**

a.	White	
b.	Black	
c.	Coloured	
d.	Indian	
e.	Other (specify)	

**4. Marital status (Tick ONE response)**

a.	Single	
b.	Married	
c.	Living with partner	
d.	Divorced	
e.	Separated	
f.	Widowed	

**5. Who is the main financial provider of the household? (Tick ONE response)**

a.	Yourself	
b.	Partner	
c.	Other	

**6. Highest educational qualification (Tick ONE response)**

a.	No schooling	
b.	Matric	
c.	Certificate	
d.	Diploma	
e.	Degree	
f.	Other (specify)	

**7. Years of service in the hotel industry (Tick ONE response)**

a.	<1 year	
b.	1-2 years	
c.	3-5 years	
d.	5-10 years	
e.	>10 years	

8. What is your position in the hotel? (Tick ONE response)

a.	Manager	
b.	Administration Staff	
c.	Front of House staff	
d.	Housekeeping staff	
e.	Food & Beverage staff	
f.	Chef	
g.	Kitchen Staff	
h.	Leisure Staff	
i.	Other (specify)	

**SECTION B**  
**KNOWLEDGE, ATTITUDES & PRACTICES (KAP) REGARDING HIV/AIDS**

9. What is the *main* way that one can get HIV or AIDS?

--

10. Do you know the difference between an HIV positive person and a person with AIDS? (Tick ONE response)

a.	Yes	
b.	No	
b.	Don't Know	

10.1. If YES, to 10, briefly outline what you consider the *main* difference between a person who is HIV positive and a person who has AIDS.

--

11. How many people do you think become infected with HIV in South Africa daily?

--

12. How did you first come to know about HIV/AIDS? (Tick ONE response)

a.	Friends	
b.	Colleagues	
c.	Family Member	
d.	Newspaper/Magazine	
e.	TV/Radio	
f.	Books/Library	
g.	Doctor/Dentists/Nurses/Health Worker	
h.	Trade Union	
i.	Programme at Workplace	
j.	Other (Specify)	

13. What/who do you think is the origin of the AIDS virus? (Tick ONE response)

a.	Curse from God	
b.	Germ from outer space	
c.	Central Africa	
d.	United States of America	
e.	Virus designed for biological warfare	
f.	Mutation	
g.	Result of contamination/accident in genetic/science laboratory	
h.	Other (specify)	
i.	Don't know	

14. HIV/AIDS is primarily being spread by .....  
(Place ONE TICK in each block of each row for the following items)

		Yes	No	Don't Know
a.	Homosexuals			
b.	Drug Users			
c.	Pre-marital sex			
d.	Extra-marital sex			
e.	Mother-to-child transmission			
e.	Unprotected sex among heterosexuals			
e.	Other (specify)			

15. Are women at higher risk of being infected with HIV/AIDS than men?  
(Tick ONE response)

a.	Yes	
b.	No	
c.	Don't know	

16. Which of the following ways do you think it is possible for the AIDS virus (HIV) to be transmitted? (Place ONE TICK in each block of each row for the following items)

		Yes	No	Don't Know
a.	Touching someone with HIV/AIDS			
b.	Kissing someone with HIV/AIDS			
c.	Having unprotected sex with someone with HIV/AIDS			
d.	From mother with HIV/AIDS to her unborn infant			
e.	Sharing food with someone who has HIV/AIDS			
f.	Sharing cooking utensils with an HIV/AIDS person			
g.	Using the same toilet used by an HIV/AIDS person			
h.	Person who has HIV/AIDS and breast-feeding her infant			
i.	Cultural/tribal circumcision			
j.	Sharing of needles for intravenous drug abuse			
k.	Needle stick injury			
l.	Blood transfusion			
m.	Receiving organ transplantation			
n.	Tattooing/ear-piercing/scarification			
o.	Sharing the same razor blades			
p.	Handshake/hugging a person with HIV/AIDS			
r.	Rape			

17. Can one have the HIV without being sick from it or showing typical symptoms of AIDS related illnesses? (Tick ONE response)

a.	Yes	
b.	No	
c.	Don't know	

18. Do you believe that one who is HIV positive can look and feel healthy for many years? (Tick ONE response)

a.	Yes	
b.	No	
c.	Don't Know	

19. Do you believe that HIV/AIDS can be prevented? (Tick ONE response)

a.	Yes	
b.	No	
c.	Don't Know	

20. If YES, in which of the following ways can HIV/AIDS be prevented?

(Place ONE TICK in each block of each row for the following items)

		Yes	No	Don't Know
a.	Eating good healthy nutritionally balanced meals			
b.	Having sex with only one uninfected partner			
c.	Always using a condom when having sex			
d.	Regular visits to the doctor/clinic			
e.	Taking antibiotics			
e.	Regular visits to the witchdoctor/faith healer			
f.	Treating sexually transmitted diseases without delay			
g.	Delaying sex until after marriage			
i.	Legalizing homosexuality			
K	HIV/AIDS education at schools/colleges/universities			
l.	HIV/AIDS education at religious institutions			
m.	HIV/AIDS education at workplace			
n.	Regular exercise/gym/sport			

21. Do you believe that HIV/AIDS can be cured? (Tick ONE response)

a.	Yes	
b.	No	
c.	Don't Know	

22. Was the topic of HIV/AIDS discussed in any of your staff meetings/staff training programmes? (Tick ONE response)

a.	Yes	
b.	No	
c.	Can't remember/recall	

22.1. If YES, in 22, please state when this took place, & how many times (month & year). Who (title of person) discussed the topic & briefly what was discussed.

a.	When	
b.	How many times (month & year)	
c.	Who (title of person) discussed the topic	
d.	What was discussed	

23. Do you think that HIV positive staff should not prepare or serve food? (Tick ONE response)

a.	Yes	
b.	No	
c.	Don't know	

24. Would you serve a guests/s in the restaurant, if you knew the guest/s was HIV positive or has AIDS? (Tick ONE response)

a.	Yes	
b.	No	
c.	Don't know	

25. Would you object to HIV positive/AIDS guests checking into your hotel? (Tick ONE response)

a.	Yes	
b.	No	
c.	Don't know	

26. Do you think AIDS-infected guests can spread the virus to hotel staff when they handle dirty bed linen or laundry? (Tick ONE response)

a.	Yes	
b.	No	
c.	Don't Know	

27. Would you object to a staff member who is HIV positive being employed in your department/hotel? (Tick ONE response)

a.	Yes	
b.	No	
c.	Don't Know	

28. How would you treat/respond/interact with a staff member in your hotel whom you know has HIV/AIDS?

--

29. Have you ever been tested for HIV? (Tick ONE response)

a.	Yes	
b.	No	

- 29.1 If YES to 29, have you ever disclosed the results of your HIV test to anyone? (Tick ONE response)

a.	Yes	
b.	No	
c.	Don't know	

- 29.2. If YES to 29.1, to whom?

a.	Partner	
b.	Friend	
c.	Family	
d.	Colleague	
e.	Other	

- 29.3. If NO to 29.1, state reason/s why would you not disclose your HIV status to anyone?

--

30. Do you know of anyone who has HIV/AIDS or died of AIDS-related disease/s?  
(Tick ONE response)

a.	Yes	
b.	No	
c.	Don't Know	

- 30.1. If YES, to 30, have you been affected by the knowledge of this person's HIV status and/or death? (Tick ONE response)

a.	Yes	
b.	No	
c.	Don't Know	

- 30.2. If YES, to 30.1, briefly explain how you were affected?

--

31. Do you think the HIV/AIDS pandemic will affect the hotel industry at all?  
(Tick ONE response)

a.	Yes	
b.	No	
c.	Don't know	

- 31.1. If YES to 31, how? Please explain.

--

**SECTION C**  
**ASSESSING YOUR OWN HIV/AIDS RISK**

32. Briefly explain what your understanding is of 'safer sex'?

--

33. What do you think would effectively prevent/reduce HIV transmission?  
(Tick ONE response)

		Yes	No	Don't Know
a.	Practicing safe sex			
b.	Practicing 'safer sex'			
c.	HIV/AIDS Awareness campaigns			
d.	HIV/AIDS Education			
f.	Other (specify)			

34. Do you think that safer sex should be promoted amongst employees at your hotel?

a.	Yes	
b.	No	
c.	Don't know	

35. In which of the following ways are safe sex/safer sex messages being promoted at your hotel? (Place ONE tick in each block)

		Yes	No	Don't Know
a.	Staff Training			
b.	Workplace programmes			
c.	HIV/AIDS Awareness campaigns			
d.	Posters			
e.	Leaflets			
f.	Pamphlets			
f.	Leaflets			
f.	Other (specify)			

36. Have you ever used a condom? (Tick ONE response)

a.	Yes	
b.	No	
c.	Don't know	

37. Do you believe that condoms are..... (Tick ONE response)

a.	100% effective	
b.	Effective, but not 100%	
c.	Only slightly effective	
d.	Not effective at all	
e.	Don't know	

38. Are you currently sexually active? (Tick ONE response)

a.	Yes	
b.	No	

39. If YES, in 38, have you had more ONE sexual partner in the past THREE years?

a.	Yes	
b.	No	

40. If YES, in 39, have you been using a condom.....? (Tick ONE response)

a.	Everytime	
b.	Sometimes	
c.	Never	

41. Do you think using a condom will prevent HIV/AIDS? (Tick ONE response)

a.	Yes	
b.	No	
c.	Don't know	

42. Are free condoms readily available at your hotel? (Tick ONE response)

a.	Yes	
b.	No	
c.	Don't know	

42.1. If NO, to 42, do you think your hotel should provide free condoms to .....? (Tick ONE response)

a.	Staff only	
b.	Guests only	
c.	Both staff & guests	
c.	Not provide condoms on hotel premises	
c.	Undecided	

43. The main theme in the HIV/AIDS campaign is the "A-B-C" preventative strategy  
What do the three letters, A-B-C mean in the context of the HIV/AIDS campaign?

A =

B =

C =

**THANK YOU VERY MUCH FOR YOUR TIME, IT IS MUCH APPRECIATED.**